CMS
Council
for Medical Schemes

ANNUAL REPORT 2024|25

For You. For Health. For Life.

ANNUAL REPORT
2024/25

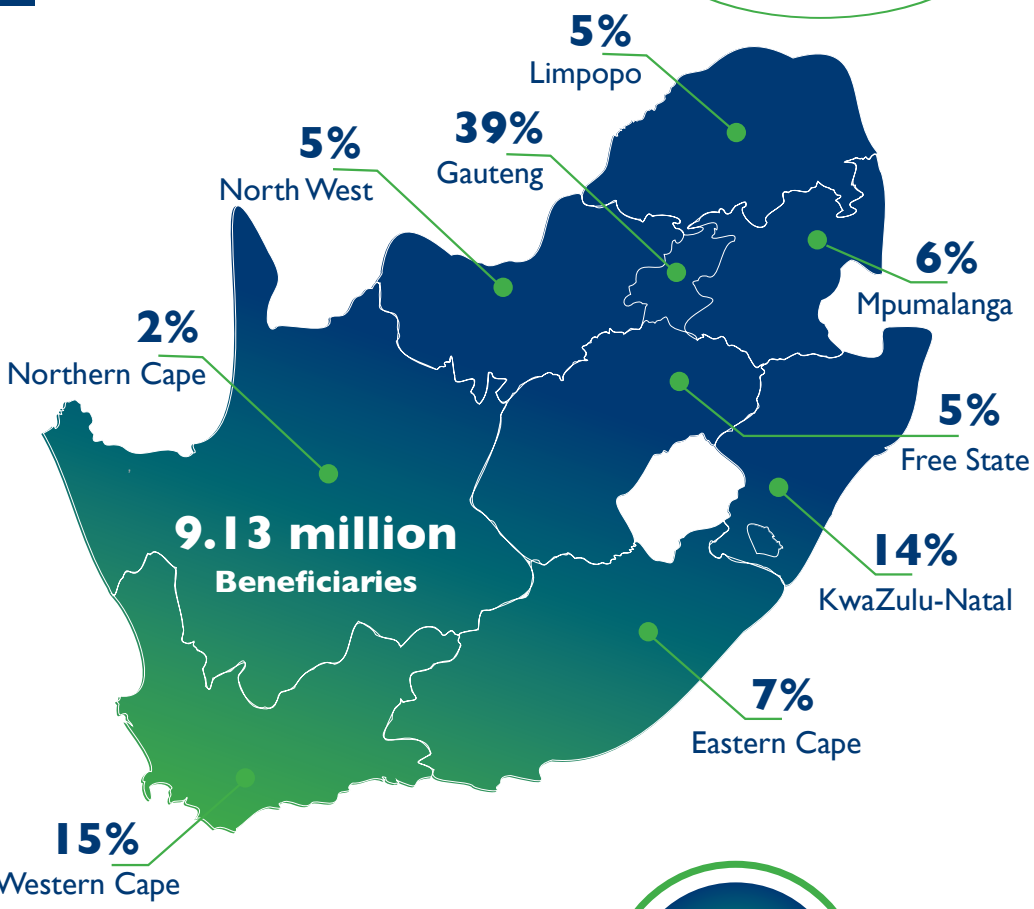
YEAR 2024/2025 AT A GLANCE

Regulation is in our DNA

96.43%
Overall performance of the organisation

Employees
136

98%
in South Africa
2%
Outside South Africa



Gender split beneficiaries

4 908 106 | **4 219 347**

Average beneficiary age
34 years

Regulated entities

- **71** Registered Medical Schemes — **16 open**, **55 restricted**
- **33** Administrators
- **43** Managed Care Organisations
- **7 773** Healthcare Brokers
- **2 223** Healthcare Brokerages

Informing

- Stakeholder awareness activities: **19** exhibitions
- Research and Publications: **5** policy-oriented research bulletins
- **3** peer-reviewed articles in the World Medical Journal

YEAR 2024/2025 AT A GLANCE

Regulation is in our DNA

Protecting

- Consumer education sessions: **84** activities
- PMB definition guidelines: **10**
- CMScript newsletters: **12**
- Customer care calls: **27836** (89% call handling rate)
- Customer care walk-in consultations: **90**

Complaints

- Complaints resolved: **1879**
- Email enquiries: **10 680** (5 776 valid queries)
- Registrar's rulings: **225**

Governance

- Circulars: **44**
- Workshop and Training sessions: **50**
- Board of Trustees and Broker training sessions: **10**
- Trustee programme with GIBS: **1**

Clinical Opinions

Clinical opinion requests: **534**

Clinical enquiries: **952**

Engagements

PO and BoT Forums: **2**

Memoranda of Understanding (MoUs): **11**

Regulation

Annual General Meetings and special meetings observed: **46**

Routine inspections: **10**

Appeals Committee Rulings

22

Industry performance

- Relevant healthcare expenditure: **R217.59 billion**
- Benefits paid: **R239 billion**
- Contribution (excluding medical savings): **R226.94 billion**
- Contributions to personal medical savings: **R24.30 billion**
- Out-of-pocket (OOP) payments: **R43.3 billion**
- Solvency: **43.45%**

More industry highlights

- Efficiency Discount Options (EDOs) increased to **71** in 2023, from **50** in 2017
- Beneficiaries on EDOs increased from **20%** in 2017 to **37%** in 2023
- Beneficiaries enrolled in Disease Management Programmes (DMPs) as of 2023:
- Hypertension and other cardiovascular conditions DMP: **3.6 million**
- Diabetes Type 2 DMP: **1.1 million**
- HIV DMP: **800 000**

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GENERAL INFORMATION

GENERAL INFORMATION

REGISTERED NAME	Council for Medical Schemes
PHYSICAL ADDRESS	Block A, Eco Glades 2 Office Park 420 Witch – Hazel Avenue Eco Park Centurion Pretoria, 0157 South Africa
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WEBSITE ADDRESS	medicalschemes.co.za
SOCIAL MEDIA	**Facebook:** Council for Medical Schemes **X/Twitter:** @CMScares4U **LinkedIn:** Council for Medical Schemes **YouTube:** CMScares4U
INTERNAL AUDITORS	Lunika Inc.
EXTERNAL AUDITORS	Auditor-General of South Africa
BANKERS	Absa Group Limited
CHAIRPERSON OF COUNCIL	Dr Thandi Mabeba
CHIEF EXECUTIVE AND REGISTRAR	Dr Musa Gumede
COMPANY/ BOARD SECRETARY	Mr Khayalethu Mvulo

LIST OF ABBREVIATIONS/ACRONYMS

AFS	Annual Financial Statements
AGM	Annual General Meeting
AGSA	Auditor-General South Africa
ANC	African National Congress
ARC	Audit and Risk Committee
AVE	Advertising Value Equivalent
B-BBEE	Broad-Based Black Economic Empowerment
BHF	Board of Healthcare Funders
BoT	Board of Trustees
CCMA	Commission for Conciliation, Mediation and Arbitration
CDL	Chronic Disease List
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHE	Catastrophic Health Expenditure
CMS	Council for Medical Schemes
COVID-19	Coronavirus Disease 2019
CPF	Consumer Protection Forum
CPI	Consumer Price Index
DAE	Directly Attributable Insurance Service Expenditure
DHC	District Health Council
DM2	Type 2 Diabetes Mellitus
DMP	Disease Management Programme
DR	Dispute Resolution
DRC	Dispute Resolution Committee
EDO	Efficiency Discount Option
EE	Employment Equity
EXCO	Executive Committee
FFS	Fee-for-Service
FSCA	Financial Sector Conduct Authority
FWA	Fraud, Waste and Abuse
GDP	Gross Domestic Product
GIBS	Gordon Institute of Business Science
GNU	Government of National Unity
GP	General Practitioner
GRAP	Generally Recognised Accounting Practice
GVA	Gross Value Added
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HIV/Aids	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HMI	Health Market Inquiry
HPCSA	Health Professions Council of South Africa
HR	Human Resources
HRC	Human Resources Committee
HWSETA	Health and Welfare Sector Education and Training Authority
ICT	Information and Communication Technology
IESBA	International Ethics Standards Board for Accountants
ISAs	International Standards on Auditing
JSE	Johannesburg Stock Exchange
KM	Knowledge Management
KPIs	Key Performance Indicators
LCBO	Low-Cost Benefit Option
LRA	Labour Relations Act
MBA	Master of Business Administration
MCO	Managed Care Organisation
MLNF	Multilateral Negotiation Forum
MMC	Medical Male Circumcision
MSA	Medical Schemes Act, No. 131 of 1998
MoU	Memorandum of Understanding
MTEF	Medium-Term Expenditure Framework
MTSF	Medium-Term Strategic Strategic Framework
NAMFISA	Namibian Financial Institutions Supervisory Authority
NDoH	National Department of Health
NDP	National Development Plan
NEMLC	National Essential Medicines List Committee
NHA	National Health Act
NHI	National Health Insurance

NPO	Non-Profit Organisation
NT	National Treasury
NTA	National Training Authority
NTCSA	National Transmission Company of South Africa
NTSA	National Transport Safety Authority
OHSHA	Occupational Health and Safety Act
OOP	Out-of-Pocket
ORS	Oral Rehydration Solution
PAA	Public Audit Act 25 of 2004
PA	Prudential Authority
PFMA	Public Finance Management Act
PHC	Primary Healthcare
PMB	Prescribed Minimum Benefit
PO	Principal Officer
PPE	Property, Plant, and Equipment
PPPFA	Preferential Procurement Policy Framework Act 5 of 2000
PPR	Preferential Procurement Regulations
QES	Quarterly Employment Statistics
RBC	Risk-Based Capital
SA	South Africa
SADC	Southern African Development Community
SANAC	South African National AIDS Council
SARS	South African Revenue Service
SCM	Supply Chain Management
SDG	Sustainable Development Goals
SEC	Social and Ethics Committee
SIU	Special Investigating Unit
SRM	Scheme Risk Measurement
TB	Tuberculosis
UHC	Universal Health Coverage
VBHC	Value-Based Healthcare

REGISTERED MEDICAL SCHEMES

Medical Schemes registered in terms of the Medical Schemes Act (131 of 1998), as at 31 March 2025

NO.	NAME OF SCHEME	TYPE
1	AECI MEDICAL AID SOCIETY	RESTRICTED
2	ALLIANCE-MIDMED MEDICAL SCHEME	RESTRICTED
3	ANGLO MEDICAL SCHEME	RESTRICTED
4	ANGLOVAAL GROUP MEDICAL SCHEME	RESTRICTED
5	BANKMED	RESTRICTED
6	BARLOWORLD MEDICAL SCHEME	RESTRICTED
7	BESTMED MEDICAL SCHEME	OPEN
8	BMW EMPLOYEES MEDICAL AID SOCIETY	RESTRICTED
9	BONITAS MEDICAL FUND	OPEN
10	BP MEDICAL AID SOCIETY	RESTRICTED
11	BUILDING & CONSTRUCTION INDUSTRY MEDICAL AID FUND	RESTRICTED
12	CAPE MEDICAL PLAN	OPEN
13	CHARTERED ACCOUNTANTS (SA) MEDICAL AID FUND (CAMAF)	RESTRICTED
14	COMPCARE WELLNESS MEDICAL SCHEME	OPEN
15	DE BEERS BENEFIT SOCIETY	RESTRICTED
16	DISCOVERY HEALTH MEDICAL SCHEME	OPEN
17	ENGEN MEDICAL BENEFIT FUND	RESTRICTED
18	FEDHEALTH MEDICAL SCHEME	OPEN
19	FISHING INDUSTRY MEDICAL SCHEME (FISH-MED)	RESTRICTED
20	FOODMED MEDICAL SCHEME	RESTRICTED
21	GENESIS MEDICAL SCHEME	OPEN
22	GLENCORE MEDICAL SCHEME	RESTRICTED
23	GOLDEN ARROW EMPLOYEES MEDICAL BENEFIT FUND	RESTRICTED
24	GOVERNMENT EMPLOYEES MEDICAL SCHEME (GEMS)	RESTRICTED
25	HORIZON MEDICAL SCHEME	RESTRICTED
26	IMPALA MEDICAL PLAN	RESTRICTED
27	IMPERIAL GROUP MEDICAL SCHEME	RESTRICTED
28	KEYHEALTH MEDICAL SCHEME	OPEN
29	LA-HEALTH MEDICAL SCHEME	RESTRICTED
30	LIBCARE MEDICAL SCHEME	RESTRICTED
31	LONMIN MEDICAL SCHEME	RESTRICTED
32	MAKOTI MEDICAL SCHEME	OPEN
33	MALCOR MEDICAL AID SCHEME	RESTRICTED

NO.	NAME OF SCHEME	TYPE
34	MASSMART HEALTH PLAN	RESTRICTED
35	MBMED MEDICAL AID FUND	RESTRICTED
36	MEDIHELP MEDICAL SCHEME	OPEN
37	MEDIMED MEDICAL SCHEME	OPEN
38	MEDIPOS MEDICAL SCHEME	RESTRICTED
39	MEDSHIELD MEDICAL SCHEME	OPEN
40	MOMENTUM MEDICAL SCHEME	OPEN
41	MOTOHEALTH CARE	RESTRICTED
42	MULTICHOICE MEDICAL AID SCHEME	RESTRICTED
43	NETCARE MEDICAL SCHEME	RESTRICTED
44	OLD MUTUAL STAFF MEDICAL AID FUND	RESTRICTED
45	PARMED MEDICAL AID SCHEME	RESTRICTED
46	PG GROUP MEDICAL SCHEME	RESTRICTED
47	PICK N PAY MEDICAL SCHEME	RESTRICTED
48	PLATINUM HEALTH	RESTRICTED
49	PROFMED	RESTRICTED
50	RAND WATER MEDICAL SCHEME	RESTRICTED
51	REMEDI MEDICAL AID SCHEME	RESTRICTED
52	RETAIL MEDICAL SCHEME	RESTRICTED
53	RHODES UNIVERSITY MEDICAL SCHEME	RESTRICTED
54	SA BREWERIES MEDICAL AID SOCIETY (SABMAS)	RESTRICTED
55	SABC MEDICAL SCHEME	RESTRICTED
56	SOUTH AFRICAN MUNICIPAL UNION NATIONAL MEDICAL SCHEME (SAMWUMED)	RESTRICTED
57	SASOLMED	RESTRICTED
58	SEDMED	RESTRICTED
59	SISONKE HEALTH MEDICAL SCHEME	RESTRICTED
60	SIZWE HOSMED MEDICAL FUND	OPEN
61	SOUTH AFRICAN POLICE SERVICE MEDICAL SCHEME (POLMED)	RESTRICTED
62	SUREMED HEALTH	OPEN
63	TFG MEDICAL AID SCHEME	RESTRICTED
64	THEBEMED MEDICAL SCHEME	OPEN
65	TIGER BRANDS MEDICAL SCHEME	RESTRICTED
66	TRANSMED MEDICAL FUND	RESTRICTED
67	TSOGO SUN GROUP MEDICAL SCHEME	RESTRICTED
68	UMVUZO HEALTH MEDICAL SCHEME	RESTRICTED
69	UNIVERSITY OF KWAZULU NATAL MEDICAL SCHEME	RESTRICTED
70	WITBANK COALFIELDS MEDICAL AID SOCIETY (WCMAS)	RESTRICTED
71	WOOLTRU HEALTHCARE FUND	RESTRICTED

FOREWORD BY THE CHAIRPERSON

DR THANDI MABEBA
Chairperson of Council

> The healthcare sector is an important establishment for any society, as access to quality healthcare services plays a crucial role in the health and well-being of its citizens. In the pursuance of our regulatory mandate, the CMS regards medical schemes, administrators, managed care organisations and other regulated entities as an imperative part of our ecosystem, tasked with ensuring that the medical schemes population obtains affordable and accessible healthcare coverage.

Tasked with overseeing the smooth functioning of this industry, CMS' regulatory actions safeguard the interests of over nine million medical scheme beneficiaries, in line with its legislative mandate. It oversees the operations of 71 medical schemes – comprising of 16 open and 55 restricted schemes – ensuring they function efficiently and in compliance with the Medical Schemes Act (131 of 1998) (MSA). This beneficiary population is serviced by 33 administrators, 43 managed care organisations, 7 773 accredited brokers, and 2 223 brokerages.

Our Strategy and Performance

CMS' strategic goals are a continuum of interdependent objectives to ensure a well-functioning and sustainable medical scheme industry. The overarching goal of providing medical scheme members with access to quality medical scheme cover is underpinned by the imperative of well-governed entities. The past financial year saw CMS conclude its five-year Strategic Plan that emphasised a two-pronged approach – improving the effectiveness and efficiency of the organisation and positioning it as a formidable player in the National Health Insurance (NHI) environment.

True to this, the CMS revised its micro and macrostructure and operating model, leading to a reduction in complaints resolution times, increased research output and the protection of members through a pandemic. Similarly, the CMS took up space, cementing its regulatory thrust by confronting contraventions of the MSA on the provision of products akin to medical schemes, undesirable business practices and misleading naming conventions. These efforts solidify CMS' role in the NHI context.

The success of attaining our strategic goals is measured through clearly defined performance outcomes and indicators, a feedback instrument of the organisation's operational efforts. As such, in the financial year under review, the organisation scored an overall performance score of **96.43%** against its target.

Strategic Relationships

The CMS actively pursues strategic relationships through the conclusion of memoranda of understanding with co-regulators and industry associations. In the past financial year, 11 such agreements were signed, cementing a commitment to cooperation in information sharing, collaboration and the addressing of industry challenges.

Strategic Focus

CMS' future orientation is guided by a new aspiration that seeks the organisation to be an *"efficient, effective, high quality, agile and trusted South African regulator generating sustainable stakeholder value"*, as articulated in CMS' 2025 – 2030 Strategic Plan. The fundamentals of this vision rest on our purpose of protecting the interests of members and beneficiaries by controlling and coordinating regulated entities, adjudicating complaints, leading as the knowledge base of the industry and advising the Minister of Health on quality healthcare imperatives.

In order to attain the desired impact of regulating the private healthcare industry to ensure improved access to affordable, cost-effective and quality healthcare, CMS' quest is to regulate in a manner that is compliant with the Medical Schemes Act, national policy, and relevant legislation. Guided by good governance and ethical leadership principles, the CMS will continue with the standardisation and consolidation of schemes in the pursuit of effective risk pooling. This will be supported by the intentional resolution to bolster innovation and stakeholder engagement locally, regionally and internationally.

National Health Insurance

The CMS supports the quest to improve healthcare access by introducing Universal Healthcare Coverage (UHC), especially for underserved communities in line with its vision. The NHI seeks to bridge the gap between private and public healthcare, with a strong focus on Primary Healthcare (PHC) and prevention to improve overall health outcomes. As the legislation progresses, the CMS is positioned to define the depth of complementary cover for medical scheme members and advising its entities on sustainable business models in the NHI environment.

Prescribed Minimum Benefits Review and the Primary Healthcare Package

We are actively continuing with the review of Prescribed Minimum Benefits (PMB), focusing on implementing a Primary Healthcare package that is fit for purpose and in line with national health priorities. With this in mind, the CMS together with the NDoH, considered various approaches to PHC, in the quest of finding the most appropriate for the country's disease burden, through the multi-stakeholder PMB Review Advisory Committee.

Similarly, in line with the Health Market Inquiry (HMI) recommendations, work on establishing and defining a base benefits package, underpinned by preventative healthcare principles is ongoing.

Fraud, Waste and Abuse

The CMS recognises that the Fraud, Waste and Abuse (FWA) undertaking – underpinned by the foundational framework of a Charter, Codes of Good Practice and Structure – is an important initiative for the medical schemes industry. As such, progress has been made on renewing the FWA Charter, institutionalising procedures and enforcement mechanisms. In responding to industry changes, the broadening of the definition of Fraud, Waste and Abuse to include error is under deliberation within the cross-sectoral FWA workstreams. This work is expected to culminate to a Fraud, Waste and Abuse Summit within the next year.

Section 59 Investigation

The release of the final report of the Section 59 Investigation marks a critical milestone for the CMS' commitment to regulatory integrity, transparency, and accountability within the private healthcare sector. I wish to thank the Council for its strategic leadership and dedication in ensuring the report's release. In line with its mandate, the CMS initiated this inquiry in response to allegations of unfair treatment and possible discriminatory practices by medical schemes and their administrators against healthcare practitioners. The investigation sought to resolve these complaints, identify trends and recommend corrective actions.

Consistent with the interim report, the final findings confirmed that black providers were disproportionately found guilty of FWA. These findings highlight deeper systemic challenges within the medical schemes industry. Central to these is the need for a fair, transparent, and standardised approach to detecting and preventing FWA, further reinforcing the importance of the FWA Codes of Good Practice and the Tribunal.

To implement the Section 59 Recommendations and support the long-term sustainability of the industry, relevant policy and legislative reforms are essential. In this regard, the CMS will work closely with stakeholders and the National Department of Health to explore and implement the necessary changes, including closing gaps in the current legislation to ensure it keeps pace with the evolving nature of the medical schemes environment and the technologies used in FWA detection.

Tariff Negotiations

The Minister of Trade, Industry and Competition, gazetted the draft Interim Block Exemption for Tariffs Determination in the Healthcare Sector, 2025, for public comment. This exemption enables the creation of two key structures – the Tariff Determination Body and the Multilateral Negotiation Forum (MLNF) – as provided for in the National Health Act (NHA) and MSA. The MLNF aims to institutionalise fair, transparent, and evidence-based price negotiations across public and private healthcare players. We view this as a

timely step to manage rising healthcare costs and improve access to affordable and quality healthcare.

Demarcation and Low-Cost Benefit Options

To demarcate the grey area between primary healthcare, hospital indemnity products, and medical schemes, Demarcation Regulations were introduced as a temporary dispensation, through an Exemption Framework, while a Low-Cost Benefit Option (LCBO) Guideline was being developed. The CMS concluded the LCBO Guideline Report in 2023 and handed it to the health ministry for consideration. To balance stakeholder interests, the NDoH has gazetted the guideline for public comment and stakeholder consultation before a policy determination on the Low-Cost Benefit Option framework is made.

While this process unfolds, the CMS, in concurrence with the NDoH, National Treasury (NT), Prudential Authority (PA), and the Financial Sector Conduct Authority (FSCA), approved a two-year extension of the Exemption Renewal Framework for insurers conducting the business of a medical scheme until 31 March 2027.

Consumer Protection and Empowerment

As part of our strategic commitment to empower stakeholders and protect members of medical schemes, the CMS continued with targeted initiatives focused on raising awareness, building capacity, and strengthening governance within the industry. Consistent with the "CMS Cares" mantra, these initiatives included workshops, exhibitions, and stakeholder engagements - delivered both in-person and virtually - to ensure broad access to information on member rights and healthcare entitlements. Strategic partnerships, such as the Advanced Trustee Leadership Programme with GIBS and CPD-accredited training with professional bodies, further enhanced the credibility and impact of these efforts.

Challenges Faced by the Board

Council remains aware of the limitations posed by the current funding model including working towards a revenue generation mechanism that is fit for purpose, encompassing a review of the levy collection dispensation. Council will continue with consultations with the National Department of Health (NDoH) and National Treasury to consider the proposals aimed at enhancing the future financial sustainability of the CMS.

In the external environment, the Council is monitoring regulatory shifts that pose a potential threat to the autonomy and core functions of the CMS, with the Financial Sector Regulation Act (FSRA) and the Conduct of Financial Institutions (CoFI) Bill. The Council has been actively engaged in interpreting the implications these laws will have on the CMS' legislative mandate, prompting the Council to seek high-level engagements. Accordingly, the Minister of Health has been approached to initiate discussions with the Minister of Finance, with the aim of reaching consensus on a policy position that safeguards CMS' mandate and ensures regulatory clarity within the healthcare funding sector.

On the other hand, the CMS continues to operate in an increasingly litigious environment, which places pressure on regulatory resources and delays decision-making processes. Furthermore, medical schemes are grappling with a shrinking membership base, driven by rising unemployment and persistent medical inflation that renders medical scheme benefits unaffordable for many South Africans. These challenges threaten the long-term sustainability of the industry and require coordinated interventions to protect beneficiaries and preserve access to private healthcare.

Acknowledgements

I would like to express my sincerest gratitude to our Executive Authority, the Honourable Minister, Dr Aaron Motsoaledi, for his oversight and ongoing support to Council.

I further extend my heartfelt appreciation to the Deputy Minister, the Honourable Dr Joe Phaahla, and the Director-General, Dr Sandile Buthelezi, for their continued guidance, which is instrumental in the CMS realising its vision.

My profound gratitude to the Council and my deputy chair, Dr Honours Mukhari, for demonstrating courage in their leadership and oversight by safeguarding the interests of members and beneficiaries of medical schemes. Thank you, Council, for your resolute determination in steering the CMS towards outstanding performance and a high ethical culture.

I also extend my deepest appreciation to the relatively new Chief Executive and Registrar of the CMS, Dr Musa Gumede, for enthusiastically heeding the call to lead this industry. This, of course, would not be without the support of all CMS Executives and staff, who work tirelessly in sometimes challenging circumstances to fulfil our mandate.

Dr Thandi Mabeba
Chairperson of Council
Council for Medical Schemes
31 July 2025

OVERVIEW BY THE CHIEF EXECUTIVE OFFICER

DR MUSA GUMEDE

Chief Executive and Registrar

> "The CMS is intensifying its efforts to improve data collection mechanisms within the medical schemes industry. By adopting digital technologies and fostering strategic partnerships, the CMS aims to enhance the reporting of key health and performance indicators. The focus is on real-time data capture from both medical scheme members and healthcare service providers, which will support improved regulatory oversight."

Financial Review of the Entity

The CMS executed its mandate with a budget of over R259 million (R235 million) in the 2024/25 financial year from the following sources:

- Principal scheme member once-off levies (78%)
- Revenues generated through regulatory activities (4%)
- Grant from the National Department of Health (2%)
- Surplus funds rolled over from the 2023/24 financial year (11%)
- Interest earned and other income (5%)

The CMS' primary source of revenue is derived from levy impositions. Approximately 4 million principal members of medical schemes, are levied a once-off amount each year. The extent of levies imposed each year is subject to the Ministers of Health and Finance's concurrence and approval of a proposal made by the CMS. The level of the levy imposed on principal members in 2024/25 was R48.58 (R46.40) per member per annum, representing a modest increase of R2.18 (4.7%) aligned with CPI per principal member per annum.

The second stream of income that contributes to the budget of the CMS is generated through regulatory activities, which are fees charged for registering schemes, registering new rules and amendments, registering, renewing, and accreditation of administrators, managed care organisations, and brokers. These tariff rates were adjusted for inflation with approval from the Minister of Health in the prior financial year. Revenue derived from this stream is dependent on the applications received.

Additionally, the entity receives a third stream of income through grant funding from the National Department of Health (NDoH). This grant funding is mainly used for the research support provided by the CMS to NDoH initiatives. Lastly, the rolled-over surplus funds are funding approved by the National Treasury in terms of s53(3) of the Public Finance Management Act (1 of 1999) relating to surplus funds generated by the CMS in the previous period. Once approved, these funds are used for specific cost pressures in the new financial year.

The entity welcomes the revision of the funding model by NDoH which will take effect in 2025/26. This will entail a full assessment of CMS' operations to determine if the current levy model is adequate, given the industry it operates in and the technological changes taking place in the medical schemes industry. It is anticipated that the revised model

will enable the CMS to generate sufficient revenue to cover all operational costs necessary for enhancing the execution of its regulatory mandate. An alternative funding model will also be developed in 2025/26 to increase the CMS' funding envelope.

Spending trends and capacity constraints

The focus is on real-time data capture from both medical scheme members and healthcare service providers, which will support improved regulatory oversight. In the current year, additional expenditure on personnel and legal fees have resulted in a reduction of the entity's net assets. The retention of surplus funds provided some additional budget to the CMS as the organisation was able to meet some of its Information and Communications Technology (ICT) investment requirements.

It is, however, important to note that the entity's compensation of employees' budget is insufficient to fund the organisation's entire structure. Therefore, the entity is phasing in the implementation of its organogram based on critical areas and affordability.

One of the major drivers of capacity constraints in the entity is the outdated ICT infrastructure. A phased-in approach has been taken to implement the long overdue ICT overhaul due to funding constraints.

Discontinued Activities

The entity did not discontinue any activities in the 2024/25 financial year.

New or proposed activities

CMS Funding Model

To ensure the alignment between strategic outcomes and resources, the CMS is undertaking to review, develop and implement a funding model that considers the long-term sustainability and effectiveness of the organisation. The funding model is expected to be agile enough to adjust itself to both the internal and external environment. This improvement to CMS' sustainability is expected to be ratified by aligned government stakeholders to ensure that it is congruous.

Fraud, Waste and Abuse

Combating healthcare FWA is a shared responsibility that requires collaboration and continuous refinement of strategies. Through structured workstreams, industry engagement, and regulatory alignment, the CMS will strengthen its ability to detect, prevent, and address FWA effectively. The updates to the FWA Charter, Code of Good Practice, and establishment of a Tribunal Framework will mark significant steps towards a more transparent and accountable system.

Data Collection

The CMS is intensifying its efforts to improve data collection mechanisms within the medical schemes industry. By adopting digital technologies and fostering strategic partnerships, the CMS aims to enhance the reporting of key health and performance indicators. The focus is on real-time data capture from both medical scheme members and healthcare service providers, which will support improved regulatory oversight. This approach will allow for more accurate monitoring of service utilisation, member experiences, and health system performance.

Base Benefit Package

The CMS will also prioritise developing a comprehensive base benefit package that ensures equitable access to essential healthcare services. The goal is to create a package that is clinically appropriate, sustainable, and responsive to the evolving health needs of the population. Public health priorities, the principles of financial protection, and a commitment to inclusive stakeholder engagement guide this process. The CMS aims to ensure that all members receive a minimum level of health coverage that supports improved health outcomes and system equity.

Roll over of funds

Through robust cost management and driving efficiencies wherever possible, the entity has been able to report an accumulated surplus of approximately R11 million in the year under review and will be applying to National Treasury for approval to retain the funds.

Supply Chain Management

Supply Chain Management (SCM) is a centralised function in the Office of the Chief Financial Officer. The SCM has improved in terms of the compliance to the internal SCM Policy and Procedures and National Treasury Regulations in the year under review and previous financial periods during the external and internal audits. However, a continuous intervention and permanent additional resources are needed to provide more support in relation to the workloads and to ease pressure in the unit. An additional resource was allocated to the SCM and the contract is extended for as required.

All concluded unsolicited bid proposals for the year under review

The CMS did not entertain, award, or conclude any unsolicited bid proposals in the 2024/25 financial year.

Whether SCM processes & systems are in place

SCM processes and systems are in place and functional. The entity has employed the services of external consultants to assist the SCM with the assessment and determination process of the Fruitless, Wasteful, and Irregular expenditure dating back from 2014, in line with National Treasury Compliance and Reporting Framework. This intervention has improved the determination and consequence management processes related to non-compliance with the National Treasury Regulations.

Audit Report Matters

There has been a steady improvement in CMS' audit outcomes over the past few financial years. In the 2024/25 audit, the CMS obtained an unqualified audit opinion with no material findings on the Annual Financial Statements (AFS) and Annual Performance Information and material non-compliance relating to consequence management.

The CMS is aiming for an improved audit outcome in 2025/26 due to the implemented improvements in financial management and governance of the entity. CMS management is committed to continuous improvement in internal controls and ensuring that all legislative prescripts are complied with.

Addressing Financial Challenges

Given the ongoing volatility in global economic conditions since the start of 2025, South Africa's economic prospects have been affected, with rising unemployment levels reported by the South African Reserve Bank. This rise in joblessness poses a challenge for the CMS, as fewer people employed means fewer members joining or maintaining medical scheme coverage, which in turn affects the CMS' revenue base.

To navigate these financial pressures, the CMS is strengthening its focus on proactively identifying vulnerabilities within the medical scheme industry. The organisation is intensifying its risk assessment processes and implementing measures aimed at addressing key threats. These efforts are part of a broader strategy to safeguard the sustainability of the industry and ensure that medical scheme beneficiaries continue to receive the necessary protections, even in the face of tough economic times.

Economic Viability

Long-term sustainability is an ongoing effort, and the AFS have been prepared on the assumption that the CMS will continue operating as a going concern for at least the next 12 months until 31 March 2026.

The CMS' financial position has stabilised over the past three financial years. A surplus was reported in the audited 2023/24 AFS, with positive liquidity and solvency. Although these indicators have declined in the 2024/25 AFS, they remain positive.

Legal matters currently underway may result in either cash outflows (if lost) or inflows (if successful), as reflected in the Contingent Liabilities and Contingent Assets notes.

There are no plans to liquidate or cease operations. The CMS remains a statutory body governed by the Medical Schemes Act and primarily funded through the Levies Act, with no indication of repeal of this law.

While revenue targets for 2024/25 were not met, management does not anticipate under-collection in 2025/26 and operations have been budgeted for.

Other

The Section 59 investigation, which commenced in 2019, was concluded by the legal panel and handed over to the Minister of Health on 7 July 2025. The Council has resolved to engage with the complainants and affected stakeholders regarding the final report, and several of these engagements have already taken place.

A dedicated task team has been established to coordinate all related activities and ensure the effective implementation of the report's findings and recommendations. This task team is supported by ongoing engagements with the National Department of Health (NDoH) to ensure alignment, reporting, and compliance with all statutory requirements for the implementation of the final report. The engagements aimed at ensuring implementation are ongoing, and further updates will be tabled as they become available.

Acknowledgments

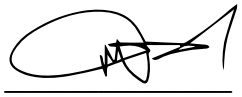
Firstly, I wish to extend my sincere gratitude to the Honourable Minister of Health, Dr Aaron Motsoaledi, Deputy Minister Dr Joe Phaahla, and the Department of Health for their steadfast leadership and support as I take up the responsibilities of this office.

I also extend my appreciation to the Chairperson, Dr Thandi Mabeba and members of the Council for your principled leadership and unwavering support as we work together to fulfil the mandate of the CMS. Your commitment to sound governance and oversight strengthens the foundation upon which we build.

To the CMS Executive and staff, thank you for the professionalism and dedication with which you have embraced this period of transition. Your warm welcome and clear sense of purpose have affirmed the strength of this institution. It is a privilege to lead a team whose commitment continues to drive the industry forward and uphold the rights of medical scheme members with integrity and care.

To the broader industry and our stakeholders, thank you for welcoming me with such openness. Your collaborative spirit and constructive engagement have been instrumental to our collective navigation of an evolving healthcare landscape.

As we look to the future, I am inspired by the possibilities that lie before us and confident that, through collaboration and shared purpose, we will continue to strengthen the regulatory environment and advance access to quality healthcare for all.



Dr Musa Gumede
Chief Executive and Registrar
Council for Medical Schemes
31 July 2025

STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY FOR THE ANNUAL REPORT

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

All information and amounts disclosed in the annual report are consistent with the Annual Financial Statements audited by the Auditor-General of South Africa.

The Annual Report is complete, accurate and is free from any omissions.

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

The Annual Financial Statements (Part F) have been prepared in accordance with the GRAP standards applicable to the public entity.

The Accounting Authority is responsible for the preparation of the Annual Financial Statements and for the judgements made in this information.

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

The external auditors are engaged to express an independent opinion on the Annual Financial Statements.

In our opinion, the Annual Report fairly reflects the operations, the Performance Information, the Human Resources information, and the financial affairs of the public entity for the financial year ended 31 March 2025.

Yours faithfully,

Dr Thandi Mabeba
Chairperson of the Board
31 July 2025

Dr Musa Gumede
Chief Executive & Registrar
31 July 2025

STRATEGIC OVERVIEW

Vision

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

Mission

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

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

Values

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

Regulatory philosophy (external)		**Shared values (internal)**	
Transparent	Cost-effective	Accountability	Honesty
Fair	Firm	Ubuntu	Respect
Equitable	Proactive	Professionalism	Responsive
Consultative	Independence	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 health care services. This means that individuals should not be unfairly excluded from the provision of health care.

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 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 health, which is an integral part of the rights to human dignity and bodily integrity in sections 9 and 12 of the Constitution, respectively.

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

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 national health objectives.

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

Everyone has the right to access to:

- Health care services, including reproductive health care.
- Sufficient food and water.
- Social security, including appropriate social assistance, if they are unable to support themselves and their dependents.

The State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of 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 registered by the Council for Medical Schemes and requires such parties to comply with the provisions 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 to actively promote and improve the national health system in South Africa. Added to this is the intent to foster 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 to benefit the entire citizenry.

The Medical Schemes Act, No. 131 of 1998 (MSA)

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 coordinate 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 health care.
- 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 the Act.

Related legislation impacting and influencing the functioning of the CMS

Council for Medical Schemes Levies 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 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

As an organ of the State, Council 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):
- Raise the life expectancy of South Africans to at least 70 years.
- Progressively improve TB prevention and cure.
- Reduce maternal, infant and child mortality.
- Reduce the prevalence of non-communicable diseases significantly.
- Reduce injury, accidents and violence by 50% from 2010 levels.
- Complete health system reforms.
- Primary health care teams provide care to families and communities.
- Universal health coverage.
- 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 achieving the desired outcomes. The priority areas are:
- Address the social determinants that affect health and disease.
- Strengthen the health system.
- Improve health information systems.
- Prevent and reduce the disease burden and promote health.
- Finance universal health care coverage.
- Improve human resources in the health sector.
- Review management positions and appointments, and strengthen accountability mechanisms.
- Improve quality by using evidence.
- 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 articulating policy developments that affect the industry. The policy mandate and context for the health sector and the medical schemes industry have 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.

ORGANISATIONAL STRUCTURE

CMS COUNCIL

DR THANDI MABEBA
CHAIRPERSON

DR HONOURS MUKHARI
DEPUTY CHAIRPERSON

MR ABDULQADIR CHOGLE

DR KARMANI CHETTY

MR LEON LANGALIBALELE

MR MABALANE MFUNDISI

MS MATSHEGO RAMAGAGA

MR MOREMI NKOSI

DR NOMBEKO MBAVA

MS PENELOPE ANNE BECK

MR SIYABONGA JIKWANA

DR SUGENDRA NAIDOO

MR TJAART ESTERHUYSE

ADV. TLHORISO MAPHIKE

DR XOLANI NGOBESE

MR KHAYALETHU MVULO
COUNCIL SECRETARIAT

CMS EXECUTIVES

DR MUSA GUMEDE
CHIEF EXECUTIVE AND REGISTRAR

MS VICTORIA LETSWALO
ACTING CHIEF FINANCIAL OFFICER

DR DENISHA JAIRAM-OWTHAR
CHIEF INFORMATION OFFICER

MR MFANA MASWANGANYI
EXECUTIVE: REGULATION

DR TOKO POTELWA
EXECUTIVE: MEMBER PROTECTION

DR MICHAEL WILLIE
EXECUTIVE: POLICY, RESEARCH & MONITORING

MR ZONGEZILE BALOYI
EXECUTIVE: CORPORATE SERVICES

MR MONDI GOVUZELA
ACTING EXECUTIVE MANAGER: OFFICE OF THE CHIEF EXECUTIVE

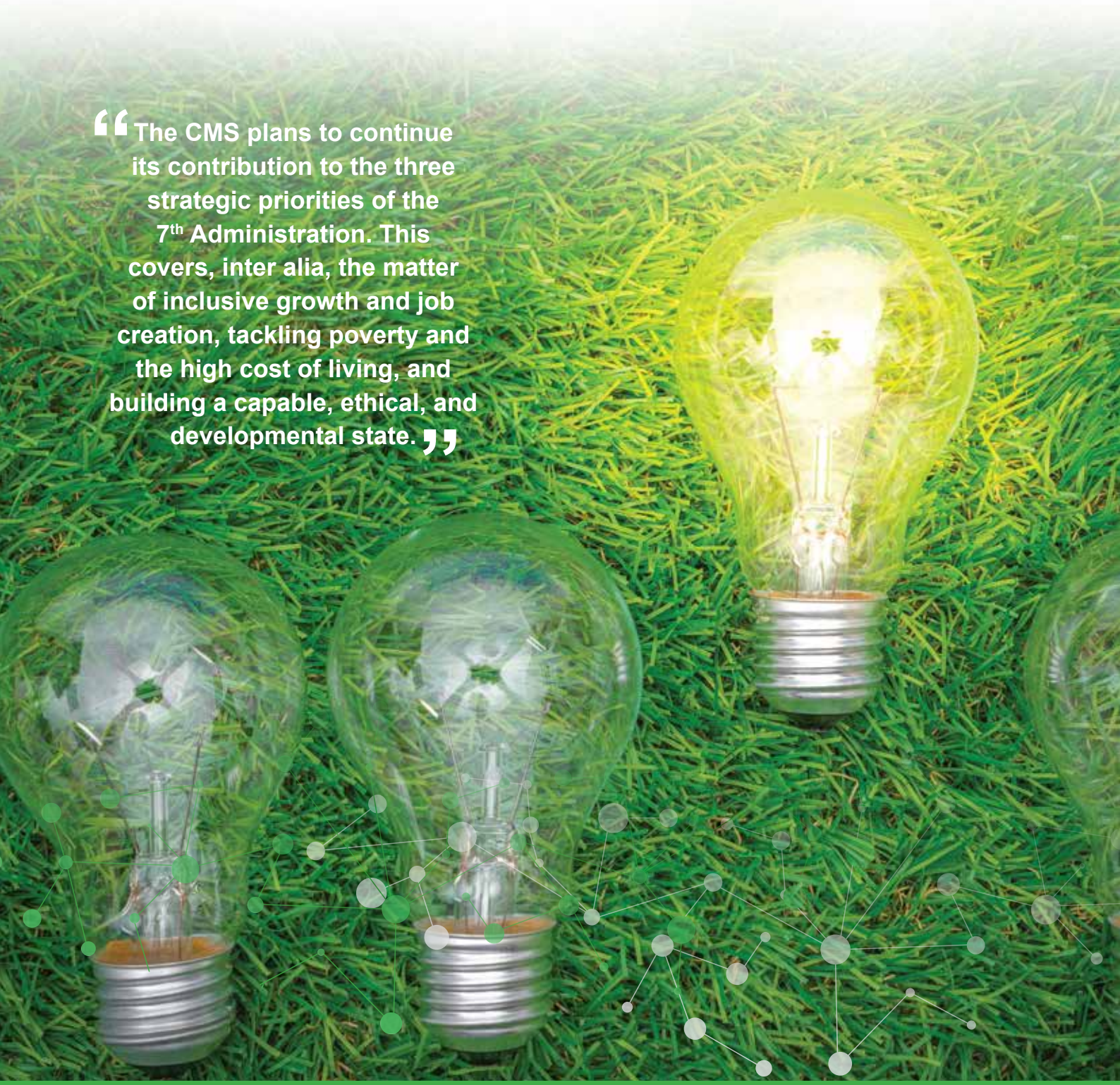
B

PERFORMANCE INFORMATION

PREDETERMINED OBJECTIVES

The Auditor-General South Africa (AGSA) currently performs the necessary audit procedures on the performance information 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 106 to 109 of the Report of the Auditor's Report, published as Part F: Financial Information.



OVERVIEW OF PERFORMANCE

Service Delivery Environment

Regulatory Scope

The Council for Medical Schemes (CMS) oversees a diverse and complex medical schemes industry, comprising multiple stakeholders with varied interests. As of 31 March 2025, the CMS regulated 71 medical schemes, 33 administrators (including self-administered schemes and limited accreditation administrators), 43 managed care organisations (including schemes providing their own managed care services), 2 223 broker organisations, and 7 773 individual brokers.

The CMS' primary mandate is to regulate these entities in accordance with the Medical Schemes Act (MSA) and its Regulations, thereby protecting the interests of all medical scheme beneficiaries. This involves ensuring that all regulated entities adhere consistently to the provisions of the MSA.

The MSA introduced critical policy reforms aimed at enhancing the risk pooling capacity of medical schemes and strengthening regulatory oversight. These include:

- A preferred health insurance vehicle, which requires that any person doing the business of a medical scheme operate in terms of a single legislative framework.
- Open enrolment, which removed the discriminatory practice of medical schemes to select only good-risk beneficiaries for membership (risk selection).
- Mandatory minimum benefits, which removed the ability of schemes to discriminate against older and sicker members through the selective non-provision of key benefits.
- Waiting periods and late joiner penalties, to eliminate any significant application of penalties for member movement between medical schemes and options, while substantially removing the opportunities for anti-selection where a member joins only when sick and then leaves or only joins for the first time later in life.
- Improved governance, which removed the historical conflicts of interest embedded in the oversight of medical schemes.
- Regulation of intermediaries, which implemented accreditation and more stringent regulatory oversight of medical scheme brokers, administrators, and managed care organisations.
- Member protection, which includes the complaint resolution mechanisms at the scheme level and providing members access to the complaint resolution mechanisms at the Registrar's office and appeals processes.

These reforms continue to shape the CMS' regulatory approach, supporting a fair, transparent, and accountable medical schemes environment. Despite these advances, certain areas of private healthcare funding and delivery remain under-regulated. This ongoing challenge contributes to gaps in coverage, quality, and cost containment while also increasing pressure on the public healthcare system.

The CMS remains committed to addressing these systemic issues through ongoing regulatory improvements and stakeholder engagement, thereby supporting a more equitable and sustainable healthcare financing system for all South Africans.

Financial Performance of Medical Schemes

Relevant healthcare expenditure continued to increase above inflation during the year. Relevant healthcare expenditure per average beneficiary per month, increased by 8.70% from R1 840.48 in 2022 to R2 000.57 in 2023. Before the COVID-19 pandemic, claims were already on the rise, and it is anticipated that this trend, interrupted by the pandemic, will continue unless drastic interventions are implemented. Increased expenditure is a function of changes in utilisation and tariffs.

Utilisation

Utilisation increases are closely linked to the worsening demographic profile of medical schemes. In 2023, medical scheme membership grew by only 1.04%, while the average age of beneficiaries increased by 0.27 years.

The aftermath of COVID-19 continued to impact medical schemes during the 2023 financial year. Increased utilisation due to the release of pent-up demand was noted across the industry. Based on monthly indicator information submitted during 2024, the increased levels of utilisation continued in 2024 and had to be factored into the 2025 year's contribution increases.

The work to introduce a standardised benefit package and review prescribed minimum benefits will address this portion of claims expenditure.

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1 Transfer to receivables

2 Group similar items

Tariffs

The CMS is excited to participate in the engagement to create a multilateral negotiating environment for funders and practitioners to determine reference tariffs. This would relieve medical schemes, as tariffs are not determined through a competitive process.

Accredited managed healthcare services increased by 7.40% from R5.53 billion in 2022 to R5.94 billion in 2023. In 2023, 9 058 631 average beneficiaries (or 99.19% of beneficiaries) were covered by these managed healthcare arrangements. Managed healthcare principles are utilised to ensure that medical scheme members receive appropriate and cost-effective healthcare within the constraints of what is affordable. These principles also address abuse and over-utilisation of services. Interventions can take various forms, such as evidence-based clinical protocols, medicine formularies, funding guidelines, and managed care provider networks. We observed a direct correlation between an individual option's demographic profile and the fees for accredited managed healthcare services incurred per member per month, with the poorest profiles incurring the highest expenditure. However, the report does not address the value proposition of these arrangements.

In the last few years, medical schemes have increasingly undertaken risk transfer arrangements to manage their insurance risks. Medical schemes incurred R5.19 billion in capitation fees and derived R5.63 billion in value from these arrangements. Pharmacy benefit management services represent the biggest component of the risk transfer arrangements in both the open and restricted scheme industries.

During the 2021 and 2022 financial years, schemes implemented contribution increases below consumer inflation to provide temporary financial relief to members during the economic downturn. Schemes were able to implement these interventions due to reserves built up during the COVID-19 pandemic. The lower contribution increases resulted in under-pricing at an insurance service result level, resulting in a deficit of R6.73 billion for the 2023 financial year. This requires a correction in future periods. The CMS encouraged medical schemes to correct the pricing over a period, rather than to implement a single, large corrective event. Insurance revenue per average beneficiary per month increased by 6.40% from R1 961.06 in 2022 to R2 086.50 in 2023. This is slightly higher than the average CPI of 6.00% for the year.

The relevant healthcare expenditure ratio increased by 2.16% to 95.88% for the 2023 financial year. This is significantly higher than the pre-COVID-19 pandemic ratios in 2018 and 2019 of 90.23% and 90.58%, respectively. Significant repricing and benefit adjustments are, consequently, necessary. The Registrar of Medical Schemes, therefore, registered contribution increases higher than CPI for the 2024 and 2025 financial years, to halt further deterioration of medical scheme reserves. The 2019 to 2025 period saw the purpose of scheme reserves hard at work, serving as a buffer against unforeseen, large-scale health events.

Directly attributable insurance service expenditure (DAE) consists of schemes' accredited administration services fees (in respect of third-party administered schemes) (67.12%), broker service fees (17.98%) and other administration expenditure (14.90%):

- When adjusting the accredited administration services fee for members, the R246.64 per average member per month incurred in respect of the 2023 year represented a 6.05% increase from 2022. This is aligned with the average CPI for 2023. Customer services (44.68%), information management and data control (16.83%) and claims management (16.41%) represented the bulk of the fees.
- The fees paid to brokers represented 79.13% of the statutory limit of R127.86 per average member per month.
- During 2023, open schemes designated 40.02% of their administration expenditure as DAE, whilst the restricted scheme environment had a lower proportion of 35.24%. Further engagement on the allocation of medical schemes' operational expenditure between these two figures is necessary. Staff remuneration and marketing represented the main components of other administration expenditure.

Interest rates and inflation continued to increase, resulting in a drop in most asset classes during 2022 and 2023. The JSE All Share Index contracted marginally in 2022 (0.90%) and produced returns of 5.26% in 2023. As medical schemes generally have a high cash asset allocation, the decrease in investment income in 2023 was somewhat limited. Investment income funded the under-priced benefits and positively contributed towards a net surplus of R1.35 billion in 2023.

Solvency

The solvency of medical schemes is calculated by excluding unrealised fair value market movements on scheme investments. Even though medical schemes incurred a net surplus for the year, due to the mathematical calculation used, the industry solvency declined from 47.14% in 2022 to 43.45% in 2023. It is expected that the solvency level will continue to decrease in the next few years due to the denominator representing the increased level of contributions

before stabilising. It should be noted that the current solvency of 43.45% exceeds pre-COVID-19 pandemic levels of 34.54% and 35.61% in 2018 and 2019, respectively. It is also significantly higher than the minimum required level of 25%.

Shift to Value-Based Healthcare (VBHC)

Internationally, there is a notable shift to VBHC, which focuses on enhancing the quality and outcomes of healthcare rather than simply increasing the volume of services. For medical schemes, this involves transitioning to payment models that compensate healthcare providers for delivering higher-quality care to improve patient outcomes (outcome-based care).

The transition to VBHC faces several significant challenges. The fee-for-service (FFS) model encourages high service volumes. This can lead to over-treatment and increased healthcare costs while diverting attention from patient outcomes.

Additionally, bundled payments, which are designed to control costs, require accurate risk adjustment to prevent under-treatment, particularly in complex medical cases. Moreover, capitation presents financial risks if healthcare costs exceed fixed payments, potentially incentivising providers to limit care to manage expenses.

The successful implementation of VBHC necessitates robust data systems for effective performance measurement. Providers must adapt to new care models, which can be resource-intensive and time-consuming. Addressing these complexities is essential to promote health equity and ensure that all populations have access to quality healthcare.

Outcome-based Care – The New Currency

Outcome-based care, often regarded as the "new currency" in the medical schemes industry, emphasises the quality and effectiveness of healthcare services rather than the quantity of services provided. Regulators establish the frameworks within which outcome-based care operates. The CMS will continue to develop guidelines that define what constitutes quality care and how outcomes are measured. This is directed, inter alia, to ensure that medical schemes and healthcare providers align their practices with national health goals, particularly those that are outcomes-based.

Digital Transformation

The rapid growth of telemedicine, artificial intelligence (AI), and digital health tools is reshaping the healthcare landscape. As medical schemes invest in digital infrastructure to enhance member engagement and improve operational efficiencies, the CMS faces significant challenges and opportunities to regulate these aspects.

Effective regulation in the digital health space requires collaboration among various stakeholders, including healthcare providers, technology developers, and medical schemes. The CMS plans to engage with these groups (and other material stakeholders) to understand the challenges and opportunities posed by digital transformation and to develop regulations that support efficiencies in the healthcare ecosystem.

National Health Insurance (NHI)

While NHI is discussed under legislative and policy matters, it is opportune to highlight that NHI encompasses several key components aimed at transforming healthcare in South Africa. Those which impact the CMS include:

- **Universal Health Coverage:** NHI aims to deliver comprehensive healthcare services to all South Africans, encompassing both preventive and curative care;
- **Single-Payer System:** Funded by taxpayers and additional contributions, the NHI will centralise healthcare purchasing, removing direct payments from patients;
- **Public and Private Integration:** Private providers will contract with the NHI under a regulated pricing framework, merging them with the public system;
- **Standardised Benefits:** A consistent package of healthcare services will be accessible to all citizens, ensuring equitable access;
- **Governance and Oversight:** The NHI Fund will oversee service purchasing, manage funds, and ensure accountability and transparency within the system, and
- **Reduced Role of Medical Schemes:** Medical schemes will only cover services not included in the NHI, diminishing their current role in healthcare funding.

NHI will have a serious impact on the regulatory role of the CMS. It proposes a shift from prioritising direct regulation of medical schemes to the addition and emphasis on a more supportive and complementary oversight and regulation approach. Envisaged challenges include navigating reduced regulatory authority, aligning operations and regulatory activities with NHI regulations, and maintaining member and beneficiary and other material stakeholder confidence and trust.

During the five-year period, the CMS will apply, inter alia, the following approaches in relation to NHI:

- **Adaptation Strategies:** Redefine and align the CMS' role in supporting NHI goals while safeguarding the interests of members;

- **Regulatory Adjustments:** Update regulations to delineate the CMS and NHI responsibilities;
- **Stakeholder Engagement:** Strengthen communication and collaboration with members and beneficiaries, medical schemes, other healthcare providers, govern-ment stakeholders, and the NHI;
- **Capacity Building:** Enhance the CMS' capacity to manage new regulatory oversight functions, including monitoring complementary coverage in relation to the NHI;
- **Risk Capacity and Risk Management:** The CMS plans to redefine its Risk Capacity and enhance its Risk Management Plans to consider strategic risks relating to the NHI, including financial sustainability, systems, technology and ICT, human capital, changing regulatory compliance obligations, and the protracted nature of litigation and legal challenges.

Economic Outlook

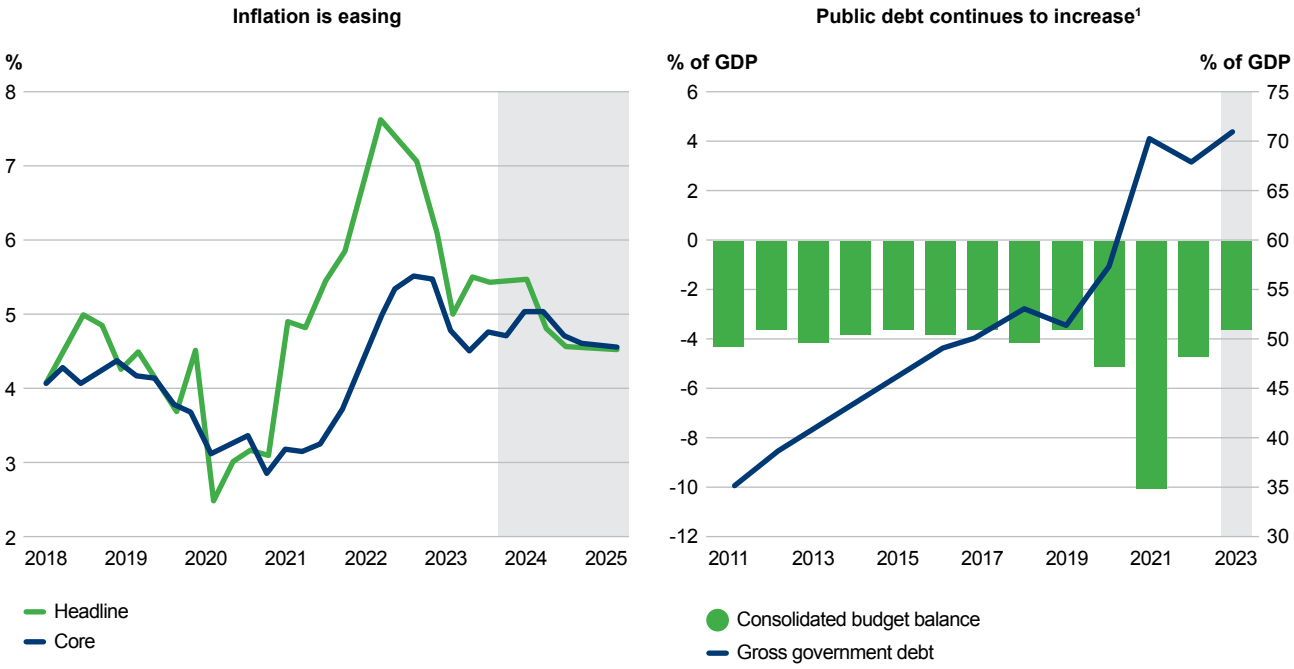
Key economic projections indicate modest Gross Domestic Product (GDP) growth for South Africa, with a projected increase of 1% in 2024 and 1.4% in 2025. This growth is primarily driven by an easing of supply constraints, including reduced power outages and improved logistics in critical sectors such as rail and ports.

Moreover, the rise in government debt remains a significant concern, particularly regarding the financing of large-scale transformative policy and legislative changes like the NHI.

In addition, the ageing population and the escalating impacts of climate change, present a growing need for government to address the pressures these factors are placing on public finances.

Figure 1 below contrasts the lowering inflation trend from 2018 to 2025 with increasing public debt between 2011 to 2023.

Figure 1: Graphic depiction contrasting the lowering inflation trend from 2018 to 2025 with increasing public debt between 2011 to 2023



Economic Outlook: Short-term Projections

South Africa's economy showed signs of recovery in the fourth quarter of 2024, with real gross domestic product (GDP) growing by 0.6% after a revised decline of 0.1% in the third quarter. The real gross value added (GVA) from the primary and tertiary sectors increased, while the secondary sector's output decreased. Annual output growth slowed slightly from 0.7% in 2023 to 0.6% in 2024, with real GDP in 2024 1.6% higher than the pre-pandemic level in 2019. This growth was driven by the higher output of the tertiary sector, while the primary and secondary sectors' outputs remained below their pre-pandemic levels.

Local Economic Outlook and its Impact on Medical Schemes

The current economic environment is characterised by several key trends that significantly influence medical schemes:

- **Economic Growth and Employment:** The current climate shows slow economic growth, insecure employment, and high unemployment. This has a significant impact on consumers, for example, in the form of reduced disposable income. This limits private healthcare affordability, and it contributes to membership losses for medical schemes.
- **Inflation and Cost of Living:** Inflation is putting pressure on household budgets. As a result, premium increases become harder to justify, requiring schemes to find cost-saving measures.
- **Regulatory Reforms:** Ongoing regulatory changes, including alignment with NHI goals, compels schemes to adapt their benefit structures and governance practices to comply with new regulations.
- **Funding and Affordability Challenges:** Employers are facing pressure to cut healthcare costs due to economic constraints. This could lead to a potential reduction in employer contributions to medical schemes and a shift toward more affordable healthcare plans.

The current macroeconomic environment features high interest rates driven by ongoing inflation, a volatile rand, rising energy prices, and slow economic growth. Consequently, many households are likely to experience budget constraints in the near future, placing consumers in a precarious financial position.

The CMS has also identified key industry-specific factors that it will consider when evaluating the appropriateness of changes to benefits, increases in contribution rates, and overall assumptions regarding cost increases. These factors include:

- Economic projections about inflation;
- The relationship between increases in medical scheme contributions (one contributor to healthcare insurance inflation) and consumer inflation;
- Headline inflation compared to medical and health insurance inflation;
- Predictions and assumptions related to healthcare utilisation;
- Other strategic implications and considerations for medical schemes.

As medical schemes navigate the evolving economic landscape, several strategic implications and considerations emerge. The following points for medical schemes outline key areas that CMS will integrate with its strategic focus:

- Navigating economic challenges by means of a focus on cost management, innovative benefit design, and affordability;
- Embracing technology, including upgrading IT systems and technology platforms, investing in digital solutions and AI to enhance regulation;
- Regulatory alignment and governance, by means of proactive adjustments to regulatory changes while enhancing internal and industry governance and compliance;
- Member-centric strategies to create products and services that meet evolving member needs and expectations, and
- Implementing diverse reimbursement models will be vital in adapting to the changing healthcare landscape, including NHI.

Employment Trends

After a tough year marked by job losses, South Africa's formal non-agricultural sector displayed a slight recovery in the last quarter of 2024. The Quarterly Employment Statistics (QES, Q4:2024) report from Statistics South Africa (Stats SA) reveals that employment in the sector grew by 12 000 jobs, reaching a total of 10.64 million by December 2024. This represents a modest increase of 0.1%, although there was a significant year-on-year drop of 91 000 jobs compared to December 2023.

Total employment in the formal non-Agricultural sector increased by 12 000 in the fourth quarter of 2024, bringing the level of employment to 10.64 million by December 2024. The trade industry was the main contributor to the increase, adding 42 000 jobs, followed by business services, which gained 22 000 jobs. However, not all sectors saw growth. The community services sector experienced the largest decline, losing 26 000 jobs, while both construction and manufacturing each saw a reduction of 13 000 jobs.

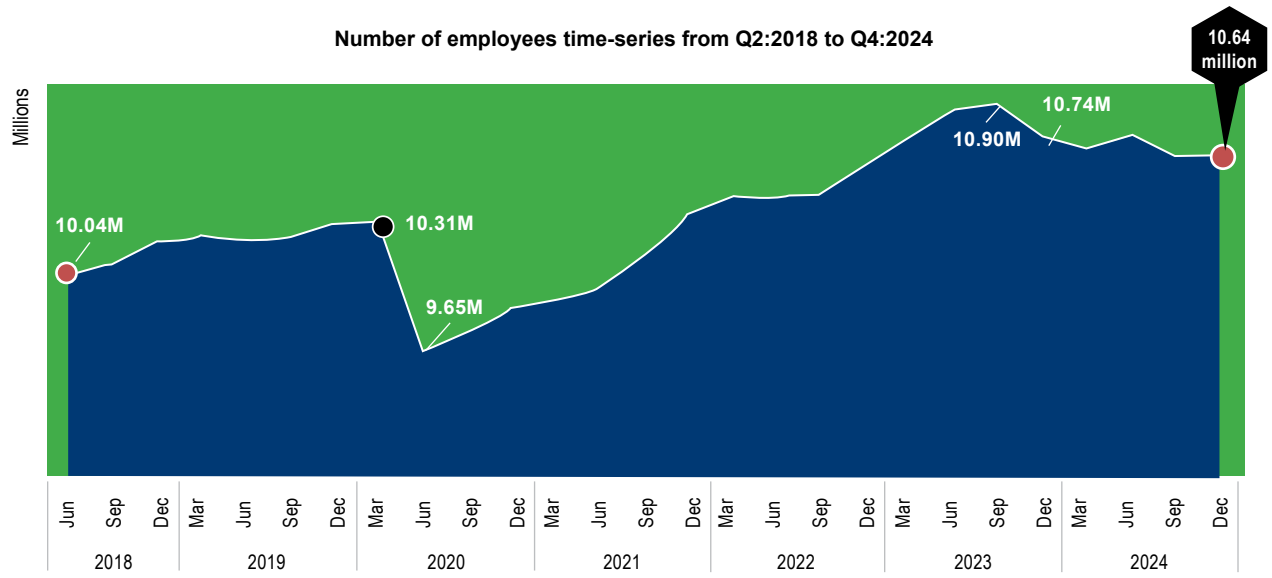
Full-time employment in the country saw a small rise of 10 000 jobs in the last quarter of 2024, increasing from 9.477 million to 9.487 million, according to the most recent employment data.

Various industries contributed to this growth. The trade sector led with an addition of 24 000 full-time positions, followed by business services, which gained 21 000 jobs. The transport and electricity sectors also saw small increases, adding 3 000 and 1 000 jobs, respectively.

However, not all sectors experienced growth. The construction industry saw a notable decline, losing 14 000 full-time jobs. Community services followed with a loss of 12 000 jobs, while manufacturing reduced its workforce by 10 000 jobs. Additionally, the mining industry reported a decrease of 3 000 full-time positions.

Despite the quarterly gains, full-time employment remains lower compared to the previous year. Between December 2023 and December 2024, the country lost 26 000 full-time jobs.

Figure 2: Employment trends



Source: Quarterly employment statistics (QES, Q4:2024)

The Impact of High Unemployment

High unemployment levels significantly influence various sectors of society, particularly in health and employment benefits such as medical schemes. Unemployment reduces individuals' ability to afford private healthcare options like medical schemes. Furthermore, retrenchment, the termination of employees due to economic downturns or organisational restructuring, has a profound effect on workers' access to medical aid and overall healthcare benefits.

High unemployment often leads to increased pressure on public health departments due to greater demand for state-sponsored healthcare services. As people lose their jobs, many cannot afford private healthcare, which increases their reliance on public healthcare services. The rising demand for services within the public health sector is correlated with prolonged waiting times, a decline in the quality of care, and insufficient funding for healthcare resources.

It is imperative to address these challenges to enhance service delivery and improve health outcomes for the population. Unemployed individuals may also face worsened physical and mental health, contributing to a higher demand for both medical and psychiatric services. As economic stress can lead to increased incidence of conditions like depression, anxiety, and substance abuse, health departments must expand their reach and services to address these emerging needs.

When individuals face retrenchment, they lose their employer-sponsored medical aid plans. This can lead to significant disruptions in their ability to access medical services, especially if they do not have the financial means to join a private medical aid plan or seek public healthcare. Following retrenchment, individuals often face delays or an inability to join medical schemes due to the financial burden of medical premiums. Additionally, there may be a lack of access to affordable options that provide comprehensive coverage, which results in individuals delaying enrolment or opting for lower-tier plans with limited benefits.

Geopolitical Tensions

Import Dependency

South Africa, like many other countries, imports a significant portion of its medical supplies, pharmaceuticals, and equipment. Conflicts in the Middle East can disrupt global trade routes, especially if the conflict impacts key shipping lanes like the Suez Canal, through which much of the global trade passes. This can lead to delays, shortages, and price hikes in essential medical supplies, such as life-saving medications, vaccines, and medical devices.

Increased Costs

Disruptions in global supply chains often lead to price increases for medical products. For instance, if pharmaceutical companies face delays or challenges in production due to the conflict, the South African government or healthcare providers may be forced to pay higher prices for essential medicines. This puts additional strain on the public health budget and medicals schemes will increase their premium and could result in reduced access to healthcare for the most vulnerable populations. Political instability in the Middle East is expected to lead to higher energy costs, trade disruptions, reduced investor confidence, and challenges for sectors like tourism and exports. These effects could slow down South Africa's economic recovery in 2024/2025, leading to potential growth stagnation or inflationary pressures.

Government of National Unity

The Government of National Unity (GNU) in South Africa, formed after the end of apartheid in 1994, played a crucial role in shaping the country's political and economic landscape. While it helped steer South Africa towards democracy and reconciliation, it also faced significant challenges, particularly with regard to economic development. The GNU was composed of various political parties, most notably the African National Congress (ANC), which became the dominant political force. Here is how the GNU has affected the economy and the health department both positively and negatively.

Policy Gridlock and Uncertainty

If the parties in the current GNU cannot reach consensus on important economic policies, it could lead to a lack of decisive action and policy gridlock. This may delay necessary reforms, such as addressing issues in education, health care, infrastructure, and the labour market, all of which can stunt long-term economic growth, for example, the delay of the delivery of the budget speech.

Positive Impacts of the GNU on Health and Medical Schemes

The formation of a GNU presents a unique opportunity to foster stability, collaboration, and policy coherence within South Africa's health sector. A unified government can facilitate a more inclusive and consultative approach to healthcare reform, ensuring that diverse political and stakeholder voices are represented in shaping policies such as the NHI and the regulation of medical aid schemes. For medical aid schemes, a stable political environment can support predictable regulatory timelines, enhanced investment confidence, and more streamlined implementation of reforms, such as benefit standardisation and other Health Market Inquiry recommendations. Overall, a well-functioning GNU can help align national health priorities, bolster public-private partnerships, and ensure that healthcare reforms are both socially equitable and financially sustainable.

Medical Scheme Coverage in South Africa

As of 2024, approximately 9.13 million South Africans, representing about 14.95% of the population, are covered by medical schemes. This reflects a stagnation in medical scheme membership despite population growth. Despite some minor fluctuations over the period, the table below shows that the percentage of individuals who were covered by a medical scheme changed very little between 2022 and 2023, declining only slightly from 15.8% to 15.7%. It is, however, notable that the number of individuals who were covered by a medical aid scheme increased from 7.3 million to 9.8 million persons in the past 21 years (General Household Survey, 2023). The differences between the actual membership reported by the Council for Medical Schemes and the figures in the General Household Survey are likely due to respondents confusing medical scheme membership with health insurance.

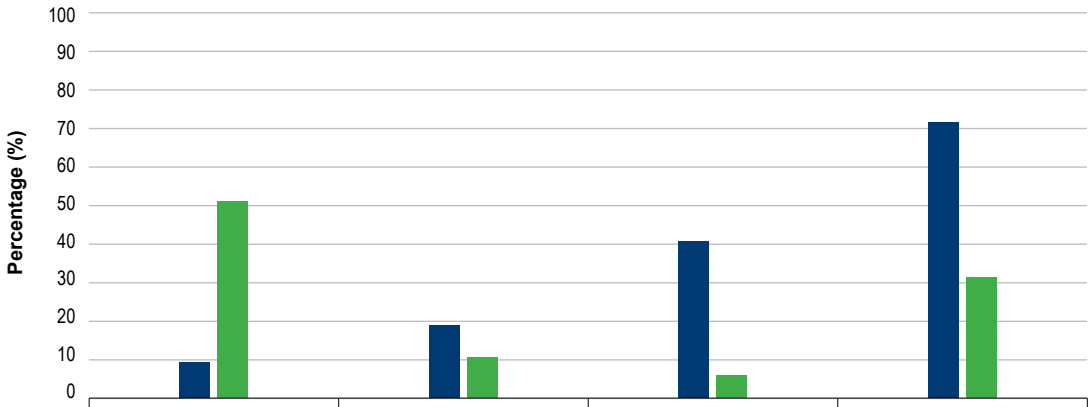
Table 1: Medical aid coverage, 2002–2023

Indicator	Years (Numbers in thousands)										
	2002	2004	2008	2010	2012	2014	2016	2018	2020	2022	2023
Number covered by a medical aid scheme	7 284	7 268	8 057	8 967	9 157	9 470	9 447	9 380	9 017	9 699	9 792
Number not covered by a medical aid scheme	38 445	39 666	41 266	41 606	42 819	43 946	45 646	47 628	50 328	51 590	52 402
Subtotal	**45 728**	**46 934**	**49 322**	**50 573**	**51 976**	**53 416**	**55 093**	**57 008**	**59 346**	**61 289**	**62 194**
Percentage covered by a medical aid scheme	**15.9**	**15.5**	**16.3**	**17.7**	**17.6**	**17.7**	**17.1**	**16.4**	**15.2**	**15.8**	**15.7**
Do not know	140	58	101	23	58	46	53	42	63	95	90
Unspecified	53	29	56	254	291	451	474	408	27	-	-
Total population	**45 868**	**46 992**	**49 423**	**50 596**	**52 034**	**53 461**	**55 146**	**57 050**	**59 409**	**61 384**	**62 283**

Source: General household survey 2023

The figure below depicts significant disparities in medical scheme coverage across population groups. While 71.7% of white individuals were members of a medical aid scheme, compared to 41.3% of Indian/Asian individuals, 19.6% of coloured individuals, and only 9.8% of black Africans, these percentages reflect the proportion within each group that has access to medical aid coverage. However, when looking at the overall composition of medical aid membership, black Africans constituted the majority at 51.2%, while white members accounted for 31.7%. This reflects South Africa's broader population demographics, where black Africans make up the largest share of the total population. Despite lower individual coverage rates, their absolute numbers drive their majority share among total scheme membership, highlighting ongoing challenges related to equitable access and affordability in the private healthcare sector.

Figure 3: Percentage (%) distribution of individuals who are members of medical aid schemes by population group, and share of medical aid scheme members by population group, 2023



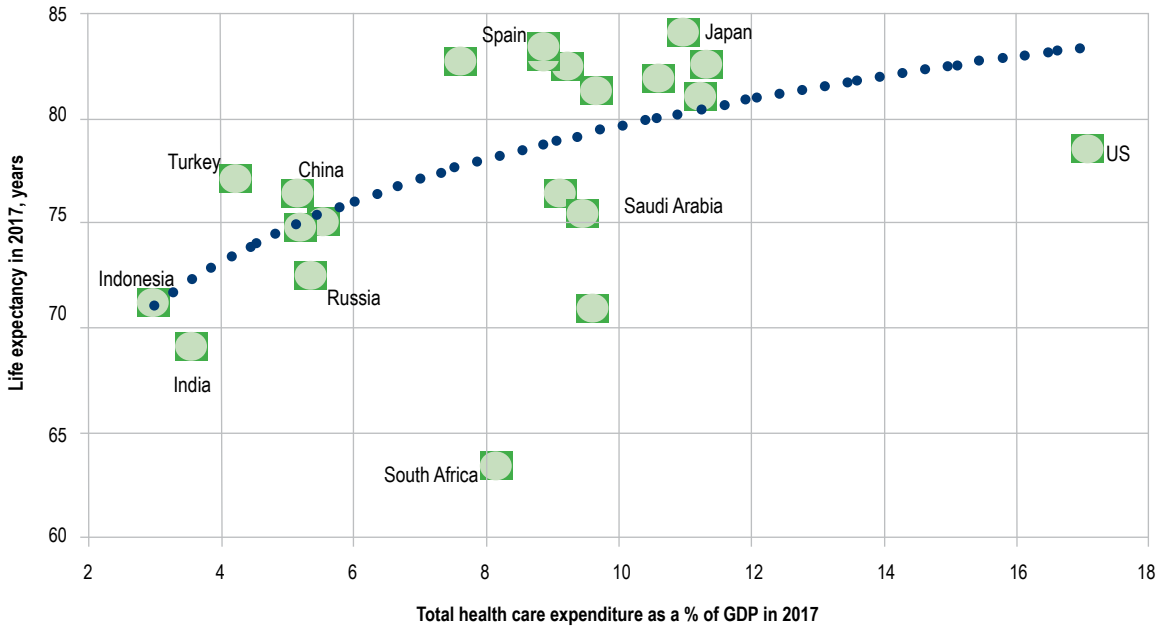
	Black African	Coloured	Indian/Asian	White
Percentage	9.8	19.6	41.3	71.7
Share of all medical aid	51.2	10.6	6.5	31.7

Source: General household survey 2023

Life Expectancy vs Health Expenditure in South Africa 2023

In 2023, South Africa's health outcomes and expenditures presented a complex picture, reflecting both progress and ongoing challenges in the healthcare sector. This research examines the relationship between life expectancy and health expenditure in South Africa. According to data from MacroTrends, South Africa's life expectancy in 2023 was 64.88 years, marking a 0.39% increase from 2022. This gradual improvement indicates positive trends in public health, likely influenced by factors such as advancements in HIV treatment and reductions in infant mortality. While South Africa spends a larger portion of its GDP on health compared to countries with similar income levels, it is not enough to raise South African population's life expectancy (64 years) to the level of countries with similar per capita incomes, such as Indonesia, with its life expectancy of 71 years **(Figure 4).**

Figure 4: Life expectancy in years and total health care expenditure, % of GDP in G20 countries (2017)



Source: World Development Indicators, World Bank

Environmental Factors

The disruption of healthcare services during and after the floods of January 2024, combined with the challenges of rebuilding, led to reduced access to essential healthcare in some areas. By 2024 and 2025, communities affected by the floods are still likely to face challenges in accessing regular health services, including maternal and childcare, chronic disease management, and routine vaccinations. This meant that health outcomes for vulnerable groups (such as children, the elderly, and low-income communities) may have remained suboptimal.

Organisational Environment

The Public Finance Management Act (PFMA) requires public entities to submit quarterly performance information reports to the relevant executive authority and the National Treasury. During the period under review, the CMS submitted all the quarterly information reports to the executive authority and the National Treasury. No issues of concern were raised by the executive authority in the reports. All the quarterly reports showed excellent performance by the organisation under the direction of the Council.

The organisation is experiencing a loss of institutional knowledge due to resignations and retirements. During the period under review, a Benefits Task Team investigation recommended employee benefits options for the organisation. The task team considered phased-in options to implement a pension or provident fund, considering the existing group benefits. Human resources coordinated wellness sessions in line with the employment wellness programme support offered by the employer to promote employee work-life balance.

Policy Mandates

The CMS operates under various policy mandates that guide its strategic direction and operational priorities. Illustrated below **(Table 2)** are the most relevant policy mandates applicable to CMS.

Table 2: Policy Mandates

Policy	Description	CMS Role
United Nations Sustainable Development Goals (SDGs)	The aim of SDG 3 is to "*ensure healthy lives and promote well-being for all at all ages.*" Good health is essential for individuals to reach their full potential, as both physical health and mental well-being significantly affect the quality of life. These aspects not only impact personal health but also influence the well-being of citizens. In South Africa, the health and well-being of the population are crucial for economic performance and social development. Achieving SDG 3 is directly related to improved health services, as accessible and quality healthcare is fundamental to fostering overall health and well-being.	South Africa subscribes to the United Nations SDGs. The CMS, a public entity, supports this imperative.
National Development Plan Vision 2030 (NDP)	The NDP seeks to eradicate poverty and decrease inequality by 2030. It asserts that South Africa can achieve these objectives by harnessing the energies of its people, developing an inclusive economy, strengthening capabilities, improving the capacity of the State, and fostering leadership and partnerships across society. The NDP outlines a strategic vision for South Africa's development, including nine (9) key priorities related to health: 1. Raise the life expectancy of South Africans to at least 70 years by 2030; 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 percent from 2010 levels; 6. Complete health system reforms; 7. Primary healthcare teams provide care to families and communities; 8. Universal health coverage, and 9. Fill posts with skilled, suitably qualified, committed and competent individuals. Additionally, the NDP Vision 2030 outlines nine priority areas that emphasise the essential interventions needed to create a more effective health system: 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 health sector; 7. Review management positions and appointments and strengthen accountability mechanisms; 8. Improve quality by using evidence, and 9. Manage meaningful public-private partnerships.	The CMS, as a public entity, discharges its legislated mandate in a manner that is consistent with national policy including the NDP Vision 2030.
The Charter For South Africa's Public and Private Health Sectors, 2006 (Health Charter)	The Health Charter was initiated in support of the NHA and provides for the public and private health sectors to constructively engage in discussions to create an improved healthcare delivery system for South Africa. Such a system targets coherent, efficient, cost-effective, quality-driven and optimised use of all sector resources to benefit all citizens.	The CMS supports the NHA by regulating private healthcare insurance providers. It, thus, contributes to the progress of the Health Charter.
National Health Insurance (NHI)	The NHI is South Africa's strategy to achieve universal health coverage. The NHI is a centralised, national insurance fund from which the government will source healthcare services from healthcare providers in both public and private sectors. NHI pursues the Constitutional right of equal access to quality and affordable healthcare.	The CMS regulates the activities of medical schemes and other affected key stakeholders in the NHI.

Policy	Description	CMS Role
Second Presidential Health Compact 2024-2029 (Presidential Health Compact)	The Second Presidential Health Summit, 2023 with the theme "*Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation*" reinforced the nine-pillar plan finalised at the Presidential Health Compact. These pillars are: 1. Augment Human Resources for Health Operational Plan; 2. Better management of supply chain equipment and machinery can ensure improved access to essential medicines, vaccines, and medical products; 3. Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities; 4. Engage the private sector in improving health services' access, coverage and quality; 5. Improve health services' quality, safety, and quantity, focusing on primary health care; 6. Improve the efficiency of public sector financial management systems and processes; 7. Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels; 8. Engage and empower the community to ensure adequate and appropriate community-based care, and 9. Develop an information system to guide the health system's policies, strategies, and investments. The main thrust of the Presidential Health Compact is to ensure the health system can successfully execute the obligations of the NHI framework. Key common themes emphasise the need for expanded health workforce development and deployment, addressing inequities, health systems strengthening and quality improvement, eliminating corruption, maladministration and incompetence, and strengthening governance at national, provincial, district, ward, and facility levels.	The CMS regulates the activities of medical schemes, key stakeholders in the NHI and the Presidential Health Compact.
Recommendations of the Health Market Inquiry, 2019 (HMI Recommendations)	The Competition Commission's HMI investigated the dynamics in the private healthcare market, identifying barriers to competition, and examining the factors that influence private healthcare costs. In a briefing to the Portfolio Committee on Health, in September 2024, the Department of Health (NDoH) highlighted several critical issues from the HMI affecting the private healthcare sector, including the high expenditure and inefficiencies that plague the system. These include excessive resource utilisation that fails to yield improved health outcomes.	The regulatory functions of the CMS are integral to supporting the implementation of the HMI Recommendations affecting medical schemes.

Information and Communications Technology (ICT)

The ICT function at the CMS is currently undergoing a digital transformation journey. This involves modernising and replacing outdated technologies to enhance the efficiency and effectiveness of the Regulator, in alignment with Fourth Industrial Revolution (4IR) digital innovations. These technological initiatives are continuously monitored for progress through the various governance structures within the CMS.

Financial Management

In the area of financial management, the CMS has matured significantly as evidenced by the unqualified audits reports issued by the Auditor-General of South Africa over the years. There are, however, areas which require much improvement. The main area of focus will be to strengthen the supply chain management aspect. To this end, a proposal has been made to have a dedicated supply chain management unit which is fully capacitated in line with developing trends.

Management must ensure that financial management through internal controls at the CMS is strengthened and that policies are reviewed and applied consistently. An area that requires further attention is that of consequence management in cases where there has been non-compliance with policies and regulations. The CMS has 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.

Financial Resources

Over the last five years, the CMS has encountered significant financial challenges and other resource constraints. The delayed approval of the proposed levy increase, coupled with the capping of the proposed increase to the Consumer Price Index (CPI), has negatively impacted the organisation's cash flow, placing additional pressure on its ability to fulfil its statutory regulatory duties.

The CMS has employed operational strategies to bolster its financial sustainability. However, it is evident that a more strategic approach is essential to ensure the organisation's long-term financial stability. As a result, the CMS will shift its focus from solely managing its budget to evaluating and enhancing its funding model through a long-term approach.

Additionally, the CMS audit outcome has shown improvement over the past five years, reflecting enhanced performance, compliance, and financial management. The objective for the upcoming strategic period is to strive for a clean audit outcome. This will signify a credible and well-governed regulator.

Human Resources (HR)

The CMS has successfully undergone a transformation by restructuring its organisational framework to better align resources with strategic goals. This involved prioritising the filling of new positions in a phased approach based on the approved budget. However, the budget has not been sufficient to fully fund the newly created positions in the new organisational structure. Six percent of the total positions in the approved organisational structure remain unfunded, and the CMS intends to fund these positions over the new Medium-Term Expenditure Framework (MTEF).

The CMS remuneration philosophy, terms and conditions of service and employee benefits policies, and employment contract provide for performance incentives and retirement benefits. However, due to budgetary constraints, the CMS is unable to fully afford employee benefits as provided for in its policies.

It should be noted that towards the end of the 2024/25 financial year, the growth of the CMS cost of employees has reached the margins of 71% of the total CMS budget. It would then be prudent for the CMS in its review of the remuneration policies to strike a balance between sustainability and the retention of talent.

Key priorities for the CMS include prioritising Employment Equity, Learning and Development, Health and Safety, Employee Wellness, and Talent Management, to ensure compliance with employment legislation and promoting work-life balance.

Looking ahead, the CMS aims to enhance employee benefits and implement strategies for process improvement, effective conflict resolution, team building, and improved communication to position itself as an employer of choice and address the challenges of the last five years.

Communications, Marketing and Stakeholder Relations Policies

CMS Stakeholder Relations Policies enable the organisation and employees, including collaboration with Member Protection, to communicate the mandate of the organisation in an effective manner and assist to bring awareness on areas or issues affecting the medical schemes and beneficiaries. In this regard, a significant milestone in the 2024/25 performance cycle has been the acceleration that resulted in conducting 66 consumer awareness activities in collaboration with the Member Protection programme.

Resolution of Complaints

One of the core functions of the CMS is the investigation of complaints and settlement of disputes in relation to the affairs of medical schemes. During the last six years, the CMS has sought to ensure protection of the interests of medical scheme beneficiaries through the resolution of complaints lodged against regulated entities. In this period, more than 14 000 complaints were successfully resolved.

Table 3 below depicts complaints resolution data over the past 5 years, specifically highlighting the number of complaints received and the number of complaints resolved:

Table 3: Complaints Resolution Statistics

Financial Year	Brought forward	Complaints registered	Total complaints	Total complaints resolved	Carried forward
2019/20	1 902	2 829	4 731	3 006	1 725
2020/21	1 725	1 729	3 454	2 490	974
2021/22	974	2 265	3 239	2 379	514
2022/23	514	2 966	3 480	3 017	463
2023/24	463	2 087	2 550	2 178	372
2024/25	372	1 962	2 334	1 879	455
Total complaints	**-**	**13 838**	**-**	**14 949**	**-**

Complaint trends over the last five years

Over the last five years, complaint trends remained the same regarding short payment of claims related to Prescribed Minimum Benefits (PMB). What seems to be on the rise is the disputes over interpretation of PMB level of care and funding liability of medical schemes for high-cost, new treatment interventions. The CMS is also seeing an increase in complaints about the funding limitations on treatment of rare diseases, some of which are not on the PMB list, as well as complaints on the interpretation of Regulations 15H and 15I (c).

The number of disputes related to the funding of non-PMB, rule-based benefit exclusions and membership terminations have remained relatively unchanged over the past five years.

Challenges over the last five years

There were significant challenges that impacted the resolution of complaints over the past five years, key among which is the regulatory uncertainty arising from the outdated Medical Schemes Act. In addition, delays in implementing legislative and regulatory amendments have resulted in excessive delays in finalising complaints.

Over the last five years, there were three key regulatory challenges that impacted the medical schemes industry and, in turn, timeous resolution of complaints.

Interpretation of Section 59(3) of the Medical Schemes Act

Disputes over the correct interpretation and lawful application of section 59(3) of the MSA have continued to challenge the CMS. The Final Report has been published and shared with all relevant stakeholders, including the Ministry of Health and members of the public healthcare sector. The availability of clear and consistent regulatory guidance is expected to support the effective interpretation and implementation of the provision.

Conflicting interpretations of Regulation 28(7)

The CMS has dealt with numerous complaints wherein the interpretation of Regulation 28(7) came under scrutiny. These were complicated by several conflicting appeal rulings as well as the involvement of other parties whose conduct fall outside the CMS' regulatory mandate. The combined difficulty posed by these factors made the timeous resolution of related complaints problematic.

Lack of clarity on the meaning and interpretation of day-to-day benefits

Following the High Court judgment in the case of Key Health Medical Scheme v Reed, the correct meaning and interpretation of the term "day-to-day benefits" became an issue of contention between medical schemes and beneficiaries. Due to the Court's departure from the commonly accepted meaning and interpretation, the new and ambiguous meaning that was attached by the Court to this term created a new wave of disputes. The CMS has acknowledged the confusion and plans to issue guidance to resolve disputes surrounding this interpretation.

ICT system challenges

In addition to the regulatory challenges, the CMS faced serious ICT-related challenges which impacted the resolution of disputes. Repeated ICT system crashes resulted in a significant loss of historical complaints data, which, in turn, led to loss of institutional memory and case precedents that are critical to making consistently sound, legal decisions. The challenges currently being faced are actively being tackled as part of the comprehensive implementation of the CMS digital transformation strategy. This strategy encompasses various initiatives aimed at modernising systems and processes, enhancing user experience, and leveraging technology to improve overall efficiency. Through collaborative efforts and innovative solutions, the CMS is committed to overcoming these obstacles and driving forward the digital evolution of the organisation.

Broad-Based Black Economic Empowerment (BBBEE) initiatives

The Government has an obligation to harness national resources towards the resolution of the historical injustice of racial, gender and class exclusion in all spheres of life. In the realm of economic life, this implies the need to transform the patterns of asset ownership in a manner that reinforces the national objective of building a South African society that truly belongs to all who live in it.

The Government has developed various policy instruments, such as the Preferential Procurement Regulations of 2017 (PPR) issued in terms of the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA). The PPPFA objective is to transform the structure of the South African economy in a manner that advances previously disadvantaged persons or categories of persons, high levels of decent employment and the demographic transformation of industrial assets.

The CMS is committed to mainstreaming enterprise growth, empowerment and equity in the economy for designated groups through the National Treasury requirements and the CMS Supply Chain Management (SCM) Policy.

In this way, the CMS will continue to leverage its procurement spend to advance historically disadvantaged persons by giving preference to designated groups (aligned to the PPPFA), exempt micro enterprises (EMEs), and qualifying small enterprises (QSEs).

Other BBBEE initiatives

The CMS has implemented the BBBEE Code of Good Practice by applying the preference points system of 80/20 for transactions of goods and services between R2 001 and R50 000 000 and the preference points system of 90/10 for transactions above R50 million when it is applicable.

More specific measures taken by the CMS include the following:

- Requesting and ensuring that each bidder submits a sworn affidavit and BBBEE credentials when responding to the invitation for bids.
- Using the quote evaluation system to allocate points for specific goals in line with Preferential Procurement Regulations 2022.

Status of CMS' Interventions relating to women, youth and people with disabilities

The CMS plans to continue its contribution to the three strategic priorities of the 7th Administration. This covers, inter alia, the matter of inclusive economic growth, the empowerment of designated groups, namely - women, youth, and people with disabilities.

The CMS supports government's call to develop the skills by providing an internship programme as well as training for qualified graduates. This initiative has enabled the CMS to host eighteen months of Work Integrated Learning that allowed learners to complete the workplace learning requirements towards their qualification.

The CMS actively contributes to the empowerment of these designated groups through its talent acquisition, management and retention. Over the past five years, the staff composition at the CMS has been comprised of, on average, 55% women, 21% youth, and 3% people with disabilities. Moving forward, the CMS is committed to ensure that its staff composition reflects the demographic representation of these designated groups within South African society.

The following Table 4 presents the distribution of staff by age and gender. This information shows one view on the level of diversity within the CMS workforce.

Table 4: Distribution of staff by age and gender

Age Distribution	2020 – 2021		2021 – 2022		2022 – 2023		2023 – 2024		2024 – 2025	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
20-24	0	0	0	0	1	0	1	1	1	0
25-29	5	6	6	6	5	6	5	3	4	4
30-34	4	7	3	10	5	11	5	10	11	10
35-39	16	15	10	12	12	8	9	10	4	11
40-44	5	12	13	10	10	11	14	12	17	10
45-49	13	6	11	9	12	11	12	11	9	10
50-54	10	4	11	3	10	5	10	6	13	9
55-59	7	0	8	1	11	1	9	3	11	5
60-64	2	1	2	1	2	1	3	1	7	0
Total	**62**	**51**	**64**	**52**	**68**	**54**	**68**	**57**	**77**	**59**

Marketing and the visibility of CMS

CMS media analysis over the years has indicated a lack of visibility of the CMS among the mainstream public. Beneficiaries of the schemes also had little or limited knowledge of their benefits and or medical aid coverage.

Multiple stakeholder engagements, media platforms and research surveys identified the lack of visibility of the CMS to be the primary reason for its marketing woes. This was also proved by most medical scheme beneficiaries who do not understand their benefit options. Previous efforts to conduct educational and consumer awareness were helpful but media analysis still indicates a need for greater visibility.

Towards the finalisation period of the 2020-2025 CMS Strategic Plan, the organisation reported on improved visibility despite a lack of financial resources. The strategic communication approach involved purposefully setting up media engagements and producing opinion pieces, augmenting social media platforms with credible content, webinars and introduction of podcasts.

The result of this outcome significantly increased or attracted more stakeholder collaborations. The CMS entered into partnerships and signed at least 11 MOUs. Our efforts to engage Principal Officers and Board of Trustees on key policy issues via hosting annual forums, included palpable efforts by schemes to educate members on PMBs. Furthermore, the CMS was instrumental in convening flagship programmes such as the Section 59 Investigation, Fraud, Waste and Abuse and the Low Cost Benefit Options.

During the coming strategic period, the CMS' marketing efforts to increase visibility shall include; digital marketing and online advertising, roadshows, CMS publications which are mainly member focused, an increased media presence, and aggressive participation in industry and stakeholder forums and events.

2.4. Progress towards achievement of institutional Impacts and Outcomes

Impact statement	To be an agile and transformative Regulator to **promote affordable** and **accessible** healthcare cover towards **universal health coverage.**
Progress Review Statement	The Council for Medical Schemes continues to advance its mandate of protecting beneficiaries and promoting affordable, quality healthcare coverage. Over the review period, the Council strengthened its regulatory frameworks, enhanced stakeholder engagement, and improved compliance monitoring to ensure greater transparency and accountability in the medical schemes industry. Efforts to drive universal health coverage were reinforced through targeted policy reforms, capacity building, and improved access to consumer education. While challenges remain in affordability and market sustainability, significant strides have been made towards an agile, responsive, and transformative regulatory environment that places beneficiaries at the centre of healthcare financing.

The CMS has developed the following Strategic Outcomes for the 2020-25 Strategic Plan aligned with the 2019-24 Medium Term Strategic Framework (MTSF).

Outcome 1	To promote the improvement of quality and the reduction of costs in the private healthcare sector
Progress Review Statement	In Section 7(e) of the Medical Schemes Act, one of the critical functions of the Council is to collect and disseminate information about private health care. The CMS is also mandated by the Medical Schemes Act (MSA) Section 7(c) to make recommendations to the Minister on the quality of healthcare in medical schemes, and it publishes the findings annually in this report. The CMS reports the utilisation of health services and monitors the prevalence of chronic conditions in the medical schemes' population. Other monitoring processes include the continued collection of the Scheme Risk Measurement (SRM) data to measure and report on the risk profiles of medical schemes and benefit options. This allows schemes to understand better the impact of age and chronic disease on the beneficiaries covered by medical schemes. The CMS Industry Report analyses indicators pertinent to the Sustainable Development Goals (SDGs), primarily focusing on mental health and child/maternal care. Specifically, findings reveal an uptick in the incidence of depression among beneficiaries, with a 3.91% increase per 1 000 beneficiaries observed from 2021 to 2022. Notably, open schemes exhibit higher levels of depression than closed schemes, with a more pronounced rise noted in open schemes, registering a 5.44% increase from 89.05 to 93.90 per 1000 beneficiaries. In contrast, closed schemes show a more modest increase from 75.45 to 76.90 per 1000 beneficiaries, indicating a 1.92% rise. Additionally, the data highlights a concerning decline in immunisation coverage from 2021 to 2022. Likewise, screening rates for cervical cancer have also declined, which could potentially lead to increased downstream costs and adverse health outcomes. This downward trend in screening rates poses financial implications. It raises concerns regarding the overall well-being of individuals, underscoring the importance of addressing and reversing this trend to mitigate potential negative consequences. This decline underscores the critical need for immunisation as a fundamental aspect of primary health care, necessitating immediate attention to funding and health promotion perspectives. The medical schemes sector continues to exhibit marginal growth, with an increase in beneficiaries resulting in coverage for over 9 million lives between 2021 and 2022. However, despite this growth, the industry still represents less than 15% of the total population. Membership in healthcare insurance schemes is resilient despite economic challenges, including rising unemployment rates and financial constraints. In contemporary healthcare insurance schemes, claim experience rates are notably high, with some schemes encountering ratios exceeding 100% while others maintain ratios below this threshold. The escalating claim experience may be attributed to the demand for healthcare services, including those deferred during the COVID-19 pandemic, warranting close monitoring of its impact on solvency and scheme reserves. These developments are likely to influence contribution rates, which will be regularly assessed through cost projections.

Outcome 2	To encourage effective risk pooling
Progress Review Statement	The 2019 Health Market Inquiry Report underscored the challenges that beneficiaries face when selecting suitable benefit options within the medical schemes sector, citing the extensive range of choices available as a primary obstacle. Consequently, a recommendation emerged to standardise supplementary benefit packages to simplify decision-making processes for medical scheme beneficiaries. Over time the CMS has made significant progress in devising a framework to standardise and streamline benefit options. As part of its continuous endeavours, the CMS has initiated the establishment of a relational database architecture to compile benefit information, thereby facilitating the assessment process. Moreover, the CMS has undertaken a project to develop a regulatory framework to identify emerging trends and craft recommendations for a responsive regulatory framework. This framework is intended to address both clinical and administrative complaints documented in the CMS complaints database. A pilot survey has been planned. The game theory framework of analysis was tested previously to find a causal path between scheme behaviour (scheme strategy), member behaviour (member strategy), and pay-offs (win or lose ruling). It is hypothesised that undesirable behaviour creates systemic reputational risk and market failure due to information asymmetry. The pilot survey incorporates Out-of-Pocket (OOP) questions, which will describe the nature of the cause of market failure (episodes associated with specific health-seeking behaviour resulting in OOP penalties due to scheme or beneficiary conduct). The responses will be used to construct a structural equation model linking behaviour to market failure. An annual evaluation of government-funded medical schemes and smaller risk pools comprising fewer than 6 000 members revealed their sustained viability and demonstrated membership growth. An examination of the solvency ratio, a critical metric overseen by the Medical Schemes Act, indicated that five of the eleven schemes adhered to Regulation 29, maintaining a solvency ratio surpassing the mandated threshold of 25%. Five of the eleven state employees' medical schemes operated with memberships less than 6 000 individuals. In the period under review, membership in smaller risk pools collectively increased by nearly 5%, indicating a positive trend. The membership of these schemes ranged from 994 to 5 993 principal members, encompassing a total of 194 015 beneficiaries. These schemes collectively generated R5.5 billion in Gross Contribution Income (GCI) while incurring R345.8 million in expenses related to gross administration services. Financially robust, these schemes-maintained solvency ratios exceeding 25% as of December 2022, ranging from 43.15% to 397.7%. The review of the Risk-Based Capital (RBC) project, where an external actuarial firm was commissioned to assess the model, has been concluded. The recommendations highlighted the need for careful consideration of input variables and the potential impact of these models. It was noted that certain schemes may require increased reserves while others may need to reduce reserves, leading to the necessity of releasing more assets. In addition, unintended consequences were identified, compounded by the fact that RBC is not legislated nor prescribed in terms of the Medical Schemes Act, alongside other implementation challenges. The recommendations proposed that RBC be utilised as a regulatory early warning tool. An industry-wide update regarding this matter was disseminated through a circular and discussed within the Principal Officer forum. This proactive communication aimed to ensure transparency and provide stakeholders with insight into the evolving regulatory landscape surrounding risk-based capital assessment in the medical schemes industry.
Outcome 3	**To ensure that all regulated entities comply with, National Policy, the MSA and Regulations**
	Numerous regulatory interventions were implemented during the strategic period under review, including monitoring and implementation of enforcement actions, governance interventions, and inspection of regulated entities. Therefore, this included observing most of the medical scheme member meetings (AGMs) and generating observation reports, along with advocating for virtual member meetings in response to the COVID-19 pandemic. During this period, routine monitoring of Compliance inspections and Commissioned inspections were instituted to review the affairs of medical schemes and other regulated entities. The oversight and responsibility of supervising health insurance products and medical schemes are provided by regulations on differentiation, which ensure that insurance products do not undermine the medical scheme environment. The CMS governance body is responsible for granting exemptions based on advice from the Registrar and team and the Exemption Framework created by the Council for Medical Schemes, the National Treasury, and the National Department of Health. Insurers conducting medical scheme business were previously granted an exemption to March 2025, which was extended to March 2027 to ensure continued coverage for existing subscribers and amid the pronouncement by the Minister on the LCBO that was concluded and handed to the Minister in November 2023. The eagerly awaited report containing recommendations on Low-Cost Benefit Options (LCBO) and specific recommendations was concluded and submitted to the Minister in November 2023. The report delineated various options grounded in both technical and policy analyses. Additionally, it conducted a detailed examination of the necessity for low-cost benefit options by medical schemes and the future of currently exempted products. Among the key principles considered were ensuring financial protection for beneficiaries, avoiding heightened out-of-pocket expenses, compliance with the Medical Schemes Act and its provisions, addressing the disease burden, and alignment with health system objectives. In January 2024, the Minister established a task team to review the report and provide further recommendations. Work on this matter is underway, with ongoing support from the CMS to facilitate these processes.

Progress Review Statement	Medical scheme administrators (including limited accreditation administrators), managed care organisations and schemes providing their own administration and/or managed care services are subject to rigorous evaluations of their compliance with the regulatory requirements and accreditation standards before accreditation is granted or compliance certificate issued (in the case of medical schemes). The CMS continued to ensure that compliance is monitored throughout the accreditation or compliance periods. Moreover, appropriate action was taken where and when non-compliance to accreditation requirements and standards were detected. The CMS is actively engaged in ongoing efforts to understand the nature of transformation within the medical schemes industry. The Health Market Inquiry Report findings 2019 underscored transformation as a significant barrier to market participation. Notably, marginal market entry has occurred, but this has predominantly involved limited involvement of previously disadvantaged groups. During the period under review, the CMS conducted a study focusing on the market dominance of external audit companies contracting external auditing services provided to medical schemers, which PWC and Deloitte primarily dominated. The study also found that the HHI index was >2 500. This indicated a concentrated Herfindahl-Hirschman Index (HHI) with 2 500, considered to be a highly concentrated market. In the light of these findings, the study recommended that the Board of Trustees (BoT) prioritise diversity and inclusivity considerations when procuring auditing services. This recommendation reflects a proactive approach to fostering a more equitable and inclusive landscape within the medical schemes industry. The CMS continues to adhere to a stringent process for assessing and registering medical scheme rule amendments that are submitted in accordance with section 31 (1) of the Act. This is done to ensure that the rules that are registered are fair to members and consistent with the Act. In addition, the CMS does this to ensure the proper governance of medical schemes. The set turnaround times for the processing of medical scheme rules are met with precision, consistency, and commitment. Changes to benefits offered by medical schemes and contribution adjustments are among the processed rule amendments. In considering these amendments, the CMS has endeavoured to safeguard beneficiaries of medical schemes from the trend of diminishing benefits and an unsustainable increase in contributions paid by medical scheme beneficiaries. The processing and approval of efficiency discounted options (EDOs) applications for exemption (Section 29(1)(n)) has ensured that a significant number of medical scheme beneficiaries have access to high-quality health services at affordable contributions. At the same time the Council has, on an annual basis, reviewed and granted approved exemptions (Section 29(1)(o)) from the provisions of PMBs for benefits options of medical schemes that were previously registered under the auspices of respective bargaining councils and typically provided health insurance coverage to beneficiaries who would ordinarily be unable to afford membership in a standard medical scheme or the cost of privately delivered health services. These exemptions are conditional on an annual review and increases in benefits that bring them in line with the PMB regulations while also considering the epidemiological profile of those who are insured.
Outcome 4	**To be a more effective and efficient organisation**
Progress Review Statement	During the 2024/25 financial year, the Council and its committees experienced an increase in the number of meetings, driven by key business imperatives and a range of emerging issues requiring attention. Despite the demanding schedule, Council members demonstrated a strong commitment to ethical governance and operational efficiency by consistently availing themselves and actively participating in meetings. Their dedication ensured that the Council continued to fulfil its mandate effectively and responsibly. During the year under review, the CMS has successfully completed the recruitment and appointment process of twenty-six employees ranging from cleaning personnel to Chief Executive and Registrar. To comply with legislations governing employment, the CMS has submitted Workplace Skills Plan and Annual Training Report for 2024/2025 on 30 April 2024. The reports were approved by the HWSETA. Progress on the implementation of the Employment Equity Plan was reported to the Department of Employment and Labour on 6 January 2025 and submitted. CMS continues to provide wellness services and benefits to its employees in a quest to keep its staff members in good mind, health and body. Various presentations on wellness topics were conducted throughout the year; a wellness walk was held in July 2024 and a wellness day in March 2025.

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
Progress Review Statement	During the reporting period, all scheduled research activities were successfully completed, yielding outputs that directly align with the Council for Medical Schemes' strategic objective of conducting policy-relevant research to inform and advise healthcare policy formulation. Notable achievements included comprehensive reviews of Bargaining Council Schemes and government-funded medical schemes, in-depth analyses of chronic disease prevalence and associated healthcare quality outcomes, and an investigative study on high out-of-pocket expenditures linked to chronic conditions and diagnostic treatment pairs. Five policy-oriented research bulletins were published, covering critical themes such as the standardisation of supplementary benefits in response to Health Market Inquiry (HMI) recommendations, reforms to Prescribed Minimum Benefits (PMBs), the impact of contribution increases on scheme members, and persistent healthcare inequalities in South Africa. Three peer-reviewed articles published in the World Medical Journal contributed to international scholarly engagement and reinforced thought leadership in the sector. Additional academic outputs reflected a multidisciplinary approach to health systems research, addressing topics such as service innovation, healthcare quality, digital marketing within medical schemes, and broader public health concerns including HIV/AIDS funding and obesity. Key strategic contributions included the development of a concept note on the Draft Interim Block Exemption for Tariff Determination, a draft framework for standardising supplementary benefits, and an economic outlook assessment that informed the 2025 contribution increase projections. Progress was also made in assessing third-party administrators and designated service providers, completing a comparative analysis of the CMS and NDoH primary healthcare (PHC) benefit packages, and ensuring the revision of PMB definitions remain on track for completion within the current quarter.
Outcome 6	**To collaborate with local, regional and international entities**
Progress Review Statement	The Council for Medical Schemes strengthened its collaboration with local, regional, and international entities to enhance regulatory capacity and share best practices. Memoranda of Understanding (MOUs) were signed with key stakeholders to formalise cooperation in areas such as compliance, consumer protection, and health policy development. The CMS also actively participated in the Committee of Insurance, Securities, and Non-Banking Financial Authorities (CISNA), contributing to regional dialogue on regulatory harmonisation and cross-border healthcare financing initiatives.

INSTITUTIONAL PROGRAMME PERFORMANCE INFORMATION

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:

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

Sub-Programme 1.2: Office of the Chief Financial Officer

Sub-Programme 1.3: Information Communication Technology and Information Management

Sub-Programme 1.4: Corporate Services

Sub-Programme 1.5: Council Secretariat

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.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 5: Sub-programme 1.1 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Sub-programme 1.1: Office of the Chief Executive and Registrar							
Outcome 4: To be 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 the Review and Development of a Strategic Plan and Annual Performance Plan is done for Council's consideration by the 31st of January each year	1	1	1	1	None	Not Applicable
	Output Indicator 1.2: Ensure that the overall performance of the entity is 80% of the predetermined objectives	89.19%	86%	≥80%	96.43% (54/56)	16.43%	The target was exceeded due to close monitoring of the organisation's program performance trends through monthly reports to the Executive Management Committee
	Output Indicator 1.3: Ensure that an Annual Performance Information report that is produced is reliable, accurate and completed by 31st July each year in line with the statutory requirements	1	1	1	1	None	Not Applicable

LINKING PERFORMANCE WITH BUDGETS

Table 6: Sub-programme 1.1 - Linking performance with budget

Office of the CEO	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Printing and stationery	6	4	2	15	14	1
Subscriptions	306	308	(2)	56	52	4
	312	**312**	**-**	**71**	**66**	**5**
Operating expenses						
Consulting	350	424	(74)	816	249	**567**
Legal costs - Labour relations matters	3 730	3 503	227	1 408	1 648	**(240)**
Travel and subsistence	160	148	12	203	161	**42**
Venue and catering	243	266	(23)	79	115	**(36)**
	4 483	**4 341**	**142**	**2 506**	**2 173**	**333**
Staff costs						
Salaries	3 727	3 996	(269)	6 889	6 760	129
	3 727	**3 996**	**(269)**	**6 889**	**6 760**	**129**
TOTAL	**8 522**	**8 649**	**(127)**	**9 466**	**8 999**	**467**

In the year under review, the CMS submitted the LCBO framework to the Executive Authority for consideration. This marked the culmination of extensive stakeholder engagement, input, and feedback. The CMS achieved an overall performance of 96.43% against predetermined objectives, an improvement compared to its performance in the previous financial year. This performance outcome has been achieved despite the fact that the organisation is still facing various resource constraints.

Strategy to overcome areas of underperformance

There were no areas of underperformance for this subprogramme. All output indicator targets were achieved.

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 the Council by maintaining an efficient, effective and transparent system of financial performance and supply chain management that complies with the applicable legislation. The Office of the CFO, in support of the Registrar, also serves the Council, Audit and Risk Committee, Internal Auditors, the NDoH, National Treasury and the Auditor-General South Africa by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, the sub-programme assists the Council to be a reputable regulator.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 7: Sub-programme 1.2 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Sub-programme 1.2: Office of the Chief Financial Officer							
Outcome 4: To be a more effective and efficient organisation							
Output 3: Ensure that reported financial information is useful and reliable, and in accordance with the Expenditure Management and Reporting Framework.	**Output Indicator 3.1:** An unqualified opinion issued by the Auditor-General South Africa on the Annual Financial Statements by 31st July each year	1	1	1	1	None	Not Applicable
Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities.	**Output Indicator 4.1:** Review, develop and implement a funding model that considers the long-term strategic outcomes of the CMS by the end of each year	0	0	1	1	None	Not Applicable
	Output Indicator 4.2: Produce a budget that is approved by Council by 31st January each year	1	1	1	1	None	Not Applicable

LINKING PERFORMANCE WITH BUDGETS

Table 8: Sub-programme 1.2 - Linking performance with budget

Office of the CEO	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Bank charges	86	80	6	120	85	35
General administrative expenses	5	7	(2)	10	2	8
Insurance	680	710	(30)	950	901	49
Penalty paid to SARS	322	692	(370)	-	-	-
Printing and stationery	92	49	43	433	28	405
Subscriptions	32	23	9	31	19	12
	1 217	**1 561**	**(344)**	**1 544**	**1 035**	**509**
Operating expenses						
Consulting	1 899	509	1 390	690	189	501
Travel and subsistence	50	17	33	2	(0)	2
Venue and catering	91	75	16	29	17	12
	2 040	**601**	**1 439**	**721**	**206**	**515**
Staff costs						
Employee benefits	-	-	-	4 088	3 889	199
Salaries	11 713	13 101	(1 388)	12 265	12 110	155
Workmen's compensation	293	166	127	274	158	115
	12 006	**13 267**	**(1 261)**	**16 627**	**16 158**	**469**
TOTAL	**15 263**	**15 429**	**(166)**	**18 892**	**17 399**	**1 493**

The allocated budget was utilised to ensure the effective functioning of the sub-programme in achieving its mandate and supporting the attainment of Key Performance Indicators (KPIs). The budget enabled the Office of the CFO to provide strategic leadership and financial oversight while ensuring that resources were efficiently allocated to organisational priorities.

This allocation supported key functions such as financial planning, performance reporting, supply chain management, and compliance with applicable legislation. It also enabled the Office of the CFO to provide accurate and timely financial information to the Council, Audit and Risk Committee, Internal Auditors, the National Department of Health, National Treasury, and the Auditor-General South Africa, thereby facilitating effective oversight and accountability.

By ensuring sound financial management and governance, the prudent use of the budget contributed directly to the overall achievement of the CMS' strategic objectives and reinforced its reputation as a credible and transparent regulator.

Strategy to overcome areas of underperformance

There were no areas of underperformance for this sub-programme. All output indicator targets were achieved.

Sub-programme 1.3: Information Communication Technology and Information Management

The purpose of the sub-programme is to provide secure, reliable, innovative and process-driven information and communication technology and knowledge management solutions, thereby improving productivity and business value. Digitisation is extremely critical for the CMS as a Regulator to enable the organisation to function in the Fourth Industrial Revolution (4IR) coupled with the current era of Artificial Intelligence that we find ourselves in.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 9: Sub-programme 1.3 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual	Reasons for deviations
Sub-programme 1.3: Information Communication Technology and Information Management							
Outcome 4: To be a more effective and efficient organisation							
Output 5: An established ICT Infrastructure that ensures information is available, accessible and protected.	**Output Indicator 5.1:** Percentage of network uptime	99%	99%	95%	99%	4%	No network downtime was experienced from Q1 to Q4 of the 2024/2025 financial year, as both the primary and secondary links remained consistently available. The failover mechanism functioned effectively throughout the period.
	Output Indicator 5.2: Percentage of IT security incidents (breaches)	5%	5%	5%	0%	5%	The target was exceeded as no security breaches occurred. This was due to our strengthened firewall rules and security policies that effectively prevented unauthorised attacks.
	Output Indicator 5.3: Number of successful IT Disaster Recovery tests	2	2	2	2	None	Not Applicable
	Output Indicator 5.4: Number of Successful Backups testing	New Indicator	New Indicator	2	2	None	Not Applicable
	Output Indicator 5.5: ICT Engagements to enable Digital Transformation and mature the Digital Culture of the CMS	New Indicator	New Indicator	30% of total respondents are satisfied overall	82.61% (19/23)	52.61%	The significant variance between the target and actual performance may be attributed to the limited number of employees (23) who responded to the survey. As this is the CMS' first digital transformation journey, the measurement process was approached with caution. Shifting the digital maturity culture is a gradual process that will evolve over time as new technologies are introduced.

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual	Reasons for deviations
Sub-programme 1.3: Information Communication Technology and Information Management							
Outcome 4: To be a more effective and efficient organisation							
Output 6: Provide software applications that serve both internal as well as external stakeholders and which improves business operations and performance.	**Output Indicator 6.1:** Modernise the ICT applications portfolio by delivering on the prioritised projects per the ICT Digital Strategy	New Indicator	New Indicator	60% complete on of prioritised project	66.7% (2/3)	6.7%	Of the digital initiatives, the BMU tender was not awarded, while M-Files was successfully awarded. The Azure project was completed at no additional cost, as it was implemented under the existing Microsoft contract. This marks a significant milestone in CMS' digital transformation journey, being the first project implemented in the cloud. The website and MCO accreditation projects are currently on hold due to budget limitations. In total, two projects were deferred due to these financial constraints.
	Outcome Indicator 6.2: Design and implement ICT Governance per ICT Policies	New Indicator	New Indicator	4 ICT Policies reviewed and implemented	8	4	ICT overachieved on this target by doing 4 more policies than planned.

LINKING PERFORMANCE WITH BUDGETS

Table 10: Sub-programme 1.3 - Linking performance with budget

Information Technology and Knowledge Management	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
General administrative expenses	530	529	1	514	449	65
Printing and stationery	9	-	9	19	7	12
Finance Costs	139	119	20	504	106	398
Security	989	929	60	599	595	4
Subscriptions	21	5	16	21	13	8
Telecommunication expense	10 208	11 812	(1 604)	11 258	9 827	1 431
	11 896	**13 394**	**(1 498)**	**12 915**	**10 997**	**1 918**
Operating expenses						
Consulting	850	5	845	141	470	(329)
Knowledge management	2 889	1 387	1 502	1 958	1 134	824
Travel and subsistence	32	33	(1)	30	28	2
Venue and catering	18	-	18	22	10	12
	3 789	**1 425**	**2 364**	**2 151**	**1 642**	**509**
Staff costs						
Salaries	16 551	17 417	(866)	15 541	13 860	1 681
	16 551	**17 417**	**(866)**	**15 541**	**13 860**	**1 681**
TOTAL	**32 236**	**32 236**	**0**	**30 607**	**26 499**	**4 108**

The allocated budget was utilised to ensure the effective functioning of the sub-programme in achieving its mandate and supporting the attainment of Key Performance Indicators (KPIs). The budget enabled the ICT and Knowledge Management (KM) sub-programme to advance the CMS's digital transformation journey by strengthening cybersecurity measures, ensuring network uptime and key application availability, and supporting the development of ICT-related policies and governance frameworks.

Through the prudent use of funds, the sub-programme enhanced organisational efficiency, improved information security, and ensured the availability of critical systems required for the CMS to deliver on its strategic objectives.

Strategy to overcome areas of underperformance

There were no areas of underperformance for this sub-programme. All output indicator targets were achieved.

Sub-programme 1.4: Corporate 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.
- Provide high-quality service to internal and external customers by assessing their needs and proactively addressing such needs through developing, delivering, and continuously improving human resource programmes that promote and support the Council's vision.
- Create and promote awareness and understanding of the Medical Schemes Act (131 of 1998) and the industry among all regulated and non-regulated entities through communication, marketing, and stakeholder engagement.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 11: Sub-programme 1.4 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Sub-programme 1.4: Corporate Services							
Outcome 4: To be a more effective and efficient organisation							
Output 7: Legal advisory and support services for effective regulation of the industry and operations of the office.	**Output Indicator 7.1:** Percentage of written and verbal legal opinions provided to internal and external stakeholders attended to within 14 days	100%	100%	95%	100% (867/867)	5%	During the year under review, the development of templates created efficiencies in turnaround times including the filling of new positions to the structure and working beyond the allocated hours of work. This enabled us to exceed our planned target, even in the delivery of legal opinions.
Output 8: Defending decisions of the Council and the Registrar.	**Output Indicator 8.1:** Percentage of court and tribunal appearances in legal matters received and action initiated by the sub-programme within 14 days, as determined by specific disputes resolutions structure's directives	100%	100%	100%	100% (47/47)	None	Not Applicable

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Sub-programme 1.4: Corporate Services							
Outcome 4: To be a more effective and efficient organisation							
Output 9: Build competencies and retain skilled employees.	**Output Indicator 9.1:** Minimise staff turnover rate to less than 15% per annum	13.82%	10.48%	<15%	11.54% (15/130)	3.46%	Favourable training and development opportunities enabled employees to obtain relevant qualifications, contributing to improved retention. As a result, the staff turnover rate remained below 15%.
	Output Indicator 9.2: Average number of days to fill a vacant funded post (turnaround time of 90 working days for each vacancy that exists during the year), excluding the position of CEO and Executives	54 days	86 days	90 days	59 days	31 days	Improvement on the release of job adverts, the setting up of selection panels, and fast-tracking approval memoranda. Almost half of the appointments were filled with internal candidates which also assisted in fast tracking the recruitment and selection process.
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 31st May each year	96%	99.19%	95%	99.21% (125/126)	4.21%	Out of 126 employees reported on 1st April 2024, 125 signed the performance agreements by 31st May. The Human Resources sub-division actively monitored and followed up on the signing process, ensuring timely compliance.
	Output Indicator 10.2: Percentage of employees performance assessment concluded bi-annually	95.16%	97%	95%	96.77% Not all employees are eligible for performance review	1.77%	All eligible employees reported on 1st April 2024, completed their biannual performance assessments. The Human Resources sub-division monitored the assessment process to ensure timely compliance.

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Sub-programme 1.4: Corporate Services							
Outcome 4: To be a more effective and efficient organisation							
Output 11: Ensure maximisation of the coordination of various planning efforts that are undertaken in relation to the CMS facilities.	**Output Indicator 11.1:** Update an Office Capacity and Utilisation Report by 30th June each year	1	1	1	1	None	Not Applicable
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations							
Output 12: To create awareness and collaboration with stakeholders while enhancing the visibility and protecting the reputation of the CMS.	**Output Indicator 12.1:** Number of stakeholder awareness activities conducted	30	51	35	127	92	External conditions, such as media coverage on medical schemes, placed the spotlight on the CMS. This increased visibility contributed to improved stakeholder engagement. While CMS had initially planned for 35 stakeholder awareness activities, heightened media attention led to greater demand for engagement.
	Output Indicator 12.2: Percentage of stakeholder awareness of the CMS resulting from a survey	60%	45%	65%	68.93% (20399/ 29592)	3.93%	The measuring question was revised to a scaled familiarity format, resulting in improved data and a more favourable result.
Output 13: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year.	**Output Indicator 13.1:** Submission of the CMS Annual Report by 31st August to the Executive Authority	1	1	1	1	None	Not Applicable

LINKING PERFORMANCE WITH BUDGETS

Table 12: Sub-programme 1.4 - Linking performance with budget

Corporate Services	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Building expenses	2 108	2 238	(130)	1 975	2 064	(89)
General administrative expenses	410	286	124	282	176	106
Printing and stationery	72	33	39	178	122	56
Rent	15 338	15 338	-	14 601	13 944	656
Rent: Operating expense	3 322	3 322	-	3 149	3 149	(0)
Subscriptions	106	93	13	287	182	105
	21 356	**21 310**	**46**	**20 472**	**19 637**	**835**
Operating expenses						
Consulting	189	143	46	1 000	850	150
Legal fees	8 565	13 375	(4 810)	11 232	10 146	1 086
Legal fees - Section 59	955	1 117	(162)	3 080	1 975	1 105
Postage and courier	12	1	11	10	-	10
Exhibition costs	2	-	2	40	37	3
Media and promotion	840	658	182	1 560	1 206	354
Printing and publication	419	378	41	300	229	71
Travel and subsistence	328	312	16	282	163	119
Venue and catering	172	159	13	196	101	95
	11 482	**16 142**	**(4 660)**	**17 700**	**14 707**	**2 993**
Staff costs						
Employee wellness	357	407	(50)	291	297	(6)
Employee benefits	4 892	4 689	203			-
Recruitment and relocation	1 089	1 121	(32)	960	513	447
Salaries	20 541	21 729	(1 188)	20 098	19 896	202
Staff training	2 385	2 374	11	2 418	1 985	433
Temporary staff	4 337	4 726	(389)	4 106	3 985	121
	33 601	**35 046**	**(1 445)**	**27 873**	**26 676**	**1 197**
Labour settlement	**10 592**	**10 592**	**-**	**-**	**-**	**-**
	10 592	**10 592**	**-**	**-**	**-**	**-**
TOTAL	**77 031**	**83 091**	**(6 060)**	**66 045**	**61 021**	**5 025**

During the period under review, the allocated budget was prudently applied to support the effective execution of the CMS mandate and the achievement of its Key Performance Indicators (KPIs). The utilisation of funds was aligned with the strategic priorities of the Council and targeted the following key areas:

Provision of Legal Advice and Representation

The budget facilitated the engagement of legal expertise necessary to provide sound legal advice and representation to the CMS and its various business units. This ensured that all regulatory decisions were legally robust, defensible, and consistent with the Medical Schemes Act (131 of 1998) and other relevant legislation.

Human Resource Development and Support

The allocated budget supported recruitment, training programmes, employee wellness initiatives, performance management systems, and other HR-related activities designed to attract, retain, and develop skilled personnel. These efforts were instrumental in promoting and sustaining the Council's vision, enabling it to function efficiently and responsively.

Communication, Marketing, and Stakeholder Engagement

The budget was also directed towards creating and promoting greater awareness and understanding of the Medical Schemes Act (131 of 1998) and the medical schemes industry. This included funding comprehensive communication strategies, marketing campaigns, and stakeholder engagement initiatives aimed at both regulated and non-regulated entities. Specific activities supported by the budget included the development and dissemination of educational materials, hosting stakeholder forums and workshops, and executing targeted outreach programmes. These initiatives enhanced transparency, encouraged compliance, and fostered informed participation across the sector.

In summary, the strategic utilisation of the budget allocated to Corporate Services during the review period ensured that the CMS was equipped to fulfil its regulatory mandate effectively. Through sustained investment in legal support, human resource development, and stakeholder engagement, the Council enhanced its capacity to govern the medical schemes industry with integrity, accountability, and transparency, thereby contributing to the overall health system's stability and sustainability.

Strategy to overcome areas of underperformance

There were no areas of underperformance for this subprogramme. All output indicator targets were achieved.

Sub-programme 1.5: Council Secretariat

The purpose of this programme is to provide corporate governance services to the Council as the Accounting Authority and its committees. The Council Secretariat also provides support to the independent Appeals Board and ensures that all rulings are communicated to key stakeholders. The programme seeks to achieve the above objective through seamless board administration, secretariat service and support.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 13: Sub-programme 1.5 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Sub-programme 1.5: Council Secretariat							
Outcome 4: To be a more effective and efficient organisation							
Output 14: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority.	**Output Indicator 14.1:** Complete meeting packs to be circulated at least 7 days before the meeting (Excluding Special Meetings)	New Indicator	20%	80%	63%	-17%	There was a challenge with receiving documents on time from various CMS business units. This challenge was encountered for most quarters of the reporting year. This resulted in the sub-programme missing this target.
	Output Indicator 14.2: Minutes of the Council and Committee meeting to the subsequent meeting	New Indicator	90%	80%	100% (4/4)	20%	The target was exceeded due to the staff working unpaid overtime and on weekends.
	Output Indicator 14.3: Percentage of communicated Council resolutions within 3 days of the meeting to the affected internal stakeholders	100%	100%	100%	100% (16/16)	None	Not Applicable
	Output Indicator 14.4: Number of training sessions held for council and/or Committee/s	1	1	1	2	1	The target was exceeded due to a request for an additional training session that was not included in the original plan.
	Output Indicator 14.5: Percentage of signed annual declaration of financial interest by Council Members (excluding Council Members out of office on extended absence)	100%	86%	90%	100% (15/15)	10%	The annual declarations were signed by all the Council members. The office was diligent in ensuring that each and every member signs the annual declaration.
Output 15: Support Dispute Resolution forums in furtherance of Council and MSA objectives.	**Output Indicator 15.1:** Support the publication of rulings of the Appeals Committee and the Appeal Board within 14 days of receipt from the Presiding Officers	100%	75%	75%	88% (22/25)	13%	The office consistently ensured the prompt submission of Appeals Committee rulings to the Communications Unit, enabling timely processing and dissemination. This proactive approach contributed to improved workflow efficiency and exceeded performance expectations.

LINKING PERFORMANCE WITH BUDGETS

Table 14: Sub-programme 1.5 - Linking performance with budget

Council Secretariat	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Printing and stationery	38	19	19	20	10	10
Subscriptions	30	25	5	57	-	57
	68	**44**	**24**	**77**	**10**	**67**
Operating expenses						
Consulting	400	532	(132)	781	394	387
Committee remuneration	333	376	(43)	480	319	161
Council member fees	5 150	6 060	(910)	4 320	4 433	(113)
Postage and courier	-	-	-	20	2	18
Transcription services	45	39	6	63	34	29
Travel and subsistence	276	244	32	197	64	133
Venue and catering	294	237	57	529	225	304
	6 498	**7 488**	**(990)**	**6 390**	**5 471**	**919**
Staff costs						
Salaries	3 309	3 233	76	2 914	2 792	122
Training	112	125	(13)	463	243	220
	3 421	**3 358**	**63**	**3 377**	**3 035**	**342**
TOTAL	**9 987**	**10 890**	**(903)**	**9 844**	**8 516**	**1 328**

The resources allocated to this programme were utilised efficiently to ensure effective corporate governance and operational support to the Council and its committees.

Strategy to overcome areas of underperformance

New interventions, including revised KPA, are planned for the new year.

PROGRAMME 2: STRATEGY, PERFORMANCE AND RISK

The purpose of this Programme is:

- To engage in projects to provide information to the Council through the office of the Registrar, on strategic organisational and health reform matters to achieve the government's objective of an equitable and sustainable healthcare financing system in support of universal access.
- To co-ordinate the review, formulation, implementation, performance monitoring and evaluation of the Strategic, Annual Performance and Operational Plans.
- To analyse developments and trends in the medical industry and advise the Registrar and Council on the appropriate responses through the use of appropriate tools.
- To facilitate engagements between the CMS and National Department of Health, Treasury and other key stakeholders
- To assume the responsibility for the preparation of key policy and technical documents for the engagements between the CMS and key stakeholders.
- To represent the CMS in key stakeholder events as delegated by the Registrar.
- To co-ordinate all efforts aimed at ensuring that the CMS is compliant with all the relevant legislation.
- To develop and maintain the CMS Enterprise Risk Management and Compliance Frameworks. Identify and evaluate the risks to the organisation's people, property, finances, and image and implement measures to control and mitigate risks in consultation with the Council through the office of the Registrar.
- To review and implement the Council's Ethics Policy in developing an ethical leadership culture within the CMS.
- To co-ordinate the CMS Audit function (Internal and External).

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 15: Programme 2 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Programme 2: Strategy, Performance and Risk							
Outcome 4: To be a more effective and efficient organisation							
Output 16: Ensure that strategic projects are scoped, and project plans are in place.	**Output Indicator 16.1:** Development and maintenance of a Strategic Projects Register by 31st March each year	1	1	1	Not Applicable	None	Requests for strategic projects were not received during the period under review.
	Output Indicator 16.2: Scope and develop plans for strategic projects	88.88%	No requests for new strategic projects were received for the period under review.	80%	Not Applicable	None	Requests for strategic projects were not received during the period under review.
Output 17: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.	**Output Indicator 17.1:** Produce Quarterly Performance Information report that is reliable, accurate and complete, at the time of submission to the Executive Authority by the end of the month following the quarter	4	4	4	4	None	Not Applicable

LINKING PERFORMANCE WITH BUDGETS

Table 16: Programme 2 - Linking performance with budget

Strategy, Performance and Risk	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Subscriptions	-	-	-	-	3	(3)
	(0)	**-**	**(0)**	**(0)**	**3**	**(3)**
Audit remuneration						
External audit	948	943	5	1 000	914	86
Internal audit	1 362	600	762	1 699	1 313	386
	2 310	**1 543**	**767**	**2 699**	**2 227**	**472**
Operating expenses						
Travel and subsistence	-	-	-	22	-	22
Venue and catering	-	-	-	40	-	40
Printing and publication	-	-	-	100	-	100
	-		**-**	**162**	**-**	**162**
TOTAL	**2 310**	**1 543**	**767**	**2 861**	**2 230**	**631**

During the period under review, the allocated budget was utilised to effectively support the coordination and implementation of policy development, and stakeholder engagements. Resources were directed towards analytical activities, the preparation of key policy and technical documents, and ensuring compliance with relevant legislation. The budget also facilitated risk management initiatives, audit coordination, and the promotion of ethical leadership within the CMS. Through prudent financial management, the programme successfully enabled the CMS to meet its strategic objectives while maintaining sound governance and regulatory oversight.

Strategy to overcome areas of underperformance

There were no areas of underperformance for this sub-programme. All output indicator targets were achieved.

PROGRAMME 3: REGULATION

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 (131 of 1998), including whether applicants are fit and proper, have the necessary resources, skills, capacity and infrastructure and are financially sound.
- To serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. The Programme analyses and approves all scheme rules to ensure consistency with the MSA. This ensures that the beneficiaries have access to affordable and appropriate quality health care. By doing this, we help the CMS ensure that the rules of medical schemes are fair to beneficiaries and are consistent with the MSA.
- Serve members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act.
- To monitor and regulate the overall financial performance of medical schemes in line with the financial requirements of the MSA, through the analysis of financial information.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 17: Programme 3 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Programme 3: Regulation							
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations.							
Output 18: Accredit regulated entities based on their compliance with the requirements for accreditation to provide accredited services and monitor legal compliance throughout the period of accreditation.	**Output Indicator 18.1:** Percentage of broker and broker organisation applications accredited within 30 working days per quarter on receipt of complete information	86.5%	88.39%	80%	94.1% (4456/4734)	14.1%	The unit received fewer incomplete applications as a result of improved internal processes and streamlined workflows, which enabled the delivery of outputs with fewer resources.
	Output Indicator 18.2: Percentage of managed care organisation and schemes providing own managed care services' applications analysis completed within three months of receipt of complete information	100%	100%	100%	100% (25/25)	None	Not Applicable
	Output Indicator 18.3: Percentage of administrators and self-administered schemes' applications analysis completed within three months of receipt of complete information	100%	100%	100%	100% (20/20)	None	Not Applicable

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Programme 3: Regulation							
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations.							
Output 19: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (131 of 1998).	**Output Indicator 19.1:** Percentage of interim rule amendments processed within 30 working days of receipt of all information	82.2%	70.4%	80%	85.7% (48/56)	5.7%	The sub-programme achieved its target by efficiently managing processes.
	Output Indicator 19.2: Percentage of annual rule amendments processed before 31st December of each year	97.1%	100%	90%	100% (68/68)	10%	The sub-programme achieved its target by efficiently managing processes.
Output 20: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, (131 of 1998) and all other related laws.	**Output Indicator 20.1:** Number of draft routine inspection reports issued annually	10	10	10	10	None	Not Applicable
Output 21: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act (131 of 1998) and all other related laws.	**Output Indicator 21.1:** Percentage of commissioned inspections reports finalised within 12 months from the date the appointment letter was signed	100%	0	60%	100% (3/3)	40%	Activities were completed ahead of schedule due to effective management and consistent effort.
Output 22: Ensure enforcement action is undertaken against regulated entities.	**Output Indicator 22.1:** Percentage of enforcement actions undertaken during the period	94%	93%	70%	92% (23/25)	22%	Activities were completed ahead of schedule due to effective management and consistent effort.
Output 23: Strengthen and monitor governance systems of medical schemes and other regulated entities.	**Output Indicator 23.1:** Percentage of governance interventions implemented during the period	100%	97%	70%	96% (26/27)	26%	Activities were completed ahead of schedule due to effective management and consistent effort.
	Output Indicator 23.2: Number of scheme member meetings attended	52	40	44	46	2	Two additional meetings were attended due to other governance action requirements.
Output 24: Monitor and regulate the financial soundness of medical schemes.	**Output Indicator 24.1:** Percentage of business plan decisions processed in respect of Regulation 29	100%	100%	100%	100% (3/3)	None	Not Applicable
	Output Indicator 24.2: Number of financial sections prepared for the Annual Report by 30th September each year	1	1	1	1	None	Not Applicable

LINKING PERFORMANCE WITH BUDGETS

Table 18: Programme 3 - Linking performance with budget

Regulation	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Printing and stationery	58	31	27	73	34	39
Subscriptions	135	94	41	131	61	70
	193	**125**	**68**	**204**	**95**	**109**
Operating expenses						
Consulting	-	-	-	54	-	54
Inspection costs	900	523	377	1 400	515	885
Travel and subsistence	499	317	182	454	535	(81)
Venue and catering	131	76	55	44	6	38
	1 530	**916**	**614**	**1 952**	**1 056**	**896**
Staff costs						
Salaries	46 870	47 555	(685)	43 538	42 960	578
	46 870	**47 555**	**(685)**	**43 538**	**42 960**	**578**
TOTAL	**48 593**	**48 597**	**(4)**	**45 694**	**44 111**	**1 583**

During the period under review, the allocated budget was effectively utilised to facilitate the accreditation of brokers, broker organisations, administrators, and managed care organisations in accordance with the requirements of the Medical Schemes Act (131 of 1998). This included rigorous assessments to ensure that applicants were fit and proper, possessed the necessary resources, skills, capacity, infrastructure, and demonstrated financial soundness.

The budget further supported the review and approval of medical schemes' contribution changes and benefit offerings, thereby safeguarding beneficiaries' access to affordable and quality healthcare. Additionally, resources were allocated to enforce compliance with the Medical Schemes Act through appropriate regulatory actions and to monitor the financial performance of medical schemes by analysing submitted financial information in line with statutory obligations.

Strategy to overcome areas of underperformance

There were no areas of underperformance for this sub-programme. All output indicator targets were achieved.

PROGRAMME 4: POLICY, 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, the programme helps the CMS to contribute to the development of policy that enhances the protection of the interests of beneficiaries and members of the public. The Unit also undertakes strategic research that enables the CMS to advise the NDoH on policy initiatives. It also provides a mechanism for the CMS to provide support to the NDoH on key policy reforms such as the NHI and HMI.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 19: Programme 4 - Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Programme 4: Policy, Research and Monitoring							
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 25: Conduct research to inform appropriate national health policy interventions.	**Output Indicator 25.1:** Number of research projects and support projects published in support of the National Health Policy	17	17	12	16	4	The planned projects for the year were 12, but a total of 16 were achieved, including 4 additional projects completed in response to ad hoc requests.
Output 26: Monitoring trends to improve regulatory policy and practice.	**Output Indicator 26.1:** Non-financial report submitted for inclusion in the annual report by 30th September each year	1	1	1	1	None	Not Applicable
Outcome 1: To promote the improvement of quality and the reduction of costs in the private healthcare sector							
Output indicator 27: Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of benefits and entitlements.	**Output Indicator 27.1:** The number of draft benefit definition guidelines developed for publication	10	5	10	10	None	Not Applicable
	Output Indicator 27.2: Develop preventative and primary healthcare package to incorporate into the PMBs	Work in progress	The primary health cost and affordability framework was completed	1	1	None	Not Applicable

LINKING PERFORMANCE WITH BUDGETS

Table 20: Programme 4 - Linking performance with budget

Policy, Research & Monitoring	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Printing and stationery	4	1	3	5	4	1
Subscriptions	17	8	9	18	10	8
	21	**9**	**12**	**23**	**14**	**9**
Operating expenses						
Consulting	2 020	1 787	233	3 009	1 501	1 508
Travel and subsistence	52	45	7	17	37	(20)
Venue and catering	4	3	1	4	4	0
	2 076	**1 835**	**241**	**3 030**	**1 542**	**1 488**
Staff costs						
Salaries	13 595	13 848	(253)	12 507	12 270	237
	13 595	**13 848**	**(253)**	**12 507**	**12 270**	**237**
TOTAL	**15 692**	**15 692**	**(0)**	**15 560**	**13 826**	**1 734**

The allocated budgets enabled the unit to advance its policy research agenda and meet its strategic targets in line with Section 7 of the Medical Schemes Act, particularly protecting beneficiaries' interests (7a), coordinating scheme functions with national health policy (7b), recommending quality and outcomes measures (7c), collecting and sharing private healthcare data (7e), advising the Minister on medical scheme matters (7g), and performing other mandated functions (7h). Specifically, the budget has supported progress on the review of PMBs, development and costing of the Primary Healthcare (PHC) package, formulation of a base benefit package, and the standardisation of benefit options, all of which are critical to promoting affordability, comparability, and equity within the medical scheme's environment. Continued financial support will maintain momentum toward evidence-based reforms and regulatory innovations.

Strategy to overcome areas of underperformance

There were no areas of underperformance for this sub-programme. All output indicator targets were achieved.

PROGRAMME 5: MEMBER PROTECTION

The purpose of the Programme is to:

- Provide customer service and training in support of the CMS stakeholder engagement initiatives.
- 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.
- Provide support to the office on clinical matters so that good quality medical scheme cover is maximised and that regulated entities are properly governed through prospective and retrospective regulation.

OUTCOMES, OUTPUTS, OUTPUT INDICATORS, TARGETS AND ACTUAL ACHIEVEMENTS

Table 21: Programme 5 - Key Performance Indicators, Planned Targets, and Actual Achievements

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Programme 5: Member Protection							
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations.							
Output 28: To enhance knowledge and skills among stakeholders to create an in-depth understanding of governance and compliance with the Medical Schemes Act through education and training interventions.	**Output Indicator 28.1:** Number of stakeholder education and training sessions	66	76	55	84	29	The target was exceeded by 29 activities because of collaboration with other public entities and members of the Consumer Protection Forum (CPF), which led to greater reach and visibility.
Output 29: To provide customer care interventions by rendering effective and efficient services.	**Output Indicator 29.1:** Percentage of customer care interventions resulting from calls, e-mailed queries and walk-in consultations handled by the customer care centre	100%	100%	90%	89% (24801/27836)	-1%	Not achieved due to insufficient human resources.
Output 30: Resolve complaints with the aim of protecting beneficiaries of medical schemes.	**Output Indicator 30.1:** Percentage of complaints older than 120 calendar days adjudicated during the reporting period in accordance with complaints standard operating procedures	84.3%	85.5%	75%	88.95% (169/190)	13.95%	The target was exceeded due to the ongoing monitoring of ageing complaints, and consistent team effort which involved willingness to work voluntary extra hours and attendance of weekly meetings to review actual performance against targets.

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Programme 5: Member Protection							
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations.							
	Output Indicator 30.2: Percentage of category 2 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures	New Indicator	85.9%	75%	82.83% (815/984)	7.83%	The target was exceeded due to improved investigation planning and weekly performance review meetings aimed at early identification and resolving of performance challenges.
	Output Indicator 30.3: Percentage of category 1 complaints adjudicated within 60 calendar days and in accordance with complaints standard operating procedures	New Indicator	97.5%	75%	88.48% (668/755)	13.48%	The target was exceeded due to the continued implementation of the early resolution strategy, which includes reviews of complaint responses immediately upon receipt, flagging all settled and non-complex complaints for immediate resolution or within the month of receipt.

Output	Output Indicator	Audited Actual Performance 2022/23	Audited Actual Performance 2023/24	Planned Annual Target 2024/25	Actual Achievement 2024/25	Deviation from planned target to Actual Achievement 2024/25	Reasons for deviations
Programme 5: Member Protection							
Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector							
Output 31: Formulate CMScripts published.	**Output Indicator 31.1:** The number of CMScripts published	New indicator	10	10	12	2	The target was exceeded by 2 (two) additional CMScripts, reflecting the team's commitment to proactive content planning and responsiveness to emerging priority topics.
Output 32: Provide clinical opinions to resolve complaints and enquiries.	**Output Indicator 32.1:** Percentage of category 1 clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication sub-programme	99.62%	99.53%	90%	99.55% (444/446)	9.55%	The target was exceeded by 9.55% due to self-allocation of clinical opinions from oldest to newest, with urgent and returned cases prioritised daily. Weekly reports identified older outstanding cases, enabling proactive workload management. Analysts collaborated to cover for unavailable team members, through open communication of planned leave days. Emergency unplanned leave of absence gets shared with the entire team, so that cases that had been allocated to a team member who is absent get re-allocated and are taken over by the next available analyst to prevent delays.
	Output Indicator 32.2: Percentage of category 2 clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication sub-programme	100%	100%	95%	100% (70/70)	5%	The target was exceeded due to structured case management, prioritisation of urgent and returned cases, and weekly reviews to identify pending cases for prioritisation. Urgent completions trigger automated e-mails to the Medical Advisor to expedite approvals. The Senior Clinical Analyst conducts daily workflow checks to identify bottlenecks, while peer support is facilitated through ongoing information sharing to ensure an uninterrupted workflow.
	Output Indicator 32.3: Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication sub-programme	100%	100%	98%	100% (18/18)	2%	The target was exceeded due to structured case management, the prioritisation of urgent and returned cases, and weekly reviews to identify and prioritise pending cases. Peer support, facilitated through open communication of planned and unplanned leave, ensured that cases assigned to absent team members were promptly reallocated to available analysts, maintaining an uninterrupted workflow.
	Output Indicator 32.4: Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days	100%	100%	98%	100% (952/952)	2%	The target was exceeded by 2% due to maintaining self-allocation of clinical opinions from oldest to newest, with urgent and returned cases prioritised daily as well as peer readiness to take cases over from team members with emergencies.

LINKING PERFORMANCE WITH BUDGETS

Table 22: Programme 5 - Linking performance with budget

Member Protection	2024/25			2023/24		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	(Over)/ Under Expenditure
	R '000	R '000	R '000	R '000	R '000	R '000
Administrative expenses						
Printing and stationery	15	16	(1)	17	14	3
Subscriptions	48	23	25	39	13	26
	63	**39**	**24**	**56**	**26**	**30**
Operating expenses						
Consulting	34	8	26	194	67	127
Postage and courier	-	-	-	50	-	50
Travel and subsistence	241	222	19	143	144	(1)
Venue and catering	90	35	55	58	9	49
	365	**265**	**100**	**445**	**220**	**225**
Staff costs						
Salaries	30 169	31 797	(1 628)	28 630	26 446	2 184
	30 169	**31 797**	**(1 628)**	**28 630**	**26 446**	**2 184**
TOTAL	**30 597**	**32 101**	**(1 504)**	**29 131**	**26 692**	**2 439**

The allocated budget contributed to the achievement of the Key Performance Indicators (KPIs) by enhancing knowledge and skills among stakeholders to promote an in-depth understanding of governance and compliance with the Medical Schemes Act through targeted education and training interventions, stakeholder engagements, and awareness campaigns, to educate members about their rights and responsibilities. The Education and Training Unit collaborated with other consumer protection organisations and internal units in its quest to leverage resources and expertise, ensuring more efficient use of the budget despite resource constraints.

In addition, the budget supported the effective streamlining and review of the complaints resolution processes to protect the rights and interests of medical scheme beneficiaries. This includes the provision of accurate and consistent clinical opinions to assist in complaint adjudication, the development and refinement of CMScripts to ensure uniform interpretation of entitlements, and the strengthening of internal processes for monitoring and quality assurance.

Importantly, the budget allocation enabled the Customer Care Centre to effectively manage and respond to high volumes of queries from members of the public and stakeholders, missing the target by only one percentage point. This function is critical for the provision of front-line support, ensuring access to information, and reinforcing stakeholder confidence in the regulatory framework. New resources for the call centre and complaints adjudication will be used to enhance the responsiveness, efficiency, and professionalism of customer services, which serve as a direct channel for education, complaint resolution, and as a stakeholder engagement gateway in general.

Strategy to overcome areas of underperformance

The organisation is in the process of supplementing the Complaints Adjudication and Customer Care units with interns in the new financial year to provide administrative support and assist with file recovery. This will also ensure that the customer care unit aligns with call centre industry benchmarking standards, following the adoption of a new system that reports on lost calls.

REVENUE COLLECTION

Revenue Collection

Table 23: Revenue Collection

Sources of Revenue	2024/25			2023/24		
	Estimate	Actual Amount Collected	Over/ (Under) Collection	Estimate	Actual Amount Collected	Over/ (Under) Collection
	R '000	R '000	R '000	R '000	R '000	R '000
Accreditation fees	8 998	7 772	(1 226)	7 094	7 810	716
Investigation fees	-	227	227	-	821	821
Government transfers: Department of Health	6 151	6 151	-	6 537	6 537	-
Surplus funds	27 820	-	(27 820)	23 636	-	(23 636)
Legal fees recovered	-	1 122	1 122	-	83	83
Levies income	201 650	201 641	(9)	190 571	190 575	4
Mandatory transfer: Department of Higher Education and Training	97	256	159	287	327	40
Registration fees	467	498	31	423	464	41
Appeal fees	-	-	-	-	23	23
Penalties	-	-	-	-	76	76
Sundry income	5 069	1 069	(4 000)	302	748	446
Interest received	8 892	8 187	(705)	6 849	8 566	1 717
TOTAL	**259 144**	**226 923**	**(32 221)**	**235 699**	**216 030**	**(19 669)**

CAPITAL INVESTMENT

During the period under review, the CMS acquired new assets with a cost price of R5 041 000, while computer equipment, furniture and other fixed assets costing R8 132 000, R123 000 and R12 000 respectively were disposed. The net book value of the disposed computer equipment and other fixed assets was zero (0) and R11 000 for furniture and fixtures.

- Property, plant, and equipment (PPE) acquisitions amounted to R5 041 000.
- Property, plant, and equipment (PPE) disposals with a cost of R8 267 000.

CAPITAL ASSETS

The CMS owned capital assets to the total carrying value of R11 511 000 as of 31 March 2025.

Table 24: Capital Assets

	Property, Plant and Equipment	Intangible Assets
Total cost	40 535 000	3 888 000
Accumulated Depreciation	(30 207 000)	(2 705 000)
Carrying value	10 328 000	1 183 000

C

GOVERNANCE

GOVERNANCE OF THE CMS

The Council for Medical Schemes (CMS) was established as a regulatory body for the medical schemes industry in terms of the Medical Schemes Act (131 of 1998) (MSA). As a section 3A entity in terms of the Public Finance Management Act (1 of 1999), the Council submits its quarterly and Annual Financial Statements as well as performance information reports to the Executive Authorities of Health and National Treasury. In addition to complying with the full suite of applicable legislation, the Council voluntarily adheres to the spirit of the King IV Code of Good Corporate Governance. Furthermore, the Council regulates its own conduct through an appropriately approved charter.

Portfolio Committees

The Portfolio Committee on Health is responsible for legislative oversight of the Council. Accordingly, the Council's Strategic Plan and Annual Performance Plans must be presented to the Portfolio Committee for approval before implementation. The Council duly complied with the prescripts and submitted its Annual Performance Plan for 2024/25 to the Committee for approval in January 2024. The Council also had the opportunity to present its statutory and strategic planning documents, including the Strategic Plan and Annual Performance Plan, before the new administration in September 2024.

Executive Authority

In terms of the Public Finance Management Act (1 of 1999), the Council is required to submit quarterly reports to the Executive Authority. These reports range from financial management, performance information, strategic risk management, and compliance.

All reports were submitted timeously during the reporting period as follows:

- Quarter 1 – 31 July 2024
- Quarter 2 – 31 October 2024
- Quarter 3 – 31 January 2025
- Quarter 4 – 30 April 2025

There were no issues of concern raised by the Executive Authority regarding the reports submitted by the Council.

The Council

The Minister of Health is responsible for the appointment of the members of the Council. In terms of the MSA, up to 15 members may be appointed to the Council. These members are required to have a broad range of skills, including economics, medicine, law, etc. During the reporting period, the Council had 15 members.

The duties of the Council as the governing body are laid out in the MSA as follows:

- Protect the beneficiaries of medical schemes.
- Control and coordinate functioning of medical schemes.
- Advise the Minister of Health on the quality and outcomes of relevant health services provided by medical schemes.
- Investigate complaints and resolve disputes.
- Collect and disseminate information about the private healthcare industry.

In addition to its statutory duties, the Council also fulfils its traditional governance oversight role by:

- Evaluating and approving the five-year Strategic Plan.
- Evaluating and approving the Annual Performance Plan.
- Evaluating and approving the Annual Financial Statements and Annual Performance Information Report.
- Exercising oversight over the executive management's performance.

The Council exercises its functions in terms of the Medical Schemes Act, Public Finance Management Act, Treasury regulations, other applicable laws, and its charter and code of conduct. Its work is carried out by various committees that report directly to it. The Chief Executive and Registrar accounts to the Council for their duties.

Composition of the Council

Table 25: Composition of Council

Name	Designation (in terms of the Public Entity Board structure)	Date appointed	Date ended	Qualifications	Area of Expertise	Board Directorships (List the entities)	Other Committees or Task Teams (e.g.: Audit committee / Ministerial task team)	No. of Meetings attended
Dr Thandi Mabeba	Chairperson of Council	15/11/23	14/11/26	Bachelor of Medicine and Bachelor of Surgery (MBChB); Bachelor of Laws (LLB); Master of Philosophy in Medical Law and Ethics (LLM); Doctor of Laws (LLD) (ug); Post Graduate Diploma (PGDip) in Health Economics; Certificate in Corporate Governance; South African Medico-Legal Association Certificate (SAMLA).	Medicine Legal		EXCO Human Resource Committee Social & Ethics Committee Appeals Committee Nominations Committee	84
Dr Honours Mukhari	Deputy Chairperson of Council	15/11/23	14/11/26	Bachelor of Medicine and Bachelor of Surgery (MBChB); Bachelor of Dental Therapy (BDent Ther).	Medicine		Appeals Committee EXCO Social & Ethics Committee Steering Committee	50
Mr Naheem Raheman	Deputy Chairperson of Council	15/11/23	Resigned 23/7/24	Master of Laws (LLM); Bachelor of Laws (LLB); Bachelor of Arts in Law (BA Law).	Legal		EXCO	4
Dr Sugendra Naidoo	Council Member	15/11/23	14/11/26	Bachelor of Medicine and Bachelor of Surgery (MBChB); Master of Business Administration (MBA).	Medicine		EXCO ICT Governance Committee Appeals Committee	83
Mr Mabalane Mfundisi	Council Member	15/11/23	14/11/26	Certificate in Principles of Business Management; Certificate in Basic Journalism.	Corporate Governance		Human Resource Committee Nominations Committee	30
Dr Xolani Ngobese	Council Member	15/11/23	14/11/26	PhD in Business Administration; Master of Business Administration (MBA); Advanced Management Development Programme; Post Graduate Diploma (PGDip) in Supply Chain Management; National Diploma in Tourism Management.	Corporate Governance		ARC Appeals Committee Human Resource Committee	89

Name	Designation (in terms of the Public Entity Board structure)	Date appointed	Date ended	Qualifications	Area of Expertise	Board Directorships (List the entities)	Other Committees or Task Teams (e.g.: Audit committee / Ministerial task team)	No. of Meetings attended
Dr Nombeko Mbava	Council Member	15/11/23	14/11/26	PhD in Public Management and Development; Master of Business Administration (MBA); Bachelor of Arts in Economics (BA Economics).	Corporate Governance Public Sector Management and Development		Nominations Committee	6
Mr Moremi Nkosi	Council Member	15/11/23	14/11/26	Master of Public Health (MPH) in Health Economics; Post Graduate Diploma (PGDip) in Health Management; Bachelor of Arts (BA) in Economics and Development Studies.	Health Policy Public Health		EXCO Social & Ethics Committee	25
Dr Peter Masegare	Council Member	15/11/23	Resigned 7/4/24	PhD in Corporate Governance and Auditing; Master of Business Administration (MBA) in Accounting and Auditing; Associates Information Systems Auditor (AISA); Diploma in Investment Analysis and Portfolio Management; Diploma in Cost and Management Accounting; Diploma in Information Systems Audit (IT Audit).	Accounting Auditing Corporate Governance		ARC ICT Governance Committee	2
Mr AbdulQadir Chogle	Council Member	15/11/23	14/11/26	Chartered Accountant (CA(SA)); Postgraduate Diploma (PGDip) in Accounting; Bachelor of Commerce (BCom).	Financial Management		ARC ICT Governance Committee	37
Mr Tjaart Esterhuyse	Council Member	15/11/23	14/11/26	Fellow of the Actuarial Society of South Africa (FASSA); Honours degree in Mathematical Statistics (with specialisation and academic achievement in mathematical statistics); Bachelor of Commerce (BCom).	Actuary		ICT Governance Committee Social & Ethics Committee	25

Name	Designation (in terms of the Public Entity Board structure)	Date appointed	Date ended	Qualifications	Area of Expertise	Board Directorships (List the entities)	Other Committees or Task Teams (e.g.: Audit committee / Ministerial task team)	No. of Meetings attended
Dr Karmani Chetty	Council Member	15/11/23	14/11/26	Bachelor of Medicine and Bachelor of Surgery (MBChB); Master of Science in Urban and Regional Planning (MSc URP); Fellow of the Faculty of Public Health (FFPH).	Medicine Governance Strategic Management Public Health		Appeals Committee Human Resource Committee	65
Ms Penelope Beck	Council Member	15/11/23	14/11/26	Bachelor of Laws (LLB); Bachelor of Arts in Law (BA Law).	Legal Corporate Governance		EXCO Appeals Committee Steering Committee	73
Ms Matshego Ramagaga	Council Member	15/11/23	14/11/26	Master of Laws (LLM) in Commercial Law; Diploma in Trial Advocacy Skills; Certificate in Advanced International Trade Law; Certificate in Forensic Accounting and Fraud Examination; Bachelor of Procurationis (BProc); Diploma in Insolvency.	Legal Corporate Governance		Appeals Committee	30
Mr Siyabonga Jikwana	Council Member	15/11/23	14/11/26	Master's Degree in Public Health; Master of Laws (LLM) in International Business; Honours Degree in Industrial Psychology; Post Graduate Diploma (PGDip) in HIV/AIDS Financing; Bachelor of Arts (BA) in Social Sciences.	Public Health Specialist Corporate Governance		Human Resource Committee	28
Mr Leon Langalibalele	Council Member	18/06/24	14/11/26	Bachelor of Commerce Honours (BCom Hons) in Accounting, Auditing and Taxation; Degree in Management Accounting; Bachelor of Commerce (BCom) in Accounting, Auditing and Taxation.	Financial Management Corporate Governance		ARC ICT Governance Committee Steering Committee	34
Adv. Tlhoriso Maphike	Council Member	09/12/24	14/11/26	Master's Degree in Labour Law and Management of Employment Relations; Advanced Diploma in Labour Law; Bachelor of Laws (LLB); Bachelor of Administration in Public Administration and Industrial Psychology.	Legal		Steering Committee	6

Council Committees

Table 26: Council Committees

Committee	No. of meetings held	No. of members	Name of members
Full Council	19	15	All Council members
Executive Committee (EXCO)	13	5	Dr Thandi Mabeba (Chairperson) Mr Moremi Nkosi Dr Honours Mukhari Dr Sugendra Naidoo Ms Penelope Beck Mr Naheem Raheman (Resigned)
Human Resource Committee (HR)	11	5	Dr Thandi Mabeba Mr Mabalane Mfundisi (Chairperson) Dr Karmani Chetty Mr Siyabonga Jikwana Dr Xolani Ngobese
Social and Ethics Committee (SE)	3	5	Mr Tjaart Esterhuyse Ms Penelope Beck Mr Moremi Nkosi Dr Thandi Mabeba Dr Honours Mukhari (Chairperson)
Information Communications and Technology Governance Committee	8	4	Dr Sugendra Naidoo (Chairperson) Mr Tjaart Esterhuyse Mr AbdulQadir Chogle Mr Leon Langalibalele Dr Peter Masegare (Resigned)
Appeals Committee	45	7	Dr Karmani Chetty Dr Sugendra Naidoo Ms Penelope Beck Dr Thandi Mabeba Dr Xolani Ngobese (Chairperson) Ms Matshego Ramagaga Dr Honours Mukhari
Nominations Committee (NomCom)	0	3	Dr Thandi Mabeba (Chairperson) Mr Mabalane Mfundisi Dr Nombeko Mbava
Audit and Risk Committee (ARC)	14	5	Dr Masibulele Phesa (Chairperson) Mr Leon Langalibalele Ms Babalwa Qwesha Dr Xolani Ngobese Mr AbdulQadir Chogle Mr John Raphela (Contract ended) Ms Dineo Thabede (Resigned) Dr Peter Masegare (Resigned)
Steering Committee	5	4	Dr Honours Mukhari (Chairperson) Mr Leon Langalibalele Ms Penelope Beck Adv. Tlhoriso Maphike

Remuneration of Council members

Table 27: Remuneration of Council members

Council Members' Remuneration	2024/25 R 000	2023/24 R 000
Dr Thandi Mabeba (Chairperson)	1 375	709
Dr Honours Mukhari (Deputy Chairperson)	473	341
Mr Naheem Raheman (Previous Deputy Chairperson)	11	181
Ms Penelope Anne Beck	793	85
Dr Karmani Chetty*	722	-
Mr AbdulQadir Chogle	297	65
Mr Tjaart Esterhuyse	126	43
Ms Matshego Ramagaga	-	-
Mr Mabalane Mfundisi	312	361
Dr Sugendra Naidoo	825	594
Dr Xolani Ngobese	929	529
Mr Leon Langalibalele	197	-
Total	**6 060**	**4 433**

**Public Official*

Note:

- The remuneration figures include Mr Naheem Raheman, former Deputy Chairperson, whose second term commenced on 15 November 2023. He resigned on 23 July 2024.
- The following non-executive members are not reflected in the table above, as they are public officials and do not receive remuneration: Mr Siyabonga Jikwana, Dr Nombeko Mbava, and Mr Moremi Nkosi. Their appointments took effect on 15 November 2023.
- Dr Karmani Chetty, previously a public official, became eligible for remuneration from April 2024.
- Advocate Tlhoriso Maphike, appointed on 9 December 2024, is also not reflected in the figures above.

Remuneration of Audit and Risk Committee members

Table 28: Remuneration of Audit and Risk Committee members

Audit and Risk Committee Members' Remuneration	2024/25 R 000	2023/24 R 000
Dr Masibulele Phesa	269	171
Mr John Raphela	56	93
Ms Babalwa Qwesha	45	-
Ms Dineo Thabede	-	54
Total	**370**	**318**

Risk Management

The CMS has a risk management policy that is reviewed annually by management and the Audit and Risk Committee (ARC) of the Council. The CMS conducts risk maturity assessments every two years with the help of an external risk management consultant, in compliance with the Enterprise Risk Management Policy and Framework. The period under review is when the risk maturity assessment is performed.

The ARC is established and continues to operate. The Office of the CEO reports to the ARC quarterly on the entity's strategic risks, its existing controls, control improvement action plans, and the progress made thereto. The ARC is continuously advised on the risk processes within the CMS.

With the aid of a risk management consultant, Council undertook a risk rating exercise during the strategic review sessions held and adjusted the CMS strategic inherent and residual risks accordingly. This exercise has shown an improvement in CMS' risk management, as the majority of the 19 strategic risks had a declined residual risk rating, thereby reflecting adequate control effectiveness.

Internal Control Unit

The CMS service delivery model allows for outsourcing the internal audit function (under which the internal control evaluation and review function falls). This approach ensures access to independent expertise, enhanced objectivity, and scalability of resources to meet evolving organisational needs. The current service provider is Lunika Inc., effective 1 April 2021, until 31 March 2024.

Lunika Inc. was initially appointed as the outsourced internal audit service provider for a three-year term. Following a competitive service provider selection process, conducted in accordance with the CMS' procurement policies and governance requirements, Lunika Inc. was reappointed for a further three-year term, effective from 1 April 2025.

In consultation with the ARC, the outsourced internal audit service provider prepared a three-year rolling Strategic Internal Audit Plan for the CMS. This strategic plan was informed by the provider's independent assessment of key risk areas facing the CMS, considering:

- The CMS' current operational landscape;
- Activities proposed in the CMS' Strategic Plan; and
- The overarching Risk Management Strategy.

Based on this strategic view, the internal audit service provider also developed an Annual Internal Audit Plan. This annual plan outlines the detailed scope, estimated cost, and projected timelines for each audit engagement scheduled for the year. The plan is subject to review and approval by the ARC.

As part of its mandate, the service provider delivers audit reports to the ARC after each engagement. These reports detail the outcomes of the audits, key findings, recommendations, and management responses. The reports also provide updates on the provider's performance against the approved Annual Audit Plan, ensuring transparency and enabling the ARC to exercise its oversight responsibilities effectively.

The scope of the Internal Audit for the period under review is outlined below.

- Conducting risk-based internal audits in accordance with the approved Internal Audit Plan;
- Providing assurance and advisory services to management and the Audit Committee;
- Reporting on control weaknesses, opportunities for improvement, and areas of non-compliance;
- Supporting management in the strengthening of the CMS' internal control environment;
- Undertaking probity reviews of procurement processes, particularly those related to tenders; and
- Evaluating operating efficiency.

The scope of the Internal Audit for the period under review is outlined below.

Internal Audit and Audit Committees

The objective of the internal audit is to provide independent, objective assurance and consulting services designed to add value and improve the CMS' operations. The mission of internal audit is to enhance and protect organisational value by providing risk-based and objective assurance, advice, and insight. Internal audit helps the CMS accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control, and governance processes.

In carrying out audits, the scope of work of Internal Audit is to determine whether the CMS' network of risk management, control systems, and governance processes, as designed and represented by management, is adequate and functioning in an effective manner to provide reasonable assurance that:

- Significant risks relating to the achievement of the CMS' strategic objectives are appropriately identified and managed. Interaction with the various governance groups within the organisation occurs as needed;
- Significant financial, operational, managerial, performance, and information technology information is accurate, reliable, and timely;
- The actions of CMS employees follow the CMS' policies, procedures, and applicable laws, regulations, and governance standards;
- Resources and assets are acquired and disposed of economically, used efficiently, and protected adequately;
- The results of operations or programmes are consistent with the established goals and objectives of the CMS and are carried out effectively and efficiently;
- Established processes and systems enable compliance with the policies, procedures, laws, and regulations that could significantly impact the CMS;
- Information and the means used to identify, measure, analyse, classify, and report such information are reliable and have integrity; and
- Assets, revenue, income, and interests of the CMS are accounted for and safeguarded against fraud, corruption, losses of all kinds, wastage, inefficient administration, and any other causes.

To achieve full effectiveness, the scope of the work to be performed by Internal Audit will be based on its assessment of risk (with management input) as approved by the ARC. Audit coverage will be based on a risk basis and any other areas as directed and approved by the ARC.

The primary purpose of the ARC is to assist the Accounting Authority in fulfilling its oversight responsibility, which includes responsibilities regarding the safeguarding of assets, operating effective systems of internal control, and preparing Annual Financial Statements as required by PFMA, Treasury Regulations, and as per the provisions of King Report IV on Corporate Governance, by reviewing:

- The financial reports and other information provided by the Accounting Authority to any government body, other stakeholders, or the public;
- The system of internal control (financial, operational, and compliance) that the Accounting Authority has established; and
- The Accounting Authority's auditing, accounting and financial reporting processes.

Consistent with its functions, the ARC should encourage continuous improvement and should foster adherence to the CMS' accounting policies, procedures, and practices at all levels. The ARC's primary objectives are to:

- Serve as an independent and objective committee to monitor and strengthen the objectivity and credibility of the CMS' financial reporting processes and internal control systems; and
- Review and appraise the audit efforts of the Auditor-General of South Africa and the Accounting Authority's Internal Audit function.

The table below discloses relevant information on the audit committee members.

Table 29: Audit and Risk Committee members

Name	Qualifications	Internal or external	Date appointed	Date ended	No. of meetings attended
Mr John Raphela	Master's Degree in Information Technology (MIT); Master of Business Administration (MBA); Bachelor of Science Honours in Computer Science; PRINCE2 Project Management Certification; ITIL Foundation Certification.	External	27/1/22	27/1/25	8
Dr Xolani Ngobese	PhD in Business Administration; Master of Business Administration (MBA).	External	15/11/23	14/11/26	14
Dr Masibulele Phesa	PhD in Accounting; Master's Degree in Accounting; Postgraduate Diploma (PGDip) in Applied Accounting Science; Postgraduate Diploma (PGDip) in Accounting Preliminary.	External	16/2/23	15/2/26	28
Ms Dineo Thabede	Master of Business Administration (MBA); Bachelor of Accounting Science; Managing Turnaround and Corporate Renewal Certificate; Practical Labour Relations Certificate; Women in Leadership Certificate.	External	16/2/23	Resigned 9/5/24	0
Mr AbdulQadir Chogle	Chartered Accountant (CA(SA)); Postgraduate Diploma (PGDip) in Accounting; Bachelor of Commerce (BCom).	External	15/11/23	14/11/26	14
Dr Peter Masegare	PhD in Corporate Governance and Auditing; Master of Business Administration (MBA) in Accounting and Auditing; Associates Information Systems Auditor (AISA); Diploma in Investment Analysis and Portfolio Management; Diploma in Cost and Management Accounting; Diploma in Information Systems Audit (IT Audit).	External	15/11/23	Resigned 7/5/24	0
Mr Leon Langalibalele	Bachelor of Commerce Honours (BCom Hons) in Accounting, Auditing and Taxation; Degree in Management Accounting; Bachelor of Commerce (BCom) in Accounting, Auditing and Taxation.	External	18/6/24	14/11/26	11
Ms Babalwa Qwesha	Master of Business Administration (MBA); Master of Commerce in Development Finance; Bachelor of Commerce (BCom) in Accounting; Foundation Certificate in Commerce.	External	9/10/24	8/10/27	8

Compliance with laws and regulations

The CMS has developed and implemented a comprehensive Regulatory Compliance Policy and Framework to guide its adherence to key applicable legislative, regulatory, and best practice requirements. This initiative underscores the CMS' continued commitment to upholding high standards of public sector accountability and governance.

The risk of non-compliance is recognised as a critical exposure for the CMS, given its obligation to comply with a wide array of legal and regulatory requirements. In addition to mandatory compliance, the CMS has voluntarily adopted recognised standards of good governance and ethical practice to further strengthen its regulatory posture.

The Regulatory Compliance Assessment is conducted on a continuous basis on key legislation and regulations and serves as an integral part of the organisation's risk management and internal control systems. Compliance findings and trends are reported quarterly to both the ARC and the Accounting Authority, enabling timely oversight and corrective action where necessary.

The Regulatory Compliance Policy was approved by the Accounting Authority in February 2025 and became effective for the financial year under review. Its implementation is a key milestone in institutionalising a culture of compliance and reinforcing the CMS' role as a credible and accountable regulator in the healthcare sector.

Fraud and Corruption

The CMS has adopted a comprehensive Fraud and Corruption Prevention Policy, which incorporates the following key components:

- The Fraud and Corruption Prevention Plan;
- The Fraud and Corruption Response Plan; and
- The CMS Whistle-Blowing Policy.

This integrated approach ensures a proactive and structured response to identify, report, and address fraudulent or corrupt activities. The policy was reviewed and updated to align with the CMS' ethics awareness priorities for the year, reinforcing its commitment to integrity and good governance.

The CMS' anti-fraud efforts are further supported by a whistle-blower hotline, managed independently by an external service provider, BeHonest. This independent mechanism enhances confidentiality, protects whistle-blowers, and encourages the early reporting of unethical conduct.

As a first line of action, employees are encouraged to raise concerns with their immediate manager, the next level of management, or the designated Investigations Committee. However, the chosen reporting channel may vary depending on the seriousness, sensitivity, or nature of the allegation, particularly if the suspected individual holds a senior position or has influence over the normal reporting line.

If an employee is uncomfortable using internal channels for any reason, they are encouraged to report the matter directly to:

- BeHonest, the independent whistle-blower service provider (contact details provided below); or
- The Registrar of the CMS.

This dual-channel reporting system ensures accessibility, confidentiality, and responsiveness in dealing with allegations of fraud and corruption, in line with the CMS' zero-tolerance stance on unethical conduct.

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 dates);
- The reason they are particularly concerned about the situation; and
- The extent to which they have personally witnessed or experienced the problem (provide documented evidence where possible).

The hotline is accessible by a 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 ARC, and Council are the contact persons to receive the whistleblower reports.

Minimising Conflict of Interest

The CMS has implemented a structured and proactive system to manage conflicts of interest among both staff and Council members. As part of this system, all employees and Council members are required to submit annual declarations of interest. These declarations are reviewed and assessed to identify any potential or actual conflicts of interest that may compromise the integrity of CMS operations.

To reinforce this process, the Supply Chain Management (SCM) unit conducts independent verification of entities and individuals conducting business with the CMS through the National Treasury's Central Supplier Database (CSD). This ensures that suppliers and service providers do not

have undisclosed relationships with CMS personnel, thereby reducing the risk of corruption or improper influence in procurement decisions.

In instances where a conflict of interest is identified, members of the relevant bid evaluation or adjudication committees are required to recuse themselves from the procurement process. This measure upholds the principles of transparency, fairness, and accountability, and ensures the integrity of CMS procurement and decision-making processes.

Code of Conduct

The CMS has formally adopted a comprehensive Code of Ethics and Conduct, which remains in full effect as the foundational framework guiding the ethical behaviour of all CMS employees, suppliers, and members of the Accounting Authority. This Code establishes the uniform ethical principles and standards that govern professional conduct, ensuring that all actions and decisions reflect the CMS' core values of integrity, accountability, transparency, and professionalism.

The Code of Ethics and Conduct is periodically reviewed to maintain relevance and effectiveness. The most recent review was conducted in consultation with a broad range of internal stakeholders, including management, staff representatives, and governance bodies. This review process aligns with the Council's annual Ethics Awareness Outlook, which seeks to embed a strong ethical culture throughout the organisation. Concurrently, the CMS continues to implement its Ethics Strategy and Awareness Plan, aimed at enhancing ethical understanding and behaviour at all organisational levels. To facilitate this, all staff members receive a detailed CMS Ethics Booklet, which serves as a practical guide to expected conduct and decision-making in various workplace scenarios.

Framework for Addressing Breaches of the Code of Conduct

The CMS has established a clear and structured disciplinary framework to address breaches of the Code of Ethics and Conduct. The framework distinguishes between less serious and serious offences, ensuring proportionality, fairness, and due process in managing misconduct.

Less Serious Offences

When a breach is deemed to be of a less serious nature, CMS management initiates an informal disciplinary hearing. The following key features apply:

- The process typically involves only the employee concerned and their immediate supervisor or manager.
- The objective is to address the issue swiftly, promote corrective behaviour, and prevent recurrence without the need for formal sanctions.
- Possible outcomes include a verbal warning or a written warning, depending on the severity and circumstances of the breach.
- Documentation of the warning is maintained for reference but is generally less formal than a full disciplinary record.

This informal approach encourages open communication, remediation, and early resolution of minor breaches.

Serious Offences

For breaches classified as serious, the CMS applies a more formal disciplinary process to uphold organisational standards and accountability. This process includes:

- Convening a formal disciplinary hearing, convened by a chairperson appointed by the Registrar.
- Appointment of an initiator who presents the case on behalf of the CMS, ensuring the facts and evidence are clearly articulated.
- The accused employee has the right to be represented by a fellow CMS employee or a recognised shop steward.
- The employee is entitled to:
  - Present their case and provide evidence in their defence;
  - Cross-examine witnesses who testify against them;
  - Make submissions in mitigation before any sanction is imposed.
- Potential sanctions for a guilty verdict include a final written warning, suspension without pay, or dismissal, depending on the gravity of the offence and any mitigating or aggravating factors.

This formal disciplinary procedure is conducted in strict adherence to principles of natural justice, ensuring that the employee receives a fair hearing and that decisions are based on objective assessment of facts.

Governance and Oversight

The disciplinary framework forms a critical component of the CMS' broader governance and ethics programme. The Registrar, supported by the Human Resources and Legal units, oversees the implementation of disciplinary processes to ensure consistency and compliance with labour legislation and CMS policy. Outcomes of disciplinary hearings, particularly those involving serious breaches, are reported to the ARC and the Accounting Authority as part of the organisation's commitment to transparency and accountability.

Continuous Ethics Development

To strengthen and sustain a culture of ethical conduct, the CMS complements its disciplinary framework with a range of preventative and developmental ethics initiatives. These initiatives are designed not only to promote awareness but also to equip employees with the practical tools necessary to recognise, address, and appropriately respond to ethical challenges in the workplace.

As part of these efforts, the CMS provides staff with the CMS Ethics Booklet, which outlines expected standards of conduct, practical guidance on ethical decision-making, and procedures for reporting misconduct. In addition, the CMS regularly facilitates ethics workshops and training sessions, tailored to promote understanding of the Code of Ethics and Conduct and its application to real-world scenarios. These sessions encourage open dialogue, clarify ethical expectations, and support employees in aligning their behaviour with CMS values.

During the period under review, the CMS also undertook a formal Ethics Assessment Exercise to evaluate the current ethical climate within the organisation. The assessment aimed to identify strengths, areas for improvement, and potential ethical risks. The results of this assessment are currently pending and will inform future ethics strategies, interventions, and policy enhancements once finalised.

These initiatives reflect the CMS' ongoing commitment to ethical governance and the promotion of integrity, accountability, and professionalism across all levels of the organisation.

Social Ethics Committee

As part of its commitment to enhance governance, Council took a conscious decision to establish a dedicated Social Ethics Committee, thereby separating social ethics matters from the scope of the HR Committee. The strategic move reflects the Accounting Authority's strong commitment to fostering an ethical culture within the CMS, upholding integrity, and ensuring clean governance.

Since its inception, the Social Ethics Committee has provided vital oversight, leadership, and strategic guidance in advancing ethical practices and implementing relevant ethics policies within the CMS.

Under the Committee's guidance, the CMS developed an Organisational Sustainability Framework, incorporating key performance indicators (KPIs) aligned with the Sustainable Development Goals (SDGs) and Environmental, Social, and Governance (ESG) outcomes.

Key milestones achieved during the financial year under review include:

- Regular dissemination of Ethics Booklets and Ethics Bulletins to internal stakeholders.
- Delivery of ethics-focused presentations to staff.
- Facilitation of ethics management training by an external service provider.
- Conducting an Ethics Awareness and Assessment Survey to evaluate the organisation's ethical culture.
- Proactive stakeholder engagement, culminating in the signing of eleven (11) Memoranda of Understanding (MOUs).

Health, Safety and Environmental Issues

In accordance with Occupational Health and Safety Act (85 of 1993), CMS established an OHSHA Committee whose role is to promote and improve occupational health and safety in the workplace. Their primary function is to advise and support the employer in implementing and improving health and safety, leading to a safer and healthier work environment. The committee participates in the identification and control of workplace hazards through assessments and developments of control programmes to ensure the safety of employees in the workplace.

Company Secretary

The Council is assisted in its duties by an appropriately qualified Company Secretary who provides guidance to the members in the execution of their duties. The Company Secretary is further responsible for the training and development of the members of the Council. The Company Secretary keeps an arm's length relationship with the Council. The Council is satisfied that the Company Secretary is fit and proper.

Social Responsibility

There was no social responsibility initiative in the year under review.

AUDIT COMMITTEE REPORT 2024/25

We are pleased to present the Audit Committee Report for the year ended 31 March 2025.

Audit and Risk Committee Responsibility

The Audit and Risk Committee confirms that it has complied with its responsibilities as crystallised in Section 51(1)(a)(ii) of the Public Finance Management Act and Treasury Regulation 3.1.13.

The Audit and Risk Committee further confirms that it has a charter in place which spells out its terms of reference. The Committee has complied with the charter and discharged its responsibilities accordingly.

Effectiveness of Internal Controls

The Committee confirms that CMS internal auditors conduct audits and provide assurance regarding the internal control framework. Internal Audit has not rated any of their reports as unsatisfactory. There were however limited exceptions noted where the adequacy and effectiveness of certain controls require improvement and one instance where the control was inadequate. These exceptions have been raised with management to address. Overall, the view of the Committee is that the effectiveness of internal controls is deemed satisfactory, with improvement required.

During the year under review, a suite of policies was reviewed to ensure that the internal control framework is practical in addressing governance failures, mismanagement, and fraud and corruption risks.

In addition, the Committee supported the Council by performing the following review activities:

- The 5-Year Strategic Plan of Council (2025 – 2030).
- The Annual Performance Plan for 2025/26.
- The Annual Financial Statements for 2024/25.
- The Annual Performance Information Report for 2024/25.
- The Quarterly Management reports, including the Performance Information Report, Management Accounts, Strategic Risk Register, as well as the Internal Audit Reports.
- The Annual Internal Audit Operational Plan for 2024/25.
- The AGSA draft management report and audit report for 2024/25.
- The review of all financial policies, risk management policies, fraud and corruption risk management strategy and framework, as well as the compliance policy.

The following were areas of concern:

- Unresolved audit findings relating to the irregular expenditure due to staff constraints that affect the Loss Control Committee's ability to fast-track and clear historic irregular expenditure cases, including implementation of consequence management.
- Lack of an alternative funding model, as the current funding model is causing financial strain to CMS, which could impact its ability to adequately fulfil its mandate.

In Year Management and Quarterly Reports

The Committee is satisfied with the quality of the CMS quarterly reports submitted to the Executive Authority and the National Treasury in terms of the PFMA.

Evaluation of Annual Financial Statements

The Committee evaluated, reviewed and satisfied itself with the quality of the annual financial statements prepared by the entity prior to being submitted to the Auditor General of South Africa.

Internal Audit

The Committee is satisfied that the CMS has an effective internal audit and there were no areas of concern raised during the year in review with regards to the performance of the internal audit.

External Audit

The entity's external auditing is performed by the Auditor-General of South Africa (AGSA). The AGSA has, for the year under review, raised concerns around consequence management in respect of irregular expenditure. The Council is leading the way in ensuring that this issue is addressed and resolved. It is worth noting that most of the items in the irregular expenditure register are historical in nature and in many cases relate to individuals who are no longer part of the organisation. The Council has made significant strides in resolving outstanding irregular expenditure.

Risk Management

The entity has a risk management framework which constitutes relevant risk management policies that are reviewed annually and was supported by the committee for approval by the Council. Based on management feedback and mitigating measures in place, the Committee is satisfied with the overall residual risk rating for the entity.

Auditor's Report

The Committee and the Council have reviewed the entity's implementation plan for external audit issues raised in the prior year, and we are satisfied that the matters have been adequately addressed, except for the following matter, which was partially resolved:

- Consequence management with respect to historic irregular expenditure. Specifically, the determination tests relating to prior periods not completed as well as the determination tests not being completed within the stipulated 30 day prescribed period.

The Audit and Risk Committee acknowledges and accords with the conclusions of the Auditor-General on the Annual Financial Statements and is of the opinion that the audited Annual Financial Statements should be accepted and read together with the report of the Auditor-General.

Dr Masibulele Phesa
Chairperson of the Audit Committee
Council for Medical Schemes
31 July 2025

BBBEE COMPLIANCE PERFORMANCE INFORMATION

The following table was completed in accordance with the compliance with the BBBEE requirements as required by the BBBEE Act and as determined by the Department of Trade, Industry and Competition. Where there had been no or only partial compliance with the criteria, CMS provided a discussion and indicated the measures taken to comply.

Table 30: BBBEE Compliance

Has the Public Entity applied any relevant Code of Good Practice (BBBEE Certificate Levels 1 – 8) with regards to the following:		
Discussion		
Criteria	**Response Yes / No**	**(include a discussion on your response and indicate what measures have been taken to comply)**
Determining qualification criteria for the issuing of licences, concessions or other authorisations in respect of economic activity in terms of any law?	**No**	Not applicable to CMS
Developing and implementing a preferential procurement policy?	**Yes**	CMS has developed and implemented preferential procurement policy in line with the National Treasury Preferential Procurement Regulations, 2022, addressing the following criteria to advance transformation: • Historically Disadvantaged Individuals • Small Medium Enterprises • Black Owned Women Enterprises • Enterprises Owned by People with Disabilities (regardless of race) • Youth Owned Enterprises (regardless of race)
Determining qualification criteria for the sale of state-owned enterprises?	**No**	Not applicable to CMS
Developing criteria for entering into partnerships with the private sector?	**No**	Not applicable to CMS
Determining criteria for the awarding of incentives, grants and investment schemes in support of Broad-Based Black Economic Empowerment?	**No**	Not applicable to CMS

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HUMAN RESOURCES MANAGEMENT

HUMAN RESOURCES MANAGEMENT

The section on Human Resources (HR) activities provides an overview of the state of the human resources of the Council for Medical Schemes during the 2024/25 reporting period. The information relates to the achievement of the Annual Performance Plan through the implementation of the HR priorities discussed below.

Overview of Human Resources

The HR sub-programme provides strategic direction and advice relating to human resources policies and practices while ensuring that these are compliant with the applicable employment legislations.

In the period under review, the HR sub-programme was involved in workforce planning, performance management, policy review and development, employee benefits administration, training and development, employment equity, employee relations, employee wellness, and budget planning and administration to support the organisational objectives efficiently and effectively.

Workforce Planning Framework & Key Strategies to Attract and Recruit a Skilled and Capable Workforce

During the 2024/25 reporting period, vacancies were filled according to the CMS recruitment and selection policy and processes. A total of 26 employees were appointed to permanent and fixed-term positions. Thirteen positions were filled by external applicants, seven were filled by internal applicants, two were filled by applicants who participated in work-integrated learning and internships, whilst four were filled by employees who were previously appointed on a fixed-term contract.

The unit continued to facilitate work-integrated learning with institutions of higher learning and TVET colleges, and seven learners were successfully appointed to receive on-the-job training during the period under review.

External Appointments	Fixed-term
Chief Executive & Registrar Senior Manager: Clinical Consulting Services Senior Accreditation Officer: MCO Accreditation Analyst: Financial Supervision (3) Clinical Research Analyst Communication Officer Actuarial Analyst Legal Advisor Executive Assistant: Regulation CPD Practitioner Cleaner	Paralegal: Complaints Adjudication Paralegal: Legal Services Marketing Coordinator Manager: Management Accounting
Internal Movement	**Internship/Work Integrated Learning**
Senior Researcher: Monitoring Senior Analyst: Financial Supervision Compliance Officer Investigator Officer (2) Cleaning Supervisor Customer Care Consultant	Data Management Analyst Administrator: Accreditation

A total of 15 terminations were processed: one due to ill-health, one due to retirement, six due to career advancement, and seven due to internal movement where employees were appointed in new roles within the organisation.

Resignations /Career Advancement	Internal Movement
Senior Manager: Compliance & Investigations Senior Researcher: Monitoring Manager: Management Accounting Executive Manager: Office of the CEO Analyst: Financial Supervision Legal Advisor	Executive Assistant: Regulation Customer Care Consultant Administrator: MCO Accreditation Cleaning Supervisor Analyst: Financial Supervision Cleaner Clinical Research Analyst
Retirement	**Ill-health**
Chief Executive & Registrar	Analyst: Benefits Management

**The staff turnover rate at the end of 2024/25 was 11.54% - an increase when compared to the 10.48% reported in the previous financial year.*

Performance Management

The HR sub-programme continued to ensure that individual performance contracts were aligned with the organisational objectives to enhance organisational performance. The bi-annual evaluations of performance scores against performance agreements entered during the reporting period were moderated and completed at the end of the first quarter of the 2025/26 financial year.

Employee Wellness Programmes

Maintaining a healthy workforce remains 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.

Employees are assisted to access the Employee Assistance Program services as and when needed. In addition, HR provided the following employee wellness initiatives aimed at assisting employees to manage a healthy and productive lifestyle:

- Wellness days where employees participated in a diverse range of health promotion activities including aerobics, a fun walk, screening services for HCT, cancer, diabetes, blood glucose and cholesterol; counselling and testing for HIV/AIDS; eye testing; Body Mass Index measurement and many more.
- Subsidised health club membership;
- Virtual Wellness Talks on current events that are of public interest and significance; and
- On-site administration of flu vaccinations.

Policy Development

Human Resources policies are reviewed annually and were approved by the Council in February 2025.

Employee Benefits

The CMS continues to enhance the employment conditions of its employees; the recommendations to subsidise and improve certain employee benefits shall be tabled to Council for consideration in the next financial year.

Training and Development

Training interventions were implemented as per the approved budget and the training development plans for the 2024/25 financial year. As a result of the training, a number of employees achieved academic success by completing undergraduate qualifications and post-degree qualifications, which included Masters and PhD qualifications.

The organisation continued to benefit from mandatory and discretionary grants from the HWSETA due to the successful submission and approval of its Workplace Skills Plan and Annual Training Report for 2024/25.

Employment Equity (EE)

Compliance with the requirements of the Employment Equity Act remains a major focus for the CMS as it strives to maintain a workplace that provides equal opportunities for all its employees when vacancies are filled at all occupational levels. The Employment Equity Forum ensures the implementation of the employment plan during its participation in the recruitment processes.

Staff consultation meetings were facilitated to identify barriers to help improve policies, procedures and practices in the work environment; and in preparation for developing the new EE plan. The analysis of the information will be finalised by the EE Forum in the beginning of the new financial year.

The CMS continues to be fairly aligned to the management control element of the BBBEE scorecard but still falls below the skills development element in spending and implementing sector skills priority training.

Employee Relations

One disciplinary action case was concluded emanating from breaching and non-compliance with CMS policies & procedures, as well as National Treasury regulations and standard operating procedures.

The HR sub-programme continued to engage with organised labour on matters of mutual interest.

Employees referred disputes to the CCMA for conciliation and arbitration regarding pay progression and the payment of performance bonuses during the reporting period.

Achievements

The human resources sub-programme achieved the following set of priorities during the period under review:

- Prioritised the filling of approved posts to improve efficiencies.
- Training initiatives were implemented according to the training plan.
- Facilitated performance enhancements through the appointment of contract employees in areas that experienced capacity shortages.
- Provided wellness programmes to support employees for an improved work-life balance.

Challenges faced by the Entity

The HR sub-programme had to deal with the following human resources challenges during the period under review:

- Re-advertisement of posts due to the unavailability of appointable and suitable candidates in critical positions.
- Performance bonuses were paid at a reduced amount due to financial constraints.
- Due to capacity and budgetary challenges, some key programmes are not being implemented, such as Talent Management.
- Recruiting and retaining key skills due to the lack of attractive employee benefits such as post-retirement benefits and medical aid subsidies.

Future HR Plans and Goals

- Review the effectiveness of the new service delivery model and organisational structure.
- Support the project for the determination of a suitable funding model.
- Develop a performance matrix framework to enhance organisational performance.
- Continue to investigate and motivate for a feasible approach to introduce more employee benefits within the available financial resources.

HR OVERSIGHT STATISTICS

Table 31: Personnel costs per programme

Programme	Total expenditure of unit (R'000)	Personnel expenditure (R'000)	Personnel expenditure as % of total expenditure	Number of employees at year end	Average personnel cost per employee (R'000)
Programme 1 - Administration					
Sub-programme 1.1 - Office of the CEO	8 649	3 996	46.20%	2	1 998
Sub-programme 1.2 - Office of the CFO	17 804	13 100	73.58%	10	1 310
Sub-programme 1.3 - ICT and Knowledge Management	32 236	17 417	54.03%	15	1 161
Sub-programme 1.4 - Corporate Services	83 091	21 729	26.15%	25	869
Sub-programme 1.5 - Secretariat	10 890	3 233	29.69%	4	808
Programme 2 - Strategy, Risk and Performance	1 543	-	0.00%	-	-
Programme 3 - Regulation	48 599	47 555	97.85%	39	1 219
Programme 4 - Research and Monitoring	15 692	13 848	88.25%	11	1 259
Programme 5 - Member Protection	32 101	31 797	99.05%	30	1 060
Total	**250 604**	**152 676**	**60.92%**	**136**	**1 123**

Table 32: Personnel costs per salary band

Salary Band	Personnel expenditure	Personnel expenditure as % of total expenditure	Number of employees at year end	Average personnel cost per employee (R'000)
Top management	18 730	12.27%	7	2 676
Senior management	19 726	12.92%	9	2 192
Professionals	69 087	45.25%	53	1 304
Skilled Technical and Academically Qualified	39 338	25.77%	52	756
Semi-skilled labour	3 657	2.39%	7	522
Unskilled labour	2 140	1.40%	8	267
Total	**152 676**	**100%**	**136**	**1 123**

Table 33: Performance rewards

Salary Band	Performance reward (R '000)	% Performance reward per level	Number of employees at year end	Average personnel cost per employee (R '000)
Top management	684	15%	6	114
Senior management	677	14%	9	75
Professionals	2 103	45%	49	43
Skilled Technical and Academically Qualified	1 098	23%	46	24
Semi-skilled labour	98	2%	7	14
Unskilled labour	54	1%	7	8
Total	**4 714**	**100%**	**124**	**38**

Table 34: Training costs per programme

Programme	Personnel expenditure (R'000)	Training expenditure (R'000)	Training expenditure as % of personnel costs (R'000)	Number of employees	Average training cost per employee (R'000)
Programme 1 – Administration					
Sub-programme 1.1 - Office of the CEO	3 996	43	1.08%	2	22
Sub-programme 1.2 - Office of the CFO	13 100	223	1.70%	10	22
Sub-programme 1.3 - ICT and Knowledge Management	17 417	587	3.37%	15	39
Sub-programme 1.4 - Corporate Services	21 729	298	1.37%	25	12
Sub-programme 1.5 - Secretariat	3 233	175	5.41%	4	44
Programme 2 - Strategy, Risk and Performance	-	-	-	-	-
Programme 3 - Regulation	47 555	572	1.20%	39	15
Programme 4 - Policy, Research and Monitoring	13 848	67	0.48%	11	6
Programme 5 - Member Protection	31 797	534	1.68%	30	18
Total	**152 676**	**2 499**	**16.30%**	**136**	**20**

Table 35: Employment and vacancies per programme

Programme	2023/24 number of employees	Approved posts 2024/25	2024/25 number of employees	2024/25 vacancies	% of vacancies
Programme 1 - Administration					
Sub-programme 1.1 - Office of the CEO	3	4	2	2	50%
Sub-programme 1.2 - Office of the CFO	10	10	10	-	0%
Sub-programme 1.3 - ICT & Knowledge Management	15	15	15	-	0%
Sub-programme 1.4 - Corporate Services	22	25	25	-	0%
Sub-programme 1.6 - Secretariat	4	4	4	-	0%
Programme 3 - Regulation	35	41	39	2	5%
Programme 4 - Policy, Research and Monitoring	9	11	11	-	0%
Programme 5 - Member Protection	27	31	30	1	3%
Total	**125**	**141**	**136**	**5**	**4%**

Table 36: Employment and vacancies per salary level

Level	2023/24 number of employees	Approved posts 2024/25	2024/25 number of employees	2024/25 vacancies	% of vacancies
Top management	8	8	7	2	25%
Senior management	9	11	9	3	27%
Professionals	49	53	53	6	11%
Skilled Technical and Academically Qualified	43	54	52	15	28%
Semi-skilled labour	7	7	7	2	29%
Unskilled labour	9	8	8	1	13%
Total	**125**	**141**	**136**	**29**	**21%**

Table 37: Employment changes per salary band

Level	Employment at the beginning of period	Appointments	Staff movement	Terminations	Employment at end of period
Top management	8	1	-	2	7
Senior management	9	1	-	1	9
Professionals	49	7	3	4	53
Skilled Technical and Academically Qualified	42	14	3	5	52
Semi-skilled labour	7	2	2	1	7
Unskilled labour	9	1	0	2	8
Total	**124**	**26**	**8**	**15**	**136**

***Note**:*

- *During the period, 8 employees moved into senior positions.*
- *The CMS employed 125 staff members as at 31 March 2024, with two employees serving notice of resignation that ended on the same date.*
- *One appointment was made on 1 April 2024, resulting in a net decrease of one staff member. Between April 2024 and January 2025, a total of 26 vacancies were filled.*

Table 38: Reasons for leaving

Reason	Number of employees	% of total number of staff leaving
Death	-	0%
Resignations	6	38%
Dismissal	-	0%
Retirement	1	6%
Ill health	1	6%
Expiry of contract	-	0%
Other (Internal movements)	7	50%
Total	**15**	**100%**

Table 39: Labour relations: misconduct and disciplinary actions

Reason	Number of occurrences
Verbal warning	-
Written warning	1.00
Final written warning	-
Dismissal	-
Total	**1.00**

E

PFMA COMPLIANCE REPORT

IRREGULAR, FRUITLESS AND WASTEFUL EXPENDITURE AND MATERIAL LOSSES

Irregular expenditure

a) Reconciliation of irregular expenditure

Table 40: Irregular, fruitless and wasteful expenditure and material losses expenditure and material losses - Reconciliation of irregular expenditure

Description	2024/25	2023/24 Restated*
	R'000	R'000
Opening balance	62 528	63 961
Adjustment to opening balance	-	56
Opening balance as restated	62 528	64 017
Add: Irregular expenditure confirmed	661	893
Less: Irregular expenditure condoned	-	-
Less: Irregular expenditure not condoned and removed	(11 532)	(2 382)
Less: Irregular expenditure recoverable[1]	-	-
Less: Irregular expenditure not recoverable and written off	-	-
Closing balance	**51 657**	**62 528**

The current irregular expenditure incurred during the financial year under review relates to non-adherence to the extension and expansion of the existing contract scope, as well as historical irregular expenditure. The services of the historical irregular expenditure were rendered in the financial year under review.

Reconciling notes

Table 41: Irregular, fruitless and wasteful expenditure and material losses expenditure and material losses - Reconciliation Notes

Description	2024/25	2023/24 Restated*
	R'000	R'000
Irregular expenditure that was under assessment	46 776	693
Irregular expenditure that relates to the prior year and identified in the current year	-	56
Irregular expenditure for the current year	661	893
Total	**47 437**	**1 642**

b) Details of irregular expenditure (under assessment, determination, and investigation)

Table 42: Details of irregular expenditure (under assessment, determination, and investigation)

Description[2]	2024/25	2023/24 Restated*
	R'000	R'000
Irregular expenditure under assessment	46 776	693
Irregular expenditure under determination	4 188	11 222
Irregular expenditure under investigation	-	-
Total	**50 964**	**11 915**

There was significant progress in the assessment and process of determination of irregular expenditure compared to the previous financial year, despite challenges related to documentation, particularly for historical transactions.

1 *Transfer to receivables*

2 *Group similar items*

c) Details of irregular expenditure removed - (not condoned)

Table 43: Details of irregular expenditure removed - (not condoned)

Description	2024/25	2023/24 Restated*
	R'000	R'000
Irregular expenditure NOT condoned and removed	11 532	2 382
Total	**11 532**	**2 382**

National Treasury declined to condone the irregular expenditure in the 2024/25 and 2023/24 financial years, and the CMS Council removed it in line with the National Treasury's Compliance and Reporting Framework.

d) Details of disciplinary or criminal steps taken as a result of irregular expenditure

Table 44: Details of disciplinary or criminal steps taken as a result of irregular expenditure

Disciplinary steps were taken against responsible persons, where possible, regarding irregular expenditure. It was also impractical to take disciplinary steps against responsible officials who are no longer working for the CMS regarding irregular expenditure.

Fruitless and wasteful expenditure

a) Reconciliation of fruitless and wasteful expenditure

Table 45: Reconciliation of fruitless and wasteful expenditure

Description	2024/25	2023/24 Restated*
	R'000	R'000
Opening balance	411	341
Adjustment to opening balance	331	70
Opening balance as restated	742	411
Add: Fruitless and wasteful expenditure confirmed	371	-
Less: Fruitless and wasteful expenditure recoverable	-	-
Less: Fruitless and wasteful expenditure not recoverable and written off	**(331)**	-
Closing balance	**782**	**411**

The fruitless and wasteful expenditure incurred in the 2024/25 financial year relates to late payment from SARS. Induded in the AFS is an amount of R321 000 SARS penalty that was not confirmed as it was still under assessment.

Reconciling notes

Table 46: Reconciling notes

Description	2024/25	2023/24
	R'000	R'000
Fruitless and wasteful expenditure that was under assessment	692	-
Fruitless and wasteful expenditure that relates to the prior year and identified in the current year	-	-
Fruitless and wasteful expenditure for the current year	371	-
Total	**1 063**	**-**

b) Details of fruitless and wasteful expenditure (under assessment, determination, and investigation)

Table 47: Details of fruitless and wasteful expenditure (under assessment, determination, and investigation)

Description[3]	2024/25	2023/24
	R'000	R'000
Fruitless and wasteful expenditure under assessment	692	436
Fruitless and wasteful expenditure under determination	371	401
Fruitless and wasteful expenditure under investigation	-	-
Total	**1 063**	**837**

The current fruitless and wasteful expenditure under determination is related to SARS' late payment penalties. Induded in the AFS is an amount of R321 000 SARS penalty that was not confirmed as it was still under assessment.

c) Details of fruitless and wasteful expenditure recoverable

Table 48: Details of fruitless and wasteful expenditure recoverable

Description	2024/25	2023/24
	R'000	R'000
Fruitless and wasteful expenditure recoverable	371	-
Total	**371**	**-**

The CMS is in the process of recovering the fruitless and wasteful expenditure in relation to SARS' late payment from the responsible officials.

d) Details of disciplinary or criminal steps taken as a result of fruitless and wasteful expenditure

Table 49: Details of disciplinary or criminal steps taken as a result of fruitless and wasteful expenditure

Disciplinary actions were taken against responsible officials in relation to SARS' late payment penalties.

3

LATE AND/OR NON-PAYMENT OF SUPPLIERS

Table 50: Valid invoices received

Description	Number of invoices	Consolidated Value
		R'000
Valid invoices received	633	26 189
Invoices paid **within** 30 days or agreed period	584	20 692
Invoices paid **after** 30 days or agreed period	10	858
Invoices older than 30 days or agreed period (unpaid and without dispute)	-	-
Invoices older than 30 days or agreed period (unpaid and in dispute)	39	4 639

Include reasons for the late and or non-payment of invoices, including reasons that the invoices are in dispute, where applicable.

The amounts in dispute relate to the SIU matter, where invoices totalling R4 458 772.50 are over 30 days past due and remain unpaid.

Travel invoices amounting to R109 120.91 were also unpaid due to various queries we have regarding those invoices. The invoices are currently sitting in Accounts Payable.

The balance of these invoices is made up of copy costs, repairs, and courier services, for which queries are being finalised with internal stakeholders. The total value of the invoices comes to R70 642.11.

SUPPLY CHAIN MANAGEMENT

3.1 Procurement by other means

Table 51: Supply Chain Management - Procurement by other means

Project description	Name of supplier	Type of procurement by other means	Contract number	Value of contract R'000
1) Deviation for the appointment of Obsidian Systems (Pty) Ltd as the preferred supplier to provide Atlassian renewals (Jira, Bitbucket and Confluence).	Obsidian Systems (Pty) Ltd	Out of five Atlassian accredited suppliers invited, only two responded.	N/A	209
2) Deviation: Appointment of ITR Technology for renewal of desktop endpoint central ops manage engine license for twelve (12) months.	ITR Technology	Sole source	N/A	150
3) Deviation for the appointment of Sage South Africa (Pty) Limited for renewal of annual license fee subscription – fixed assets.	Sage South Africa (Pty) Limited	Single source	N/A	3
4) Deviation: Appointment of Tiana Business Consulting for CCMA Arbitration scheduled on 8 May 2024.	Tiana Business Consulting	Single source	N/A	11
5) Deviation: Appointment of Chavani Risk Advisory & Forensic Services as the preferred service provider for a medical scheme commissioned inspection.	Chavani Risk Advisory & Forensic Services	Out of four suppliers invited, only one responded.	N/A	460

Project description	Name of supplier	Type of procurement by other means	Contract number	Value of contract R'000
6) Deviation: Appointment Finware Enterprise Systems as the preferred service provider to assist Internal Finance with upgraded SAGE (fixed asset system) in the preparation of the external auditors.	Finware Enterprise System	Urgent procurement	N/A	6
7) Deviation: Appointment of Dipitseng Caterers CC as the preferred service provider for catering services for the appeal committee hearings on 4 June 2024.	Dipitseng Caterers CC	Out of five suppliers invited only two responded.	N/A	10
8) Deviation from the procurement process to approve the appointment of CaseWare for software subscription on a sole source provider basis.	CaseWare (Pty) Limited	Sole source	N/A	110
9) Appointment of Pro vision IT to assist with M-Files upgrade and support subscription renewal for a period of six months.	Pro vision IT	Out of eleven service providers invited, only one responded.	N/A	168
10) Variation memorandum for Xfour Consulting Solutions as the preferred service provider on ad-hoc basis to provide support and consulting services (SAGE 300) to the Internal Finance and Human Resource Units for a period of twelve months.	Xfour Consulting Solutions	Variation Order	N/A	18
11) Deviation from the procurement process to approve the appointment of a service provider to conduct investigations - Roshmed Hospital Investment.	Nexia SAB&T	Out of sixteen service providers invited, only two responded.	N/A	331
12) Deviation from procurement process to request the services of Tiana Business Consulting Services to testify on behalf of CMS at CCMA.	Tiana Business Consulting Services	Single source	N/A	13
13) Appointment of a service provider to provide catering services for FSU workshop.	Mami Flavours Catering and Events	Out of five service providers invited, only two responded.	N/A	32
14) Deviation from normal procurement for appointment of Mandlondo Enterprise (Pty) Ltd as the preferred service provider to assist with the service of CMS' Toyota Hilux Double Cab.	Mandlondo Enterprise (Pty) Ltd	Out of six service providers invited only one responded (RFQ was also published on the CMS Website).	N/A	10
15) Deviation from the normal procurement processes and appointment of Hotel 224 (Pty) Ltd as the preferred service provider of catering service for stakeholder engagement with NAMFISA on 1 August 2024.	Hotel 224 (Pty) Ltd	Out of five service providers invited, only one responded.	N/A	14
16) Appointment of service provider for Accountmate Annual License Subscription.	ERP 365 (Pty) Ltd	Sole source	N/A	70
17) Deviation: Appointment of Mami Flavours Catering and Events to assist with the catering services for the EMC Workshop.	Mami Flavours Catering and Events	Out of five service providers invited, only one responded.	N/A	27
18) Deviation: Appointment of a service provider for the renewal and additional SAS licenses.	SAS Institute (Pty) Ltd	Sole source	N/A	344
19) Deviation: Appointment of 7ITR Technology for the renewal of managed engine licenses.	ITR Technology	Sole source	N/A	238
20) Deviation: Appointment of a service provider for the renewal of SignFlow licenses for a twelve (12) month period.	SignFlow (Pty) Ltd	Sole source	N/A	43
21) Deviation: Appointment of Sage South Africa (Pty) Limited for Renewal of Annual License Fee Subscription.	Sage South Africa (Pty) Ltd	Single source	N/A	147

Project description	Name of supplier	Type of procurement by other means	Contract number	Value of contract R'000
22) Deviation: Appointment of Reportstar as the preferred service provider for the renewal of checkpoint firewall for 6 months.	ReportStar (Pty) Ltd	Out of fourteen service providers, only two responded.	N/A	547
23) Deviation from the procurement process to approve the appointment of a service provider to provide CMS with Library & information resource sharing facilities.	SABINET Ltd	The RFQ was advertised on eTender and the CMS Website, and only two service providers responded.	N/A	133
24) Deviation from the procurement process to approve the appointment of Evanto Group (Pty) Ltd as the preferred service provider to administer flu vaccination of 25 CMS employees on 19 March 2025.	Evanto Group (Pty) Ltd	The RFQ was sent to the CSD-registered service providers. Out of six service providers invited, only two responded.	N/A	9
25) Deviation from the usual procurement process to appoint Titlonyeni Catering Services (Pty) Ltd as the preferred service provider to cater for the Gauteng PO forum on 27 March 2025 for approximately hundred people.	Titlonyeni Catering Services (Pty) Ltd	RFQs were sent to the CSD-registered service providers. Out of five service providers invited, only two responded.	N/A	30
Total				**3 133**

All the deviations comply with TR 18A6.43 and internal SCM policies and procedures. The CMS maintains a deviation register and reviews it for patterns of collusion risks.

52% of deviations were due to non-responsive service providers when RFQs were advertised, 24% were sole source providers related to the renewal of software, 16% were for single source procurement and the balance of 8% was related to urgent procurement.

3.2 Contract variations and expansions

Table 52: Contract variations and expansions

Project description	Name of supplier	Contract modification type (Expansion or Variation)	Contract number	Original contract value	Value of previous contract expansion/s or variation/s (if applicable)	Value of current contract expansion or variation
				R'000	R'000	R'000
Extension of scope of work for Checkpoint firewall license for 6 months.	Reportstar Technologies CC	Expansion	RFQ/CMS/ ITT/030460	993	-	349
Extension of scope of work for managed Voice and Data services for the period of 12 months.	MTN	Expansion	Transversal	1 006	-	447
Expansion of the scope of work for Microsoft Ireland as the preferred service provider for the additional licenses for the period of twenty-one (21) months.	Microsoft Ireland	Expansion	Transversal	10 869	-	543
Total				**12 868**	**-**	**1 339**

F

FINANCIAL INFORMATION

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

REPORT ON AUDIT OF THE ANNUAL FINANCIAL STATEMENTS

Opinion

1. I have audited the financial statements of the Council for Medical Schemes set out on pages 113 to 145, which comprise the statement of financial position as at 31 March 2025, statement of financial performance, statement of changes in net assets, cash flow statement 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 2025 and its financial performance and cash flows for the year then ended in accordance with the Generally Recognised Accounting Practice (GRAP) and the requirements of the Public Finance Management Act 1 of 1999 (PFMA).

Basis for opinion

3. I conducted my audit in accordance with the International Standards on Auditing (ISAs). My responsibilities under those standards are further described in the responsibilities of the auditor-general for the audit of the financial statements section of my report.

4. I am independent of the public entity in accordance with the *International Ethics Standards Board for Accountants' 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 accounting authority is responsible for the preparation and fair presentation of the financial statements in accordance with the 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.

Responsibilities of the Auditor-General 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. This description, which is located at page 110 of the annexure forms part of my auditor's report.

REPORT ON THE ANNUAL PERFORMANCE REPORT

10. In accordance with the Public Audit Act 25 of 2004 (PAA) and the general notice issued in terms thereof; I must audit and report on the usefulness and reliability of the reported performance information against predetermined objectives for the selected material performance indicators presented in the annual performance report. The accounting authority is responsible for the preparation of the annual performance report.

11. I selected the following material performance indicators related to members protection presented in the annual performance report for the year ended 31 March 2025. I selected those indicators that measure the public entity's performance on its primary mandated functions and that are of significant national, community or public interest.

    - Percentage of customer care interventions resulting from calls, e-mailed queries and walk-in consultations handled by the customer care centre.
    - Percentage of complaints older than 120 calendar days adjudicated during the reporting period in accordance with the complaints standard operating procedures.
    - Percentage of category 2 complaints adjudicated within 120 calendar days and in accordance with the complaints standard operating procedures.
    - Percentage of category 1 complaints adjudicated within 60 calendar days and in accordance with the complaints standard operating procedures.
    - The number of CMScripts published.
    - Percentage of category 1 clinical opinions provided within 30 working days of receipt of a request from the complaints adjudication sub-programme.
    - Percentage of category 2 clinical opinions provided within 60 working days of receipt of a request from the complaints adjudication sub-programme.
    - Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from the complaints adjudication sub-programme
    - Percentage of clinical enquiries received via e-mail or telephone and responded to within seven days.

12. I evaluated the reported performance information for the selected material performance indicators against the criteria developed from the performance management and reporting framework, as defined in the general notice. When an annual performance report is prepared using these criteria, it provides useful and reliable information and insights to users on the public entity's planning and delivery on its mandate and objectives.

13. I performed procedures to test whether:

    - the indicators used for planning and reporting on performance can be linked directly to the public entity's mandate and the achievement of its planned objectives.
    - all the indicators relevant for measuring the public entity's performance against its primary mandated and prioritised functions and planned objectives are included.
    - the indicators are well defined to ensure that they are easy to understand and can be applied consistently, as well as verifiable so that I can confirm the methods and processes to be used for measuring achievements.
    - the targets can be linked directly to the achievement of the indicators and are specific, time bound and measurable to ensure that it is easy to understand what should be delivered and by when, the required level of performance as well as how performance will be evaluated.

- the indicators and targets reported on in the annual performance report are the same as those committed to in the approved initial or revised planning documents.
- the reported performance information is presented in the annual performance report in the prescribed manner
- there is adequate supporting evidence for the achievements reported and for the reasons provided for any over- or underachievement of targets.

14. I performed the procedures to report material findings only; and not to express an assurance opinion or conclusion.

15. I did not identify any material findings on the reported performance information for the selected indicators.

Other matters

16. I draw attention to the matters below.

Achievement of planned targets

17. The annual performance report includes information on reported achievements against planned targets and provides explanations for over- or under- achievements.

18. The table that follows provide information on the achievement of planned targets and list the key indicators that were not achieved as reported in the annual performance report. The reasons for any underachievement of targets are included in the annual performance report on pages 30 to 73.

Member Protection

Targets achieved: 89% *Budget spent: 105%*		
Key [service delivery] indicator not achieved	**Planned target**	**Reported achievement**
Percentage of customer care interventions resulting from calls, e-mailed queries and walk- in consultations handled by the customer care centre.	90%	89%

Material misstatements

19. I identified a material misstatement in the annual performance report submitted for auditing. This material misstatement was in the reported performance information for Member Protection. Management subsequently corrected the misstatement, and I did not include any material findings in this report.

REPORT ON COMPLIANCE WITH LEGISLATION

20. In accordance with the PAA and the general notice issued in terms thereof, I must audit and report on compliance with applicable legislation relating to financial matters, financial management and other related matters. The accounting authority is responsible for the public entity's compliance with legislation.

21. I performed procedures to test compliance with selected requirements in key legislation in accordance with the findings engagement methodology of the Auditor-General of South Africa (AGSA). This engagement is not an assurance engagement. Accordingly, I do not express an assurance opinion or conclusion.

22. Through an established AGSA process, I selected requirements in key legislation for compliance testing that are relevant to the financial and performance management of the public entity, clear to allow consistent measurement and evaluation, while also sufficiently detailed and readily available to report in an understandable manner. The selected legislative requirements are included in the annexure to this auditor's report.

23. The material findings on compliance with the selected legislative requirements, presented per compliance theme, are as follows:

Consequence management

24. I was unable to obtain sufficient appropriate audit evidence that disciplinary steps were taken against the officials who had incurred irregular expenditure in prior years, as required by section 51 (1)(e)(iii) of the PFMA. This was because investigations into irregular expenditure were not performed on some of the cases.

OTHER INFORMATION IN THE ANNUAL REPORT

25. The accounting authority is responsible for the other information included in the annual report which includes the chairperson's foreword, chief executive officer's overview, audit committee's report and human resources management. The other information referred to does not include the financial statements, the auditor's report and those selected material indicators in the scoped-in programme presented in the annual performance report that have been specifically reported on in this auditor's report.

26. My opinion on the financial statements and my reports on the audit of the annual performance report and compliance with legislation do not cover the other information included in the annual report and I do not express an audit opinion or any form of assurance conclusion on it.

27. My responsibility is to read this other information and, in doing so, consider whether it is materially inconsistent with the financial statements and the selected material indicators in the scoped-in programme presented in the annual performance report or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

28. I did not receive other information prior to the date of the auditor's report. When I do receive and read this information, if I conclude that there is material misstatement, I am required to communicate the matter to the accounting authority 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 auditor's report as appropriate. However, if it is correct this will not be necessary.

INTERNAL CONTROL DEFICIENCIES

29. I considered internal control relevant to my audit of the financial statements, annual performance report and compliance with applicable legislation; however, my objective was not to express any form of assurance on it.

30. The matter reported below is limited to the significant internal control deficiencies that resulted in the material finding on compliance with legislation included in this report.

31. The accounting authority did not review and monitor compliance with applicable legislation, resulting in material non-compliance in consequence management.

Auditor-General

Pretoria
31 July 2025

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

ANNEXURE TO THE AUDITOR'S REPORT

The annexure includes the following:

- The Auditor-General's responsibility for the audit.
- The selected legislative requirements for compliance testing.

Auditor-General's responsibility for the audit

Professional judgement and professional scepticism

As part of an audit in accordance with the ISAs, I exercise professional judgement and maintain professional scepticism throughout my audit of the financial statements and the procedures performed on reported performance information for selected material performance indicators and on the public entity's compliance with selected requirements in key legislation.

Financial statements

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 public entity's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made
- conclude on the appropriateness of the 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 public entity 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 a public entity to cease operating as a going concern
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and determine whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

Communication with those charged with governance

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.

I also provide the accounting authority with a statement that I have complied with relevant ethical requirements regarding independence and 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.

Compliance with legislation – selected legislative requirements

The selected legislative requirements are as follows:

Legislation	Sections or regulations
Public Finance Management Act 1 of 1999 (PFMA)	Section 51 (1)(b)(i); 51 (1)(b)(ii); 51 (1)(e)(iii); 53(4) Section 54(2)(c); 54(2)(d); 55(1)(a); 55(1)(b) Section 55(1)(c)(i); 56(1); 57(b); 66(4)
Treasury Regulations	Regulation 8.2.1; 8.2.2; 16A3.2; 16A3.2(a) Regulation 16A6.1; 16A6.2(a) 16A6.2(b) Regulation 16A6.3(a); 16A6.3(b); 16A6.3(c) Regulation 16A6.3(e); 16A6.4; 16A6.5; 16A6.6 Regulation 16A7.1; 16A7.3; 16A7.6; 16A7.7 Regulation 16A8.3; 16A8.4; 16A9.1(b)(ii) Regulation 16A9.1 (d); 16A9.1 (e); 16A9.1 (f) Regulation 16A9.2; 16A9.2(a)(ii); 30.1.1 Regulation 30.1.3(a); 30.1.3(b); 30.1.3(d); 30.2.1 Regulation 31.1.2(c); 31.2.1; 31.2.5; 31.2.7(a) Regulation 33.1.1; 33.1.3
Preferential Procurement Regulations of 2017 (PPR)	Paragraph 4.1; 4.2; 5.1; 5.3; 5.6; 5. 7; 6.1; 6.2 Paragraph 6.3; 6.5; 6.6; 6.8; 7.1; 7.2; 7.3; 7.5 Paragraph 7.6; 7.8; 8.2; 8.5; 9.1; 10.1; 10.2 Paragraph 11.1; 11.2
Construction Industry Development Board Act 38 of 2000	Section 18(1)
Construction Industry Development Board Regulations 2004	Regulation 17; 25(7A)
Second amendment National Treasury Instruction No. 5 of 2020/21	Paragraph 1
Erratum National Treasury Instruction No. 5 of 2020/21	Paragraph 2
National Treasury Instruction No. 5 of 2020/21	Paragraph 4.8; 4.9; 5.3
National Treasury Instruction No. 1 of 2021/22	Paragraph 4.1
National Treasury Instruction No. 4 of 2015/16	Paragraph 3.4
National Treasury SCM Instruction No. 4A of 2016/17	Paragraph 6
National Treasury SCM Instruction No. 03 of 2021/22	Paragraph 4.1; 4.2 (b); 4.3; 4.4(a); 4.17; 7.2; 7.6
National Treasury SCM Instruction No. 11 of 2020/21	Paragraph 3.4(a); 3.4(b); 3.9
National Treasury SCM Instruction No. 2 of 2021/22	Paragraph 3.2.1; 3.2.4; 3.2.4(a); 3.3.1
Practice Note 11 of 2008/9	Paragraph 2.1; 3.1(b)
Practice Note 5 of 2009/10	Paragraph 3.3
Practice Note 7 of 2009/10	Paragraph 4.1.2

Legislation	Sections or regulations
Preferential Procurement Policy Framework Act 5 of 2000	Section 1; 2.1(a); 2.1(f)
Preferential Procurement Regulations, 2022	Paragraph 4.1; 4.2; 4.3; 4.4; 5.1; 5.2; 5.3; 5.4
Preferential Procurement Regulations, 2017	Paragraph 4.1; 4.2; 5.1; 5.3; 5.6; 5. 7; 6.1; 6.2 Paragraph 6.3; 6.5; 6.6; 6.8; 7.1; 7.2; 7.3; 7.5 Paragraph 7.6; 7.8; 8.2; 8.5; 9.1; 10.1; 10.2 Paragraph 11.1; 11.2
Prevention and Combating of Corrupt Activities Act 12 of 2004	Section 34(1)

ACCOUNTING AUTHORITY'S RESPONSIBILITIES AND APPROVAL

The 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 was 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 Council members to meet these responsibilities, the Council members sets 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 2026 and, in the light of this review and the current financial position, they are satisfied that the entity has or has access to adequate resources to continue in operational existence for the foreseeable future even though the net assets position has decreased.

The Annual Financial Statements are prepared on the basis that the entity is a going concern and that the entity has neither the intention nor the need to liquidate or curtail materially the scale of the entity.

Although the Council members are primarily responsible for the financial affairs of the entity, they are supported by the entity's management.

The external auditors are responsible for independently reviewing and reporting on the entity's annual financial statements. The Annual Financial Statements have been examined by the entity's external auditors and their report is presented on page 106.

The Annual Financial Statements set out on page 113, which have been prepared on the going concern basis, were approved by the members on 31 July 2025 and were signed on its behalf by:

Dr T. Mabeba
Council Chairperson

Dr M. Gumede
CEO and Registrar

STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2025

	Note(s)	2025 '000	2024 Restated* '000
Assets			
Current Assets			
Receivables from exchange transactions	8	7 491	7 444
Cash and cash equivalents	9	39 222	59 123
		46 713	**66 567**
Non-Current Assets			
Property, plant and equipment	3	10 328	7 487
Intangible assets	4	1 183	1 359
Security deposit	5	-	4 540
		11 511	**13 386**
Total Assets		**58 224**	**79 953**
Liabilities			
Current Liabilities			
Finance lease obligation	6	489	486
Payables from exchange transactions	7	26 410	27 639
Unspent conditional grants and receipts	12	2 080	2 080
Provisions	10	6 141	3 517
		35 120	**33 722**
Non-Current Liabilities			
Finance lease obligation	6	268	758
Provisions	10	9 306	8 262
		9 574	**9 020**
Total Liabilities		**44 694**	**42 742**
Net Assets		**13 530**	**37 211**
Accumulated surplus		13 530	37 211
Total Net Assets		**13 530**	**37 211**

** See Note 26*

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 31 MARCH 2025

	Note(s)	2025 '000	2024 Restated* '000
Revenue	11	218 736	207 464
Loss on disposal of assets	15	(11)	(43)
Administrative expenses	19	(39 560)	(35 153)
Finance costs	14	(119)	(106)
Auditor's remuneration	18	(1 543)	(2 227)
Operating expenses	17	(33 035)	(27 468)
Staff costs	13	(163 378)	(141 654)
Depreciation and amortisation	3	(2 366)	(4 021)
Labour settlement	16	(10 592)	-
Operating deficit		**(31 868)**	**(3 208)**
Interest income	11	8 187	8 566
(Deficit) surplus for the year		**(23 681)**	**5 358**

** See Note 26*

STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEAR ENDED 31 MARCH 2025

	Accumulated surplus / deficit '000	Total net assets '000
Opening balance as previously reported	30 815	30 815
Adjustments		
Correction of errors 26	1 038	1 038
Balance at 01 April 2023 as restated*	**31 853**	**31 853**
Changes in net assets	5 358	5 358
Surplus for the year	5 358	5 358
Total changes	**37 211**	**37 211**
Balance at 01 April 2024 as restated		
Changes in net assets		
Deficit for the year	(23 681)	(23 681)
Total changes	(23 681)	(23 681)
Balance at 31 March 2025	**13 530**	**13 530**

** See Note 26*

CASH FLOW STATEMENT

FOR THE YEAR ENDED 31 MARCH 2025

	Note(s)	2025 '000	2024 Restated* '000
Cash flows from operating activities			
Receipts			
Proceeds from levies and fees		210 832	200 693
Transfers		6 407	6 864
Interest income		8 183	8 567
		225 422	216 124
Payments			
Employee costs		(157 999)	(141 605)
Suppliers		(75 624)	(64 745)
Labour settlement		(10 592)	-
Finance costs		(119)	(106)
		(244 334)	(206 456)
Net cash flows from operating activities	20	**(18 912)**	**9 668**
Cash flows from investing activities			
Purchase of property, plant and equipment	3	(5 041)	(1 646)
Proceeds from sale of property, plant and equipment	3	-	17
Disinvestment of the security deposit	5	4 751	-
Interest on security deposit	5	(212)	(340)
Net cash flows from investing activities		**(502)**	**(1 969)**
Cash flows from financing activities			
Finance lease payments		(487)	(284)
Net increase/(decrease) in cash and cash equivalents		**(19 901)**	**7 415**
Cash and cash equivalents at the beginning of the year		59 123	51 708
Cash and cash equivalents at the end of the year	9	**39 222**	**59 123**

** See Note 26*

STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

FOR THE YEAR ENDED 31 MARCH 2025

Budget on Cash Basis						
	Approved budget '000	Adjustments '000	Final Budget '000	Actual amounts on comparable basis '000	Difference between final budget and actual '000	Reference
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Accreditation fees, registration, appeal fees and inspection fees recovered	9 465	-	**9 465**	8 437	**(1 028)**	
Levy income	199 684	1 966	**201 650**	201 641	**(9)**	
Legal fees recovered	-	-	**-**	(118)	**(118)**	
Other income	317	4 752	**5 069**	5 412	**343**	
Total revenue from exchange transactions	**209 466**	**6 718**	**216 184**	**215 372**	**(812)**	
Revenue from non-exchange transactions						
Taxation revenue						
Interest received	3 323	5 569	**8 892**	8 183	**(709)**	
Transfer revenue						
Government transfer: Department of Health	6 151	-	**6 151**	6 151	**-**	
Mandatory transfer: Department of Higher Education and Training	-	97	**97**	256	**159**	
Surplus funds	11 880	15 940	**27 820**	-	**(27 820)**	1
Total revenue from non-exchange transactions	**21 354**	**21 606**	**42 960**	**14 590**	**(28 370)**	
Total revenue	**230 820**	**28 324**	**259 144**	**229 962**	**(29 182)**	
Expenditure						
Personnel	(148 156)	1 681	**(146 475)**	(148 418)	**(1 943)**	3
Social contributions	(4 480)	(705)	**(5 185)**	(4 855)	**330**	
Staff costs	(3 561)	(2 222)	**(5 783)**	(5 874)	**(91)**	
Training and development	(2 511)	14	**(2 497)**	(2 294)	**203**	
Advertising	(734)	(106)	**(840)**	(768)	**72**	
Agent and support/outsourced services	(90)	45	**(45)**	(39)	**6**	
Audit costs	(1 048)	100	**(948)**	(943)	**5**	
Board costs	(5 031)	(452)	**(5 483)**	(6 207)	**(724)**	
Bank charges	(126)	40	**(86)**	(80)	**6**	
Building expenses (Property payments)	(5 777)	(642)	**(6 419)**	(6 555)	**(136)**	
Communication	(3 329)	1 671	**(1 658)**	(1 107)	**551**	
Consultants	(11 430)	3 426	**(8 004)**	(6 691)	**1 313**	

Budget on Cash Basis						
	Approved budget	Adjustments	Final Budget	Actual amounts on comparable basis	Difference between final budget and actual	Reference
	'000	'000	'000	'000	'000	
Computer services	(6 034)	(1 966)	**(8 000)**	(9 313)	**(1 313)**	
Labour settlement	-	(10 592)	**(10 592)**	(10 592)	**-**	
Legal fees	(6 200)	(7 050)	**(13 250)**	(17 286)	**(4 036)**	2
Non-life insurance	(838)	159	**(679)**	(691)	**(12)**	
Printing and publication	(715)	230	**(485)**	(448)	**37**	
Rental of buildings and office equipment	(9 465)	(5 873)	**(15 338)**	(15 335)	**3**	
Repairs and maintenance	(1 124)	320	**(804)**	(663)	**141**	
Travel and subsistence	(1 473)	(164)	**(1 637)**	(1 166)	**471**	
Venue and facilities	(657)	(386)	**(1 043)**	(797)	**246**	
Other unclassified goods and services	(3 012)	(1 828)	**(4 840)**	(4 093)	**747**	
Finance costs	(529)	390	**(139)**	(119)	**20**	
Total expenditure	**(216 320)**	**(23 910)**	**(240 230)**	**(244 334)**	**(4 104)**	
Deficit for the year	**14 500**	**4 414**	**18 914**	**(14 372)**	**33 286**	
Actual Amount on Comparable Basis as Presented in the Budget and Actual Comparative Statement	**14 500**	**4 414**	**18 914**	**(14 372)**	**33 286**	
Reconciliation						
Basis of accounting difference						
Depreciation and amortisation				(2 366)		
Gain/(loss) on disposal of assets				(11)		
Movement in provisions				(3 668)		
Change in receivables				47		
Change in payables				1 229		
Change in security deposit				(4 540)		
Actual Amount in the Statement of Financial Performance				**(23 681)**		

Basis of accounting

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

Classification basis

The classification basis adapted in the approved budget is according the economic classification as per the National Treasury ENE database.

Period of the approved budget

01 April 2024 - 31 March 2025

Approval of the levy rate

The 2024/25 levy rate was approved in terms of the section 2(4) of the Council for Medical Schemes Levies Act (Act no 58 of 2000) by the Minister of Health with concurrence of the Finance Minister on 19 July 2024.

Calculated materiality significance value as determined in terms of Treasury regulation 28.3.1 amounts to R2 160 000. Positive and negative differences above the calculated materiality are explained below:

1. **Surplus funds:** CMS obtained approval to retain surplus funds relating to 2023/24 financial year.
2. **Legal fees:** The over expenditure is driven by increased number of complex legal cases, spanning over years, high-conflict disputes leading to the high court, and the need for specialised expertise including Senior Counsel.
3. **Personnel:** Additional performance bonuses and back pay of pay progression was paid in the 2024/25 financial year.

SIGNIFICANT ACCOUNTING POLICIES

1. Significant accounting policies

The significant accounting policies applied in the preparation of these Annual Financial Statements are set out below.

1.1. Basis of preparation

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 91(1) 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. They are presented in South African Rand.

These accounting policies are consistent with the previous period.

1.2 Presentation currency

These Annual Financial Statements are presented in South African Rands, which is the functional currency of the entity and figures are rounded off to the nearest thousand.

1.3 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.

1.4 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.

In preparing the annual financial statements, management is required to make estimates and assumptions that affect the amounts represented in the Annual Financial Statements and related disclosures. Use of available information and the application of judgement is inherent in the formation of estimates. Actual results in the future could differ from these estimates which may be material to the annual financial statements. Significant judgements include:

- Other significant judgements, sources of estimation uncertainty and/or relating information, have been disclosed in the relating 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 asset's ability to continue to generate cash flows (in the case of cash-generating assets). For non-cash generating assets, estimates are made regarding the depreciated replacement cost, restoration cost, or service units of the asset, depending on the nature of the impairment and the availability of the information.

1.4 Significant judgements and sources of estimation uncertainty (continued)

Provisions

Provisions are measured at 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.

Provisions were raised and management determined an estimate based on the information available.

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 Scheme's expectations about the residual value and useful life of assets included in 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 the Standards of GRAP on accounting policies, Change in Accounting Estimates and Errors.

1.5 Property, plant and equipment

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

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

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

Property, plant and equipment is initially measured at cost.

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

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

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

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

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

1.5 Property, plant and equipment (continued)

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
Office equipment leased	Straight-line	5 years
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 discloses expenditure to repair and maintain property, plant and equipment in the notes to the financial statements.

The entity discloses relevant information relating to assets under construction or development, in the notes to the financial statements.

1.6 Intangible assets

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.

1.6 Intangible assets (continued)

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.

1.7 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 uncontrollability.

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.

1.7 Financial instruments (continued)

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
Receivable from exchange transactions	Financial asset measured at amortised cost
Cash and cash equivalents	Financial asset measured at amortised cost
Security deposit	Financial asset measured at amortised cost

Financial instruments include security deposits which are classified as non-current assets in the statement of Financial Position. Security deposits comprise of funds placed in a security deposit as mandated by S145 of Labour Relations Act pending cases either at CCMA or Labour court. These funds are paid back to CMS once cases are settled.

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

Payables from exchange transactions are obligations for goods and services that have been acquired from suppliers in the ordinary course of business. Payables from exchange transactions are classified as current liabilities if payment is due within one year or less. If not they are presented as non-current liabilities.

1.8 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.

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.

Other CMS receivables comprise sundry debtors, which are receivables other than the CMS statutory receivables.

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.

1.8 Statutory receivables (continued)

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.

1.9 Cash and cash equivalents

Cash and cash equivalents include cash on hand and demand deposits. Cash equivalents are held for the purposes of meeting the short-term cash commitments rather than for investment or other purposes. For an investment to qualify as a cash equivalent, it must be readily convertible to a known amount of cash and be subject to an insignificant risk of changes in value. Therefore, an investment normally qualifies as a cash equivalent only when it has a short maturity of, say, three months or less from the date of acquisition. Equity investments are excluded from cash equivalents unless they are, in substance, cash equivalents. Current tax for current and prior periods is, to the extent unpaid, recognised as a liability. If the amount already paid in respect of current and prior periods exceeds the amount due for those periods, the excess is recognised as an asset.

1.10 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.

Finance leases - lessee

Finance leases are recognised as assets and liabilities in the statement of financial position at amounts equal to the fair value of the leased property or, if lower, the present value of the minimum lease payments. The corresponding liability to the lessor is included in the statement of financial position as a finance lease obligation.

The CMS used prime rate in calculating the present value of the minimum lease payments.

Minimum lease payments are apportioned between the finance charge and reduction of the outstanding liability. The finance charge is allocated to each period during the lease term so as to produce a constant periodic rate of on the remaining balance of the liability.

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

Operating leases - lessee

An operating lease is a lease other than finance lease and for the CMS it is the 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.

1.11 Employee benefits

Identification

Employee benefits

Employee benefits are all forms of consideration given by an entity 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.

Short-term employee benefits

Recognition and measurement

All short-term employee benefits

Short-term employee benefits are employee benefits (other than termination benefits) that are due to be settled within twelve months after the end of the period in which the employees render the related service.

Short-term employee benefits include items such as:

- wages, salaries and social security contributions;
- short-term compensated absences (such as paid annual leave and paid sick leave) where the compensation for the absences is due to be settled within twelve months after the end of the reporting period in which the employees render the related employee service;
- bonus, incentive and performance related payments payable within twelve months after the end of the reporting period in which the employees render the related service; and
- non-monetary benefits (for example, medical care, and free or subsidised goods or services such as housing, cars and cellphones) for current employees.

1.11 Employee benefits (continued)

When an employee has rendered service to the entity during a reporting period, the entity recognises the undiscounted amount of short-term employee benefits expected to be paid in exchange for that service:

- as a liability (accrued expense), after deducting any amount already paid. If the amount already paid exceeds the undiscounted amount of the benefits, the entity recognises that excess as an asset (prepaid expense) to the extent that the prepayment will lead to, for example, a reduction in future payments or a cash refund; and
- as an expense, unless another Standard requires or permits the inclusion of the benefits in the cost of an asset.

The expected cost of compensated absences is recognised as an expense as the employees render services that increase their entitlement or, in the case of non-accumulating absences, when the absence occurs. The entity measures the expected cost of accumulating compensated absences as the additional amount that the entity expects to pay as a result of the unused entitlement that has accumulated at the reporting date.

The entity recognises the expected cost of bonus, incentive and performance related payments when the entity has a present legal or constructive obligation to make such payments as a result of past events and a reliable estimate of the obligation can be made. A present obligation exists when the entity has no realistic alternative but to make the payments.

1.12 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/inflow 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.

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 the amount cannot be measured reliably. Contingent assets and liabilities are not recognised.

1.13 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:

1.13 Commitments (continued)

- 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.

1.14 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.

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.
- **Levy 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.
- **Interest income:** It is an interest earned from the current account and the CPD account.

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.

1.15 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.

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 comprise the following:

1. A grant from the Department of Health (DoH) which is sometimes conditional or unconditional. Conditional grant is recognised as a liability only when there is terms and conditions stipulated by DoH. It is reduced by the expenditure incurred towards the projects aligned to the grant and that expenditure is recognised as revenue in the statement of Financial performance.
2. Mandatory transfer from the Department of Higher Education and Training.

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

1.15 Revenue from non-exchange transactions (continued)

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. The 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.

1.16 Finance costs

Finance costs are interest and other expenses incurred by the CMS in relation to interest payable in any given period.

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

1.17 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 there are material accounting errors which relate to prior periods, 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. Where necessary comparative figures have been restated/reclassified to conform to changes made in the current year.

1.18 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.

1.19 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.

Irregular expenditure is accounted for and disclosed in terms of National Treasury Instruction 4 of 2022/23: PFMA compliance and reporting framework effective from 03 January 2023.

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 the exception of updating the note to the financial statements.

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

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

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

1.20 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 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 2024 to 31 March 2025.

The Annual Financial Statements and the budget are not prepared 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.

1.21 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.

A 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.

1.22 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.

1.23 Prepayments

A prepaid expense is an expense paid for in one accounting period but for which the underlying asset will not be consumed until a future period.

A prepaid expense is carried on the Statement of Financial Position of the CMS as a current asset until it is consumed. If a prepaid expense was likely to not be consumed within the next 12 months, it would instead be classified on the Statement of Financial Position as a non-current asset. Once consumption has occurred, the prepaid expense is removed from the Statement of Financial Position and is instead reported in that period as an expense on the Statement of Financial Performance.

1.24 Income received in advance

Income received in advance is revenue received for a service that has not yet been rendered by the CMS at the end of the financial year. The income received in advance is carried as a liability on the Statement of Financial Position. As the service is been rendered, the liability is released onto the Statement of Financial Performance and recognised as revenue.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

2. New standards and interpretations

2.1 Standards and interpretations issued, but not yet effective

The entity has not applied the following standards and interpretations, which have been published and are mandatory for the entity's accounting periods beginning on or after 01 April 2025 or later periods:

Standard/ Interpretation:	Effective date: Years beginning on or after	Expected impact:
GRAP 107 (as revised) Mergers	01 April 2026	Unlikely there will be a material impact
GRAP 106 (as revised) Transfer of Functions Between Entities Not Under Common Control	01 April 2026	Unlikely there will be a material impact
GRAP 105 Transfer of Functions Between Entities Under Common Control	01 April 2026	Unlikely there will be a material impact
GRAP 2023 Improvements to the Standards of GRAP 2023	01 April 2026	Unlikely there will be a material impact
GRAP 1 (amended): Presentation of Financial Statements (Going Concern)	01 April 2026	Unlikely there will be a material impact
GRAP 103 (amended): Heritage Assets	01 April 2026	Unlikely there will be a material impact
iGRAP 22 Foreign Currency Transactions and Advance Consideration	01 April 2025	Unlikely there will be a material impact
GRAP 104 (as revised): Financial Instruments	01 April 2025	Unlikely there will be a material impact

3. Property, plant and equipment

	2025			2024		
	Cost	Accumulated depreciation	Carrying value	Cost	Accumulated depreciation	Carrying value
Furniture and fixtures	9 766	(6 967)	2 799	8 479	(6 330)	2 149
Motor vehicles	470	(448)	22	470	(425)	45
Office equipment - leased	1 527	(490)	1 037	1 527	(184)	1 343
Computer equipment	14 496	(8 507)	5 989	19 270	(15 579)	3 691
Computer software	1 049	(1 032)	17	1 049	(1 000)	49
Leasehold improvements	11 980	(11 980)	-	11 980	(11 920)	60
Other fixed assets	1 247	(783)	464	763	(613)	150
Total	**40 535**	**(30 207)**	**10 328**	**43 538**	**(36 051)**	**7 487**

Reconciliation of property, plant and equipment - 2025

	Opening balance	Additions	Disposals	Depreciation	Total
Furniture and fixtures	2 149	1 187	(11)	(526)	2 799
Motor vehicles	44	-	-	(23)	21
Office equipment - leased	1 343	-	-	(306)	1 037
Computer equipment	3 691	3 358	-	(1 060)	5 989
Computer software	49	-	-	(32)	17
Leasehold improvements	60	-	-	(60)	-
Other fixed assets	150	496	-	(182)	464
	7 486	**5 041**	**(11)**	**(2 189)**	**10 327**

Reconciliation of property, plant and equipment - 2024

	Opening balance	Additions	Disposals	Depreciation	Total
Furniture and fixtures	2 914	57	(8)	(814)	2 149
Motor vehicles	67	-	-	(23)	44
Office equipment - leased	-	1 527	-	(184)	1 343
Computer equipment	4 186	1 589	(50)	(2 035)	3 690
Computer software	75	-	-	(26)	49
Leasehold improvements	777	-	-	(717)	60
Other fixed assets	192	-	-	(42)	150
	8 211	**3 173**	**(58)**	**(3 841)**	**7 485**

4. Intangible assets

	2025			2024		
	Cost	Accumulated amortisation	Carrying value	Cost	Accumulated amortisation	Carrying value
Computer software, internally generated	2 977	(2 324)	653	2 977	(2 182)	795
Computer software, other	911	(381)	530	911	(347)	564
Total	**3 888**	**(2 705)**	**1 183**	**3 888**	**(2 529)**	**1 359**

Reconciliation of intangible assets - 2025

	Opening balance	Amortisation	Total
Computer software, internally generated	795	(143)	653
Computer software	564	(34)	530
	1 359	**(177)**	**1 183**

Reconciliation of intangible assets - 2024

	Opening balance	Disposals	Amortisation	Total
Computer software, internally generated	929	-	(134)	795
Computer software	611	(2)	(45)	564
	1 540	**(2)**	**(179)**	**1 359**

5. Security deposit

Invested amount	-	4 540

Terms and conditions

These funds were placed under security deposit as mandated by S145 of Labour Relations Act. There was disinvestment in January 2025 as settlement was reached between parties. This amount is included in CMS cash and cash equivalents. An interest of R211 000 was earned during the year from this investment.

Non-current assets		
Residual interest at cost	-	4 540

6. Finance lease payables

	2025 '000	2024 '000
Gross investment in the lease due		
- within one year	**606**	606
- in second to fifth year inclusive	217	824
	823	1 430
less: Unearned finance revenue	(66)	(186)
	757	**1 244**
Present value of minimum lease payments due		
- within one year	489	486
- in second to fifth year inclusive	268	758
	757	**1 244**

The CMS entered into a finance leasing agreement for photocopier machines. The lease term is 3 years ending on 31 August 2026 and the effective rate is 11.75%. The lease payments do not escalate over the lease period. The leasing arrangement has an option to renew for maximum of 2 years at no cost.

None of the leased assets has been pledged as security for liabilities or contingent liabilities.

7. Payables from exchange transactions

Trade payables	13 512	10 948
Income received in advanced	1 183	1 380
Accrual for leave pay	4 895	4 474
Accruals	6 820	10 837
	26 410	**27 639**

Accounts paable ageing	Current	30 days	60 days	90 days	120 days	Over 120 days
	5 830	70	-	23	1	2 865
Subtotal	5 830	70	-	23	1	2 865
	5 830	**70**	**-**	**23**	**1**	**2 865**

Accounts payables include R4 722 421 which is current and made up of PAYE: R4 085 082. Employee wellness: R55 386, and medical aid: R581 955.

8. Receivables from exchange transactions

Statutory receivables included in receivables from exchange transactions above are as follows:		
Rule amendments in terms of Regulation 31 of the Medical Schemes Act (No.131 of 1998)	229	169
Included in receivables from exchange transactions above are prepaid expenses and interest receivable	**7 262**	**7 275**
Total receivables from exchange transactions	**7 491**	**7 444**

Accounts receivable ageing	Current	30 days	60 days	90 days	120 days	Over 120 days
Sundry debtors	1 201	-	-	-	-	2 433
Statutory receivables	33	-	4	10	-	182
Subtotal	1 234	-	4	10	-	2 615
	1 234	**-**	**4**	**10**	**-**	**2 615**

Sundry debtors of R3 633 633 comprise: legal fees recovered of R1 121 898 current, R2 424 351 over 120 days, interest received of R17 030 current, staff loans of R16 320 current and tea club R54 034 current. The aging is from the invoice date.

Statutory receivables include rule amendment of R33 231 current, R3 919 over 60 days, R10 266 over 90 days, R181 583 over 120 days.

Reconciliation for debtor impairment

Sundry debtor	4 603	3 528
Provision for doubtful debt	(969)	(969)
	3 634	**2 559**

An allowance for a doubtful debt of R969 000 (2024: R969 000) was raised in relation to inspection fees recoverable from a scheme.

9. Cash and cash equivalents

Bank balances	18 579	8 143
CPD account	20 643	50 980
	39 222	**59 123**

Corporation for Public Deposits (CPD) account, a subsidiary of the Reserve Bank of South Africa, consists of surplus funds held in terms of S31.3.3(a) of National Treasury regulations.

10. Provisions

	2025 '000	2024 '000

Reconciliation of provisions - 2025

	Opening Balance	Additions	Utilised during the year	Total
Provision for long service award	8 801	1 363	(537)	9 627
Provision for court cases	820	-	-	820
Provision for performance bonus	2 158	5 000	(2 158)	5 000
	11 779	**6 363**	**(2 695)**	**15 447**

10. Provisions (continued)

Reconciliation of provisions - 2024

	Opening Balance	Additions	Utilised during the year	Total
Provision for long service award	7 612	2 042	(853)	8 801
Provision for court cases	820	-	-	820
Provision for performance bonus	1 190	2 158	(1 190)	2 158
	9 622	**4 200**	**(2 043)**	**11 779**

Non-current liabilities	9 306	8 262
Current liabilities	6 141	3 517
	15 447	**11 779**

Provision for long service award

Employees receive long service awards in intervals of 10 years. The provision for long service award represents management's best estimate of the CMS' 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 factored by the expectancy rate of employees being in service after 10 years, based on historic information.

The assumptions applied in the calculation of the provision are as follows:

- Salary inflation 7.24% (2023/24: 7.74%)
- Discount rate 11.00% (2023/24: 11.75%)
- Retention rate 89.00% (2023/24: 89.00%)

Provision for performance bonus

The performance bonus provision is based on the performance management policy.

Provision for court cases

The provision for court cases relates to cases that have been finalised but costs still to be determined by the Tax Master. The provision arose from a case against Sizwe Medical Scheme which CMS lost in 2020 financial year. The reasonable estimate made by lawyers for the costs was R820 170.

11. Revenue

	2025 '000	2024 '000
Accreditation fees	7 772	7 810
Levies income	201 641	190 575
Registration fees	498	464
Sundry income	1 069	824
Legal fees recovered	1 122	83
Appeal/inspection fees recovered	227	844
Interest received - investment	8 187	8 566
Government transfers: Department of Health	6 151	6 537
Mandatory transfer: Department of Higher Education and Training	256	327
	226 923	**216 030**

11. Revenue (continued)

The amount included in revenue arising from exchanges of goods or services are as follows:		
Accreditation fees	7 772	7 810
Levies income	201 641	190 575
Registration fees	498	464
Sundry income	1 069	824
Legal fees recovered	1 122	83
Appeal/inspection fees recovered	227	844
Interest received - investment	8 187	8 566
	220 516	**209 166**

The amount included in revenue arising from non-exchange transactions is as follows:		
Transfer revenue		
Government transfers: Department of Health	6 151	6 537
Mandatory transfer: Department of Higher Education and Training	256	327
	6 407	**6 864**

12. Unspent conditional grants and receipts

Grant received from Department of Health		
Conditional grant received	2 080	2 080

The CMS received grants in the amount of R2 556 000 in 2015/16 and R1 613 000 in 2016/17 with a condition to complete development and maintenance of Medicines Pricing Registry and Central Beneficiary Registry which incurred costs amounting to R2 089 000. Both these projects are now closed. The remaining funds from these projects are ring-fenced in the CPD account.

13. Staff costs

	2025 '000	2024 '000
Salaries	152 676	133 109
Workmen's compensation	166	158
Employee benefits	4 689	3 889
Recruitment and relocation	1 121	513
Temporary staff	4 726	3 985
	163 378	**141 654**
Total number of employees	136	125

14. Finance costs

Finance lease	119	106

15. Operating surplus

(Loss)/gain on disposal of assets	(11)	(43)

16. Labour settlement

Labour settlement	10 592	-

A settlement for a labour dispute with 3 former General Managers (GMs) and a previous CFO.

17. Operating expenses

Audit and risk committee remuneration	376	318
Consulting	3 409	3 720
Council member's fees	6 060	4 433
Exhibition costs	-	37
Inspection costs	523	515
Knowledge management	1 387	1 583
Legal costs-employee matters	3 503	1 648
Legal fees	14 492	12 121
Media and promotions	658	1 205
Postage and courier	1	4
Printing and publication	396	229
Transcription	39	34
Travel - local	1 337	1 133
Venue and catering	854	488
	33 035	**27 468**

18. Auditors' remuneration

External audit	943	914
Internal audit	600	1 313
	1 543	**2 227**

The reduction in Internal Audit fees is due to change in the internal audit plan during the financial year necessitated by postponement of IT audit.

19. Administrative expenses

	2025 '000	2024 '000
Bad debts	-	969
Bank charges	80	85
Building expenses	2 374	2 064
Insurance	710	901
Printing and stationery	134	232
Rent - Office building	15 321	13 944
Security	929	595
Subscriptions	580	352
Telecommunication expenses	11 261	9 262
Training	2 499	2 228
General administrative expenses	2 350	1 372
Rent - operating costs	3 322	3 149
	39 560	**35 153**

Included in the general administrative expenses above are the repairs and maintenance costs disclosed below for property, plant and equipment:

Repairs and maintenance	665	544

20. Cash (used in) generated from operations

(Deficit) surplus	(23 681)	5 358
Adjustments for:		
Depreciation and amortisation	2 366	4 051
Loss on disposal of assets and liabilities	11	43
Movements in operating lease assets and accruals	-	(650)
Movements in provisions	3 668	2 155
Changes in working capital:		
Receivables from exchange transactions	(47)	(809)
Payables from exchange transactions	(1 229)	(480)
	(18 912)	**9 668**

21. Financial instruments disclosure

	2025 '000	2024 '000
Categories of financial instruments		

2025

Financial assets

	At amortised cost	Total
Trade and other receivables from exchange transactions	3 634	3 634
Cash and cash equivalents	39 222	39 222
	42 856	**42 856**

Financial liabilities

	At amortised cost	Total
Trade and other payables from exchange transactions	20 332	20 332

21. Financial instruments disclosure (continued)

2024

Financial assets

	At amortised cost	Total
Trade and other receivables from exchange transactions	2 559	2 559
Cash and cash equivalents	59 123	59 123
Security deposit	4 540	4 540
	66 222	**66 222**

Financial liabilities

	At amortised cost	Total
Trade and other payables from exchange transactions	21 785	21 785

22. Operating lease commitment

Operating lease commitment		
Minimum lease payments due		
- within one year	12 847	15 318
- in second to fifth year inclusive	60 262	1 283
	73 109	**16 601**

An old lease ended on 30 April 2025 and a new CMS building lease agreement was entered into for 5 years, starting from 1 May 2025 and ending 30 April 2030 with an escalation rate of 6.5%.

23. Contingencies

23.1 Contingency liabilities

The following cases are still ongoing in courts of which the judgements are still pending and it is impracticable to estimate their outcome probability. In some matters below it is impractical to estimate the costs.

- The CMS vs Mokoditoa S59 challenge. The estimated cost is R350 000. The CMS is defending against an allegation of discrimination in the Equality Court.
- The CMS vs Government Employees Medical Schemes. The CMS has instituted civil proceedings in the High Court against GEMS to recover outstanding inspection fees. The estimated cost of legal fees is R100 000.
- Discovery Medical Schemes vs CMS (Illegal vouchers). Costs are estimated at R500 000. The CMS is defending an appeal by Discovery Health (Pty) Ltd (DH) in respect of directives issued by the Registrar to request that DH desist from further contravening the business of doing a medical scheme as envisaged by S20 read with S24 of the Medical Schemes Act.
- Kinsman vs the Registrar. The costs are estimated at an amount of R500 000. The CMS is defending a high court proceeding brought by the litigant for alleged removal from the trustee election.
- The CMS vs Netcare (Curatorship). The CMS brought curatorship proceedings to the High Court due to the scheme's failure to hold an elective general meeting as mandated by the scheme rules. The costs of legal fees are estimated at R800 000.
- The CMS vs Polmed (Regulatory Matters). The CMS is defending an interdict brought by Polmed, alleging that the process for implementing the inspection under S44 of the Medical Schemes Act was unlawful and irrational.
- CMS/Discovery Holdings accreditation (appeal on the imposition of a condition for DHMS to be accredited as an administration service provider). The CMS is defending an appeal by Discovery Holdings (Pty) Ltd (DH) against the alleged imposition of an alleged unfair condition imposed without due process and consultation.

23. Contingencies (continued)

- LCBO cases (appeals in respect of Circulars 80 and 82 to abolish primary healthcare products). Costs estimated at R4 000 000. The CMS is defending high court proceedings brought by BHF for alleged failure by CMS to develop a base benefit option package.
- The CMS/Le Roux vs Genesis Medical Scheme. The CMS is defending high court proceedings brought by Genesis for an alleged failure by the scheme to honour PMB's related claims.

23.2 **Dispute over invoices from Special Investigative Unit (SIU)**

- CMS/Registrar vs SIU (CMS disputing SIU invoices of which the cost is R15 000 000) plus R950 000 legal costs to a 3rd party. The CMS brought High Court proceedings against the SIU to review and place the SIU final report into the CMS affairs under judicial scrutiny.

23.3 **Surrender of surplus funds**

- In line with section 53(3) of the PFMA, the CMS may not accumulate surpluses that were realised in previous financial years without obtaining prior written approval from National Treasury. In the 2024/25 financial year, the CMS has reported an accumulated surplus of R11 593 000 and will be applying to the National Treasury to retain these funds by the end of September 2025 as required by the National Treasury instruction note 12 of 2020/21. The probability of success is uncertain as the decision vests with the National Treasury.

23.4 **Contingent assets**

- The CMS vs Government Employees Medical Scheme. The cost is estimated at an amount of R3 153 428. The CMS has instituted civil proceedings in the High Court against GEMS to recover outstanding inspection fees.

24. 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 the Medical Schemes Act, No 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 balances		
Transfer paid to/(received from) related parties		
Department of Health	(6 151)	(6 537)

25. Remuneration of Management

Executive

2025

	Basic salary	Other benefits	Performance management	Total
Chief Executive and Registrar - Dr S. Kabane (Retired 31 July 2024)	1 348	368	140	1 856
Chief Executive and Registrar - Dr M. Gumede (Appointed 1 December 2024)	1 106	-	-	1 106
Chief Financial Officer - Ms A. Zinja	2 455	11	105	2 571
Chief Information Officer - Dr D. Jairam-Owthar	2 440	11	-	2 451
Executive: Corporate Services - Mr Z. Baloyi	2 440	17	79	2 536
Executive: Research and Monitoring - Dr M. Willie	2 438	11	104	2 553
Executive: Regulation - Mr M. Maswanganyi	2 450	500	86	3 036
Executive: Member Protection - Dr T. Potelwa	2 439	10	88	2 537
Executive Manager: Office of the Chief Executive and Registrar - Mr R. Sadiki	167	104	81	352
	17 283	**1 032**	**683**	**18 998**

2024

	*Basic salary	Performance management	Total
Chief Executive and Registrar - Dr S. Kabane	3 397	152	3 549
Chief Financial Officer - Ms A. Zinja	2 604	103	2 707
Chief Information Officer - Dr D. Jairam-Owthar	1 336	-	1 336
Executive: Corporate Services - Mr Z. Baloyi	2 491	41	2 532
Executive: Research and Monitoring - Dr M. Willie	2 594	84	2 678
Executive: Regulation - Mr M. Maswanganyi	2 563	73	3 636
Executive Manager: Office of the Chief Executive and Registrar - Mr R. Sadiki	2 104	78	2 182
Executive: Member Protection - Dr T. Potelwa (Appointed 1 November 2023)	969	-	969
	18 058	**531**	**18 589**

*Basic salary includes back-pay for salary benchmark outcome.

25. Remuneration of Management (continued)

Non-executive

2025

	Members' fees	Total
Dr T. Mabeba	1 375	1 375
Mr M. Mfundisi	312	312
Dr H. Mukhari	473	473
Mr N. Raheman	11	11
Dr S. Naidoo	825	825
Dr X. Ngobese	929	929
Mr T. Esterhuyse	126	126
Mr A. Chogle	297	297
Ms P. Beck	793	793
Dr K. Chetty (from April 2024)	722	722
Mr L. Langalibalele	197	197
	6 060	**6 060**

Not Included in the above non-executive members are Mr S. Jikwana, Dr P. Mbava and Dr M. Nkosi who are public officials and who were appointed 15 November 2023. Dr K. Chetty only got remunerated from April 2024 as she was a public official before.

Non-executive

2024

	Members' fees	Total
Dr T. Mabeba (2nd term 15 November 2023)	709	709
Mr M. Maimane (Term ended 15 November 2023)	407	407
Dr M. Makiwane (Term ended 15 November 2023)	593	593
Mr M. Mfundisi (2nd term 15 November 2023)	361	361
Dr H. Mukhari (2nd term 15 November 2023)	341	341
Ms D. Terblanche (Term ended 15 November 2023)	470	470
Mr N. Naheman (2nd term 15 November 2023)	181	181
Dr S. Naidoo (2nd term 15 November 2023)	594	594
Dr X. Ngobese (2nd term 15 November 2023)	529	529
Mr T. Ersterhuyse (Appointed 15 November 2023)	43	43
Dr P. Masegare (Appointed 15 November 2023)	44	44
Mr A. Chogle (Appointed 15 November 2023)	65	65
Ms M. Ramagaga (Appointed 15 November 2023)	11	11
Ms P. Beck (Appointed 15 November 2023)	85	85
	4 433	**4 433**

Not included in the above non-executive members are Mr I. Vanker, Dr A. Thulare and Adv. R. Mareume who are public servants and whose term ended on the 15 November 2023. Also not included in the above non-executive members are Dr K. Chetty and Mr M. Nkosi who are public officials and appointed on the 15 November 2023. Also not included is Dr P. Mbava who was appointed for the 2nd term but serves in a public entity.

25. Remuneration of Management (continued)

Independent audit and risk committee members' remuneration

2025

	Fees for service as member of audit and risk committee	Total
Mr J.N Raphela	56	56
Dr M. Phesa(Chairperson)	269	269
Ms B. Qwesha (Commenced 9 October 2024)	45	45
	370	**370**

Not included in above committee members are Mr L. Langalibalele, Mr A. Chogle and Dr X. Ngobese who represent Council in this committee.

2024

	Fees for service as member of audit and risk committee	Total
Mr J.N Raphela	93	93
Ms D. Thabede	54	54
Dr M. Phesa	171	171
	318	**318**

Not included in the above audit and risk committee members are Dr X. Ngobese, Dr P. Masegare and Mr A. Chogle who represent Council in this committee.

26. Prior period errors

A prior period error was identified in relation to NEHAWU wage agreement transactions amounting to R3 986 123 accounted for in 2023/24 financial year when activities occurred in the prior year. A prior period error was identified in relation to depreciation for leased office equipment was overstated in 2023/24 financial year.

A prior period error was identified in relation to accruals raised based on statements in 2019/20, 2020/21, 2021/22 and 2022/23 financial years but it was later discovered with suppliers that there was no liability.

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

	Previously Reported	Correction	Restated
Decrease in Accruals 31 March 2024	15 857	(3 986)	11 871
Decrease in salaries 31 March 2024	137 095	(3 986)	133 109
Decrease in accumulated depreciation - Leased office equipment 31 March 2024	(214)	30	(184)
Decrease in depreciation 31 March 2024	4 051	(30)	4 021
Decrease in accruals in 31 March 2020	17 391	(21)	17 370
Decrease in accumulated deficit 31 March 2020	(19 643)	21	(19 623)
Decrease in accruals 31 March 2021	16 065	(68)	15 997
Decrease in accumulated deficit 31 March 2021	(17 993)	68	(17 925)
Decrease in accruals 31 March 2022	9 099	(491)	8 608
Increase in accumulated surplus 31 March 2022	2 256	491	2 747
Decrease in accruals 31 March 2023	10 114	(458)	9 656
Increase in accumulated surplus 31 March 2023	30 815	458	31 273

27. Risk management

Financial risk management

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

Liquidity risk

The entity's risk in relation to liquidity is a result of payment of its payables. These payables are all due within the short-term. The CMS manages its liquidity risk by holding sufficient cash in its bank account, supplemented by cash available in the CPD account of R20 643 158 as at 31 March 2025.

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/decrease of R206 432.

28. Going concern

We draw attention to the fact that at 31 March 2025, the entity had an accumulated surplus of R13 530 000 and that the entity's total assets exceed its liabilities by R13 530 000. 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.

29. Irregular expenditure

	2025 '000	2024 '000
Add: Irregular Expenditure - current	661	893
Add: Fruitless and wasteful expenditure-current	692	-
Closing balance	**1 353**	**893**

The irregular expenditure identified mainly relates to non-compliance with Treasury Regulation 16(a)(6).

Irregular expenditure and fruitless and wasteful expenditure are investigated by the Loss Control Committee. In the 2024/25 financial year, no matters relating to criminality were identified. Where disciplinary steps have not been taken and are warranted, the Loss Control Committee makes recommendation accordingly.

G

OVERVIEW OF CMS ACTIVITIES

STRENGTHENING POLICY THROUGH RESEARCH INSIGHTS

Support to the National Department of Health

During the period under review, the CMS provided continued policy and technical support to the NDoH in line with Section 7 of the Act. This included ongoing assistance in collecting HIV/STI data from medical schemes on a biannual basis to support the South African National AIDS Council (SANAC) and technical support for the National Health Accounts (NHA) regarding private sector health expenditure data, which was subsequently submitted to the Minister for consideration. In addition, the CMS addressed ad hoc data requests and aligned efforts on the development of the PMB Primary Healthcare (PHC) package. The CMS also completed its support to develop guidelines addressing undesirable practices, such as excessive co-payments and designated service providers.

Key Policy Research Outputs

During the reporting period, all scheduled research activities were completed, yielding outputs that align with the Council for Medical Schemes' strategic objective to conduct policy-relevant research to inform and advise healthcare policy formulation. Notable achievements included comprehensive reviews of Bargaining Council Schemes and government-funded medical schemes, in-depth analyses of chronic disease prevalence and associated healthcare quality outcomes, and an investigative study on high out-of-pocket expenditures linked to chronic conditions and diagnostic treatment pairs.

Five policy-oriented research bulletins were published, covering critical themes such as the standardisation of supplementary benefits in response to Health Market Inquiry (HMI) recommendations, reforms to Prescribed Minimum Benefits (PMBs), the impact of contribution increases on scheme members, and persistent healthcare inequalities in South Africa. Three peer-reviewed articles published in the World Medical Journal contributed to international scholarly engagement and reinforced thought leadership in the sector. Additional academic outputs reflected a multidisciplinary approach to health systems research, addressing service innovation, healthcare quality, digital marketing within medical schemes, and broader public health concerns, including HIV/AIDS funding and obesity.

Key strategic contributions included the development of a concept note on the Draft Interim Block Exemption for Tariff Determination, a draft framework for standardising supplementary benefits, and an economic outlook assessment that informed the 2025 contribution increase projections.

Progress was also made in assessing third-party administrators and designated service providers, completing a comparative analysis of the CMS and NDoH primary healthcare benefit packages, and advancing the revision of PMB definitions, which remain on track for completion.

Prevalence of chronic diseases in the population covered by medical schemes in South Africa: 2014-2023

The primary objective of this study was to examine the trends in the prevalence of chronic diseases among beneficiaries of South African medical schemes from 2014 to 2023, focusing on the identification of disease burdens by demographic groups, scheme types, and hospitalisation rates. Specifically, the study aimed to compare general and Scheme Risk Measurement (SRM) prevalence rates for Chronic Disease List (CDL) conditions and assess whether current disease management strategies, particularly Disease Management Programmes (DMPs), adequately address the growing burden of chronic illness. Additionally, the research explored gender disparities and the role of age in the distribution and progression of chronic conditions within the medical scheme population.

The findings revealed a steady and concerning increase in the prevalence of key chronic conditions, notably hypertension, hyperlipidaemia, and Type 2 Diabetes Mellitus (DM2), which remain the most common conditions across all scheme types. The burden of disease was disproportionately high among individuals aged 60 years and older, who now account for nearly 14% of the covered population, exhibiting elevated rates of multiple chronic illnesses and hospitalisation. While SRM prevalence for some conditions, such as Type 1 Diabetes and HIV/AIDS, declined, general prevalence rates remained consistently higher, indicating that many diagnosed patients were not captured by risk-adjusted reporting mechanisms, often due to exclusion from DMPs.

Gender disparities were also evident in the data, with women more likely to be hospitalised for chronic conditions, despite a higher overall prevalence of some conditions in men. Notably, respiratory and gastrointestinal conditions, including bronchiectasis, chronic renal disease, and ulcerative colitis, saw significant growth in prevalence and hospitalisation rates. Restricted schemes demonstrated

sharper increases in hyperlipidaemia and DM2, while open schemes recorded spikes in cardiomyopathy and other cardiovascular disorders. The improvements in data quality and alignment between reporting systems have facilitated more reliable monitoring of trends, providing a solid foundation for evidence-based policy development.

Given the escalating burden of chronic diseases, particularly among older adults, the study signals the urgent need for reforms in chronic disease management. Broader enrolment into DMPs, targeted interventions for high-risk age groups, and gender-responsive care strategies are essential. The discrepancies between SRM and general prevalence highlight the need to revise eligibility criteria to ensure all diagnosed individuals receive appropriate, sustained care. The study recommends an integrated approach to data reporting, preventive care, and lifestyle modification programmes to address the rise in metabolic and cardiovascular diseases and improve long-term healthcare sustainability in South Africa's private health financing sector.

Analysis and Interventions on High Levels of Out-of-Pocket Payments: A 2023 Overview of Chronic Disease and Diagnostic Treatment Pairs

The escalating financial burden of healthcare in South Africa, particularly Out-of-Pocket (OOP) expenses, presents significant challenges for medical scheme members, especially those managing CDL conditions. These costs vary based on several factors, including the type of scheme (open vs. restricted), care setting (in-hospital vs. out-of-hospital), geographic location, and age demographics. Understanding the distribution and drivers of OOP expenditure is crucial for informing equitable benefit design and financial protection strategies.

This study aimed to analyse patterns of OOP healthcare expenditure among medical scheme beneficiaries in 2023, focusing on CDL conditions. The objectives were to identify the CDL conditions with the highest OOP costs, compare spending between open and restricted schemes, evaluate the cost implications of different care settings, and assess disparities across provinces and age groups. Scheme-submitted statutory data were used, which were then stratified and analysed using descriptive and comparative methods to uncover key expenditure patterns.

The findings revealed that open schemes recorded higher overall OOP costs, largely driven by out-of-hospital care. Chronic renal disease emerged as the most expensive condition per patient, followed by haemophilia and cardiomyopathy. KwaZulu-Natal had the highest OOP expenditure, largely due to access to healthcare providers. Children under five faced significant costs for conditions such as cardiac failure, while adults over 75 bore high OOP costs for respiratory and cardiac conditions, including bronchiectasis. Notably, high OOP costs were frequently associated with common CDL conditions, not necessarily rare ones. Although gap cover products offered some financial relief, they may obscure the full extent of catastrophic health expenditure (CHE) risks.

The study highlights the need for targeted reforms to reduce OOP healthcare costs. Key recommendations include expanding scheme coverage for high-cost CDL conditions, particularly for vulnerable groups such as the elderly and children; implementing innovative benefit designs to improve affordability; addressing geographic disparities by enhancing access to specialist services; and developing age-specific interventions. These actions are essential to advance equitable, efficient, and sustainable healthcare financing for medical scheme beneficiaries in South Africa.

Performance and Compliance of Bargaining Council Schemes

Bargaining Council Schemes, established under the Labour Relations Act (LRA) of 1995 to provide healthcare and other benefits to workers in specific industries, have evolved into medical schemes governed by the Medical Schemes Act (MSA) (131 of 1998). Some of these schemes operate under exemptions from PMBs, allowing them to offer limited benefits tailored to low-income earners. This study assesses the performance of PMB-exempted Bargaining Council Schemes in 2022, focusing on their compliance with legislative obligations, demographic and disease profiles, and financial sustainability.

In 2022, five Bargaining Council Schemes – Moto Health, Food Workers, Fish-Med, Golden Arrows, and Building & Construction – operated under PMB exemptions, offering a combined total of 13 benefit options. These schemes primarily served younger, working-age populations, with average ages ranging from 27.5 to 37.3 years, and had lower pensioner ratios compared to other restricted schemes. The disease burden varied significantly across schemes, with Moto Health and Food Workers experiencing high rates of chronic diseases such as hypertension and diabetes. PMB-related expenditure also differed across schemes, with some, like Moto Health, reporting high per beneficiary costs, while others, such as Food Workers, showed no expenditure in this category.

The analysis revealed that schemes exempt from PMBs, which are typically designed to serve low-income earners, often rely on affordability-driven cost-containment strategies. While these approaches aim to enhance financial sustainability, they simultaneously constrain the breadth

and quality of healthcare services offered, limiting members' access to comprehensive care.

While Moto Health reflected high Prescribed Minimum Benefit (PMB) utilisation and associated expenditure, schemes such as Golden Arrow and Fish-Med reported limited access to PMB services, which may be attributed to the structure of their benefit options and affordability limitations faced by members.

Despite their exemptions, these schemes are expected to progressively enhance their benefits, notably by expanding coverage for chronic diseases and increasing outpatient and inpatient services. The varying financial sustainability across schemes underscores the need for more targeted oversight and support to ensure long-term viability.

To align with the goals of the MSA and ensure better healthcare access, the CMS will strengthen its monitoring of PMB-exempted schemes. Recommendations for these schemes include the gradual expansion of their benefit packages, improved disease management programmes, and the reassessment of their contribution models to enhance affordability without compromising the quality of care.

A key limitation of this study is its reliance on transactional data, which may provide a one-sided view of utilisation indicators and fail to capture the broader context of service quality or patient experience. Moreover, the analysis does not consider the financial performance or sustainability of the medical schemes, which may significantly influence benefit design and healthcare access. Future research should include qualitative insights, assess long-term health outcomes, and evaluate the financial health of schemes to offer a more balanced and comprehensive policy perspective.

Annual review of government-funded schemes: Improving Healthcare Access through Preventive Interventions

Healthcare access and utilisation in South Africa's medical schemes exhibit notable disparities, particularly in preventive care, mental health screenings, HIV testing, and services targeting male beneficiaries. While some medical schemes offer broader preventive services, there are persistent challenges in service uptake, awareness, and integrating primary healthcare services. This study compared healthcare access and utilisation between government-funded and non-government-funded medical schemes, identified service uptake disparities, and proposed actionable recommendations to improve healthcare access across these schemes.

The study employed a cross-sectional design, analysing secondary data from the CMS utilisation returns. Key health services examined included mental health screenings, HIV testing, medical male circumcision (MMC), cervical cancer screenings, and healthcare benefits paid for hospital services, specialist care, and medications. The findings revealed significant disparities between the two types of schemes.

Government-funded schemes had lower mental health screening utilisation, fewer men tested for HIV, and a greater number of medical male circumcisions compared to non-government schemes. Conversely, non-government schemes had lower utilisation rates for certain child health services like oral rehydration solution (ORS) and cervical cancer screenings.

Several recommendations emerged to address these disparities. First, there is a need to integrate mental health services more effectively into government-funded schemes and raise awareness to improve service uptake. Gender-sensitive strategies should be developed to encourage higher male participation in HIV testing, particularly in government schemes. Additionally, successful interventions from government-funded schemes, such as higher rates of male medical circumcision and contraceptive use, should be adopted by non-government schemes. Furthermore, child health education should be enhanced to boost the use of ORS, especially in non-government schemes, and cervical cancer screening services need to be expanded in these schemes to match the higher rates in government-funded schemes.

To promote equity in healthcare access, the study recommends re-prioritising preventive and primary healthcare within benefit design. Regular monitoring of utilisation data should inform policy and resource allocation. This can help reduce disparities and improve outcomes across both government and non-government medical schemes in South Africa.

DEMARCATION REGULATIONS UPDATE

The exemption period granted to insurers conducting the business of a medical scheme was extended as per Circular 9 of 2025. The extension was granted after the receipt of inputs from the National Department of Health (NDoH) and the National Treasury and taking into consideration the impact of the notice published by the NDoH in the Government Gazette on 17 March 2025 to call for comments on the CMS Low-Cost Benefit Option (LCBO) report of October 2023.

The exemption is effectively extended for an additional two years from 1 April 2025 to 31 March 2027, or until such time as the Minister of Health has decided on the the LCBO framework and provided directives with regard to the exempted products, whichever comes first. Circular 9 of 2025 also outlines the timeframes, process and handling fees associated with the extension of the exemption period.

PMB REVIEW PROJECTS

Progress has been made on the PMB Review, which continues to focus on establishing, costing and implementing a primary health care package of services for consideration and inclusion into the PMBs. This focus is in keeping with national health priorities and principles with the aim to achieve Universal Health Coverage (UHC). The PMB Review remains the responsibility of the CMS, the NDoH and the Minister of Health, and, thus, alignment of key strategic objectives pertaining to UHC needs to be considered and agreed upon. This financial year saw the alignment between the PHC packages established by the CMS and the NDoH. Considerations on the various ways to implement the PHC as part of the PMB offering were explored. These included the addition of a PHC package of services into the PMBs, the offering of PHC services as a supplementary add-on benefit to the current PMBs and lastly, the offering of the PHC package as a stand-alone option (with or without the inclusion of PMBs).

Work was also started on the Health Market Inquiry recommendation to establish a base benefits package of services. This base benefits package is an envisioned revised PMB package which will consist of core prioritised PHC services, along with some of the current, prioritised PMB conditions that cover catastrophic health expenditure. The future direction of this project aligns with the PMB Review and aims to establish a revised PMB package with the addition of core PHC services as set forth by the NDoH PHC package, some wider PHC cover (focusing on basic dental, mental health and rehabilitative services) and prioritised PMBs.

Prioritisation of the PMBs will entail a full review of the current PMBs in terms of the health needs of our country, disease burden, health utilisation, health expenditure and other agreed principles of prioritisation. The PMB Review is conducted under the governance and guidance of the PMB Review Advisory Committee.

Ten draft PMB definition guidelines were developed, which describe the entitlements or minimum benefits that should be made available to all beneficiaries. The definition guidelines consider new advancements in terms of evidence-based technologies and changing best practices for the PMB conditions. The PMB definition guidelines developed this year include PMB conditions that cover medical nutritional therapy, neurogenic bowel, neurogenic bladder, tetanus, cardiovascular and diabetes mellitus. New PMB conditions for the next financial year will be prioritised based on out-of-pocket expenditure, changing best practice, and/or complaint trends, among other criteria.

A circular is published requesting participation from health professionals, health economists, health technology assessment specialists and medical schemes to form multi-disciplinary and multi-stakeholder-driven Clinical Advisory Committees to assist in agreeing upon and developing these definition guidelines for use by the industry.

PROTECTING MEMBERS OF MEDICAL SCHEMES

The Member Protection Division of the Council for Medical Schemes (CMS) continued to deliver on its mandate of safeguarding the interests of medical scheme members through responsive engagement, education, complaint resolution, and clinical support services during the 2024/25 financial year. The division comprises of the Clinical unit, Customer Care Centre, Education and Training, and the Complaints Adjudication unit.

Clinical Consulting Services

This unit advanced member empowerment through clinical guidance and education. It published 12 CMScripts addressing key health topics and provided 534 clinical opinion requests. Of these, 446 were Category 1 opinions (provided within 30 working days of request receipt), 70 were Category 2 (within 60 working days), and 18 were Category 3 (within 90 working days). The team handled 952 clinical enquiries, prioritising urgent cases, and actively supported CMS policy development through contributions to the Benefit Definition Guideline and PMB Review processes. Collaboration with external stakeholders remained strong, highlighted by joint training initiatives and partnerships with the Department of Health via the Essential Medicines List Committee (NEMLC). Notably, CMS shared expertise with the Namibian Association of Medical Aid Funds (NAMAF) to support Namibia's ICD-10 rollout.

Customer Care Centre Trends

The Customer Care Centre, located within the Member Protection Division, is crucial to ensure that stakeholders, especially medical scheme members, receive timely, accurate, and accessible support. This aligns with the CMS' mandate to protect the interests of beneficiaries as outlined in Section 7 of the MSA.

During the previous financial year, Call Centre operations were tracked manually, which led to challenges in detailed analysis and performance monitoring. However, a new automated call logging and reporting system was successfully deployed at the end of April 2024.

The current system-based reporting, is a baseline for future performance tracking. The unit is also exploring opportunities to extend its case management system functionality to other units within the CMS.

Service Volumes: 2024/25

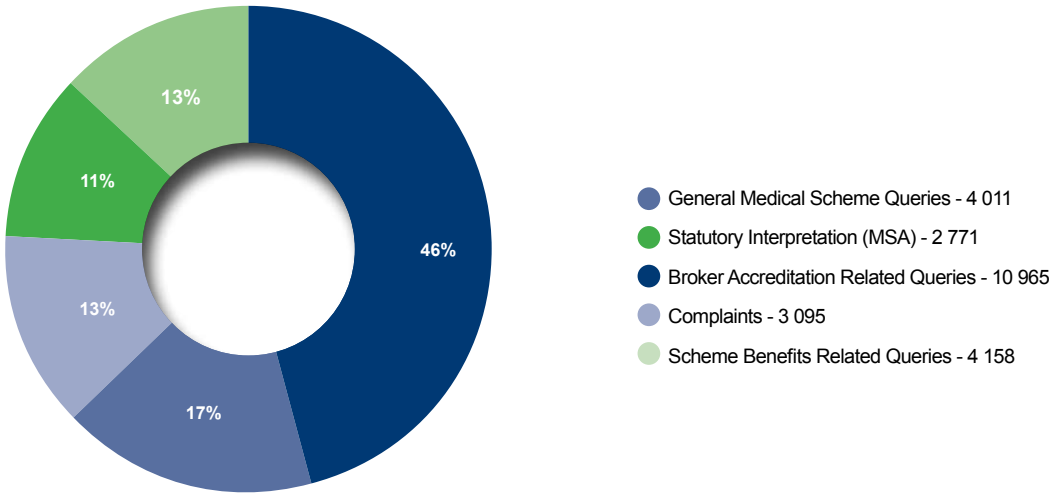
In the reporting period, the Customer Care Centre handled:

- **27 896** inbound telephone calls *(This number represents calls received, including lost/dropped calls)*
- **10 860** emails received (*of which 5 776 were valid service queries*)
- **90** in-person walk-in consultations

These figures reflect the Centre's expanding role as a trusted and responsive first point of contact for public and industry stakeholders.

Nature of Queries

Figure 5: Nature of queries



The table below outlines the key categories of queries received:

Table 53: Categories of queries received

Query Category	Description
Broker Accreditation Related Queries - 10 965 (**46%**)	Queries related to broker accreditation applications, certificate issuance, portal access issues, and application follow-ups.
General Medical Scheme Queries - 4 011 (**17%**)	Questions related to scheme rules, underwriting, membership issues, and any other scheme operations or business, guidelines, circulars, etc.
Complaints - 3 095 (**13%**)	Queries to complaint change depending on complexity, assistance with lodging complaints, tracking progress, and understanding outcomes.
Statutory Interpretation (MSA 131 of 1998) 2 771 (**11%**)	Legal clarification requests on sections such as PMBs, waiting periods, late joiner penalties, rule application, payment of accounts, legislation vs scheme rules etc.
Scheme Benefits Related Queries - 4 158 (**13%**)	Queries received from members of medical schemes regarding issues related to their benefit entitlements, such as what is covered, how benefits are applied, or how to interpret their plan options. These queries are often misdirected to the CMS due to members' lack of understanding, unclear communication from schemes, or perceived inaccessibility of scheme representatives.

Key Highlights

- **Broker Engagement:** Over 10 000 queries were received from brokers, primarily relating to the portal, certification, and accreditation. Many were resolved at first contact, improving turnaround times.
- **Complaint Support:** More than 3 000 contacts were handled around the complaints process and follow-ups enabling early intervention and informed stakeholder participation.
- **Statutory Interpretation:** A total of 2 771 queries required detailed application of the Medical Schemes Act and scheme rules – emphasising the Call Centre's role in member education and compliance support.
- **Scheme Benefits Related Queries:** Over 4 000 queries were received from members of medical schemes. Although these queries are primarily the responsibility of the scheme, CMS receives them frequently due to public confusion, limited benefit literacy, or members' lack of access to scheme information. Proper tracking helps identify trends that may require broader education or regulatory intervention.
- **Email Filtering:** In addition to calls, we receive similar queries through our support email platform. We strive to maintain a turnaround time of 48 hours from receipt to ensure prompt and efficient responses.
- **System Expansion:** The system can do more, and we are currently exploring integration with the WhatsApp platform, where frequently asked questions will be made accessible at users' fingertips to enhance accessibility and convenience.

Member and Stakeholder Empowerment

To strengthen industry knowledge and empower stakeholders, the Education and Training unit executed 84 activities, encompassing education, empowerment, and awareness sessions targeted at consumers (members and beneficiaries), board of trustees, brokers, and affiliated Consumer Protection Forum (CPF) entities. The visibility of the CMS and awareness of members' rights and responsibilities were further enhanced through 19 exhibitions and 15 stakeholder engagement sessions. The team hosted 50 workshops, 10 of which focused specifically on trustees, brokers, and industry stakeholders, to deepen understanding of medical scheme governance and protect member interests.

Activities were delivered both in-person and virtually: 57 sessions were conducted across five provinces – KwaZulu-Natal, Limpopo, Mpumalanga, Northern Cape, and Gauteng, while 25 were held virtually, alongside two radio interviews. The Advanced Trustee Leadership Programme, developed in partnership with the Gordon Institute of Business Science (GIBS), was successfully delivered and certified 30 delegates at a complexity level aligned with NQF Level 8. Additionally, Continuing Professional Development (CPD) offerings were introduced, focusing on Prescribed Minimum Benefits (PMBs) and dental-specific PMB matters.

Adjudication of Complaints

Complaints Adjudication is a sub-division of the Member Protection Division within the CMS, whose primary mandate is to protect medical scheme beneficiaries through the investigation and resolution of complaints lodged against medical schemes and other regulated entities such as medical scheme administrators, managed care organisations, brokers and brokerage companies.

Additionally, the Complaints Adjudication sub-division investigates complaints against entities exempted to offer specific health insurance products under the Demarcation Exemption Framework of 2017.

As a sub-division of the CMS Member Protection Division, the Complaints Adjudication sub-division has been consistent in its endeavour to *"protect the interests of medical scheme beneficiaries at all times"*.

Complaint Volumes

Overall, the number of complaints submitted to the Registrar for adjudication has been on a consistent downward trend over the past three financial years. The 2024/25 financial year was no different, with 1 962 new complaints being registered.

Figure 6: 3-year complaints volume comparison

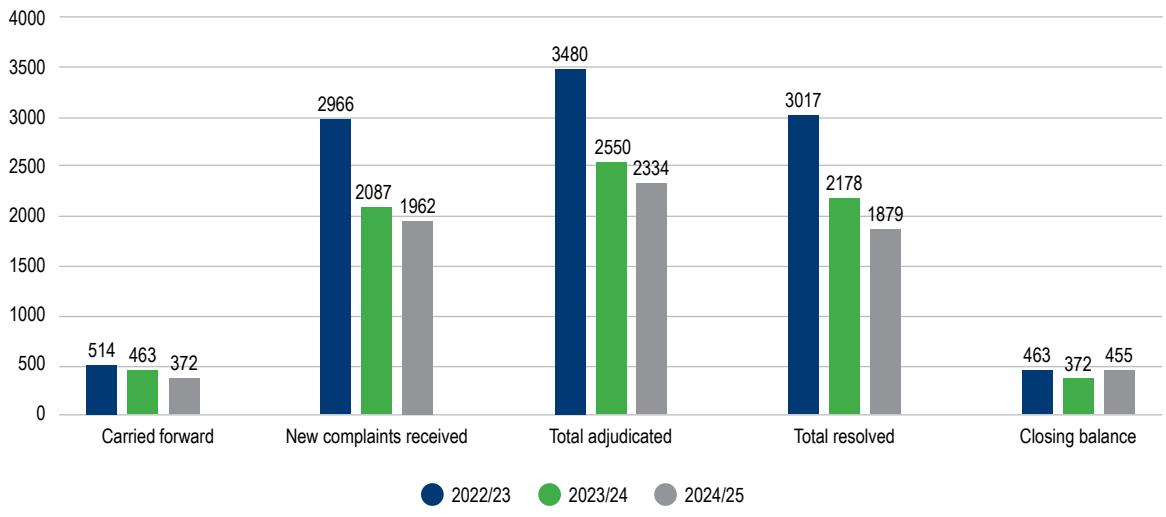


Table 54: Complaints lodged in the past three years

Financial Year	Carried forward	New complaints	Total adjudicated	Total resolved	Closing balance
2022/23	514	2 966	3 480	3 017	463
2023/24	463	2 087	2 550	2 178	372
2024/25	372	1 962	2 334	1 879	455

Lodged Complaints

Of the 1 962 complaints received between 1 April 2024 and 31 March 2025, 99% was lodged against medical schemes. The remaining 1% was split between administrators, providers of exempted health insurance product and one managed care organisation.

1937

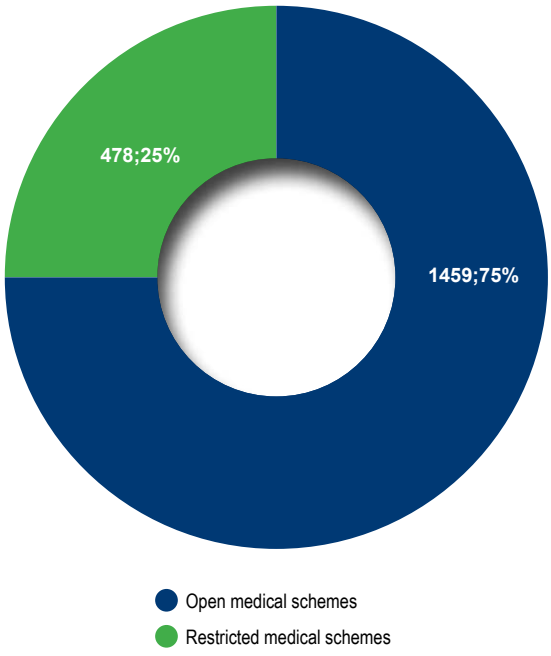
Complaints lodged against open medical schemes

25

Complaints lodged against other regulated entities

Complaints lodged against medical schemes

Figure 7: Lodged complaints: open vs restricted medical schemes



Complaints lodged against other regulated entities

Complaints lodged against exempted insurers offering demarcation health insurance products increased from 10 in 2023/24 to 17 in 2024/25

17

Only 1 complaint was lodged against a Managed Care Organisation

1

Administrator complaints decreased from 20 in 2023/24 to 7 in 2024/25 financial year

7

During the period under review, non-medical scheme complaints decreased by 32% from the previous financial year. The number of complaints against Administrators decreased by 65%, whereas complaints against Exempted Insurers offering Demarcation health insurance products increased by 70%.

Complaints against Managed Care Organisations also reduced from 3 to 1, indicating a 66% reduction. No complaints were received in respect of broker-related conduct.

Advice to Medical Scheme Beneficiaries

Foremost to investigating and resolving complaints, the Complaints Adjudication sub-division is responsible for provision of advice to medical scheme beneficiaries and the general public in relation to the Medical Schemes Act, medical scheme rules and complaints processes.

During the reporting period, the sub-division also attended to 11 741 written enquiries. Through these interactions with beneficiaries and the public, valuable information regarding the business of a medical scheme was dispensed and beneficiaries were empowered on how to navigate the complex medical scheme environment. Where warranted, complainants were assisted to formally submit complaints against their medical schemes.

In doing so, the Complaints Adjudication sub-division played the very significant role of affording aggrieved medical scheme beneficiaries with a platform to voice their grievances, and learn about their benefit entitlements, rights and obligations.

Resolution of Complaints

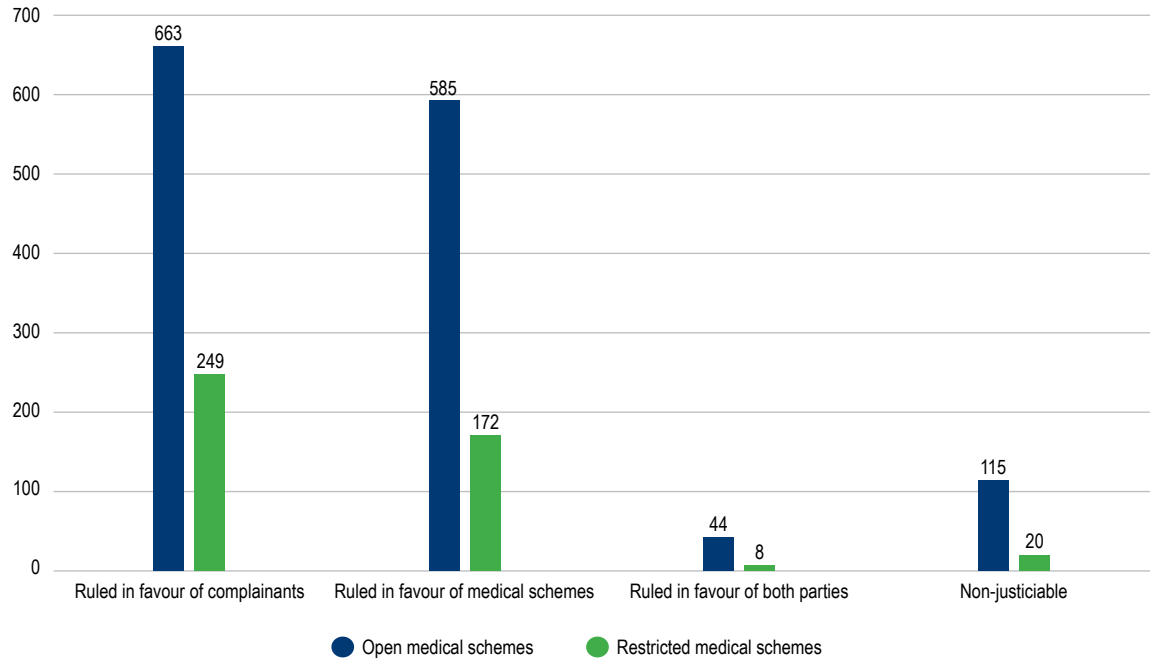
The total number of complaints resolved during the period under review was 1 879, which comprised of 1 740 justiciable complaints and 139 non-justiciable complaints. Of the 1 879 resolved complaints, 1 856 were in respect of medical schemes while 23 were related to non-medical schemes such as administrators and managed care organisations. The split between open and restricted medical scheme complaints was 1 407 and 449 respectively.

Table 55: Breakdown of Complaints and Rulings by Scheme Type: Open vs Restricted Schemes

Entity Type	No. of complaints	Ruled for complainant	Ruled for Entity	Ruled for both	Non-justiciable
Open schemes	1 407	663	585	44	115
Restricted schemes	449	249	172	8	20
Total	**1 856**	**912**	**757**	**52**	**135**

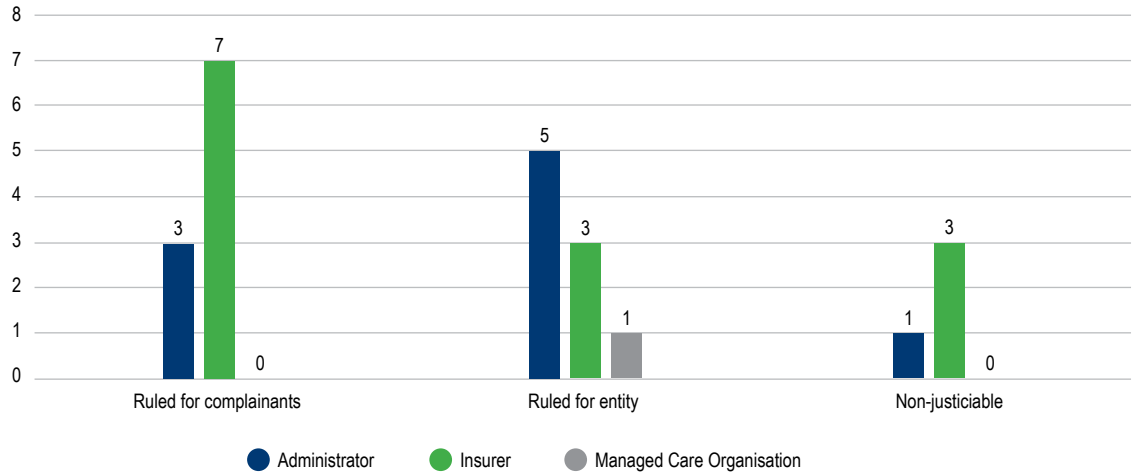
The percentage split representative of the resolution outcomes is depicted below for open and restricted medical schemes as well as other regulated entities.

Figure 8: Resolved complaint outcomes: Open vs restricted medical schemes



Other regulated entities (Administrators, Exempted insurers, Managed care organisation):

Figure 9: Resolution outcomes: Other regulated entities



Average resolution days

The sub-division continued to reduce the number of complaints ageing beyond the resolution timeframes and kept the average resolution days low for more than 80% of resolved complaints. A concerted effort is made to keep the average number of days taken to resolve complaints as short as possible, dependent on legal and clinical complexity of investigations.

Table 56: Percentage of complaints resolved per category

Percentage resolved per Category	Average days to resolution
88.4% of Category 1 complaints	14 days
82.8% of Category 2 complaints	60 days

REACHING MEMBERS THROUGH CMS COMMUNICATIONS

The Communication, Marketing and Stakeholder Relations unit uses email communication as a key channel to engage stakeholders subscribed to its official mailing lists. These mailers include regulatory updates, health communication newsletters, and other stakeholder-specific information intended to ensure timely and relevant communication.

Over the reporting period, a total of 717 527 emails were distributed to stakeholders. Of these, 293 285 were read, resulting in an average open rate of 41%. This level of engagement is significant, as it exceeds the typical industry open rates for government and nonprofit communications, which generally range between 25% and 40%. The above-average open rate suggests that the content disseminated by CMS remains relevant and valuable to its audience.

Closely linked to the CMS' email communications is its official website, which serves as the central information hub for all stakeholders. The website hosts essential regulatory resources, updates, and support services, and remains one of the Council's most effective tools for public engagement and transparency.

In total, the CMS website recorded 2 144 358 page views across its most visited sections, reflecting sustained interest in the Council's online content and services. On average, users viewed approximately 2 pages per session, indicating that visitors explored multiple areas of the site, rather than exiting after a single page.

The homepage received the highest traffic, followed by the PMB section and the Publications page – together accounting for nearly two-thirds of total views. Other frequently accessed pages included Careers, Medical Schemes in South Africa, and the Complaints Procedure, highlighting a broad range of user interests from employment and entitlements to complaints resolution.

Media Coverage

The CMS achieved extensive media visibility during the 2024/25 financial year, generating a total of 1 493 media items across traditional and social media platforms. Traditional media accounted for 791 items, with the majority of coverage appeared in online publications (44% share of voice), followed by print (41%) and broadcast (15%). These engagements yielded a combined Advertising Value Equivalent (AVE) of R31.3 million. The tonality of traditional media coverage was largely neutral (85%), with 9% positive and only 6% negative sentiment recorded. Prominent themes included the Low-Cost Benefit Option framework, the role of medical schemes in the context of the NHI, and regulatory enforcement matters, affirming the CMS' continued relevance in national health discourse.

On social media, the CMS published 702 posts across platforms, generating an additional AVE of R35.1 million and a reach of over 36 million users. The platform with the highest share of voice was X (52%), followed by LinkedIn (25%), Facebook (22%), and YouTube (1%).

Social media tonality was also largely neutral (73%), with 18% of posts perceived as positive and only 9% negative. The CMS' growing online presence enabled real-time communication with the public, stakeholder updates, and greater visibility through consumer education campaigns. Collectively, these efforts supported transparency and advanced the strategic objective of increasing public awareness and stakeholder engagement.

Internal Communication

The unit plays a central role in keeping staff informed, connected, and aligned with the strategic direction of the CMS. Internal communication was disseminated through various channels, including regular staff email and WhatsApp announcements, Ethics Bulletins that commemorate significant days and reinforce the CMS values, and the *Masihambisane* internal newsletter, which serves as a platform for sharing organisational updates and celebrating staff milestones.

Additionally, the unit facilitated the distribution of memoranda to ensure seamless cross-unit collaboration and transparency. These efforts not only encourage a culture of ethical conduct, inclusivity and accountability but also strengthen internal cohesion. By ensuring that employees are consistently informed and reminded of their role in upholding the CMS mandate, internal communication directly supports the organisation's broader goals of operational excellence, stakeholder trust and a values-driven culture.

Awareness Survey

The CMS conducted its annual stakeholder awareness survey from 6 to 28 February 2025 as part of Output 13 of the Corporate Services programme, which focuses on enhancing public visibility. Using a new familiarity scale to replace the previously binary "Yes/No" format, the survey allowed respondents to indicate varying degrees of awareness from "very familiar" to "not at all familiar." Of the 29 592 respondents, 68.93% demonstrated some level of awareness, with 7.49% indicating they were very familiar with the CMS and 17.75% being familiar, thus exceeding the annual target of 65% awareness.

Further analysis revealed that the most effective outreach channels were direct communication methods, such as letters to Principal Officers and targeted mail campaigns, accounting for the majority of responses. While social media yielded lower participation, it remains a strategic avenue for broader visibility. The survey also found that 36.54% of respondents first heard about the CMS through their medical schemes, reinforcing the importance of collaboration with schemes in disseminating regulatory information.

PO and BoT Forums

Stakeholder engagement is a critical pillar of effective regulation, enabling the CMS to build trust, improve transparency, and align industry practices with evolving policy and legislative frameworks. Through regular, structured dialogue with medical scheme leadership, the CMS ensures that regulatory priorities are clearly communicated while also remaining responsive to sector-specific challenges.

In support of this objective, the CMS hosted two Principal Officer and Board of Trustees (PO and BoT) Forums during the reporting period. These forums created a platform for meaningful engagement between the regulator and scheme leadership, covering a range of strategic topics including medical scheme governance, audit quality indicators, PMB updates, member complaints trends, FWA, and legal and regulatory developments such as the Section 59 report and LCBO submissions. They also provided an opportunity for Principal Officers and Trustees to raise their concerns and receive responses directly from CMS senior executives. These engagements continue to strengthen the partnership between the CMS and the industry it regulates, contributing to a more coherent, informed, and sustainable healthcare funding environment.

ENFORCING AND ENCOURAGING COMPLIANCE FOR A HEALTHY INDUSTRY

Routine Inspections

The Compliance and Investigations unit conducted 10 routine inspections during the period under review. These inspections were proactive measures to assess the compliance status of medical schemes and identify any potential areas of concern. Through these routine inspections, the unit ensured ongoing compliance with regulatory requirements and provided early detection of any emerging issues. By conducting regular inspections, the unit maintained a proactive approach to compliance oversight, contributing to the overall integrity and stability of the medical scheme industry.

Scheme Meeting Engagements

The unit observed 46 scheme meetings throughout the year, including annual general and special meetings. During these engagements, the unit gained insights into compliance with regulatory requirements and industry best practices. In addition to attendance, the unit prepared meeting reports, noting attendance, duration and important discussion points.

It was observed that most medical schemes prepared detailed Annual General Meeting notice packs, and that thorough presentations of the schemes' operations, financial statements, risks and performance were made to the members. This allowed the CMS to make an informed analysis and identify potential compliance-related issues and areas for improvement.

Feedback on various regulatory and compliance matters were communicated to principal officers and trustees at the various Principal Officer and Trustee Forum meetings held in Pretoria and Cape Town. These engagements promote collaboration and regulatory compliance to foster a continuous culture of improvement and adherence to regulatory requirements.

Post-curatorship Monitoring – Medipos Medical Scheme

The Curator, who was appointed in February 2023, assisted in stabilising the scheme, collect long outstanding debt from the scheme's main employer group (the South African Post Office (SAPO)) and recommended possible solutions to ensure the continued sustainability of the scheme. The curatorship was effectively lifted on 19 July 2024 through an order of the High Court.

The Curator's achievements over the approximate 18-month period in respect of the interventions implemented include:

- Instituted court proceedings to ensure that SAPO pays over current monthly contributions as well as the long outstanding contributions debt owed;
- Ensured that the scheme was recorded as a preferred creditor in SAPO's Business Rescue Plans and effectively ensuring that Medipos was entitled to 12 cents and 38 cents in the Rand of the debt amounts owed to the scheme from the R2.4 billion and R3.8 billion bailouts

received by SAPO from the National Treasury, respectively. This resulted in a collection of R550 million of the outstanding debt owed by SAPO and an improvement in the scheme's statutory solvency ratio from 46% to 85%.

Since the management of the scheme was effectively handed back to the trustees of the scheme in July 2024, quarterly meetings were held with the scheme to monitor its progress following the termination of the curatorship. Areas being monitored include the scheme's financial performance, membership growth, and progress with SAPO business rescue proceedings.

Enforcement Actions

Various enforcement actions were undertaken through Section 43 enquiries during the period under review to uphold regulatory standards and protect the interests of medical scheme beneficiaries. Appropriate actions were taken as necessary following the outcome of the enquiries, which in some instances included instituting commissioned inspections.

CISNA

The CMS actively engaged with the Committee of Insurance, Securities, and Non-Banking Financial Authorities (CISNA), of which it is a member, to promote collaboration and knowledge-sharing within the Southern African Development Community (SADC) region. The CMS submitted two comprehensive reports to CISNA, highlighting statistics of the medical schemes industry and outlining consumer initiatives undertaken by the CMS to enhance consumer protection and welfare. These reports provided valuable insights into the state of the medical scheme industry, trends, challenges, and regulatory initiatives aimed at promoting a sustainable and inclusive healthcare system.

In addition to submitting reports, the CMS participated in the 2024 CISNA conference, which was held in Zanzibar in October 2024. This conference served as a platform for regulatory authorities from across the SADC region to exchange ideas, share best practices, discuss emerging issues and build capacity for the insurance and non-banking regulators in the region. After thorough consultation with the Namibian Financial Institutions Supervisory Authority (NAMFISA), the CMS presented a report at the 2024 CISNA AGM indicating the need for the harmonisation of medical schemes regulation in the region to enable member movement and funding of services within the region.

Through its active participation in CISNA activities and conferences, the CMS continues to demonstrate its commitment to regional cooperation and collaboration in addressing common challenges and advancing regulatory standards to ensure the stability and integrity of the healthcare financing sector within the SADC region.

ACCREDITATION OF MEDICAL SCHEMES ADMINISTRATORS & SELF-ADMINISTERED SCHEMES

Administrators and self-administered schemes' accreditation and compliance certificate application evaluations completed during 2024/25:

Table 57: Administrators and self-administered schemes application evaluations completed

ADMINISTRATORS AND SELF-ADMINISTERED SCHEMES APPLICATION EVALUATIONS COMPLETED				
	New applications	**Renewals**	**On-site evaluations completed**	**Conditions compliance on-site evaluations**
Administrators	*hearConnect (Pty) Ltd	3Sixty Health (Pty) Ltd	*ER24 EMS (Pty) Ltd	None
		Afrocentric Health Integrated Administrators (Pty) Ltd	Medscheme Holdings (Pty) Ltd	
		Agility Health (Pty) Ltd	*Opticlear (Pty) Ltd	
		Discovery Administration Services (Pty) Ltd	*Professional Provider Negotiators (Pty) Ltd	
		*Europ Assistance Worldwide Services (South Africa) (Pty) Ltd		
		*Iso Leso Optics (RF) (Pty) Ltd		
		Kaelo Prime Cure (Pty) Ltd		
		Momentum Health (Pty) Ltd (previously Momentum Health Solutions (Pty) Ltd)		
		*Opticlear (Pty) Ltd		
		*Preferred Provider Negotiators (Pty) Ltd		
		Universal Healthcare Administrators (Pty) Ltd		
Self-Administered Schemes	None	Bestmed Medical Scheme	None	Medshield Medical Scheme
		Cape Medical Plan		
		Chartered Accountants (SA) Medical Aid Fund		
		Genesis Medical Scheme		
		Medihelp		
		Platinum Health		
		Umvuzo Health Medical Scheme		
		Witbank Coalfields Medical Aid Scheme		

* *Limited Administrator Accreditation*

Third-party Administrators and Self-administered Schemes:

- Seven administrator accreditation renewals, eight self-administered scheme compliance certificate renewals, one new limited administrator and four limited administrator accreditation renewal evaluations were finalised during the 2024/25 financial year. (Note that one administrator accreditation renewal application was declined);
- One administrator and three limited accreditation administrator on-site evaluation findings reports were finalised; and
- The Accreditation sub-programme continued to monitor compliance by accredited entities with conditions imposed and continued financial soundness.

Managed Care Organisations and medical schemes providing own managed care services' accreditation/compliance certificate application evaluations completed during 2024/25:

Table 58: Managed Care Organisation's and medical schemes application evaluations completed

MANAGED CARE ORGANISATIONS AND MEDICAL SCHEMES APPLICATION EVALUATIONS COMPLETED				
	New applications	**Renewals**	**On-site evaluations completed**	**Conditions compliance on-site evaluations**
Managed Care Organisations	JointCare (Pty) Ltd	Aid for AIDS Management (Pty) Ltd	Centre for Diabetes and Endocrinology (Pty) Ltd	None
		CareWorks (Pty) Ltd	Discovery Health (Pty) Ltd	
		Discovery Administration Services (Pty) Ltd	Medscheme Holdings (Pty) Ltd	
		Discovery Health (Pty) Ltd	Universal Care (Pty) Ltd	
		Health Calibrate (Pty) Ltd		
		ICON Managed Care (Pty) Ltd		
		Improved Clinical Pathway Services (Pty) Ltd		
		Kaelo Prime Cure (Pty) Ltd		
		Lifesense Disease Management (Pty) Ltd		
		MediKredit Integrated Healthcare Solutions (Pty) Ltd		
		Mediscor PBM (Pty) Ltd		
		Momentum Health (Pty) Ltd (previously Momentum Health Solutions (Pty) Ltd)		
		Momentum Thebe Ya Bophelo (Pty) Ltd		
		National Health Group (Pty) Ltd		
		Pan-African Managed Care (Pty) Ltd		
		Performance Health (Pty) Ltd		
		Professional Provident Society Healthcare Administrators (Pty) Ltd		
		Rx Health (Pty) Ltd		
		Scriptpharm Risk Management (Pty) Ltd		
		South African Oncology Consortium (Pty) Ltd		
Medical Schemes providing own managed care services		Cape Medical Plan	None	None
		Chartered Accountants (SA) Medical Aid Fund		
		Medihelp		
		Medshield Medical Scheme		

Managed Care Organisations and medical schemes providing own managed care services:

- One new accreditation application, twenty accreditation renewal applications, and four managed care compliance certificate renewal application evaluations were finalised during the year under review;
- One managed care organisation's accreditation was withdrawn due to it no longer complying with the key requirements for accreditation;
- Four on-site evaluation findings reports were finalised, and
- The Accreditation Programme continued to monitor compliance by accredited entities with conditions imposed and continued financial soundness.

Broker Accreditation

Individual brokers and broker organisations accredited:

Table 59: Broker Accreditations

Total number of broker and broker organisation applications received	4 734
Total number of broker and broker organisation applications accredited within thirty working days of receipt of complete information	4 456
Percentage of broker and broker organisation applications accredited within 30 working days of receipt of complete information	94.1%
Total number of accredited brokers and broker organisations as at 31 March 2025	9 996

Verification of academic qualifications:

The sub-programme continued to verify the academic qualifications of individuals applying to be accredited as brokers. The qualifications of 899 individuals were verified independently 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 R121.84 per member per month, with effect from 1 January 2025. A circular in this regard was published on the CMS website.

COURT RULINGS

Discovery Health (Pty) (Ltd) vs The Registrar of Medical Schemes (*Appeals Committee*)

The Registrar was successful at the Appeals Committee to ensure that the vouchers sold by Discovery Health (Pty) (Ltd) (DH) be held in contravention of the business of a medical scheme.

DH launched a prepaid healthcare payment system targeting individuals who could not afford traditional medical scheme cover. This system involved issuing digital vouchers that could be used to pay for specified health services or products provided by certain healthcare providers. DH had agreements with these providers to accept the vouchers as payment, and DH charged the providers an administration fee.

The Registrar decided on 31 January 2022 that DH was contravening Section 20(1) of the Medical Schemes Act by carrying on the business of a medical scheme without registration. DH was directed to take steps and to make arrangements aimed at ensuring compliance therewith. This decision was informed by the findings of a Section 45 enquiry that found:

"The issuing of prepaid vouchers to members of the public against a fee, DH was effectively conducting the business of a medical scheme as defined in the MSA. The Section 45 inquiry found that this amounts to the undertaking of a liability to grant assistance in defraying future expenditure incurred by the purchaser in connection with the rendering of a relevant health service, which was a violation of Section 20(1) of the MSA which provides that no person shall carry on the business of a medical scheme unless registered as a medical scheme under Section 24 of the MSA".

DH appealed this decision to the Appeals Committee and the Registrar successfully argued that its decision was based on several key points:

a) Definition of a Medical Scheme: The Registrar argued that DH's prepaid healthcare vouchers meet the definition of the business of a medical scheme as outlined in the Medical Schemes Act (MSA). Specifically, the vouchers involve undertaking liability to provide or defray the cost of healthcare services, which is a core activity of a medical scheme.

b) Substance Over Form: The Registrar emphasizes that the substance of DH's business activities should be considered over the form. Even if the activities do not technically meet all the criteria of a medical scheme, the overall nature and effect of the prepaid vouchers align with the business of a medical scheme.

c) Consumer Protection: The legislative intent of the MSA is to protect the interests of beneficiaries of medical schemes. By operating without registration, DH's activities fall outside the regulatory framework designed to ensure consumer protection.

The Registrar highlighted that the MSA is designed to regulate medical schemes in the public interest, ensuring that consumers receive the protections afforded by the Act.

The Appeal committee agreed with the Registrar and found that DH Prepaid health voucher involves undertaking a liability providing for the obtaining of any relevant health service or defraying the cost of healthcare services, which is a core activity of a medical scheme, and that DH was in contravention of section 20 of the MSA, which prohibits carrying on the business of a medical scheme without registration.

Sisonke Health Medical Scheme and Lonmin Medical Scheme v Registrar of Medical Schemes (*Appeals Board*)

The Registrar's defense of the merger between Sisonke Health Medical Scheme and Lonmin Medical Scheme, was unsuccessful due to a return of a lower percentage for votes as required by the rules of the schemes.

At the end of 2024, the Appeals Board of the Council for Medical Schemes, its decision regarding the merger between in the matter of: Sisonke Health Medical Scheme and Lonmin Medical Schemes against the Registrar and Council for Medical Schemes. The arguments advanced by the Registrar of the CMS were rejected and the proposed merger was allowed.

Following the aforesaid ruling of the Appeals Board, the CMS, as aggrieved, approached an external Counsel for a legal opinion in clarifying the ruling as its contention was the correctness of such decision. Counsel advised that the challenge that the CMS faces is, its contention to the correctness of the ruling, which, Counsel found, in their view, that it was irrelevant in the context of judicial review.

Coupled with the above, the other difficulty that the CMS faced with its contention related to the interpretation of Rule 31.3, which was not presented at the Appeals Board and consequently, the Board could not be faulted. The Registrar did not dismiss the application based on the interpretation that the CMS now asserts is correct with respect to rule 31.3. The fact that the Registrar engaged in a good cause inquiry regarding the application submitted by the medical schemes, presupposes that the Registrar accepted that rule 31.3 permits consideration of ratification where less than 50% of the members of a medical scheme who voted, have voted in favour of an amalgamation.

It was found, in legal opinion by Counsel, that the order is not contradictory, as the CMS suggested which was the basis of the Registrar refusing to implement the merger despite the Appeal Board having ordered him to do so. It was further found in that opinion, that a contradiction would arise only if the order required the Registrar and the CMS to perform conflicting actions and that it was not the case. The order effectively grants both the primary relief sought (ratification of a lower percentage) and, alternatively, the exemption relief and that it was incorrect that if the Registrar was to exercise its discretion, he might reach the same conclusion that schemes uphold against.

Furthermore, it was found in the legal opinion that since the Appeal Board found that good cause does exist, a proper interpretation of the decision and the order dictates that the Registrar should exercise his discretion in favour of the medical schemes and "condone" so to speak non-compliance with rule 31.2. In other words, the order requires that the Registrar act as he would have acted if he found that good cause does exists.

The independent legal opinion found that, properly interpreted, the order requires the Registrar to exercise his discretion and ratify the lower percentage in favour of the medical schemes, as the Appeal.

Board has determined that good cause exists and has been shown.

These efforts were followed by the Registrar as regulatory processes highlighted that the MSA is designed to regulate medical schemes in the public interest, ensuring that consumers receive the protections afforded by the Act. Unfortunately, the Registrar faced with the Appeals Board ruling and the independent legal opinion had to allow the merger to be implemented.

BHF vs CMS – LCBO Challenge (*High Court*)

The CMS successfully challenged the application by Board of Healthcare Funders (BHF) to declare LCBO permissible under the Medical Schemes Act.

Acting Judge Ledwaba found that the BHF lacked the legal standing (locus standi) to bring the application. It examined whether the BHF met the requirements under section 38 of the Constitution, which allows various categories of litigants to approach a court for infringements of rights.

The High Court found that the BHF failed to demonstrate a direct and substantial interest in the relief sought, either in its own right, on behalf of its members, or in the public interest.

The High Court found that the BHF claimed to represent about 40 medical schemes and 4.5 million beneficiaries, asserting it acted in its own interest, on behalf of its members,

and in the public interest. However, it provided no specific mandate or resolution from these schemes authorising the litigation.

The BHF, as a non-profit company, did not sufficiently establish its own legal interest separate from the schemes it claimed to represent: Own-interest litigant referred to section 38(a) of the Constitution must show that the decision it seeks to attack has the capacity to affect its own legal right or its interest.

The High Court went further to indicate that the BHF did not show it was genuinely acting for the public or that no other reasonable means existed to bring the challenge. The court was circumspect in affording the BHF standing for the purpose of public interest.

The High Court held that as an agent, the BHF could not claim the rights of its principals (the medical schemes) in its own name. It is generally accepted that as a representative of its principal, an agent cannot institute proceedings against a third party in its own name.

The court found that the exemptions were lawfully granted by the CMS under section 8(h) of the MSA, and the BHF had not supported its case of a procedural irregularity.

The court found that no current moratorium existed, and the BHF failed to substantiate its claim that any medical schemes have submitted an application that was rejected based on the alleged moratorium. The court found that the CMS lawfully processed applications, and no blanket refusal was proved. The court found that the delay was not irrational, and the Minister of Health was still considering the CMS' LCBO report, which did not recommend the implementation of LCBOs.

Importantly, the court found the BHF did not prove a constitutional breach or PAJA grounds for review. The CMS and Minister of Health's actions were not irrational or unlawful, and they acted in terms of the discretion granted by the MSA and in conformity with national health policy.

OUTCOMES OF THE SECTION 59 INVESTIGATION

The release of the final report of the Section 59 Investigation marks a critical milestone for the CMS' commitment to regulatory integrity, openness, and accountability within the private healthcare sector. In line with its mandate, the CMS initiated this inquiry in response to allegations of unfair treatment and possible discriminatory practices by medical schemes and their administrators against healthcare practitioners. The investigation sought to resolve these complaints, identify trends and recommend corrective actions. Consistent with the interim report, the final findings confirmed that black providers were disproportionately found guilty of FWA. These findings highlight deeper systemic challenges within the medical schemes industry. Central to these is the need for a fair, standardised, and equitable approach to detecting and preventing FWA, further reinforcing the importance of the FWA Codes of Good Practice and the Tribunal.

The CMS takes these findings and recommendations seriously and has already initiated urgent reforms to address the shortcomings identified. A multi-disciplinary task team has been established to coordinate implementation efforts, supported by legal experts who will advise the Council on appropriate action and protection mechanisms for affected providers. The CMS is engaging with statutory bodies such as the HPCSA and the Information Regulator to address confidentiality, coding standards, and systemic fairness.

Urgent mechanisms are being developed to ensure visibility and oversight in the use of algorithms and artificial intelligence by schemes in their claims monitoring processes. At the same time, work is underway to establish an independent platform, such as an FWA Tribunal or enhanced dispute resolution processes, for providers to challenge unfair FWA accusations. CMS is also reviewing the clawback period, considering tighter limits to ensure procedural fairness.

To support the long-term sustainability of the industry, policy and legislative reforms are essential. The CMS will work closely with the National Department of Health and other stakeholders to implement changes, including amending Section 59(3) of the Medical Schemes Act and initiating a process to declare unfair clawbacks and unlawful AODs as undesirable business practices. These reforms will ensure that medical schemes are accountable not only to the regulator but also to the public they serve.

In strengthening oversight and restoring trust, the CMS remains steadfast in its role as a protector of beneficiaries and an advocate for the equitable treatment of healthcare providers. The recommendations of the Section 59 report will serve as a foundation for regulatory transformation, and the CMS will lead this process with urgency, openness, and determination.

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