

The background is a blue-toned collage featuring various medical and technological icons. These include a stethoscope, a hand holding a pulse oximeter, a line graph, a heart rate monitor, a brain scan, a DNA helix, a circuit board, a clipboard, and a heart. A large, dark blue hexagon is centered on the page, containing the title text. A green hexagon with a white circuit-like icon is positioned above the main title.

ANNUAL REPORT

2020/21

**REGULATING
THROUGH A PANDEMIC**



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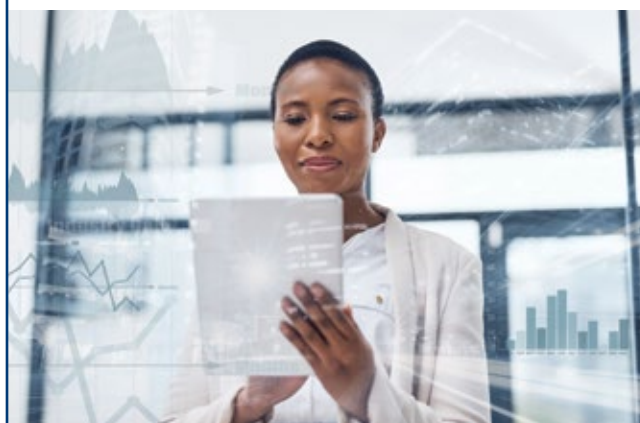
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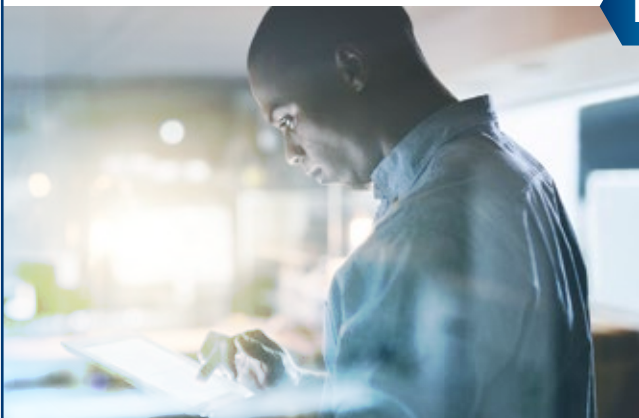
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A

PART A General information

GENERAL INFORMATION



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Chairperson of Council

Dr Memela Makiwane:
16 November 2020 (current)

Adv. Harshila Kooverjie SC:
8 August – 13 November 2020

Prof. Lungile Pepeta:
13 May – 7 August 2020 (deceased)

Dr Clarence Mini:
14 November 2017 – 12 May 2020 (deceased)



Chief Executive and Registrar

Dr Sipho Kabane



Council Secretariat

Mr Khayaletu Mvulo



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ABBREVIATIONS AND ACRONYMS

ARC	Audit and Risk Committee
AVE	Advertising Value Equivalent
BBBEE	Broad Based Black Economic Empowerment
BHF	Board of Healthcare Funders
BoT	Board of Trustees
CDL	Chronic Disease List
CMS	Council for Medical Schemes
COVID-19	Coronavirus Disease 2019
CPF	Consumer Protection Forum
DDDR	Dynamic Data Driven Return
DES	Demarcation Exemption System
DMP	Disease Management Programme
DRC	Dispute Resolution Committee
DRSaaS	Microsoft Disaster Recovery as a Service
DTP	Diagnosis and Treatment Pairs
EXCO	Executive Committee
FFS	Fee for Service
GM	General Manager
GP	General Practitioner
HFA	Health Funders Association
HIV/Aids	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HPCSA	Health Professions' Council of South Africa
HR	Human Resources
HRSE	Human Resource, Social & Ethics Committee
HSACF	Health Sector Anti-Corruption Forum
HWSETA	Health and Welfare Sector Education and Training Authority

ICT	Information and Communication Technology
KM	Knowledge Management
LCBO	Low-Cost Benefit Option
MCO	Managed Care Organisation
MoU	Memorandum of Understanding
MSA	Medical Schemes Act, No. 131 of 1998
NDoH	National Department of Health
NDP	National Development Plan
NHA	National Health Act
NHI	National Health Insurance
NomCom	Nominations Committee
PA	Prudential Authority
PFMA	Public Finance Management Act
PMB	Prescribed Minimum Benefit
POs	Principal Officers
RBC	Risk-Based Capital
SA	South Africa
SADC	Southern African Development Community
SC	Senior Counsel
SCM	Supply Chain Management
SCR	Scheme Community Rate
SIU	Special Investigating Unit
SRM	Scheme Risk Measurement
TB	Tuberculosis
The Act	Medical Schemes Act, No. 131 of 1998

FOREWORD BY THE CHAIRPERSON

The Council for Medical Schemes (CMS) was established on 1 April 2000, following the full implementation of the Medical Schemes Act (No.131 of 1998, (MSA)) in 1998. The MSA brought about critical reforms in the medical schemes industry with the incorporation of open enrolment, community rating and prescribed minimum benefits.

The CMS is tasked to provide, among others, measures for the control and coordination of medical schemes, administrators, managed care organisations and brokers, and most importantly to protect the interests of members of medical schemes.

The financial year in review was the first year of the 2020 – 2024 Strategic Plan. This strategic plan is founded on two pillars namely to improve the regulatory effectiveness and efficiency of the organisation, and for the CMS to become a central participant in the implementation of the National Health Insurance (NHI).

Regulating for purpose

In the past 20 years of existence, the CMS has regulated a dynamic, ever-changing industry. For example, on inception, the organisation regulated 144 medical schemes (47 open and 97 restricted) compared to the 75 medical schemes (20 open and 55 restricted) supervised currently. Although there are fewer medical schemes largely due to amalgamations, the industry has grown in its complexity and its demand for regulation.

The industry showed growth in the number of medical scheme members, having had just over seven million members in 2000 compared to 8.9 million in 2021. In addition, the organisation supervises 25 administrators, 41 managed care organisations, 949 broker organisations and 3 596 individual brokers.



In the past 20 years of existence, the CMS has regulated a dynamic, ever-changing industry.

In order for the organisation to be responsive and on par with the dynamic nature of the industry it regulates, Council approved a new micro and macro structure, and operating model for the CMS during the year under review. The new approach seeks to improve the CMS as an organisation, consistent with its vision to be an agile and transformative regulator to promote affordable and accessible health cover. In addition, this approach positions the CMS to be a significant player in the implementation of universal coverage in South Africa - the NHI.



As such, the CMS continued to support in the NHI War Room Steering Committee, as well as four of the workstreams. The War Room Steering Committee oversees key activities that focus on improving dialogue between stakeholders within the NHI policy space. The CMS established an NHI Regulatory Forum where different NHI policy issues are discussed within the ambit of the Medical Schemes Act. This forum also deals with Health Market Inquiry recommendations.

Regulating through a pandemic

The 2020/21 financial year has not been an easy one for the CMS. The outbreak of the coronavirus pandemic set off unprecedented ripples of health, economic, social and political challenges. Despite this, the organisation achieved its objectives, goals and targets in the 2020/21 financial year. Through the dedication of CMS staff, the organisation's overall performance score was 90%, and the organisation continued in its trajectory from unqualified to clean audit outcomes.

As a responsive regulator, the CMS put in motion various regulatory interventions to ensure the protection of the interests of members of medical schemes, while maintaining a sustainable industry in a tough climate. In concurrence with the Department of Health, COVID-19 was gazetted as a prescribed minimum benefit (PMB) condition, making way for all registered schemes to fund the diagnosis, treatment, care, vaccination and rehabilitation of the infection. The industry saw COVID-19 claims to the value of R10.10 billion in 2020.

To protect beneficiaries who were financially affected by the national lockdown and resultant limit to commercial activity, the CMS set a dispensation where medical schemes could utilise accumulated medical savings to offset member contributions.

Through this, 19 914 members were granted contribution deferrals to the value of R586.90 million, while 16 654 members received relief through their personal medical savings accounts to the value of R180.11 million.

The CMS also extended a hand to small, medium and micro-sized enterprises (SMMEs) with less than 200 employees, allowing schemes to make payment arrangements with these businesses in order to protect their employees' cover. This allowed 30 725 members to receive relief through rule amendments and the impact was R133.31 million. A further 5 447 members received other types of relief such as debt policy relaxation to the value of R53.68 million.

The CMS serves beneficiaries of medical schemes and the general public by investigating and resolving complaints related to medical schemes. A total of 2 490 complaints were resolved during the year under review and about 50% of these were resolved within 60 days. Ten appeal judgements were handed down by the Appeals Committee and Board for members who appealed rulings of the Registrar and Council.



A total of 2 490 complaints were resolved during the year under review and about 50% of these were resolved within 60 days.

CMS' regulatory tasks were increased as a result of above-mentioned exemptions and the Council had more sittings, albeit virtual sittings. Moreover, in the third quarter of the financial year, the Minister of Health, Dr Zwelini Mkhize appointed a new Council for a period of three years. I was appointed as Chairperson, supported by Ms Diane Terblanche as Deputy Chairperson.

The pandemic also had an effect on statutory obligations for the organisation – the approval of the Annual Performance Plan and budget were delayed while CMS' interaction with the Portfolio Committee on Health was also limited.

In the face of all of this, the interim report by the Section 59 Investigation Panel was released to the public for comment in January 2021. The investigation was launched as a response to allegations of bullying, coercion, racial profiling, blacklisting and non-payment of claims by black (African, Indian and Coloured) professionals and service providers against medical schemes and administrators. The Council expects that the final report will be released in the 2021/22 financial year.

The CMS continued in earnest with its fraud, waste and abuse (FWA) deliverables through a series of online FWA webinars that took place over a two-week period during March 2020. The webinars replaced the usual annual FWA Summit held in previous years.

The webinars focused on the creation of standards for the industry to effectively deal with fraudulent activities through the establishment of an FWA tribunal. In addition, the webinars set the scene for developing codes of good practice for the industry, to the benefit of members of medical schemes.

A highlight of FWA webinars was the collaboration with the Health Professions Council of South Africa on the FWA tribunal. With a memorandum of understanding in progress, the CMS is proud of this partnership as a very necessary occurrence in the quest to better co-regulate within the health care sphere.

At the time of writing this report, the CMS had also concluded cooperation agreements with the Competition Commission. As such, the CMS contributed several regulatory opinions to the Competition Commission on section 10 (1) of the Competition Act, related to mergers and amalgamations by medical schemes.

The CMS is a permanent observer on the board of the Health Quality Assessment, a non-profit organisation that assesses the clinical quality of health care offered by medical schemes through the use of health care quality indicators.

Acknowledgements

I wish to acknowledge the Minister of Health, Dr Zwelini Mkhize for the support he has consistently given the CMS during this pandemic. The Minister together with the Department of Health at large, played an important role in CMS' ability to regulate previously uncharted waters. *Ngiyabonga Khabazela.*

I convey my sincere gratitude to the previous Council of the CMS who were at the helm for seven months of the financial year and ensured a smooth transition.

To my colleagues in Council, a few months into our new term, I wish to thank you for making yourselves available to serve and protect medical scheme members through your participation in Council and at various committees. I have the utmost faith and confidence in your collective ability to steer CMS into a better future.

I also wish to extend my gratitude to the Registrar of Medical Schemes, Dr Sipho Kabane, who ran a tight ship in the past year. The CMS has achieved many successful outcomes, which would otherwise have been impossible without a dedicated captain.

To our regulated entities and industry associations, whom we often called to meetings or requested input and information at short notice, my sincere appreciation for your continued cooperation.

Finally, it would be amiss of me to not acknowledge and appreciate CMS personnel, who endured a very trying year having to suddenly work and be productive at home. Many had to restructure their lives and homes to make things work – and through this – they managed to go above and beyond. Thank you team CMS. It is a pleasure and privilege to be part of the Council for Medical Schemes.



Dr Memela Makiwane

Chairperson of the Council

Council for Medical Schemes

31 March 2021

OVERVIEW BY THE REGISTRAR AND CHIEF EXECUTIVE

The Council for Medical Schemes (CMS) is mandated to regulate the medical schemes industry, ensuring that medical scheme members are protected at all times. As an entity, the CMS had a budget of over R179 million to execute this mandate in the 2020/21 financial year.

Budget and funding

CMS' budget originates from the following sources:

- Principal scheme member once-off levies (90%)
- Revenues generated through regulatory activities (6%)
- Grant from National Department of Health (4%)



Table 1: Funding of the CMS in Rands – 2019 to 2021

Description of source	2021 R'000	2020 R'000	2019 R'000
Levies income	164 162	156 215	144 980
Accreditation fees	6 868	8 170	7 787
Inspection fees recovered	370	2 097	3 491
Legal fees recovered	2 948	–	418
Registration fees	450	469	456
Government transfers: Department of Health	6 530	6 481	5 899
Mandatory transfer: Department of Higher Education and Training	136	215	104
Sundry income	1 579	926	431
TOTAL	183 043	174 573	163 566

Table 2: Funding of the CMS in percentage of total – 2019 to 2021

Description of source	2021 %	2020 %	2019 %
Levies income	90%	89%	89%
Accreditation fees	4%	5%	5%
Inspection fees recovered	0%	1%	2%
Legal fees recovered	2%	0%	0%
Registration fees	0%	0%	0%
Government transfers: Department of Health	4%	4%	4%
Mandatory transfer: Department of Higher Education and Training	0%	0%	0%
Sundry income	1%	1%	0%
TOTAL	100%	100%	100%

Principal members of schemes, who number approximately four million, are levied a once-off amount each year. The level of levies imposed each year is subject to the concurrence and approval of the Minister of Health and of the National Treasury with the level proposed by the CMS. The level of the levy imposed on principal members in 2020/21 was R40.41 per member per annum, which represents a modest increase of R1.74 (4.5%) per principal member per annum. The levy of R40.41 was approved by Minister of Health on 28 April 2021. Table 3 shows the levies that have been imposed on principal members over the past three years and their level of contribution to the budget.

Table 3: Levies from principal members – 2019 to 2021

Description	2021	2020	2019
Levy imposed on principal members	40.41	38.67	36.13
	R'000	R'000	R'000
Actual levy income	164 162	156 215	144 980
Budgeted levy income	162 878	155 336	144 246
Contribution to total revenue	90%	89%	89%

The second stream of income that contributes to the budget of the CMS is generated through regulatory activities, which are fees charged for the registration of schemes, registration of new rules and amendments, registration, renewals of and accreditation of administrators, managed care organisations and brokers.

The tariffs charged to these entities have not been adjusted regularly and have not kept up with inflation. The CMS is in the process of appointing a Tariff Advisory Committee that will review tariffs on an annual basis. Table 4 demonstrates the revenue that has been generated by the CMS in the past three years and how this has contributed to its budget. The decline is mainly impacted by the slower than anticipated recovery of inspection and legal fees, with the decline in accreditation fees in 2021 linked to the effects of the COVID-19 pandemic.

Table 4: Revenue generated by CMS – 2019 to 2021

Description	2021 R'000	2020 R'000	2019 R'000
Accreditation fees	6 868	8 170	7 787
Inspection fees recovered	370	2 097	3 491
Legal fees recovered	2 948	–	418
Registration fees	450	469	456
Total generated income (actual)	10 636	10 736	12 152
Total generated income (budget)	7 395	19 281	9 960
Contribution to the total revenue	4%	11%	6%

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

Table 5: Funding from the National Department of Health – 2019 to 2021

Description	2021 R'000	2020 R'000	2019 R'000
Government transfers: Department of Health	6 530	6 481	5 899
Growth rate	1%	10%	3%

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

Table 6: Accumulated surplus – 2019 to 2021

Description	2021 R'000	2020 R'000	2019 R'000
Accumulated surplus/(deficit)	(17 993)	(17 645)	6 988

Expenditure trends

Table 7 illustrates expenditure patterns by the CMS over the past three years. These trends indicate that CMS expenditure increased significantly from 2019 (R175 739) to 2020 (R198 316) financial years, with a slight decrease in 2021 (R181 473) and therefore incurring a deficit. The increase in expenditure is due to regulatory work that CMS had to undertake that could not be postponed.

The incurrance of the deficit and the increased expenditure are a clear indication that the CMS has been faced with an expansionary mandate that has not been matched by its funding stream. Management is proactively working on strategies to strengthen CMS' financial sustainability. These strategies, which include cost containment, have started to bear fruit as CMS showed a significant reduction in deficit in the 2020/21 financial year in comparison to the 2019/20 financial year thus slowing down the growth in the accumulated deficit reported. Financial sustainability is identified as a significant risk that is currently being managed through a comprehensive review of the CMS funding model.

Table 7: Expenditure patterns – 2019 to 2021

Description	2021		2020		2019	
	R'000	%	R'000	%	R'000	%
Administration expenses	27 029	15%	26 619	13%	24 254	14%
Audit fees	2 583	1%	2 715	1%	2 613	1%
Operating expenses	38 936	21%	47 740	24%	35 215	20%
Staff costs	112 925	62%	121 242	61%	113 657	65%
Total expenditure (actual)	181 473	100%	198 316	100%	175 739	100%

It is important to note that the major expenditure is on personnel (62%), followed by goods and services at 36%. Given that the expenditure on personnel is fixed and extremely difficult to manage downwards without collapsing the operations, any cost-containment is only possible on goods and services.

Capacity constraints and challenges

The capacity constraints and challenges faced by the CMS must be understood in the context of the reality that we were allocated a budget of R179m in 2020/21, and yet we regulated entities that collected more than R219bn in member contributions that year. The reserves that schemes held were collectively approximately R97bn in the year in question. This apparent resource mismatch severely constrained the CMS from effectively carrying out its regulatory mandate.

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

Surplus rollover

CMS incurred an accumulated deficit of R17.9m in the year under review, and as such there will not be a surplus rollover.

Supply Chain Management

The centralisation of supply chain management (SCM) in the organisation was approved by the Council to address the inefficiencies and non-compliance challenges experienced in

previous financial periods. This process is being implemented by management and is working well in strengthening controls. In terms of the approved organisational structure, the unit is capacitated by three officials: a supply chain management manager, an officer and an administrator to implement the centralised SCM function. The financial year closed with the CMS in the process of filling the Supply Chain Officer position and recruiting an intern for further support. All other SCM positions have been filled.

SCM processes and systems

During the year under review, the CMS Supply Chain Management Structure and Standard Operating Procedure manual was developed to address the roles and responsibilities of the newly appointed officials. Furthermore, the following was carried out:

- The organisation's SCM policy was reviewed and supported by the Audit Risk Committee in March 2021 for Council approval. The review aimed to address shortcomings identified within CMS and to align it with best practice.
- The unit has developed SCM and contract management standard working procedures for uniformity and compliance.
- The CMS Loss and Control Committee is fully functional and discharging its duties in addressing non-compliance with the organisation's SCM policies and procedures, and National Treasury Regulations.

Concluded unsolicited bid proposals for the year

CMS did not entertain, award or conclude any unsolicited bid proposals in the 2020/21 financial year.

Audit report matters

The CMS obtained an unqualified audit opinion with no material misstatements on the financial statements. This is a welcomed improvement from the previous financial year. A major audit matter that is being handled is irregular expenditure incurred because of a panel of lawyers that were not appointed through a bidding process in the previous reporting periods. CMS has subsequently appointed a new legal panel through a competitive bidding process for all CMS legal matters.

Discontinued key activities

There are no key activities that the CMS discontinued during the period under discussion.

Plans for the future to address financial challenges

The financial soundness and sustainability of the CMS is intimately linked to its ability to collect and effectively utilise principal member levies in its operation and regulatory activities. The extent of the availability of the levies is in turn tied to the number of principal members that belong to medical schemes. The number of principal members of schemes is linked to the country's employment rate and the growth of the economy in general.

The current stagnant economy offers fewer employment opportunities than before and consequently limits the growth of medical schemes' membership. We are, however, convinced that these losses have not reached a significant level in the short-term to affect our sustainability. We will continue to monitor the impact of scheme member growth on the affordability and ability to pay these levies and make timely interventions when this is required.

There is internal consensus at the CMS that our funding model that is highly dependent on the levies, presents sustainability risks. The plans to revise this funding model are at an advanced stage and these are primarily aimed at accelerating revenue generating activities through regulation. This plan and its proposals are currently being discussed with key stakeholders such as National Treasury and the National Department of Health to ensure support.

Events after reporting date

The operational and regulatory challenges caused by the COVID-19 pandemic continue. There is a national vaccine roll-out that is part of the battle against the pandemic. It is our hope that this will reverse the negative impacts of the pandemic at an individual, community and national level. This intervention coupled with other measures is expected to save lives, improve the growth of the economy, increase employment and reduce poverty in our country.

The CMS is still eagerly awaiting the release of the Section 59 Investigation Report. The parliamentary hearings on the National Health Insurance have begun and the CMS will be provided with an opportunity to articulate its position on this key policy matter.

The CMS had to submit a revised budget and proposed levy increase for the 2020/21 financial year to be in line with National Treasury guidelines. The CMS levy increase for the 2020/21 financial year was approved on 29 April 2021. Medical schemes were billed for the difference subsequent to the levy approval as outlined in notes 3 and 11 of the Annual Financial Statements on page 83 of this report.

Other than what has been mentioned above, there have been no significant developments that are likely to affect the regulatory work of the CMS.

Acknowledgements

I'd like to extend my deepest gratitude and appreciation to CMS staff and management for delivering on the objectives and targets of the organisation.

The past year has been a difficult one - the odds posed by the COVID-19 pandemic were nothing we could have prepared for. Despite its impact on our lives, society, public health and the economy, CMS staff pulled together and got work done. I am immensely proud to lead a group of people who continuously live the values of professionalism, integrity, responsiveness and accountability.

I would also like to express my appreciation to the current Council of the CMS led by Dr Memela Makiwane, and the past Council, that was ultimately led by Adv. Harshila Kooverjie after the losses of Dr Clarence Mini and Prof. Lungile Pepeta. Their leadership in unprecedented times kept the organisation focused and striving to deliver on the mandates for the benefit of all medical scheme members.

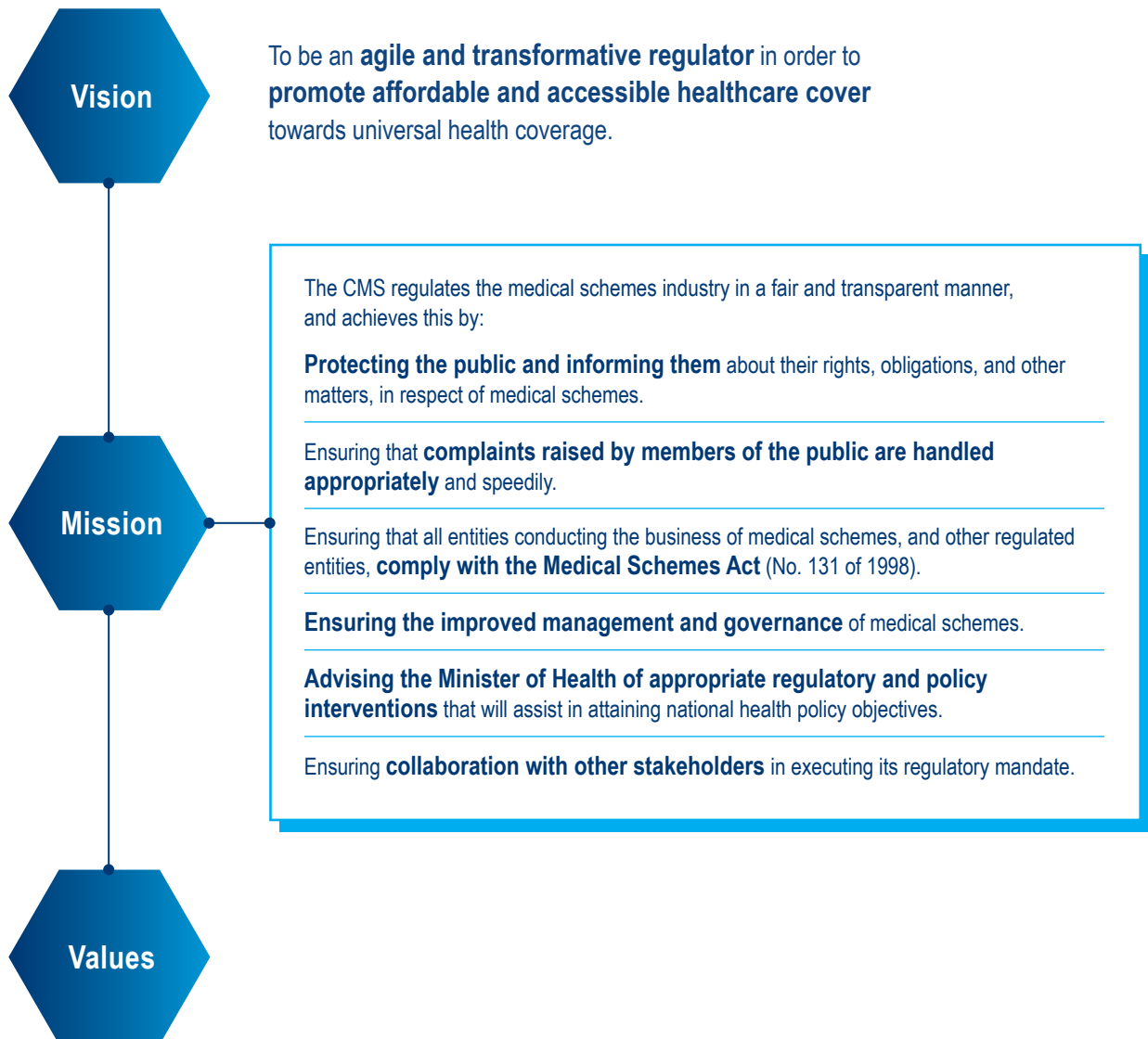


Dr Siphon Kabane

Chief Executive & Registrar
Council for Medical Schemes

31 March 2021

STRATEGIC OVERVIEW



Regulatory philosophy (external)	
Transparent	Cost-effective
Fair	Firm
Equitable	Proactive
Consultative	Independence

Shared values (internal)	
Accountability	Honesty
Ubuntu	Respect
Professionalism	Responsive
Integrity	

LEGISLATIVE AND OTHER MANDATES

Legislative mandates

Section 9 of the Constitution of the Republic of South Africa (No. 108 of 1996), states that everyone has the right to equality, including access to healthcare services. This means that individuals should not be unfairly excluded in the provision of healthcare.

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

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

The Medical Schemes Act (No. 131 of 1998) (MSA) represents such legislation, which creates the framework for non-discriminatory access to medical schemes. The MSA provides for the regulation of the medical schemes industry to ensure synchrony and consonance with the national health objectives.

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

Everyone has the right to access to:

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

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

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

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

The National Health Act, No. 61 of 2003 (NHA)

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

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

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

The Medical Schemes Act, No. 131 of 1998

The Medical Schemes Act (No. 131 of 1998) established the Council for Medical Schemes (CMS). Section 7 of the MSA confers the following functions on the CMS:

- Protect the interests of the beneficiaries at all times.
- Control and co-ordinate the functioning of medical schemes in a manner that is complementary to the national health policy.
- Make recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of the relevant health services provided by medical schemes, and such other services as the Council may from time to time determine.
- Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act.
- Collect and disseminate information about private healthcare.
- Make rules not inconsistent with the provisions of the Act for the purpose of the performance of its functions and the exercise of its powers.
- Advise the Minister of Health on any matter concerning medical schemes.
- Perform any other functions conferred on the CMS by the Minister of Health or by the Act.

Related legislation impacting and influencing the functioning of the CMS

- Council for Medical Schemes Levy Act (No. 58 of 2000) - Provides a legal framework for the Council to collect levies from medical schemes.
- Public Finance Management Act (No. 1 of 1999 (PFMA)) - Provides for the effective, efficient, and economic financial management in government departments and public entities.
- Financial Sector Regulation Act (No. 9 of 2017 (FSRA)) - Establishes a system of financial regulation by establishing the Prudential Authority and the Financial Sector Conduct Authority

National Development Plan Vision 2030

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

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

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

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

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

Policy mandates

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

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

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

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

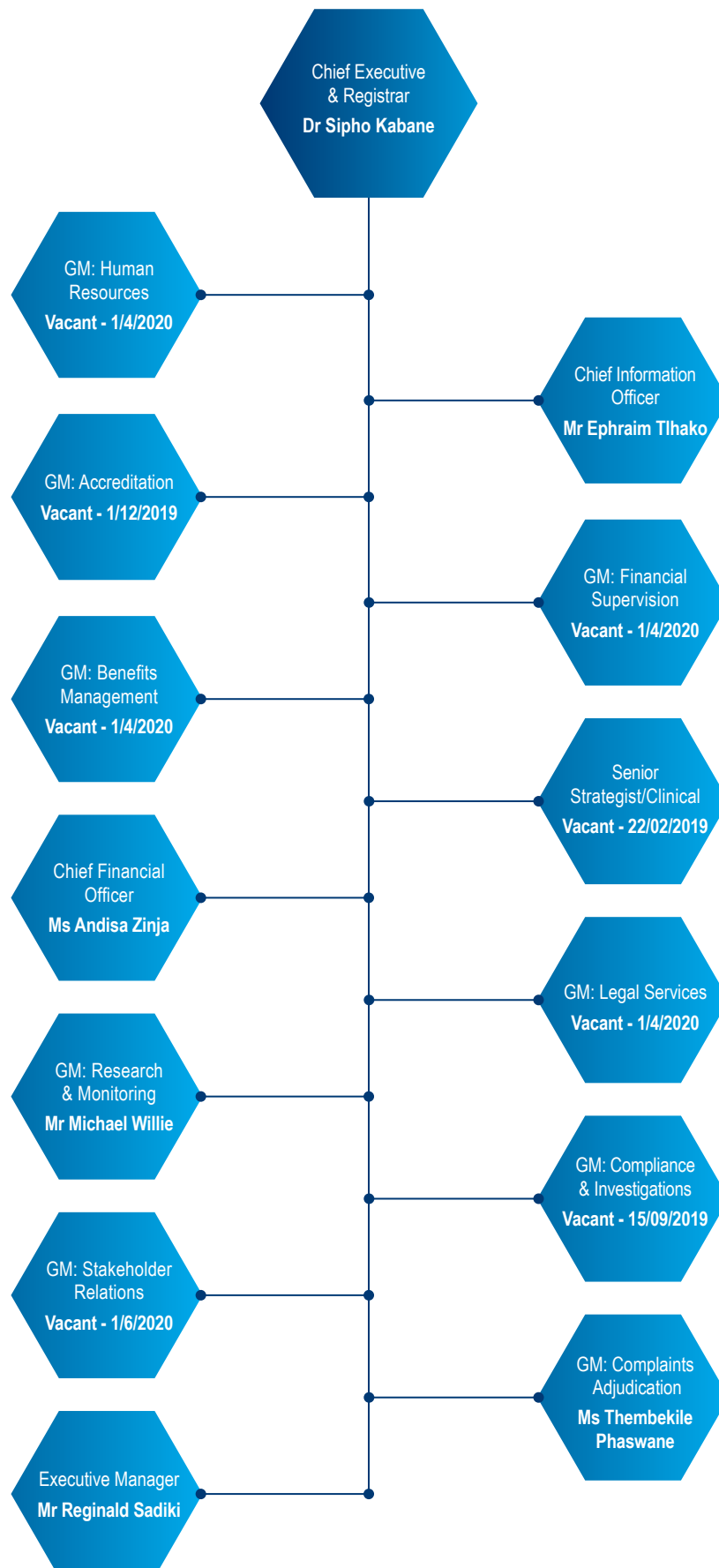
REGISTERED MEDICAL SCHEMES

Table 8: Medical schemes registered in terms of the Medical Schemes Act as at 31 March 2021

Name of medical scheme	Type
AECI MEDICAL AID SOCIETY	Restricted
ALLIANCE-MIDMED MEDICAL SCHEME	Restricted
ANGLO MEDICAL SCHEME	Restricted
ANGLOVAAL GROUP MEDICAL SCHEME	Restricted
BANKMED	Restricted
BARLOWORLD MEDICAL SCHEME	Restricted
BESTMED MEDICAL SCHEME	Open
BMW EMPLOYEES MEDICAL AID SOCIETY	Restricted
BONITAS MEDICAL FUND	Open
BP MEDICAL AID SOCIETY	Restricted
BUILDING & CONSTRUCTION INDUSTRY MEDICAL AID FUND	Restricted
CAPE MEDICAL PLAN	Open
CHARTERED ACCOUNTANTS (SA) MEDICAL AID FUND (CAMAF)	Restricted
COMPCARE WELLNESS MEDICAL SCHEME	Open
DE BEERS BENEFIT SOCIETY	Restricted
DISCOVERY HEALTH MEDICAL SCHEME	Open
ENGEN MEDICAL BENEFIT FUND	Restricted
FEDHEALTH MEDICAL SCHEME	Open
FISHING INDUSTRY MEDICAL SCHEME (FISH-MED)	Restricted
FOODMED MEDICAL SCHEME	Restricted
GENESIS MEDICAL SCHEME	Open
GLENCORE MEDICAL SCHEME	Restricted
GOLDEN ARROW EMPLOYEES MEDICAL BENEFIT FUND	Restricted
GOVERNMENT EMPLOYEES MEDICAL SCHEME (GEMS)	Restricted
HEALTH SQUARED MEDICAL SCHEME	Open
HORIZON MEDICAL SCHEME	Restricted
HOSMED MEDICAL AID SCHEME	Open
IMPALA MEDICAL PLAN	Restricted
IMPERIAL GROUP MEDICAL SCHEME	Restricted
KEYHEALTH MEDICAL SCHEME	Open
LA-HEALTH MEDICAL SCHEME	Restricted
LIBCARE MEDICAL SCHEME	Restricted
LONMIN MEDICAL SCHEME	Restricted
MAKOTI MEDICAL SCHEME	Open
MALCOR MEDICAL AID SCHEME	Restricted
MASSMART HEALTH PLAN	Restricted
MBMED MEDICAL AID FUND	Restricted

Name of medical scheme	Type
MEDIHELP MEDICAL SCHEME	Open
MEDIMED MEDICAL SCHEME	Open
MEDIPOS MEDICAL SCHEME	Restricted
MEDSHIELD MEDICAL SCHEME	Open
MOMENTUM MEDICAL SCHEME	Open
MOTO HEALTH CARE	Restricted
MULTICHOICE MEDICAL AID SCHEME	Restricted
NEDGROUP MEDICAL AID SCHEME	Restricted
NETCARE MEDICAL SCHEME	Restricted
OLD MUTUAL STAFF MEDICAL AID FUND	Restricted
PARMED MEDICAL AID SCHEME	Restricted
PG GROUP MEDICAL SCHEME	Restricted
PICK N PAY MEDICAL SCHEME	Restricted
PLATINUM HEALTH	Restricted
PROFMED	Restricted
QUANTUM MEDICAL AID SOCIETY	Restricted
RAND WATER MEDICAL SCHEME	Restricted
REMEDI MEDICAL AID SCHEME	Restricted
RETAIL MEDICAL SCHEME	Restricted
RHODES UNIVERSITY MEDICAL SCHEME	Restricted
SA BREWERIES MEDICAL AID SOCIETY (SABMAS)	Restricted
SABC MEDICAL SCHEME	Restricted
SOUTH AFRICAN MUNICIPAL UNION NATIONAL MEDICAL SCHEME (SAMWUMED)	Restricted
SASOLMED	Restricted
SEDMED	Restricted
SISONKE HEALTH MEDICAL SCHEME	Restricted
SIZWE MEDICAL FUND	Open
SOUTH AFRICAN POLICE SERVICE MEDICAL SCHEME (POLMED)	Restricted
SUREMED HEALTH	Open
TFG MEDICAL AID SCHEME	Restricted
THEBEMED MEDICAL SCHEME	Open
TIGER BRANDS MEDICAL SCHEME	Restricted
TRANSMED MEDICAL FUND	Restricted
TSOGO SUN GROUP MEDICAL SCHEME	Restricted
UMVUZO HEALTH MEDICAL SCHEME	Restricted
UNIVERSITY OF KWAZULU NATAL MEDICAL SCHEME	Restricted
WITBANK COALFIELDS MEDICAL AID SOCIETY (WCMAS)	Restricted
WOOLTRU HEALTHCARE FUND	Restricted

ORGANISATIONAL STRUCTURE



CMS COUNCIL

16 November 2020 – 31 March 2021



Dr Memela Makiwane
Chairperson



Ms Diane Terblanche
Deputy Chairperson



Adv. Thabo Mareume



Dr Aquina Thulare



Dr Honours Mukhari



Dr Leavit Mkansi



Dr Nombeko Mbava



Dr Sugendra Naidoo



Dr Thandi Mabeba



Dr Xolani Ngobese



Mr Imran Vanker



Mr Lusani Mulaudzi



Mr Mabalane Mfundisi



Mr Moerane Maimane



Mr Naheem Rahman

CMS EXECUTIVES



Dr Siphokabane
Chief Executive & Registrar



Ms Andisa Zinja
Chief Financial Officer



Mr Ephraim Tlhako
Chief Information Officer



Mr Michael Willie
GM: Research and
Monitoring



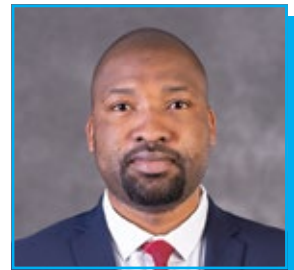
Mr Reginald Sadiki
Executive Manager



Ms Thembekile Phaswane
GM: Complaints Adjudication



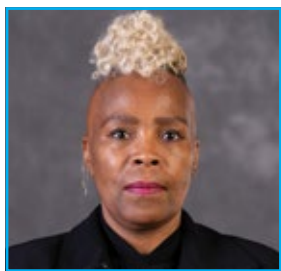
Ms Mmatsie Mphahane
Acting GM:
Stakeholder Relations



Mr John Letsoalo
Acting GM: Legal Services



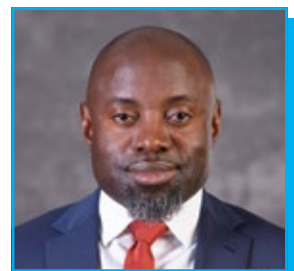
Ms Hannelie Cornelius
Acting GM: Accreditation



Ms Mpho Sehloho
Acting GM:
Benefits Management



Ms Elizabeth Figueiredo
Acting GM:
Financial Supervision



Mr Mfana Maswanganyi
Acting GM: Compliance
& Investigations



Ms Agnes Sethogoa
Acting GM:
Human Resources



B

PART B Performance Information

STATEMENT OF RESPONSIBILITY FOR PERFORMANCE INFORMATION

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

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

In our opinion, the performance information provided in this report fairly reflects the actual achievement against planned objectives, indicators, and targets which are set out in the Strategic Plan and Annual Performance Plan of the CMS for the financial year ended 31 March 2021.

The performance information of the CMS for the financial year ended 31 March 2021 has been audited by the Auditor-General of South Africa. This information, as contained on pages 33 to 62 of the 2020/21 Annual Performance Plan, has also been approved by Council, which is the Accounting Authority of the CMS.

Yours faithfully,



Dr Memela Makiwane
Chairperson of the Council

31 March 2021



Dr Siphon Kabane
Chief Executive & Registrar

31 March 2021

AUDITOR-GENERAL'S REPORT: PREDETERMINED OBJECTIVES

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

Refer to page 85 for the Report of the Auditor-General, published as Part E: Financial Information.

SITUATIONAL ANALYSIS

The situational analysis is informed by scenario planning, a strengths, weakness, opportunities and threats (SWOT) analysis, and a political, economic, social and technological (PEST) analysis, in order to identify key challenges and priorities for the CMS in the coming five years. Due to the complex nature and the volume of information generated, comprehensive presentations to this effect have been summarised with the intention to avoid overwhelming the reader.

External environment analysis

The medical schemes industry regulated by the CMS consists of various key stakeholders with diverse interests and agendas. As of March 2021 the CMS regulates 75 medical schemes, 25 administrators, 41 managed care organisations, 949 broker organisations and 3 596 individual brokers. The role of the CMS is to regulate these entities utilising the Medical Schemes Act (MSA) and Regulations to ensure that the interests of all 8.9 million scheme beneficiaries are protected. This means that the CMS should ensure that all the regulated entities are at all times compliant with the MSA and its provisions.

Impact of COVID-19

The impact of COVID-19 was felt by the CMS on both the regulatory and operational fronts. At a regulatory level, the key impacts are related to the ability of schemes to comply with their own rules, the Medical Schemes Act and its Regulations on the one hand, and the ability of the CMS to carry out its regulatory activities, on the other hand.

Some schemes were not able to conduct Annual General Meetings (AGMs) due to COVID-19 regulations. The CMS found itself being unable to conduct training sessions, investigations and inspections. Schemes were encouraged to carry out their AGMs using the virtual platforms or to postpone them. The CMS resorted to carry out its training sessions, investigations and inspections through the virtual platform.

In response to the COVID-19 pandemic, the CMS developed a guidance framework to support schemes, administrators and members, to cope with its negative impacts. This guidance framework was disseminated through the circulars that were regularly published.

The job-shedding and salary cuts that employers implemented as a result of COVID-19, also impacted member's ability to pay monthly contributions. The reduced income experienced by some members resulted in affordability constraints, which were evidenced in benefit option buy-downs. The CMS, encouraged and guided schemes to seek exemption from compliance with certain specific provisions of the Medical Schemes Act, utilising section 8(h), by recognising the extraordinary circumstances that the COVID-19 presented to the schemes industry.

In response to the support and guidance provided by the CMS, various exemption applications were considered to provide relief to scheme members and these included:

- Relief by way of Personal Medical Savings Account (PMSA) utilisation
- Relief by way of contribution deferrals
- Relief by way of rule amendments allowing schemes the use ex-gratia payments to financially assist their members.

The risk of the health care facility or in-hospital patient exposure to COVID-19 also reduced utilisation rates of health facilities. These reduced utilisation rates resulted in a lower claims ratio when compared to the previous period (2019/20). Although the lower claims ratio reported by most medical schemes may seem to depict a favourable financial position for schemes, this change is short-term. The CMS recommended an annual contribution increase to the industry that was below the Consumer Price Index, in order to provide relief to scheme members.

At an operational level, the CMS allowed its personnel to work from home for the greater part of the year as a result of COVID-19. The on-site operations were left open for those instances, where officials found it difficult to work from home. A number of officials and members of the governing body did contract COVID-19 during 2020. Two members of the governing body (Dr Clarence Mini and Prof. Lungile Pepeta) succumbed to COVID-19 in the year in question, but the organisation soldiered on despite this major setback. The CMS premises were treated regularly to ensure that the chances of contracting COVID-19 was minimised.

Industry trends

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

Positive industry trends:

Schemes have maintained an average solvency ratio of 44.55% compared to the statutory requirement of 25% throughout the period under consideration.

Between 2014 and 2020, four schemes failed to meet the 25% statutory solvency. At the end of 2020, only three schemes were below the statutory solvency level.

The number of efficiency discounted options (EDOs) increased from 40 in 2014 to 69 in 2020.

All medical schemes which were recently placed under curatorship by the CMS were able to turn around their financial statuses by improving their solvency ratio. Governance was restored when new fit and proper boards of trustees were elected with strong governance systems.

These positive industry trends essentially mean that medical schemes have mainly been successful in compliance with the 25% solvency requirements during this period. Due to the lower claims ratio experience in 2020 compared to the previous year, there was a significant improvement in solvency levels at industry level. Scheme beneficiaries are expected to have benefited from an increase in the number of EDO options through lower annual contribution increases during this period.

Negative industry trends:

The number of scheme beneficiaries declined by nearly one percent between 2019 and 2020.

The proportion of the beneficiaries covered by EDOs decreased marginally from 25.8% to 23.5% between 2019 and 2020.

Poor governance and financial management of schemes resulted in three schemes being placed under curatorship.

The number of accredited administrators decreased from 28 in 2014 to 25 in 2020.

The number of accredited brokers (brokerages and individual brokers) decreased from 10 780 in 2014 to 4 545 in 2020.

The number of accredited managed care organisations increased from 39 in 2014 to 41 in 2020.

The main conclusion that can be drawn from these observed trends is that the medical aid industry is faced with serious growth and member benefit challenges. These challenges are characterised by low beneficiary growth, a reduction in the number of registered and regulated entities, increasing beneficiary dissatisfaction, and an increase in the number of non-EDO scheme options.

Other significant developments have characterised the industry in the period under consideration.

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

There has also been an increase in complaints related to diagnostic and procedure code disputes between schemes and service providers. The CMS will establish a mechanism to address these disputes with the support of other regulators, such as the Health Professions Council of South Africa (HPCSA). The disputes between schemes and service providers in the management of alleged fraudulent transactions are of great concern to the CMS. The CMS believes that through the implementation of the recommendations of the final report of the Section 59 Investigation Panel, it can play a significant role in developing and implementing interventions to address these disputes. The success of these interventions will, however, depend support provided by the industry and fellow regulators.

Economic outlook

The global outbreak of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), which causes coronavirus disease 2019 (COVID-19), has disrupted global supply chains and almost ground international trade to a halt, as governments imposed national lockdowns in an effort to curb the spread of the virus. Despite countries easing lockdown restrictions, global economic recovery is mired by many uncertainties since the rate of infections keeps rising up from the first wave and currently moving towards the third wave.

In South Africa, the economic shock sparked by recessions following the onset of the COVID-19 pandemic and the subsequent sub-investment grading by credit agencies has exacerbated the country's economic distress. This happened when the South African economy was already experiencing the effects of a technical recession. Lockdown restrictions exacerbated the contraction of the economy. According to National Treasury, government interventions have, to some extent, cushioned the impact on workers and businesses, these have not offset the full impact of COVID-19.

The rate and the speed of domestic economic recovery remain highly uncertain due to the current unfolding COVID-19 pandemic and overall global weak investor confidence. Accordingly, the country's well documented electricity supply constraints, the current sub-investment grade coupled with the burgeoning public sector debt, imply that economic recovery in South Africa is likely to lag behind those of its counterparts in other emerging economies. This will likely affect scheme members, who may consider reducing (or even relinquishing) medical cover.

The CMS thus encourages the consolidation of schemes as it ensures risk pooling and encourages social solidarity and affordability of scheme costs to members. The standardisation of scheme options is also supported by the CMS as it will assist members in making rational choices in the purchase of options in schemes. The number of scheme options is currently 251, and this high number adds to the complexities of making rational choices as a scheme member.

However, the CMS is concerned about a market concentration within the funding and provider market – which could potentially lead to monopolies, price/contribution hikes, and barriers of entry – as well as the increasing market concentration of administrators and managed care organisations that has occurred in the past six years. Market failures will result in market dominance and other anti-competitive behaviour by these entities, at odds with beneficiary interests and welfare. The full implementation plan based on the final recommendations of the Health Market Inquiry (HMI) report is expected to address these concerns.

Internal environment analysis

Capacity

The Council, with the support of the Office of the CEO, undertook an organisational diagnostic exercise to address key organisational challenges at the CMS. The key findings and recommendations revealed that there is a need to review the organisation's operational and service models and conduct a level 1 to 3 business process mapping. Members of staff have been advised that this process could potentially lead to a restructuring of the organisation.

We recognise and value our people as our most important asset in achieving the vision of the CMS, which is to promote fair and equitable access to healthcare in order to maximise the health of South Africans. To this end, the human resources sub-programme strategy for the next five years focuses on improving the culture, leadership, talent management, performance, reward and recognition, and personal development. In order to achieve this, the human resources sub-programme will implement several key strategic projects. More information can be found in Part D of this report.

Financial management

In the area of financial management, the CMS has matured significantly, as evidenced by the unqualified audit reports issued by the Auditor-General of South Africa over the years. There are, however, areas that need a more focused attention. The main area of focus will be strengthening supply chain management. To this end, a proposal to have a dedicated supply chain management unit, which is fully capacitated in line with developing trends, is under consideration.

Management is ensuring that financial management and internal controls of the CMS are strengthened and policies are reviewed and applied consistently. Another area that requires further attention, is the implementation of consequence management in cases where there has been non-compliance with policies and regulations. The CMS has the relevant governance structures in place to oversee the financial environment of the entity. The Audit and Risk Committee operates under an approved charter and oversees the work of the internal auditors and the internal finance unit. A three-year rolling audit plan has been reviewed and approved by both the Audit and Risk Committee as well as Council during the financial year under review.

Key policy developments and legislative changes

Various regulations were promulgated during the pandemic period to ensure that COVID-19 coverage, including the administration of the appropriate vaccines were declared a Prescribed Minimum Benefit for scheme members. It required massive effort on the part of the CMS to ensure that these amendments in the public interest were released on an urgent basis.

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

The promulgation of the National Health Insurance (NHI) Bill.

The promulgation of the Medical Schemes Act Amendment Bill (MSAAB).

The Health Market Inquiry Report.

The review of the Financial Sector Regulation Act and the Conduct of Financial Institutions (CoFI) Bill.

The Presidential Health Compact.

The MSAAB and the NHI Bill were released on 28 June 2018 for public comment until the middle of September 2018. The release of these bills was preceded by the release of the NHI White Paper (2016), NHI Policy Document (2017) and the Gazette on the NHI Implementation Structures (2017). These documents were aimed at providing a detailed policy direction for Universal Health Coverage in South Africa, in the form of National Health Insurance. There have been various discussions with the NHI forum to track the progress and update the National Department of Health (NDoH) on emerging matters in respect of the MSAB and NHI bill.

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

PROGRESS TOWARDS ACHIEVEMENT OF INSTITUTIONAL IMPACTS AND OUTCOMES

The Public Finance Management Act requires public entities to submit quarterly performance information reports to the relevant executive authority and the National Treasury. During the period under review, CMS submitted all the quarterly information reports to the executive authority and the National Treasury within the set statutory deadlines. There were no issues of concern raised by the executive authority on the reports. All the quarterly reports showed excellent performance by the organisation under the direction of the Council.

The CMS regulates the medical schemes industry through beneficiary training and education; registering of medical schemes and options; accrediting administrators, brokers, and managed care organisations; resolving complaints; conducting inspections; and defending legal challenges. Other important regulatory functions include the collection of key industry data, the review of the beneficiary entitlements in the form of prescribed minimum benefits (PMBs), and the provision of training and support to regulated entities.

The private health industry organically responds to the demand for healthcare – but does not address healthcare needs. For this reason, public policy intervention is necessary to balance what the private system does well with shortcomings in areas where the private system fails. If interventions are well designed and successfully implemented, the private health system is capable of fully supporting the country's broader social goals. Where a coherent strategy for the private health system is absent, however, coverage will invariably diminish in both extent and quality, with knock-on effects on the public health system and the quality of life possible in South Africa.

Over the past 100 years, health insurance in various forms has evolved in South Africa along with changes to regulatory instruments. It was, however, not until 1998 that a framework was implemented to modernise and update the system with a view to maximising fair access to medical scheme cover along the lines of developments in Europe and South America. The main aim of these reforms, provided for in the MSA, was to enhance the risk pooling potential of medical schemes and other important regulatory and oversight mechanisms by introducing a preferred health insurance vehicle, which required that any party defined as a medical scheme must operate in terms of a single legislative framework that incorporates:

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

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

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

Despite our best intentions with the promulgation of the MSA and its regulations in 2000, the CMS has met with serious challenges in being an effective regulator due to challenges by industry players and certain legislative limitations. This situation has led to the CMS seeking to amend specific areas of the MSA in order to strengthen its effectiveness and efficiency as a regulator. In the past five years, the CMS has not been successful in effecting the necessary legislative changes due to the long and onerous route that this process has taken. The release of the Medical Schemes Act Amendment Bill (MSAAB) for public comment in June 2018 represents a massive shift towards the legislative empowerment of the CMS, and we wholeheartedly welcome this development. However, there has not been much progress since then.

The CMS has, in the past six years (2014-2020), carried its mandate of regulating medical schemes, administrators, brokers and managed care organisations with great determination and success within the context of limited resources at its disposal. The level of the CMS' effectiveness as a regulator has largely been determined by internal and external environmental factors. These environmental factors can either have a positive or negative impact on the organisation's effectiveness and efficiency as a regulator.

The HMI Report identified market and regulatory failures in the private health industry, and has made recommendations to address them. A significant number of these recommendations will require the CMS to perform specific functions while the establishment of the proposed Supply-Side Health Regulator (SSHR) gets underway.

The CMS continues to participate in the Presidential Health Compact, a product of a Presidential Health Summit that convened in October 2018. This committed public-private partnership is aimed at addressing the key challenges that have been identified in both the public and private sectors in preparation for the implementation of Universal Health Coverage through National Health Insurance.

The level of implementation of the interventions increased to 49% in 2020/21 from 23% in 2019/20 and seven indicators from four pillars were fulfilled (these indicators accounted for 13% of the implementation rate of the 53 indicators, compared to 2% achievement rate in 2019/20):



The Council for Medical Schemes is responsible for the coordination of different stakeholders for the implementation of Pillar 9 interventions within the Compact.

Outcome oriented goals

The CMS has developed the following Strategic Outcomes for the 2020 – 2025 period in terms of its Strategic Plan:

Table 9: Strategic outcomes 2020 to 2025

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

The Council reviewed its Annual Performance Plan in September 2020 to ensure that it is still in line with its five-year Strategic Plan. The Annual Performance Plan for 2021/22 financial year, was approved and submitted to the executive authority in January 2021. The Council enjoys a good relationship with the executive authority and ensures that all matters that need to be brought to the attention of the Minister and conveyed and to him and that necessary support is provided to him where necessary.

Section three articulates progress on the strategic goals mentioned above.

PERFORMANCE INFORMATION BY PROGRAMME

Programme 1: Administration

The administrative programmes of the Council for Medical Schemes focus on the efficient functioning of the office and provide support to the core programmes to effectively carry out their mandates. The administration programme entails five sub-programmes, namely:

- 1.1 Office of the Chief Executive and Registrar
- 1.2 Office of the Chief Financial Officer
- 1.3 Information Communication Technology and Knowledge Management
- 1.4 Human Resources Management
- 1.5 Legal Services

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

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

The CEO and Registrar is responsible for leading the development and execution of the CMS' strategy. The CEO and Registrar is ultimately responsible for all day-to-day management decisions and for implementing the CMS' strategic and annual plans.

Performance

Table 10: Sub-programme 1.1 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 4: To become a more effective and efficient organisation								
Output 1: Ensure that reported performance information is in accordance with the Framework for Strategic and Annual Performance plans.								
Output Indicator 1.1	Ensure that overall performance of the entity is maintained at above 80%	New indicator	New indicator	New indicator	80%	90.83%	10%	Various units experienced pockets of excellence and overachievement toward their targets.
Output Indicator 1.2	Produce Annual Performance Information report that is reliable, accurate and complete by 31 July each year	1	1	1	1	1	–	–
Output 2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS								
Output Indicator 2.1	Number of strategic risk register reports submitted to the Council for monitoring	4	4	4	4	4	–	–
Outcome 6: To collaborate with local, regional and international entities								
Output 3: Collaboration with local, regional and international entities								
Output Indicator 3.1	Number of signed Memoranda of Understanding	New indicator	New indicator	New indicator	4	4	–	–

Achievement of strategic objectives

A strategic risk assessment and risk rating workshop was held during the year under review, jointly between Council, the Audit and Risk Committee, and CMS management. The governance structures continued to exercise their oversight over the organisation's strategic risks. The CMS submitted its Annual Performance Plan for the 2021/22 financial year on 31 January 2021. The CMS achieved an overall performance of 90% against predetermined objectives.

Strategy to overcome areas of underperformance	Changes to planned targets
There were no areas of underperformance in this sub-programme.	There were no changes to planned targets for this sub-programme during the year under review.

Linking performance with budget

Table 11: Sub-programme 1.1. linking performance with budget

	2020/21			2019/20	
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Office of the CEO					
Administrative expenses					
Printing and stationery	–	–	–	28	27
Refreshments	–	–	–	2	–
Subscriptions	5	4	1	–	27
	5	4	1	30	54
Operating expenses					
Committee remuneration	424	417	7	202	225
Consulting	3 914	4 012	(99)	1 500	4 624
Council member fees	3 011	2 797	214	2 738	3 232
Labour relations costs	1 522	3 150	(1 629)	1 840	2 794
Postage and courier	8	8	(1)	70	44
Transcription services	–	–	–	170	520
Travel and subsistence	–	–	–	1 326	1 228
Venue and catering	–	–	–	619	520
	8 878	10 386	(1 507)	8 465	13 187
Staff costs					
Salaries	7 330	6 901	428	5 832	5 351
Staff training	16	12	4	131	148
	7 346	6 914	432	5 963	5 499
TOTAL	16 231	17 305	(1 074)	14 458	18 740

Sub-programme 1.2: Office of the Chief Financial Officer

The purpose of the sub-programme is to serve all business units in the CMS, the executive management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the Public Finance Management Act. The sub-programme also supports the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and the Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities.

Performance

Table 12: Sub-programme 1.2 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 4: To be a more effective and efficient organisation								
Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities								
Output Indicator 4.1	An unqualified opinion issued by the Auditor-General on the Annual Financial Statements by 31 July each year	1	1	1	1	1	–	–
Output 5: Ensure that reported performance information is useful and reliable and in accordance with the Performance Management and Reporting Framework								
Output Indicator 5.1	Produce a budget that is reliable, accurate, complete and approved by Council by 31 January each year	1	1	1	1	1	–	–

Achievement of strategic objectives

The CMS manages its finances under the direction of the Public Finance Management Act (PFMA) and maintains a strong system of internal controls for effective and efficient management of its finances. It constantly seeks ways to improve its systems to better align with the requirements of the PFMA and best practice. This is evidenced by the unqualified audit opinion on its annual financial statements for 2019/20 from the Auditor-General.

Final approval of the proposed levy increase for the 2020/21 financial year was only received in April 2021. The delayed approval has put the financial position of CMS under significant pressure. The CMS is considering different models that will strengthen its financial position for long-term sustainability.

Strategy to overcome areas of underperformance	Changes to planned targets
There were no areas of underperformance in this sub-programme.	There were no changes to planned targets for this sub-programme during the year under review.

Linking performance with budget

Table 13: Sub-programme 1.2 linking performance with budget

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Office of the CFO						
Administrative expenses						
Bank charges	55	53	1	83	85	(2)
Building expenses	1 759	1 794	(35)	2 021	2 044	(23)
General administrative expenses	183	163	20	224	807	(583)
Insurance	627	658	(30)	458	449	9
Penalty paid to SARS	–	51	(51)	–	–	–
Printing and stationery	221	191	30	319	328	(9)
Refreshments	18	14	5	66	84	(18)
Rent	11 705	11 701	4	12 614	11 981	633
Rent: Operating expense	2 739	2 755	(16)	2 320	2 539	(219)
Subscriptions	16	15	1	18	10	8
	17 325	17 396	(72)	18 123	18 327	(204)
Audit remuneration						
External audit	1 389	1 092	297	903	1 123	(220)
Internal audit	547	1 491	(944)	1 375	1 592	(217)
	1 936	2 583	647	2 278	2 715	(437)
Operating expenses						
Consulting	116	138	(22)	385	326	59
Postage and courier	1	4	(3)	11	6	5
Travel and subsistence	2	6	(3)	30	28	2
Venue and catering	6	7	(0)	51	29	22
	126	155	(29)	477	389	88
Staff costs						
Employee benefits	3 209	3 290	(81)	3 003	3 104	(101)
Salaries	10 812	10 342	470	12 493	12 026	467
Staff training	146	147	(1)	156	94	62
Workmen's compensation	569	569	0	187	187	–
	14 736	14 347	388	15 839	15 411	428
Bad Debt	–	291	(291)	–	–	–
TOTAL	34 122	34 772	650	36 717	36 842	(125)

Sub-programme 1.3: Information Communication Technology and Knowledge Management

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

Performance

Table 14: Sub-programme 1.3 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 4: To be a more effective and efficient organisation								
Output 6: An established ICT Infrastructure that ensures information is available, accessible and protected								
Output Indicator 6.1	Percentage of network and server uptime	99.45%	99.41%	99%	99%	99%	–	–
Output Indicator 6.2	Percentage of IT security incidents (breaches)	0.27%	0%	5%	5%	0.75%	4.25%	The achieved performance is 0.75%. There is, therefore, a positive deviation of 4.25% due to fewer IT security incidents experienced.
Output Indicator 6.3	Number of successful IT Disaster Recovery (DR) failover tests	New indicator	New indicator	1	2	2	–	–
Output 7: Provide software applications that serve both internal as well as external stakeholders that improve business operations and performance								
Output Indicator 7.1	Percentage of uptime, of all installed application systems where network access exists	99.47%	100%	99%	99%	99%	–	–
Output 8: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing								
Output Indicator 8.1	Percentage of physical requests for information received and finalised within 30 days	97.5%	98.5%	95%	95%	95%	–	–

Achievement of strategic objectives

In the 2020/21 financial year, the Information Communication Technology and Knowledge Management (ICT&KM) unit achieved its annual targets, which can be attributed to the team's dedication and commitment to supporting the CMS in achieving its business objectives. The unit achieved 99% network and server uptime, 99% uptime on applications and systems where networks exist. It also successfully conducted two disaster recovery failover tests, had less than 5% of major security incidents/attacks, and achieved 95% in responding to information requests within 30 days.

The 2020/21 financial year was not business as usual as the CMS, like most organisations, had to rapidly adapt to new ways of running its business operations as a result of the COVID-19 pandemic. With the rapid spread of the disease and the national COVID-19 lockdown regulations implemented, CMS employees were suddenly expected to work from home, and the ICT&KM unit had the enormous task of ensuring that all employees were able to work remotely from the safety of their homes. This was made possible by the provisioning of technology enablers including mobile devices, maximising the use of digital technologies such as Microsoft Teams for employee collaboration, SignFlow for workflow and internal memorandum approvals, and M-Files for electronic document management.

The ICT&KM unit will continue to enable the CMS to function effectively and efficiently and also for its employees to work remotely from home in this "new normal". However, this new way of working remotely has its disadvantages as it has led to cyber security vulnerabilities and an increase in information security incidents as criminals took advantage of the new conditions brought about by the COVID-19 pandemic. There is, therefore, a need to improve information security capabilities, and this prompted the implementation of additional security measures such as deploying Microsoft 365 Enterprise Mobility and Security, which includes full disk encryption on laptops, multi-factor authentication, and mobile device management. The fully-functional network security firewall and the email security and archiving technology assisted in identifying and preventing security attacks.

A number of key business-enabling projects were implemented, and these include the migration to Microsoft 365, development of the new CMS website, changing of the domain to medicalschemes.co.za, and the appointment of a new internet service provider. In line with the "new normal" demands as a result of the pandemic, the COVID-19 vaccine returns data collection platform was developed, and business processes that include scheme rules and exemption submissions, and routine inspections, were automated. The new CMS website also enables stakeholders to interact effectively with the CMS; for example, stakeholders are now able to submit complaints electronically. The aim is to expand on this and create a more comprehensive and interactive digital platform for stakeholder engagement and customer relations.

The establishment of the National Beneficiary Registry (NBR), which is one of the enablers for the successful implementation of the NHI programme, remains a strategic project under the ICT&KM unit. A number of engagements with various stakeholders including the NDoH, medical schemes, administrators, and industry associations were held to discuss data security and confidentiality concerns. GEMS has been supportive of the project and has agreed to participate in a proof of concept to demonstrate the benefits of the NBR, and the CMS remains optimistic that this project will be successfully implemented with the support of all stakeholders.

In order to ensure that the CMS continues to be an effective and efficient regulator of the medical schemes industry, the ICT&KM unit will prioritise the digitisation and automation of as many business processes as possible, integrate siloed applications, and upgrade legacy systems in order to develop a more integrated regulatory system that is responsive to the needs of the industry. Digitised business processes and integrated applications will enable the delivery of business insights for effective monitoring and evaluation of CMS performance as a regulator. The implementation of a hot disaster recovery site (to enable business continuity) still remains one of the key priorities for the new financial year and there is a strategic consideration to implement a hybrid cloud solution as it is more cost effective.

Strategy to overcome areas of underperformance

There were no areas of underperformance in this sub-programme. However, a new Chief Information Officer was appointed during the period under review, and had to be briefed on the developments around strategic projects relating to the NDoH, which included the NBR, hosting of the Pulse system, and the Single Exit Price system. As a result, the CMS spent most of the time discussing the background and planning on the way forward and not much development work completed.

Changes to planned targets

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

Linking performance with budget

Table 15: Sub-programme 1.3 linking performance with budgets

Information Technology and Knowledge Management	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Administrative expenses						
General administrative expenses	279	457	(179)	567	750	(183)
Printing and stationery	–	–	–	16	6	10
Refreshments	–	–	–	2	–	2
Rent: Copiers	401	401	0	443	401	42
Security	511	515	(4)	506	713	(207)
Subscriptions	4	2	2	5	1	4
Telecommunication expense	8 046	7 826	219	4 886	5 578	(692)
	9 240	9 201	39	6 425	7 449	(1 024)
Operating expenses						
Consulting	633	475	158	281	260	21
Knowledge management	1 253	1 390	(137)	1 298	1 561	(263)
Travel and subsistence	1	1	0	57	75	(18)
Venue and catering	–	–	–	21	15	6
	1 888	1 866	22	1 657	1 911	(254)
Staff costs						
Salaries	13 691	13 306	385	12 667	11 846	821
Staff training	122	96	26	269	291	(22)
	13 813	13 402	411	12 936	12 137	799
TOTAL	24 941	24 469	471	21 018	21 497	(479)

Sub-programme 1.4: Human Resources Management

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

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

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

Performance

Table 16: Sub-programme 1.4 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Output 9: Build competencies and retain skilled employees								
Output Indicator 9.1	Minimise staff turnover rate to less than 10%	7.1%	4.48%	<10%	<10%	18.3%	8.3%	High turnover rate resulted from the non-renewal of 5-year fixed-term contracts of senior managers, non-filling of vacancies that have been impacted by the BMP, and a high number of resignations due to career advancements during the reporting year.
Output Indicator 9.2	Turnaround time to fill a vacancy (turnaround time of 120 working days for each vacancy that exists during the year), excluding position of CEO	There were 16 vacancies during the period; 12 were filled within 120 days, one took longer than the 120 days to fill and the recruitment process was underway for another two.	There were 14 vacancies during the period; 9 were filled within 120 days, three took longer than 120 days and the recruitment process was underway for another two.	18 vacancies during the reporting period were filled within 120 days	120 days	70.8 days	-49.2 days	Exceeded the turnaround time of 120 days to fill all vacancies. An average of 46 days maintained quarterly from the date of advertising to filling vacancies.
Output Indicator 9.3	Achievement of employment equity targets (according to the BBBEE targets), annually	79.82%	97.12%	85%	85%	108.57%	23.57%	Exceeded the BBBEE scorecard target by 23.57% on Black people employed at senior management, professionally qualified and skilled technical and Black women employed at senior management levels.
Output 10: Maximise performance to improve organisational efficiency and maintain high performance culture								
Output Indicator 10.1	Percentage of employee performance agreements are signed by no later than 31 May of each year	100%	100%	100%	95%	100%	5%	All 115 employees, excluding the Registrar, signed the performance agreement by no later than 30 May.
Output Indicator 10.2	Percentage of employees' performance assessments concluded, bi-annually	100%	93.97%	100%	95%	99.10%	4.10%	110 employees, excluding the CE, participated in the 1st performance assessment during the reporting period. Appraisals for the 2nd review cycle are underway.

Achievement of strategic objectives

The CMS workforce profile for the reporting period ending 31 March 2021 comprised of 128 employees made up of 107 permanent appointments, six appointed on five-year fixed-term contracts, five on temporary fixed-term contract and nine on internship programmes.

One employee has been seconded to Presidency for a period of two years starting 1 September 2020.

CMS had 26 vacancies during the reporting period. Four of the vacancies were from the previous financial year.

Vacancies were filled according to the CMS' recruitment and selection process. A total of 15 employees were appointed into permanent positions; eight were filled by external applicants, four filled by internal applicants, two filled by applicants that participated in internship programme, and one filled by an employee that was appointed on a fixed term contract.

There were 22 terminations during the reporting year made up of nine resignations, five non-renewals of five years' fixed-term contracts, three dismissals, one CCMA award and four internal movement (where employees were appointed into other positions). The vacant positions of Senior Analyst: BMU, Accreditation Analyst: Admin and MCO as well as those of general managers whose contracts were not renewed were impacted by the restructuring process and will no longer be filled as in the old organisational structure.

Strides were made to develop and review policies under the review period. The Council approved the following revised policies on 29 May 2020, namely Harassment; Terms and Conditions Of Service and Employee Benefits; Disciplinary; and Code of Ethics and Code of Conduct.

A new performance management template that is aligned to the balanced scorecard system and SMART criteria was successfully implemented during the reporting period. Training of the new performance contracting was facilitated through Microsoft Teams. Ongoing support was also provided to all units during the performance assessment and appraisal period to reduce levels of bias in the implementation of the SMART criteria.

The remuneration philosophy and employee value proposition policy culminating from employee grievances approved by Council was implemented with effect from 1 April 2020.

The unit submitted the WSP/ATR for 2019/20 was submitted to the HWSETA on 24 May 2020 as extended by the Department of Higher Education due to the challenges of the COVID19 pandemic.

The cost-of-living inflationary annual increase of 6.1% for levels A – D bands and 5.1% for executive management was implemented with effect from 1 April 2020. The implementation was made before the organisation received a directive from the Ministry of Health advising on the implementation of any changes to conditions of service and benefits pending the outcome of the work undertaken by the Presidential Enterprise Council.

A service provider for COVID-19 Employee Assessment was secured for a period of 12 months. The services include preparation of the workplace for resumption of business operations, prepare employees to return to work, manage ongoing employee disease surveillance pursuant and in respect of COVID- 19. The life risk assessment tool was also downloaded on employee cellphones to ensure that they complete their risks assessment prior to coming to work. Ongoing screening of staff takes place as and when they report to work.

Changes to planned targets

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

Linking performance with budget

Table 17: Sub-programme 1.4 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Human Resources						
Administrative expenses						
General administrative expenses	17	17	(1)	31	30	1
Printing and stationery	17	14	3	9	6	3
Subscriptions	169	166	3	177	161	16
	203	198	5	217	197	20
Operating expenses						
Consulting	241	181	60	688	805	(117)
Transcription services	4	3	1	46	43	3
Travel and subsistence	21	20	1	23	40	(17)
Venue and catering	22	17	6	47	114	(67)
	288	220	68	804	1 002	(198)
Staff costs						
Employee wellness	145	193	(48)	302	302	–
Recruitment and relocation	451	337	114	697	1 039	(342)
Salaries	5 661	5 520	140	6 269	5 654	615
Staff training	23	17	6	95	42	53
Temporary staff	2 099	2 109	(10)	3 316	3 492	(176)
	8 378	8 176	202	10 679	10 529	150
TOTAL	8 869	8 594	275	11 700	11 728	(28)

Sub-programme 1.5: Legal Services

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

Performance

Table 18: Sub-programme 1.5 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 4: To become a more effective and efficient organisation								
Output 11: Legal advisory and support services for effective regulation of the industry and operations of the office								
Output Indicator 11.1	Number of written and verbal legal opinions provided to internal and external stakeholders, attended to within 14 days	267	279	80%	85%	85%	–	–
Output 12: Defending decisions of the Council and the Registrar								
Output Indicator 12.1	Percentage of court and tribunal appearances in legal matters received and action initiated by the unit within 14 days	100%	100%	100%	100%	100%	–	–

Achievement of strategic objectives

We have ensured that as the legal unit, we maximise efficiency, avoidance of duplication and redundancies. Also, we have been able to minimise re-work and maintain quality control and provide excellent quality of work and service with a high probability of success of outcomes predictability.

The CMS Legal Services unit has consistently outperformed and exceeded its set targets. Due to the volatile and unpredictable nature of output indicator 11.1, the projected number was exceeded, and in terms of output indicator 12.1 more matters were received than anticipated. The deviation in all instances has been a positive one and speaks to the dedication and commitment of the members of the unit in positively contributing to the strategic objectives and overall scorecard of the CMS. As the legal unit, we correctly applied our metrics and monitored them closely all year. We also ensured that our days were specifically spent doing what will make the unit achieve its targets. This enabled the unit to over-achieve on its target.

The tracking of relevant laws and judgements ensured that current legislative developments and jurisprudence could be taken into account when making decisions. The unit has a great interest in the outcome of its strategic objective and thus puts in the work to achieve the strategic objective.

The unit assisted in trustee training workshops. Principal Officers Forum, broker, and trustee training created awareness of the need for good corporate governance and, by so doing, ensured sound compliance with the CMS mandate and the law. The unit prioritises and completes high revenue/cost saving and strategic commercial agreements for the organisation. The unit continuously and successfully defends and protects the interests of the organisation (litigation, IP, regulatory affairs, compliance). Keyhealth Medical Scheme was successfully placed under curatorship.

Strong legal capacity has enabled CMS to enforce its statutory mandate with an exemplary success rate. CMS has consistently maintained legal and regulatory certainty in the medical schemes environment. The unit has also made an important contribution to the implementation of Health Market Inquiry recommendations.

The unit has also made an important contribution to the LCBO processes; it is also playing a significant role in the amendment of the Medical Schemes Act in accordance with the NHI and HMI. The unit is further engaged with the National Treasury and the FSCA in challenges and plays a role in the alignment of the FRSA and CoFI Bill. The CMS ability to highlight and legally challenge uncompetitive practices by service providers and associations has played a vital role in shaping the behaviour of service providers.

Strategy to overcome areas of underperformance

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

Changes to planned targets

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

Linking performance with budget

Table 19: Sub-programme 1.5 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Legal services						
Administrative expenses						
Printing and stationery	1	1	0	5	4	1
Refreshments	–	–	–	2	–	2
Subscriptions	–	–	–	–	–	–
	1	1	0	7	4	3
Operating expenses						
Legal fees	15 345	19 788	(4 443)	6 400	17 958	(11 558)
Legal fees-Section 59	1 509	2 348	(838)	–	–	–
Travel and subsistence	16	16	(1)	73	76	(3)
Venue and catering	–	–	–	–	4	(4)
	16 870	22 152	(5 282)	6 473	18 038	(11 565)
Staff costs						
Salaries	5 075	4 631	444	5 022	4 584	438
Staff training	28	32	(3)	86	83	3
	5 103	4 663	440	5 108	4 667	441
TOTAL	21 975	26 816	(4 842)	11 588	22 709	(11 121)

Programme 2: Strategy Office

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

Performance

Table 20: Programme 2 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector								
Output 13: Formulate prescribed minimum benefits (PMBs) definitions to ensure members are adequately protected								
Output Indicator 13.1	The number of benefit definitions published	10	10	10	10	10	–	–
Output Indicator 13.2	Develop primary health care package to incorporate into the PMBs	Draft costed PMB benefit package completed but not submitted to the Council	A service based preventative and primary healthcare package and costing methodology report was submitted to the Executive Authority	Develop primary healthcare package for incorporation into the PMBs	Review and update revised PMB benefit package	Revised and updated PMB benefit package costed	–	–
Output 14: Provide clinical opinions with a view to resolve complaints and enquiries								
Output Indicator 14.1	Percentage of category 1 clinical opinion provided	98%	54%	90%	90%	92.75%	2.75%	The unit was able to exceed the target owing to fewer competing work.
Output Indicator 14.2	Percentage of category 2 clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication unit	100%	99%	95%	95%	100%	5%	The unit was able to exceed the target owing to fewer competing work demands whilst working virtually during the national lockdown period.
Output Indicator 14.3	Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication unit	100%	100%	98%	98%	100%	2%	The unit was able to exceed the target owing to fewer competing work demands whilst working virtually during the national lockdown period.
Output Indicator 14.4	Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days	99%	98%	98%	98%	100%	2%	The unit was able to exceed the target owing to fewer competing work demands whilst working virtually during the national lockdown period.
Output 15: Conduct research to inform appropriate national health policy interventions								
Output Indicator 15.1	Number of research projects and support projects published in support of the National Health Policy	5	5	5	5	11	6	Special projects responding to research requests are often urgent and unpredictable. This is the reason for the achievement being above target.

Achievement of strategic objectives

The Prescribed Minimum Benefits (PMB) review is a multi-stakeholder-driven process that culminated in the publication of the preventative and primary healthcare package last year. This package has now been costed to determine affordability and sustainability.

The following PMB benefit definitions guidelines were published:

- COVID-19
- Chronic lymphocytic leukaemia
- Hodgkin's lymphoma
- T-cell prolymphocytic leukaemia
- Cutaneous T-cell lymphoma
- Multiple Myeloma
- Acute myeloid leukaemia (AML)
- Myelodysplastic syndromes (MDS)
- Myeloproliferative neoplasms (MPN)
- Chronic myeloid leukaemia (CML)

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

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

Strategy to overcome areas of underperformance

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

Changes to planned targets

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

Areas where targets were exceeded

Targets for all categories of clinical opinions and enquiries were exceeded because, despite their complexity, the clinical analysts had more time to complete them owing to fewer competing office demands whilst working virtually during the national lockdown. They, therefore, were able to analyse, research and complete these categories of opinions before the target deadlines.

Linking performance with budget

Table 21: Programme 2 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Strategy Office						
Administrative expenses						
Printing and stationery	–	–	–	3	8	(5)
Refreshments	–	–	–	2	–	2
Subscriptions	3	5	(2)	13	5	8
	3	5	(2)	18	13	5
Operating expenses						
Consulting	774	1 190	(416)	1 571	2 546	(975)
Travel and subsistence	3	2	1	263	341	(78)
Venue and catering	–	–	–	181	256	(75)
	777	1 192	(415)	2 015	3 143	(1 128)
Staff costs						
Salaries	8 988	8 595	392	10 596	10 056	540
Staff training	99	73	27	131	121	10
	9 087	8 668	419	10 727	10 177	550
TOTAL	9 868	9 865	2	12 760	13 333	(573)

Programme 3: Accreditation

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

Performance

Table 22: Programme 3 key performance indicators, planned targets and actual achievements

		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Performance indicators								
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 16: Accredit regulated entities based on their compliance with the requirements for accreditation in order to provide accredited services and monitor legal compliance throughout the period of accreditation.								
Input Indicator 16.1	Percentage of broker and broker organisations' applications finalised within 30 working days on receipt of complete information	5 500	5 030	80%	80%	84.8%	4.8%	The unit received more complete application forms than anticipated.
Input Indicator 16.2	Percentage of managed care organisations' applications analysis completed and outcome communicated to applicants, within three months of receipt of complete information	15	22	100%	100%	100%	–	–
Input Indicator 16.3	Percentage of administrators and self-administered schemes' applications analysis completed and outcome communicated to applicants, within three months of receipt of complete information	6	14	100%	100%	100%	–	–

Achievement of strategic objectives

Third-party administrators and self-administered schemes

- Eight administrator accreditation renewal evaluations and one new self-administered scheme application were finalised during the year.
- No on-site evaluations were conducted during the 2020/21 year due to the COVID-19 pandemic.
- The Accreditation unit continued to monitor compliance by accredited entities with conditions imposed and continued financial soundness.

The revised administrator accreditation standards (Version 6) were published during the year with an effective date from 1 January 2020. A number of administrator accreditation related documents, (e.g. administration agreement guideline), were updated and published following the publication of the revised administration standards.

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

The unit led the task team, which proposed an accreditation framework for optometry benefit management organisations. Council approved the framework, and it is currently being finalised for implementation.

Managed care organisations

- One new and 22 renewal managed care accreditation applications were evaluated during the year.
- Accreditation was declined by Council in respect of two new and one renewal accreditation applications due to the entities not performing managed care services as defined and therefore not needing to be accredited.
- One managed care organisation elected not to renew its accreditation as it ceased to operate as a managed care organisation.
- No on-site evaluations were conducted during the 2020/21 year due to the COVID-19 pandemic and National Lockdown requirements.

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

A number of managed care accreditation documents are in the process of being updated following the publication of the revised managed care accreditation standards in 2020.

Broker and broker organisations

The unit continued to verify the qualifications of individuals applying to be accredited as brokers. The unit successfully verified 2 670 qualifications submitted by applicants in the period under review. From the 4 554 brokers and broker organisations received in the period under review, 3 861 were accredited within 30 working days on receipt of complete information, resulting in an achievement of 84.8% against the target.

Strategy to overcome areas of underperformance	Changes to planned targets
The unit will ensure that an intern is always appointed to assist with processing applications received from applicants. The new online system implemented in January 2020 will not allow applicants to proceed and submit incomplete applications.	There were no changes to planned targets for the programme during the year under review. However, the performance indicators were changed to better reflect the unit's effort and performance.

Linking performance with budget

Table 23: Programme 3 linking performance with budgets

Accreditation Unit	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Administrative expenses						
Printing and stationery	–	–	–	22	12	10
Refreshments	–	–	–	2	–	2
Subscriptions	273	205	67	319	348	(29)
	273	205	67	343	360	(17)
Operating expenses						
Consulting	–	–	–	–	–	–
Travel and subsistence	–	–	–	576	615	(39)
Venue and catering	–	–	–	7	4	3
	–	–	–	583	619	(36)
Staff costs						
Salaries	8 082	7 388	694	9 260	8 412	848
Staff training	96	119	(23)	54	89	(35)
	8 179	7 507	672	9 314	8 501	813
TOTAL	8 451	7 712	739	10 240	9 480	760

Programme 4: Research and Monitoring

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

Performance

Table 24: Programme 4 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry								
Output 17: Conduct research to inform appropriate policy interventions								
Output Indicator 17.1	Number of research projects finalised	9	14	12	12	12	–	–
Outcome 18: Monitoring trends to improve regulatory policy and practice								
Input Indicator 18.1	Non-financial report submitted for inclusion in the annual report	1	1	1	1	1	–	–

Achievement of strategic objectives

Through the analysis of medical schemes' risk profiles, the prevalence of chronic conditions, provider distribution, measurement of quality in medical schemes, and utilisation of healthcare services, the unit assists in advocating for key priority areas and interventions that will aid member protection. It also provided support to the NDoH on various projects which included collecting and reporting of HIV/STI data by the private sector, and technical support to the National Health Accounts (NHA) task team. For the period under review, the unit conducted a survey study on COVID-19 vaccines amongst members of medical schemes to gauge the level support for vaccines. The study was submitted to the Ministerial Advisory Committee to assist with various strategies employed by the NDoH on COVID-19 vaccines.

The unit has set itself targets for the year, including publishing research work in research journals and participating in industry forums (such as conferences) as a method of disseminating policy and research outputs. The unit published six research papers in peer-reviewed journals. Some of the research output was also presented at industry conferences, such as the Health Quality Assessment (HQA) Annual Industry Results Presentation and Clinical Quality Conference, and the 6th annual Board of Healthcare Funders (BHF) Titanium Awards where the unit published three research papers – with one being nominated as the best research paper submitted. The unit also presented a topic on governance failures in medical schemes at the African Union Governance seminar.

Strategy to overcome areas of underperformance

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

Changes to planned targets

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

Linking performance with budget

Table 25: Programme 4 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Research and Monitoring						
Administrative expenses						
Printing and stationery	–	–	–	4	3	1
Refreshments	–	–	–	2	–	2
Subscriptions	–	0	(0)	14	12	2
	–	0	(0)	20	15	5
Operating expenses						
Consulting	–	–	–	85	–	85
Travel and subsistence	–	–	–	78	96	(18)
Venue and catering	–	–	–	14	4	10
	–	–	–	177	100	77
Staff costs						
Salaries	6 460	6 162	299	6 695	8 209	(1 514)
Staff training	32	77	(45)	155	144	11
	6 493	6 239	254	6 850	8 353	(1 503)
TOTAL	6 493	6 239	253	7 048	8 468	(1 421)

Programme 5: Stakeholder Relations

The purpose of the programme is to create and promote awareness and understanding of the Medical Schemes Act and the industry among all regulated and non-regulated entities, through communication; marketing; education and training; customer care interventions; and stakeholder engagement.

Performance

Table 26: Programme 5 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 19: To create awareness and collaboration with stakeholders, while enhancing the visibility and protecting the reputation of the CMS								
Output Indicator 19.1	Number of stakeholder awareness activities conducted	7	85	21	25	55	30	Overachieved per annum: (55 versus 25). Due to collaboration with other professional bodies and co-regulators e.g. FSCA, HPCSA, National Treasury. COVID-19 also necessitated a lot of unplanned stakeholder engagement activities.
Output Indicator 19.2	Percentage of stakeholder awareness of CMS resulting from survey	n/a	64%	50%	55%	50%	-5%	There were limited resources to publicise the survey due to budgetary constraints therefore, the interest and response rate was low. In addition, this survey came on the back-end of the vaccination survey.
Output 20: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year								
Output Indicator 20.1	Submission of Annual Report by 31 August to the Executive Authority	1	1	1	1	1	–	–
Output 21: To enhance knowledge and skills among stakeholders, in order to create an in-depth understanding of governance and compliance with the Medical Schemes Act, through education and training interventions								
Output Indicator 21.1	Number of stakeholder education and training sessions	New indicator	New indicator	35	40	56	16	Overachieved per annum: (56 versus 40) due to collaboration with other professional bodies and co-regulators e.g. HPCSA, FSCA, FPI, National Treasury and requests received for COVID-19 as a PMB training.

Achievement of strategic objectives

The Stakeholder Relations unit strengthened collaboration with co-regulators and professional bodies, resulting in increased stakeholder awareness and education and training activities.

- Collaboration with the Health Professions Council of South Africa (HPCSA) bore a successful Fraud, Waste and Abuse (FWA) Webinar that set the scene for industry codes of good practice and an FWA Tribunal.
- In the interest of protecting the public, the unit, together with the Financial Sector Conduct Authority (FSCA) produced education material differentiating between medical schemes and health insurance products.
- In another partnership with the FSCA and National Treasury, the unit participated in Money Smart Week interviews which were broadcast online.
- In response to the COVID-19 pandemic, the unit also hosted free webinars on COVID-19 as a PMB, unpacking member entitlements, rights and responsibilities. These were held weekly in four languages: English, Nguni, Sotho and Venda. These education webinars gave rise to community radio interviews in vernacular languages.

The unit's ongoing project, the Section 59 Investigation, released its interim report in January 2021, and called for submissions and comments until April 2021. The unit organised the virtual launch and public relations for this release. In alliance with the Compliance and Investigations unit, the unit hosted several LCBO Advisory Committee meetings, which led to the development of an LCBO portal for committee members.

The CMS annual report was submitted to the Executive Authority on 31 October 2020 in line with amended statutory requirements due to the COVID-19 pandemic. The release of the CMS annual report led to several interviews on the topics of the growth of the medical schemes industry and out-of-pocket payments. As such, the organisation realised a total advertising value equivalent (AVE) of R155 million during the financial year.

A member awareness survey was released to medical scheme members, which yielded a 49.9% awareness result.

In the year under review (2020/21) the CMS Customer Care Centre operated in remote settings under strict requirements of COVID-19 Lockdown regulations and social distancing to help curb the spread of the virus. This, therefore, meant calls were redirected from the Customer Care Line 0861 123 267 and the Switchboard line 012 431 0500 to customer care centre cell phones. A total of 23 680 calls and 9 352 e-mailed enquiries were received.

Strategy to overcome areas of underperformance	Changes to planned targets
There were no areas of underperformance.	There were no changes to planned targets.

Linking performance with budget

Table 27: Programme 5 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Research and Monitoring						
Administrative expenses						
Printing and stationery	9	4	5	10	5	5
Refreshments	14	11	3	18	26	(8)
Subscriptions	–	–	–	2	–	2
	23	15	8	30	31	(1)
Operating expenses						
Consulting	270	132	138	36	10	26
Postage and courier	–	0	(0)	–	–	–
Exhibition costs	–	–	–	86	115	(29)
Media and promotion	265	303	(38)	1 743	1 385	358
Printing and publication	758	651	107	893	935	(42)
Travel and subsistence	1	1	0	550	825	(275)
Venue and catering	–	–	–	389	702	(313)
	1 294	1 088	206	3 697	3 972	(275)
Staff costs						
Employee wellness	–	–	–	2	–	2
Salaries	7 834	7 467	367	9 296	9 524	(228)
Staff training	21	15	5	122	81	41
	7 854	7 482	372	9 418	9 605	(187)
TOTAL	9 171	8 585	586	13 145	13 608	(463)

Programme 6: Compliance and Investigations

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

Performance

Table 28: Programme 6 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 23: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 23.1	Number of routine inspections finalised if applicable	14	11	13	15	10	-5	The unit experienced some setbacks in terms of completing the balance of 5 routine inspections to reach the set target due to lack of adequate capacity to finalise inspections that were initiated. Furthermore, the impact of the COVID-19 pandemic resulted in schemes requesting more time to submit information which led to a delay in finalisation of routine inspections. The remainder will be transferred to the 2021/22 financial year.
Output 24: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 24.1	Percentage of commissioned inspections finalised	New indicator	New indicator	80%	80%	33%	-47%	As a result of the COVID-19 related national lockdown which restricted movement, the unit could not appoint investigators to conduct the investigations. Where Inspectors were appointed, they could not commence inspections on time. Some investigations were held off due to budgetary constraints and they will be attended to during the 2021/22 financial year.

Output 25: Ensure enforcement action is undertaken against regulated entities								
Output Indicator 25.1	Percentage of enforcement actions undertaken to ensure compliance with the Medical Schemes Act (1998)	100%	92%	100%	100%	100%	–	–
		72	37					
Output 26: Strengthen and monitor governance systems of medical schemes and other regulated entities								
Output Indicator 26.1	Percentage of governance interventions implemented	100%	100%	100%	100%	100%	–	–
		108	116					
Output Indicator 26.2	Number of scheme member meetings attended	33	38	40	42	26	-16	Due to the postponement of scheme AGMs because of the national lockdown restrictions, the unit was not able to observe AGMs as per the target.

Achievement of strategic objectives

During the challenging year characterised by the COVID-19 pandemic, the unit managed to enforce compliance with the Medical Schemes Act by conducting routine inspections, issuing directives, issuing section 43/45 inquiries, exemption application adjudication, board notice inspections, virtual AGM attendance, and participation in various Demarcation Committees.

Annual general meetings

The unit issued a Circular noting the beginning of the AGM season wherein medical schemes were duly advised that due to the COVID-19 pandemic, they could apply for exemption from complying with their scheme rules as far as it relates to the date of convening an AGM until such time that the pandemic has been brought under control, or to apply for permission to convene a virtual AGM. The unit analysed exemptions applications which were submitted to EXCO and Council for approval.

Due to the exemption applications which were received to postpone most of the 2020 AGMs to a later date(s) in the year or to move AGMs to 2021, the unit was only able to attend two in person and 24 virtual meetings to observe meeting proceedings via various digital platforms.

Regulatory Workshop and Advisory Committee meetings

The unit, together with the Research and Monitoring unit, convened two virtual meetings on behalf of the Registrar wherein presentations were made to external stakeholders to provide an update on the developments related to the exemption of primary healthcare insurance products, Circular 80 and 82 of 2019, as well as Circular 56 of 2020. The workshop was well attended.

Demarcation exemptions

The unit received, analysed, and submitted demarcation renewal applications and submitted an executive summary to Exco. At the Council Exco meeting dated 30 June 2020, Council requested that some documents be re-worked and submitted via round-robin. On 5 August 2020, a meeting was convened with internal units regarding exemption conditions imposed on insurers conducting the business of a medical scheme. A memorandum was prepared for the attention of the Registrar to advise that the exemption conditions that were proposed to Council Exco on 30 of June 2020, would potentially need to be amended, with possible legal implications for the CMS. The memorandum was presented at the Council Exco meeting on 27 August 2020. The Council subsequently accepted the relevant recommendations to amend the exemption conditions relating to the accreditation of administrations and managed care organisations that render services to insurers.

Commissioned inspections

Two commissioned inspections, for Medshield Medical Scheme and Optivest Health Services respectively, were finalised during the reporting year. On 24 June 2019, the Registrar instituted an inspection into the affairs of Medshield Medical Scheme in terms of section 44(4)(a) of the MSA and sections 134 and 135 of the FSR Act based on the insistence of the scheme.

The Registrar instituted an inspection into the affairs of Optivest Health Services in terms of section 44(4)(a) of the MSA and sections 134 and 135 of the FSR Act on 27 July 2019. A report was sent to the entity under investigation for comments, but it has since challenged the Registrar's jurisdiction in conducting the inspection.

Achievement of strategic objectives continued**Routine Inspections**

The Registrar approved fifteen (15) routine inspections to be conducted into the affairs of various medical schemes in terms of section 44(4)(b) of the MSA and sections 134 and 135 of the FSR Act. The unit completed 10 routine inspections during the quarter and issued directives. Some routine inspection findings have resulted in the Registrar approving commissioned inspections for the 2021/22 financial year.

The setbacks experienced in completing the balance of five routine inspections were due to capacity constraints and the COVID-19 pandemic affecting the routine inspection submission process, which resulted in a delay in finalising the routine inspections.

Strategy to overcome areas of underperformance

It should be noted that the unit underperformed due to capacity, COVID-19 and time constraints in that it could not finalise five out of 15 routine inspections and could only attend 26 out of 42 AGMs held virtually and in person.

Routine Inspections

Routine inspections are allocated at the beginning of the financial year and are evenly distributed to ensure that each member has the same number of routine inspections to conduct. When the number of targeted inspections exceeds the number of people in the unit available to conduct the routine inspections, then a team-based approach is adopted. This means that members of the unit will be paired to conduct the routine inspections to ensure timeous submission of the final reports.

Annual General Meetings

The unit requested medical schemes that were granted exemptions to host virtual AGMs for 2020 to review their scheme rules and make the necessary amendments where the rules of the scheme do not cater for virtual AGMs, considering the COVID-19 pandemic and the national lockdown rules against convening large events. The amendment of rules will assist in ensuring that all medical schemes host their scheme meetings within the year and that the unit can monitor more schemes to reach the minimum target set for the year.

Changes to planned targets

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

Linking performance with budget**Table 29: Programme 6 linking performance with budgets**

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Compliance Investigation						
Administrative expenses						
Printing and stationery	–	–	–	16	12	4
Refreshments	4	4	0	34	21	13
Subscriptions	–	–	–	2	–	2
	4	4	0	52	33	19
Operating expenses						
Inspection costs	661	1 853	(1 192)	6 917	4 779	2 138
Travel and subsistence	27	20	7	500	500	–
Venue and catering	–	–	–	1	2	(1)
	688	1 873	(1 185)	7 418	5 281	2 137
Staff costs						
Salaries	10 215	9 751	463	10 406	9 976	430
Staff training	152	143	9	150	80	70
	10 367	9 895	472	10 556	10 056	500
TOTAL	11 058	11 771	(713)	18 026	15 370	2 656

Programme 7: Benefits Management

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

Performance

Table 30: Programme 7 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 27: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act								
Output Indicator 27.1	Percentage of interim rule amendments processed within 14 working days of receipt of all information	96.3%	96.2%	80%	80%	96.8%	16.8%	The unit exceeded its target of analysing 80% of the rule submissions within 14 days by 16.8%.
		108	106					
Output Indicator 27.2	Percentage of annual rule amendments processed before 31 December of each year	100%	100%	90%	90%	100%	10%	The unit was able to exceed its target of 90% by reviewing 100% of the submissions relating to the changes to benefits and contributions increases.
		91	78					

Achievement of strategic objectives

The unit is responsible for the registration of the rules of medical schemes and, as such, contributes to the objective of the CMS to ensure that schemes are regulated efficiently based on rules that are fair and compliant with the MSA. The unit comprises five analysts with technical expertise to assist the Office of the Registrar and the CMS in achieving its mandate of protecting the interests of beneficiaries of medical schemes.

All the general operations of medical schemes relating to governance, contribution rates and benefits offered are based on registered scheme rules. It is therefore important that the targets set annually are met with great precision, consistency and commitment. The unit set itself high targets for the year and has managed to exceed these targets in the 2020/21 financial reporting period even after losing one analyst during the period under review, and with this, the Office of the Registrar and the CMS was able to deliver on its mandate successfully. The unit endeavours to continue this stellar performance and has implemented a peer review strategy, where senior analysts review the analysts' work to ensure quality output and that the mandate is achieved.

Strategy to overcome areas of underperformance

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

Changes to planned targets

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

Linking performance with budget

Table 31: Programme 7 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Benefits Management						
Administrative expenses						
Printing and stationery	1	5	(5)	19	12	7
Refreshments	–	–	–	2	–	2
Subscriptions	–	–	–	19	20	(1)
	1	5	(5)	40	32	8
Operating expenses						
Travel and subsistence	–	–	–	49	49	–
Venue and catering	–	–	–	1	4	(3)
	–	–	–	50	53	(3)
Staff costs						
Salaries	5 975	5 347	628	6 701	6 968	(267)
Staff training	54	46	8	47	72	(25)
	6 029	5 393	637	6 748	7 040	(292)
TOTAL	6 030	5 398	632	6 838	7 125	(287)

Programme 8: Financial Supervision

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

Performance

Table 32: Programme 8 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 3: To ensure that all regulated entities comply with National Policy the MSA and Regulations								
Outcome 28: Monitor and promote the financial soundness of medical schemes								
Output Indicator 28.1	Percentage of business plans processed in respect of Regulation 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar)	100%	88%	100%	100%	0	100%	No business plans were received in the period under review
Output Indicator 28.2	Percentage of business plans processed in respect of schemes with rapidly reducing solvency (but above statutory minimum)	100%	n/a	100%	100%	0	100%	No business plans were received in the period under review
Output Indicator 28.3	Percentage of auditor applications analysed	100%	100%	100%	100%	100%	–	–
Output Indicator 28.4	Number of quarterly financial return reports published (excluding quarter four)	3	3	3	3	3	–	–
Output Indicator 28.5	Number of financial sections prepared for the Annual Report	1	1	1	1	1	–	–

Achievement of strategic objectives

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

- Regulation 29 of the MSA prescribes that the minimum accumulated funds of medical schemes should be at least 25% of gross contributions to ensure that members' interests are protected and to guarantee the continued operation of the scheme, ensuring that it is able to pay members' claims when due.

The prescribed solvency also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities or expenses. When reserves fall below the prescribed solvency ratio, this serves as a warning of a medical scheme's possible inability to meet its obligations. The schemes that fell below the minimum required statutory solvency level were placed under close surveillance and submitted business plans detailing their turnaround strategies. Regular meetings were also held with the management of these schemes to monitor progress against the submitted plans. For the period under review, there were no schemes that fell below the minimum required statutory solvency levels.

The annual statutory returns form the basis for the financial sections prepared for the annual report. The unit completed the input for 2020/21 timeously. There were no significant analysis findings, and the medical schemes industry remained above the statutory solvency requirement of 25% overall.

- The MSA requires that the annual financial statements of medical schemes are audited. The reliance that is placed on the information contained in the annual financial statements is high, and it is therefore important to ensure, not only the quality of audits, but that auditors are familiar with the very complex medical schemes environment.

The purpose of the auditor approval process is to assess the capability of the proposed audit firms and audit partners to be engaged in the audit assignment of medical schemes. The unit has to make sure that all medical schemes have appointed suitable qualified auditors, and all applications received were assessed in the period under review.

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

No deviations occurred during the period under review.

Strategy to overcome areas of underperformance	Changes to planned targets
No underperformance occurred during the period under review.	There were no changes to planned targets for the programme during the year under review.

Linking performance with budget

Table 33: Programme 8 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Financial Supervision						
Administrative expenses						
Printing and stationery	–	–	–	10	7	3
Refreshments	–	–	–	2	–	2
Subscriptions	40	47	(7)	51	68	(17)
	40	47	(7)	63	75	(12)
Operating expenses						
Consulting	–	–	–	30	–	30
Travel and subsistence	–	–	–	42	9	33
Venue and catering	–	–	–	28	4	24
	–	–	–	100	13	87
Staff costs						
Salaries	11 656	11 450	207	13 061	13 108	(47)
Staff training	82	67	16	128	65	63
	11 739	11 516	222	13 189	13 173	16
TOTAL	11 778	11 563	215	13 352	13 262	91

Programme 9: Complaints Adjudication

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

Performance

Table 34: Programme 9 key performance indicators, planned targets and actual achievements

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 29: Resolve complaints with the aim of protecting beneficiaries of medical schemes								
Output Indicator 29.1	Percentage of complaints adjudicated within 120 working days and in accordance with standard operating procedures	68%	55%	65%	70%	76%	6%	The unit exceeded the target as the focus was mainly on investigation and resolution of complaints while other activities were held in abeyance due to the restrictive movements associated with the national lockdown.
Output Indicator 29.2	Percentage of complaints adjudicated within 30 working days and in accordance with standard operating procedures	New target	New target	New target	70%	76%	6%	The unit exceeded the target as the focus was mainly on investigation and resolution of complaints while other activities were held in abeyance due to the restrictive movements associated with the national lockdown.
Output Indicator 29.3	Percentage of complaints adjudicated within 60 working days and in accordance with standard operating procedures	New target	New target	New target	70%	76%	6%	The unit exceeded the target as the focus was mainly on investigation and resolution of complaints while other activities were held in abeyance due to the restrictive movements associated with the national lockdown.
Output Indicator 29.4	Percentage of complaints adjudicated within 90 working days and in accordance with standard operating procedures	New target	New target	New target	70%	76%	6%	The unit exceeded the target as the focus was mainly on investigation and resolution of complaints while other activities were held in abeyance due to the restrictive movements associated with the national lockdown.

Performance indicators		Actual achievement 2017/18	Actual achievement 2018/19	Actual achievement 2019/20	Planned target 2020/21	Actual achievement 2020/21	Deviation from planned target to actual achievement 2020/21	Comment on deviations
Output Indicator 29.5	Percentage of rulings published on the CMS website within 7 days of issuing the ruling	New target	New target	New target	100%	100%	–	–
Strategic objective 30: Percentage of Appeal Committee hearings attended based on Council Secretariat schedules								
30.1	Percentage of Appeal Committee hearings attended based on Council Secretariat schedules	100%	100%	100%	100%	100%	–	–
30.2	Percentage of Appeals Committee and Appeals Board Rulings published on the CMS website within 7 days of issuing by the Appeals Committee and Appeals Board	New target	New target	New target	100%	100%	–	–

Achievement of strategic objectives

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

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

Continuous engagement with medical schemes on complaints trends also ensures that trends that are identified are addressed promptly in order to avoid recurrence. This also gives medical schemes the opportunity to do a root-cause analysis to curb the increase in the volume of complaints handled internally at medical schemes and to reduce those that may be referred to the Registrar's Office. The unit worked overtime, and this led to the unit exceeding the target.

Strategy to overcome areas of underperformance	Changes to planned targets
The unit exceeded the target, and there was no area of underperformance.	There were no changes to planned targets for the programme during the year under review.

Linking performance with budget

Table 35: Programme 9 linking performance with budgets

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Complaints Adjudication						
Administrative expenses						
Printing and stationery	–	–	–	3	3	–
Refreshments	–	–	–	2	–	2
	–	–	–	5	3	2
Operating expenses						
Travel and subsistence	–	–	–	63	30	33
Venue and catering	–	–	–	–	2	(2)
	–	–	–	63	32	31
Staff costs						
Salaries	9 094	8 683	411	8 437	7 563	874
Staff training	41	42	(0)	115	80	35
	9 136	8 725	411	8 552	7 643	909
TOTAL	9 136	8 725	411	8 620	7 678	942

REPORTING ON THE INSTITUTIONAL RESPONSE TO COVID-19

Internal Interventions

To respond to the national state of disaster in terms of the Disaster Management Act (No. 57 of 2002) the CMS placed mechanisms in place to ensure that business units continued to operate and met their strategic objectives. In the absence of a remote working policy, the CMS allowed employees to work remotely during the various levels of lockdown to reduce the spread of COVID-19. Employees were provided with the necessary tools of trade. It was pleasing to observe how quickly employees adjusted to the new way of work. The CMS also continued to ensure that the working environment was safe and without risk for all CMS employees.

REVENUE COLLECTION

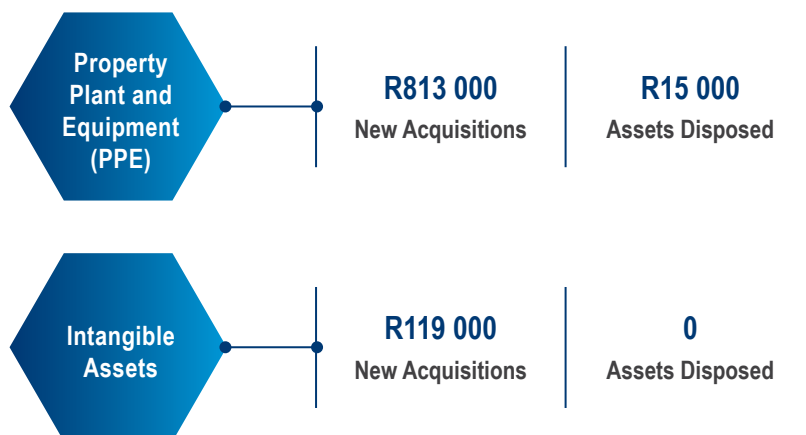
Table 36: Revenue collection

	2020/21			2019/20		
	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000	Budget R'000	Actual expenditure R'000	(Over) Under expenditure R'000
Revenue collection						
Accreditation Fees	6 868	6 875	95	9 536	8 170	(1 366)
Inspection fees recovered	370	363	261	9 322	2 097	(7 225)
Government transfers: Department of Health	6 530	6 530	–	5 987	6 481	494
Legal fees recovered	–	2 948	2 948	–	–	–
Levies income	162 878	164 162	1 284	155 336	156 215	879
Mandatory transfer: Department of Higher Education and Training	–	136	136	–	215	215
Registration fees	513	450	(63)	423	469	46
Sundry income	274	1 579	1 304	790	926	136
Interest received	1 946	1 633	(313)	–	–	–
Gain/loss on disposal of asset	–	17	17	–	–	–
TOTAL	184 723	184 692	5 669	181 394	174 573	(6 821)

The Council for Medical Schemes has over collected by 3% in terms of its estimated revenue for the financial year. The Council was able to recover legal fees that were not planned for whereas in the previous financial year there were no legal fees recovered.

CAPITAL INVESTMENT

The CMS acquired new assets to the value of R932 000 during the period under review, while assets to the value of R15 000 were disposed of.



Asset Register

The CMS fixed assets register and accounting system is updated on a regular basis. The two systems are interfaced through a monthly reconciliation. Physical verification of fixed assets is done on a quarterly basis and asset movements are updated in the register.

Capital Assets

The organisation owned capital assets to the total value of R46 108 000 as at 31 March 2021.

	Property Plant and Equipment (PPE)	Intangible Assets	Good assets: 99.77%	Bad assets: 0.23%
Total cost price	R40 682 000	R5 426 000	R46 003 120	R104 880
Accumulated depreciation	R29 622 000	R4 103 000	R33 648 613	R76 387
Carrying value	R11 060 000	R1 323 000	R12 354 507	R28 493



C

PART C Governance

INTRODUCTION

The Council for Medical Schemes is a Section 3A entity established in terms of the Medical Schemes Act (No. 131 of 1998)(MSA). The Minister of Health exercises political oversight in accordance with the MSA. He can appoint up to 15 members who are responsible for providing strategic direction to the organisation and oversight over the CMS Executive Management. The Minister of Health also appoints the CMS Registrar and Chief Executive who is responsible for managing the business of the Council.

PORTFOLIO COMMITTEES

Parliament exercises its role through evaluating the performance of the CMS by interrogating the annual financial statements and other relevant documents which have to be tabled, as well as any other documents tabled from time to time.

The Standing Committee on Public Accounts (SCOPA) reviews the annual financial statements and the audit reports of the external auditor.

The Portfolio Committee exercises oversight over the service delivery performance of the CMS and, as such, reviews the non-financial information contained in the annual reports and is concerned with service delivery and enhancing economic growth.

The CMS engaged with the Portfolio Committee on Health during February 2021 to discuss the findings and recommendations contained in the interim report of the Section 59 Investigation Panel.

The Section 59 Investigation was established to examine allegations made by medical practitioners that they were being treated unfairly, and that their claims were being withheld by medical schemes and administrators based on their ethnicity and colour of their skin.

EXECUTIVE AUTHORITY

The Public Finance Management Act requires public entities to submit quarterly performance information reports to the relevant executive authority and the National Treasury. During the period under review, CMS submitted quarterly information reports to the CMS Executive Authority and the National Treasury on due date. No issues of concern were raised by the Executive Authority nor the National Treasury, stemming from the reports. The quarterly reports showed excellent performance by the organisation under the direction of the Council.

The Council reviewed its annual performance plan in September 2020 to ensure that it is still in line with its five-year strategic plan. The annual performance plan was approved and submitted to the CMS Executive Authority in January 2021. The Council enjoys a good relationship with the Executive Authority and ensures that all matters that need to be brought to the attention of the Minister are conveyed to him and that the necessary support is provided to him.

THE COUNCIL

A new Council was appointed after the previous Council's term came to an end on 13 November 2020. The new Council started on 16 November 2020 and immediately thereafter held its first meeting. The Minister ensured that there is an appropriate combination of skills and expertise in the Council.

The Council has a duty in terms of the MSA to ensure that the following is carried out:

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

The Council has ensured that its business strategy as well the design of the organisation enable the successful execution of its legislated mandates.

The Council also performs the following functions:

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

The Council adheres to the principles of good corporate governance and subscribes to the King IV Code. The Council and its committees also have charters that govern their conduct.

The Council is expected to sit four times a year for ordinary meetings and two times a year for special meetings, as provided for by the Medical Schemes Act. Council meetings often exceed that number due to the volume of work that is performed. Council engages with management in strategic and risk planning meetings annually over a three-day period.

Two chairpersons of the Council, Dr Clarence Mini and Prof. Lungile Pepeta sadly passed away during the year under review. The Vice-chairperson at the time, Adv. Harshila Kooverjie held the reins until the end of the Council term on 13 November 2020. The Minister of Health appointed Dr Memela Makiwane as the Chairperson of the new Council from 16 November 2020 for a period of three years.

Composition of the Council and Council Committees

The Minister of Health appointed the new Council on 16 November 2020. Four members of the previous Council were re-appointed to the new Council and the committees they serve appear on the table below.

Table 37: Composition of Council during the year under review

Term 14/11/2017 to 13/11/2020							
Name of Council Member	Title	Date appointed	End date	Qualification	Area of expertise	Council committees	Total no. of meetings attended
Clarence Mini	Dr	14/11/17	12/05/20 (Deceased)	• MBChB • Postgraduate Diploma in Palliative Medicine • Advanced Diploma in Negotiation Skills	Medicine, strategic governance and leadership	EXCO HRSE Committee	0
Harshila Kooverjie	Adv.	14/11/17	13/11/20	• BA • LLB	Law	EXCO Appeal Committee	18
Mosidi Maboye	Ms	14/11/17	13/11/20	• PGD in Healthcare Management • BA in Nursing Science • Occupational Health Nursing • Advanced Diploma in Nursing	Healthcare management	Appeals Committee HRSE Committee Nominations	23
Johan van der Walt	Mr	14/11/17	13/11/20	• Master's Degree in Financial Management • CA(SA) • BCompt	Accounting, Auditing, Strategic Governance and Management	ICT Strategic Committee Audit & Risk Committee	18
Steven Mabela	Dr	14/11/17	13/11/20	• PhD Economics • MBA • BSc	Corporate Governance	EXCO HRSE Committee	22
Rebaone Gaoraelwe	Adv.	14/11/17	13/11/20	• BProc • LLB • LLM • Higher Diploma in Company Law • Certificate in Public Sector Governance and Strategy	Law, Corporate Governance, Dispute Resolution	Appeal Committee ICT Strategic Committee HRSE Committee	13
Yogan Pillay	Dr	14/11/17	3/05/20 (Resigned)	• BHSc in Physiology, Biochemistry and Psychology • PhD in Health Policy and Planning	Healthcare Management	EXCO	0
Lungile Pepeta	Prof.	14/11/17	7/7/20 (Deceased)	• MBChB • DCH (SA) • FC Paed (SA) • Cert Cardiology (SA) • MMed • FSCAI	Medicine	EXCO	5
Moerane Maimane	Mr	14/11/17	13/11/20	• MBA • BPA (Hons) • Diploma in Public Administration • BAdmin Accounting	Corporate Governance	HRSE Committee Nominations Appeal Committee EXCO	22
Memela Makiwane	Dr	14/11/17	13/11/20	• MMed • MBChB • Diploma in HIV Management (Dip HIV Man) • Post Graduate Diploma in Pharmaceutical Medicine (PGDip PharmMed) • FCCP (Fellowship of the College of Clinical Pharmacologists)	Medicine	Appeal Committee ICT Strategic Committee Audit & Risk Committee	23
Diane Terblanche	Ms	14/11/2017	13/11/20	• BA Law • LLB • LLM	Law, Corporate Governance, Strategic Management, Consumer Law, Dispute Resolution	Appeal Committee EXCO Nominations	26
Aquina Thulare	Dr	14/11/2017	13/11/20	• MBA • BSc MedS (Hons) • MBChB	Medicine	ICT Strategic Committee Audit & Risk Committee EXCO	16

Term 16/11/2020 to 15/11/2023							
Name of Council Member	Title	Date appointed	End date	Qualification	Area of expertise	Council committees	Total no. of meetings attended
Memela Makiwane	Dr	16/11/20	15/11/23	- MMed - MBChB - Diploma in HIV Management (Dip HIV Man) - Post Graduate Diploma in Pharmaceutical Medicine (PGDip PharmMed) - FCCP (Fellowship of the College of Clinical Pharmacologists)	Medicine	EXCO HRSE Committee Nominations Committee	11
Diane Terblanche	Ms	16/11/20	15/11/23	- BA Law - LLB - LLM	Law , Corporate Governance, Strategic Management, Consumer Law, Dispute Resolution	EXCO Appeals Committee ICT Governance	12
Moerane Maimane	Mr	16/11/20	15/11/23	- MBA - BPA (Hons) - Diploma in Public Administration - BAdmin Accounting	Corporate Governance	EXCO HRSE Committee	10
Aquina Thulare	Dr	16/11/20	15/11/23	- MBA - BSc MedS (Hons) - MBChB	Medicine	EXCO Audit & Risk Committee	4
Thandi Mabeba	Dr	16/11/20	15/11/23	- SAMLA Medico Legal certificate - MPhil Medical Law and Ethics - MBChB	Medicine	Appeals Committee HRSE Committee Nominations Committee	11
Sugendra Naidoo	Dr	16/11/20	15/11/23	- MBA - MBChB	Medicine	Appeals Comm ICT Governance	9
Mfundisi Mabalane	Mr	16/11/20	15/11/23	- Certificate in Principles of Business Management - Certificate in Basic Journalism	Corporate Governance	HRSE Committee	7
Xolani Ngobese	Dr	16/11/20	15/11/23	- PhD in Business Administration - MBA	Corporate Governance	Audit & Risk Committee	9
Imran Vanker	Mr	16/11/20	15/11/23	- BCom (Hons) - CA (SA) - Certificate in Labour Law	Accounting, Auditing, Corporate Governance	Audit & Risk Committee	6
Naheem Rahman	Mr	16/11/20	15/11/23	- LLM - LLB - BA Law	Legal	Appeals Committee	8
Honours Mukhari	Dr	16/11/20	15/11/23	- B Dent Ter (Bachelor of Dental Therapy) - MBChB	Medicine	Appeals Committee	9
Roger Mareume	Adv.	16/11/20	15/11/23	- Certificate in Investigation & Management of Cyber and Electronic crimes - Certificate Prosecuting Child Sex Offenders - LLB - BJuris	Legal	Appeals Committee ICT Governance Committee	6
Nombeko Mbava	Dr	23/11/20	22/11/23	- PhD in Public Management and Development - MBA - BA Economics	Corporate Governance, Public Sector Management & Development	HRSE Committee Nominations Committee	8
Lusani Mulaudzi	Mr	16/11/20	17/05/21 (Resigned)	- Fellow of the Actuary Society of South Africa - Post Graduate Diploma in Actuarial Science - BCom (Hons)	Actuarial Science	EXCO	8
Leavit Mkansi	Dr	16/11/20	15/11/23	- LLD - LLM - BProc	Legal	Appeals Committee ICT Governance Committee	9

Committees of the Council

The Council has the following committees:

Table 38: Committees of the Council

Executive Committee (EXCO) 5 members	Chaired by the Chairperson of the Council and is responsible for day-to-day tasks of the Council.
Human Resource, Social and Ethics Committee (HRSE) 5 members	Responsible for governance of human resources, remuneration, social and ethics matters
Audit and Risk Committee 6 members	Assists Council in fulfilling its oversight responsibility which includes responsibilities regarding the safeguarding of assets, operating effective systems of control and preparing annual financial statements as required by the PFMA, Treasury Regulations, risk management and internal audit oversight.
Information Communications & Technology Strategic Committee 3 members	Responsible for information & communications technology governance in the organisation in line with the Corporate Governance of ICT Policy Framework.
Appeals Committee 7 members	Responsible for hearing appeals against decisions of the Registrar relating to the settlement of complaints or disputes between beneficiaries (section 48 of the MSA) and decisions of the Registrar against regulated entities (section 49).
Nominations Committee (NomCom) 3 members	NomCom monitors the transparent nomination and appointment of members of the committees of Council, ensuring the necessary knowledge, skills, experience, balance of power, and diversity of gender and race. NomCom oversees the composition of Council committees.

Table 39: Membership of Council committees during the year under review

Term 14/11/2017 to 13/11/2020			
Council Committee	No. of meetings held	Number of members of the committee	Names of members of the committee
Full Council	10	12	All Council Members
EXCO	6	6	Dr Clarence Mini (1951 – 2020) Adv. Harshila Kooverjie Dr Steven Mabela Ms Diane Terblanche Dr Yogan Pillay Prof Lungile Pepeta (1974 – 2020)
HRSE	5	5	Dr Clarence Mini (1951 – 2020) Ms Mosidi Maboye Adv. Rebaone Gaoraelwe Dr Steven Mabela Mr Moerane Maimane
Nominations Committee	1	3	Mr Moerane Maimane Ms Diane Terblanche Ms Mosidi Maboye
ICT Strategic Committee	2	4	Mr Johan Van der Walt Dr Memela Makiwane Dr Aquina Thulare Adv. Rebaone Gaoraelwe
Appeals Committee	6	6	Adv. Rebaone Gaoraelwe Dr Memela Makiwane Ms Diane Terblanche Mr Moerane Maimane Ms Mosidi Maboye Adv. Harshila Kooverjie
Audit and Risk Committee	6	6	Mr Lesetsa Matshekga Ms Michelle Pillay Mr Johan Van der Walt Dr Memela Makiwane Ms Sizo Mzizi Dr Aquina Thulare

Term 16/11/2020 to 15/11/2023			
Council Committee	No. of meetings held	Number of members of the committee	Names of members of the committee
Full Council	6	15	All Council Members
EXCO	2	5	Dr Memela Makiwane Ms Diane Terblanche Mr Moerane Maimane Dr Aquina Thulare Mr Lusani Mulaudzi
HRSE	1	5	Dr Memela Makiwane Mr Moerane Maimane Dr Thandi Mabeba Mr Mfundisi Mabalane Dr Nombeko Mbava
Nominations Committee	1	3	Dr Memela Makiwane Dr Thandi Mabeba Dr Nombeko Mbava
ICT Strategic Committee	0	4	Ms Diane Terblanche Dr Sugendra Naidoo Dr Leavit Mkansi Adv. Roger Mareume
Appeals Committee	1	7	Ms Diane Terblanche Dr Thandi Mabeba Dr Sugendra Naidoo Dr Leavit Mkansi Adv. Roger Mareume Dr Honours Mukhari Mr Naheem Raheman
Audit and Risk Committee	2	6	Dr Aquina Thulare Dr Xolani Ngobese Mr Imran Vanker Mr Lesetsa Matshekga Ms Michelle Pillay Ms Sizo Mzizi

Table 40: Remuneration of Council members: 1 April 2020 – 13 November 2020

Name of Council member	Remuneration 2019/20 R'000	Other allowances / reimbursement/s R'000	Total Remuneration 2020/21 R'000
Adv. Rebaone Gaoraelwe	180	–	180
Adv. Harshila Koooverjie	113	–	113
Dr Steven Mabela	130	–	130
Ms Mosidi Maboye	284	–	284
Mr Moerane Maimane	308	–	308
Dr Memela Makiwane	191	–	191
Dr Clarence Mini	0	–	0
Prof. Lungile Pepeta	0	–	0
Ms Diane Terblanche	169	–	169
Mr Johan van der Walt	99	–	99
TOTAL	1 474	–	1 474

Table 41: Remuneration of Council members: 16 November 2020 – 31 March 2021

Name of Council member	Remuneration 2019/20 R'000	Other allowances / reimbursement/s R'000	Total Remuneration 2020/21 R'000
Dr Memela Makiwane	241	–	241
Ms Diane Terblanche	301	–	301
Mr Moerane Maimane	116	–	116
Dr Thandi Mabeba	81	–	81
Dr Nombeko Mbava	58	–	58
Dr Sugendra Naidoo	58	–	58
Dr Honours Mukhari	58	–	58
Mr Mabalane Mfundisi	43	–	43
Dr Leavit Mkansi	82	–	82
Mr Lusani Mulaudzi	74	–	74
Dr Xolani Ngobese	81	–	81
Mr Imran Vanker	51	–	51
Mr Naheem Raheman	79	–	79
TOTAL	1 323	–	1 323

RISK MANAGEMENT

The CMS Enterprise Risk Management Framework and Policy is reviewed on an annual basis. This policy spells out the organisation's risk management methodology and approach.

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

The CMS Risk Management Committee was established to advise management on the overall system of risk management. The committee sits on regular basis. In addition, CMS has a layer of risk champions who exercise risk management at business unit level, and they feed into the CMS Risk Management Committee which reports to the CMS Executive Management.

The CMS Executive Management reports to the Audit and Risk Committee in all matters pertaining to risk management. The Audit and Risk Committee of the Council is ultimately responsible for the governance of risk in the organisation and regular reports are presented to all its meetings to ensure that all strategic as well operational risks are identified and that adequate measures are in place to address them and that management follows up on any issue raised by the Auditor-General or the internal auditors.

The CMS Strategic Risk Register is presented to the Audit and Risk Committee of Council to review and exercise its oversight role towards the independent monitoring and effectiveness of the enterprise system of risk management. The CMS Enterprise Risk Management Framework enables the organisation to improve its performance.

INTERNAL CONTROL UNIT

In terms of the CMS Service Delivery Model, the internal audit function (under which the internal control evaluation and review function falls) was outsourced to an external service provider. The contract with this service provider, Nexia-SAB&T, started on 1 December 2017 and ran until 31 March 2021. The scope of internal audit for the period under reviewed, is outlined below.

In consultation with the Audit and Risk Committee (ARC) of Council, the outsourced internal audit service provider prepared:

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

The internal audit service provider assisted the CMS Accounting Authority in maintaining effective controls by evaluating those controls and developing recommendations for enhancement or improvement. Furthermore, the service provider assisted the CMS Accounting Authority in achieving the objectives of the CMS by evaluating and developing recommendations for the enhancement or improvement of the processes through which:

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

Other audits that needed to be taken into account at the CMS included:

- IT security and systems processes audit.
- Conducting special assignments and investigations, on behalf of Audit and Risk Committee or the CE, into any matter or activity affecting the probity, interest and operating efficiency of the CMS.
- Audit designed to detect fraud.

COMPLIANCE WITH LAWS AND REGULATIONS

In line with the resolution taken by the CMS Accounting Authority during the financial year under review, the compliance function falls under the Office of the Accounting Officer. This function is coordinated with the risk and performance management functions as planned and reported to the Audit and Risk Committee and well as full Council sittings, as scheduled.

FRAUD AND CORRUPTION

The CMS Fraud and Corruption Prevention Policy encompasses the Fraud and Corruption Prevention Plan, Fraud and Corruption Response Plan, as well as the CMS Whistle Blowing Policy. The Fraud and Corruption Prevention policy was reviewed in line with Council's ethics awareness outlook for the year.

The CMS Fraud and Corruption Prevention Policy is supported by a Whistle Blower Hotline mechanism which is managed independently by a service provider called BeHonest.

As a first step, employees must raise concerns with their immediate manager or their superior, or the delegated investigations committee. This depends, however, on the seriousness and sensitivity of the issues involved and who is suspected of the malpractice.

If an employee is for any reason uncomfortable using the normal business channels, they can then contact the whistle-blower service provider on the contact details below or the Registrar.

Concerns may be raised verbally or in writing. Employees who wish to make a written report are invited to use the following format:

- The background and history of the concern (providing adequate information with relevant date;
- The reason they are particularly concerned about the situation;
- The extent to which they have personally witnessed or experienced the problem (provide documented evidence where possible).

The hotline is accessible by shared call centre toll-free number 0800 867 423, secure email address cms@behonest.co.za and website www.behonest.co.za with a chat function. The Chief Executive and Registrar, chairpersons of the Audit and Risk Committee as well of Council are the contact persons to receive the Whistle Blower reports.

MINIMISING CONFLICT OF INTEREST

The CMS Declaration of Interest and Acceptance of Gifts Policy is in place. The policy was reviewed during 2020/21 in consultation with all internal stakeholders and in line with the Council's ethics awareness outlook for the year.

The CMS uses the Standard Bidding Declaration 4 (SBD 4) and the Central Supplier Database (CSD) report to verify the list of directors and minimise risks associated with conflict. The organisation engages with the affected parties should the conflict of interest arise during the compliance process.

CODE OF ETHICS AND CONDUCT

A new code of ethics and conduct was adopted during the year under review. The code sets down common ethical standards that CMS employees should adhere to on a consistent basis to ensure that their actions are in accordance with the CMS values and standards.

The new CMS Code of Ethics and Conduct was accepted after consultation with all internal stakeholders and the annual review done in line with the Council's ethics awareness outlook for the year. In addition, the CMS Ethics Strategy and Awareness Plan was approved and implemented. All staff members are provided with the CMS Ethics Booklet.

The process followed in the event of a breach of code of conduct is as follows:

Less serious offence

If CMS Management deems the breach to be less serious, then an employee will be subjected to an informal disciplinary hearing which may result in verbal or written warning if the employee is found guilty. Normally the process will only involve the employee and his supervisor/manager.

Serious Offence

If CMS Management deems the breach to be serious, then an employee will be subjected to a formal disciplinary hearing which may result in final written warning, suspension without pay, and/or dismissal if the employee is found guilty.

In a formal disciplinary hearing, the Registrar appoints a chairperson to preside over the hearing and an initiator to present the case on behalf of CMS. The employee has a right to be represented by a CMS employee or a shop steward. Furthermore, an employee is afforded the opportunity to state their side of the story, cross examine CMS witnesses and to plead in mitigation of penalty should they be found guilty.

HEALTH, SAFETY AND ENVIRONMENTAL ISSUES

The Occupational Health and Safety Act (No. 85 of 1993) requires organisations to provide reasonable, practical, and maintenance of a safe and risk-free working environment for its employees. In compliance, the CMS established the new CMS Health and Safety Committee on expiry of the term of the old committee during the reporting period.

Committee members will receive training during the new financial year to ensure that the committee performs its mandate in a competent manner. The committee is expected to review the health and safety policy once the training has taken place.

Furthermore, the CMS was required to comply with the provisions of the Disaster Management Act (No. 57 of 2002) in the wake of the COVID-19 pandemic. In the absence of a remote working policy, the CMS allowed employees to work remotely during the various levels of lockdown to reduce the spread of COVID-19. Employees were provided with the necessary tools of trade.

The CMS also continued to ensure that the working environment was safe and without risk for all CMS employees, stakeholders and visitors. Stakeholders are requested to wear a face mask. Hand sanitising, temperature screening, exposure and contact information was and continues to be mandatory.

A total of 13 COVID-19 positive cases were reported during the year under review. Two Council members namely Dr Clarence Mini and Prof. Lungile Pepeta succumbed to the pandemic. Employees virus that tested positive for COVID-19 during 2020/21 have recovered.

CMS COMPANY SECRETARY

The CMS Council is assisted by the CMS Company Secretary who provides corporate governance and administration services. He is further delegated with the mandate of guiding members as to their duties, responsibilities and functions. He facilitates full and unfettered access to the organisation's information including records for the use of Council. The CMS Company Secretary maintains an arm's length relationship with the Council and the governing body is satisfied that he is fit and proper to perform his functions. During the year under review, Mr Khayaletu Mvulo served as CMS Company Secretary.

SOCIAL RESPONSIBILITY

The Stakeholder Relations unit presented a draft CMS Corporate Social Responsibility Strategy to the Human Resources Sub-Committee in 2019. The committee approved it for submission to Council. It will be submitted to Council during the 2021/22 financial year. When the strategy is adopted, the CMS will partner with regulated entities on social responsibility projects and so contribute to doing good for the community.

B-BBEE COMPLIANCE PERFORMANCE INFORMATION

The following table was completed in accordance with the compliance to the B-BBEE requirements as required by the B-BBEE Act and as determined by the Department of Trade, Industry and Competition.

Table 42: B-BBEE compliance performance

Has the public entity applied any relevant code of Good Practice (B-BBEE Certificate Levels 1- 8) with regards to the following:

Criteria	Response Yes /No	Discussion (measures taken/not taken to comply)
1. Determining qualification criteria for the issuing of licences, concessions or other authorisations in respect of economic activity in terms of any law?	No	The CMS B-BBEE Technical Team recently developed a project plan to address its accreditation standards.
2. Developing and implementing a preferential procurement policy?	No	The CMS applies the Preference Point System for transactions above R30 000 through the quote evaluation template provided by National Treasury.
3. Determining qualification criteria for the sale of state-owned enterprises?	Not applicable	Selling of state owned enterprises does not fall within the scope of the work of CMS.
4. Developing criteria for entering into partnerships with the private sector?	Not applicable	CMS does not enter into partnerships with the private sector
5. Determining criteria for the awarding of incentives, grants and investment schemes in support of Broad Based Black Economic Empowerment?	Not applicable	CMS does not award grants, incentives or investment schemes

AUDIT COMMITTEE REPORT

We are pleased to present our report for the financial year ended 31 March 2021.

Audit Committee responsibility

The Audit Committee reports that it has complied with its responsibilities arising from Section 51 (1)(a)(ii) of the Public Finance Management Act and Treasury Regulation 27.1. The Audit Committee also reports that it has adopted appropriate formal terms of reference as its Audit Committee Charter, has conducted its affairs in compliance with this charter and has discharged all its responsibilities as contained therein, except that we have not reviewed changes in accounting policies and practices.

The Audit and Risk Committee's terms of reference

During the year under review, the committee reviewed and amended its terms of reference to align with changes noted in the business and regulatory environment. A formal and systematic process is in place for determining strategic and operational objectives setting and monitoring performance. Oversight of CMS's risk management and control activities are in place, co-ordinated and continuous improvement monitored. The Committee is satisfied that it has conducted and discharged its affairs and responsibilities in compliance with its terms of reference, and all applicable legal and regulatory requirements.

Audit and Risk Committee members and attendance

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

Table 43: Audit and Risk Committee members and attendance

Members of the Audit and Risk Committee	Number of meetings attended
Mr Lesetsa Matsheka (Chairperson)	8
Dr Xolani Ngobese ¹	2
Mr Imran Vanker ¹	1
Mr Johan van der Walt ²	6
Dr Memela Makiwane ²	6
Ms Michelle Pillay	7
Ms Sizo Mzizi	7
Dr Aquina Thulare	6

¹ Appointed on 16 November 2020

² Resigned on 13 November 2020

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

Internal audit

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

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

The effectiveness of internal control

The Audit and Risk Committee received and reviewed Internal Audit's written statement on effectiveness of internal controls. While controls are in place and effective in most areas, some weaknesses were identified in other areas of the business notably supply chain management (SCM) and IT. Remedial actions will be implemented by management, going forward, to address the weaknesses identified.

A Loss Control Committee has been established to look into all matters related to irregular and fruitless and wasteful expenditure, in line with the SCM Framework.

In-year management and monthly/quarterly reporting

The public entity has reporting monthly and quarterly to the National Treasury as is required by the PFMA.

Evaluation of financial statements

We have reviewed the annual financial statements prepared by the public entity.

Auditor's report

The Committee reviewed the annual financial statements and annual performance report of the CMS for the financial year ended 31 March 2021 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 2021 to Council for approval.



Lesetsa Matshekga

Chairperson of the Audit Committee
Council for Medical Schemes

31 July 2021



D

PART D
Human Resources
Management

INTRODUCTION

The CMS Human Resources unit provides support to the entire organisation. The unit has overall responsibility for developing and delivering human resource programmes to attract, develop and retain skilled and knowledgeable personnel through an effective recruitment and selection process.

During the 2020/21 financial year, the CMS reviewed and reassessed the organisational design with a view to improve effectiveness and efficiencies. The review resulted in a new organisational structure and a revised service delivery and operating model, which were approved by Council on 29 May 2020. Some key HR deliverables were adversely affected by the changes and a different approach was required in order to align project deliverables and implementation requirements.

Furthermore, activities to improve the conditions of employment were placed on hold in response to the directive by the Ministries of Health, Finance, and Public Services and Administration with the current state of public finance following the Medium-Term Policy Budget Statement (MTBPS). The CMS will action these activities when the moratorium is lifted.

To respond to the national state of disaster in terms of the Disaster Management Act (No. 57 of 2002) the CMS placed mechanisms in place to ensure that business units continued to operate and met their strategic objectives. In the absence of a remote working policy, the CMS allowed employees to work remotely during the various levels of lockdown to reduce the spread of COVID-19. Employees were provided with the necessary tools of trade. It was pleasing to observe how quickly employees adjusted to the new way of work. The CMS also continued to ensure that the working environment was safe and without risk for all CMS employees. A total of 13 COVID-19 positive cases (including Council members) were reported during the year under review. Two Council members succumbed to the pandemic. Employees that tested positive for COVID-19 during 2020/21 have recovered.

The following section provides an overview of the activities of the CMS Human Resources (HR) unit during the reporting period. The information focuses on the execution of the CMS Human Resources Strategy 2020/21 as outlined in the CMS Annual Performance Plan (APP), covering aspects such as remuneration philosophy and employment value proposition; talent management and staff retention; performance management; training and development; employment equity; health and safety, as well as personnel and related costs.

Remuneration philosophy

A remuneration philosophy and employment value proposition policy was approved by Council at a special meeting on 29 November 2019. It became effective on 1 April 2020 and was implemented.

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

During the 2020/21 reporting period, vacancies were filled according to the CMS recruitment and selection process. A total of 15 employees were appointed into permanent positions; eight were filled by external applicants, four filled by internal applicants, two filled by applicants that participated in the internship programme, and one was filled by an employee appointed on a fixed-term contract.

External appointments

- Chief Information Officer
- Chief Financial Officer
- Organisational Development Manager
- Financial Analyst
- Accountant
- Legal Advisor
- Helpdesk Technician
- Administrator: Complaints and Adjudication

Internal appointments

- Senior Researcher
- Senior Legal Adjudication Officer
- Communications Manager
- Legal Adjudication Officer

Internship appointments

- Finance Officer: Debtors
- Registry Officer

Fixed-term contract

- Broker Accreditation Analyst

To ensure continuity and delivery on strategic objectives, the HR unit facilitated the appointment of employees to act in the following vacant positions:

- General Manager: Compliance and Investigations
- General Manager: Legal Services
- General Manager: Benefits Management
- General Manager: Accreditation
- General Manager: Financial Supervision
- General Manager: Human Resources
- General Manager: Stakeholder Relations
- Chief Financial Officer

However, the seven general management positions will become redundant when the approved CMS Service Delivery and Operating Model is implemented. The elimination of these positions in the new structure will serve to reduce the span of control of the CMS Registrar and Chief Executive.

Terminations

There were 22 terminations during the year under review. The terminations comprised of nine resignations, five non-renewal of fixed-term contracts, three dismissals, one CCMA award, and four internal movements (where employees were appointed into other positions).

Resignations

- General Manager: Stakeholder Relations
- Accountant
- Medical Advisor
- Senior Researcher
- Senior Legal Adjudication Officer
- Senior Benefits Analyst
- Accreditation Analyst: MCO
- Legal Adjudication Officer
- Supply Chain Management Officer

Non-renewal

- Chief Financial Officer
- General Manager: Financial Supervision
- General Manager: Human Resources
- General Manager: Benefits Management
- General Manager: Legal Services

Dismissals

- Communications Manager
- Risk & Performance Manager
- Compliance Officer

Internal movement

- Data Management Analyst
- Legal Adjudication Officer
- Customer Relations Officer
- Paralegal Assistant

CCMA award

- Registry Officer

The CMS continued to support government's call to develop the skills of qualified graduates. For the period under review, the CMS appointed 10 graduates to participate in the internship programme, four of whom were appointed into permanent positions.

Learning and development

CMS has a professional development programme (PDP) that encourages employees to further their studies and improve skills and knowledge in line with their specific areas of accountability. In addition to the PDP, budget is made available for employees to attend other learning opportunities such as workshops, conferences, and seminars to keep abreast of industry trends. The PDP cost is borne by the CMS within the budgeted PDP amount for the year.

CMS is currently registered with the HWSETA. CMS pays the skills development levy (SDL) to SARS and annually benefits from mandatory grants by annually submitting a workplace skills plan and annual training report (WSP/ATR). Eight employees completed their qualifications during 2020/21. The six employees registered on the Adult Education Training (AET) programme to increase their competencies in numeracy and literacy, progressed to the next level during 2020/21.

A secondment opportunity was granted to an employee for a period of 24 months, starting in September 2020. The employee provides technical and secretariat support to the projects within the Office of the Social Policy Advisor at the Presidency. Participation in secondments ensures that CMS employees share their knowledge and skills as well as enhance their own experience while they further the interests of the Republic of South Africa. It also enables them to continue working towards the attainment of CMS strategic objectives of being responsive to the environment by being a fair, transparent, effective and efficient organisation through well targeted programs and best practice regulation.

Employee engagement

To ensure that employees remained engaged while working remotely, the HR unit facilitated information sharing sessions on managing performance remotely, burnout and resilience. Support was also provided to employees using the employee assistance programme to deal with their personal and professional problems.

The unit facilitated several employee consultations and information sharing sessions in preparation to implement the new service delivery and operating models. As a result of the implementation project, and the response to the lockdown regulations, some of the planned employee engagement activities were deferred to the next financial year.

Employee performance management framework

Performance management continued to be a high priority. The HR unit implemented a new performance management template which is aligned to the balanced scorecard system and emphasises the SMART criteria requirement. Training on this new performance contracting system was facilitated through a secure online communications platform. Employees signed performance agreements with their supervisors at the beginning of the financial year. Two formal performance reviews were conducted in line with the performance management and incentive policies. To supplement the balanced scorecard system, a 360° assessment tool was developed and implemented for the first time in the CMS.

Talent management

During the year under review, the HR unit developed a draft talent management framework as well as a qualification and work experience framework. The qualifications and work experience framework has been through the consultation process and awaits approval by the CEO. The draft talent management policy framework will be subjected to an employee consultation process in the next financial year.

Employee relations

To ensure good practices that enable the achievement of organisational objectives compliant with the legislative framework and appropriate to socio-economic conditions, the HR unit continued to provide framework and strategies for effective conflict resolution and stability in the workplace. This was achieved through constructive trade union engagement and workshops that were conducted during the year.

The CMS had eight labour disputes during the reporting period. These disputes of unfair labour practice were referred to the CCMA for conciliation and arbitration. There was one case of suspension pending investigation into allegations of serious acts of misconduct during the third quarter of the reporting year. The investigation did not find wrongdoing on the part of the employee and the suspension was lifted, and the employee has since returned to work.

The CCMA awarded a ruling against the CMS in the matter involving payment of the 2019/20 performance bonuses. Due to financial constraints, performance bonuses were paid to employees on 7 May 2021.

The CMS implemented annual salary increases of 5.1% for executive management and 6.1% for other employees on 1 April 2020. The directives from the Ministers of Health, Finance and Public Services and Administration to not change conditions of service of employees were received after the CMS had implemented the annual inflationary increases on 12 May 2020. For the 2021/22 financial year, wage negotiations with Nehawu have started and are continuing.

Employee wellness programmes

Maintaining a healthy workforce is an important part of the HR function. The CMS has an outsourced employee wellness programme that provides staff members with access to guidance on work-life balance. The service provider (Careways) reported an increase in the number of employees using the programme. Due to COVID-19 lockdown regulations, wellness day and World Aids Day (which is usually commemorated on or around 1 December) for CMS could not be held.

Policy review

Strides were made in developing and reviewing policies during the period under review. The following policies were reviewed and approved by Council on 29 May 2020:

- Harassment
- Terms and conditions of service and employee benefits
- Disciplinary
- Code of Ethics and Conduct

In the absence of secondment and remote working policies, the secondment and working remotely policies were developed through a consultative process and await Council approval.

Employment equity

Compliance with the requirements of employment equity remains a major focus for the CMS as it strives to build and maintain an environment that provides equal opportunity for all its employees, with special consideration for previously disadvantaged groups at all occupational levels.

The Employment Equity Forum participated in the recruitment and selection processes to monitor implementation of the CMS Employment Equity Plan. Furthermore, a member of the forum was key in finalising the Employment Equity Report and Income Differentials Statement which were submitted on 15 January 2021.

The CMS is fairly aligned to the Broad-Based Black Economic Empowerment (B-BBEE) Scorecard. The CMS has made great progress in attaining employment equity targets of 10.86 points when compared to the target of 10 points determined by the B-BBEE scorecard. Recruiting persons with disabilities was a challenge during 2020/21 and continues to be a challenge. However, the CMS consciously strives to correct the gap in this designated category by specifically inviting candidates that can fulfil the gap. Currently, the organisation is at 0.44% to reach the target of 4% as illustrated in Table 44.

Table 44: BBEEA Scorecard

Criteria	A		B	C	D	%	Achievement/ Challenge
Black people with disabilities employed by the entity as a percentage of all full-time employees	1	113	0.88%	4%	2	0.44	1.56
Black people employed by the entity at senior management level as a percentage of employees at senior management level	5	5	100%	60%	2	3.33	-1.33
Black women employed by the entity at senior management level as a percentage of employees at senior management level	2	5	40%	30%	2	2.67	-0.67
Black people employed by the entity at professionally qualified level as a percentage of employees at professionally qualified level	31	36	86.11%	75%	2	2.30	-0.30
Black women employed by the entity at professionally qualified level as a percentage of employees at professionally qualified level	14	36	38.89%	40%	1	0.97	0.03
Black people employed by the entity at skilled technical & academically qualified workers as a percentage of employees at skilled technical & academically qualified level	44	48	91.67%	80%	1	1.15	-0.15
Weighting points					10	10.96	-0.96

Key

Measurement of the employment equity criteria

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

Formula: $A = B/C \times D$

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

B is the percentage of category of black people being measured

C is the percentage compliance target in respect of that criteria

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

Highlights and achievements

- Approval and implementation of four policies to ensure compliance with legislation regulating employment.
- Employment equity reports submitted to the Department of Labour.
- Workplace skills development and annual training reports submitted to HWSETA.

Challenges faced by the organisation

- High staff turnover-rate of skilled personnel.
- Lack of an effective talent management strategy.
- Lack of attractive employee benefits (medical aid subsidy, housing, 13th cheque, pension/provident fund benefits).
- Lack of succession in senior positions to ensure continuity.

Future HR plans/goals

- Reduce labour relations costs by appointing internal capacity to chair and initiate disciplinary hearings.
- Develop and implement the organisational development strategy.
- Develop and implement talent management strategy to ensure that talent is developed, and retained within the organisation.
- Improve the performance management process and procedure to ensure objectivity.

HUMAN RESOURCES OVERSIGHT STATISTICS

Table 45: Personnel costs per programme

Programme	Total expenditure of the unit (R'000)	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	Number of employees	Average personnel cost per employee (R'000)
Programme 1 - Administration					
Sub-programme 1.1 - Office of the CEO	17 305	6 901	39.88%	6	1 150
Sub-programme 1.2 - Office of the CFO	37 999	10 342	27.22%	19	544
Sub-programme 1.3 - ICT and Knowledge Management	24 469	13 305	54.37%	15	887
Sub-programme 1.4 - Human Resources	8 594	5 520	64.24%	6	920
Sub-programme 1.5 - Legal Services	26 816	4 631	17.27%	3	1 544
Programme 2 - Strategy Office	9 865	8 595	87.13%	8	1 074
Programme 3 - Accreditation	7 712	7 388	95.79%	8	923
Programme 4 - Research and Monitoring	6 240	6 162	98.75%	6	1 027
Programme 5 - Stakeholder Relations	8 585	7 467	86.98%	8	933
Programme 6 - Compliance and Investigations	11 771	9 751	82.84%	8	1 219
Programme 7 - Benefit Management	5 352	5 346	99.89%	5	1 069
Programme 8 - Financial Supervision	11 563	11 450	99.02%	10	1 145
Programme 9 - Complaints Adjudication	8 725	8 683	99.52%	11	789
TOTAL	184 996	105 541	57.05%	113	934

Table 46: Personnel costs per salary level

Programme	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	Number of employees at Year end	Average personnel cost per employee (R'000)
Top management	2 620	2.48%	1	2 620
Senior management	8 118	7.69%	5	1 624
Professionals	50 362	47.72%	35	1 439
Skilled labour	37 467	35.50%	49	765
Semi-skilled labour	5 775	5.47%	14	413
Unskilled labour	1 199	1.14%	9	133
TOTAL	105 541	100%	113	934

Table 47: Performance rewards

Programme	Performance reward (R'000)	% Performance reward per level	Number of employees at year end	Average personnel cost per employee (R'000)
Top management	–	0%	1	–
Senior management	–	0%	5	–
Professionals	–	0%	35	–
Skilled labour	–	0%	49	–
Semi-skilled labour	–	0%	14	–
Unskilled labour	–	0%	9	–
TOTAL	0	0	113	0

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

Table 48: Training costs per programme

Programme	Personnel expenditure (R'000)	Training expenditure (R'000)	Training expenditure as % of personnel cost	Number of employees	Average training cost per employee (R'000)
Programme 1 - Administration					
Sub-programme 1.1 - Office of the CEO	6 901	12	0.18%	6	2.04
Sub-programme 1.2 - Office of the CFO	13 305	96	0.72%	19	7.71
Sub-programme 1.3 - ICT and Knowledge Management	5 520	147	0.31%	15	6.43
Sub-programme 1.4 - Human Resources	10 342	17	1.42%	6	2.82
Sub-programme 1.5 - Legal Services	4 631	32	0.68%	3	10.51
Programme 2 - Strategy Office	8 595	73	0.85%	8	9.09
Programme 3 - Accreditation	7 388	119	1.61%	8	14.88
Programme 4 - Research and Monitoring	6 162	78	1.26%	6	12.94
Programme 5 - Stakeholder Relations	7 467	15	0.21%	8	1.93
Programme 6 - Compliance and Investigations	9 751	143	1.47%	8	17.92
Programme 7 - Benefit Management	5 346	46	0.86%	5	9.19
Programme 8 - Financial Supervision	11 450	67	0.58%	10	6.66
Programme 9 - Complaints Adjudication	8 683	42	0.48%	11	3.80
TOTAL	105 541	886	0.84%	113	7.84

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

Table 49: Employment and vacancies per programme

Programme	2019/20 number of employees	Approved posts 2020/21	2020/21 number of employees	2020/21 vacancies	% of vacancies
Programme 1 - Administration					
Sub-programme 1.1 - Office of the CEO	7	0	6	1	3.85%
Sub-programme 1.2 - Office of the CFO	19	0	19	4	15.38%
Sub-programme 1.3 - ICT and Knowledge Management	13	0	15	2	7.69%
Sub-programme 1.4 - Human Resources	6	0	6	1	3.85%
Sub-programme 1.5 - Legal Services	3	0	3	2	7.69%
Programme 2 - Strategy Office	9	0	8	1	3.85%
Programme 3 - Accreditation	8	0	8	2	7.69%
Programme 4 - Research and Monitoring	7	0	6	1	3.85%
Sub-programme 5 - Stakeholder Relations	10	0	8	3	11.54%
Sub-programme 6 - Compliance and Investigations	9	0	8	2	7.69%
Sub-programme 7 - Benefits Management	7	0	5	2	7.69%
Sub-programme 8 - Financial Supervision	10	0	10	1	3.85%
Sub-programme 9 - Complaints Adjudication	12	0	11	4	15.38%
TOTAL	120	0	113	26	100%

Table 50: Employment and vacancies per salary level 2020/21

Level	2019/20 number of employees	Approved posts 2020/21	2020/21 number of employees	2020/21 vacancies	% of vacancies
Top management	1	0	1	0	0.00%
Senior management	9	0	5	8	30.77%
Professionals	35	0	35	7	26.92%
Skilled labour	55	0	49	9	34.62%
Semi-skilled labour	11	0	14	2	7.69%
Unskilled labour	9	0	9	0	0.00%
TOTAL	120	0	113	26	100%

Four of the vacancies were from the previous year. Vacancies emanated from new non-renewal of 5 years' fixed-term contracts, terminations, resignations, and internal movement.

There were no newly created positions in the 2020/21 reporting year. Vacancies resulted from internal movements, medical boarding, non-renewal of fixed-term contracts, and terminations.

Table 51: Employment changes per salary band 2020/21

Level	Employment at beginning of period	Appointments	Terminations	Employment at end of period
Top management	1	0	0	1
Senior management	5	2	6	5
Professionals	35	5	5	35
Skilled labour	55	5	11	49
Semi-skilled labour	11	3	0	14
Unskilled labour	9	0	0	9
TOTAL	116	15	22	113

Vacancies between appointments and terminations resulted from terminations during the reporting period.

Table 52: Reasons for staff leaving 2020/21

Reason	Number of employees	% of total number of staff leaving
Death	0	0%
Resignation	10	45%
Dismissal	3	14%
Retirement	0	0%
Ill health	0	0%
Expiry of contract	5	23%
Other	4	18%
TOTAL	22	100%

Table 53: Labour relations: Misconduct and disciplinary action 2020/21

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



E

PART E

Financial information

STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY OF THE ANNUAL FINANCIAL STATEMENTS

The Council members are required by the Public Finance Management Act (Act 1 of 1999), to maintain adequate accounting records and are responsible for the content and integrity of the annual financial statements and related financial information included in this report. It is the responsibility of the members to ensure that the annual financial statements fairly present the state of affairs of the entity as at the end of the financial year and the results of its operations and cash flows for the period then ended. The external auditors are engaged to express an independent opinion on the annual financial statements and are given unrestricted access to all financial records and related data.

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 upon appropriate accounting policies consistently applied and supported by reasonable and prudent judgements and estimates.

The Council members acknowledge that they are ultimately responsible for the system of internal financial control established by the entity and place considerable importance on maintaining a strong control environment. To enable the members to meet these responsibilities, the members set standards for internal control aimed at reducing the risk of error or deficit in a cost effective manner. The standards include the proper delegation of responsibilities within a clearly defined framework, effective accounting procedures and adequate segregation of duties to ensure an acceptable level of risk. These controls are monitored throughout the entity and all employees are required to maintain the highest ethical standards in ensuring the entity's business is conducted in a manner that in all reasonable circumstances is above reproach. The focus of risk management in the entity is on identifying, assessing, managing and monitoring all known forms of risk across the entity. While operating risk cannot be fully eliminated, the entity endeavours to minimise it by ensuring that appropriate infrastructure, controls, systems and ethical behaviour are applied and managed within predetermined procedures and constraints.

The Council members are of the opinion, based on the information and explanations given by management, that the system of internal control provides reasonable assurance that the financial records may be relied on for the preparation of the annual financial statements. However, any system of internal financial control can provide only reasonable, and not absolute assurance against material misstatement or deficit.

The Council members have reviewed the entity's cash flow forecast for the year to 31 March 2022 and, in the light of this review and the current financial position, they are satisfied that the entity has access to adequate resources to continue in operational existence for the foreseeable future.

The annual financial statements are prepared on the basis that the CMS is a going concern and that the CMS has neither the intention nor the need to liquidate or curtail materially the scale of the CMS.

Although the Council members are primarily responsible for the financial affairs of the CMS, they are supported by the CMS' external auditors.

The external auditors are responsible for independently reviewing and reporting on the CMS' annual financial statements. The annual financial statements have been examined by the CMS' external auditors and their report is presented on page 85 to 88.

The annual financial statements set out on pages 89 to 120 which have been prepared on the going concern basis, were approved by the Council members on 27 May 2021 and were signed on its behalf by:



Dr Memela Makiwane
Chairperson of the Council

31 March 2021



Dr Siphon Kabane
Chief Executive & Registrar

31 March 2021

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

Report on the audit of the financial statements

Opinion

1. I have audited the financial statements of the Council for Medical Schemes set out on pages 89 to 120 which comprise the statement of financial position as at 31 March 2021, the statement of financial performance, statement of changes in net assets, statement of cash flows and statement of comparison of budget information with actual information for the year then ended, as well as 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 2021, and financial performance and cash flows for the year then ended in accordance with South African General Recognized Accounting Practice (SA GRAP) and the requirements of Public Finance Management Act 1 of 1999 (PFMA).

Context for the opinion

3. I conducted my audit in accordance with the International Standards on Auditing (ISAs). My responsibilities under those standards are further described in the auditor-general's responsibilities for the audit of the financial statements section of this auditor's report.
4. I am independent of the entity in accordance with the International Ethics Standards Board for Accountants' *International code of ethics for professional accountants (including International Independence Standards)* (IESBA code) as well as other 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.

Responsibilities of the accounting authority for the financial statements

6. The board of directors, which constitutes the accounting authority, is responsible for the preparation and fair presentation of the financial statements in accordance with SA GRAP and the requirements of the PFMA and for such internal control as the accounting authority determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

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

Report on the audit of the annual performance report

Introduction and scope

10. In accordance with the Public Audit Act of South Africa 25 of 2004 (PAA) and the general notice issued in terms thereof, I have a responsibility to report on the usefulness and reliability of the reported performance information against predetermined objectives for selected programmes presented in the annual performance report. I performed procedures to identify material findings but not to gather evidence to express assurance.
11. My procedures address the usefulness and reliability of the reported performance information, which must be based on the entity's approved performance planning documents. I have not evaluated the completeness and appropriateness of the performance indicators included in the planning documents. My procedures do not examine whether the actions taken by the entity enabled service delivery. My procedures do not extend to any disclosures or assertions relating to the extent of achievements in the current year or planned performance

strategies and information in respect of future periods that may be included as part of the reported performance information. Accordingly, my findings do not extend to these matters.

12. I evaluated the usefulness and reliability of the reported performance information in accordance with the criteria developed from the performance management and reporting framework, as defined in the general notice, for the following selected programme presented in the entity's annual performance report for the year ended 31 March 2021:

Programme	Pages in the annual performance report
Programme 6 – Compliance and Investigations	52 - 54

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

Other matters

I draw attention to the matter below.

Achievement of planned targets

15. Refer to the annual performance report on pages 33 to 62; for information on the achievement of planned targets for the year and management's explanations provided for the under-/ over achievement of targets.

Adjustment of material misstatements

16. I identified material misstatements in the annual performance report submitted for auditing. These material misstatements were on the reported performance information of programme 6 – Compliance and Investigations. As management subsequently corrected the misstatements, I did not raise any material findings on the usefulness and reliability of the reported performance information.

Report on the audit of compliance with legislation

Introduction and scope

17. In accordance with the PAA and the general notice issued in terms thereof, I have a responsibility to report material findings on the entity's compliance with specific matters in key legislation. I performed procedures to identify findings but not to gather evidence to express assurance.
18. Included below are material findings on compliance with selected specific requirements of applicable legislation, as set out in the general notice issued in terms of the PAA.

Expenditure Management

19. Effective and appropriate steps were not taken to prevent irregular expenditure amounting to R5 379 000 as disclosed in note 27 to the annual financial statements, as required by section 51(1)(b)(ii) of the PFMA. Most of the irregular expenditure was caused by the entity sourcing services from suppliers that are on a panel that was not established through competitive bidding processes. Similar non-compliance was also reported in the prior year.

Other information

20. The accounting authority is responsible for the other information. The other information comprises the information included in the annual report, which includes the council's report and the audit committee's report. The other information does not include the financial statements, the auditor's report thereon and those selected programmes presented in the annual performance report that have been specifically reported on in the auditor's report.
21. 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.
22. 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 programme presented in the annual performance report, or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

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

Internal control deficiencies

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

25. Management did not adequately monitor compliance with applicable laws and regulations, as well as related internal control as evident by the non-compliance with SCM prescripts that resulted in irregular expenditure.

26. Management did not adequately implement review controls over performance reporting as evident by material errors identified in the annual performance report and corrected during the audit.

Auditor - General

Pretoria
31 July 2021



AUDITOR - GENERAL
SOUTH AFRICA

ANNEXURE – AUDITOR-GENERAL'S RESPONSIBILITY FOR THE AUDIT

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

Financial statements

2. In addition to my responsibility for the audit of the financial statements as described in this auditor's report, I also:
 - identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error; design and perform audit procedures responsive to those risks; and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control
 - obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control
 - evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the board of directors, which constitutes the accounting authority
 - conclude on the appropriateness of the accounting authority's use of the going concern basis of accounting in the preparation of the financial statements. I also

conclude, based on the audit evidence obtained, whether a material uncertainty exists relating to events or conditions that may cast significant doubt on the ability of the Council for Medical Schemes to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements about the material uncertainty or, if such disclosures are inadequate, to modify my opinion on the financial statements. My conclusions are based on the information available to me at the date of this auditor's report. However, future events or conditions may cause the entity to cease operating as a going concern

- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and determine whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

Communication with those charged with governance

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

STATEMENT OF FINANCIAL POSITION

as at 31 March 2021

	Note(s)	2021 R'000	2020 Restated R'000
Assets			
Current Assets			
Receivables from exchange transactions	3	10 354	4 903
Cash and cash equivalents	4	5 156	4 929
		15 510	9 832
Non-Current Assets			
Property, plant and equipment	5	11 060	13 248
Intangible assets	6	1 323	1 447
Security deposits	29	3 847	–
		16 230	14 695
Total Assets		31 740	24 527
Liabilities			
Current Liabilities			
Operating lease liability	9	2 870	1 730
Payables from exchange transactions	7	37 370	28 742
Unspent conditional grants and receipts	12	2 080	2 080
Provisions	8	494	257
		42 814	32 809
Non-Current Liabilities			
Operating lease liability	9	4 757	7 615
Provisions	8	2 162	1 748
		6 919	9 363
Total Liabilities		49 733	42 172
Net Assets		(17 993)	(17 645)
Accumulated deficit		(17 993)	(17 645)
Total Net Assets		(17 993)	(17 645)

STATEMENT OF FINANCIAL PERFORMANCE

for the year ended 31 March 2021

	Note(s)	2021 R'000	2020 Restated R'000
Revenue	11	183 043	174 573
Administrative expenses	13	(27 029)	(26 616)
Audit fees	14	(2 583)	(2 715)
Operating expenses	15	(38 936)	(47 740)
Staff costs	16	(112 925)	(121 241)
Depreciation and amortisation	5/6	(3 226)	(4 576)
Bad debt	17	(291)	–
Gain on disposal of assets	18	17	(66)
Operating deficit		(1 930)	(28 381)
Interest received	20	1 633	3 281
Finance costs	30	(51)	(63)
Surplus/(deficit) for the year		(348)	(25 163)

STATEMENT OF CHANGES IN NET ASSETS

for the year ended 31 March 2021

	Accumulated deficit R'000	Accumulated deficit R'000
Balance at 01 April 2019	6 988	6 988
Correction of prior year error	530	530
Balance at 1 April 2019 – restated	7 518	7 518
Deficit for the year – restated	(25 163)	(25 163)
	(25 163)	(25 163)
Balance at 01 April 2020	(17 645)	(17 645)
Surplus for the year	(348)	(348)
Balance at 31 March 2021	(17 993)	(17 993)

CASH FLOW STATEMENT

for the year ended 31 March 2021

	Note(s)	2021 R'000	2020 Restated R'000
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		170 635	168 257
Transfers		6 666	6 202
Interest income		1 621	3 281
		178 922	177 740
Payments			
Employee costs		(111 385)	(116 337)
Suppliers		(62 563)	(79 999)
		(173 948)	(196 336)
Net cash flows from operating activities	19	4 974	(18 596)
Cash flows from investing activities			
Purchase of property, plant and equipment	5	(813)	(2 372)
Proceeds from sale of property, plant and equipment	5	32	26
Purchase of other intangible assets	6	(119)	(760)
Security deposit		(3 847)	–
Net cash flows from investing activities		(4 747)	(3 106)
Net increase/(decrease) in cash and cash equivalents		227	(21 702)
Cash and cash equivalents at the beginning of the year		4 929	26 631
Cash and cash equivalents at the end of the year	4	5 156	4 929

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

for the year ended 31 March 2021

Budget on Cash Basis	Approved budget R'000	Adjustments R'000	Final Budget R'000	Actual amounts on comparable basis R'000	Difference between final budget and actual R'000	Reference
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Accreditation fees, registration, appeal fees & inspection fees recovered	7 395	–	7 395	8 113	718	
Levies income	162 878	–	162 878	157 090	(5 788)	1
Legal fees recovered	–	–	–	2 948	2 948	2
Interest received	1 946	–	1 946	1 621	(325)	
Other income	274	–	274	2 220	1 946	3
Total revenue from exchange transactions	172 493	–	172 493	171 992	(501)	
Revenue from non-exchange transactions						
Taxation revenue						
Government transfers:	6 530	–	6 530	6 530	–	
Department of Health						
Mandatory transfer:	–	–	–	136	136	
Department of Higher Education and Training						
Total revenue from non-exchange transactions	6 530	–	6 530	6 666	136	
Total revenue	179 023	–	179 023	178 658	(365)	

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

for the year ended 31 March 2021

Budget on Cash Basis	Approved budget R'000	Adjustments R'000	Final Budget R'000	Actual amounts on comparable basis R'000	Difference between final budget and actual R'000	Reference
Expenditure						
Personnel	(126 763)	15 891	(110 872)	(107 001)	3 871	4
Social contributions	(195)	(374)	(569)	(569)	–	
Employee benefits	(3 166)	(43)	(3 209)	(3 290)	(81)	
Advertising	(1 832)	1 567	(265)	(303)	(38)	
Agency and support/outsourced services	(186)	182	(4)	(3)	1	
Audit costs	(950)	(439)	(1 389)	(892)	497	3
Board costs	(1 596)	(1 839)	(3 435)	(2 939)	496	
Bank charges	(111)	56	(55)	(53)	2	
Building expenses	(2 444)	685	(1 759)	(1 729)	30	
Communication	(662)	(1 783)	(2 445)	(2 582)	(137)	
Consultants	(18 092)	10 935	(7 157)	(5 693)	1 464	5
Computer expenses	(3 668)	(1 623)	(5 291)	(4 794)	497	
Legal fees	(9 520)	(8 856)	(18 376)	(21 891)	(3 515)	6
Non-life insurance	(481)	(146)	(627)	(658)	(31)	
Printing and stationery	(1 381)	374	(1 007)	(841)	166	
Rental of buildings and office equipment	(16 181)	1 315	(14 866)	(14 878)	(12)	
Repairs and maintenance	(730)	394	(336)	(322)	14	
Staff costs	(2 279)	(416)	(2 695)	(525)	2 170	
Security costs	(490)	(21)	(511)	(515)	(4)	
Training and development	(1 452)	538	(914)	(620)	294	
Subscriptions and publications	(426)	(101)	(527)	(420)	107	
Travel and subsistence local	(2 303)	2 231	(72)	(64)	8	
Venue and facilities	(1 034)	1 004	(30)	(25)	5	
Other unclassified goods and services	(1 951)	240	(1 711)	(2 048)	(337)	
Total expenditure	(197 893)	19 771	(178 122)	(172 655)	5 467	
Surplus/(deficit) for the year	(22 684)	22 685	1	5 071	5 070	
Actual Amount on Comparable Basis as Presented in the Budget and Actual Comparative Statement	(22 684)	22 685	1	5 071	5 070	
Reconciliation						
Basis of accounting difference						
Depreciation and amortisation				(3 226)		
Bad debts				(291)		
Gain(loss) on sale of assets				17		
Movement in provisions						
Movement in provisions				651		
Change in receivables from exchange transactions				(5 742)		
Change in payables from exchange transactions				7 805		
Movement in operating lease				(1 718)		
Change in security deposits				(3 847)		
Movement in capital expenditure				932		
Actual Amount in the Statement of Financial Performance				(348)		

NOTES TO THE STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

for the year ended 31 March 2021

Basis of accounting: The approved budget is based on a cash basis, thus recognising transactions and other events only when cash is received or paid.

The actual amounts are based on an accrual basis of accounting and were adjusted to be comparable to the budget which is on cash basis.

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

Period of the approved budget: 01 April 2020 to 31 March 2021.

The approval of levy rate: The 2020/2021 levy rate was approved in terms of section 2(4) of the Council for Medical Schemes Levies Act, 2000 (58 of 2000) by the Minister of Health with the concurrence of the Finance Minister on 29 April 2021. The CMS had to revise its 2020/2021 approved budget downwards to incorporate the approved levy rate.

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

1. The actual amount received for levies is based on the 2019/2020 approved levy rate. The 2020/2021 levy rate was only approved in April 2021.
2. There is an over collection of legal fees recovered. The main contributor in this variance is in respect of a court case that CMS won against Keyhealth Medical Scheme. As a successful party, the CMS was awarded costs of R1.9 million on a party to party scale. The bill of costs related to this matter were approved by the Taxation Master of the Court.
3. There was an over collection of penalty income which arises as a result of contravention of section 66 of the Medical Schemes Act (131 of 1998) by medical schemes.
4. The variance is due to National Treasury cost containment measures and vacant General Managers' positions.
5. The main contributor to this variance is costs attributable to the Business Process Mapping exercise.
6. The variance reflects the actual legal fees paid in cash, however a significant portion of legal fees expenditure for the 2020/2021 financial year is included in the accruals balance.
 - a. Legal fees expenditure is by nature unpredictable as this industry is very litigious. Costs are incurred as and when there are cases in progress.
 - b. Costs were incurred on the case around Sizwe Medical Fund, Keyhealth and Polmed Medical Schemes' curatorship cases as well as Compcare Medical Aid rule change.
 - c. There were also additional costs incurred on the Section 59 Investigation, payable to the panel members appointed to conduct the investigation.
 - d. The legal fees also comprise of costs paid for legal services rendered in labour related matters with respect to CMS current and former employees, including former General Managers.

ACCOUNTING POLICIES

for the year ended 31 March 2021

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.

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

A summary of the significant accounting policies, which have been consistently applied in the preparation of these annual financial statements, are disclosed below.

These accounting policies are consistent with the previous period.

1.1 Presentation currency

These annual financial statements are presented in South African Rand, which is the functional currency of the entity and figures are rounded off to the nearest thousand ("1000").

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 Significant judgements and sources of estimation uncertainty

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

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

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

Other significant judgements, sources of estimation uncertainty and/or relating information, have been disclosed in the corresponding notes.

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 assets' ability to continue to generate cashflows (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 the information.

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.

Effective interest rate

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

Allowance for doubtful debts

On Accounts receivable, an impairment loss is recognised in surplus and deficit when there is objective evidence that it is impaired. The impairment is measured as the difference between the debtors carrying amount and the present value of estimated future cash flows discounted at the effective interest rate, computed at initial recognition.

Depreciation and amortisation

At the end of each financial year, management assesses whether there is any indication that the Council for Medical Schemes' expectations about the residual value and 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 is accounted for as a change in accounting estimate in accordance with standards of GRAP on accounting policies, Change in Accounting Estimates and Errors.

1.4 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

ACCOUNTING POLICIES continued

for the year ended 31 March 2021

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.

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

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

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

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

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

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

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.

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

1.5 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.

1. Presentation of Annual Financial Statements continued

1.5 Intangible assets continued

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.

An intangible asset arising from development (or from the development phase of an internal project) is recognised when:

- it is technically feasible to complete the asset so that it will be available for use or sale.
- there is an intention to complete and use or sell it.
- there is an ability to use or sell it.
- it will generate probable future economic benefits or service potential.
- there are available technical, financial and other resources to complete the development and to use or sell the asset.
- the expenditure attributable to the asset during its development can be measured reliably.

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	Depreciation method	Average useful life
Developed software	Straight-line	7 years
Acquired software	Straight-line	7 years

Intangible assets are derecognised:

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

1.6 Financial instruments

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or a residual interest of another entity.

The amortised cost of a financial asset or financial liability is the amount at which the financial asset or financial liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortisation using the effective interest method of any difference between that initial amount and the maturity amount, and minus any reduction (directly or through the use of an allowance account) for impairment or uncollectibility.

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation.

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

Liquidity risk is the risk encountered by an entity in the event of difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk.

Classification

The entity has the following types of financial assets (classes and category) as reflected on the face of the statement of financial position or in the notes thereto:

Class	Category
Receivables from exchange transactions	Financial asset measured at amortised cost
Cash and cash equivalent	Financial asset measured at amortised cost
Security deposit	Financial asset measured at amortised cost

The entity has the following types of financial liabilities (classes and category) as reflected on the face of the statement of financial position or in the notes thereto:

Class	Category
Payables from exchange transactions	Financial liability measured at amortised cost

ACCOUNTING POLICIES continued

for the year ended 31 March 2021

1.7 Statutory receivables

Identification

Statutory receivables are receivables that arise from legislation, supporting regulations, or similar means, and require settlement by another entity in cash or another financial asset. For CMS, additional disclosure is included in note 3 of the financial statements.

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

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

Nominal interest rate is the interest rate and/or basis specified in legislation, supporting regulations or similar means.

The transaction amount for a statutory receivable means the amount specified in, or calculated, levied or charged in accordance with, legislation, supporting regulations, or similar means.

Recognition

The entity recognises statutory receivables as follows:

- if the transaction is an exchange transaction, using the policy on Revenue from exchange transactions;
- if the transaction is a non-exchange transaction, using the policy on Revenue from non-exchange transactions (Taxes and transfers); or
- if the transaction is not within the scope of the policies listed in the above or another Standard of GRAP, the receivable is recognised when the definition of an asset is met and, when it is probable that the future economic benefits or service potential associated with the asset will flow to the entity and the transaction amount can be measured reliably.

Initial measurement

The entity initially measures statutory receivables at their transaction amount.

Subsequent measurement

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

- interest or other charges that may have accrued on the receivable (where applicable);
- impairment losses; and
- amounts derecognised.

Impairment losses

The entity assesses at each reporting date whether there is any indication that a statutory receivable, or a group of statutory receivables, may be impaired.

In assessing whether there is any indication that a statutory receivable, or group of statutory receivables, may be impaired, the entity considers, as a minimum, the following indicators:

- Significant financial difficulty of the debtor, which may be evidenced by an application for debt counselling, business rescue or an equivalent.
- It is probable that the debtor will enter sequestration, liquidation or other financial re-organisation.
- A breach of the terms of the transaction, such as default or delinquency in principal or interest payments (where levied).
- Adverse changes in international, national or local economic conditions, such as a decline in growth, an increase in debt levels and unemployment, or changes in migration rates and patterns.

If there is an indication that a statutory receivable, or a group of statutory receivables, may be impaired, the entity measures the impairment loss as the difference between the estimated future cash flows and the carrying amount. Where the carrying amount is higher than the estimated future cash flows, the carrying amount of the statutory receivable, or group of statutory receivables, is reduced, either directly or through the use of an allowance account. The amount of the losses is recognised in surplus or deficit.

In estimating the future cash flows, an entity considers both the amount and timing of the cash flows that it will receive in future. Consequently, where the effect of the time value of money is material, the entity discounts the estimated future cash flows using a rate that reflects the current risk-free rate and, if applicable, any risks specific to the statutory receivable, or group of statutory receivables, for which the future cash flow estimates have not been adjusted.

An impairment loss recognised in prior periods for a statutory receivable is revised if there has been a change in the estimates used since the last impairment loss was recognised, or to reflect the effect of discounting the estimated cash flows.

Any previously recognised impairment loss is adjusted either directly or by adjusting the allowance account. The adjustment does not result in the carrying amount of the statutory receivable or group of statutory receivables exceeding what the carrying amount of the receivable(s) would have been had the impairment loss not been recognised at the date the impairment is revised. The amount of any adjustment is recognised in surplus or deficit.

1. Presentation of Annual Financial Statements continued

1.8 Leases

A lease is classified as a finance lease if it transfers substantially all the risks and rewards incidental to ownership. A lease is classified as an operating lease if it does not transfer substantially all the risks and rewards incidental to ownership.

Operating leases – lessee

Operating lease is the lease other than the finance lease and for CMS it in relation to rental of the office building. Operating lease payments are recognised as an expense on a straight-line basis over the lease term. The difference between the amounts recognised as an expense and the contractual payments are recognised as an operating lease asset or liability.

1.9 Employee benefits

Employee benefits are all forms of consideration given by an CMS in exchange for service rendered by employees.

A qualifying insurance policy is an insurance policy issued by an insurer that is not a related party (as defined in the Standard of GRAP on Related Party Disclosures) of the reporting entity, if the proceeds of the policy can be used only to pay or fund employee benefits under a defined benefit plan and are not available to the reporting entity's own creditors (even in liquidation) and cannot be paid to the reporting entity, unless either:

- the proceeds represent surplus assets that are not needed for the policy to meet all the related employee benefit obligations; or
- the proceeds are returned to the reporting entity to reimburse it for employee benefits already paid.

Termination benefits are employee benefits payable as a result of either:

- an entity's decision to terminate an employee's employment before the normal retirement date; or
- an employee's decision to accept voluntary redundancy in exchange for those benefits.

1.10 Provisions and contingencies

Provisions are recognised when:

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

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

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

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

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

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

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

Contingent assets and contingent liabilities are possible assets and liabilities whose occurrence depends on whether some uncertain future event occurs or payment is not probable or amount cannot be measured reliably. Contingent assets and liabilities are not recognised. Contingencies are disclosed in note 22.

1.11 Commitments

Items are classified as commitments when an entity has committed itself to future transactions that will normally result in the outflow of cash.

Disclosures are required in respect of unrecognised contractual commitments.

Commitments for which disclosure is necessary to achieve a fair presentation should be disclosed in a note to the financial statements, if both the following criteria are met:

- Contracts should be non-cancellable or only cancellable at significant cost (for example, contracts for computer or building maintenance services); and
- Contracts should relate to something other than the routine, steady, state business of the entity – therefore salary commitments relating to employment contracts or social security benefit commitments are excluded.

1.12 Revenue from exchange transactions

Revenue is the gross inflow of economic benefits or service potential during the reporting period when those inflows result in an increase in net assets, other than increases relating to contributions from owners.

ACCOUNTING POLICIES continued

for the year ended 31 March 2021

An exchange transaction is one in which the entity receives assets or services, or has liabilities extinguished, and directly gives approximately equal value (primarily in the form of goods, services or use of assets) to the other party in exchange.

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

Measurement

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

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

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

1.13 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. Revenue from non-exchange transactions comprises the following: 1. Grant from Department of Health which is sometimes conditional or unconditional. 2. Mandatory transfer from Department of Higher Education and Training.

Control of an asset arises 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.

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

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

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

Transfers are inflows of future economic benefits or service potential from non-exchange transactions, other than taxes. CMS receives conditional and unconditional transfers. The conditional transfer is for the Beneficiary Registry and Single Exit Pricing list development. The unconditional transfer is utilised in the operations of CMS.

Recognition

An inflow of resources from a non-exchange transaction recognised as an asset is recognised as revenue, except to the extent that a liability is also recognised in respect of the same inflow.

As the entity satisfies a present obligation recognised as a liability in respect of an inflow of resources from a non-exchange transaction recognised as an asset, it reduces the carrying amount of the liability recognised and recognises an amount of revenue equal to that reduction.

Services in-kind

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

1. Presentation of Annual Financial Statements continued

1.13 Revenue from non-exchange transactions continued

Services in-kind continued

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

1.14 Comparative figures

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 the reason for such reclassifications and restatements are also disclosed.

Where material accounting errors, which relate to prior periods, have been 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 the 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.

1.15 Fruitless and wasteful expenditure

Fruitless expenditure means expenditure which was made in vain and would have been avoided had reasonable care been exercised.

Fruitless and wasteful expenditure is accounted for as an expenditure in the Statement of Financial Performance and where it is recovered, it is accounted for as revenue in the Statement of Financial Performance.

Fruitless and wasteful expenditure is disclosed in the notes to the Annual financial statements.

1.16 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, no 86 of 1968 or any regulations made in terms of the Act.
- (c) Any provincial legislation providing for procurement procedures in that provincial government.

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

Irregular expenditure that was incurred and identified during the current financial year and which was condoned before year end and/or before finalisation of the financial statements must also be recorded appropriately in the irregular expenditure register.

In such instances, no further action is required with exception of updating the note to the financial statements.

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

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

Irregular expenditure that was incurred and identified during the current financial year and which was not condoned by National Treasury or the relevant authority must be recorded appropriately in the irregular expenditure register. If liability for the irregular expenditure can be attributed to a person, a debt account must be created if such a person is liable in law, immediate steps must thereafter be taken to recover the amount from the person concerned. If recovery is not possible, the accounting officer or accounting authority may write off the amount as debt impairment and disclose such in the relevant note to the financial statements. The irregular expenditure must 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 in the note to the financial statements and updated accordingly in the irregular expenditure register.

1.17 Segment information

A segment is an activity of an entity:

- that generates economic benefits or service potential (including economic benefits or 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.

ACCOUNTING POLICIES continued

for the year ended 31 March 2021

1.18 Budget information

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

General purpose financial reporting by an 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 1 April 2020 to 31 March 2021.

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

1.19 Related parties

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

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

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

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

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

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

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

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

1.20 Events after reporting date

Events after 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); and
- those that are indicative of conditions that arose after the reporting date (non-adjusting events after the reporting date).

The entity will adjust the amount 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

for the year ended 31 March 2021

2. New standards and interpretations

2.1 Standards and interpretations effective and adopted in the current year

In the current year, the entity has adopted the following standards and interpretations that are effective for the current financial year and that are relevant to its operations:

- GRAP 1 Presentation of financial statements
- GRAP 2 Cashflow statement
- GRAP 3 Presentation of financial statements
- GRAP 9 Accounting policies, Change in accounting Estimates and Errors Revenue from exchange transactions
- GRAP13 Leases
- GRAP14 Events after the Reporting Date
- GRAP17 Property, Plant and Equipment
- GRAP18 Segment Reporting
- GRAP19 Provisions, Contingent Liabilities and Contingent Assets
- GRAP 20 Related Party Disclosures
- GRAP 21 Impairment of Non-cash Generating Assets
- GRAP 23 Revenue from Non-exchange Transactions
- GRAP 24 Presentation of Budget Information in Financial Statements
- GRAP 25 Employee benefits
- GRAP 31 Intangible assets
- GRAP 104 Financial Instruments
- GRAP 108 Statutory receivables

3. Receivables from exchange transactions

	2021 R'000	2020 R'000
Accounts receivable	7 442	91
Sundry debtors	974	1 434
Prepaid expenses	1 938	3 378
	10 354	4 903
Statutory receivables included in receivables from exchange transactions above are as follows:		
• Rule Amendments in terms of Regulation 31 of Medical Schemes Act (131 of 1998)	120	91
• Inspection costs recoverable from inspected schemes in terms of Regulation 4B of Financial Sector Regulation Act No. 9 of 2017	969	1 434
• Levies in terms of Council for Medical Schemes Levies Act (58 of 2000)	7 072	–
• Penalties in terms of S66 of Medical Schemes Act (131 of 1998)	251	–
	8 412	1 525

Excluded from this total of statutory receivables is an amount of R291 400 for which a provision for doubtful debts has been raised during the year as outlined in Note 17.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

	2021 R'000	2020 R'000
Other non-financial asset receivables included in receivables from exchange transactions above are as follows:		
Prepaid expenses	1 938	3 378
	–	–
Total receivables from exchange transactions	10 354	4 903

Accounts receivables ageing	current	30 days	60 days	90 days	120 days	Over 120
Accounts receivable	7 083	257	6	21	–	75

Part of the receivables from exchange transactions are the following: Sundry debtors of R973 589 which is over 120 days.

4. Cash and cash equivalents

	2021 R'000	2020 R'000
Cash and cash equivalents consist of:		
Cash on hand	2	4
Bank balances	3 077	4 411
CPD account	2 077	514
	5 156	4 929

5. Property, plant and equipment

	2021			2020		
	Cost	Accumulated depreciation and accumulated impairment	Carrying value	Cost	Accumulated depreciation and accumulated impairment	Carrying value
Furniture and fixtures	8 542	(4 910)	3 632	8 542	(4 304)	4 238
Motor vehicles	470	(352)	118	470	(326)	144
Computer equipment	16 738	(12 645)	4 093	15 944	(11 645)	4 299
Computer software	2 163	(2 036)	127	2 163	(2 007)	156
Leasehold improvements	11 980	(9 173)	2 807	11 980	(7 898)	4 082
Other fixed assets	789	(506)	283	789	(460)	329
Total	40 682	(29 622)	11 060	39 888	(26 640)	13 248

5. Property, plant and equipment continued

Reconciliation of property, plant and equipment – 2021

	Opening balance	Additions	Disposals	Depreciation	Total
Furniture and fixtures	4 238	–	–	(606)	3 632
Motor vehicles	144	–	–	(26)	118
Computer equipment	4 299	813	(15)	(1 004)	4 093
Computer software	156	–	–	(29)	127
Leasehold improvements	4 082	–	–	(1 275)	2 807
Other fixed assets	329	–	–	(46)	283
	13 248	813	(15)	(2 986)	11 060

Reconciliation of property, plant and equipment – 2020

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

6. Intangible assets

	2021			2020		
	Cost	Accumulated depreciation and accumulated impairment	Carrying value	Cost	Accumulated depreciation and accumulated impairment	Carrying value
Computer software	2 977	(1 708)	1 269	2 858	(1 489)	1 369
Acquired software	2 449	(2 395)	54	2 449	(2 371)	78
Total	5 426	(4 103)	1 323	5 307	(3 860)	1 447

Reconciliation of intangible assets – 2021

	Opening balance	Additions	Amortisation	Total
Developed software	1 369	119	(219)	1 269
Acquired software	78	–	(24)	54
	1 447	119	(243)	1 323

Reconciliation of intangible assets – 2020

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

7. Payables from exchange transactions

	2021 R'000	2020 R'000
Accounts payables	16 030	8 653
Income received in advance	1 721	1 651
Accrual for leave pay	3 554	3 042
Accruals	16 065	15 396
	37 370	28 742

Accounts payables ageing	current	30 days	60 days	90 days	120 days and over
	5 724	6 049	–	2 834	1 588

Included in the account payables is an amount of R2 664 943 for PAYE still to be paid, tea club, employee wellness and medical aid.

8. Provisions

Reconciliation of provisions – 2021

	Opening balance	Additions	Utilised during the year	Reversed during the year	Total
Provision for long service award	2 005	2 656	(1 155)	(850)	2 656

Reconciliation of provisions – 2020

	Opening balance	Additions	Utilised during the year	Reversed during the year	Total
Provision for long service award	1 983	464	(180)	(262)	2 005

	2021 R'000	2020 R'000
Non-current liabilities	2 162	1 748
Current liabilities	494	257
	2 656	2 005

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

9. Operating lease asset (accrual)

	2021 R'000	2020 R'000
Non-current liabilities	(4 757)	(7 615)
Current liabilities	(2 870)	(1 730)
	(7 627)	(9 345)

10. Financial instruments disclosure

Categories of financial instruments - 2021

	2021	
	At fair value	Total
Financial assets		
Trade and other receivables from exchange transactions	8 412	8 412
Cash and cash equivalents	5 156	5 156
Security deposits	3 845	3 845
	17 413	17 413
Financial liabilities		
Trade and other payables from exchange transactions	37 370	37 370

Categories of financial instruments - 2020

	2020	
	At fair value	Total
Financial assets		
Trade and other receivables from exchange transactions	1 525	1 525
Cash and cash equivalents	4 929	4 929
	6 454	6 454
Financial liabilities		
Trade and other payables from exchange transactions	28 742	28 742

11. Revenue

	2021 R'000	2020 R'000
Accreditation fees	6 868	8 170
Government transfers: Department of Health	6 530	6 481
Inspection fees recovered	370	2 097
Legal fees recovered	2 948	–
Levies income	164 162	156 215
Mandatory transfer: Department of Higher Education and Training	136	215
Registration fees	450	469
Sundry income	1 579	926
	183 043	174 573

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

	2021 R'000	2020 R'000
Accreditation fees	6 868	8 170
Inspection fees recovered	370	2 097
Legal fees recovered	2 948	–
Levies income	164 162	156 215
Registration fees	450	469
Sundry income	1 579	926
	176 377	167 877

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

Interest received is disclosed separately under note 20 and forms part of revenue from exchange transactions.

	2021 R'000	2020 R'000
The amount included in revenue arising from non-exchange transactions is as follows:		
Government transfers: Department of Health	6 530	6 481
Mandatory transfer: Department of Higher Education and Training	136	215
	6 666	6 696

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

The CMS receives reports from the Board of Healthcare Funders (BHF) on the Practice Code numbering System for research purposes for which CMS does not pay.

12. Unspent Conditional grants and receipts

Grant received from Department of Health

	2021 R'000	2020 R'000
Opening balance	2 080	2 574
Conditions met transfer to revenue	–	(494)
	2 080	2 080

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

- (a) Development and maintenance of Medicines Pricing Registry.
- (b) Development and maintenance of Beneficiary Registry for medical schemes members.

No work was conducted on these projects in the 2020/2021 financial year due to a change in leadership in the ICT and KM unit. The new Chief Information Officer was appointed and had to be apprised on the developments around strategic projects relating to the DoH which included Beneficiary Registry, hosting of the Pulse system and the Single Exit Price (SEP) system. As a result of this, the CMS spent most of the time discussing the background and planning on the way forward and there was therefore not much development work on these projects.

13. Administrative expenses

	2021 R'000	2020 R'000
Bank charges	53	85
Building expenses	1 794	2 044
General administrative expenses	638	1 587
Insurance	658	449
Rent	11 701	11 981
Printing and stationery	216	435
Refreshments	14	84
Rent-operating expenses	2 755	2 539
Rental copiers	401	401
Security	515	713
Subscriptions	458	700
Telecommunication expenses	7 826	5 601
	27 029	26 619

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

	2021 R'000	2020 R'000
Repairs and maintenance		
Repairs and maintenance costs	379	513

14. Audit fees

	2021 R'000	2020 R'000
External audit	1 092	1 123
Internal audit	1 491	1 592
	2 583	2 715

15. Operating Expenses

	2021 R'000	2020 R'000
Committee remuneration	417	225
Consulting	6 128	8 571
Council members' fees	2 797	3 232
Exhibition costs	–	115
Inspection costs	1 853	4 779
Labour relations costs	3 150	2 794
Legal fees	22 137	17 958
Media and promotions	303	1 385
Knowledge management	1 390	1 561
Postage and courier	13	50
Printing and publication	651	935
Transcriptions	3	563
Travel – local	68	3 913
Venue & catering	26	1 659
	38 936	47 740

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

16. Staff costs

	2021 R'000	2020 R'000
Employee benefits	3 290	3 104
Employee wellness	193	302
Recruitment and relocation	337	1 039
Salaries	105 541	111 728
Staff training	886	1 390
Temporary staff	2 109	3 492
Workmen's compensation	569	187
	112 925	121 242
Total number of employees	113	120

17. Provision for doubtful debt

	2021 R'000	2020 R'000
Debt impairment	291	–

A debt relating to statutory receivables in respect of the former Board of Trustees of Genesis Medical Scheme was raised in the 2013/2014 financial year. After the court awarded in favour of CMS, the former Board of Trustees of Genesis Medical Scheme were ordered to pay CMS legal costs of R291 000. Several unsuccessful attempts were made by the CMS legal unit to recover the debt. After it was apparent recoverability was not feasible, management decided to raise a doubtful debt provision.

18. Operating deficit

The CMS disposed of some assets during the year with proceeds of R32 337 and a gain of R17 000:

	2021 R'000	2020 R'000
Gain(loss) on disposal of assets	17	(66)

19. Cash generated from (used in) operations

	2021 R'000	2020 R'000
(Deficit)/Surplus	(348)	(25 163)
Adjustments for:		
Depreciation and amortisation	3 226	4 576
(Gain)/Loss on sale of assets and liabilities	(17)	66
Debt impairment	291	–
Movements in operating lease assets	(1 718)	(387)
Movements in provisions	651	22
Changes in working capital:		
Receivables from exchange transactions	(5 742)	(1 196)
Payables from exchange transactions	8 631	3 980
Unspent conditional grants and receipts	–	(494)
	4 974	(18 596)

20. Interest received

Interest received forms part of revenue from exchange transactions.

	2021 R'000	2020 R'000
Interest earned on investment	1 633	3 281

21. Commitments

This committed expenditure relates to office rental.

Operating leases – as lessee (expense)

	2021 R'000	2020 R'000
Minimum lease payments due		
– within one year	14 560	13 419
– in second to fifth year inclusive	18 475	33 035
	33 035	46 454

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 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. Contingencies

Contingent liabilities

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

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

Bonitas Medical Aid Scheme vs the CMS

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

Labour matters

Two General Managers and the CFO whose contracts with CMS expired on 31 March 2020 and were not renewed referred a dispute of legitimate expectation of renewal of their fixed term contracts to CCMA. They received the award in their favour with CCMA and CMS has since referred the matter to the Labour Court for review. The amount of the award is estimated at R5 536 962. Another General Manager referred an unfair dismissal dispute to CCMA and he received an award in his favour. The CMS had since referred the matter to the Labour Court for review. The amount of the award is estimated at R2 835 000 however it is impracticable to estimate the outcome probability for cases in the Labour Court.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

The Communications Manager and the Compliance Officer referred an unfair dismissal dispute against them to CCMA of which the cost and outcome probability was impracticable to estimate.

The Network Manager and the Knowledge Management Manager referred an unfair labour practice dispute regarding a grading exercise which they lost at CCMA to the Labour Court for review. It was impracticable to determine the cost estimate and outcome probability in both of these cases.

Contingent assets

The CMS won court cases against the following parties:

- CMS vs Polmed Medical Scheme curatorship
- The CMS vs Keyhealth Medical Scheme curatorship

The CMS, as the successful party in these cases, was awarded costs on the party and party scale. The bill of costs relating to these matters have to date not been approved by the Taxation Master of the Court due to uncertainties relating to the amount and timing of the legal fees recovered. It was therefore impracticable to estimate costs and outcome probability for both contingent assets

The following cases are still ongoing in courts of which the judgements are still pending and it is impracticable to estimate their outcome probability:

- The CMS vs National Health Care Professionals section 59(2) challenge
- City Hospital vs the CMS and others
- W. Alberts and others vs the CMS section 46 challenge
- Compcare Medical Aid vs Registrar and CMS name change
- Reed vs Keyhealth Medical Scheme and Registrar of Medical Schemes
- The CMS vs Medihelp Medical Scheme inspection challenge
- The CMS vs Polmed Medical Scheme immovable property sale challenge
- The CMS vs Sizwe Medical Fund curatorship
- The CMS vs Keyhealth Medical Scheme curatorship
- The CMS vs Mokoditso Section 59 Investigation challenge

The following cases are in the process of adjudication before the Appeals Committee and it is impractical to estimate their outcome probability:

- The CMS vs Government Employees Medical Scheme
- The CMS vs Medihelp Medical Scheme
- The CMS vs Genesis Medical Scheme

23. Related parties

Relationships

Executive authority:	The Executive authority as defined in Section 1 of the PFMA, is the Minister of Health, as the CMS falls under the portfolio of the Department of Health.
Accounting authority:	Council, as defined in Section 49 of the PFMA, is the controlling body of the CMS. Council members, who are appointed by the Minister of Health, control the financial and operating activities of the CMS.
Executive management:	In terms of section 8(a) of Medical Schemes Act, (131 of 1998), Council shall appoint such staff as the Council may deem necessary to employ, to assist Council in the performance of its functions and execution of its duties.

Related party transactions

	2021 R'000	2020 R'000
Transfer paid to (received from) related parties		
Department of Health	(6 530)	(5 987)

Remuneration of management

Council members' remuneration

Name	2021	
	Meeting attendance Fees	Total
Adv R. Gaoraelwe	180	180
Adv H. Kooverjie	113	113
Dr M.S. Mabela	130	130
Dr T. Mabeba	81	81
Ms M. Maboye	284	284
Dr P. Mbava	58	58
Mr M. Maimane	424	424
Dr M. Makiwane	432	432
Mr M. Mabalane	43	43
Dr L. Mkansi	82	82
Dr H. Mukhari	58	58
Mr L. Mulaudzi	74	74
Mr N. Raheman	79	79
Dr S. Naidoo	58	58
Dr X. Ngobese	81	81
Ms D. Terblanche	470	470
Mr I. Vanker	51	51
Mr J. van der Walt	99	99
	2 797	2 797

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

Name	2020	
	Meeting attendance Fees	Total
Adv R. Gaoraelwe	383	383
Adv H. Kooverjie	108	108
Dr M.S. Mabela	257	257
Ms M. Maboye	401	401
Mr M. Maimane	523	523
Dr M. Makiwane	313	313
Dr C. Mini	537	537
Prof L. Pepeta	16	16
Ms S. Ranchod (resigned in 2018/19 financial year)	–	–
Ms D. Terblanche	516	516
Mr J. van der Walt	179	179
	3 233	3 233

Independent audit and risk committee members' remuneration

Name	2021	
	Fees for services as a member of Audit and risk committee	Total
Mr L. Matshekga	285	285
Ms S. Mzizi	70	70
Ms E.M. Pillay	62	62
	417	417

Name	2020	
	Fees for services as a member of Audit and risk committee	Total
Mr H. Kariem	94	94
Mr L. Matshekga	10	10
Ms S. Mzizi	8	8
Ms E.M. Pillay	62	62
Ms M. Strydom	51	51
	225	225

24. Executive management remuneration

Executive

	2021		
	Basic salary	Acting allowance and other	Total
Chief Executive and Registrar – Dr S. Kabane	2 569	–	2 569
Chief Financial Officer – Ms A. Zinja (from 1 November 2020)	718	–	718
Chief Information Officer – Mr E. Tlhako	1 601	–	1 601
General Manager: Complaints Adjudication – Ms T. Phaswane	1 514	133	1 647
General Manager: Research and Monitoring – Mr M. Willie	1 636	–	1 636
Executive Manager: Office of the Chief Executive and Registrar – Mr R. Sadiki	1 527	–	1 527
	9 565	133	9 698

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

25. Risk management

Financial risk management

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

Liquidity risk

The entity's risk in relation to liquidity is a result of payment of its payables. These payables are all due within the short-term. CMS manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the CPD account of R2 076 666 as at 31 March 2021.

Credit risk

Credit risk consists mainly of cash deposits, cash equivalents, derivative financial instruments 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 R15 623 or decrease of R15 623 respectively.

26. Fruitless and wasteful expenditure

	2021 R'000	2020 R'000
Opening balance as previously reported	608	37
Penalty waived during the year	(280)	–
	328	37
Add: Expenditure identified – current	239	571
Closing balance	567	608

During the year, the CMS did not incur any fruitless and wasteful expenditure. A penalty of R553 516 was paid to SARS for a late PAYE payment for months of June and August 2019 of which R280 240 was waived by SARS during the year. R239 000 relates to interest and penalty on late payment of VAT on imported services.

27. Irregular expenditure

	2021 R'000	2020 R'000
Opening balance	59 184	44 423
	–	–
Add: Irregular Expenditure – current	5 379	14 761
Less: Amounts condoned – current	(468)	–
Closing balance	64 095	59 184

The CMS has established a Loss Control Committee in terms of the National Treasury Irregular Expenditure Framework at the beginning of 2020/2021 financial year. This committee is looking at the irregular expenditure incurred in the previous years which amounts to R59 184 000 as the priority. Part of this amount has already been submitted to National Treasury for condonation and was approved by National Treasury in April 2021.

Irregular expenditure amounting to R44 165 000 was submitted to National Treasury for condonation in December 2018. A negative response was received in February 2021, identifying areas where CMS did not provide sufficient information. CMS is reviewing the matter and will make further submissions for condonation to National Treasury.

In the current year, the CMS incurred irregular expenditure of R139 000 due to extension of scope of work by more than 15% without prior approval. The CMS also incurred irregular expenditure of R4 734 000 in establishing a panel of lawyers in the prior years. The CMS did not go through a bidding process as required for all procurement above R500 000.

A further R506 584 relates to awards without following proper processes.

Analysis of expenditure – movement for the year

	2021 R'000	2020 R'000
Current year	5 379	14 060
Prior year	–	701
	5 379	14 761

Detail of irregular expenditure

	2021 R'000	2020 R'000
Bid awarded without following correct procedures	506	1 526
More than 15% extension	139	579
Bid awarded to lawyers whose panel was not established through bidding process.	4 734	12 656
	5 379	14 761

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

28. Segment information

General information

Identification of segments

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

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

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

29. Security deposits

	2021 R'000	2020 R'000
Invested amount	3 847	–

This amount comprises of R2 835 000 and R1 000 000 relating to a CCMA award for one former General Managers and 3 other former General Managers respectively. The CMS has placed these funds into a security deposit account as mandated by S145 of Labour Relations Act. An amount of R12 000 is interest on the investment which is compounded.

30. Finance costs

	2021 R'000	2020 R'000
Late payment of tax	51	63

CMS did not account for VAT implication on Imported Services as required in terms of the VAT Act. Imported services refer to the supply of services by a supplier who is not a resident of South Africa or who carries on business outside South Africa, to a recipient who is a resident of South Africa, where such services are utilised or consumed in South Africa for non-taxable services. As a result, CMS incurred finance costs on late payment of VAT on imported services.

31. Change in estimate

Property, plant and equipment

CMS has reassessed the useful lives property, plant and equipment and intangible assets which resulted in certain assets' remaining useful lives to change to reflect the actual pattern of service potential derived from the assets. The effect of the change in accounting estimate has resulted in a decrease in depreciation and amortisation for the current period amounting to R641 372 and R19 689 respectively. The impact of the adjustment in future periods could not be ascertained.

Category	Cost price	Current depreciation	Revised depreciation	Difference
Computer equipment	8 952	1 534	1 002	532
Computer software	506	30	29	1
Intangible assets	340	35	23	12
Internally developed software	2 389	227	219	8
Motor vehicles	470	89	26	63
Other assets	589	46	46	–
Office equipment	1 531	156	153	3
Office furniture	5 965	495	453	42
	20 742	2 612	1 951	661

32. Prior period errors

A prior period error was identified in relation to a CCMA award to a former General Manager which was expensed whilst it was paid into an trust investment account while CMS had referred the matter to Labour Court for review (R2 835 000).

A prior period error was identified whereby CMS did not account for VAT implication on Imported Services as required in terms of the VAT Act. Imported services refer to the supply of services by a supplier who is not a resident of South Africa or who carries on business outside South Africa, to a recipient who is a resident of South Africa, where such services are utilised or consumed in South Africa for non-taxable services (R840 000).

The correction of the error results in an adjustment as follows:

	2021 R'000	2020 R'000
Decrease in salaries 31 March 2020	–	(1 550)
Decrease in accruals 31 March 2020	–	1 550
Decrease in accruals in 31 March 2019	–	1 285
Decrease in salaries in 31 March 2019	–	(1 285)
Decrease in accumulated surplus 31 March 2019	–	755
Increase in accruals 31 March 2019	–	(755)
Increase in software license 31 March 2020	–	85
Increase in accruals 31 March 2020	–	(85)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS continued

for the year ended 31 March 2021

33. Going concern

We draw attention to the fact that at 31 March 2021, the entity had an accumulated deficit of R17 993 000 and that the entity's total liabilities exceed its assets by R17 993 000.

The 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. CMS has been experiencing significant financial difficulties due to resource constraints. The delayed approval of the proposed levy increase tabled for the 2020/21 financial year negatively impacted the organisation's cashflow and ability to fully meet all its obligations timeously. Further, CMS closed both 2020 and 2021 financial years with a deficit, casting doubt of its ability to pay liabilities as they fall due. This was mainly caused by unexpected and urgent regulatory work that could not be postponed and a decline in other revenue that CMS collects outside of levies over the past three years.

Management is cognizant of the fact that the deficit will not be eliminated overnight. There needs to be a deliberate plan in improving the financial position. Therefore, CMS is working on a more long-term sustainability financial model that will ensure CMS can effectively and efficiently regulate. Part of CMS plans include:

- Cost reduction and management.
- Annual tariff fees review.
- Business case proposals for insufficiently funded projects submitted to NDoH and National Treasury.
- Options for additional long-term funding to be submitted to NDoH and National Treasury.

CMS has collected over 90% of revenue budgeted for in 2020/2021 financial year. Management further anticipates same for 2021/2022 budgeted revenue. The operations for 2021/2022 financial year have been budgeted for. Controls have been strengthened to monitor the budget to manage risk of overspending.

34. Events after the reporting date

The CMS had to submit a revised budget and proposed levy increase for the 2020/21 financial year to be in line National Treasury Guide lines. The CMS levy increase for the 2020/2021 financial was approved on 29 April 2021. The schemes were billed for the difference subsequent to the levy approval as outlined in notes 3 and 11.

Irregular expenditure amounting to R467 768 was submitted for condonation during the year to National Treasury. Condonation was subsequently received on 30 April 2021.

Management identified additional accruals amounting to R917 230. These items were identified after annual financial statements were submitted for audit on the 31 May 2021 and were subsequently adjusted for.



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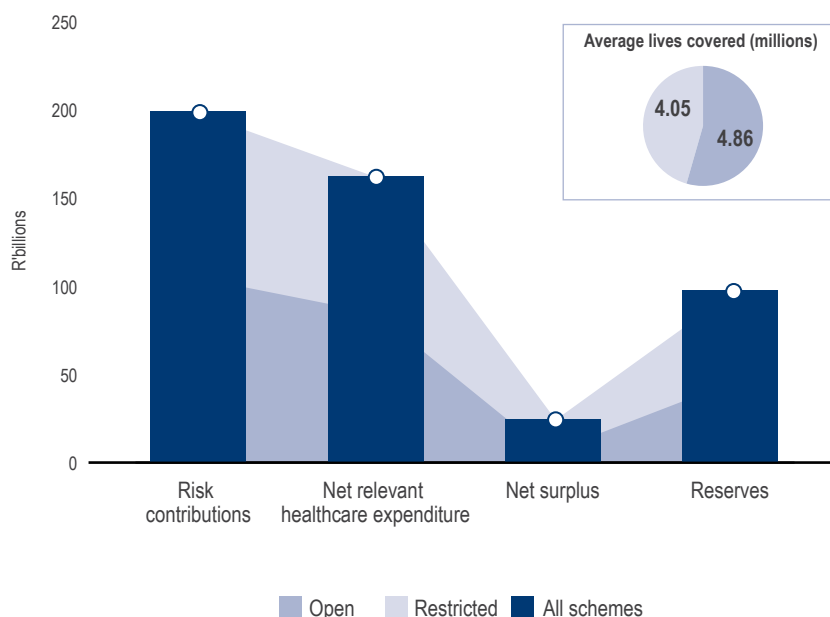
PART F

Overview of activities

MONITORING THE INDUSTRY'S FINANCIAL WELLBEING

Industry performance is measured from 1 January to 31 December of each year, consistent with the benefits of medical scheme members.

Figure 1: A snapshot of the industry's financial performance



A snapshot of the industry's financial performance

Membership

Medical scheme membership decreased slightly (by 56 910 beneficiaries) during 2020, to end the year with 8.9 million beneficiaries.

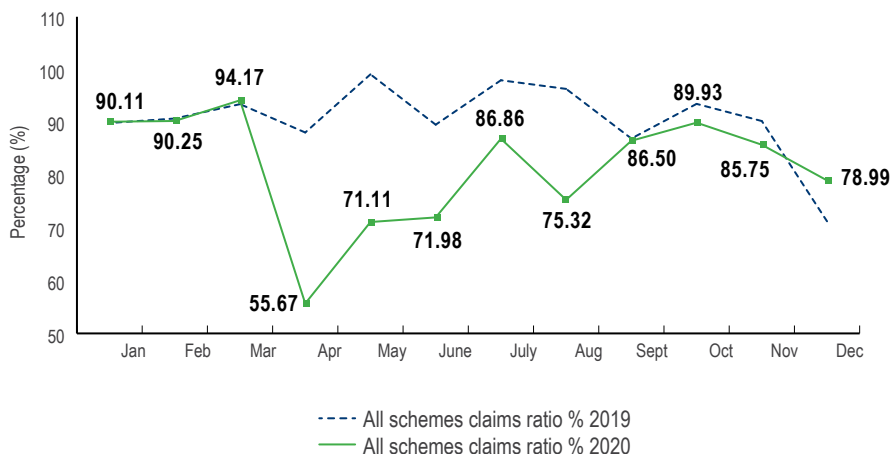
Contributions and net relevant healthcare expenditure

During 2020, a total of R199.08 billion was collected in risk contributions from members (2019: R186.66 billion) and expenditure on relevant healthcare services was reported at R162.00 billion (2019: R169.07 billion).

On average, medical schemes incurred a much lower claims experience compared to 2019. The utilisation of services was substantially reduced with the postponement of elective procedures in response to the COVID-19 pandemic although some of the pent-up demand was released during the last quarter of the year.

The claims ratio therefore decreased significantly from 90.58% in 2019 to 81.38% in 2020. This resulted in a net healthcare result of R19.93 billion (2019: R1.03 billion).

Figure 2: Comparing the seasonality of claims during 2019 and 2020

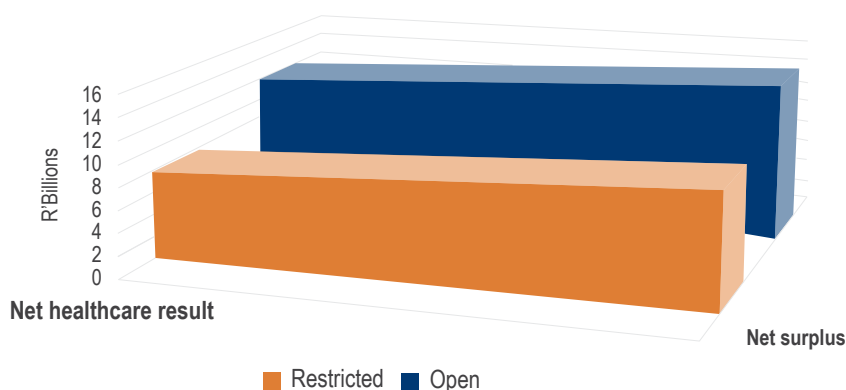


Investment income and net results

The financial market was hit by wholesale selling during the first quarter of 2020. South Africa fared worse than most countries due to its deteriorating economic fundamentals, which were exacerbated by Moody's downgrade of its sovereign credit rating to below investment grade status in late March 2020.

Even though the financial markets demonstrated resilience by rebounding during the latter part of 2020, lower investment income was accrued than in 2019. The investment income positively contributed towards a net surplus of R24.85 billion in 2020, compared to a net healthcare result of R19.93 billion. In 2019, a net surplus of R7.08 million was incurred.

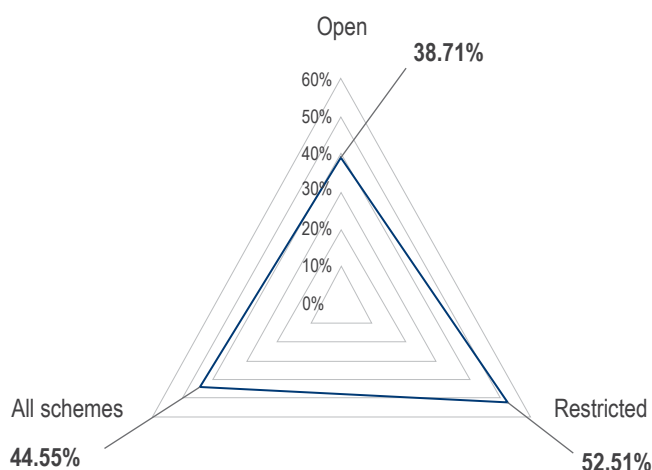
Figure 3: The reliance of medical schemes on investment income to maintain and grow its reserves



Solvency and reserving

The higher net healthcare results together with the investment yields had a positive effect on the overall reserving of medical schemes during the year under review. Regulation 29 reserves increased by 33.60% and solvency by 25.11% to reach R97.92 billion and 44.55% respectively.

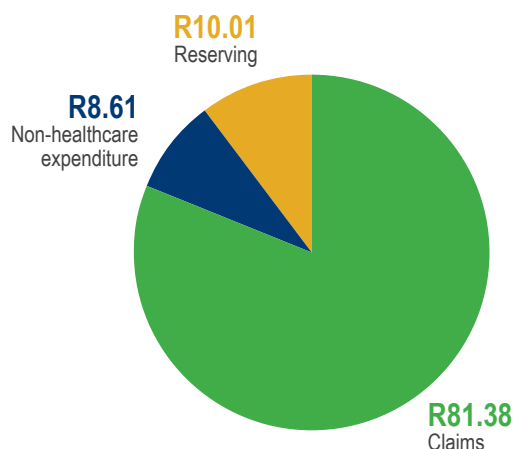
Figure 4: A snapshot of the industry in terms of solvency



Healthcare rand spent

For every R100 received in 2020, R81.38 was spent on claims (compared to 2019 pre-COVID-19 at R90.58), R8.61 was spent on non-healthcare expenditure and R10.01 was allocated towards reserves. Medical schemes generally price to break even on a net healthcare result level. The effect of lockdown on the 2020 claims patterns is evident.

Figure 5: A snapshot of the industry spend for every R100 received



Reserves of medical schemes in 2020

The reserves of medical schemes serve to protect members' interests and to guarantee the continued operation of schemes. They also serve as a buffer against unforeseen, large-scale health events such as the COVID-19 pandemic.

Schemes provided various financial relief measures to members during the COVID-19 pandemic such as utilising personal medical savings accounts to offset contributions, the relaxation of credit policies, contribution holidays and lower future contribution increases.

A pandemic without lockdown measures curbing the spread would have been detrimental to scheme reserves, as the cost per hospitalisation event increased drastically in 2020. It is further envisaged that scheme reserves will be utilised when the pent-up demand is released in coming years. The decrease in screening activities during 2020 would also affect downstream costs as early detection normally results in lower costs and better clinical outcomes. The full impact of the pandemic is therefore not confined to COVID-related claims.

COVID-19 pandemic exposure

During 2020, CMS collected unaudited data relating to schemes' COVID-19 exposure. 73 of the 75 schemes (representing 99.84% of medical scheme beneficiaries) submitted data for the year ending 31 December 2020:

Table 54: COVID-19 pandemic exposure

Total lives infected by COVID-19	422 894
Total lives recovered from COVID-19	383 585
Mortality rate	3.02%

COVID-19 claims to the value of R10.10 billion were received during 2020.

19 914 members

were granted contribution deferrals to the value of

R586.90 million

16 654 members

received relief via personal medical savings account utilisation to the value of

R180.11 million

30 725 members

received relief through rule amendments and the impact was worth

R133.31 million

5 447 members

received other types of relief such as debt policy relaxation to the value of

R53.68 million

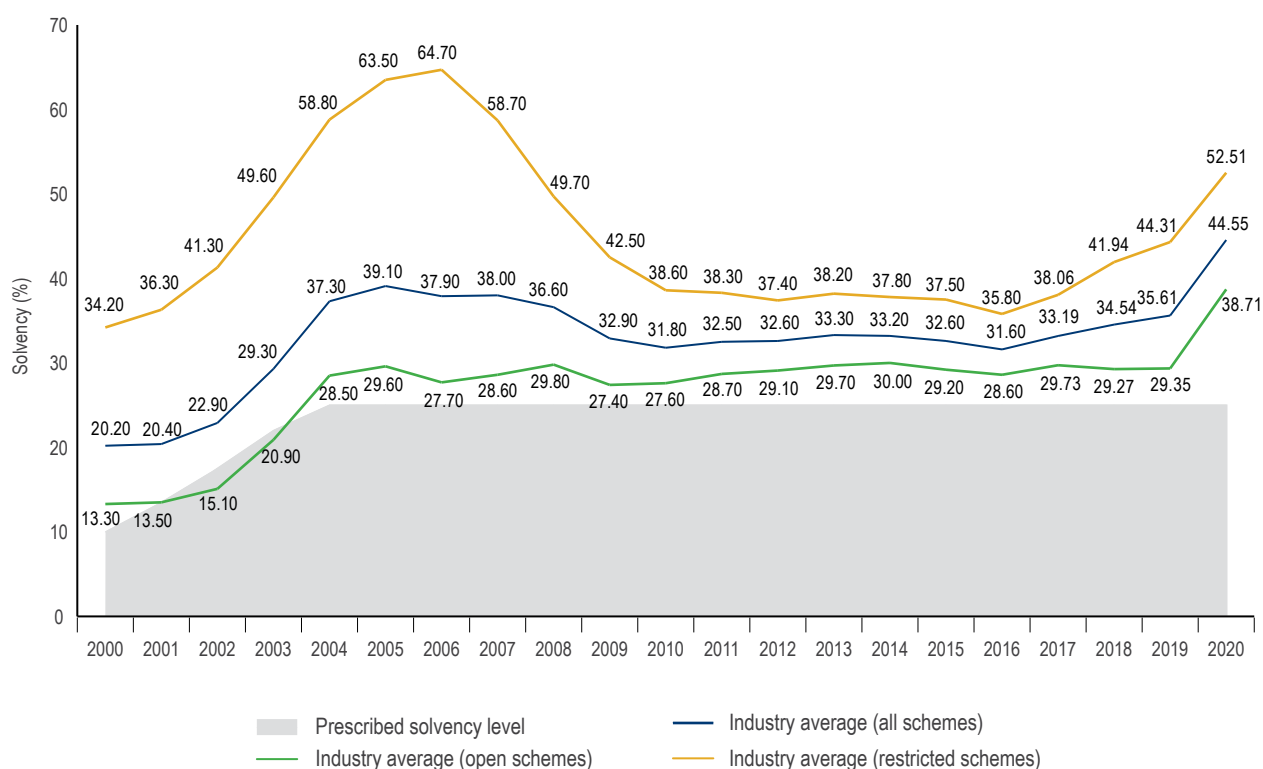
Solvency

The medical scheme industry is financially sound and the industry solvency of 44.55% exceeds the minimum required solvency level of 25.00%.

The open scheme industry's solvency level has been stable over the past decade, reaching a solvency level of 29.35% at the end of 2019. The increased level of reserves in the open scheme industry resulted in a year-end solvency level of 38.71%.

The restricted scheme solvency level is mostly affected by the performance of Government Employee Medical Scheme (GEMS). As such the overall restricted scheme market reported an improved solvency of 44.31% in 2019, from 35.80% in 2016. A solvency of 52.51% was noted at the end of 2020.

Figure 6: Industry solvency level for all medical schemes: 2000 – 2020



Schemes under close monitoring

Medical schemes that fall short of the statutory minimum solvency level of 25% are required to notify the CMS of the underlying causes of failure, and the corrective action to be undertaken. Such schemes are then closely monitored by the CMS. As at 31 December 2020, three medical schemes were below the minimum statutory solvency requirement of 25% (ICU schemes) – two open and one restricted scheme.

Open medical schemes experienced a significant increase in solvency, from 29.35% at the end of December 2019 to 38.71% at the end of December 2020. In total, there were 4 831 121 beneficiaries in the open scheme market (December 2019: 4 936 896), of which 1.08% (52 056) were in schemes not meeting the prescribed minimum solvency requirement (December 2019: 15.94% or 786 919 beneficiaries).

The solvency ratio for all restricted schemes increased by 18.51%, from 44.31% as at 31 December 2019 to 52.51% as at 31 December 2020. The restricted scheme market had 4 065 045 beneficiaries (31 December 2019: 4 016 180) of which 0.74% (30 211) were in schemes not meeting the prescribed minimum solvency requirement (December 2019: 0.86% or 34 703 beneficiaries).

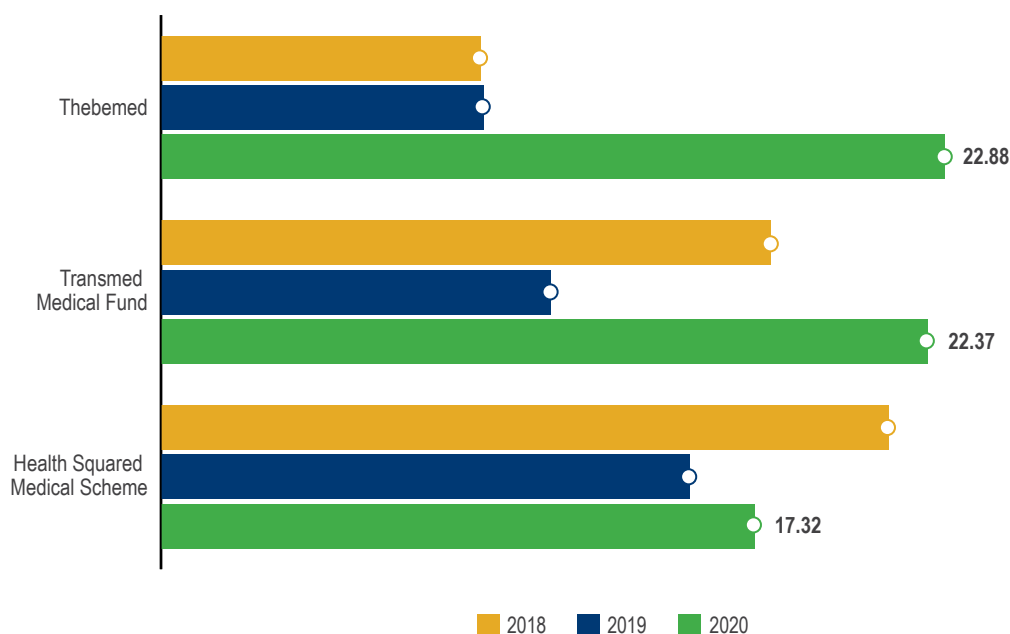
Other reasons for schemes being closely monitored include governance-related concerns and concerns regarding high non-healthcare expenditure levels.

Spectramed fell below the minimum statutory solvency level of 25% in 2018. The scheme amalgamated with Resolution Health Medical Scheme, on 1 January 2019 and the amalgamated entity is now known as Health Squared Medical Scheme. The scheme reported a solvency level of 17.32%, an increase from 15.42% in 2019. The CMS holds monitoring meetings with its board of trustees on a regular basis and the scheme submits monthly management accounts.

Thebemed's solvency ratio increased marginally from 9.41% in 2019 to 22.88% at the end of 2020. The scheme was placed under curatorship in 2019.

Transmed Medical Fund reported a solvency ratio of 22.37%, a significant increase from 11.38% in the previous year. A business plan was submitted by the scheme and approved by the CMS. Transmed remained under close monitoring in the year under review and regular monitoring meetings were held to discuss progress against turnaround plans.

Figure 7: Schemes with solvency levels below 25% as at 31 December of each relevant year



MEDICAL SCHEMES, BENEFIT OPTIONS AND CONSOLIDATION TRENDS

Member contribution increases for 2021

The average gross contribution increases for all medical schemes in 2021 was 2.9%. The gross contribution increase is based on the actual number of principal members as well as adult and child dependants. Table 55 shows a summary based on medical scheme contribution increase submitted to CMS as at 31 December 2020, for implementation on the 1 January 2021. Overall, the abnormally lower average contribution increase for open schemes, is mainly attributed to Discovery Health Medical Scheme (DHMS), implementing a zero contribution increase for a six-month period from 1 January 2021 until 1 July 2021.

Table 55: Average gross contribution increases for 2021

	Principal member %	Adult dependant %	Child dependant %	Family %
Restricted schemes	5.1%	17.9%	1.8%	7.1%
Open schemes	0.1%	0.0%	-0.4%	0.0%
All schemes	2.1%	6.7%	0.7%	2.9%

Table 56: Average monthly gross contribution for 2021

	Principal member	Adult dependant	Child dependant	Family
Restricted schemes	2 727.17	2 378.57	975.61	4 641.33
Open schemes	2 835.80	2 412.57	964.51	4 588.06
All schemes	2 791.67	2 399.94	970.37	4 609.70

The average risk contribution increase for all medical schemes in 2021 was 2.9%. The risk contribution is equal to the total contribution paid, less the amount that is allocated to a savings account for a beneficiary.

Table 57: Average risk contribution increases for 2020/21 benefit and contribution review period

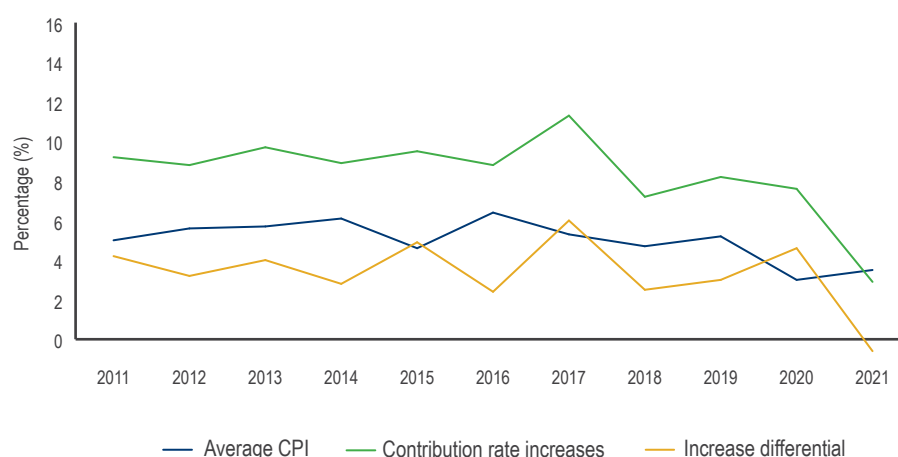
	Principal member %	Adult dependant %	Child dependant %	Family %
Restricted schemes	5.1%	18.4%	1.6%	7.2%
Open schemes	-0.2%	-0.4%	-0.7%	-0.3%
All schemes	2.0%	7.1%	0.6%	2.9%

Medical scheme contribution increases relative to consumer inflation

The contribution rate increases reflected in Figure 8 below show that on average contribution rates across the industry, increased by 2.9% in 2021. According to National Treasury's Economic Outlook, Consumer Price Index (CPI) is projected to average 3.9% in 2021. While annual contribution increases have consistently surpassed CPI, the actual average contribution increase rate of 2.9% for 2021 benefit year is 1.0% below the projected average CPI rate of 3.9%. It is for the first time in over a decade that the industry has implemented contribution increase below consumer inflation.

The lower than CPI contribution increase implemented during the period under review, is mainly due to a collaborative effort between the CMS and the industry, aimed at providing financial relief to members grappling with the adverse economic contagion due to the COVID-19 pandemic.

Figure 8: Medical scheme contribution increases and inflation: 2011 – 2021



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

Medical schemes, benefit options and consolidation trends

In February 2021, the CMS published a list of all 75 registered medical schemes and their contact details in the Government Gazette, as required by section 25 of the MSA. No new medical schemes were registered during the period under review.

Amalgamated schemes

During the period under review, there was only one amalgamation in the industry. Bestmed Medical Scheme merged with Grinteck Electronics Medical Aid Society with effect from 1 July 2020.

Benefit options

As at March 2021, the total number of registered benefit options increased to 251, comprising of 118 options in the open schemes and 133 options in the restricted schemes. These options exclude the 69 efficiency discount options (EDOs) as at March 2021, that are part of the individual options registered. While the number of EDOs in the open schemes decreased marginally from 57 to 56, this was evened out by a corresponding increase from 12 to 13 in the number of EDOs in the restricted schemes, resulting in the total number of EDOs remaining unchanged at 69, during the period under review.

Table 58: Registered benefit options as of March 2021

Classification of medical scheme	Open scheme options	Restricted scheme options	Total options
New options - non-EDO	2	1	3
New options - EDO	0	1	1
Discontinued options - non-EDO	-2	0	-2
Discontinued options - EDO	-1	0	-1
Discontinued options due to scheme mergers	0	-1	-1
Discontinued options due to scheme liquidations	0	0	0
Options registered as at 31 March 2021 (excluding efficiency-discounted options)	118	133	251
Efficiency discount options*	56	13	69
Options registered as at 31 March 2021	174	146	320

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

Efficiency-discounted options (EDOs)

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

As at 31 March 2021, there were 17 schemes offering efficiency-discounted options: 11 open and six restricted. The schemes include:

1 **Bestmed Medical Scheme**

2 **Bonitas Medical Fund**

3 **Compicare Wellness Medical Aid Scheme**

4 **Discovery Health Medical Scheme (DHMS)**

5 **FedHealth Medical Scheme**

6 **Government Employees Medical Scheme (GEMS)**

7 **Hosmed Medical Aid Scheme (Hosmed)**

8 **Medihelp**

9 **Medshield Medical Scheme**

10 **Momentum Health**

11 **MotoHealth Care**

12 **Old Mutual Staff Medical Aid Fund**

13 **Profmed**

14 **Sasolmed**

15 **Sizwe Medical Fund**

16 **Thebemed**

17 **Umvuzo Health Medical Scheme**

The percentage of members of EDO options, measured as a percentage of members of all options has remained relatively stagnant around 25.4% during the period under review.

The net healthcare results shows that EDOs continue to report positive results. The net healthcare result of the EDOs and non-EDOs is shown in Table 59. During the period under review, the EDOs collectively contributed up to 24.5% of the total surplus, even though these options accounted for mere 25.4% of the total membership.

Table 59: Net healthcare results of EDOs and non-EDOs: 2015 - 2020

Type of option	2015 R'000	2016 R'000	2017 R'000	2018 R'000	2019 R'000	2020 R'000
EDOs	587 271	630 314	1 054 804	983 335	1 772 484	2 735 989
Non-EDOs	341 593	-179 323	2 202 764	1 632 130	4 585 935	8 453 338
All schemes	928 864	450 991	3 257 568	2 615 465	6 358 442	11 189 327

One of the reasons for the better operating results of EDOs can be attributed to the fact that the average age of beneficiaries of EDOs is younger than the average age of the scheme. As at December 2020, the average age of EDOs beneficiaries was 32.95 compared to 37.43 for Non-EDOs. Similarly, the claims ratio for EDOs was 74.5% compared to 82.03% for Non-EDOs. Refer to Annexure U for detailed information on the EDOs.

Accreditation of medical scheme administrators and self-administered schemes

Table 60: Administrators and self-administered schemes' accreditation and compliance certificate application evaluations completed during 2020/21

ADMINISTRATORS AND SELF-ADMINISTERED SCHEMES APPLICATION EVALUATIONS COMPLETED				
	New applications	Renewals	On-site evaluations completed	Conditions compliance on-site evaluations
Administrators	None	Private Health Administrators (Pty) Ltd	None	None
		Agility Health (Pty) Ltd		
		Universal Healthcare Administrators (Pty) Ltd		
		3Sixty Health (Pty) Ltd		
		Liberty Health Administration (Pty) Ltd		
		National Health Group (Pty) Ltd		
		Momentum Health Solutions (Pty) Ltd		
		Afrocentric Integrated Health Administrators (Pty) Ltd		
Self-Administered Schemes	Medshield Medical Scheme		None	None

Third-party administrators and self-administered schemes

Eight administrator accreditation renewal applications and one new self-administered scheme application were evaluated and finalised during the year. Due to the COVID-19 pandemic no on-site evaluations were conducted during the year. The Accreditation unit continued to monitor compliance by accredited entities with conditions imposed and the audited financial statements of administrators annually to ensure their financial soundness.

Several administrator accreditation related documents/guidelines were revised and published following the publication of the revised administrator accreditation standards (version 6) in the previous financial year.

Managed care organisations and self-administered schemes

Table 61: Managed Care Organisations and self-administered schemes' accreditation and compliance certificate application evaluations completed during 2020/21

MANAGED CARE ORGANISATIONS AND SELF-ADMINISTERED SCHEMES APPLICATION EVALUATIONS COMPLETED				
	New applications	Renewals	On-site evaluations completed	Conditions compliance on-site evaluations
Managed Care Organisations	Health Window (Pty) Ltd	Aid for Aids Management (Pty) Ltd	None	None
		ICAS Managed Care (Pty) Ltd		
		Momentum Thebe Ya Bophelo (Pty) Ltd		
		National Health Group (Pty) Ltd		
		South African Oncology Consortium Limited		
		Kaelo Primecure (Pty) Ltd		
		RX Health (Pty) Ltd		
		Health Calibrate (Pty) Ltd		
		Agility Health (Pty) Ltd		
		Momentum Health Solutions (Pty) Ltd		
		Careworks (Pty) Ltd		
		Lifesense Disease Management (Pty) Ltd		
		Performance Health (Pty) Ltd		
		Scriptpharm Risk Management (Pty) Ltd		
		Professional Provident Society Healthcare Administrators (Pty) Ltd		
		Liberty Health Administration (Pty) Ltd		
		Mediscor PBM (Pty) Ltd		
		Discovery Health (Pty) Ltd		
		Dental Risk Company (Pty) Ltd		
		ICON Managed Care (Pty) Ltd		
		Improved Clinical Pathway Services (Pty) Ltd		
		Optimal Managed Care (Pty) Ltd		

One new and 22 renewal managed care organisation accreditation applications were evaluated and finalised during the year. No on-site evaluations were conducted during the year due to the COVID-19 pandemic.

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

Brokers and broker organisations

Table 62: Individual brokers and broker organisations accredited - new and renewals

Total number of broker and broker organisation applications received	4 554
Total number of broker and broker organisation applications accredited within 30 working days of receipt of complete information	3 861
Percentage of broker and broker organisation applications accredited within 30 working days of receipt of complete information	84.8%
Total number of accredited brokers and broker organisations as at 31 March 2021	10 102

Table 63: Brokers Accreditation Withdrawn

Broker Numbers	Action	Effective Date	Reason
Mr CG Nilsson (BR31245)	Withdrawn	11/01/2021	Broker no longer provides broker services
Mr BC Nilsson (BR3934)	Withdrawn	11/01/2021	Broker no longer provides broker services

Table 64: Brokerage Accreditation Withdrawn

Brokerage Number	Action	Effective Date	Reason
Nilsson and Associates CC (ORG1775)	Withdrawn	11/01/2021	Brokerage no longer provides broker services

Table 65: Broker Accreditation Rejected

Broker Number	Action	Effective Date	Reason
Mr AG Stephan (BR8963)	Rejected	23/09/2020	Broker is unrehabilitated insolvent

Verification of academic qualifications

The Accreditation unit continued to verify academic qualifications of individuals applying to be accredited as brokers. The qualifications of 2 670 individuals were verified independently during the period under review.

Exemptions granted to broker applicants

The Registrar approved exemption to 49 individual broker applicants from complying with Regulation 28B(2)(a), in terms of section 8 of the Medical Schemes Act (131 of 1998) during the period under review.

Adjustments of broker fees

The Minister of Health announced an increase in the maximum amount payable to brokers by medical schemes in respect of broker clients who are members of medical schemes, in terms of section 65 of the Medical Schemes Act. The amount was increased to R101.91 per member per month, with effect from 1 January 2021.

ENFORCING AND ENCOURAGING COMPLIANCE

Annual General Meeting monitoring

The CMS noted the pronouncements by the President and concluded that medical schemes' ability to convene AGMs for 2020, consistent with registered scheme rules will be adversely impacted. In this regard, the CMS issued Circular 23 and 36 of 2020 wherein all medical schemes were strongly encouraged to consider applying for an exemption to convene virtual AGMs for the 2020 financial year. Consequently, 74 schemes were exempted to hold virtual AGMs. CMS also observed 26 AGMs virtually in real-time and/or by reviewing the electronic documents.

Routine inspections

The COVID-19 pandemic and the resultant lockdown necessitated a change in the manner in which we conduct routine on-site inspections. Schemes were required to upload the documents relevant for the purpose of the routine inspections on the CMS FTP site to enable virtual inspections thereof. Ten schemes were inspected during the period under review and the outcomes were communicated to the schemes. These schemes will be monitored until all remedial actions have been implemented. Routine inspections are used to measure the schemes' level of compliance with the Medical Schemes Act and other applicable laws and governance standards. The routine inspections outcomes are therefore used to improve the scheme's compliance to the benefit of members.

Commissioned inspections

CMS also has a responsibility to conduct investigations of alleged irregularities where tip-offs or information pointing to a commission of irregularities is received. CMS finalised two commissioned inspections/investigations against medical schemes.

Enforcement actions

CMS achieved 100% performance for enforcement actions and governance interventions in that it received and completed 70 enforcement actions and 93 governance interventions which included the following interventions:

- Section 43 enquiries
- Section 45 enquiries
- Exemption assessment
- Enforcement of the Registrar/Appeal board rulings
- Curatorship monitoring
- Inspection directives
- Board notice inspection

Demarcation

On 30 June 2020, the Council considered the renewal exemption applications of insurers in terms of section 8(h) of the Medical Schemes Act and the Renewal Framework, from complying with the provisions of section 20(1) of the Medical Schemes Act. Section 20(1) provides that no person shall carry on the business of a medical scheme unless that person is registered as a medical scheme under section 24.

Council resolved to renew the exemptions to insurers that conduct the business of a medical scheme on option or products with active policyholders, subject to specific conditions. The exemptions were granted to insurers that applied for exemption and that had active policyholders as at 31 March 2017. Conversely, exemption was not granted for new products or products that had no active policyholders. The renewal period was initially set from the 1 April 2019 to 31 March 2021, however, after consultation with National Treasury, Financial Sector Conduct Authority (FSCA) and the Prudential Authority (PA), and considering the impact of COVID-19, the Council resolved to extend the exemption by another year, from 1 April 2021 to 31 March 2022.

During 2020, the CMS established two advisory committees as per Circular 12 of 2020, for the Insurance Stream and the Administration and Funders Stream. The purpose of the advisory committees is to develop a Low-Cost Benefit Option framework, for submission to Council and the Department of Health. During May/June 2020, the CMS issued the charter and code of conduct of the advisory committees. The nominees on the advisory committees consist of key industry players and delegates from NDoH, National Treasury, FSCA, and the PA.

Due to the COVID-19 pandemic, the CMS was unable to arrange physical workshops and all engagements were conducted virtually.

The CMS hosted a virtual Regulatory Workshop in September with the NDoH, National Treasury, FSCA and the PA to deliberate on insurers conducting the business of medical schemes as well as on the development of the LCBO Framework.

The first joint advisory committee meeting was held virtually in October 2020 and yielded a positive return from nominees. The purpose of the meeting was to provide an update on the developments of insurers conducting the business of a medical scheme and to discuss the terms of reference.

The second advisory committee meeting was held on 3 December 2020 and the purpose of this meeting was to update and adopt the terms of reference, given feedback from the nominees as per the October 2020 meeting. A proposal on the technical work that the advisory committees will be responsible for, as well as the establishment of related workstreams, was also discussed. During March 2021, various workstream meetings were held with the advisory committee members.

BURDEN OF DISEASE AND UTILISATION OF HEALTHCARE SERVICES

Healthcare utilisation annual statutory returns data collection system

Section 7 (e) of the Medical Schemes Act describes that one of the key functions of the Council is to collect and disseminate information about private health care, this also includes utilisation of health care services. The Dynamic Data Driven Return (DDDR) System was implemented recently, coupled with continuous improvement of utilisation statistics indicators and data specification guidelines. The CMS continues to see an improvement in reporting the quality of healthcare data. Various circulars were published that looked at critical areas for data improvement, including new validation rules to define better and standardised the indicators.

Analysis of scheme risk measurement returns

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

There was a noticeable increase in the variation between schemes' risk profiles, evident by the rise in the risk rate measured from the ICR. Schemes with favourable risk profiles (young and healthy beneficiaries) recorded at rates of R558 below the ICR and schemes with unfavourable risk profiles recorded rates at over R1 299 above the ICR.

The findings continue to depict a significant degree of variation in risk between medical schemes and is directly attributable to the actual differences in the risk profiles of individual medical schemes. The observed increase in the industry community rate is possibly a result of a change in the risk profile of medical schemes' beneficiaries.

Scheme-specific reports detailing the Scheme Community Rate by benefit option

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

Prevalence of chronic diseases in the medical schemes' population

The CMS continues to monitor the prevalence of chronic conditions in the medical schemes' population. Hypertension, hyperlipidemia and diabetes mellitus type 2 are the most prevalent chronic conditions, and these are also ranked highest in beneficiaries that are 60 years and older as well as for the entire industry.

Analysis of the PMB coverage for beneficiaries with chronic conditions revealed that 7.77% was admitted to hospital. Close to 21.04% of beneficiaries admitted to hospital received treatment for hypertension, 11.62% for coronary artery disease and 11.83% was treated for diabetes mellitus 2.

General prevalence that is defined as beneficiaries having at least one claim for a chronic condition, at rates over 1.8 times higher than the strict prevalence, set by the Entry and Verification criteria. Considering the current COVID-19 pandemic, all beneficiaries with underlying conditions are at higher risk for severe COVID-19 infection. This analysis has assessed the prevalence of conditions in the specific vulnerable proportions of the population, such as beneficiaries 60 years and over, beneficiaries with hypertension, diabetes, respiratory conditions, cardiac conditions and chronic renal disease, as indicated by the Ministry of Health.

POLICY RESEARCH AREAS

Out-of-pocket expenditure by beneficiaries of medical schemes 2013 – 2019

The unit conducted a study that focused on out-of-pocket (OOPs) expenditure by medical schemes which was published by the 2020 BHF Southern African Health Journal. This study evaluated the increasing trend in OOPs incurred about various disciplines in the context of medical schemes' benefit design. The membership data showed a declining trend of enrolees in comprehensive types of benefit options and an uptick in other types of benefit options such as Efficiency Discounted Options, partial cover plans and hospital plans over the review period. This further attests to affordability issues of comprehensive plans which are associated with higher premiums and richer benefits.

The study also showed that OOPs incurred by members have increased at an annual rate of 7.9%, from an estimated R22.3 billion in 2013 (R2 562.83 per beneficiary per annum (pbpa)) to over R35.2 billion in 2019 (R3 913.94 pbpa), in real terms. OOPs made up just over 18% of the total amount claimed from medical schemes in 2019; this increased from 15.5% in 2013. OOPs incurred for medicines dispensed increased annually by 7.8% between 2013 and 2019, from R7.4 billion to R11.6 billion, respectively.

Claims billed for medicines dispensed constituted 40.6% of total out-of-hospital claims and only 17.1% of the total amount claimed in 2019. OOPs incurred for hospital services increased at an annual rate of 14.9% between 2013 and 2019, from R1.1 billion to R2.4 billion. Hospital services make up approximately 61% of in-hospital claims and 36.6% of total amount claimed in 2019.

The findings of this study suggest the need for innovative strategies such as a primary benefit package, standardisation of benefit options, inclusion of primary healthcare services as part of prescribed minimum benefit (PMB) entitlements and a review of medicine benefits and hospital benefits to deal with escalating levels of OOPs.

Patient Experience Survey Report

The Research and Monitoring unit did not conduct a patient experience survey for beneficiaries living with diabetes, for the 2020/21 financial year. That said, the patient experience survey responses from the previous year's survey were used to develop patient empowerment scores. Patient empowerment is important for people living with chronic conditions. This is because positive treatment outcomes of these conditions depend on self-management and strong partnerships between the care giver and the patient.

The dimensions which were used to inform overall patient empowerment were:

- Patient activation.
- Patient self-management.
- Patient self-efficacy.

Responses from the patient experience survey were used to develop a measurement construct which linked patient experience dimensions to the patient empowerment dimensions. The findings were that beneficiaries living with diabetes had better patient activation and self-management scores, relative to patient self-efficacy dimension.

Using a structural equation model, we observed that beneficiaries who were empowered tended to be more likely to adhere to disease treatment protocols. The significance of the study is that patient empowerment can have a positive impact on treatment adherence. Better treatment adherence means that chronic conditions are under control and are less likely to result in hospital admissions.

Benefit standardisation

The Research and Monitoring unit did research related to the standardisation of the design of benefit options in order to improve the comparability of benefit options and thus improve beneficiaries' benefit option decisions.

During 2020/21, the research team conducted a needs assessment for carrying out a market segmentation survey to better understand beneficiaries' preferences in choosing benefit options. It is hoped that this information will improve cluster analyses for grouping similar benefit options together, thereby, allowing appropriate benefit option comparisons.

Risk-Based Capital Solvency Framework

The unit reviewed various risk-based models during the 2020 – 2021 period and did a comparative analysis amongst these. The unit is currently doing an impact assessment at the level of the individual scheme. The 2021/22 financial year activities will entail communication and consultation with medical schemes and the unit will solicit feedback on the performance of these models.

COVID-19 Vaccines Study

The CMS conducted an online survey to gauge support for COVID-19 vaccination by members of medical schemes. The results of the month-long study, with over 75 000 participants, will be used to facilitate planning and communication strategies in the rollout of the vaccine program. A total 82% of respondents reported that they would get vaccinated, while 76% indicated that they would trust the vaccine if someone close to them would get vaccinated. The study also assessed the main attributes of the participants who stated intent not to get vaccinated. For 34% of respondents, the main reason for not getting inoculated was that the vaccines were too new, and they wanted to wait and see how it worked on other people.

On the question of funding, more than half (53%) of participants thought it was appropriate for medical schemes to cross-subsidise non-members for the COVID-19 vaccine. Those who were against cross-subsidisation fared at 27% and those unsure at 20%, respectively.

On the preferred vaccination site, the study showed that general practitioners (GPs) and pharmacists were the select vaccination sites as these accounted for 50% and 33%, respectively. The 17% balance chose hospitals, clinics, community centres and other types of settings as their preferred vaccination sites. The findings of the study provided critical insights to improving access and highlighting some of the strategies that could be employed in Phase II and III of the COVID-19 vaccination rollout plans.

Essential Primary Hypertension Diagnosis, COVID-19 and Other Types of Admission Study

The study sought to assess the characteristics of patients admitted to the hospital for COVID-19, essential primary hypertension, and other types of diagnosis. The study found that, the median age of patients admitted to hospital for confirmed primary diagnosis was 54 (IQR 44-63) years; essential primary hypertension was 54 (IQR 45-63) years; other types of diagnosis was 48 (IQR 35-62) years; and COVID-19 suspected diagnosis admission was 54 (IQR 38-67) years.



A total 82% of respondents reported that they would get vaccinated, while 76% indicated that they would trust the vaccine if someone close to them would get vaccinated.

This study also showed that admissions increase with age across all four groups of diagnosis, with the average number of admissions highest in the age band 45-55 years. This age group accounted for 22% of all admissions.

The results further show very similar characteristics between COVID-19 and essential hypertension admissions diagnosis with similar rates across age bands. Higher rates of hospitalisation were most prevalent in the age bands 35-55 years. There were few COVID-19 suspected diagnoses in the age band 65+ years.

COVID-19-related admissions accounted for just over a third of all admissions while other types of admissions, non-COVID-19-related, accounted for just under two-thirds of admissions. Despite various studies showing a declining utilisation trend of hospitals on non-COVID-19 diagnosis in fear of contracting COVID-19, this study does indicate some admissions for non-COVID-19-related admissions in 2020.

RESEARCH PUBLICATIONS

The unit published six research papers in peer-reviewed journals, including topics on COVID-19 medical schemes admissions. It continued participation in industry conferences, such as the Healthcare Quality Assessment (HQA) annual industry results presentation and clinical quality conference, the 6th annual Board of Health Funders (BHF) Titanium Awards, where the unit published three research papers with one being nominated as the best research paper submitted. Lastly, the unit participated in the African Union Governance seminar and presented a topic on governance failures in medical schemes.

CLINICAL OUTCOMES TO SUPPORT CMS STRATEGY

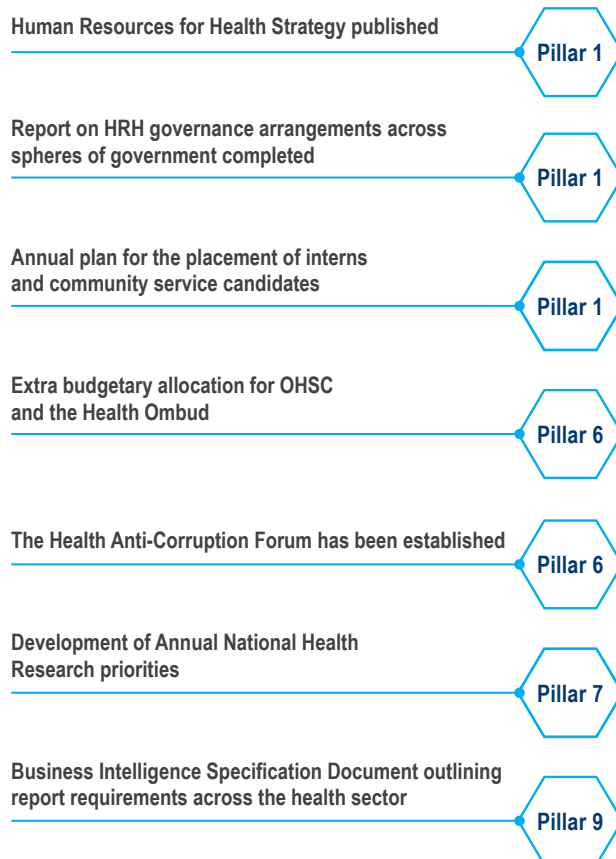
The clinical unit undertook several important activities in support of the strategic objectives of the CMS. It played a significant role in the initiation of the gazetting of COVID-19 as a Prescribed Minimum Benefit diagnosis and in ensuring that the COVID-19 vaccine qualified as PMB level of care. The unit participated in several media engagements and provided input to educational publications for members and beneficiaries of medical schemes. It published several benefit definition guidelines and CMScripts in respect of COVID-19 as well as other PMB conditions.

The PMB review project being undertaken in conjunction with industry stakeholders was further advanced. The draft Preventative and Primary Healthcare package's costing is at an advanced stage with a first draft costing report completed. The costing committee also undertook a study to determine members' willingness to pay for the proposed primary healthcare package. The turnaround time for the provision of clinical opinions used in the adjudication of complaints from members and beneficiaries of schemes was significantly improved upon. The backlogs of the last few years were cleared and the quality of opinions were greatly improved. Several contentious healthcare technologies were adjudicated upon while ensuring that member and beneficiary entitlements were protected.

PRESIDENTIAL HEALTH COMPACT

The CMS continued to participate in the Presidential Health Compact during the year under review. This compact is a product of a Presidential Health Summit that convened in October 2018. Over 600 diverse stakeholders in the health sector came together during the summit to discuss their concerns about quality of care in the public health sector, leading to its signing in 2019.

Between 2019 and 2021, there was an incremental improvement of 49% in the implementation of the interventions included in the compact. In addition, seven indicators from four pillars completed implementation of their interventions. These indicators accounted for an additional 13% of the 53 indicators, compared to 2% achievement rate in 2019:



The Council for Medical Schemes is responsible for coordinating the different stakeholders for implementation of Pillar 9 interventions, within the Presidential Health Compact.

LITIGATION

The Legal Services unit was successful in numerous fronts most notably in implementing the mandate and protecting the regulatory powers of the CMS. The unit engaged in several key interventions, which included giving effect to the Registrar's decision to place KeyHealth Medical Scheme under curatorship.

CMS vs COMPCARE

The Registrar successfully rejected a rule amendment to change the name of the Compcare Medical Scheme to that of Universal – Compcare's administrator. The Registrar found that this arrangement would be misleading to the public and the rejection of the amendment would protect members. Both the High Court and the Supreme Court of Appeal were in favour of the CMS' decision.

CMS vs KEYHEALTH

The Registrar successfully placed Keyhealth Medical Scheme under curatorship due to section 43 enquiry that indicated material irregularities at the scheme. These irregularities placed the interest of members in jeopardy. This included lack of adherence to corporate governance controls, lack of adherence to policy and other ancillary matters that were of grave concern to the members of the scheme.

CMS vs GW ALBERTS

The applicants, erstwhile trustees of the Board of Bestmed Medical Scheme, sought an order to review and declare invalid a decision of the CMS taken in 2014 in terms of the provisions of section 46(1) of the Medical Schemes Act to remove them as trustees from the Board of Bestmed.

The Court concluded that there were no merits in concluding that a decision taken by the Council was irrational on the basis that there was retrospective compliance with the directives issued by the Council. It was therefore against this background that the High Court ruled that the grounds for the review had no merit and dismissed the application for review with costs.

PROMOTING A HEALTHY INDUSTRY THROUGH STAKEHOLDER ENGAGEMENT

The Stakeholder Relations unit is tasked to manage stakeholder relations, integrated marketing communication, education and training, and customer care. The CMS manages its stakeholder relations through engagements and forums, the signing of MoUs with strategic players and by creating platforms for industry-wide concessions on matters affecting private healthcare in South Africa. As such, the unit leads various special projects including the following:

SECTION 59 INVESTIGATION

The Section 59 Investigation Panel released the Section 59 Investigation Interim Report at a virtual press conference in January 2021, following the successful opposition of an interdict application against its release from the Government Employees Medical Scheme (GEMS) and the Board of Healthcare Funders (BHF).

The Section 59 Investigation was launched by the CMS in July 2019, in terms of its regulatory mandate, to investigate allegations of racial discrimination by medical schemes and administrators. An independent panel – consisting of advocates Tembeka Ngcukaitobi SC, Adila Hassim and Kerry Williams – was tasked to investigate the complaints, identify trends and make recommendations that may require legal or policy interventions, and amendments to legislation and regulations.

The panel called for written submissions to the Interim Report with a deadline of 5 March 2021, and subsequently granted an extension to 5 April 2021. The panel is at work to release the final report before the end of 2021.

Fraud, Waste and Abuse (FWA)

The CMS collaborated with the Health Professions Council of South Africa (HPCSA) to bring the Fraud Waste and Abuse (FWA) webinar in March 2021, following the proclamations of the Section 59 Investigation Interim Report. The report mentioned the two regulators as key players in addressing FWA fairly and reasonably for the benefit of both schemes and providers.

Held over two weeks, the webinars set the scene for the establishment of codes of good practice and standards for the industry to effectively deal with fraudulent activities. This includes fair sanctions for convicted fraudsters through the establishment of an FWA tribunal.

Communications

The sub-unit manages all CMS communications and in the 1 April 2020 – 31 March 2021 period issued 60 circulars, 20 press releases and 10 CMScripts newsletters. CMS social media pages carried campaigns on PMBs, COVID-19 webinars and promotion of the new CMS website. The sub-unit provided publishing support to the Research and Monitoring unit for the publication of two research reports, namely Medical Scheme Beneficiaries living with Diabetes 2019/20 and the COVID-19 Vaccines Survey Report 2021.

The advertising value estimate (AVE) for the CMS in print, online and broadcast media was R155 million for the financial year, with clip mentions increasing by 3% year on year. The main topics ranged from COVID-19 (PMB entitlements and the vaccine), the Section 59 Investigation, out-of-pocket payments and enforcement actions.

Noticing the high bounce rate of website visitors from countries outside the SADC region, the Communications sub-unit spearheaded the migration of all CMS domains from .com to .co.za to make the organisation more relatable and appealing as a South African organisation.

This domain move was complemented by the launch of CMS' newly designed website, a faster, easier and responsive portal on www.medicalschemes.co.za. The new website realises CMS' mandate through enhanced information sharing, simpler medical scheme member complaints lodging and appeals tracking.

To maintain and track CMS' marketing efforts, the sub-unit also acquired an email marketing platform that allows stakeholders to select the kind of communication they would like to receive from the CMS, allowing for ongoing segmentation of audience.

Education and Training

The Education and Training sub-unit conducted a total of 59 education, and awareness sessions to medical scheme members and their beneficiaries. The sub-unit was also featured in 13 radio stations and community radio stations countrywide.

The Education and Training unit could not conduct face-to-face engagements due to the COVID-19 pandemic but introduced online consumer education webinars which attracted much interest. The webinars were conducted in English, Setswana, Isizulu, Xitsonga and Tshivenda. The sub-unit also received a considerable number of requests for training on COVID-19 as a PMB, and subsequently partnered with other business units to honour the requests. All provinces were reached through the consumer webinars.

Continuing Professional Development (CPD) virtual training for both brokers and trustees was also introduced and received excellent response and attendance. Partnerships with professional bodies and co-regulators were sought in an endeavour to reach members of medical schemes to arm them with knowledge and information during the pandemic.

The CMS collaborated with the Consumer Protection Forum (CPF) chaired by the National Consumer Commission (NCC), the Financial Planning Institute (FPI) and the National Consumer Financial Education Committee (NCFEC) chaired by National Treasury. This led to CMS' participation in Money Smart Week online broadcast sessions spearheaded by the Financial Sector Conduct Authority (FSCA). Collaboration with the FPI produced the first CMS CPD public event for both brokers and members of medical schemes.

More members of medical schemes, healthcare brokers and trustees were reached despite the pandemic due to the use of virtual communication platforms.

Customer Care

The CMS Customer Care Centre operated remotely for the better part of the year in review. Calls were diverted from the call centre system to agent cell phones. Due to this, calls had to be recorded manually.

A total of 23 680 calls were recorded as received and handled through manual collection of data and 9 352 emailed enquires were received. The call centre saw a high rate of PMB related queries, flowing from CMS circulars on exemptions and payment holidays during the lockdown. This peak stabilised after the publication of the COVID-19 Benefit Guideline for the industry and the public.

COMPLAINTS STATISTICS

The number of complaints received by the CMS has decreased gradually over time. The actual reduction in the volume of complaints for the period under review was 12.50% as shown in the table below.

Table 66: Complaints ratio per 1 000 beneficiaries

2018	2019	2020	% change in 2019/20
3 808	2 829	2 490	-11.98%
0.43	0.32	0.28	-12.50%

The total number of complaints received and resolved included the roll-over from the previous periods.

Table 67: Number of complaints received and resolved

Type of option	2019	2020
Complaints carried forward from the previous year	1 902	1 725
Complaints received during the year	2 829	1 729
Total complaints	4 731	3 454
Total complaints resolved during the year	(3 006)	(2 490)
Closing balance as at 31 December	1 725	964

Table 68 shows a resolution rate of 49.72% complaints within a period of 60 days compared to 29.97% complaints that were resolved in the same period in 2019.

Table 68: Resolution turnaround times

Resolution turnaround times in days

Complaints resolved in days	0 - 30	31 - 60	61 - 90	91 - 120	+ 120	Total
Total number of complaints resolved	756	482	284	247	721	2 490
% of complaints resolved	30.36%	19.36%	11.41%	9.92%	28.96%	100%

The same complaints trends observed in 2019 were also observed in 2020. Similarly as in the previous period, complaints relating to administrative issues remain the highest category of complaints received. Under this category, most members were concerned about the payment of benefits, with most members indicating that their accounts were short-paid or rejected unlawfully. This was followed by members who were aggrieved that pre-authorisation was declined due to various reasons. The second highest category of complaints received relates to clinical matters.

Table 69: Number of complaints resolved by category

Main category	Number of complaints resolved
Administrative	1 575
Clinical	555
Legal / compliance	257
Sub-total	2 387
Inquiries / non-justiciable complaints	103
Total	2 490

Table 70: Rulings on resolved complaints per regulated entities in 2020

Entity Type	Number of complaints	Ruled in favour of complainant	Ruled in favour of regulated entity	Ruled in favour of both	Inquiries / non-justiciable complaints
Open medical schemes	1 693	690	778	141	84
Restricted medical schemes	768	389	275	90	14
Administrators	22	2	14	3	3
Managed healthcare organisation	2	1	1	–	–
Brokers	5	3	–	–	2
Total	2 490	1 085	1 068	234	103



8.9 million
members

Regulates

75
medical schemes

25
administrators

41
managed care
organisations

949
broker organisations

3 596
individual brokers