gems

Government Employees Medical Scheme

ANNUAL INTEGRATED REPORT 2017

Working towards a healthier you

Content

Introduction

The GEMS 2017 Annual Integrated Report is the 12th annual report issued by the Scheme with the first report issued in the year 2007.

Scope of the report

This report covers the operations of the Government Employees Medical Scheme for the financial year 1 January 2017 to 31 December 2017. The report was prepared to provide members of the Scheme, the Minister for Public Service and Administration, representing the employer, and the Scheme's stakeholders with an assessment of the Scheme's performance and impact for the 12-month period. It is intended to provide an understanding of the Scheme's strategic approach over the short and medium term to pertinent issues impacting on the Scheme and the effectiveness of this approach.

There were no significant changes during the reporting period in the Scheme's business model, boundaries and the Scheme's supply chain. The Scheme's organisational structure was reviewed to optimise delivery under the Five-year Strategic Plan and a new executive structure was approved by the Board on 27 July 2017.

No restatements of information provided in previous reports are contained in this report.

GEMS Integrated Reporting Framework

The GEMS Board of Trustees formally adopted an Integrated Reporting Policy and Framework during 2016. GEMS' Integrated Reporting Framework is entity-specific and has as its basis the Medical Schemes Act, the Registered Rules of GEMS, the South African Institute of Chartered Accountants (SAICA) Accounting Guidelines for Medical Schemes and the International Integrated Reporting Framework. The legislation and regulation are supplemented in GEMS' Integrated Reporting Framework by the GRI G4 Guidelines and the King IV Report Recommended Practices.

GEMS' Materiality Determination Process

GEMS is committed to ensuring that its members, the employer and stakeholders have access to accurate and reliable information. The GEMS Board of Trustees acknowledges its responsibility to assure the integrity of GEMS' Annual Integrated Report. As such, it has taken responsibility for determining the matters that materially impact the Scheme's ability to create value for its members and ensure the sustainability of the Scheme.

The purpose of the materiality process is to ensure that matters that substantively affect GEMS' ability to create value are identified and reported on. A material matter will usually be one that substantively impacts, or has the potential to substantively impact, GEMS' strategy, governance practices, performance, prospects or its important capitals such as financial capital, social and relationship capital, human capital and intellectual capital.

The steps taken to determine the materiality include the following:

Step One: Identifying relevant matters based on its ability to impact value creation

Information from the Board and Committee's meeting agendas, the Scheme's strategic objectives and performance scorecard, the Scheme's strategic risk register and risk appetite matrix, membership growth and benefit enhancement opportunities available to the Scheme, as well as the Scheme's compliments and complaints reporting, were used to determine material matters. Stakeholder feedback and input was also considered as an integral part of the process. The latter has been obtained through a range of stakeholder activities and feedback sessions as well as informal interactions with various stakeholders.

Step Two: Determining material aspects and information to disclose

The list of material issues was considered by the Scheme's Executive Committee and was submitted to the Audit Committee for consideration and recommendation to the Board. The identified material matters were reviewed and recommended for approval by the Audit Committee and subsequently approved by the Board of Trustees for inclusion in the Annual Integrated Report.

The Scheme's Materiality Determination Process is being refined and in future, will include formal input processes to verify and prioritise aspects of each material matter.

List of identified material issues

Material Aspects	Section of Report	Impact
Ethics, Fraud and Corruption by GEMS Officers (Tender Investigation)	• Chairperson Overview • Internal Operating Environment • Value Statement and Ethics • Risk Management	• Member Satisfaction • GEMS Reputation • Stakeholder Trust • Sound Corporate Governance Practices
Implementation of new Five-year Strategic Plan	• Chairperson Overview • Internal Operating Environment • Strategy and Resource Allocation • Risk Management • Performance and Outcomes	• Sustainability • Corporate Responsibility • Corporate Governance
National Health Insurance	• Chairperson Overview • External Operating Environment • Strategy and Resource Allocation	• Sustainability • Corporate Responsibility
Sustainability	• Chairperson Overview • Strategy and Resource Allocation • Risk Management • Performance and Outcomes	• Financial Performance • Sustainability • Stakeholder Satisfaction • Corporate Responsibility
Member Satisfaction and creating value for the GEMS stakeholders	• Chairperson Overview • Business Model and Value Creation • Internal Operating Environment (impact on capacity due to staff terminations) • Organisational Overview (member contact points, e.g. CLO Unit) • Performance and Outcomes: Complaints Report (CMS Complaints issue)	• Growth • Sustaining the Scheme • GEMS Reputation • Stakeholder Trust • Governance
Fraud, Waste and Abuse	• Strategy and Resource Allocation • Risk Management • Performance and Outcomes • Business Model and Value Creation	• Financial Performance • Affordability of Member Contributions

Material Aspects	Section of Report	Impact
Supply Chain Management Reform	• Chairperson Overview • Business Model and Value Creation • Ethics and Governance	• GEMS' reputation • Stakeholder trust • Operational excellence
Standing Committee Structure Review	• Chairperson Overview • Organisational Overview • Governance Report	• Governance
Employer Medical Assistance Subsidy	• Financial Performance • Stakeholder Management Report • Outlook	• Growth • Stakeholder satisfaction
Innovative Strategic Procurement of Healthcare Services	• Performance and Outlook • Governance	• Financial performance • Health outcomes
Scheme Capabilities (processes, systems, skills and competencies)	• Strategy and Resource Allocation • Business Model and Value Creation • Performance and Outcomes • ICT Governance Report • Remuneration Report	• Operational excellence • Stakeholder satisfaction • Value creation
Stakeholder Relationships	• Principal (employer) Relationship Report • Stakeholder Report • Strategy and Resource Allocation • Risk Report	• Stakeholder satisfaction • Regulatory intervention
Health Outcomes	• Performance and Outlook	• Stakeholder satisfaction • Sustainability
Membership Growth	• Performance and Outlook	• Sustainability
Business Continuity	• Risk Report	• Operational excellence • Stakeholder satisfaction

Material Aspects	Section of Report	Impact
Compliance	• Compliance in Governance Section • Stakeholder Report	• Scheme reputation • Stakeholder trust
Board Composition	• Chairperson Overview • External Operating Environment • Governance Section • AGM Action List	• Governance • Stakeholder trust • Stakeholder satisfaction
Efficiency of Scheme Administration	• Business Model and Value Creation • External Business Environment (Public Service Coordinating Bargaining Council Resolution 4 of 2017) • Performance and Outcomes	• Operational excellence • Stakeholder satisfaction
Affordability (contributions and co-payments)	• Chairperson Overview • Performance and Outcomes • Stakeholder Report	• Growth • Sustainability • Creating value
Benchmarking of GEMS/Industry comparisons	• Performance and Outcomes	• Stakeholder satisfaction
Benefit Enhancement	• Performance and Outcomes	• Growth • Health outcomes

The precautionary approach is not addressed by GEMS.

A guide to access the GEMS 2017 Annual Integrated Report

- The detailed GEMS 2017 Annual Integrated Report, inclusive of the Scheme's summarised annual financial statements for the period ended 31 December 2017, is available and accessible on the Scheme's website at www.gems.gov.za.
- The Scheme's complete audited Annual Financial Statements for the period ended 31 December 2017 are available on the Scheme's website at www.gems.gov.za.
- A summary of the key matters reported in the main GEMS 2017 Annual Integrated Report, inclusive of the highlights of the Scheme's financial performance, is made available to members of GEMS in hard copy and is accessible on the Scheme's website at www.gems.gov.za.

Assurance

The Trustees received assurance on the content and processes listed below and the accuracy thereof from both internal and external assurance providers. A combined assurance approach was followed, with coverage and outcomes by the relevant assurance providers contained in the table below:

Content and processes	Assurance provider	Outcome
Annual Financial Statements	External Audit	Unqualified audit opinion
Greenhouse Gas Assessment Audit (Impact on the environment)	Climate Standard sustainableIT	Percentage decrease from base year: - 57% Achieved Level 2 of the Climate Standard by developing a reductions and monitoring plan for their GHG emissions in line with Climate Standard Recommendations
Operating Surplus	External Audit	Limited assurance provided
Leverage existing strategic assets towards improving member value: Reduce KZN hospital admission rate to ≤ 30.5%	External Audit	Limited assurance provided
Simplified Core Product Offering: 5% Emerald option members moved to Emerald Value option	External Audit	Limited Assurance provided
Stakeholder Satisfaction Model – Complaints ratio <= 0.25%	External Audit	Limited Assurance provided
Innovative strategic procurement of healthcare services: 1 500 specialists contracted	External Audit	Limited Assurance provided
Key strategic performance indicators disclosed in the 2017 Annual Integrated Report	Internal Audit	Conducted a review of the process design to gather and report the key strategic performance indicator data disclosed in the 2017 Annual Integrated Report, excluding those reviewed by Deloitte

King IV Report of Corporate Governance

The Board of Trustees conducts the Scheme's business with integrity by applying appropriate corporate governance policies and practices. In 2017, the Scheme applied, where appropriate, the principles and recommended business practices outlined in the King III Report on Corporate Governance for South Africa ("King III Report"). The Board resolved on 28 February 2017 to adopt the King IV Report on Corporate Governance for South Africa ("King IV Report") with effect from 1 January 2018, i.e. from the commencement of the Scheme's new financial year. During 2017, the King IV Report was used as best practice guide with a view to commence aligning the Scheme's business practices to those outlined in King IV.

Statement by the GEMS Board of Trustees

The GEMS Board of Trustees acknowledges its responsibility to assure the integrity of GEMS' Annual Integrated Report.

The GEMS Board of Trustees has applied its collective mind in the preparation and presentation of this Annual Integrated Report.

The development of this Report was furthermore guided by GEMS' Integrated Reporting Framework adopted by the Board during 2016.

Mr NL Theledi
Chairperson

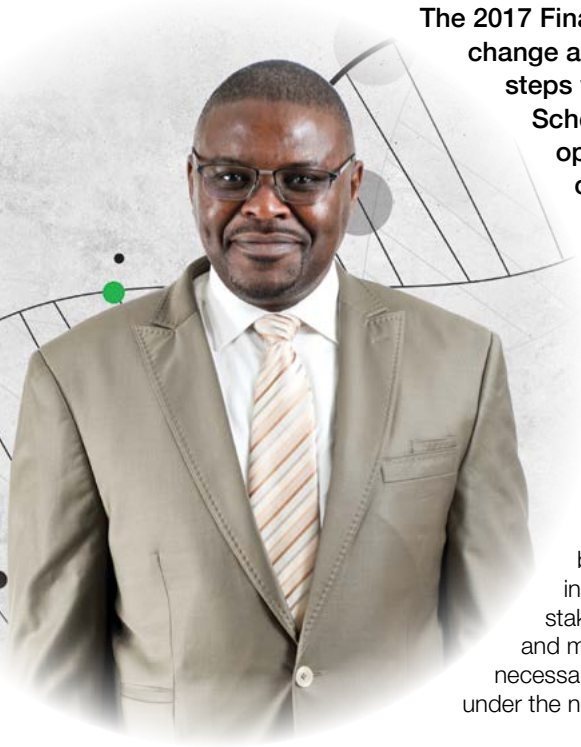
25 April 2018

Key Indicators 2017

The Scheme's performance in relation to key business indicators relevant to 2017, compared to the previous reporting period, is summarised in the table below:

Key indicators	2017	2016
Principal members	692,092	694,262
Beneficiaries	1,807,538	1,833,137
Percentage of eligible public service employees on GEMS	56.51%	56.78%
Percentage of salary level 1 to 5 public service employees on GEMS	47.49%	46.58%
Average age per beneficiary	31.87	31.01
Average family size	2.61	2.64
Pensioner ratio	15.25%	14.36%
Applications (monthly average)	5,113	6,317
Claim lines settled	91.0 mil	92.2 mil
Claim lines rejected	12.0%	11.2%
Average ratio of complaints to registered members	0.27%	0.24%
Annualised gross contributions	R35,496,532,752	R31,043,708,744
IBNR	R1,123,600,000	R960,000,000
Net surplus/(deficit) – YTD	R3,270,200,899	(R484,651,051)
Accumulated funds	R5,446,277,917	R2,176,074,017
Cash at the end of period – excluding PMSA Trust funds	R5,488,609,210	R3,177,474,070
Non-healthcare expenditure	5.60%	5.70%
Reserve ratio %	15.22%	6.99%

Chairperson Overview



The 2017 Financial Year was a period of change and value creation. Decisive steps were taken to embed the Scheme's new strategic and operational direction which centres on becoming a blueprint for National Health Insurance.

The implementation of the new GEMS Five-year Strategic Plan for the period 2017 to 2021 got underway with the important objectives of building financial strength, renewing commitment to ethical leadership and accountability, pursuing service excellence, taking ownership of business intelligence, influencing industry transformation, strengthening stakeholder engagement channels and making the organisational changes necessary to deliver the required output under the new strategic plan.

Stabilise for sustainability

Important achievements for 2017 are:

- The Scheme's financial performance improved significantly. In contrast with the deficit of R484.7 million reported for the 2016 Financial Year, the Scheme reported a surplus of R3.3 billion for the 2017 Financial Year. More information on the Scheme's financial performance and the programmes and initiatives that underpin the results can be found on pages 102 to 111 and pages 62 to 70 of the Report.
- Care coordination in the Scheme gained traction. The results achieved by the new Emerald Value option, in line with the NHI Policy – Primary Healthcare will be the heartbeat of NHI – exceeded expectations and the option is regarded as a model for curtailing costs without compromising the quality of care. A description of the results and learnings flowing from the implementation of the Emerald Value option can be found on pages 67 to 70.
- The Scheme's vision of driving industry transformation towards universal healthcare was pursued by improving healthcare purchasing and using selective contracting to innovate healthcare services procurement. In 2017, the Scheme successfully executed its strategic decision to increase the specialist network and establish a second major network, namely the renal dialysis network. More information on the specialist network is available on page 123. The groundwork for establishing a Back and Neck Rehabilitation Network was completed in 2017 and the new network went live on 1 January 2018.
- The Scheme supported the ongoing work of the Health Market Inquiry by supplying information and data regarding the procurement of healthcare networks.
- A comprehensive internal organisational review and design process was finalised. The Board approved the new top structure on 27 July 2017. The recruitment of new executives of the calibre required to represent the top structure was advanced by the end of the year.
- The Scheme's operating model was reviewed comprehensively. As an important outcome, a roadmap for implementing changes to the Scheme's delivery structures was finalised. Where the Scheme faced operational challenges following an internal investigation into tender irregularities, the new operational direction guided the consolidation of services and the commencement of work to build internal capabilities.
- The Scheme's Enterprise Risk Management Function was reviewed comprehensively and a new procedure, appropriate for GEMS, was approved by the Board and was introduced to the business.

- A Change and Communication Management Programme was rolled-out to secure employee buy-in and support for the Scheme's new strategic and operational direction.

The financial strength achieved in 2017 placed the Board in a position to introduce an average contribution increase of 8.58% for the 2018 financial year. For members on the Emerald Value option, the average increase after subsidy was approximately 3.55%.

The Scheme's 11th Annual General Meeting of members (AGM) was successfully held on 31 July 2017 at Ginsberg, King William's Town. The AGM was attended by 215 members while 296 members were represented by proxy. The members at the AGM adopted all resolutions tabled at the meeting. The issues raised by members at the AGM were recorded and an action list was developed to ensure that all issues receive attention. The action list, with an indication of progress made, can be found after the draft Minutes of the 11th AGM on page 202.

Any organisation's ability to create value is eroded by fraud, corruption and other unethical behaviour. GEMS is not immune to the instances of fraud, irregularities and corruption that currently plague our society. The Board, working with management, dealt with significant instances of fraud and abuse involving contracted providers and GEMS employees. The Board launched an internal investigation after receiving a complaint from a whistle-blower in September 2016. At initiation, the investigation focused on a tender process that was concluded in July 2016. The initial investigation, as well as a media article containing additional allegations, raised more concerns than the issue initially reported and was broadened in 2017. The broadened investigation was conducted by legal and forensic investigators who worked under the auspices of the Board of Trustees. The process included a protected disclosures process for GEMS employees. Ultimately, disciplinary proceedings were instituted against seven employees, made up of two executives, two senior managers, two middle managers and one junior employee. The charges included tender irregularities, nepotism, soliciting donations from contracted providers and the unauthorised disclosure of confidential Scheme information. Five (5) of the seven (7) employees resigned prior to the conclusion of the disciplinary hearings in 2017 and two (2) employees were dismissed after the disciplinary hearings. Based on legal advice, the Scheme terminated seven contracts. The matters were reported to relevant statutory authorities and criminal charges were subsequently filed with the Directorate for Priority Crime Investigation (HAWKS). The Chairperson of the Board and the Chairpersons of two of the Standing Board Committees attended an engagement with GEMS employees on 23 June 2017 to provide information on the investigation, to listen to employees' concerns and to answer questions.

This matter indicated a need for a systematic review of the Scheme's policy environment and other preventative and detective controls. The Board approved a series of policy changes during its meeting on 5 December 2017 and more policy revisions are planned for 2018. A disclosure on the work performed is included on page 169.

Board Composition

A large body of work has been performed by the Scheme in line with the Medical Schemes Act since 2010 to address member concerns regarding the composition of the Board. The issues include a lack of diversity in respect of member-elected Trustees and a request that seats on the Board be allocated to trade unions. In 2017, the Public Service Coordinating Bargaining Council (PSCBC) requested the Scheme to amend the GEMS Rules to enable the appointment of four Trustees by the Unions in the PSCBC and the election of the remaining two Trustees by means of direct election by principal members. To overcome the legal barrier posed by section 57(2) of the Medical Schemes Act, an exemption application was submitted to the Council for Medical Schemes. The exemption application sought to achieve:

- The appointment of four Trustees by the unions in the PSCBC;
- The election of two Trustees by members; and
- The prescription of equity targets in the GEMS Rules for elected Trustees.

The Scheme was notified on 6 November 2017 that Council for Medical Schemes (CMS) had declined the exemption application. In the response, the CMS expressed the view that the Scheme's circumstances are not sufficiently exceptional to warrant an exemption from the Medical Schemes Act. Other reasons provided include that the CMS deems the GEMS Board of Trustees to be fully functional and that the Scheme is managed by persons who are deemed to be fit and proper. The Scheme will cooperate with the PSCBC to exhaust all consultation and legal remedies to achieve the desired outcome.

Inspection by the Council for Medical Schemes

On 7 September 2017, the Scheme was advised of the Council for Medical Schemes' intention to perform an inspection on GEMS in terms of Section 44(4)(a) of the Medical Schemes Act.

The Scheme has cooperated fully with the inspection and engaged the Council for Medical Schemes (CMS) on issues of concern. The Scheme's concerns were conveyed formally to the CMS and the decisions taken by the CMS were implemented. The inspection report is currently expected in Quarter 2 of 2018.

Vote of Thanks

I wish to thank Ms Nontobeko Ntsinde who served as the Chairperson of the Board until 5 February 2018 for her strong leadership and immeasurable contribution throughout her tenure at GEMS.

Ms Nombulelo Mkhumane served as the Deputy Chairperson of the Board until 5 February 2018 and her contribution in respect of steering the Scheme through the various challenges managed in 2017 is appreciated. She chaired the GEMS Investment Committee, under whose auspices the Scheme's investment performance has gone from strength to strength.

Trustees who served on the Board were confronted with complex decisions in 2017. The Trustees demonstrated their willingness to address challenges in a decisive manner to protect the interests of all GEMS beneficiaries. The Board maintained a results-driven approach and exemplified ethical leadership. I wish to thank you for your ongoing support in engaging stakeholders where board level engagement was needed.

I also wish to thank Dr Clarence Mini; Mr Daniel de Villiers; Ms Lungile Zondi, Dr Kobus van Zyl and Ms Nombulelo Mkhumane for chairing the Clinical Governance and Ex Gratia Committee; Governance, Risk and Ethics Committee; Dispute Committee, Remuneration Committee and Investment Committee respectively during the period under review. Dr Mini resigned from the GEMS Board with effect from 15 December 2017 and is now the Chairperson of the Board of the Council for Medical Schemes. GEMS has benefited considerably from his expertise and deep understanding of the medical schemes industry and we look forward to his impact on the whole industry in his new position.

On behalf of the Board of Trustees, I wish to thank the former Independent Chairperson of the GEMS Audit Committee, Ms Mmathabo Sukati, for leading the Scheme's Audit Committee. The Board is appreciative of her valuable contribution to the effective corporate governance of the Scheme. We also wish to thank the new Independent Audit Committee Chairperson, Mr Joe Lesejane, who became part of GEMS on 1 January 2018, for taking on this critical role.

The Board and Scheme continued to benefit from the advice and input from Independent Committee members who served on the GEMS Audit Committee and Dispute Committee. On behalf of the Board, I wish to thank them for their commitment, expertise and collective contribution to GEMS.

On behalf of the Board, I wish to express my sincere appreciation to Dr Gunvant (Guni) Goolab for leading the Scheme's Executive Management team in 2017. The Board is appreciative of the excellent manner in which the new Five-year Strategy implementation was driven, in addition to dealing with the challenges arising from the extensive tender investigations.

The Board is pleased with the operational results achieved by the Scheme for the period ended 31 December 2017.

Statement of responsibility by the Board of Trustees

The Board of Trustees are responsible for the preparation, integrity and fair presentation of the Annual Integrated Report and Financial Statements of the Government Employees Medical Scheme. The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and include amounts based on judgements and estimates by Management.

Accounting policies applied by the Scheme are informed and updated, when required, based on Circulars issued by the Council for Medical Schemes, the Annual Medical Schemes Accounting Guide issued by SAICA and updates on the latest International Financial Reporting Standards (IFRS) developments. The Trustees consider that in preparing the Annual Financial Statements, they have used the most appropriate accounting policies, consistently applied these policies and supported the application of these policies with reasonable and prudent judgements and estimates.

The Scheme takes cognisance of the King Report on Corporate Governance for South Africa 2016 (King IV) and seeks to apply the principles thereof where appropriate to the business of a medical scheme and its Trustees.

The Trustees are satisfied that the information contained in the Annual Integrated Report fairly presents the results of operations for the year and the financial position of the Scheme at year-end. The Trustees also prepared the other information included in the annual report and are responsible for both its accuracy and consistency with the Annual Financial Statements.

The Annual Integrated Report fairly presents the results of operations for the year.

The Trustees are responsible for ensuring that adequate accounting records are maintained. The accounting records disclose with reasonable accuracy the financial position of the Scheme, which enables the Trustees to ensure that the Annual Financial Statements comply with the relevant legislation.

The Trustees are also responsible for such internal controls as the Trustees determine are necessary to enable the preparation of annual financial statements that are free from material misstatement, whether due to fraud or error, and for maintaining an effective system of risk management.

The Government Employees Medical Scheme operates in a well-established control environment, which is well documented and regularly reviewed. This control environment incorporates risk management and internal control procedures, which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and that the risks facing the business are assessed and controlled.

The going concern basis has been adopted in preparing the Annual Financial Statements. Based on the forecasts and available cash resources the Trustees have no reason to believe that the Scheme will not be a going concern in the foreseeable future. These Annual Financial Statements support the viability of the Scheme.

The Scheme's External Auditors, Deloitte and OMA Chartered Accountants JV, are responsible for auditing the Financial Statements in terms of International Auditing Standards and their unqualified report is presented with the Scheme's Annual Financial Statements.

The Annual Financial Statements for 2017 were approved by the Board of Trustees on 25 April 2018 and are signed on its behalf by:

Mr NL Theledi
Chairperson

Dr SM Hlatshwayo
Deputy Chairperson

Dr G Goolab
Principal Officer

25 April 2018

Organisational Overview of GEMS

GEMS at a glance

GEMS is registered as a restricted membership medical scheme in accordance with the Medical Schemes Act, 1998, as amended from time to time.

The Scheme's Head Office is situated at the Hillcrest Office Park, c/o Lynnwood and Dyer Road, Tshwane.

GEMS' history in brief

Cabinet gave approval for the establishment of GEMS in November 2004, followed by the registration of GEMS by the Council for Medical Schemes with effect from 1 January 2005. After a year of preparing the Scheme for operations, GEMS commenced operations from 1 January 2006. Since its inception, GEMS has grown to become South Africa's second-largest medical scheme overall, at approximately 1.8 million beneficiaries, and the biggest restricted membership medical scheme.

The Cabinet mandate underpinning the establishment of GEMS is summarised as follows:

"To ensure that there is **adequate provisioning of healthcare coverage** to public service employees that is **efficient, cost-effective and equitable**; and to provide **further options** for those who wish to purchase more extensive cover."

Under the GEMS Five-year Strategic Plan (2017 to 2021), the Scheme seeks to make a meaningful contribution to the healthcare industry and universal healthcare in South Africa with the long-term goal of becoming a blueprint for National Health Insurance. GEMS' current mandate remains relevant to the new strategic direction. There is still considerable scope to achieve the Scheme's current mandate while pursuing the contribution that the Scheme wants to make to National Health Insurance.

Vision, Mission and Values

Vision

The GEMS Vision recognises the Scheme's ambition to drive transformation and contribute to the wider healthcare ecosystem and is:

"An **excellent, sustainable and effective** medical scheme that **drives transformation** in the healthcare industry, aligned with the principles of **universal health coverage**."

Mission

The GEMS Mission inspires and motivates us to achieve the GEMS Vision and is:

"To provide **all members** with **equitable access** to **affordable and comprehensive** healthcare, promoting member **well-being**."

Values

We strive to live up to the GEMS Values of:

- **Excellence**
- **Integrity**
- **Member Value**
- **Innovation**
- **Collaboration**

Our main activities, products, services and target market

As a registered medical scheme, GEMS undertakes liability in return for contributions from members to:

- Provide for the obtaining of relevant health services.
- Grant assistance in defraying expenditure incurred in connection with the rendering of relevant health services.

Our product offering

GEMS offers six benefit options that were each designed using a rigorous analytical approach taking into account the requirements of the Council for Medical Schemes, member affordability and benefit design assessment.

Sapphire: This is the entry-level option. It provides out-of-hospital care such as visits to a GP, dentist and optometrist, maternity care at private facilities, and in-hospital cover at public facilities. This option is designed to be inexpensive, with the 2017 average member contribution at R1,997. In 2017, the percentage of members subscribing to this option was 6.4% as at year-end.

Beryl: This is an entry-level option where cover is provided by designated provider networks. This product offers members comprehensive in- and out-of-hospital benefits through a network of healthcare providers in both public and private hospitals. The 2017 average member contribution was R2,603. The percentage of members on this option in 2017 was 4.4% as at year-end.

Ruby: This option offers comprehensive in- and out-of-hospital benefits through a Personal Medical Savings Account (PMSA), a hospital benefit and a block benefit. The average 2017 member contribution was R4,121, with 20% of this contribution going towards the PMSA. The percentage of members on this option in 2017 was 11.8% as at year-end.

Emerald Value: Introduced with effect from 1 January 2017, this option is an efficiency discounted option based on Emerald. Members on this option pay discounted membership fees in exchange for adhering to care coordination rules (Family Practitioner Nomination and Specialist Referral) and are required to use the Scheme's hospital network. The average 2017 member contribution was R4,378, and the percentage of members on this option in 2017 was 6.0% as at year-end.

Emerald: This option is designed to provide comprehensive cover that offers access to care at the member's chosen provider, subject to benefits and Scheme rules. This is a higher-end option, with a 2017 average contribution of R4,549. The percentage of members on this option in 2017 was 66.4% as at year-end.

Onyx: This is a top-of-the-range benefit option that offers extensive cover. On the Onyx option, the member can claim certain out-of-hospital expenses such as GP and specialist visits, contraceptives or basic radiology, from their day-to-day block benefit. The 2017 average contribution was R5,234. The percentage of members on this option in 2017 was 5.0% as at year end.

Our market

Under the registered Rules of GEMS, persons employed under the Public Service Act, Act 103 of 1994, in National Departments, Provincial Administrations, Provincial Departments or Government Components, as contemplated in section 7(2) of the Act, are eligible to join GEMS. The registered Rules of GEMS further allow for persons employed by employers approved by the GEMS Board of Trustees to join the Scheme. Persons who retired from the service of the relevant employers are also eligible to join.

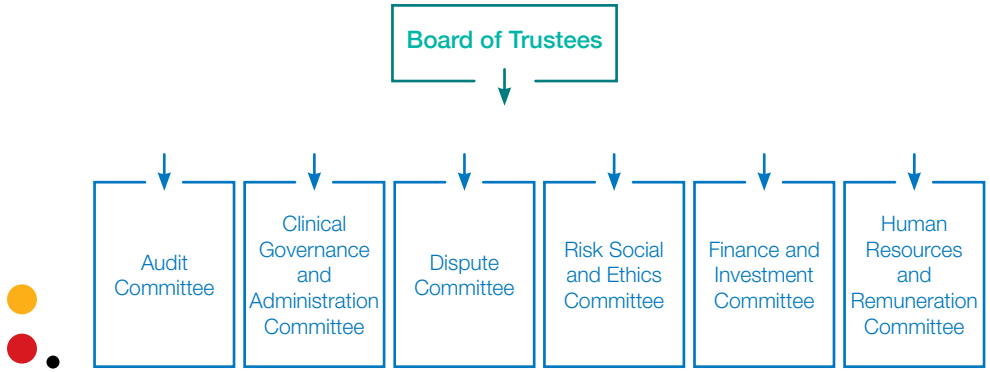
Membership of GEMS is not compulsory for employees employed under the Public Service Act, Act 103 of 1994, but is encouraged by an employer subsidy. Currently, there are an estimated 433,000 public service employees nationally who are eligible but not yet covered by GEMS.

The approved National Health Insurance Policy states that medical schemes covering state employees will be consolidated into GEMS. GEMS will continue to engage the relevant stakeholders on the eligibility of member groups that are not strictly defined

in the mandate approved by Cabinet in November 2004. This is a stakeholder-driven process that may extend beyond the Scheme's five-year strategy and may result in a recommendation for the Scheme's mandate to be amended accordingly.

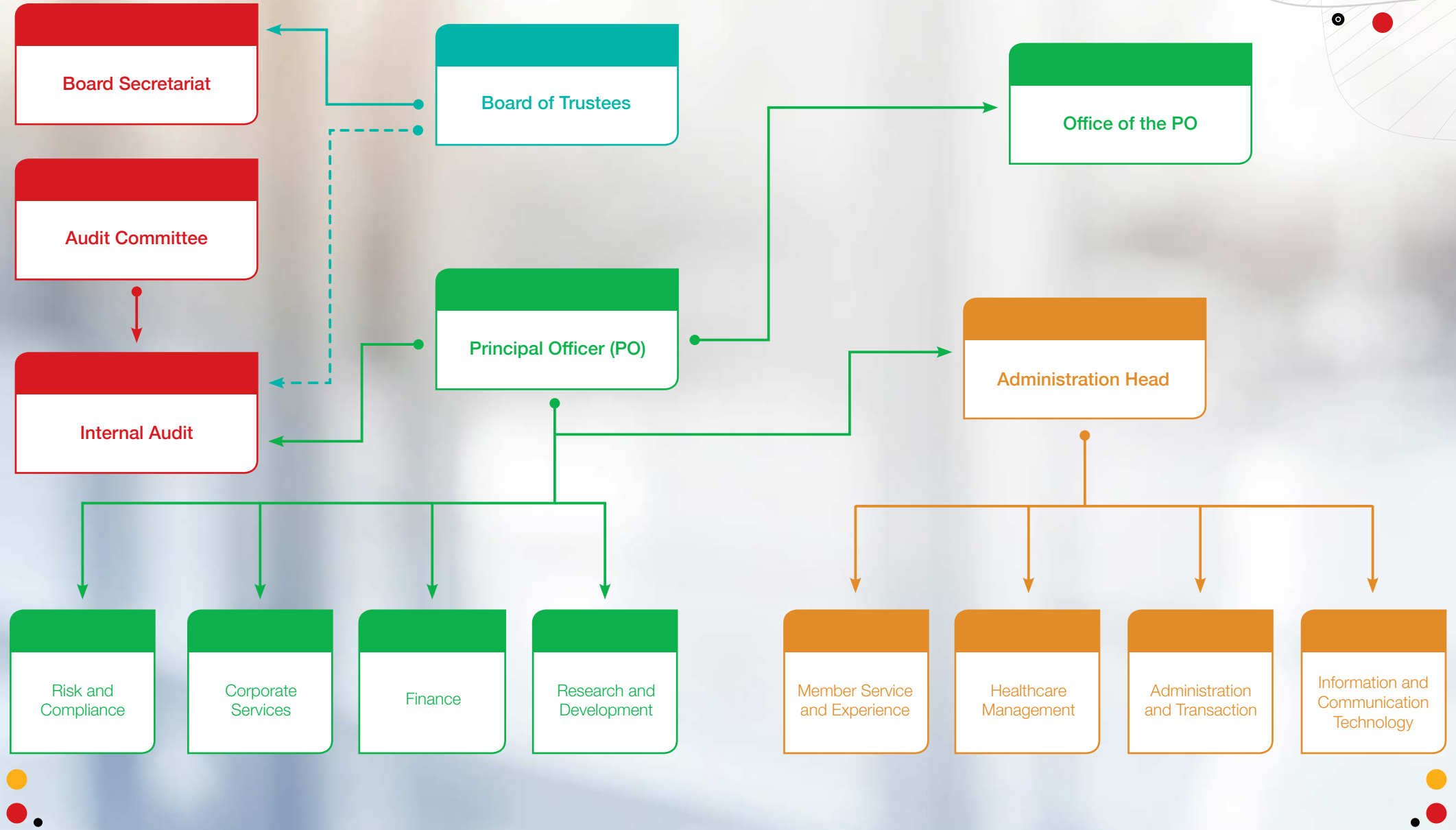
Structure and Leadership

The GEMS governance structure enables the Board to oversee critical aspects of the Scheme. The Standing Committee Structure supporting the Board was revised in 2017 and aligned to the new Five-year Strategic Plan and the Scheme's new organisational structure. The structure below was approved by the Board in September 2017 and was implemented with effect from 1 January 2018. More information on the Standing Committees in 2017 is available in the Governance Report from page 140.



The structure was approved by the Board in July 2017 and was implemented with most of the new positions filled by 1 March 2018.

Leadership structure



Board of Trustees

Back row (from left to right): Dr IJ van Zyl, Mr EB de Vries, Mr RA Manoko, Mr JS Roux, Mr DJ de Villiers

Front row (from left to right): Dr JA Breed, Mr EM Phophi, Dr ECT Moloko, Mr NL Theledi (Chairperson), Mr CJ Booyens, Dr SM Hlatshwayo (Deputy Chairperson)

Insert: Mr MR Nkabinde

The Trustees in office in 2017 were:

	Name	Elected or appointed			Other significant positions held in 2017
	**Mr EB de Vries** (21 July 1943)	Elected, tenure commenced 30 July 2013, ends 29 July 2019		• B.Ed (PE Univ.) • BA (Stellenbosch Univ.) • Secondary Teacher's Cert. (Stellenbosch Univ.)	• N/A
	**Dr CM Mini** (6 November 1951)	Appointed 30 July 2014, resigned from the Board effective 15 December 2017		• Bachelor of Medicine • Bachelor of Surgery (MBChB) • Dip. Community Medicine • Dip. Palliative Care Medicine	• Acting CEO: Board of Healthcare Funders
	**Dr ECT Moloko** (16 May 1959)	Appointed 28 October 2016, tenure ends 27 October 2022		• M.B.Ch.B., (MEDUNSA) • B.Sc. (Med), (MEDUNSA)	• Chairperson: Health and Welfare Sector Education and Training Authority
	**Mr CJ Booyens** (25 February 1942)	Elected, tenure commenced 30 July 2013, ends 29 July 2019		• B.Sc (UP) • THOD Teaching Diploma (Pretoria Teacher Training College)	• Trustee: Government Employees Pension Fund

	Name	Elected or appointed			Other significant positions held in 2017
	**Mr DJ de Villiers** (21 July 1955)	Elected, tenure commenced 30 July 2013, ends 29 July 2019		• BA (Communication Science) (Potch. Univ.) • Adv. Dip. in Labour Law (UJ)	• N/A
	**Dr JA Breed** (14 March 1951)	Elected, tenure commenced 30 July 2014, ends 29 July 2020		• BSc (PU for CHE) • THOD (POK) BEd (PU for CHE) • MEd (PU for CHE) • PhD (NWU)	• N/A
	**Dr IJ van Zyl** (31 January 1951)	Elected, tenure commenced 30 July 2014, ends 29 July 2020		• B Mil • Hons B Com (Personnel Management) • MBA • PhD (Industrial Economics) • Industrial Relations Development Programme	• N/A
	**Mr NL Theledi** (30 June 1963)	Appointed 09 September 2013, tenure ends 8 September 2019		• B Tech (TUT) • ND. Human Resource (UJ) • Public Mgt. & Dev. (Wits Graduate School of Public and Management) • MTech (TUT)	• Secretary General: POPCRU

	Name	Elected or appointed		Qualifications	Other significant positions held in 2017
	**Ms NM Ntsinde** (21 December 1957)	Appointed 30 July 2013, tenure ended 5 February 2018		• B. Proc (Univ. of Fort Hare) • MBA (Wits Business School)	• University of KwaZulu-Natal Council Member
	**Ms NH Mkhumane** (3 June 1973)	Appointed 25 September 2014, tenure ended 5 February 2018		• Dip. Law & Tax, IEIC (CIMA) • Exec. Mgt. Dev. Prog. (WBS) • Capital Proj. Mgt. Appraisal (Queens Univ. Canada) • Bachelor of Commerce (UNISWA) • Certificates: Board Leadership (GIBS), Corp. Gov., Audit Roles, Supply Chain Mgt & Prop. & Asset Mgt	• Chairperson: South African Diamond and Precious Metals Regulator
	**Mr EM Phophi** (6 October 1952)	Appointed, tenure commenced 26 Sept 2017, ends 25 Sept 2023		• BA (Human Resource Management) • International Labour Organization (ILO) Course on Labour Relations and performance management in the Public Service • International Labour Organization (ILO) Course on Advanced Negotiations Skills	• Chief Negotiator for the State as employer • Chairperson on National Labour Relations Forum for the Public Service • Chairperson of the State as employer in the Public Service Coordinating Bargaining Council
	**Mr JS Roux** (8 January 1944)	Elected, tenure commenced 30 July 2014, ends 29 July 2020		• B.Sc • L.S.T.D • B.Ed. (Univ. of Stellenbosch)	• N/A

Note: The Minister for Public Service and Administration appointed three new Trustees to replace the three Trustees who left on 15 December 2017 and 5 February 2018:

	Name	Elected or appointed		Qualifications	Other significant positions held in 2017
	**Dr SM Hlatshwayo** (9 January 1964)	Appointed, tenure commenced 20 February 2018, ends 19 February 2024		• BSc (MEDUNSA) • MB ChB (MEDUNSA)	• Casualty Doctor: Arwyp Private and OR Tambo Travel Clinic
	**Mr RA Manoko** (6 June 1966)	Appointed, tenure commenced 20 February 2018, ends 19 February 2024		• B.Proc (1989) (Univ. of the North) • LLB (Univ. of the North)	• Attorney
	**Mr MR Nkabinde** (11 May 1984)	Appointed, tenure commenced 20 February 2018, ends 19 February 2024		• Information & System Management Certificate	• ANCYL National Treasurer (Treasurer General)

Note: Trustees' qualifications are verified by means of the Scheme's annual vetting procedure.

Executive Management

Back row (from left to right): Ms Jeannie Combrink, Mr Samuel Lewatle, Ms Karyna Pierce, Dr Guni Goolab, Ms Masingita Chavalala (acting), Mr Evan Theys

Front row (from left to right): Mr Molapo Masekoameng, Dr Vuyokazi Gqola, Ms Zandile Nqweni-Chamane (acting), Ms Gloria Nkadimeng, Mr Michael Willie

Executive Management

The Scheme's Executive Structure in 2017 consisted of the GEMS Principal Officer (Chief Executive Officer) and eight Chief Officers. The positions* below reflect the Scheme's top structure prior to the implementation of the revised structure:

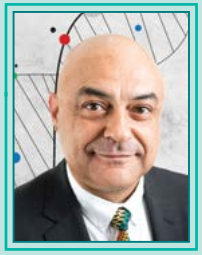
Name/position*	Summarised profile
Dr Guni Goolab Principal Officer 	Dr Goolab is a qualified medical practitioner, who graduated from the University of Witwatersrand (Wits) in 1985 and later completed an MBA with the University of Cape Town (UCT). Dr Goolab also has an extensive public and private healthcare background spanning nearly three decades. He has extensive executive experience, having led AstraZeneca, a multinational healthcare company, and one of the fastest growing pharmaceutical companies in South Africa. From 2008 to 2013, he led the expansion of AstraZeneca into Sub-Saharan Africa, with a particular focus on Nigeria, Ghana, Kenya and Angola. Since 1 August 2013, he was appointed as the Principal Officer of the Government Employees Medical Scheme. Notable successes during his tenure were: • The Scheme's financial position has strengthened considerably achieving record reserves of R5.4 billion and the highest ever reserve ratio of 15.17%. • Leading the Claims Management Programme, consisting of underwriting, hospital admission tracking, and fraud, waste and abuse. • The development and introduction of the Emerald Value option aligned to primary healthcare as the heartbeat of NHI. • The expansion of the CLO Unit services to seven provinces. • The strong focus on stakeholder engagements including the DPSA, PSCBC, Unions, DOH, National Treasury and the CMS.
Ms Gloria Nkadimeng Chief Information Officer 	Ms G Nkadimeng holds a Master's Degree in Automated Management Systems acquired in Havana, Cuba and a certificate in Business Management from the Centre for Business Management, UNISA. Prior to joining GEMS, Ms Nkadimeng was Group Head: Information & Communication Technology at the City of Johannesburg, Public Services Business Executive at Gijima, Enterprise Strategy Consultant at Microsoft and General Manager Information Management at the City of Tshwane. Currently, Ms Nkadimeng is charged with providing strategic leadership, vision and direction to the ICT Division in rendering Information & Communication Technology services to GEMS.
Mr Molapo Masekoameng Chief Audit Executive 	Mr Masekoameng joined the Scheme in August 2014. He holds a B Tech Degree in Internal Auditing (UNISA), diploma in Treasury Management and Trade Finance (Institute of Bankers), International Executive Development Programme (Wits Business School) and is accredited by the Institute of Internal Auditors as a Certified Internal Auditor (CIA) and Certified Financial Services Auditor (CFSA). Prior to joining GEMS, he was the Regional Internal Audit Director for Barclays Internal Audit – Southern Africa (overseeing internal audit services for Botswana, Mozambique, Tanzania, Zambia and Zimbabwe) and most recently as Head of Internal Audit, Barclays Shared Services Africa. Other career highlights include more than two years' experience as the Chief Operating Officer of Absa Internal Audit and a two-year tenure as Head of Audit for Absa Retail Banking. He is responsible for the Scheme's Internal Audit Function.

Name/position*	Summarised profile
Dr Vuyokazi Gqola Chief Healthcare Management Officer 	Dr Gqola has years of experience at both private and public healthcare institutions. Dr Gqola holds a Bachelor of Medicine and Surgery (MBChB) from the University of Cape Town, a BSc degree, as well as a BSc Hons degree in Microbiology from the University of KwaZulu-Natal. She is a registered Medical Practitioner with the Health Professions Council of South Africa (HPCSA). Dr Gqola's most recent employment was at Medscheme Holdings as a Senior Specialist: GEMS Medical Advisor since 2010. She was appointed as GEMS Executive: Healthcare Management in September 2015. She is responsible for the Scheme's managed care services including disease management programmes, tariff negotiations, healthcare provider relations, healthcare networks and strategic sourcing.
Ms Zandile Nqweni-Chamane Acting Chief Communication and Member Affairs Officer (from 1 April 2017) 	Ms Nqweni-Chamane joined GEMS in July 2015 as Senior Manager CLO (Client Liaison Unit), responsible for driving the strategy and operational oversight of the Customer Experience delivered through CLO Units. She has been progressively successful in implementing the Face to Face Strategy as adopted by the Scheme as a strategic imperative, to government departments in order to improve service delivery, access and overall customer experience. This role has resulted in her successfully overseeing the establishment of 4 additional regional offices in Free State, Polokwane, Mpumalanga and North West, though with a national oversight of 7 regions including Gauteng, KZN and EC. Zandile commenced her career as a Healthcare Consultant at Alexander Forbes Financial Services and played a key role in the team that supported the establishment of GEMS in 2005. With a strong exposure in the banking sector, Zandile has worked as Project and Innovation Manager and Customer Experience Manager at FNB and Postbank. At ABSA, she headed a national portfolio of Client Relations and Stakeholder Management for the Cash Management Solutions Division. A career highlight was being the Ambassador for Cash Division at SARB and work stream lead for the Customer and Stakeholder portfolio during the introduction of the new currency in 2012. She is the (Acting) Chief Member Experience Executive at GEMS and has ensured continuity and integration of GEMS strategic member experience deliverables. Her qualifications include, NDip Marketing (NMMU), Certificate in Basic of Project Management, (UNISA) ,Management Development Programme (GIBS), Certificate in Customer Experience (UP) and the Executive Leaderships Development Programme (SUN).

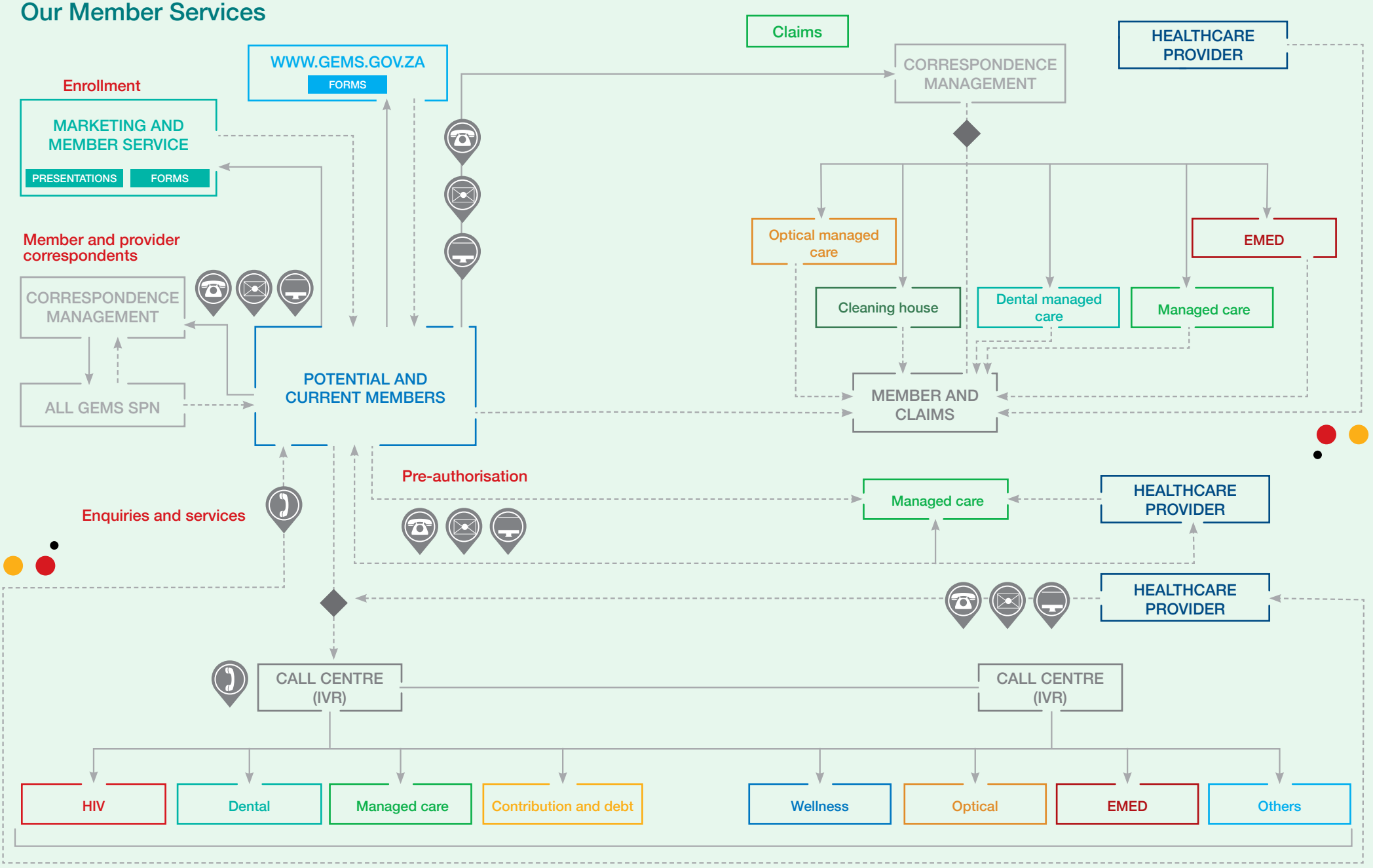
Name/position*	Summarised profile
Ms Karyna Pierce Chief Financial Officer 	Ms Pierce qualified as a Chartered Accountant in 2004 and completed a senior management course at the University of Pretoria. Her career highlights include a five-year tenure as Head of Finance at the Competition Commission responsible for Strategic and Business Planning (finance area), People Management, Basic Administration and Compliance, Policy Implementation and Service Delivery. She joined GEMS in 2007 as the Executive: Finance. She is responsible for managing Scheme finances, Scheme investments, implementation and processing of financial, accounting and administrative requirements (inclusive of relevant policies) as well as the management of Scheme actuarial work. Until 31 December 2017, she was also responsible for overseeing the Scheme's procurement function.
Ms Masingita Chavalala Acting Chief Contracts and Operations Officer (from 19 December 2016) 	Ms Chavalala joined GEMS in November 2015 as a Senior Manager responsible for the Scheme's Project Management Office (PMO). In December 2016, in addition to her primary role, Ms Chavalala was appointment as Acting Chief Contracts and Operations Officer, in charge of the Scheme's operational and contracting environment, including member claims administration, member contribution and debt, operational risk exposure (fraud, waste and abuse), Pharmaceutical Benefit Management and Emergency Management Services. Her experience prior to joining GEMS includes working as a Senior Project Manager for the Edcon Group and as Deputy Director in the office of the Minister of Economic Development. Her career highlights includes appointment as Project Manager for Edcon's Africa Expansion project and serving as part of a team tasked with the establishment of the Economic Development Department after the 2009 National Elections. She holds an Advanced Diploma in Project Management, a Postgraduate Diploma in Programme Management (Cranefield College of Project and Programme Management), a Certificate in Strategic Management and Postgraduate Certificate Advanced Strategic Management (UNISA) and completed a General Management Development Programme (GIBS).

Name/position*	Summarised profile
Ms Jeannie Combrink Chief Governance and Compliance Officer 	Ms Combrink holds a BA Degree in State Administration, Human Resource Management, Public Administration and Political Science as well as a BA Hons in Public Administration. Prior to joining GEMS, she worked as a Deputy Director: Conditions of Service in the Department of Public Service and Administration. Other highlights include serving at the Public Service Commission from 1993 to 1999. Prior to that, she formed part of the team that implemented PERSAL across the public service. She was part of the team tasked with establishing GEMS and formally became a Scheme employee in 2006. She is responsible for managing the Scheme's corporate governance functions, including the provision of support to the Board of Trustees and Committees. She is also responsible for ensuring compliance with the regulatory framework applicable to the Scheme and the Scheme's stakeholder management function.
Mr Samuel Lewatle Chief Corporate Services Officer 	Mr Lewatle holds a Master's in Business Administration (MBA) from Oxford Brookes University (UK), Bachelor of Business Administration (BBA), National Diploma in Education, Certificates in Macro Economics and Industrial Relations, Certificate in Executive and Business Coaching and a Postgraduate Certificate in Executive Leadership. He has extensive experience, having worked for a multinational organisation as Africa Area: Human Resources Manager and locally for the Independent Development Trust (IDT) as Senior Manager/Acting General Manager. He managed members for his management/consulting business, which he established and managed for three years. He was the Executive Director: Human Capital for the National Development Agency prior to joining GEMS. His career highlights include working internationally and managing HR operations in countries such as Ghana, Nigeria, Kenya and Democratic Republic of Congo, achieving the Employer Brand Management accreditation and best company to work for during the period 2009-10 from Corporate Research Foundation (CRF). Mr Lewatle joined GEMS in March 2014 as Executive: Corporate Services. He is responsible for the Corporate Service Division in driving the full human capital services that include change management, performance management, remuneration, strategic human resources planning and offices infrastructure planning and management.

The Chief Officers appointed from 1 January 2018 are:

Name/position	Summarised profile
Mr Evan Theys Company Secretary 	Mr Theys joined GEMS on 1 February 2018 as the Company Secretary and Legal Counsel. He has a BA LLB from the University of the Western Cape, LLM and Postgraduate Diploma in Tax Law from UCT and an MBA from the University of Stellenbosch. Mr Theys is an admitted attorney with experience in the life insurance industry and as a company secretary and has been in various sectors of the medical schemes industry for the past 16 years.
Mr Michael Willie Chief Research and Development Officer 	Mr Willie joined GEMS on 1 February 2018. He holds a BSc (Mathematics and Statistics) and a Masters (MSc in Mathematical Statistics) from University of the Free State (UFS). He also holds postgraduate certificates in Marketing Management and Strategic Management from UNISA. Prior to joining the Scheme, he was employed as a Data Scientist by Nedbank, prior to that he was with Liberty Corporate and Rand Mutual Assurance involved in Analytics and Data Management. Mr Willie also previously worked for the Council for Medical Schemes as a senior researcher and acting head of department. Other previous engagements were with Wits Health Consortium where he worked as a biostatistician. He is responsible for the Research and Development function of the Scheme.

Our Member Services



Member Servicing and Communication Platforms in 2017

Communication platform	Impact
Provincial Member Walk-in Centres	These centres provide direct access to Scheme services and information. There were **634,097** visits to the 18 walk-in centres across the country recorded for the year. The average number of visits per office in 2017 was 52,841.
Call Centres	The call centres operated across the GEMS Service Provider Network remain the contact point used most frequently by members. During the course of 2017, a total number of 3,594,869 calls were recorded overall. The average number of calls per month was 276,528.
Electronic Communication	The extent of interaction with members by means of electronic communication was significant: • 10,916,370 inbound and outbound emails were recorded. Note that this does not include the emails received via enquiries@gems.gov.za. • 15,733,199 letters/statements were sent to members. • 22,786,931 inbound and outbound short message service (SMS) messages were recorded. The key driver is 'claims received' notifications. • 2,518,754 website hits were recorded, translating to an increase of 1.8%. The average number of hits per month was 209,896.
Newsletters	The Scheme ensures that regular communication is disseminated to all stakeholder groups throughout the year. Members receive targeted newsletters ensuring that they have full understanding of their medical scheme. nDoH, departmental HR practitioners and healthcare providers also receive newsletters to enable them to better assist Scheme members as well as potential members. The Scheme distributed two segmented member newsletters in 2017. The member newsletters are segmented into five different member profiles, to directly target member needs. The following newsletters were also distributed in 2017: • DoH Connect Newsletter • HR Newsletter • SP Newsletter

Communication platform	Impact
Client Liaison Office (CLO Unit)	As at the end of 2017, the CLO Unit was fully operational in Gauteng, KwaZulu-Natal, Eastern Cape, Free State, Limpopo, Mpumalanga and the North West. The Unit increased its footprint across the provinces to 4,370 new sites while services at 1,612 sites were reactivated in 2017. With the deployment of the CLO Unit to date, 16,077 service events were held. 288,321 service interactions comprising of 191,210 engagements with GEMS members and 97,111 with potential GEMS members were undertaken. A total of 290,664 enquiries were received for investigation and finalisation with an average on-site query resolution rate of 88% across all regions. Health and wellness is at the heart of the Scheme's foundational principles and the Scheme activated 2,761 wellness events, coordinated via the CLO Unit's service engagements. Further to this, the promotion of the exercise programme via the CLO Unit saw 1,810 such events held. The CLO Unit drives member education sessions and workshops to empower members and improve understanding of benefit entitlements, Scheme Rules and processes. A total of 9,120 member education sessions were rolled out across the Provinces. In addition to this, the Unit hosted 412 focus group meetings to engage members around their understanding, expectations and experience of the Scheme.
Wellness Screenings (Health and Wellness Days)	3,497 Health and Wellness Days were held where public service employees were able to engage with the Scheme while checking their health and wellness status through screening services. A total of 39,524 HIV Counselling and Testing engagements were conducted where members received counseling pre and post their HIV test. This represents a reduction in uptake of 5,248 as compared to the previous year. In total, 130,397 wellness screening tests were conducted in 2017. 86,464 members were identified as high risk and referred to an appropriate disease management programme for intervention. These tests included blood glucose, blood pressure, cholesterol, waist circumference measurement and a determination of Body Mass Index.

Communication platform	Impact
GEMS Days	Five GEMS Days were held. GEMS Days are activation events held in partnership with departments or unions, with the aim of bringing GEMS services closer to members and potential members while strengthening collaboration with stakeholders to reach common objectives. Members are able to access all Scheme services such as membership services, contributions and debt query handling, maternity programme registration, wellness screening and chronic disease registration, at these events. The five events held were: • Eastern Cape GEMS Day in partnership with Department of Correctional Services, where approximately 700 attendees were engaged. • Limpopo GEMS Day had approximately 1,200 public service employees in attendance. • Gauteng GEMS Day had approximately 1,000 public service employees in attendance. • KZN GEMS Day attracted approximately 1,000 public service employees. • Mpumalanga GEMS Day had approximately 700 public service employees in attendance.

Communication platform	Impact
Lekgotla (Member Engagement Activities)	Lekgotla roadshows were held to engage members on key Scheme developments and receive their feedback and input. This initiative is part of the Scheme's continued drive to enhance and increase face-to-face interaction with members. Two Lekgotla roadshows were held in 2017, one in Quarter 2 of 2017 to engage members around the new benefits as well as to gain further insights for product development for 2018. The second roadshow was held during November and December 2017 with the main objective of engaging members on the 2018 benefit changes, option selection processes and the Emerald Value option. The roadshows covered nine provinces. In total, 33 engagements were held with an average of 34 members attending each session. The first roadshow focused on the following themes: • Fraud, waste and abuse • Benefit design process • Anti-selective behaviour and underwriting • Update on care coordination The second roadshow covered the following themes: • Introduction of the 2018 benefits and changes to each option • Underwriting • Emerald Value option • 2018 value adds • 2018 contribution increases across all options • Guide to the option selection period • Introduction of the GEMS Member App • Fraud, waste and abuse
Stakeholder Engagements	In a continued initiative to strengthen the relationship between the Scheme and Human Resources, Wellness and Salary Administration practitioners, six stakeholder engagements were held in five provinces, namely Gauteng, Mpumalanga, Limpopo, KwaZulu-Natal and Northern Cape. These were attended by an average of 150 practitioners per session. Eight HR stakeholder sessions were held, including Northern and Western Cape, to engage and provide feedback regarding Scheme processes as well as to explore partnering between the Scheme and HR Practitioners towards ensuring a healthy public service.

Improved efficiency to enhance member experience

The launch of the GEMS Member App and Portal in October 2017 marks a new era in our interaction with members. Harnessing the power of digital technology not only empowers members to understand their benefits and Scheme services better, it also allows GEMS and our service providers to work smarter and more efficiently to enhance our service and, ultimately, the member experience.

This new service solution has been specially designed for GEMS members and their beneficiaries. The app and portal mean that members are able to submit claims, update their personal information and submit hospital authorisation requests themselves.

Many of the services that previously required members to fill out paperwork or phone the GEMS contact centre can now be directly accessed by members via the App or Portal. For the member, this reduces reliance on the call centre or having to visit a GEMS Walk-in Centre for day-to-day queries and services. For GEMS and relevant service providers, this enhanced efficiency means we have greater capacity to focus on other aspects of improving the GEMS experience for our members.

This new development brings a highly personalised and interactive tool for communication to our members, while reducing the need for paperwork in line with GEMS' commitment to sustainability.

Features include:

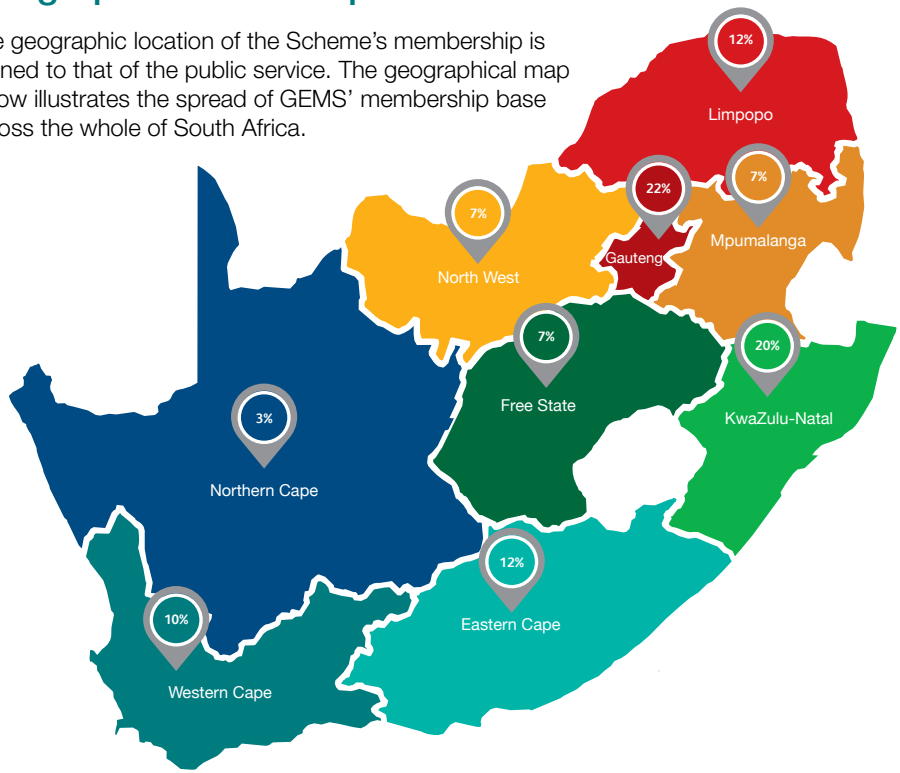
- Personal profile – 360° member view
- Find your provider
- Order a new medical aid card
- View contributions
- Download Tax Certificate
- Download member certificate
- View your authorisations
- Change communication preferences
- Benefit utilisation
- View and submit claims
- Member feedback
- Compliments and Complaints

The GEMS Service Provider Network (SPN) in 2017

Service Category	Provider
Generalised managed care services and management of the Sapphire and Beryl healthcare provider networks	Medscheme Health Risk Solutions
Administration for Members and Claims	Metropolitan Health Corporate
Administration for Correspondence Management	Metropolitan Health Corporate
Administration for Contribution and Debt Management	Medscheme Holdings
Emergency Medical Evacuation Dispatch Services	Europe Assistance
Management of the HIV/AIDS Programme	Thebe Health Risk Management
Dental Managed Care Services	Denis
Optical Managed Care Services	PPN
Health and Wellness Screening Services	Healthi Choices
Maternity Management Programme	Healthi Choices
Medicine Management Services	Universal Care
Strategic Managed Care Services	Universal Care
Pharmaceutical Benefit Management	Medikredit
Chronic Medicine Courier Services	Medipost Pharmacy
Telemarketing, Marketing and Member Services	EOH Abantu
Workplace-based exercise programme (GEMS Fitness)	EOH Abantu

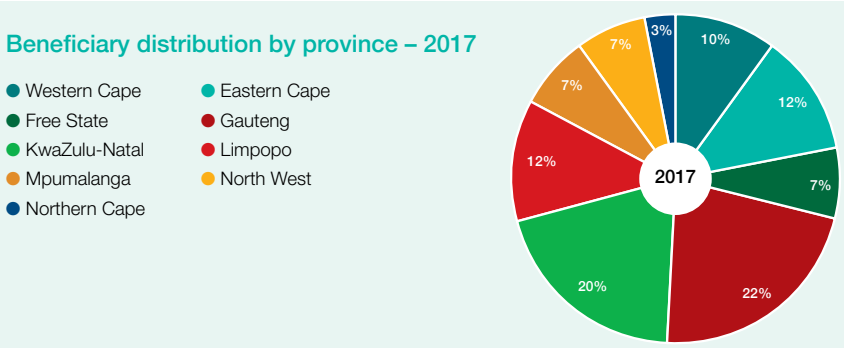
Geographic areas of operation

The geographic location of the Scheme's membership is aligned to that of the public service. The geographical map below illustrates the spread of GEMS' membership base across the whole of South Africa.



Gauteng, representing 22% (390,071) of beneficiaries, is the province which accounts for the largest percentage and is followed by KwaZulu-Natal with 20% (362,367). The Northern Cape still accounts for the lowest number of beneficiaries at 3% (51,119) of members. These statistics are also representative of the spread of public service departments across the country.

Beneficiary distribution by province – 2017

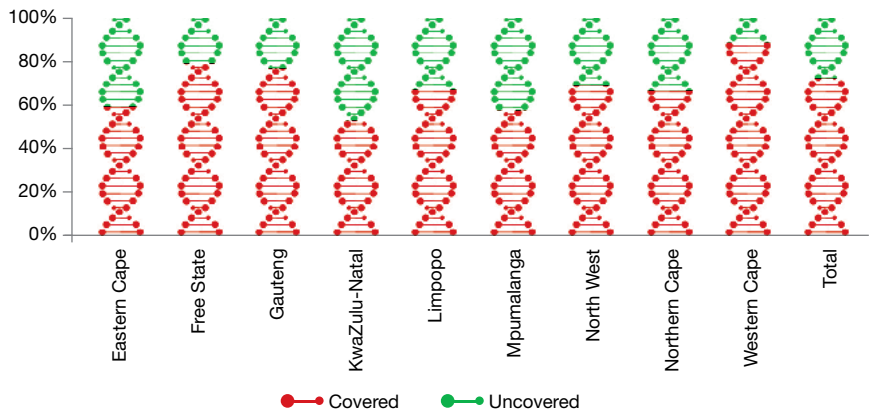


The following graph illustrates the trends in respect of the GEMS coverage of eligible employees across the provinces:

Provinces with low conversion rates are being actively targeted by the Scheme through various interactions, some of which are the following:

- Participation in Health and Wellness events of the various departments;
- Various GEMS days organised by the Scheme; and
- The continued establishment of CLO presence in all provinces.

Coverage of eligible employees as members 2017

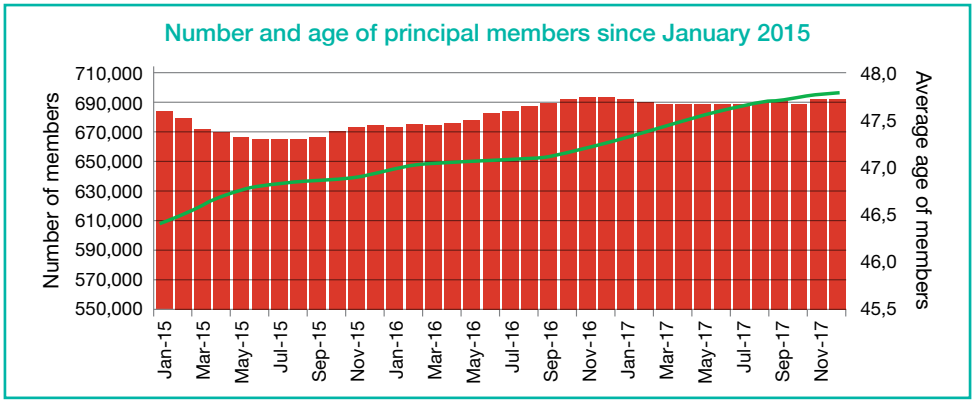


Membership profile

The table overleaf summarises the membership statistics of the Scheme's benefit options as at 31 December 2017. The industry average or totals column shows the figures available for restricted medical schemes as reported in the Council for Medical Schemes Annual Report for 2016-2017.

Membership statistics	Sapphire	Beryl	Ruby	EVO	Emerald	Onyx	GEMS	Industry average or totals (Restricted schemes) 31 Dec '16
Principal membership	44,508	30,629	81,682	41,317	459,486	34,470	692,092	1,635,066
Beneficiaries	142,620	80,679	217,976	115,687	1,192,230	58,346	1,807,538	3,894,480
Average family size	3.20	2.63	2.67	2.80	2.59	1.69	2.61	2.4
Average age of principal members	45.38	42.80	44.65	46.95	47.48	68.44	47.82	Not available
Average age of beneficiaries	29.16	29.99	28.81	32.04	31.59	57.79	31.87	30.6
Number of beneficiaries aged 65+ years	4,239	4,137	7,911	8,732	67,988	26,191	119,198	245,352
Percentage of beneficiaries aged 65+ years	2.97%	5.12%	3.63%	7.54%	5.70%	44.87%	6.59%	6.3%

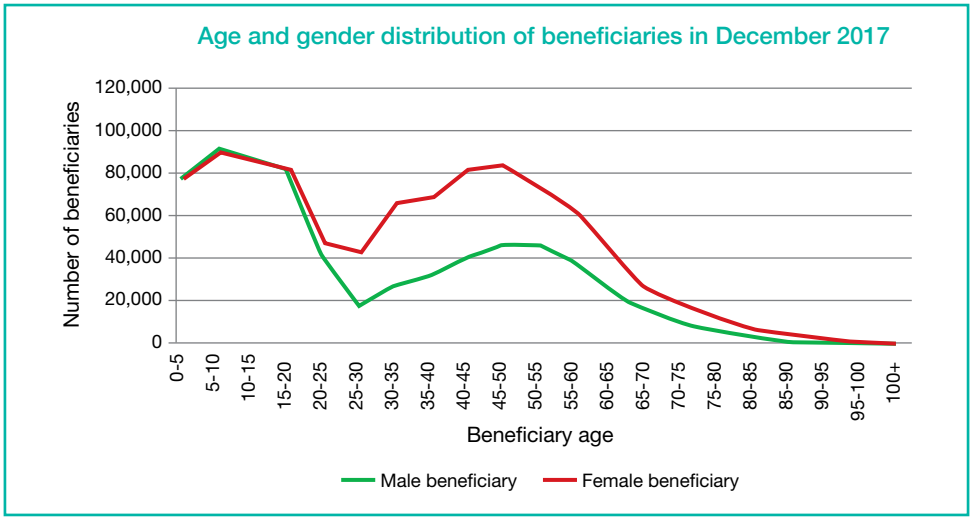
The graph below summarises the average age and total number of members over time. It is clearly visible that the Scheme's membership is ageing which has a direct impact on the claims experience of the Scheme.



The average age of principal members on the Scheme as at December 2017 was 47.8 years (2016: 47.3 years) and that of beneficiaries (principal members and dependants) was 31.9 years (2016: 31.5 years) indicating that the Scheme experienced a slight increase in the average age of all beneficiaries.

The oldest beneficiary on the Scheme is a female member on the Onyx option born in 1910 (aged 107).

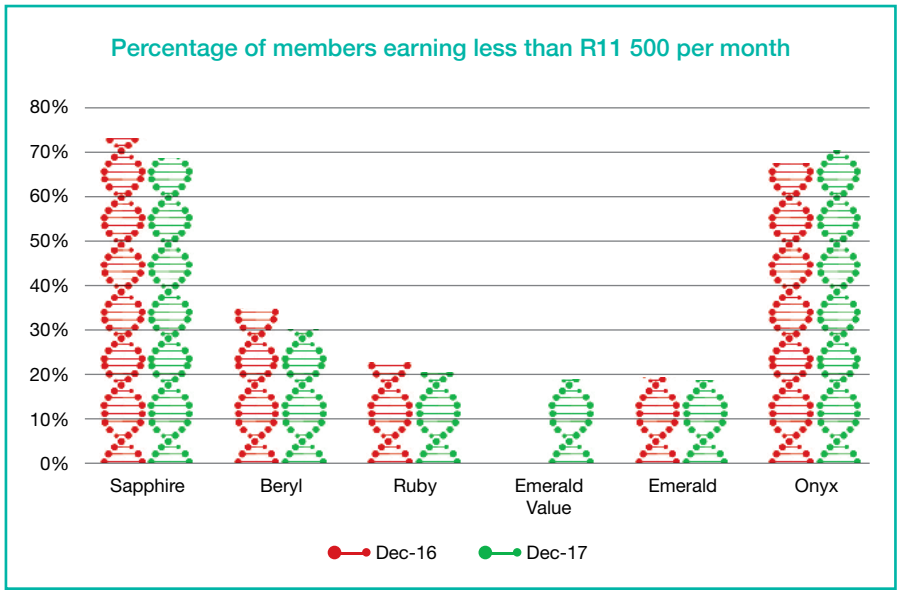
The graph below illustrates the split between male and female beneficiaries of the Scheme as at 31 December 2017 with the percentage of females at 58. 6% being significantly higher than that of males at 41.4% which is not dissimilar to the 2016 experience.



Salary level 1 to 5 public service employees

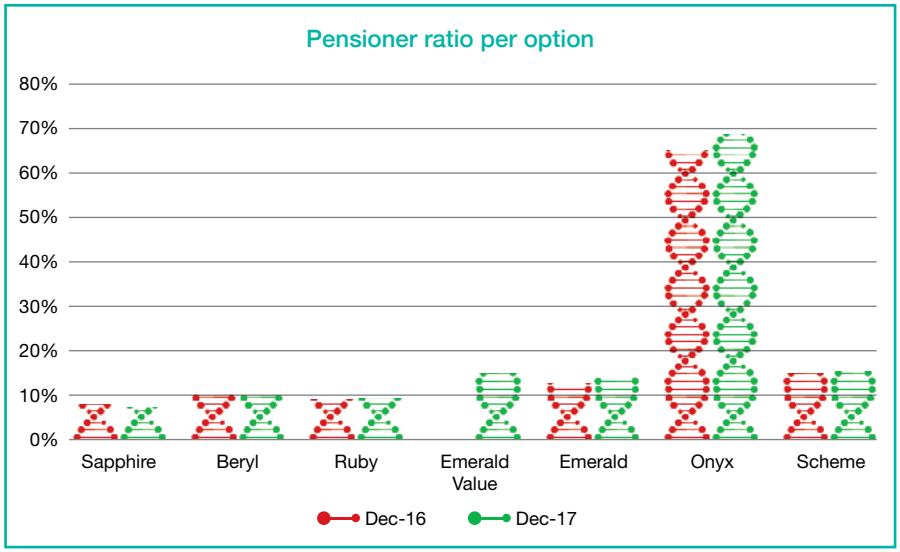
The Scheme ended the year with 184 119 (2016: 187 458) level 1 – 5 employees split across all the options in GEMS. This represents 26.6% (2016: 27.0%) of the total membership on GEMS and 47.49% of all level 1 to 5 public service employees on PERSAL. The change in the coverage of level 1 – 5 employees measured against the overall membership is due to a higher rate of resignation of lower salary employees. Other reasons include Occupation Specific Dispensation and cost of living increases as well as the general slow growth in the uptake of new members. Employees in the public service employed on salary levels 1 – 5 typically earn between R8,000 and R15,000 per month.

The Sapphire option has 88.3% members on salary level 1 – 5 compared to 49.4% for the Beryl option. This is expected since the Sapphire option is the least expensive option and fully subsidised up to a maximum of R4,592. The graph below depicts the year-on-year fluctuation per option, in respect of members earning less than R11,500 on average per month. The Scheme structures its member contributions into various salary bands in order for members to access benefits and pay contributions in relation to their monthly income earned. Pensioners* also benefit due to the fact that they are defaulted to the lowest income band.



*Pensioners

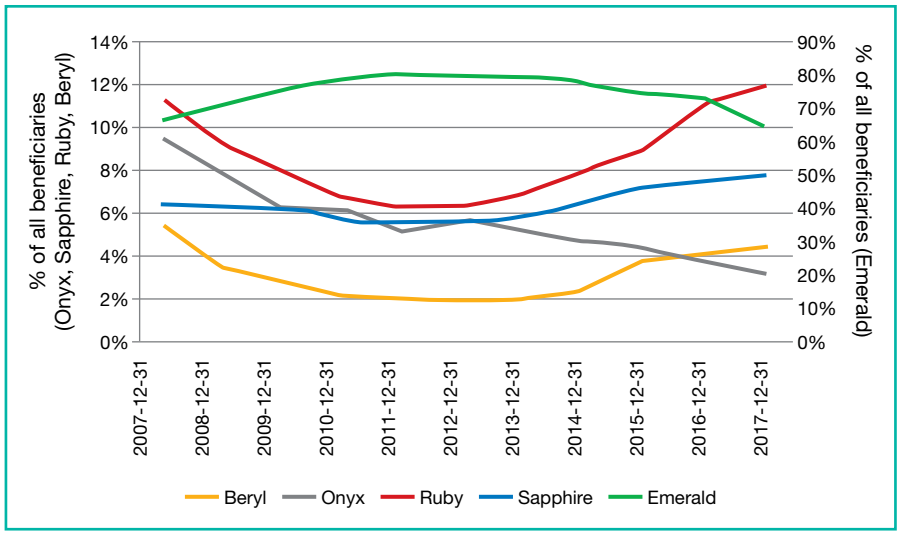
In this section, “pensioners” are being defined as any beneficiaries older than 60 years of age. The reliance on age for purposes of this definition is in line with the reporting practice of the Council for Medical Schemes. The demographic analysis of the Scheme is indicative of a persistent increase in pensioners over time.



The total number of principal members older than 60 years increased with 5.9% from 99,693 in 2016 to 105,554 in the 2017 financial year. This trend was observed across most options. The pensioner ratio for principal members over 60 years increased to 15.3% in 2017 from 14.36% in 2016.

Membership trends

The figure below shows trend data as a percentage of beneficiaries across the five benefit options (except Emerald Value) from 2011-12. Eminent trends in the data is the increasing trend in Ruby, Sapphire and Beryl benefit options which are lower end benefit options of the Scheme. However, a reverse trend is observed in Onyx and Emerald. Further research work is currently being undertaken to understand consolidation of risk pools within the Scheme.



Number of claim lines per beneficiary

The number of claim lines per beneficiary were higher for the Onyx benefit option at 174 (154 in 2016) claims per beneficiary and was consistent with the older age profile of beneficiaries. The Sapphire benefit option had a lower proportion of claim lines received per beneficiary compared to the other benefit options at 31 (31 in 2016) in 2017. A summary of other benefit options is provided below:

- Sapphire: 12 (11 in 2016) claim lines/beneficiary in 2017
- Beryl: 31 (31 in 2016) claim lines/beneficiary in 2017
- Ruby: 55 (54 in 2016) claim lines/beneficiary in 2017
- Emerald Value: 69 (None in 2016) claim lines/beneficiary in 2017
- Emerald: 77 (72 in 2016) claim lines/beneficiary in 2017
- Onyx: 174 (154 in 2016) claim lines/beneficiary in 2017

Our external operating context

Important developments in the external operating context that are expected to have an influence on the Scheme's ability to create value are:

Issue	Implication
The imminent National Health Insurance (NHI) impact on the medical scheme landscape	The NHI Policy was published in June 2017. The implementation of NHI requires GEMS to alter the manner in which it currently conducts business, and to strategically position itself for the NHI. In keeping with the NHI Policy, GEMS will lead the progressive consolidation of medical schemes that currently provide medical aid cover to state employees, thus presenting the State with a unique opportunity to continue learning and progressively strengthening its capacity to administer a large national health fund. This work will take place under the auspices of the NHI National Advisory Committee on Consolidation of Financial Arrangements.
The Public Service Coordinating Bargaining Council (PSCBC) Resolution 4 of 2017	The Public Service Coordinating Bargaining Council (PSCBC) was established in terms of Section 35 of the Labour Relations Act to provide a platform for negotiation on matters of mutual interest between the State and Employer and Trade Unions. Matters of mutual interest include the conditions of employment of public service employees such as the medical assistance subsidy. The PSCBC resolved in 2015 to perform a review of GEMS, including a review of the efficacy of GEMS' operating model, and to determine whether the objectives for which GEMS was established are being met. The PSCBC concluded Resolution 4 of 2017 on 4 December 2017 which concludes the initial performance review of GEMS. Under PSCBC Resolution 4 of 2017, a working committee that considers the performance of the Scheme on an ongoing basis will be established. The working committee will consist of the employer, admitted Trade Unions in the PSCBC and GEMS.

Issue	Implication
The Public Service Coordinating Bargaining Council (PSCBC) Resolution 4 of 2017 (continued)	The Committee's task is to meaningfully consult on: • The strategic direction of the Scheme; • The efficiency of the administration of the Scheme; • Reports on the financial sustainability of the Scheme; • The Scheme benefit offering relative to other schemes in the market; • The bettering of the member benefit structure; • Reports on member satisfaction; and • Ongoing member education and recruitment. Also under PSCBC Resolution 4 of 2017, parties will pursue the amendment of the composition of the GEMS Board of Trustees to comprise of: • Six Trustees appointed by the Minister for Public Service and Administration; • Four Trustees appointed by the admitted Trade Unions in the PSCBC; and • Two Trustees elected directly by members.
Personal Medical Savings Accounts (PMSA): The Constitutional Court found on 6 June 2017 that PMSA liabilities do not need to be treated separately or differently from any other liabilities of the Genesis Medical Scheme, and that the scheme is the right holder of the funds. The guidance provided by the Council for Medical Schemes is that the judgement affects the technical accounting treatment of members' personal medical savings accounts. In addition, medical schemes are no longer required to invest these funds separately and accrue interest to PMSA accounts. The Council for Medical Schemes has since guided medical schemes to implement the required changes and to amend their registered rules as part of their 2018 benefit and pricing submissions.	The GEMS Rules were amended with effect from 1 January 2018 and all PMSA interest accrues to the Scheme with effect from this date.

Issue	Implication
Challenges inherent to the medical schemes industry: Several gaps exist in the South African medical schemes industry in respect of affordability, quality in the standard of healthcare and services delivery as well as accessibility challenges.	Similar to other medical schemes, GEMS has to adopt proactive health and wellness management methodologies to curtail costs, drive innovation and enhance efficiencies.
Review of Prescribed Minimum Benefits	The impact of Prescribed Minimum Benefit claims on GEMS is discussed on page 115 of the report. The Council for Medical Schemes has embarked on a process to review the Prescribed Minimum Benefits against the background of the work underway to implement National Health Insurance. GEMS is participating in the review by serving on the committees established by the Council for Medical Schemes and by making written submissions when afforded with an opportunity to do so.
Other legislative and regulatory reform	Medical schemes and their stakeholders are preparing to comply with the Protection of Personal Information Act (POPIA). GEMS had developed a POPIA Compliance Plan to define the actions required from the Scheme and to work towards full compliance. The Health Market Inquiry Administrative Timetable was amended and the Final Report will be published by 31 August 2018. GEMS supports the objective of the Health Market Inquiry by means of responding to submission and information requests. Submissions made by the Scheme in 2017 included detailed information on the establishment of healthcare provider networks through competitive tender processes and the results achieved by the GEMS Emerald Value option.

Our internal operating context

The Scheme's internal operating context in 2017 were characterised by the following matters:

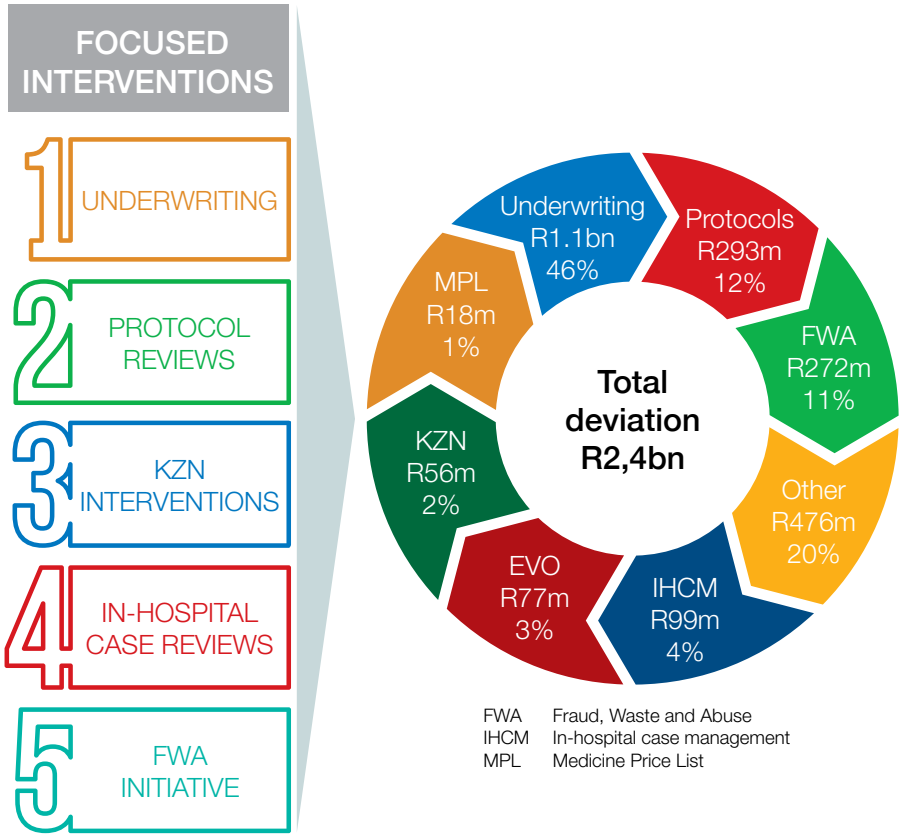
Issue	Implication
Outcome of the investigation into tender irregularities	The Scheme encountered operational capacity constraints due to the service termination of seven employees, of which five were senior/managerial employees during or after disciplinary proceedings. The Scheme terminated seven contracts in line with legal advice in respect of the following services: • Publication and Printing Services • Member Self-service Kiosk Services • Quality Management and Assurance Services • Correspondence Management Services • Legal Services (one provider in the legal services panel) • Member Survey Services • Promotional Material The operational impact related to the seven employees was managed by means of the appointment of employees to act in the affected roles and the appointment of contract employees. The residual impact is addressed under the implementation of the Scheme's new top structure. The operational impact related to the seven terminated contracts was managed by: • Reverting Correspondence Management Services and Printing and Publication Services to the Scheme's Administrator for Member and Claims Services. • Introducing a Member App and other member touchpoints while the future of the Member Self-service Kiosk Services remains under consideration. The termination of the other services did not have an operational impact.
Claims Management	The Claims Management Programme introduced in 2016 to address the Scheme's adverse claims experience was formalised in 2017 under the leadership of the Principal Officer. The programme is discussed from page 63 of the Report.
Implementation of the Emerald Value option	The Emerald Value option is an efficiency-discounted option centered on care coordination principles. The option is discussed on page 67 to page 70 of the Report.

Claims management

The multifaceted **Claims Management Programme** focusses on:

- Continued identification, early warning and analysis of risk factors;
- Development of mitigation measures; and
- Committing to a clear approach with firm timeframes.

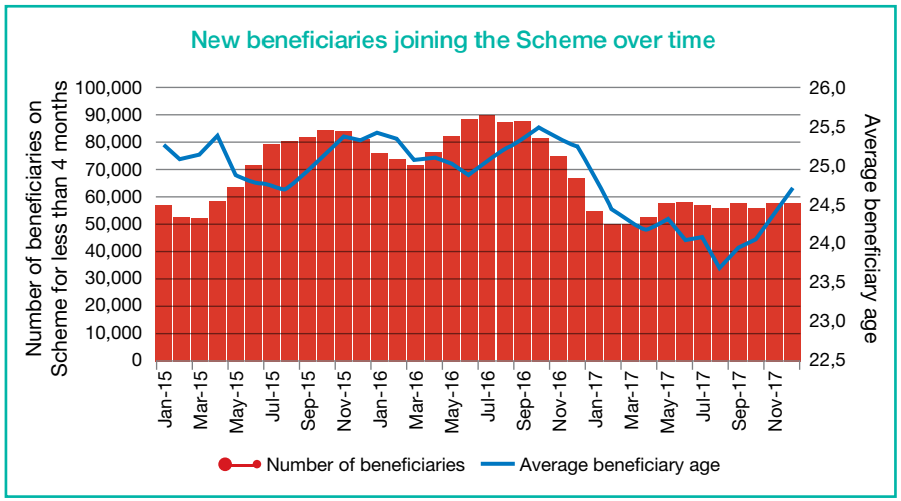
For the most part of 2017, the Scheme, together with its Service Provider Network, engaged in a rigorous process of research and analysis, review of processes, collaboration with industry players which saw the introduction of several initiatives which yielded significant positive results for the Scheme. Below is a breakdown of these initiatives and savings achieved by the Scheme for the year.



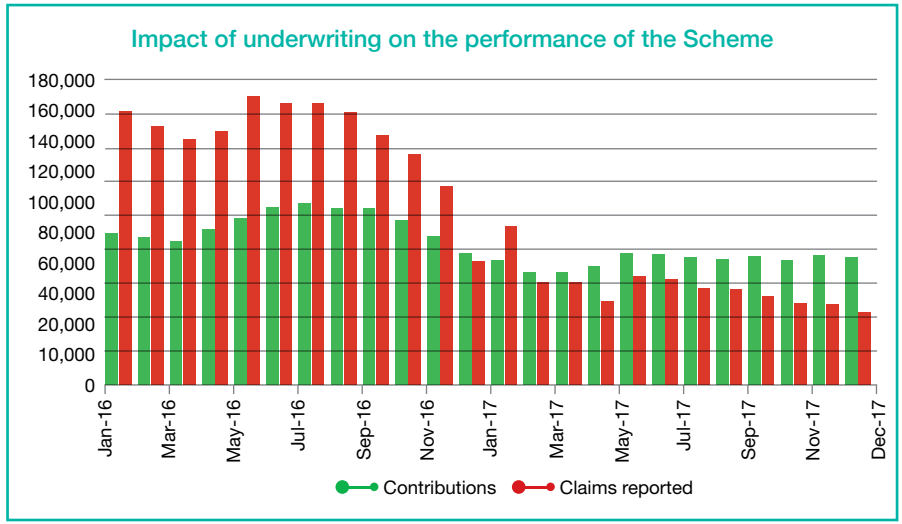
FWA Fraud, Waste and Abuse
IHCM In-hospital case management
MPL Medicine Price List

Anti-selection and underwriting

Underwriting was implemented in the latter part of 2016 as a result of the anti-selective behaviour shown by certain members of the Scheme. The introduction of underwriting has played a significant part in the enhancement of the Scheme's financial performance. Because of the underwriting implemented in October 2016 we saw fewer new members and dependants joining the Scheme in 2017. The graph below shows the reduction in number of new entrants in recent months as well as their average age. Since October 2016 we observed a change from the previous number of new entrants.



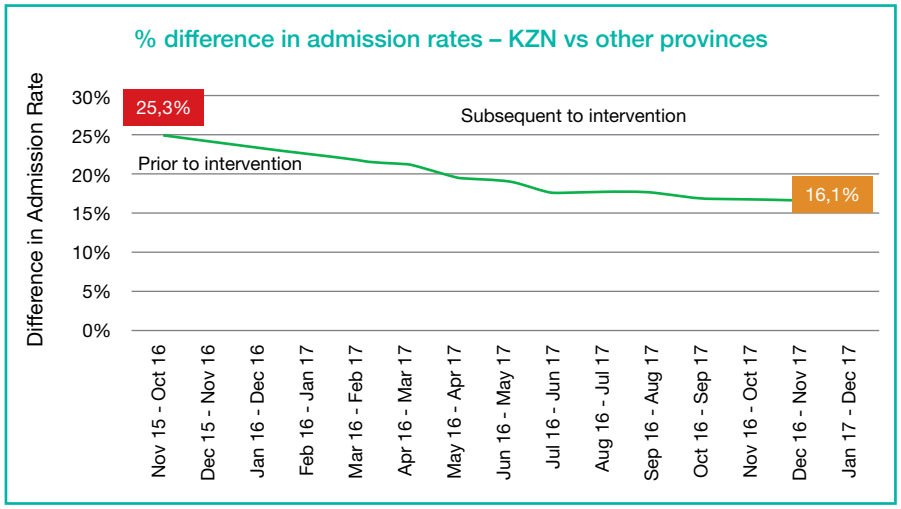
Since fewer new entrants are now entering the Scheme, the Scheme is reporting lower contributions than originally anticipated. This is summarised in the graph on the next page. Of more importance is the claims incurred by new beneficiaries being much lower than in previous years.



Fraud, waste and abuse

The hospital admission rate in KwaZulu-Natal was found to be 25,3% higher than other provinces on a risk-adjusted basis in 2016. This prompted the Scheme to implement a programme to review claims patterns within this province as well as the placement of on-site case managers in certain high claiming hospitals within the province. Providers found to be outside the norm were engaged and in certain instances forensic investigators were deployed to further investigate the matter. The work performed in this area should be seen in the context of the Scheme's commitment to ethical leadership and accountability.

The graph overleaf illustrates the impact of these interventions implemented by the Scheme on the admission rate:



GEMS developed and implemented a comprehensive early warning system that allows the hospital authorisation rates to be tracked on a weekly basis and delineated without delay. The monthly and cumulative change in the hospital admission rates when compared to 2016 is reflected below.

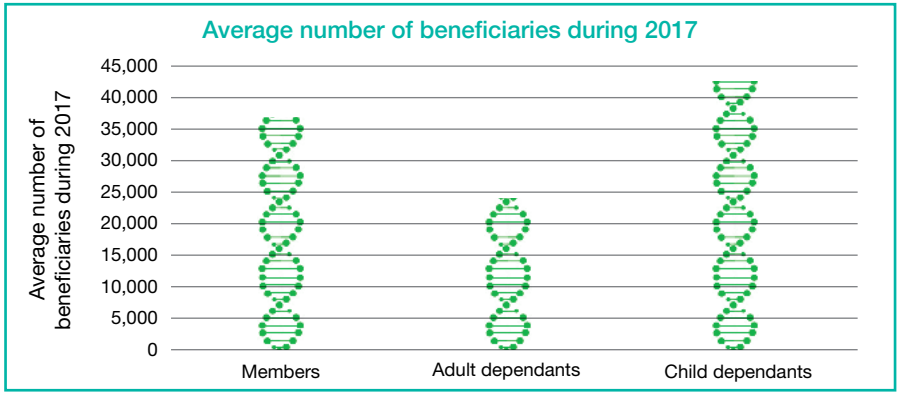
	Monthly			Cumulative		
	2016	2017	% change 16-17	2016	2017	% change 16-17
Jan	28.0%	26.5%	-5.3%	28.0%	26.5%	-5.3%
Feb	26.4%	25.7%	-2.5%	27.2%	26.1%	-3.9%
Mar	27.9%	27.0%	-3.4%	27.4%	26.4%	-3.8%
Apr	26.5%	24.6%	-7.2%	27.2%	25.9%	-4.6%
May	26.8%	25.6%	-4.3%	27.1%	25.9%	-4.5%
Jun	27.0%	24.0%	-11.0%	27.1%	25.6%	-5.6%
Jul	29.6%	30.2%	2.1%	27.5%	26.2%	-4.4%
Aug	27.1%	26.4%	-2.7%	27.4%	26.3%	-4.2%
Sep	26.2%	25.5%	-2.9%	27.3%	26.2%	-4.1%
Oct	25.8%	25.5%	-1.4%	27.1%	26.1%	-3.9%
Nov	22.9%	22.9%	0.0%	26.7%	25.8%	-3.6%
Dec	19.1%	19.4%	1.4%	26.1%	25.3%	-3.2%

During 2017 the Scheme implemented a methodology and approach to identify, prevent and recover irregular/fraudulent claim amounts from providers. The table below illustrates the methodology implemented and targets to be achieved and progress against each of these.

1 IDENTIFICATION	R2.8bn (10%) Identification of outlier providers	• Overall 915 providers identified • Value of claims paid for providers identified as outliers for 2016 – R3.75 billion • Value of potential irregularities identified on outliers to date – R162m
2 PREVENTION	R280m (10%) Change in outlier behaviour as a result of interventions	• The behaviour change has been quantified • Savings to date as per FWA initiative estimated at R175m • KZN cost reduction is approximately R63m
3 RECOVERY	R28m (10%) Recoveries from outlier providers	• R19.76m (Banked recoveries to date R5.2m and AOD's to the value of R14.56m)

Implementation of Emerald Value option

The Scheme launched an efficiency discounted option, i.e. the Emerald Value option (EVO) from 1 January 2017 with a significant portion of members electing to move to this option. This option has the same benefits and limits as the Emerald option, but members have to access benefits through a network of hospitals and GPs as well as being formally referred for Specialist services required. The graph below indicates the number of members and beneficiaries that were active on the option during 2017.



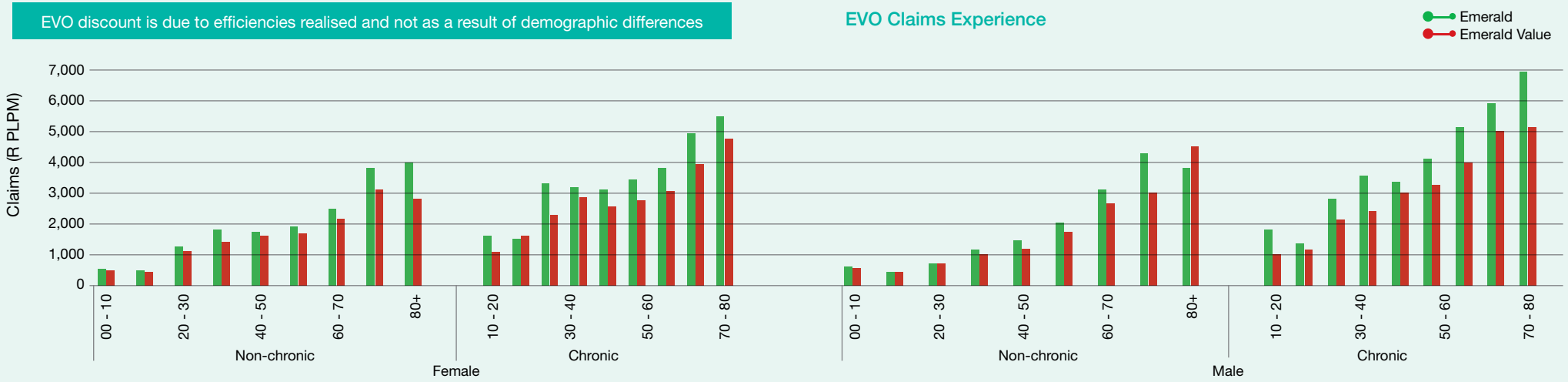
The Emerald Value option (EVO) was launched with a 10% discount to the current Emerald option contribution rates but through further efficiencies achieved by the Scheme the actual savings achieved was more than 10% as is indicated in the graph below. The additional savings were used to pass through a lower contribution increase for 2018 for those on the EVO option when compared to the other options of the Scheme.

EVO discount is due to efficiencies realised and not as a result of demographic differences

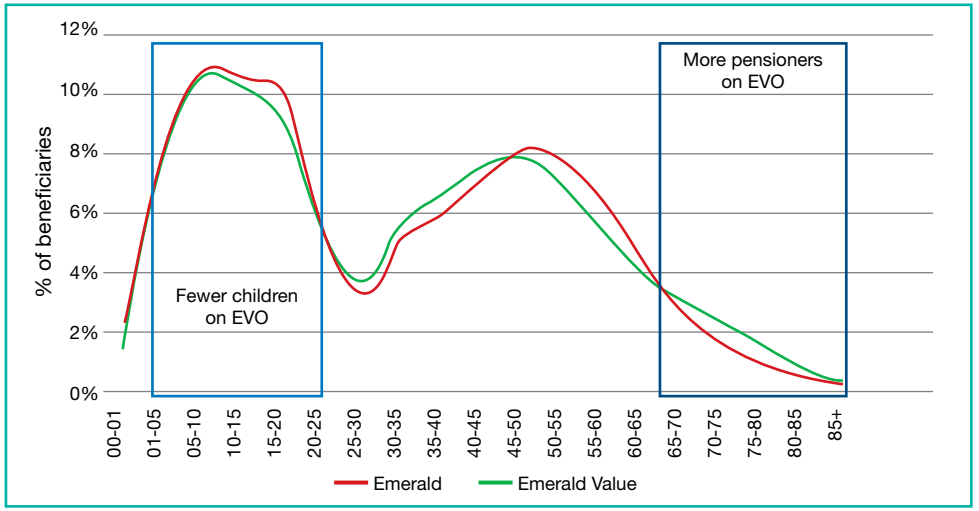
The claims experience on EVO for the 2017 financial year, in comparison with the Emerald option is shown in the graph below:

In summary, the Emerald Value option impact is illustrated below:

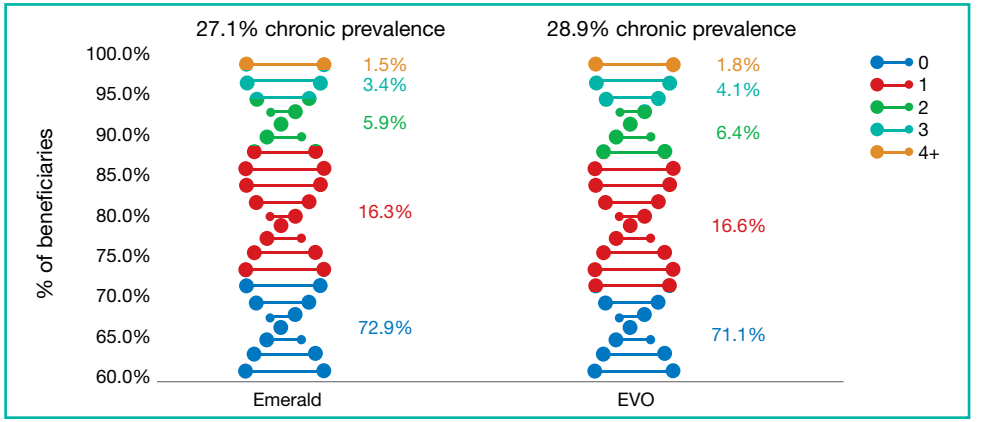
EVO Claims Experience



An interesting observation that emerged when the membership of the new option was analysed was that more pensioner members joined this option than what the Scheme had expected.



As a result of the above higher pensioner ratio on the EVO it also impacted in the chronic profile of this option with it being higher than the normal Emerald option. Although this could be perceived as a negative impact, this is not the case as it is these members who benefit from the coordinated care approach that underpins EVO. Below is a comparison of the chronic profiles on the Emerald option compared to EVO.



The Emerald Value option offers the same comprehensive benefits as the Emerald option except that it is underpinned by care coordination

GP nomination | Efficient hospital network | GP to specialist referrals | 10% contributions discount

In just 12 months:

- The Emerald Value option has grown to cover **115 687 beneficiaries**
- The **cost of care has reduced by 15%; healthcare outcomes have improved**

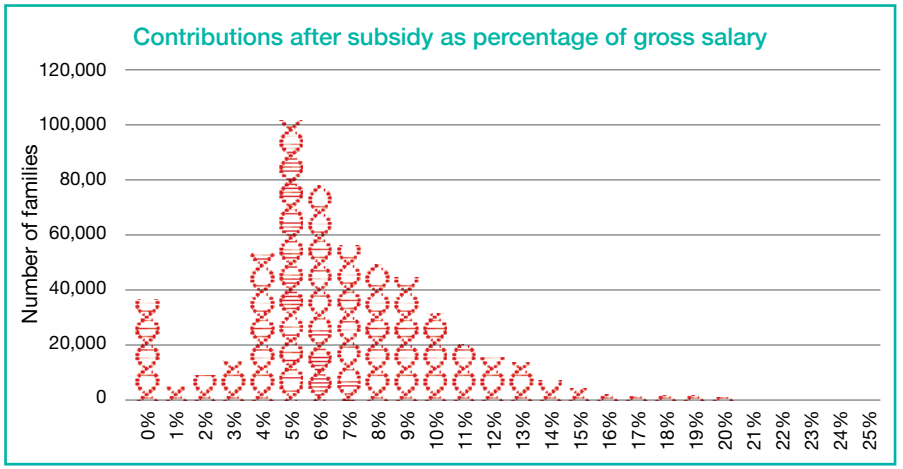
Feature	Outcome
A comprehensive GP nomination process	**99%** of members have nominated GP
Doctor hopping is less common	**12%** reduction in doctor hopping
GPs are consulted more frequently	**20%** increase in GP consultations relative to specialist consultations
Specialists are consulted less frequently	**18%** reduction in consultations
Patients are admitted less frequently	**12%** reduction in hospitalisations

Market positioning

GEMS is currently the largest restricted membership scheme and the second largest medical scheme overall in the South African medical scheme environment. This provides the Scheme with the size and scale to negotiate competitive rates with our service providers and the healthcare providers in the market.

The Scheme does an annual assessment of its benefits and contributions based on publicly available information in comparison to other open and closed Schemes in the market. The table below summarises how GEMS compares on average to the medical schemes considered in the analysis, based on the average contribution per family:

GEMS Option	% saving/(cost) between GEMS average family contribution and average family contribution of competing schemes before subsidy
Sapphire	26%
Beryl	1%
Ruby	-1%
Emerald Value	33%
Emerald	33%
Onyx	23%
All	29%



The graph above indicates that the majority of members on GEMS pay between 0% and 10% of their gross salary towards contributions after the subsidy.

Based on the results of the analysis outlined above, the Scheme is comfortable that GEMS' offering still provides good value for money when compared to other similar benefit options available in the market.

Business model and value creation

GEMS' Operating Model

GEMS' current operating model is anchored in outsourcing, e.g. member administration services, are outsourced to professional administrators and other service providers. The multi-party administration model was innovated and introduced by GEMS to the industry based on the requirement for expanding B-BBEE by enabling more entities to contract with GEMS and expand the pool of capable service providers. The Scheme has segmented its operations in order to ensure opportunities for large and small administrators within the industry and other service providers to achieve its transformation agenda. Due to this, the core business operations are outsourced, and oversight carried out internally from head office.

The current strengths of the operating model include:

- GEMS has enabled introduction of new players in the market which has encouraged competition.
- GEMS is able to leverage different strengths across the different service providers, giving it the ability to re-assign a contract if one service provider is performing poorly.
- GEMS has built strong project management and contract management capabilities.

The operating model was revised with a view to build the identified core capabilities needed to implement the GEMS Five-year Strategic Plan and to address weaknesses.

GEMS creates value for members by means of sustained low non-healthcare costs, initiatives aimed at reducing the price paid for healthcare services, by providing benefits and services for healthcare prevention and by managing a rigorous ex gratia function to assist members who are in need.

Providers of healthcare services benefit from our expanded member base, especially in respect of those members who were not previously on a medical scheme.

Our key stakeholders benefit from having access to information based on the analysis of scheme data and lower expenditure in respect of the medical assistance subsidy for certain groups of employees and former employees.

Over the first decade of its existence, GEMS has attained a significant measure of success as an effective vehicle to drive Government's agenda to expand healthcare coverage. Based on GEMS' track record, there is an opportunity for the Scheme to be an enabler and/or catalyst for driving the necessary change and progression towards Universal Health Coverage objectives through NHI implementation and by drawing on synergies between government policy and the aspiration of GEMS' mandate.

The relevance of the six capitals to GEMS in 2017:

Capital Name	Inputs in 2017
Financial Capital	• Contribution income (page 102) • Investment Income (page 110)
Social and Relationship Capital	• Relationship with the Minister for Public Service and Administration (page 82) • Stakeholder relationship management (page 83) • Development of GEMS Healthcare Networks (page 122) • Membership of Board of Healthcare Funders • Encouraging Broad-Based Black Economic Empowerment (page 76) • Member satisfaction and loyalty (pages 100 and 124)
Human Capital	• Recruitment and retention policies and systems (page 153) • Employee training programmes and outcomes (page 76) • Performance Management policies, systems and processes (page 155) • Ethics management (page 168)
Intellectual Capital	• GEMS Member App (page 50) • Scheme policies, standard operating procedures, business processes and operational manuals, including Fraud Policy and Prevention Approach and the GEMS Supply Chain Management Policy and related GEMS business documents • Intellectual property developed in executing scheme contracts, i.e. the development of clinical protocols of the Scheme • GEMS Risk Management Framework (page 93) • GEMS members' health and demographic profile (page 52)
Natural Capital	• Use of resources such as paper, water and electricity (page 129)
Manufactured Capital	• Service Provider Network Infrastructure (page 51) • Client Liaison Officer Unit Infrastructure (page 47)

How our business model creates value over time in a sustainable manner

Inputs

1 Financial Capital

Contributions and Investment Income

2 Social and Relationship Capital

GEMS Healthcare Networks, stakeholder relationships, supplier relationships, Member satisfaction and loyalty

3 Human Capital

Our employees – recruitment and selection, training programmes, performance management system, ethics and values

4 Intellectual Capital

Intelligems, GEMS policies, GEMS standard operating procedures, GEMS business processes and operational manuals, GEMS Risk Management Framework

5 Natural Capital

Paper, water and electricity

6 Manufactured Capital

Client Liaison Officer Infrastructure (offices, mobile office, SPN infrastructure)

Business model, activities and outputs

1 Financial Capital	2 Social and Relationship Capital	3 Human Capital	4 Intellectual Capital	5 Natural Capital	6 Manufactured Capital
Application of managed care protocols and funding decisions, disease management, claims adjudication and payment, financial management and reporting, investment mandate implementation, operational service provider fee negotiations	Tariff negotiations, stakeholder engagements, healthcare network management, contract SLA management, Member and healthcare complaint management, Member communication, Member roadshows, Member contact services and CLO service rendering	Recruitment and selection, employee training, performance management, ethics management processes	Procurement, contracting, fraud management, Intelligems implementation, product development and benefit design, claims containment processes, ex gratia award process	GEMS CO2 emission reduction initiatives	Used but not transformed by GEMS

Outcomes

Positive

- Surplus of R3.3 billion
- Solid investment performance
- Low non-healthcare costs

Positive

- Increased stakeholder interest and buy-in
- Improved healthcare provider relationships
- Contained PMB spend in specialist network
- Improved Member understanding due to CLO service rendering

Negative

- Overall Member satisfaction level remains below target
- Increased number of CMS complaints

Positive

- Job creation due to the establishment of the CLO Unit
- Promotion of employment equity
- Employee training – 100% of employees
- High level of ethics awareness

Positive

- Curbing of fraud, waste and abuse
- Strong market competitiveness
- Improved disease management
- Improved care coordination
- Affordability of Member contributions
- Improved control over Scheme data
- Promotion of B-BBEE
- Ex gratia assistance to Members in need

Negative

- Member and healthcare provider dissatisfaction due to claims containment programme

Positive

- Reduced CO2 emission footprint

Corporate citizenship

Our approach to corporate citizenship is embodied in our drive to investment in GEMS employees, promote Broad-Based Black Economic Empowerment (B-BBEE), and supporting vulnerable communities.

Investing in our people

The GEMS Learning and Development Policy and the GEMS Talent Management and Succession Policy guide our investment in GEMS employees.

During the course of 2017, the Scheme invested R5,705,112 in various employee training initiatives.

GEMS employees are empowered through robust learning and development initiatives to fast track and foster skills development in the medical aid industry. Some noteworthy training initiatives conducted during 2017 include learnership and graduate programmes.

The Client Liaison Officers (CLO) Wealth Management Learnership Programme commenced in March 2017 and will run for a period of 18 months across all GEMS regional offices. A total of 82 CLOs will attend the programme. On completion of the programme the Client Liaison Officers will receive an NQF level 5 qualification, together with Financial Advisory and Intermediary Services (FAIS) accreditation to enable employees to provide financial advice to members.

The Graduate Placement programme was rolled out as part of practicing effective acquisition and talent management within the Scheme. This programme commenced on 01 March 2017 with a total of 29 graduates placed across the Scheme. The internship programme offers graduates real-world insights and exposure to the actual working environment. The aim is to equip them with the skills required to succeed in their career of choice.

A Management Development Programme (MDP) for all Managers, Regional Managers and Team Leaders commenced in April 2017. Institutions that were contracted include Wits Business School and the University of Stellenbosch. The programme was funded by INSETA and a total of 21 employees attended the programme. The purpose is to develop strong leadership at management level and establish a pipeline for future leaders.

Broad-Based Black Economic Empowerment

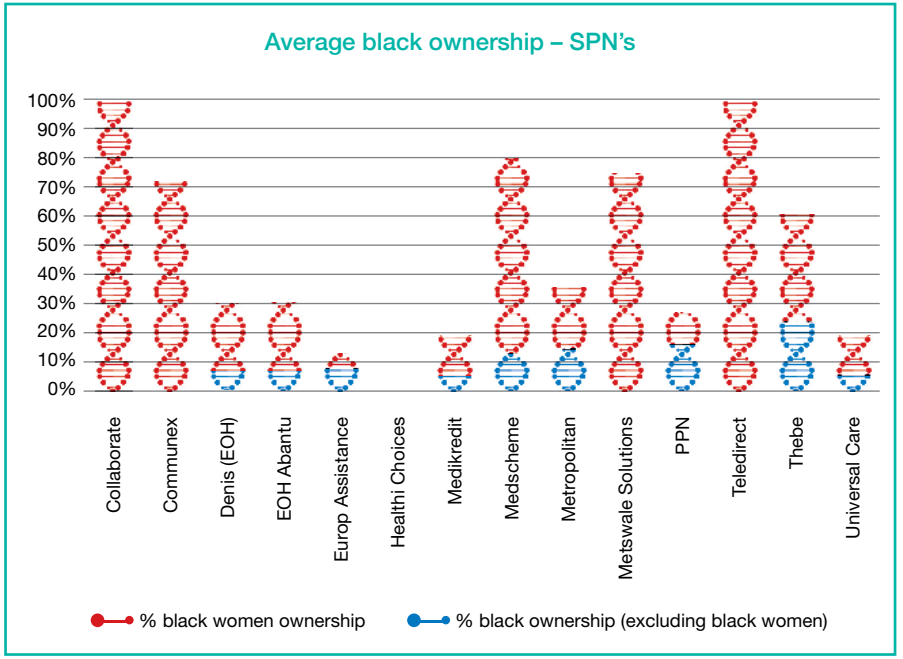
GEMS promotes B-BBEE through preferential procurement. Together with this, GEMS also promotes exempted micro enterprises and qualifying small enterprises.

GEMS allocates 30% of its bid evaluation criteria towards B-BBEE for bids and quotes above a certain threshold. This confirms GEMS' dedication towards promoting B-BBEE through procurement as part of promoting the country's larger socio-economic objectives.

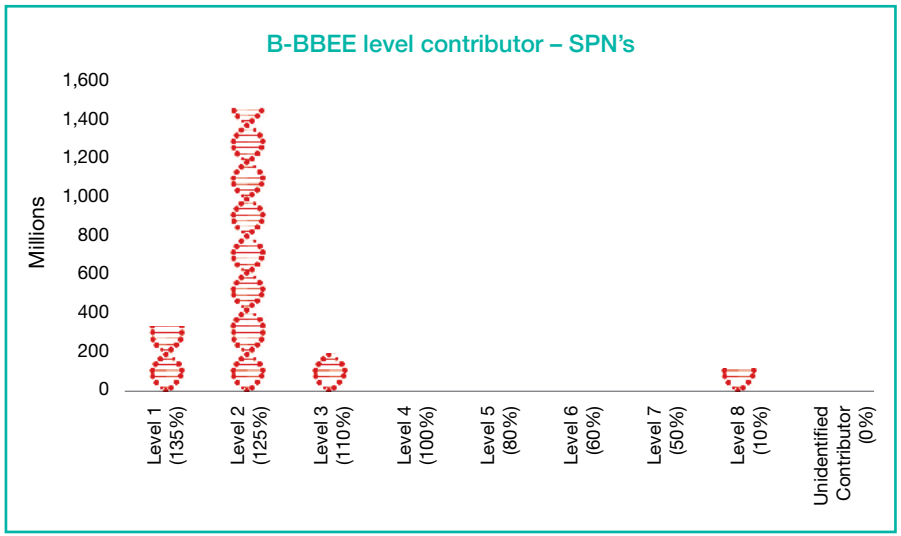
Contracted providers forming part of the GEMS Service Provider Network are contractually bound to spend at least (5%) of the fees paid by GEMS on B-BBEE sub-contractors that are at least a Level 1, 2 or 3 contributor with Level 3 that must have a black ownership status of at least 30% and/or promote individuals who are part of the black designated groups, as defined in the amended Codes of Good Practice and newly employed for purposes of the project.

Black ownership is an important element within the GEMS procurement processes and during 2017 the average black ownership in the Scheme's Service Provider Network (SPN) was 47.17%. This value has reduced from the previous year's value reported, largely as a result of the amended Codes of Good Practice that came into full effect during the year where certain providers found it difficult to maintain their initial procurement recognition levels when assessed against the new Codes. The SPN providers still mostly have status levels of contribution of 1 to 3. The Scheme is working closely with its service providers to ensure that B-BBEE levels are maintained and improved as this is a stipulated contractual condition that they have to achieve and are assessed against.

The graph below provides an overview of the black ownership of SPN in 2017 and also indicates more specifically the black women ownership statistics of the SPN of the Scheme.



The B-BBEE level of these service providers are depicted below.



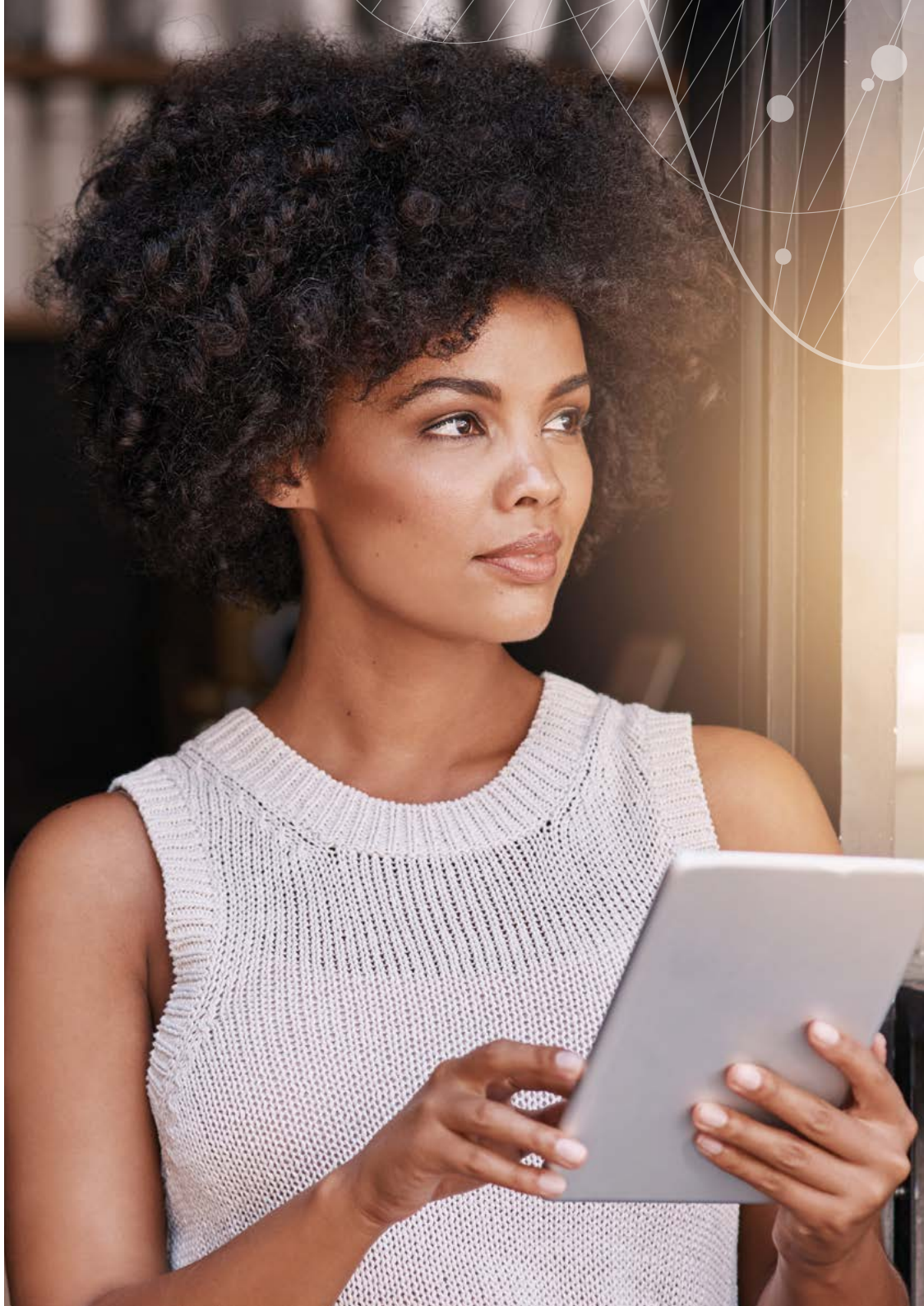
The majority of GEMS' spend on SPN-contracted service providers achieved a level 2 rating which, even in the absence of any benchmark data, is considered as a very good result and an indication that the B-BBEE elements in the Scheme's Supply Chain Management Policy are adding value to the service providers involved in delivering these services to the Scheme.

A detailed record of the GEMS measured spend is maintained on an on-going basis, highlighting the procurement spend on contracts entered into. This enables GEMS to view its tangible contribution towards B-BBEE through preferential procurement.

GEMS also embarked on a new initiative to support identified developing suppliers through mentoring/capacity building in the support functions of their business; an initiative which will be rolled out in the next financial year.

In the 2017 financial year, GEMS issued, evaluated and adjudicated 15 tenders in various threshold categories including strategic sourcing. During the year there was very good participation by Exempt Micro Enterprises and Qualifying Small Enterprises in the GEMS bidding process; being more than double the number of large companies participating. Four times more awards have been made to Qualifying Small Enterprises and Exempt Micro Enterprises than to large companies with a number of awards to joint ventures who responded to bids.

GEMS restricts the number and type of contracts one service provider may hold in certain categories, and on the percentage of the GEMS budget held through the combined value of its contracts. The purpose is to enable more service providers to do business with GEMS in an environment where the core contracts are large.



Supporting vulnerable communities

Though our CSI initiatives we aim to promote education, wellness, healthcare awareness and the physical improvement of facilities in which these activities take place. A special focus is placed on rural and underprivileged communities. The initiatives further aim to ensure that individuals are capacitated with skills, knowledge or resources to self-sustain, to play a vital role in their communities and to realise their full potential despite their circumstances.

Our CSI Selection Process is based on a nomination process involving GEMS members:

1. Nomination received from member
2. Is the CSI proposal aligned to the Scheme's CSI strategic objectives and CSI Policy?
3. Member verification and requirements check
   - If yes
   - If OK
4. Recipient criteria checklist and site visit
5. Divisional sign off and report back to committees

The 2017 CSI was nominated by Dr Bruce Damons

Our large CSI projects coincide with important Scheme events such as the Annual General Meeting of members and the Annual GEMS Symposium:

The Sapphire Road Primary School was selected for the 2017 AGM event. GEMS Trustees and Management spent the morning of 30 July 2017 at the school and enjoyed engaging with learners, teachers and members of the community, who volunteer at the school. The Scheme's donation served to upgrade the School's computer laboratory and to provide learners with new school uniforms.

CSI project: Sapphire Road Primary School, Booysen Park

Other institutions supported during 2017

- The Home from Home Trust in Khayelitsha where renovations and household equipment were funded.
- The Badirammogogo Old Age Foundation where infrastructure upgrades, household appliances and food were funded.
- The Cho Cho Cho Centre and focus identified child-headed households due to HIV/AIDS where household appliances and groceries were funded.
- The Ponelopele Reading Club and Library (Polokwane) where assistance was provided in respect of building costs. This project is still underway.

Principal Relationship Report

GEMS is a restricted membership scheme with membership eligibility determined by employment. Under the GEMS Rules, the "employer" is defined as the Government of the Republic of South Africa represented by the Minister for Public Service and Administration.

The Board of Trustees, supported by Scheme Management, engaged with the Minister during the course of the year by means of quarterly reports, briefing notes, correspondence and meetings. Engagements focused on the Scheme's strategic direction, financial performance, member enrolment trends and pertinent matters such as the Board Composition Matter, the Scheme's 2018 Benefit Design and Pricing and the financial impact of the pre-92 pensioners.

The Scheme received support from the Minister in respect of resolving late contribution payments by key departments such as Correctional Services. A focus area initiated by the Minister is to improve the enrolment of public service employees on salary levels 1-5 on the Scheme.

The Scheme was invited to the DPSA's strategic planning session held on 23 and 24 November 2017. Both the Board Chairperson and the Principal Officer participated in the DPSA's strategic planning session.

The Scheme was a sponsor for the health category of innovation projects within the Department and attended the CPSI Awards and supported the Batho Pele Awards.

Stakeholder Relationships

Stakeholder Relations Management Policy and process

GEMS has multiple internal and external legitimate stakeholders and stakeholder relationship management and engagement is deemed critical to GEMS' success.

The principles and measures guiding our stakeholder management activities and processes are set out in a Stakeholder Management Policy that was reviewed by the Board of Trustees on 5 December 2017. Key activity stakeholder management areas are:

- The identification of, and engagement with stakeholders;
- The disclosure of information to stakeholders;
- The management of stakeholder perceptions and satisfaction;
- The balancing of Scheme and stakeholder interests; and
- The development and implementation of the Scheme's annual Stakeholder Management Approach and Plan.

The Scheme's stakeholders and their legitimate expectations (interest) and influence (power) were identified and analysed with a view to determine the best approach (strategy) in respect of engaging with them.

The stakeholder analysis was conducted in the context of the Scheme's 2017 Strategic Plan, risk mitigation plan and other business requirements. Stakeholders' legitimate interests were considered while the Scheme's concerns (i.e. objectives to be reached by means of stakeholder engagement) were also considered.

Focus areas and outcomes

Stakeholder engagements in 2017 focused on briefing stakeholders on the GEMS Five-year Strategic Plan and keeping stakeholders informed of the progress made by the Scheme in respect of addressing challenges reported in respect of the 2017 financial year. Other pertinent engagement areas in 2017 were:

Focus areas and outcomes

Stakeholder	Key Engagement Areas	Modes of Engagement	Outcome
Department of Public Service and Administration	• Employer Subsidy Adjustments • PERSAL Data • 2018 Benefit and Contribution Design	• Meetings • Letters	• Determination and Directive on Medical Assistance for employees in the Public Service • Quarterly meetings held to appraise the Department on the Scheme progress and pertinent matters • Memorandum of understanding to be finalised in 2018 regarding data requirements
National Treasury	• Pre-1992 Funding Impact • Financial Sustainability of the Scheme	• Meetings • Reports	• Quarterly meetings held to appraise the Department on the Scheme progress and pertinent matters • Actuarial reports submitted to National Treasury on the impact of the pre-1992 pensioners • Progression of work to include the pre-92 pensioner impact in the balance sheet of government
National Department of Health	• Implementation of NHI • Male Circumcision Data • Access to ARV medicines at State Tender prices • Submission to the Health Market Inquiry on the development and application of a fair tariff structure • Rejection of claims from State Health facilities due to non-authorisations • GEMS' possible participation in the Beneficiary Registry Pilot Project • GEMS participation in the Notifiable Medical Condition Surveillance System pilot project	• Meetings • Letters	• Participation of GEMS in the DOH Adult Hospital Level Expert Review Committee • Quarterly meeting with Provincial Departments of Health to assist in claims submissions • Submission to the Health Market Enquiry • Scheme's Male Circumcision data shared with DoH • GEMS agreeing to participate in the Notifiable Medical Condition Surveillance System Pilot Project
PSCBC	• Composition of the GEMS Board • 2018 Benefit and Contribution Design • Rule Changes	• Meetings • Letters	• Finalisation of PSCBC Resolution 4 of 2017 • Successful AGM on 31 July 2017

Focus areas and outcomes (continued)

Stakeholder	Key Engagement Areas	Modes of Engagement	Outcome
Individual Unions	• 2018 Benefit Design • Fraud Waste & Abuse • Affordable Contributions • Financial Sustainability of the Scheme	• Bi-Annual meetings • Letters	• Bi-Annual meetings held with Union leadership to share the Scheme's progress and pertinent matters • Meeting held prior to the Annual General Meeting held on 31 July 2017 supported a successful AGM
Members	• Tender Investigations & GEMS Employee Investigations • Affordable Contribution Increases • Rich Benefit Offering • Non-payment of Claims • Poor Management of Fitness Programme	• Lekgotla • Focus Groups Meetings • GEMS Day events • Member Education Sessions • Social Media • Newsletters • Member Guides • Member Visits	• AGM Member guide provided at the Annual General Meeting held on 31 July 2017 contributed to a successful AGM • Various Lekgotla held in various provinces contributed to member information • 2 GEMS Days provided members with information and health and wellness services • CLO visits to Departments assisted in member servicing • Focus group meetings assisted in understanding member concerns on matters such as the Emerald Value option
Healthcare Providers	• Remunerative Work outside Public Service (RWOPS) • Engagement on mandatory GP referrals	• Meetings • Letters • Workshop	• Improved information to GEMS on approved RWOPS applications • GEMS position on care coordination was submitted to the CMS, HMI and NHI • Implementation of Emerald Value effective 1 January 2017 • Scheme's Provider Relationship Strategy was maintained • Tariff negotiations for the adjustment for the 2018 financial year successfully conducted
GEMS employees	• Internal investigations into corrupt activities by GEMS employees • Implementation of the new GEMS Strategic Plan • Staff development • Organisational redesign	• Staff meetings • Quarterly Staff Training • Staff workshops, including a Diversity Awareness Workshop • Divisional breakaway meetings and team building sessions	• Staff training provided on new GEMS policies • Protected Disclosure Process for employees successfully conducted • Buy-in for new strategic direction

Strategy and resource allocation

Our strategy evolution

From 2008, the Scheme has been operating on the basis of medium-term strategic plans based on three-year periods. The main focus areas of the Scheme's **first** (2008 to 2010) and **second** (2011 to 2013) strategic plans were **membership growth** and the **aggressive containment of non-healthcare costs**. The Scheme's third strategic plan spanning 2014 to 2016 represented an important shift towards the **containment of healthcare costs**.

The three-year strategic plans were revised and updated annually considering performance against targets and changes in the Scheme's external and internal operating environment.

The Board approved a new Five-year Strategic Plan for the period 2017 to 2021 in 2016. The approved strategic plan was developed after an independent review of the Scheme's strategy and business model as part of the Scheme's medium- term strategic planning process.

The new Five-year Strategic Plan is the result of an extensive process of:

- Organisational introspection;
- The identification of strategic issues affecting the performance of GEMS;
- Consensus on a clear vision and a focused set of key strategic objectives; and
- Reviewing the Scheme's operating model.

The strategic themes and trade-offs considered in the development of the GEMS Five-year Strategic Plan (2017 to 2021) is summarised on the right:

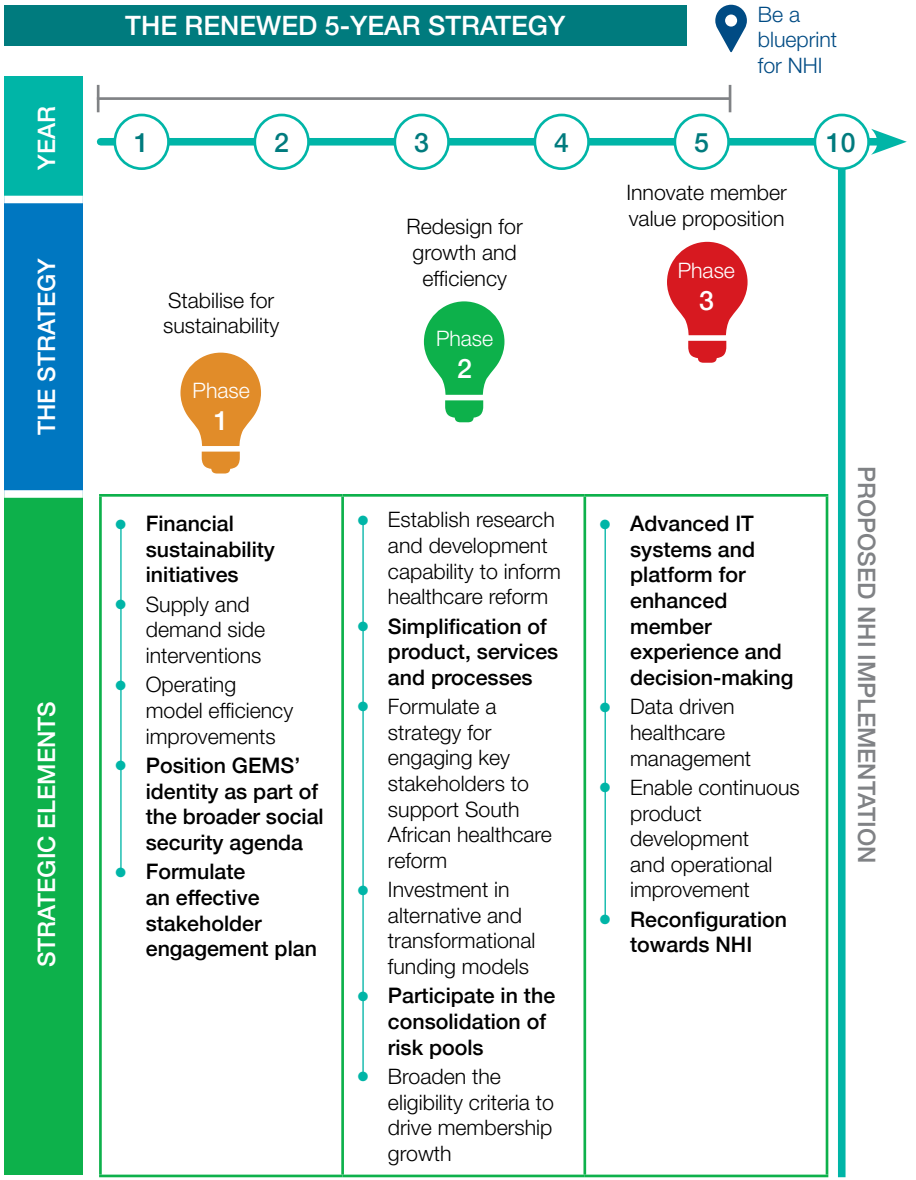
The new GEMS Five-year Strategic Plan objectives

The overarching strategic objective of the new Five-year Strategic Plan is for GEMS to become a blueprint for National Health Insurance. In line with the strategic themes, the following strategic objectives have been approved:

Strategic Objective	Rationale
Be an organisation that is effective in communication, proactive in decision making and accountable to all stakeholders.	• Empower GEMS stakeholders to engage with GEMS to ensure a mutually beneficial and desired outcome. • To enable GEMS as an organisation to make informed decisions based on timely and accurate reporting. • Communication and stakeholder engagement to be structurally embedded in GEMS.
Advance financial strength and drive the Scheme to a position of long-term sustainability.	• Financial sustainability is required to ensure continued value creation to members. • Financial strength and sustainability provides GEMS with a solid base from which to grow and impact transformation industry wide.
Shape the transformation of the healthcare industry towards universal healthcare, coordinated across the healthcare ecosystem.	• The cost of healthcare can only be managed if the entire ecosystem is considered. • The focused use of state infrastructure (including employees) would assist in the improvement of this infrastructure. • Participating in community health centres would improve community-based healthcare and create employment while reducing hospital costs.
Be a strategic purchaser of healthcare services by leveraging GEMS' unique positioning and relationships.	• Innovative alternative reimbursement models should be implemented in the purchasing of healthcare services. • Strategic relationships with healthcare providers should be established to more effectively leverage GEMS' size.
Be an agile data-driven scheme that leverages people, systems and processes to derive value for the member.	• Data is at the centre of GEMS' operations and a source of competitive advantage. • Business intelligence enables more effective decision making, communication and value creation. • Develop capabilities and competencies for people to drive Scheme performance.
Sustainably grow membership ensuring inclusion and progressive cross subsidisation.	• Growth is required to ensure that stipulated reserve targets are met. • Risk pooling within all benefit options should ensure the sustainability of each option. • To achieve effective cross subsidisation.

The strategic journey

To achieve the strategic objectives, a 'three-phased' strategic journey will be followed. This will enable GEMS to strengthen its core and position for sustainable growth.



Building a Supporting Organisational Structure

The Organisational Structure of the GEMS Head Office and Client Liaison Regional Offices was expanded to support the successful implementation of the Five-year Strategic Plan that commenced in 2017. GEMS attracted 40 permanent employees during the period under review and the Scheme's permanent employee complement increased by 17% to 263.

The table below depicts the total number of Scheme employees since 2011:

Total Employees	2011	2012	2013	2014	2015	2016	2017
GEMS	87	95	76	130	170	241	310
Employees per Office	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Head Office	47	45	43	60	93	123	150
Client Liaison Office	40	50	33	70	77	118	160
Total	87	95	76	130	170	241	310
Employees per Contract Type	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Contract	41	51	2	0	8	11	19
Permanent	46	44	74	130	162	223	263
Internship	n/a	n/a	n/a	n/a	n/a	7	28
Total	87	95	76	130	170	241	310
Employees per Gender	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Male	23	24	20	35	48	76	95
Female	64	71	56	95	122	165	215
Total	87	95	76	130	170	241	310
Turnover		**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Total		16%	9%	0.77%	0.4%	3.9%	5.4%

Risk and **Opportunity**

Governance of risk

The Board retains overall accountability for the governance of risk and is committed to effective risk management in pursuit of our strategic objectives. The GEMS Risk Social and Ethics Committee is responsible to review and assess the integrity of the risk management processes, working closely with the Audit Committee to ensure that these processes comply with the relevant governance requirements and standards and are implemented. The GEMS Executives are responsible and accountable for managing risks in their Divisions, including the significant outsourced business processes components.

The GEMS Enterprise Risk Management Function is the owner of the risk management framework, and is responsible for entrenching a risk management culture as well as facilitating risk management and integration across the business.

Risk management commitment

At GEMS, we understand our responsibility to balance risk and reward while pursuing our goals. The Scheme is firmly committed to robust risk management as a fundamental pillar to our business sustainability. Operating in the medical scheme sector in South Africa, GEMS is exposed to financial, political, legal, regulatory, technology, health and other risks that could potentially affect achievement of goals.

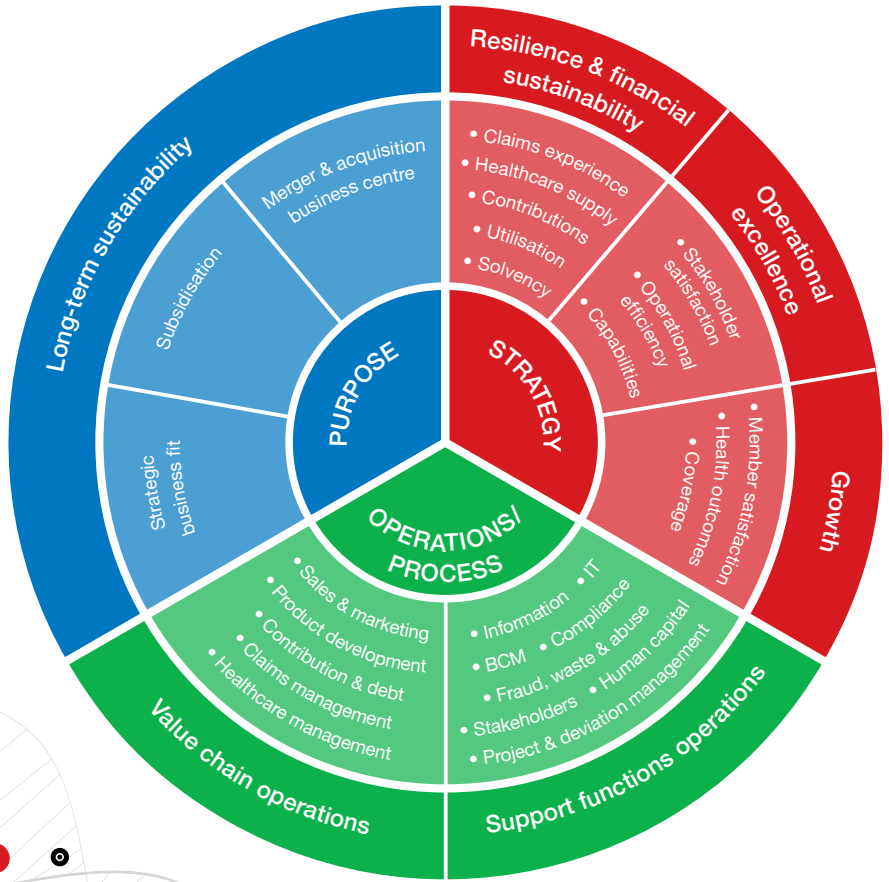
GEMS views risk management as a continuous, proactive and systematic process, built on robust principles and practices in a risk intelligent entity, informing our decisions and actions to deal with and benefit from uncertainties that we may encounter while we pursue our goals.

Risk Management Strategy

GEMS' risk management strategy is to manage risks that may impact our business sustainability in context of our internal and external environments. Our risk management process, also covering the Scheme's outsourced service providers, enables us to manage our risk profile within our risk appetite. Through combined assurance, GEMS Management and Board of Trustees transparently report on the Scheme's performance to stakeholders.

Risk universe

GEMS' risk universe illustrates the specific risk environment in which we operate, that constitutes the sources of risks that we may be exposed to. This represents the minimum scope of application of our risk management processes and is segmented into 3 levels relating to our 'purpose', 'strategy' and 'operational' realities. We continuously review and update the risk universe as an accurate representation of our strategic and operating environments. We anchor each identified risk in the relevant operational, strategic and purpose activity to enable decision-makers to contextualise and understand the interrelationships between our activities and the risks we face.



Risk appetite

Risk Appetite, Tolerance and Risk Bearing Capacity demarcate various levels of risk that allows GEMS to escalate and deal with risk aligned to the delegation of authority. We recognise the importance of aligning our risk universe and risk appetite metrics with our impact on the six capitals (Financial, Manufactured, Intellectual, Human, Social and Relationship & Natural Capitals). It allows us to deal with risk appropriately depending on the level of severity. These are reviewed annually and submitted to the Board for approval.

Risk management capabilities

GEMS' key risk management capabilities, are:

- Responsibly assume risk in pursuit of objectives
- Pursue opportunities responsibly
- Take accountability for risk response decisions
- Execute risks response strategies timeously at strategic, operational and process levels
- Integrate risk interdependencies across GEMS and outsourced service providers
- Provide reasonable assurance on risk management outcomes
- Improve risk management capabilities continuously

Our risk management capabilities are underpinned by internationally-recognised processes (ISO31000) and Codes of Practice (King Code for Corporate Governance).

Risk management plan

GEMS followed a Board-approved annual work plan for the 2017 Financial Year:

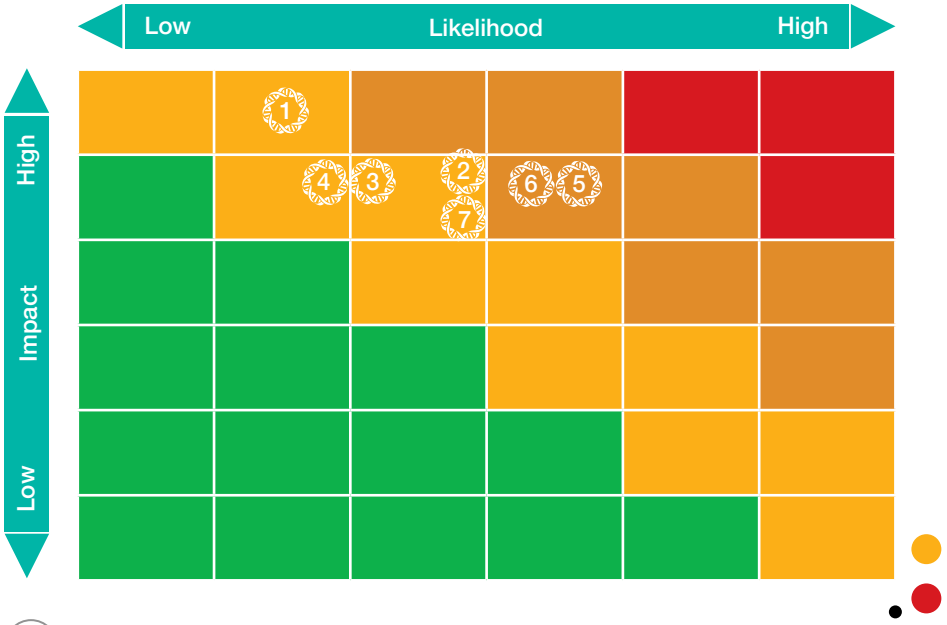
- An Annual Risk Management Maturity Assessment was completed to inform strengthening of various risk management capabilities.
- Our Risk Management IT system was implemented.
- The Risk Management Framework, Standard Operating Procedure and Policy were significantly enhanced to ensure full alignment with the GEMS strategy and operating environment.
- The Board of Trustees conducted a formal annual risk assessment to identify the top risks faced by GEMS. The Board monitored these risks on a quarterly

basis, continuously evaluating significant changes in the risk landscape as well as effectiveness of risk mitigations.

- Divisional risk management was conducted in a similar fashion, with an annual risk assessment and quarterly risk monitoring. In particular, risk management was conducted in the significant outsourced service provider network.
- Focused Deep Dive risk assessments were conducted to inform the top risks as well as to facilitate risk management on a process level. These included Budget, Benefit Design, Stakeholder Management, National Health Insurance Compliance and Cybercrime risks.
- Organisational improvement activities, including appointment of new service providers and the GEMS strategy implementation programme were treated through the GEMS formal project management methodology that includes project risk management.

Top risks facing the Scheme

The GEMS top risks, monitored by the Board, indicate that all top risks are adequately managed with no risks exceeding the risk bearing capacity (red), while two risks exceed the scheme risk tolerance levels (orange). These are dealt with as priority items where risk controls are actively monitored for effectiveness, and continuously assessed for possible improved and additional risk controls.



1. Major misprojection of key inputs into GEMS' budget

GEMS, the second largest medical scheme in the country, manages a total budget of more than R34 billion. GEMS fundamentally balances income (contributions) to a risk-based uncertain outcome (claims). The mandate of GEMS, to provide affordable healthcare to a broad base of the population, puts high demand on accurate budgeting. The risk has been demonstrated in the past where budget errors occurred (albeit at a very low frequency). At the same time the Scheme's financial position had gradually deteriorated, evident in a low reserve ratio, low operating surplus and high claims ratio.

A robust budget requires complex actuarial modeling of a myriad of factors (clinical profile, age, demographic, employment, healthcare cost). A modeling error or inaccuracies in input data and assumptions, may lead to material misprojections. The added complexity is that key model input data resides at service providers. The current reserve ratio is below regulatory requirement, and a sudden imposing of this requirement may materially impact on budget projections.

- Robust actuarial models
- Actuarial reports and monthly management accounts
- Actuarial peer reviews
- Benefit design committee review

2. Unsustainable operating cost increase

Healthcare cost represents 95% of the Scheme's operating costs. Fraud, having a major impact on healthcare cost, is estimated to be as high as 15% nationwide. Excessive, unnecessary, fraudulent member claims, materially affects operating cost, and the Scheme has already experienced this with elevated levels in KZN. Syndicate crime, collusion and negative impact of the economy has increased prevalence. Supply side pricing (regularly above CPI), and demand created by excessive growth in medical facilities put upward pressures on claims. Utilisation is severely impacted by changes in clinical profiles (in extreme cases epidemics). Global mobility has demonstrated the speed and severity of these impacts. Lifestyle and behavior also have a significant impact.

Non-healthcare cost represents 5% of scheme operating costs, where upward pressures come from implementation of the new strategy and a suboptimal insource/outsource operating model.

- Approved business plan with Council of Medical Schemes, with monthly engagements on performance against the business plan
- Participation in infectious diseases working group
- Analysis of Health Quality Assessment panels and comparison to industry norms
- Forensic investigation services

3. A significant detrimental media exposure

Unexpected and unfavorable depiction of GEMS in the media, is exacerbated by accessing traditional and social media channels with great speed to drum up support and voice requirements. This was recently demonstrated in the #feesmustfall campaign. GEMS has experienced exposure relating to its fees, solvency and service delivery. Where members are misalignment on brand identity, it may also result in unfavorable public expression.

Significant social reaction to GEMS' perceived obligation to deliver services to a broader membership base, in conflict with current mandate and capacity is another possible event. This may materialise as conflicting pronouncements by key high-level stakeholders in context of GEMS' mandate and capacity, or malicious misinformation to discredit GEMS by parties opposed to GEMS future role. On a broader front, pronouncements relating to healthcare and the future role of medical schemes in general impacts directly on GEMS.

Unintentional or intentional publication of GEMS information by internal stakeholders, may be caused by disgruntled employees and stakeholders. Since a significant portion of GEMS data resides with service providers, leakage is a higher risk and is more difficult to detect and remediate.

- Stakeholder management policy
- Stakeholder engagement strategy
- Quarterly government stakeholder engagements
- Advocacy (member protection role)
- Sponsorship and donations policy
- Departmental stakeholder management plans

4. Significant breakdown in alignment, integration and mobilisation of all stakeholders into NHI process

The healthcare industry is materially influenced by the implementation of a National Health Insurance framework that may be significantly different from the current dispensation. The key strategic imperative for GEMS is to shape a future that is in line with its social responsibility towards accessible affordable healthcare, in a way that secures its own future position. To be recognised as a thought leader, and a reckoned provider is essential.

Industry players may oppose and not contribute constructively to implementation of universal healthcare through the NHI agenda and GEMS role therein, rather protecting their current market position and profitability. A complex stakeholder interaction environment affects the eventual outcomes. Material divergence or major breakdown in goals of, and relationships between, key role players in the health care transformation debate, may occur. The implementation of a future health dispensation may fail to allocate, activate and coordinate the large resource base required for the universal healthcare environment.

- Stakeholder management policy
- Stakeholder engagement strategy
- Departmental stakeholder management plans

5. A significant lag in reliable, secure big data analytical capability

GEMS is positioning to deliver more value to members through a sophisticated big-data capability. This will enable GEMS to craft products that are better aligned to requirements, and also deliver its services in a modern ICT-enabled way. This capability is hinged on the right ICT technology, business processes and people capacity.

Implementation of the ICT backbone is a complex project and may have delayed schedules and escalated costs. Data that can reside with various service providers may not be of sufficient quality, and GEMS may not have ownership and Intellectual Property Rights over it. The business intelligence and knowledge management capability may not be sufficiently robust. Failure of all these components to work in unison may result in not leveraging benefits from a robust data repository and intelligent big data analysis.

Operationally, this business-critical ICT infrastructure risks a major IT business interruption and cyber security incidents.

- Disaster recovery plan
- Business continuity plan
- Cyber security architecture
- Data governance framework
- Business integration architecture to service providers
- Advanced analytics and business intelligence architecture and capability
- Client-facing cloud-mobile technology-enabled capability
- Research and intelligence capability

6. Not breaking through current realities impeding optimal strategic purchasing

GEMS is positioned as provider of quality, affordable healthcare to a large constituent, and in particular to government employees. Leveraging the organisations size and positioning is essential. GEMS may not interpret its role in a social context accurately, to leverage obvious opportunities. In particular this refers to government preferential procurement and pricing.

GEMS plays a significant role in the healthcare market, with an annual spend of more than R34 billion, through a large healthcare provider network. The possibility exists that GEMS may enter into agreements that negatively impact GEMS' ability to ensure financial sustainability.

The current GEMS operating model is significantly outsourced to around 19 providers with the related complexity and inefficiency. A sub-optimal outsource versus insource model may significantly influence performance and non-healthcare costs.

- Benchmarking and peer review
- Incentives and re-imbursement of healthcare providers
- Strategic sourcing programmes aligned to overall NHI imperative and purchasing power of GEMS
- Access to state and preferential pricing (ARV, HPV, oncology, biology)

7. Prolonged negative trend in member resignation or new member uptake

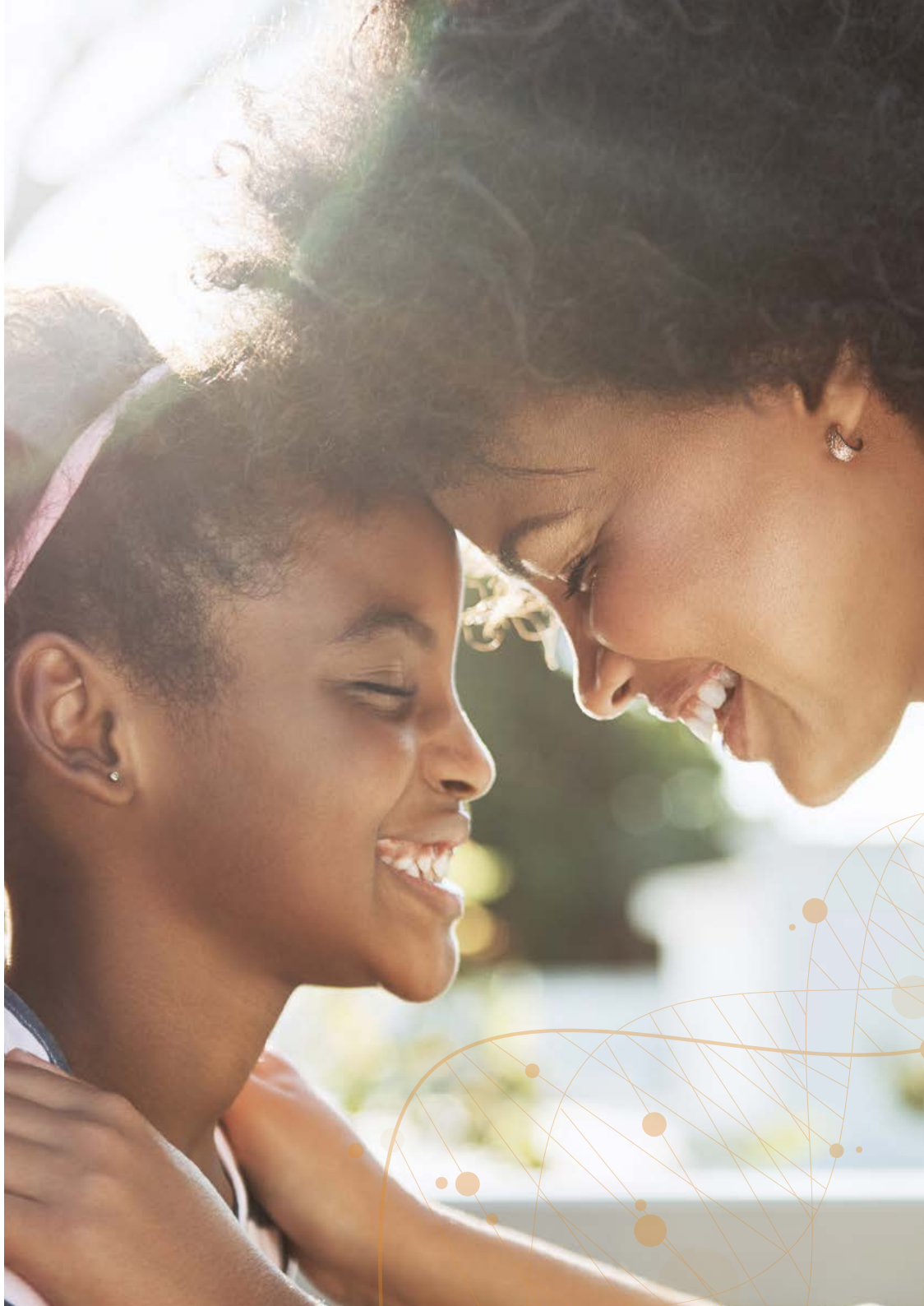
At present GEMS is growing according to targets, positioned for strong strategic growth. This is informed by a strong value proposition of the Scheme in terms of product suite, affordability and benefits.

GEMS products enjoy significant government subsidies. Recent stakeholder expressions have called for equalisation of subsidies. Misalignment of subsidy decisions with medical inflation trends, or revocation of subsidies will significantly impact on cost advantage. Together with prolonged negative macro-economic trends relating to healthcare, products may simply become unaffordable to members.

The medical insurance market is highly competitive regarding value for money and product differentiation. Non-alignment of product offerings with market demand or expectations, including quality of service delivery and differentiated products for various age and income groups may hamper growth aspirations. This is demonstrated where members choose competitor products even forfeiting government subsidies, and a rise in member complaints.

GEMS leverages risk pooling to arrive at an appropriate risk profile. A significant resistance of the target market to cross-subsidisation may materially impact on the model. At the same time inadequate management of expansion opportunities through mergers and expansion, may result in an unfavorable overall risk profile.

- Member communication, education, servicing and retention strategies
- Product Development and Benefit design, especially to drive cost-effective and flexible products
- Scheme rules
- Member-centric engagement processes
- Pre-post benefits design stakeholder engagement



Report on **Performance and Outcomes**

Financial Performance

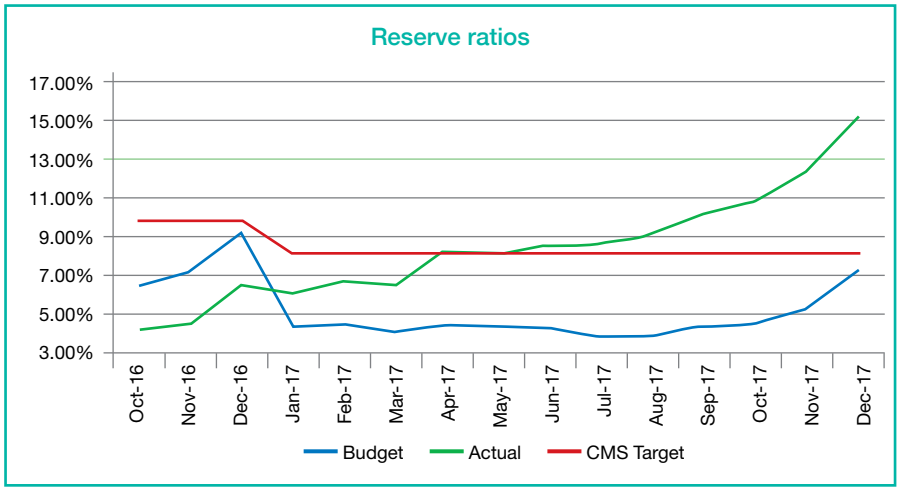
The Scheme recorded a surplus of R3.3 billion for 2017 (2016 deficit R 484 million). This can mainly be attributed to the following factors which are reflected in the Statement of Comprehensive Income:

- Risk contributions (R473 million lower than budgeted);
- Net claims incurred (R2.5 billion lower than budgeted);
- Non-healthcare cost (R52 million lower than budgeted); and
- Investment and other income (R184 million higher than budget).

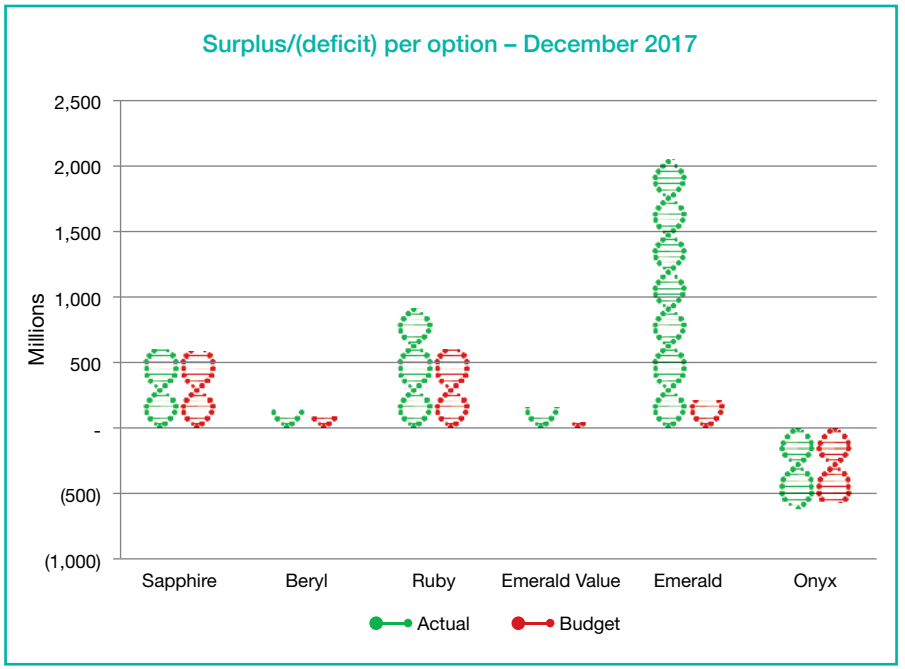
In the business world, solvency is defined as the degree to which current assets exceed current liabilities and relates to the ability of an entity to settle its liabilities in the short term (12 months).

The reserve ratio within the medical scheme environment relates to contributions and accumulated funds that it has in place and is calculated as a scheme's accumulated funds as a percentage of its Annual Gross contributions. As such the reserve ratio fluctuates during the course of any financial year due to the formula applied. The Scheme commenced the year with reserves of R2.2 billion and through the significant positive claims experience had managed to build reserves and conclude the year with reserves of R5.4 billion.

The graph on the next page plots GEMS' solvency ratios for 2017. The Scheme's reserve ratio at 31 December 2017 was 15.22% (2016: 6.99%) which compared favourably to the reserve level approved by the Registrar of Medical Schemes for 2016 of 8.2%.



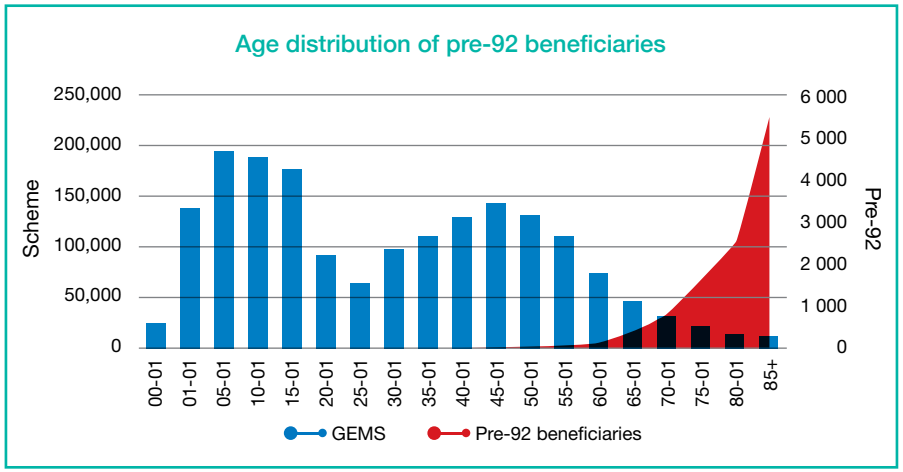
The claims ratio for GEMS overall was 86.0% (2016: 96.6%) for 2017, significantly lower than expected (92.04%). The graph below summarises the net results of the various options against the budget for 2017, indicating a positive variance against the budget for most of the Scheme's options.



Financial Impact of pre-1992 pensioners

In April 2012, the pre-1992 pensioners were migrated to GEMS. The table below compares the membership profile of the pre-1992 pensioners as at 31 December 2017 to the rest of the Onyx members (the option on which these members reside) and the Scheme as a whole.

	Pre-92 members	Onyx option	Scheme
Number of principal members	9,792	34,470	692,092
Average age	84.3	68.5	47.8
% male	20.0%	35.4%	30.8%
% chronic users	85.6%	76.9%	40.4%
% over age 60	99.3%	69.0%	15.3%
Number of beneficiaries	11,206	58,346	1 807,538
Beneficiary ratio	1.14	1.69	2.61
Average age	83.3	57.9	31.9
% adult beneficiaries	12.4%	27.0%	19.4%
% chronic users	85.6%	64.2%	23.6%
% over age 60	98.2%	55.1%	10.7%



The table below illustrates the financial impact of the pre-92 pensioners for 2017.

	Actual	Expected
Members (Dec 2017)	10,316	10,316
Net contribution income	509,422,581	509,422,581
Claims incurred	696,860,533	726,192,357
Managed care	10,678,039	10,678,039
Gross underwriting result	-198,115,991	-227,447,815
Management expenses	27,625,031	27,625,031
Managed care	3,381,915	3,381,915
Surplus/(deficit) from operations	-229,122,937	-258,454,761

At year-end, the actual financial impact experienced from the pre-92 pensioners was very close to the expected financial impact which was based on the actuarial analysis that was done prior to these members joining GEMS. Overall, the pre-92 pensioners contributed a deficit of R229.1 million towards the financial results of the Scheme.

Per-member cost analysis

The table below provides an analysis of the manner in which Scheme funds were allocated to healthcare and non-healthcare services. Additionally, the comparison of these parameters provides insight into the extent to which the Scheme has grown and is realising economies of scale to the benefit of its members.

	Sapphire Option		Beryl Option		Ruby Option		Emerald option		EVO		Onyx Option		Total Scheme	
	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016
Net contributions per member per month (average)	R1,997	R1,751	R2,603	R2,273	R3,297	R2,692	R4,550	R3,990	R4,379	N/A	R5,238	R4,648	R4,191	R3,692
Net contributions per beneficiary per month	R622	R543	R985	R860	R1,230	R1,002	R1,747	R1,506	R1,564	N/A	R3,064	R2,606	R1,602	R1,400
Healthcare management expense per member per month	R86	R85	R86	R85	R86	R85	R86	R85	R86	N/A	R86	R85	R86	R85
Healthcare management expense per beneficiary per month	R27	R26	R32	R32	R32	R32	R33	R32	R31	N/A	R50	R48	R33	R32
Non-healthcare expenses as a percentage of gross contributions	11.9%	12.1%	9.2%	7.9%	5.8%	5.8%	5.2%	5.4%	5.5%	N/A	4.7%	4.6%	5.6%	5.6%
Administration cost per member per month	R237	R212	R238	R180	R241	R209	R238	R216	R242	N/A	R248	R215	R239	R214
Administration cost per beneficiary per month	R74	R66	R90	R68	R90	R78	R92	R82	R86	N/A	R145	R121	R91	R81
Amounts paid to administrator/s (R'000)	R59,904	R52,375	R40,536	R34,042	R111,999	R91,683	R649,165	R643,194	R52,326	N/A	R49,868	R51,620	R963,798	R872,914
Number of registered new members	5,044	6,832	4,951	6,588	8,625	14,607	19,739	36,232	2,597	N/A	720	1,078	41,676	65,337

Per-member cost analysis

	Sapphire Option		Beryl Option		Ruby Option		Emerald option		EVO		Onyx Option		Total Scheme	
	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016
Number of resigning members	518	2,295	958	2,388	3,732	5,021	14,263	28,552	1,251	N/A	1,040	2,746	21,762	41,002
Chronic prevalence of beneficiaries	5.5%	7.4%	12.1%	16.3%	14.0%	16.3%	25.0%	26.8%	28.5%	N/A	62.7%	61.7%	23.6%	26.1%
Average number of members during the year	42,815	40,951	28,944	26,632	80,129	71,719	465,338	503,541	37,050	N/A	35,796	40,442	653,022	683,286
Number of members as at 31 December 2016	44,508	43,197	30,629	28,509	81,682	76,118	459,486	506,907	41,317	N/A	34,470	39,531	692,092	694,262
Number of beneficiaries as at 31 December 2016	142,620	138,768	80,679	75,041	217,976	204,339	1,192,230	1,345,015	115,687	N/A	58,346	69,974	1,807,538	1,833,137
Dependant ratio to members as at 31 December 2016	2.2	2.2	1.6	1.6	1.7	1.7	1.6	1.7	1.8	N/A	0.7	0.8	1.6	1.6
Average accumulated funds per member	R7,808	R3,134	R7,808	R3,134	R7,808	R3,134	R7,808	R3,134	R7,808	N/A	R7,808	R3,134	R7,808	R3,134
Return on investments as a percentage	7.2%	6.1%	7.2%	6.1%	7.2%	6.1%	7.2%	6.1%	7.2%	N/A	7.2%	6.1%	7.2%	6.1%
Relevant healthcare expenditure (claims) pm	R630	R564	R1,980	R1,911	R2,156	R2,221	R3,988	R3,887	R3,847	N/A	R6,466	R6,091	R3,604	R3,566
Relevant healthcare expenditure (claims) ratio	31.5%	32.2%	76.1%	84.1%	65.4%	82.5%	87.7%	97.4%	87.8%	N/A	123.5%	131.0%	86.0%	96.6%
Non-healthcare expenditure pm	R237	R212	R238	R180	R241	R209	R238	R216	R242	N/A	R248	R215	R239	R244
Net healthcare result (R'000)	R580,572	R479,589	R133,441	R58,007	R865,144	R225,139	R1,804,273	(R681,339)	R129,253	N/A	(R634,424)	(R804,556)	R2,878,260	(R723,160)

Investment performance

During 2014, GEMS established an Investment Committee (reconstituted as the Finance and Investment Committee from 1 January 2018) which is responsible for monitoring the performance of the Scheme's investments. The Committee is supported by the Scheme's Investment Consultant to ensure that maximum returns are achieved with limited risk exposure of Scheme funds. Expert advice is provided to the Committee in developing an appropriate investment strategy and investment portfolio for the Scheme. This investment strategy is developed to ensure that the Scheme maintains a sound financial position, has enough liquidity to meet the liabilities of the Scheme as they become due and ensures compliance to all aspects of regulations 29 and 30 of the Medical Schemes Act 131 of 1998 as well as Annexure B. Compliance to the regulatory requirements are reported to the Investment Committee on a quarterly basis.

The investment strategy was expanded during 2017 and is now executed using the services of four Asset Management companies who were appointed during 2015 and 2017 and who are responsible for the following portfolios:

- Money Market Portfolio
- Segregated Absolute Return Portfolio
- Excess Cash Portfolio
- Personal Medical Savings Account Portfolio

The main objective of a Scheme is to provide medical benefits to its members and for this reason a moderate risk appetite is adopted in the investing activities of the funds of the Scheme.

The Scheme has set a target to achieve an investment return in excess of inflation and this is achieved through a mixture of fixed deposits, investment in the money market and absolute return portfolios. The performance of the Asset Managers is monitored through monthly and quarterly reports to the Scheme to ensure they achieve the targets set for each of these portfolios. They are also required to present feedback to the Investment Committee at least once a year.

The Scheme performs a review of its investment mandate and strategy annually and this process is supported by inputs received from the Investment Consultant to ensure that the Investment Strategy delivers optimal returns on the funds of the Scheme. As a result of the review and the success of the current Asset Managers a decision was made to appoint two additional Asset Managers in order to further enhance the Investment strategy of the Scheme.

Although GEMS is not an institutional investor, the Scheme subscribes to the principles and recommended practices of the Code of Responsible Investing in South Africa (CRISA). The Investment Committee reviewed the Scheme's alignment to CRISA on a quarterly basis in 2017.

Summary of investments held at year end

	2017 R'000	2016 R'000
Current accounts	480,628	69,764
Call accounts	3,097,980	2,547,710
Fixed deposits	1,910,000	560,000
Asset manager investments	1,687,346	861,524
Medical Savings Account – Trust monies	789,277	577,622
Total	**7,965,232**	**4,616,620**

The average effective interest rates for the year ended 31 December were as follows:

	2017	2016
Current accounts	5.25%	5.46%
Call accounts	6.61%	6.69%
Fixed deposits	7.70%	7.51%
Asset manager investments	8.88%	8.39%
Medical Savings Account – Trust monies	7.65%	6.76%

The personal medical savings account, which is managed by the Scheme on behalf of its members, represents savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered rules and bank charges.

Unspent savings at year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded from the Scheme's funds, and the risk of impairment is carried by the Scheme.

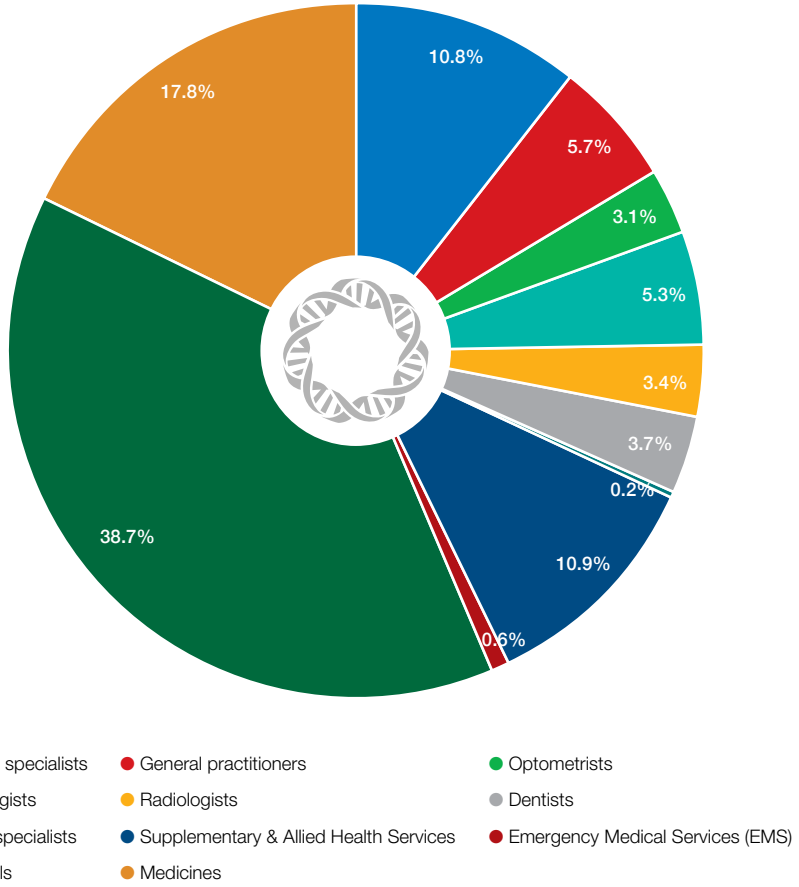
The personal medical savings accounts are invested on behalf of members in deposits held on call with Investec Bank. These monies are initially recognised at fair value and subsequently measured at amortised cost using the effective interest rate method.

As at 31 December 2017, the PMSA balance managed by the Scheme on the members' behalf stood at R789 million.

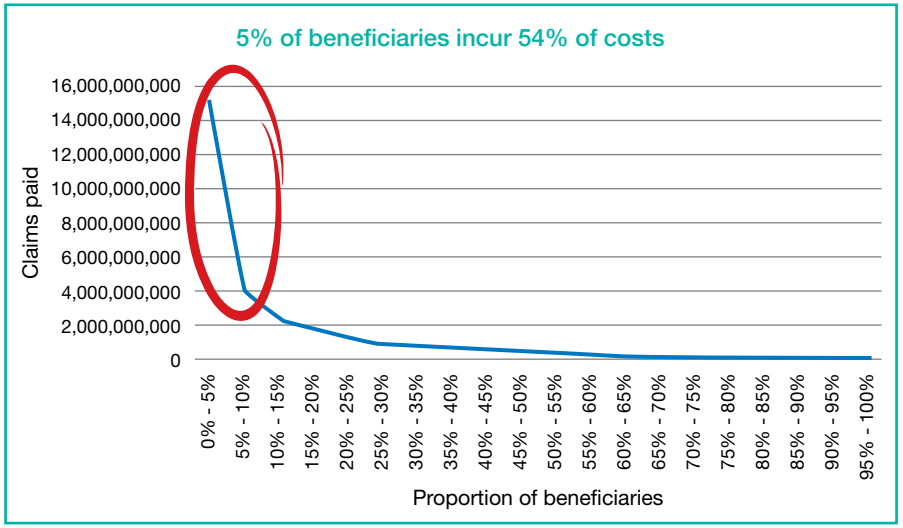
Claims Experience

In 2017 the Scheme settled claims to the value of R29.1 billion (91.0 million claim lines). This represents a 1.7% increase from 2016 during which GEMS settled claims to the value of R28.6 billion (92.2 million claim lines). The largest claim attributable to a single beneficiary for service dates in 2017 amounted to R7.8 million (2016: R6.5 million) while the second largest claim cost was R5.8 million (2016: R4.6 million). The total cost of the 10 most expensive claimants in 2017 amounted to over R49.2 million (2016: R44.9 million).

Below is a breakdown of claims per discipline paid by the Scheme in December 2017:



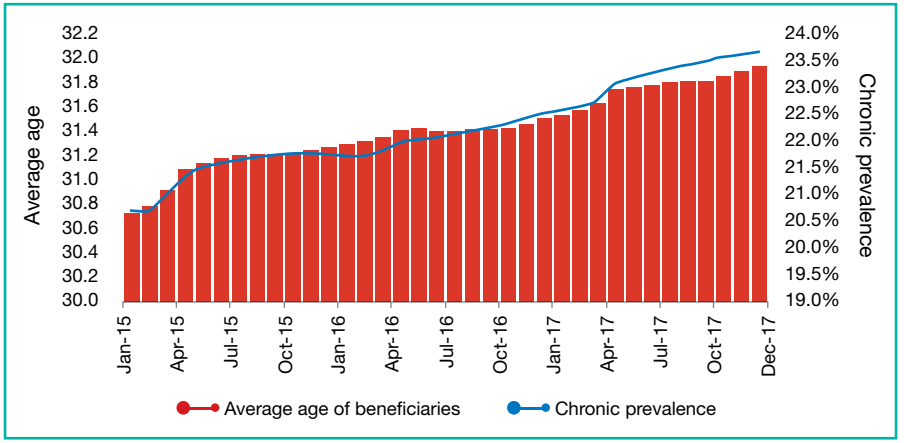
In line with industry trends a small proportion of members are responsible for a majority of the claims in any given year. In GEMS, 5% of beneficiaries incur 54% of costs in any given year, as demonstrated below:



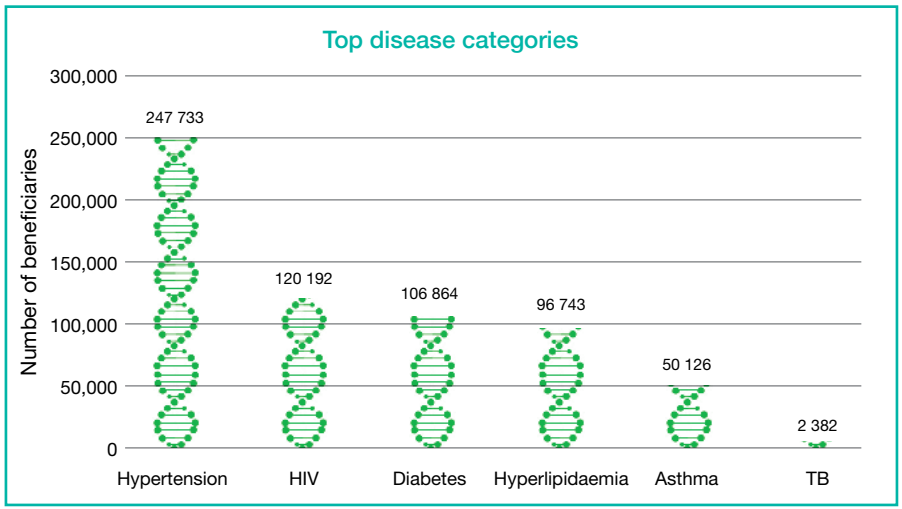
Chronic Prevalence

Historically, some members would have claimed for chronic medication without registering, effectively depleting their acute medication benefit. This resulted in higher out-of-pocket expenditure for these members.

The graph below illustrates the increasing trend in the Scheme's chronic prevalence:



During this benefit year, chronic medicine utilisation was 1.1% higher than in 2016. The top diseases in 2017 by incidence and by cost are shown below:



Pensioners

The table below shows the total claims for pensioners in 2017 compared to the total claims for the Scheme in 2017:

	Pensioners	Scheme total	Percentage of total
In-hospital	5,610,326,516	18,287,086,904	30.7%
Out-of-hospital	880,208,872	5,610,179,378	15.7%
Medication	1,215,668,084	4,954,987,896	24.5%
EMS	44,632,262	227,154,068	19.6%
Total	7,750,835,733	29,079,408,246	26.7%

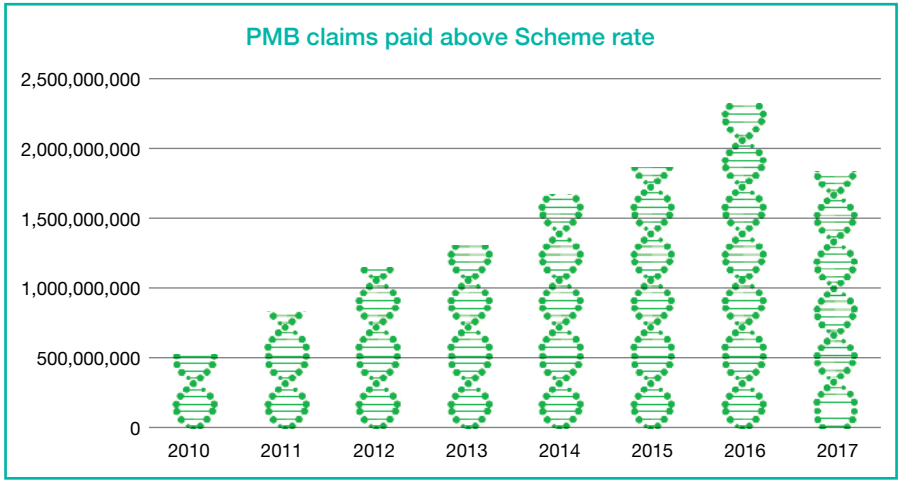
Pensioners account for 26.7% of the Scheme claims. Considering that pensioners only comprise 15.3% of the membership on the Scheme, it can be seen that the claims experience for pensioners is worse than for non-pensioner members. The continued growth of the pensioner ratio will result in a deterioration of the Scheme's risk profile, worsening the claims experience of the Scheme.

Prescribed Minimum Benefit (PMB) claims

Section 29(1)(o) of the Medical Schemes Act requires every medical scheme to make provision in its rules for the scope and level of minimum benefits that must be available to beneficiaries. Regulation 8(1) of the Medical Schemes Act provides that every benefit option that a medical scheme offers must reimburse the diagnosis, treatment and care costs of the PMBs in full without any co-payment or deductibles, subject to the provisions of Regulation 8. The diagnosis, medical management and medication of the chronic conditions must be funded in accordance with therapeutic algorithms published in the Government Gazette.

The level of reimbursement could be linked to the provision of care through designated service providers. Annexure G of the Scheme rules makes provision for the scope and level of minimum benefits that are available to beneficiaries. The Scheme has further implemented a PMB Manual in order to facilitate the adjudication of PMB entitlements for Scheme beneficiaries in a manner that makes GEMS fully compliant with the PMB Legislation. GEMS promotes the principle of equity and fairness in funding PMB benefits.

During 2017 the Scheme's net claims incurred amounted to R29.1 billion (2016: R28.6 billion). PMB claims paid during 2017 amounted to R20.6 billion (2016: R20.4 billion), equating to 71% of the total claims incurred by the Scheme. Of the R20.6 billion PMB claims settled, R1.8 billion was settled above scheme rates. This is an improvement when compared to the 2016 experience, as illustrated below.

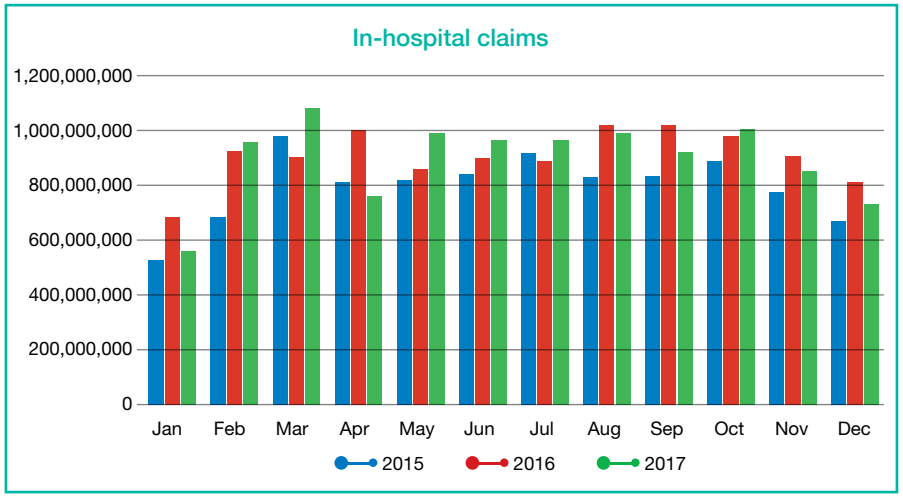


The contribution of ex gratia assistance to our members' health and well-being

The Board of Trustees has established an Ex Gratia Committee (now called the Clinical Governance and Administration Committee) to consider member requests for ex gratia assistance. These are requests for financial assistance in respect of healthcare services for beneficiaries which do not form part of their benefit entitlements. The Scheme's ex gratia function contributes to the health and well-being of members and their families by further enhancing access to healthcare services in a responsible manner. The total value of ex gratia payments approved for the period ended 31 December 2017 was R27.4 million and a total of 829 beneficiaries were assisted.

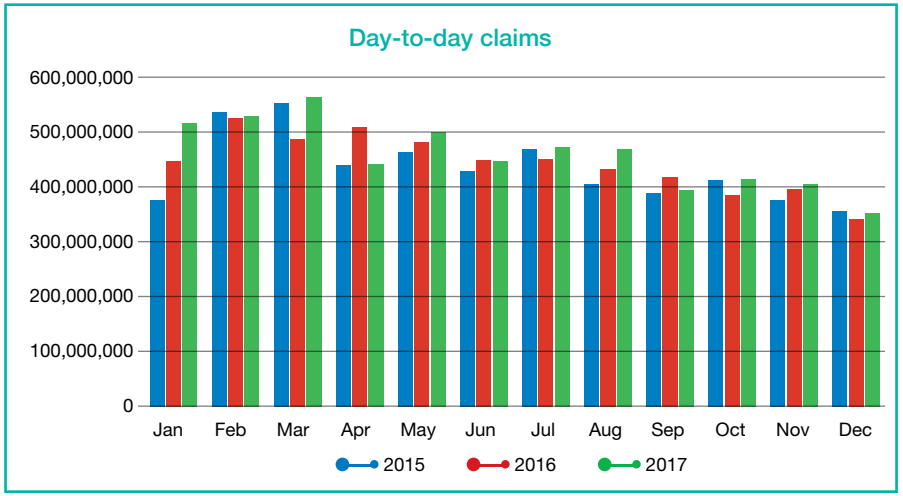
Hospital claims

The hospital claims experience during 2017 was the main contributor to the better than budgeted claims experience. The Scheme experienced a 0.3% (year-on-year) increase in 2017 for in-hospital claims processed when compared to the same period in 2016.

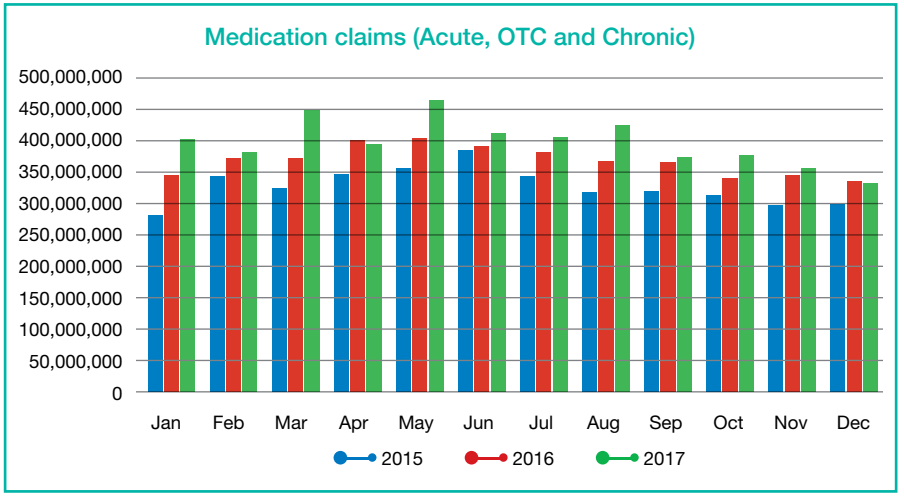


Other claims

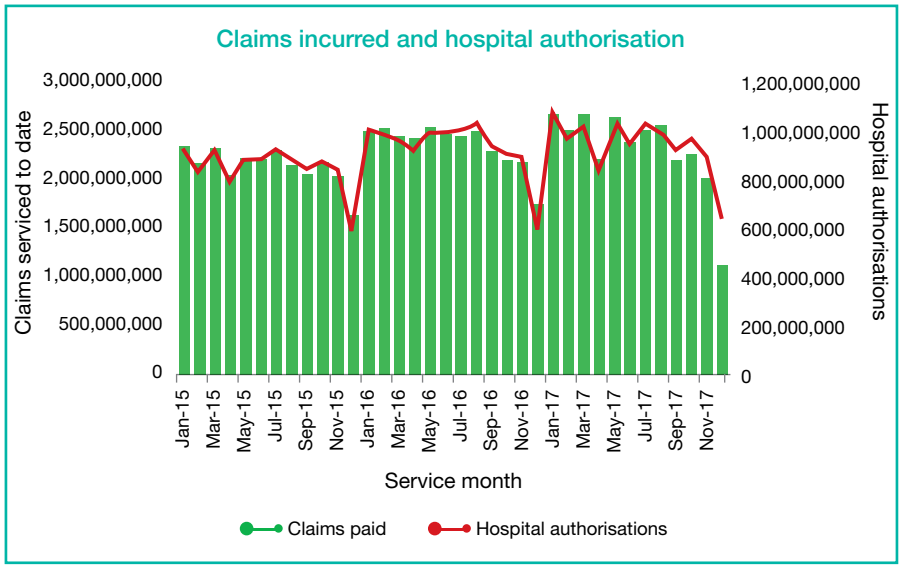
The Scheme experienced an increase in day-to-day claims processed in 2017, which were 3.4% higher than in 2016. This is still below the expected CPI increase.



The Scheme experienced an 8.3% increase in medication claims from 2016 to 2017. As these claims are processed in real time, they are a suitable indicator of the general utilisation of healthcare services.



Over the years the actuaries have shown that there is a strong correlation between the claims incurred and the hospital authorisations which continued in 2017, as can be seen from the graph below.



Progress against the GEMS strategic plan performance indicators for 2017 and relevant risk factors

Strategic objective	Performance indicator	Target 2017	Target 2021	Performance in 2017	Main risk factors that may impact on performance outlook
Be an organisation that is effective in communication, proactive in decision making and accountable	Complaints ratio: Number of complaints expressed as a percentage of enrolled members	0.25%	0.15%	0.27%	• Quality of service delivery • Effective complaints management
	Formation of the Stakeholder Integration Forum	Stakeholder Integration Forum formed with Terms of Reference and functioning	Review and update Terms of Reference	All work required from the side of the Scheme was concluded. This included the development of a Terms of Reference for the Forum and stakeholder consultations. Despite various approaches by the Scheme, no names were put forward.	• Individual stakeholder risk level • Consolidated stakeholder risk profile • Stakeholder interdependence/ interrelationship

Strategic objective	Performance indicator	Target 2017	Target 2021	Performance in 2017	Main risk factors that may impact on performance outlook
Advance financial strength and drive the Scheme to a position of long-term sustainability	Reserve ratio	8.2% As per CMS approval	25% CMS target TBD	15.22%	• Regulatory relationship and agreed targets • Factual reserve impact from semi-permanent historical anomalies • Impacts of new cohorts on reserve ratio
	Liquidity ratio	2.1	2.1	2.7	
	Operating surplus	≥ 2%	≥ 2%	8.3%	• Claims performance • Budget and pricing prudency
	Investment income	Return ≥ CPI + 1.9%	Return ≥ CPI + 3.5%	Return ≥ CPI + 1.95% R124 million ahead of budgeted investment return	• Budget and pricing prudency
Shape the transformation of the healthcare industry towards universal healthcare, coordinated across the healthcare ecosystem	Simplified core product offering	5% Emerald members moved to Emerald Value option	>80% membership covered by 3 sustainable options All products to have best practice care coordination The base product should have no out-of-pocket payments at point of care	7.4% Emerald members have moved to Emerald Value option	• Relative attractiveness in creating value at a cost-effective price point
	A developed healthcare accountability model that progressively aligns healthcare expenditure, quality and access with affordability levels	Develop a healthcare accountability framework with appropriate clinical governance, financial and health-related metrics	Use the framework to track and progressively enhance value-based healthcare, aligned to UHC goals/priorities	The clinical governance and health toolkit was developed, and the methodology was refined. Clinical categories were defined	
	A developed healthcare accountability model that progressively aligns healthcare expenditure, quality and access with affordability levels	Disease management interventions for top 6 chronic diseases progressively translated into increase in admission rates lower than 3.5%	Disease management interventions for top 6 chronic diseases progressively translated into increase in admission rates lower than actuarial calculation (HIV, TB, diabetes, hypertension, hyperlipidaemia, asthma)	The Scheme is in the process of refining the reporting criteria for this KPI. Work that was concluded in 2017 entailed identification of the six chronic conditions (Asthma; Diabetes; Hypertension; Hyperlipidaemia; HIV; and TB) for which changes in overall hospital admission rates for linked patients will be reported in the future	• Preventative care • Managed care • Appropriate level and quality of care

Strategic objective	Performance indicator	Target 2017	Target 2021	Performance in 2017	Main risk factors that may impact on performance outlook
Be a strategic purchaser of healthcare services by leveraging GEMS' unique positioning and relationships	Leverage existing strategic assets towards improving member value	Fraud, waste and abuse targets (provider and member): Fraud identification (10%) Prevention (10%, prior and post intervention) Recovery of at least 10% of the prevention	Fraud, waste and abuse (FWA) targets (provider and member): Fraud identification (10%) Prevention (10%, prior and post intervention) Recovery of at least 10% of the prevention	R3.75 billion identified R300 million change The Scheme is in the process of refining the reporting criteria for this KPI. Work concluded during 2017 entailed conclusion of Acknowledgement of Debt Letters, Reversal of claims and blocked payments, all of which, contribute to the actual banked recoveries once their respective processes are concluded	• Criminal behaviour in internal, external and transactional environments • Adequacy of internal controls • Adequacy of risk transfer provisions in outsourced service providers' contracts
	Participation in healthcare supply-side reform in line with social security agenda	1,500 specialists contracted	3,000 specialists contracted	1,503 specialists contracted: • Paediatricians: 317 • Obstetricians and Gynaecologists: 329 • Physicians: 440 • Psychiatrists: 265 • Anaesthetists: 152	• Supply side reforms and access to preferential rates with healthcare suppliers may not be realised • Poor network growth and access. Contracted specialist not charging the agreed reimbursement rate, and not agreeing to peer review
	Leverage existing strategic assets towards improving member value	Reduce KZN hospital admission rate to ≤ 30.5%	Reduce KZN risk-adjusted admission rate ≤ 27%	32.1% Note: More information is available under the Scheme's internal operating context on page 65	• Failure to reduce risk-adjusted KZN admission rate to national average of 26.9%. Increased hospital utilisation rates not explained by demographics. High prevalence of fraud, waste and abuse in KwaZulu-Natal (when compared to the national average)
	Participation in healthcare supply side reform in line with social security agenda	≥ 5% reduction in appliances and prosthesis sourcing costs	Maintain a deflationary cost trend for defined appliances and prosthesis (≤ CPI)	The Scheme is in the process of refining the reporting criteria for this KPI. Work that commenced during 2017 entailed tracking of ex-gratia, price and utilisation savings, all of which, contribute to the actual overall savings for appliances and prosthesis	• Realistic discounts, supply-side reforms and access to preferential rates with healthcare suppliers
Be an agile data-driven Scheme that leverages people, systems and processes to derive value for the member	Ownership of all Scheme data to inform strategic and operational decision making	Introduce advanced digital channels to increase interface with members and providers	At least 70% digital channel adoption rate	The GEMS Member App went live in July 2017. It has a record of 4,076 downloads and 3,998 members completed the registration process	• Adequate and robust systems to drive outcomes • Cover internal and outsourced systems

Strategic objective	Performance indicator	Target 2017	Target 2021	Performance in 2017	Main risk factors that may impact on performance outlook
Sustainably grow membership, ensuring inclusion and progressive cross-subsidisation	Client Liaison Offices roll-out and presence	Finalise CLO Model Review Expand CLO presence to seven provinces	Expand CLO presence to all nine provinces and 50% of CLO staff FAIS-accredited	Footprint established in seven provinces: • Gauteng: 2013 • KwaZulu-Natal: 2014 • Eastern Cape: 2015 • Free State: 2016 • Limpopo: 2016 • Mpumalanga: 2017 • North West: 2017	• Adequate and robust skills and competencies to drive outcomes • Cover internal and outsourced competencies and skills
	Sustainable membership growth and retention	45% of salary level 1-5 enrolled	At least 70% of salary level 1-5 enrolled	47.49% of salary level 1 to 5 Employees that are on PERSAL are members of GEMS	• Brand perception • Benefit design impacting on attractiveness • Target market not aware of the extent of the available subsidy

Complaints

The most frequent reasons for complaints against the Scheme are: Short paid accounts, the adjudication of PMB claims, claims older than four months, rejected accounts, short paid hospital accounts, appliance and procedure authorisation decisions, and delays in paying member refunds on settled accounts.

Complaints Management Processes

The Scheme's compliments and complaints experience is deemed an important business indicator in respect of member and stakeholder satisfaction and Scheme performance. The Scheme has a well-defined complaints management process which ensures that complaints are resolved and the root cause is addressed as far as possible.

A dedicated email address (complaints@gems.gov.za) is available for the submission of complaints to the Scheme. Complaints received by means of other channels such as those submitted directly to the Service Provider Network contractors, the CLO Unit, the PO email address, and the Media email addresses are also channelled to dedicated email addresses. A formal Complaints Management Standard Operating Procedure is in place and complaints are managed accordingly across the Scheme's Service Provider Network. To this end, the complaint collation and response process is managed centrally by the Scheme's contracted administrator for Member and Claims Services – Metropolitan Health. The Scheme reviews the complaints@gems.gov.za email address in order to confirm the accuracy of reporting by the administrator. The Principal Officer ensures that complaints are analysed to identify underlying causal factors that could be resolved through the enhancement of existing business processes.

The Board of Trustees monitor the service failures, issues and concerns raised by members, and receive quarterly and ad-hoc reporting from the Principal Officer on the Scheme's performance against the following performance indicators:

Performance Indicator	Target
Ratio of complaints to registered members	≤0.25%
Ratio of compliments to complaints	≥15%
Complaints lodged against the Scheme with the Council for Medical Schemes relative to the medical schemes industry	CMS complaints below overall CMS industry average complaints Do not appear in list of top 10 closed schemes with the highest number of CMS complaints

The Scheme's risk appetite matrix includes reporting on movements in the ratio of complaints to registered members.

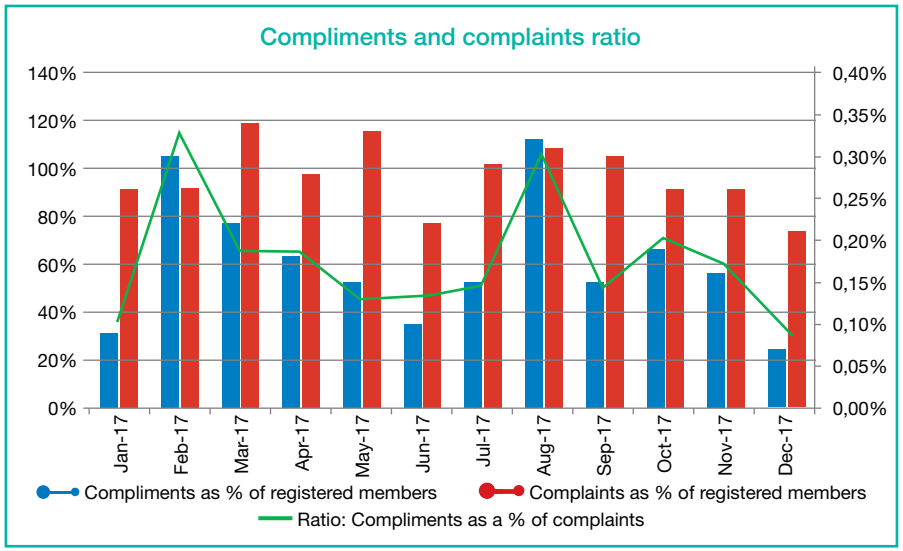
Complaints statistics

During 2017 the Scheme received a total of 22,199 general and CMS complaints. This indicates an increase of 14% when compared to complaints lodged in 2016 (19,399). The increase in the total number of complaints can be attributed to a number of factors including the:

- Implementation of a number of clinical risk management interventions following a challenging 2016 financial year for GEMS, but also for the industry at large;
- Change in the process of the approval of claims older than four months;
- Process change relating to informal CMS complaints which have been logged as formal CMS complaints with effect from 2017;
- Continued expectation of providers to be reimbursed for Prescribed Minimum Benefit conditions at cost;
- Introduction of Underwriting and the new Emerald Value option; and
- Media coverage regarding the Scheme's financial standing resulting in members and providers more frequently contacting the Scheme to determine whether claims had been paid.

The Scheme average ratio of complaints to the number of registered members for the year was 0.27% (2016: 0.24%) which was outside the Scheme's risk tolerance level of 0.25%.

The graph below illustrates the complaints ratio for the year compared to membership growth:



Complaints/Matters with the Council for Medical Schemes

For the period of 1 January 2017 to 31 December 2017, the Council for Medical Schemes referred 1,145 complaints to GEMS in terms of section 47 of the Medical Schemes Act No. 131 of 1998.

As compared to 2016, formal complaints against the Scheme have increased by 53%. (2017: 1,145; 2016: 750).

As indicated above, in 2017 all complaints received by the Council for Medical Schemes were submitted as formal CMS complaints in comparison to 2016, whereby 406 complaints were submitted as informal complaints. Had the same basis been applied in 2017, there would have been a 1% decrease year-on-year.

Of the total number of complaints received from the Council for Medical Schemes:

- 422 complaints were referred directly to the Council for Medical Schemes;
- 51 were enquiries that were unresolved by GEMS and directed to the Council for Medical Schemes; and
- 672 complaints were addressed by GEMS but disputed at the Council for Medical Schemes.

The table below depicts the total numbers for 2017:

Month	Referred directly to CMS without Scheme intervention	Unresolved enquiries directed to CMS	Addressed by the Scheme and disputed to CMS	Total
Jan-17	35	2	49	86
Feb-17	48	4	46	98
Mar-17	30	10	49	89
Apr-17	30	7	46	83
May-17	30	4	48	82
Jun-17	91	5	10	106
Jul-17	75	5	13	93
Aug-17	33	7	87	127
Sep-17	8	2	81	91
Oct-17	9	2	77	88
Nov-17	20	2	121	143
Dec-17	13	1	45	59
Total	**422**	**51**	**672**	**1,145**
Percentage	36.86%	4.45%	58.69%	100.00%

GEMS appeared in the list of ten medical schemes most complained about as published in the Annual Report of the Council for Medical Schemes for the 2016-2017 financial year.

The main causal factors for the increased complaints volumes have been enumerated above.

In terms of sections 48 and 49 of the Medical Schemes Act, 131 of 1998, as amended, any person who is aggrieved by a decision relating to a complaint or dispute may appeal such decision with the Council. During 2017, a total of six appeals were lodged with the Appeals Committee of which five were brought about by the Scheme appealing against the decision of the Registrar. All the 2017 appeals remain unresolved. One appeal, which arose in 2015, was concluded during the reporting period and the Appeal Committee ruled in the Scheme's favour. No appeals were submitted to the Appeal Board of the Council in terms of section 50(3) of the Medical Schemes Act, Act No. 131 of 1998, as amended.

In 2016, medical schemes in South Africa experienced a surge in claims by members and healthcare providers. For a Scheme like GEMS, this had a detrimental impact on the reserve ratio and the focus on achieving financial stability was an imperative for the Scheme. The situation was exacerbated by a media article alluding to alleged insolvency, resulting in concerns within the Scheme, key stakeholders and beneficiaries. The Scheme was further confronted with other serious employee-related matters. These factors contributed to a surge in complaints which impacted complaints management efficiencies. The Scheme's ability to manage complaints was further subjected to resource constraints. As such, in 2017 the Scheme focused on strengthening policy, procedures, processes and practices to improve the management of complaints.

In addition to strengthening systems to monitor the effectiveness of complaints management, engagements with key stakeholders, members, healthcare providers and Council were held and issues were addressed. Mechanisms were put in place to ensure complaints are addressed timeously.

The Scheme continues to make strides in reducing the number of complaints that could have been prevented. In 2018, the focus areas include improved monitoring, reporting and root cause analysis. Further attention is given to member and provider education.

Claims payment period performance

Reporting delays

The table on the right depicts the average reporting delays in 2017; reporting delays are depicted with the time interval from date of service and date received and acknowledged by the Scheme. The average reporting delays for the Scheme was five days. The Sapphire and Beryl options had higher reporting delays than the other benefit options. Onyx had the least reporting delays.

Average days from service to receipt	
Sapphire	9.63
Beryl	7.43
Ruby	5.22
Emerald	5.26
Emerald Value	5.06
Onyx	4.48
GEMS	5.28

Claims processing cycle

The average claims processing cycle for the Scheme was four days. The Beryl and Sapphire options had a higher processing cycle; the Ruby, Emerald, Emerald Value and Onyx options had a processing cycle ranging between 2 to 3 days.

Average days from receipt to settle (processing cycle)		
	2016	2017
Sapphire	5	6
Beryl	6	6
Ruby	3	3
Emerald	2	2
Emerald Value	N/A	3
Onyx	3	3

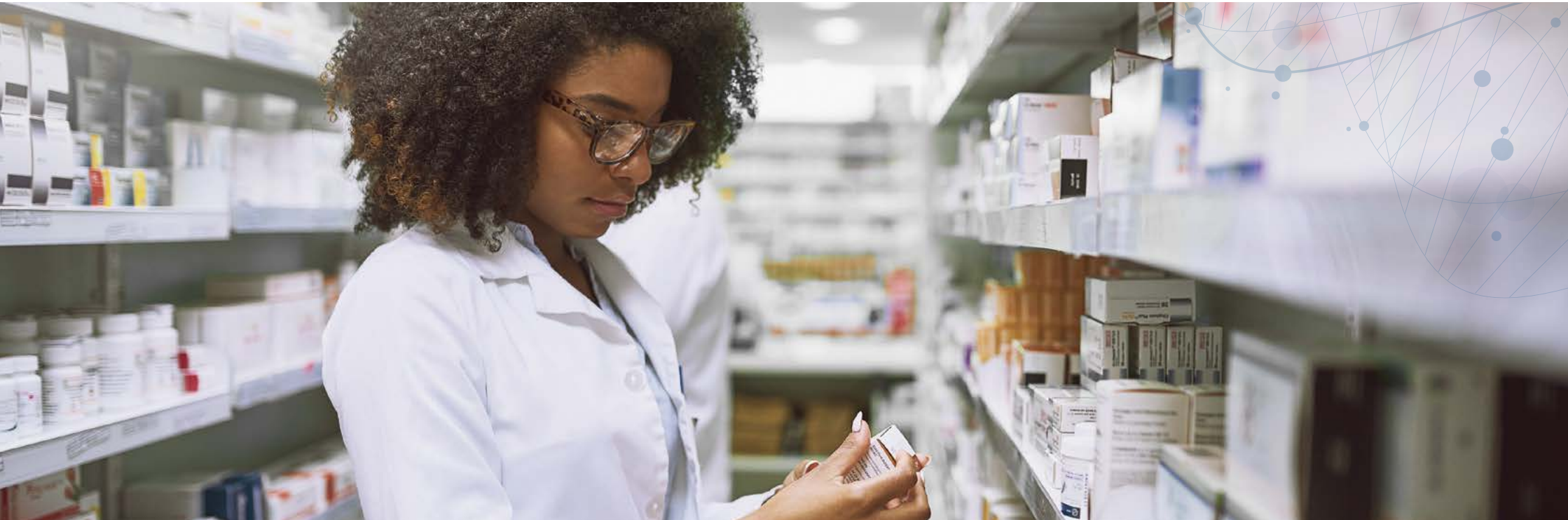
Limiting our impact on the environment

GEMS uses the environmental reporting methodologies prescribed by the World Resources Institute (WRI) and the World Business Council for Sustainable Development (WBCSD) Greenhouse Gas Protocol Corporate Accounting and Reporting Standard. Emissions are reported as carbon dioxide equivalent (CO_2e) per employee, per annum. Both the UK Government and Eskom's published emission factors are used in calculating CO_2e. The GEMS' Environmental Management Manual specifies GEMS' emissions sources and the data collection methodologies prescribed in the manual are applied.

The Scheme's CO2/employee for 2017 was well below target, indicating that the Scheme's Environmental Management initiatives are achieving the desired outcome.

The table below depicts the Scheme's CO2e/employee (expressed as tCO2/employee) as against its annual reduction targets for 2012, 2013, 2014, 2015, 2016 and 2017, respectively:

CO2e Source	2012 Targets (CO2e base year)	2013 Targets	2014 Targets	2015 Targets	2016 Targets	2017 Targets	2013 Actuals	2014 Actuals	2015 Actuals	2016 Actuals	2017 Actuals
Scheme vehicles	0.101	0.096	0.091	0.087	0.082	0.078	0.121	0.164	0.384	0.453	0.282
Electricity	6.803	6.463	6.140	5.833	5.541	5.264	5.500	5.304	3.329	3.214	2.662
Paper	2.101	1.996	1.896	1.801	1.711	1.625	2.084	1.545	0.381	0.456	0.164
Water	0.036	0.034	0.032	0.031	0.029	0.028	0.034	0.035	0.030	0.019	0.013
Air travel	1.544	1.467	1.393	1.324	1.258	1.195	2.727	2.335	1.891	1.687	1.421
Car rental	0.069	0.066	0.062	0.059	0.056	0.053	0.079	0.099	0.098	0.157	0.082
Total	10.654	10.121	9.615	9.135	8.678	8.243	10.545	9.482	6.113	5.986	4.626



Summarised 2017
Annual Financial Statements

The Financial information presented hereunder has been extracted from and is in agreement with the audited Annual Financial Statements of the Scheme for the 2017 financial year.

Statement of Financial Position as at December 2017

	Notes	2017 R '000	2016 R '000
ASSETS			
Non-Current Assets			
Property & Equipment	3	97,906	11,943
Intangible assets	4	55,344	48,019
Financial assests at fair value through profit or loss	5	571,230	684,275
		724,480	**744,237**
Current Assets			
Financial assests at fair value through profit or loss	5	1,905,393	177,249
Trade and other receivables	6	405,117	305,114
Cash and cash equivalents	7	5,488,609	3,755,096
		7,799,119	**4,237,459**
Total Assets		**8,523,599**	**4,981,696**
FUNDS AND LIABILITIES			
MEMBERS' FUNDS			
Accumulated funds		5,446,276	2,176,075
LIABILITIES			
Current Liabilities			
Personal medical savings account liability	8	759,387	656,318
Trade and other payables	9	1,193,272	1,188,560
Outstanding risk claims provision	10	1,123,600	960,000
Lease escalation reserve		1,064	743
		3,077,323	**2,805,621**
Total Funds and Liabilities		**8,523,599**	**4,981,696**

Statement of Comprehensive Income

	Notes	2017 R '000	2016 R '000
Risk contribution income	12	34,703,985	30,271,405
Relevant healthcare expenditure		(29,844,481)	(29,241,001)
Risk claims incurred	13	(29,134,469)	(28,543,347)
Accredited managed healthcare services	14	(710,012)	(697,654)
Gross healthcare result		**4,859,504**	**1,030,404**
Administration expenditure	15	(1,782,952)	(1,567,415)
Marketing services		(121,718)	(120,382)
Impairment losses on healthcare receivables	17	(77,104)	(65,766)
Net healthcare result		**2,877,730**	**(723,159)**
Investment income	18	388,236	261,773
Dividends received		8,101	6,713
Interest received on financial assets at fair value through profit or loss		88,851	47,803
Net realised gain on financial assets at fair value through profit or loss		13,306	5,224
Net unrealised gain on financial assets at fair value through profit or loss		19,392	8,468
Interest received on Scheme cash invested		210,409	156,207
Interest received on Personal medical savings account monies invested		48,177	37,358
Other income		58,769	17,478
Sundry income		58,769	17,478
Other expenses		(54,534)	(40,742)
Investment management fees		(6,357)	(3,384)
Interest allocated to members' personal medical savings accounts monies		(48,177)	(37,358)
Total comprehensive surplus/(deficit) for the year		**3,270,201**	**(484,650)**

Statement of changes in funds

	R '000 Accumulated funds	R '000 Member funds
Balance at January 1, 2016	**2,660,725**	**2,660,725**
Total comprehensive deficit for the year	(484,650)	(484,650)
Balance at January 1, 2017	**2,176,075**	**2,176,075**
Total comprehensive surplus for the year	3,270,201	3,270,201
Balance at December 31, 2017	**5,446,276**	**5,446,276**

Statement of
Corporate Governance

The Government Employees Medical Scheme is committed to the principles and practice of fairness, openness, integrity and accountability in all dealings with its stakeholders. The Board conducts all its affairs according to ethical values and within a recognised governance framework.

The Scheme acknowledges its role within the medical scheme industry as well as its responsibilities to each individual beneficiary and the wider community. The Scheme recognises that sustainability can only be achieved through strong relationships with all stakeholders and responsible management of risk.

Transparency and ethics

The Scheme has adopted a stakeholder-inclusive approach to corporate governance and is bound by mandates and principles of treating members fairly. The close stakeholder relationship and the election and appointment of the Board of Trustees by the members and the employer allow the Scheme to recognise the concerns and objectives of stakeholders in its decision-making process.

The Board of Trustees acknowledges that the perception of stakeholders affects the reputation of the Scheme.

Therefore, clear and open communication with stakeholders enhances the reputation of the Scheme. The Trustees have produced a holistic and reliable integrated report to illustrate both the financial and non-financial performance of the Scheme.

Board of Trustees

The Board of Trustees is responsible for the stewardship and governance of the Scheme. The Trustees are elected and appointed by the members of the Scheme and the employer respectively (as defined in the Rules of the Scheme), according to the provisions of the Medical Schemes Act, No 131 of 1998, as amended, and the Rules of the Scheme. The Trustees are representatives of the Scheme's members and are legally responsible for the management and strategic direction of the Scheme on behalf of the members.

The Board meets regularly and monitors the performance of the Scheme's employees, administrators and other contracted service providers. The Board addresses a range of issues and ensures that discussion of policy, strategy, risk management, fraud management and operational performance are critical, informed and constructive.

The affairs of the Scheme are managed according to the Rules of the Scheme and also adhere to all aspects of governance as required by the Medical Schemes Act 131 of 1998, as amended. The Board is also committed to the principles of the Code of Corporate Practices and Conduct as set out in the King Report on Corporate Governance for South Africa (King IV).

A collective board-effectiveness evaluation and peer review is performed every second year. The Chairperson meets with individual Trustees on a one-to-one basis during induction training of new Trustees and should the need arise.

All Trustees have access to the Principal Officer and, where appropriate, may seek independent professional advice at the expense of the Scheme.

Internal controls

Management and the administrators of the Scheme maintain internal controls and systems designed to provide reasonable assurance as to the integrity and reliability of the financial statements and to safeguard, verify and maintain accountability for its assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

The Scheme's Internal Audit service also performs an independent analysis of the controls of the Scheme as well as those of the service providers of the Scheme as part of its annual audit plan.

The Board-appointed Governance, Risk and Ethics Committee, consisting of Board of Trustee members and attended by senior management of the Scheme, has the duty to assess the risk register and plans to mitigate the risks. This Committee reports to the Board of Trustees independently.

On an annual basis the Board assesses the risks facing the Scheme and determines the impact and likelihood of such risks through the development of a risk register. Once the risk register is approved by the Board, monitoring of the implementation of mitigation measures and internal controls takes place at least quarterly to ensure that all risks are effectively managed. No event or item has come to the attention of the Board of Trustees that indicates any material breakdown in the functioning of the key internal control and systems during the year under review.

Mr NL Theledi
Chairperson

Dr SM Hlatshwayo
Deputy Chairperson

Dr G Goolab
Principal Officer

25 April 2018

Governance Structures

An independent Board of Trustees forms the core of the Scheme's corporate governance structure and is ultimately accountable and responsible for the performance and affairs of the Scheme.

The GEMS Board Charter defines the governance parameters within which the Board exists, sets out the role of the Board and specific responsibilities and duties to be discharged by the Board and Trustees collectively, as well as certain roles and responsibilities incumbent upon Trustees. As such, the GEMS Board Charter is aligned to the provisions of the Medical Schemes Act, 1998 (the Act), as amended; the Regulations promulgated under the Act and the registered Rules of GEMS. The full Board Charter is available from www.gems.gov.za.

The Board of Trustees has a process in place to perform reviews of the effectiveness, the role of the Board and its Chairperson, as well as the effectiveness of the respective Board Committees.

The Board is responsible for providing strategic guidance to the Scheme. An annual strategic plan gives effect to the Board's responsibility to govern the affairs of the Scheme by directing the activities of the Principal Officer, management and employees, providing an effective oversight through which performance can be monitored and to ensure that the business of the Scheme operates efficiently and effectively. The Scheme's Five-year Strategic Plan for 2017 to 2021 was approved by the Board on 27 September 2016. The Board monitored the implementation of the approved Strategic Plan by means of quarterly reports from Scheme Management. Throughout 2017, the Board was kept appraised of the status of the business by means of standardised presentations covering key business indicators, including membership growth and financial performance.

The performance targets in the Three-year Strategic Plan are reviewed annually by the Board and are adjusted based on changing realities and interrelated plans such as the business plans approved for the Scheme by the Registrar of Medical Schemes from time to time. A view of the Scheme's performance against the Five-year Strategic Plan for 2017 to 2021 is provided from page 102 of the Board Report.

The Board of Trustees is responsible for governing the management of risk and a formal risk management process is in place in accordance with the Scheme's approved Risk Management Policy. The approach to risk management and the governance of risk management is discussed on page 93 of the Board Report.

The Board monitored the implementation of the approved strategic and operational risk mitigation measures as well as the Scheme's changing risk environment during 2017 by means of quarterly and ad hoc reports from Scheme Management. The Board is comfortable that the residual risks facing the Scheme were managed throughout 2017 and that risk assessments and mitigation measures, aimed at safeguarding Scheme and member interests, were effective.

Structures and officers

The Board consists of 12 Trustees made up as follows:

- 50%, i.e. (six) Trustees elected by the members of the Scheme; and
- 50%, i.e. (six) Trustees appointed by the Minister for Public Service and Administration.

The GEMS Board of Trustees held 12 meetings during 2017 (9: 2016) as follows:

1. 28 February 2017 (Quarterly Board Meeting);
2. 25 April 2017 (Quarterly Board Meeting);
3. 06 June 2017 (Ad hoc Meeting, focused on the Corruption Investigations);
4. 29 June 2017 (Interim Meeting, focused on the AGM);
5. 27 July 2017 (Quarterly Board Meeting);
6. 26-27 September 2017 (Strategic planning Meeting);
7. 28 September 2017 (Interim Meeting, focused on the Scheme's 2018 benefit and pricing submission to the Council for Medical Schemes);
8. 30 October 2017 (Quarterly Board Meeting);
9. 20 November 2017 (Ad hoc Meeting, focused on the Corruption Investigations);
10. 5 December 2017 (Interim Meeting, focused on key approvals required for 2018);
11. 14 December 2017 (Ad hoc Meeting, focused on the Corruption Investigations); and
12. 15 December 2017 (Ad hoc Meeting, focused on the Corruption Investigations).

The Board also held 2 half-day workshops (2: 2017) as follows:

1. 27 January 2017 (Board Risk Workshop deferred from 31 October 2016); and
2. 31 October 2017 (Board Risk Workshop).

Standing committee structure and responsibilities

The Board of Trustees has established its own governance practices and standing committee structure that comply with the applicable governance and regulatory requirements. These Committees fulfil key roles in ensuring good corporate governance.

The Board reviewed the Standing Committee Structure in 2017 and a new Structure was established effective 1 January 2018. The review was informed by:

- Statutory requirements
- The King IV Report on Corporate Governance
- The GEMS Strategic Plan Accountability and Strategic Oversight Framework
- The GEMS operational structure
- Cost-effectiveness and value-for-money considerations

The Committees listed below functioned until 31 December 2017. The Committees were mandated by the Board of Trustees by means of written terms of reference as to their membership, authority and duties.

A Standing Committee Responsibility Matrix (RACI matrix) was used to clarify and demarcate the Standing Committees' responsibility areas.

The Standing Committees meet at least quarterly and as indicated in the year planner approved for each year. Committee meetings are attended by Scheme Management on invitation.

The Committees in operation in 2017 were:

Audit Committee

The Audit Committee is mandated by the Board of Trustees by means of a written Audit Committee Charter as to its membership, authority and duties. The Committee's Charter was reviewed and approved by the Board of Trustees on 05 December 2017.

The primary responsibilities of the Audit Committee include assisting the Board of Trustees in its evaluation of the adequacy and efficiency of the internal control systems, accounting practices, financial reporting processes, financial and other reporting risks, information systems, oversight of assurance provided over external reports other than financial statements; and oversight of combined assurance processes applied by the Scheme and its service providers network. With regard to the external auditors, the Audit Committee considers and recommends the appointment of the external auditors, monitors and reports on their independence. The Committee is also responsible for the appointment, performance assessment and/or dismissal of the Chief Audit Executive; approval of the internal audit plan as well as the annual review and approval of the Internal Audit Charter.

Committee composition, including members' qualifications and experience

The Committee consisted of five members, of which two were members of the Board of Trustees. The majority of the members, including the Chairperson, are not Trustees, officers of the Scheme or of any of its service providers. For the year ended 31 December 2017, the Committee members were:

Name	Designation	Qualifications	Recent work experience
Ms MA Sukati	Independent member, re-appointed as Chairperson with effect from 1 April 2015, resigned on 29 November 2017	• BCom (Acc) • BCom Hons (Acc) • Postgraduate Diploma in Accounting • CA (SA) • CIA • MBA (UP)	• Role during 2017: Chief Audit Executive: Transnet • Previous employers: South African Revenue Service (SARS): Group Executive – Internal Audit Pricewaterhouse-Coopers (Nelspruit) Position: Partner
Ms NF Msiza	Independent member, appointed with effect from 1 April 2013 and re-appointed for a second term with effect from 1 April 2016	• Chartered Director South Africa (CD SA) • B.Com degree and Higher Diploma in Taxation • Master's in Business Administration	• Role during 2017: Executive Director – Governance, Risk and Compliance: Raubex Group Limited • Previous employers: Group Chief Audit Executive: Denel Director: Risk, Assurance and Compliance – City Power

Name	Designation	Qualifications	Recent work experience
Ms R Eksteen	Independent member, appointed with effect from 1 November 2015	• B.Com Law • LLB • CIS • Masters' in Development Finance • Certificate of Conduct Certificate • Sustainability Assurance Practitioner	• Role during 2017: Group Compliance Officer & Manager – Group Legal Services: Pioneer Food Group Ltd
Ms NH Mkhumane	Trustee, term as Audit Committee member commenced on 1 November 2014	• Dip. Law & Tax • IEIC (CIMA) • Exec. Mgt. Dev. Prog. (WBS) • Capital Proj. Mgt. Appraisal (Queens Univ. Canada) • Bachelor of Commerce (UNISWA) • Certificates: • Board Leadership (GIBS) • Corp. Gov., Audit Roles • Supply Chain Mgt. & Prop. & Asset Mgt	• Role during 2017: Chairman: South African Diamond and Precious Metals Regulator
Dr IJ Van Zyl	Trustee, term as Audit Committee member commenced on 1 November 2014	• B Mil • Hons B Com (Personnel Management) • MBA • PhD (Industrial Economics) • Industrial Relations Development Programme	• Most recent: Labour Consultant • Previous employers: Chief Consultant (Labour Relations): ArcelorMittal SA Chief Director (Labour Relations): Department of Labour

The Audit Committee carried out their responsibilities in terms of the Board-approved Audit Committee Charter. The external auditors and internal auditors reported formally to the Committee on critical findings arising from audit activities.

The Committee met on five occasions during the course of 2017 (6: 2016) as follows:

1. 14 March 2017 (Quarterly Meeting)
2. 13 April 2017 (Special Meeting)
3. 11 July 2017 (Quarterly Meeting)
4. 21 September 2017 (Quarterly Meeting)
5. 29 November 2017 (Quarterly Meeting)

The Principal Officer, the Chief Financial Officer of the Scheme, the Chief Audit Executive, the Scheme's outsourced internal auditors and the external auditors attend Committee meetings upon invitation and have unrestricted access to the Chairperson of the Audit Committee.

Operations Committee (The Committee was discontinued and its functions were moved to other Committees from 1 January 2018)

The primary responsibility of the Committee was to assist the Board of Trustees in ensuring the efficient operations of the Scheme by providing oversight, assessment and review of all aspects of the business and operations of the Scheme. Monitoring the Scheme's organisational and financial performance were key responsibilities of the Committee. Oversight by this Committee was necessitated by the Scheme's business model which requires ongoing review of the contracting of service providers to render scheme services. To this end, the Committee assisted the Board of Trustees in ensuring seamless interaction between the various service providers in order to meet the operational objectives of the Scheme. The other areas of oversight of the Committee were the Scheme's Information Communication Technology Function and the Scheme's communication and marketing activities.

The Committee met on eight occasions in 2017 (8: 2016) on:

1. 15 January 2017 (Quarterly Meeting)
2. 11 April 2017 (Quarterly Meeting)
3. 12 May 2017 (Special Meeting and Strategy Workshop)
4. 24 July 2017 (Quarterly Meeting)
5. 29 August 2017 (Special Meeting/Workshop in preparation for the Board Strategic Planning Meeting)
6. 14 September 2017 (Quarterly Meeting)
7. 18 October 2017 (Special Meeting)
8. 31 October 2017 (Special Meeting coincided with Board Meeting)

Committee members in 2017 were:

- Dr JA Breed (Trustee, tenure commenced 30 July 2014)
- Ms NM Ntsinde (Trustee and Chairperson, tenure commenced 30 July 2013)
- Mr NL Theledi (Trustee member, tenure commenced 27 September 2013)
- Dr CM Mini (Trustee, tenure commenced 30 July 2014)

Clinical Governance and Ex Gratia Committee

The primary responsibilities of the Committee are to:

- Assess, decide and report on the approval of ex gratia payments to members of the Scheme. The Committee is mandated to approve ex gratia payments only where the condition and the withholding of therapy is life-threatening; the treatment will result in the improved quality of life of the applicant; the treatment is clinically appropriate and based on internationally accepted evidence-based treatment guidelines and protocols or the applicant has proven a financial inability to afford the treatment by any other means.
- Assist the Board in ensuring the implementation of the Healthcare Management Strategic Objective, namely: To improve the Scheme's clinical risk profile and contain claims experience; and
- Oversee the Scheme's product development and benefit design work.

The Committee met every eight weeks over two days, for a total of eight meetings (9: 2016) on:

1. 25-26 January 2017
2. 15-16 March 2017
3. 17-18 May 2017
4. 12-13 July 2017
5. 8 August 2017 (Interim Meeting focused on the Scheme's 2018 benefit design)
6. 5-6 September 2017
7. 1-2 November 2017
8. 13-14 December 2017

For the year ended 31 December 2017, the committee members were:

- Mr CJ Booyens (Trustee, tenure commenced 30 July 2013)
- Mr JS Roux (Trustee, re-elected, tenure commenced 30 July 2014)
- Ms NM Ntsinde (Trustee, tenure commenced 30 July 2013)
- Dr CM Mini (Trustee, tenure commenced 30 July 2014)
- Mr DJ de Villiers (Trustee, re-elected, tenure commenced 30 July 2013)

Governance, Risk and Ethics Committee

The Committee has been mandated by the Board of Trustees to ensure sound corporate governance by providing oversight, assessment and review of all governance and compliance aspects of the business of the Scheme. The Committee's responsibilities include ensuring compliance with the Medical Schemes Act and its Regulations; patent and trademark legislation; and any other legislative framework relevant to the business of the Scheme. The Committee has also been mandated to ensure effective ethical governance, risk management and stakeholder management.

The Committee met on five occasions in 2017 (4: 2016):

1. 9 February 2017
2. 12 April 2017
3. 5 July 2017
4. 10 October 2017
5. 20 November 2017

For the year ended 31 December 2017, the committee members were:

- Dr JA Breed (Trustee member, tenure commenced July 2014)
- Mr DJ de Villiers (Trustee member – Chairperson, re-elected, tenure commenced 30 July 2013)
- Mr EB de Vries (Trustee, tenure commenced 30 July 2013)
- Mr JS Roux (Trustee member, re-elected, tenure commenced 30 July 2014)

Investment Committee

The Investment Committee was set up by the Board in December 2013 and commenced its work in March 2014. The primary responsibility of the Committee is to assist the Board in fulfilling its oversight responsibilities of the Scheme's investment activities and to consider issues arising from investment decisions and activities. As such, the Committee monitors the Scheme's cash flow position, investment performance and compliance to the regulatory framework applicable to medical scheme investments. The Committee is also responsible for overseeing the performance of the Scheme's contracted asset consultants and managers.

The Committee met on four occasions in 2017 (5: 2016):

1. 13 February 2017
2. 23 May 2017
3. 16 August 2017
4. 30 November 2017

Committee members in 2017 were:

- Ms NH Mkhumane (Trustee, Chairperson tenure commenced on 25 September 2014)
- Mr CJ Booyens (Trustee, commenced on 30 July 2013, moved to the Investment Committee on 1 July 2015)
- Dr JA Breed (Trustee, tenure commenced 30 July 2014)
- Dr C Moloko (Trustee, tenure commenced on 28 October 2016)

Dispute Committee

The primary responsibility of the Committee is to independently consider and preside over any dispute referred by the Principal Officer to the Dispute Committee for adjudication and to advise the Board of Trustees on the handling of disputes in general.

The Dispute Committee met on:

1. 13 February 2017
2. 4 December 2017

For the year ended 31 December 2017, the committee members were:

- Ms M David (Independent member, re-appointed for second term with effect from 1 April 2016)
- Dr P Ford (Independent member, re-appointed for second term with effect from 1 April 2016)
- Ms L Zondi (Chairperson, Independent member, tenure ended 31 July 2017)
- Rev F Chikane (Independent member, appointed with effect from 1 August 2017)

Remuneration Committee

The primary responsibility of the Committee is to ensure sound people management of Scheme employees by providing oversight, assessment and review of the maintenance of relevant HR and remuneration policies of the Scheme. In addition, the Committee's responsibilities include advising the Board on the annual cost of living adjustment for Scheme employees; the criteria to be used in benchmark exercises pertaining to annual remuneration surveys; the remuneration rates applicable to employees, trustees and independent committee members; the implementation of remuneration survey results; the implementation of performance reward measures for employees and overseeing the disclosure of the remuneration of trustees, independent committee members and members of the GEMS Executive Committee in the Scheme's annual integrated report.

The Remuneration Committee met on five occasions in 2017 (5: 2016):

1. 7 February 2017
2. 6 April 2017
3. 6 July 2017
4. 17 October 2017
5. 21 November 2017

For the year ended 31 December 2017, the Committee members were:

- Mr EB de Vries (Trustee, tenure commenced on 30 July 2013)
- Dr IJ van Zyl (Trustee, tenure commenced on 30 July 2014)
- Mr NL Theledi (Trustee member, tenure commenced on 27 September 2013, moved to the Remuneration Committee with effect from 1 July 2015)
- Dr C Moloko (Trustee, tenure commenced on 28 October 2016)

In addition to the Standing Committees, the Board also appointed one ad-hoc committee in 2017 to formulate recommendations on specific matters:

Benefit Design Committee

Recommendations pertaining to the GEMS benefits and contributions for 2018 were developed by the GEMS Benefit Design Committee for the Board's consideration.

The Committee met on two occasions (2: 2016) on the following dates:

1. 24 August 2017
2. 07 September 2017

Attendance of Benefit Design Committee Meetings was open to all Trustees and most Trustees attended these meetings in 2017.

GEMS Trustees and Principal Officer: 2017 Summarised Attendance Register

The numbers reported for actual meetings attended is based on signing of attendance registers and minutes of meetings. The number of meetings that could have been attended reported takes into account the appointment and tenure expiry dates of the respective individuals. The numbers are calculated based on pure attendance and tenure – irrespective of whether remunerated or not.

A – Meetings attended
B – Meetings that could be attended

		Board meetings		Audit Committee meetings		Benefit Committee meetings		Clinical Governance and Ex Gratia Committee meetings		Dispute Committee	
Trustee	**AGM**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Booyens, C	1	12	12			2	2	8	8		
Breed, J	1	11	12			2	2				
De Villiers, D	1	12	12			2	2	8	8		
De Vries, EB	1	12	12			2	2				
Mini, C	1	12	12			1	2	8	8		
Mkhumane, N	1	12	12	4	5	2	2				
Moloko, C	1	11	12			2	2	1	1		
Ntsinde, N	1	12	12			2	2	8	8		
Phophi, E		7	8	1	1	1	2				
Roux, S	1	12	12			2	2	8	8		
Theledi, N	1	11	12			1	2				
Van Zyl, K	1	12	12	5	5	2	2				
Goolab, G (Principal Officer)	1	12	12	2	5	2	2	7	8	1	2

Governance Risk and Ethics Committee meetings		Operations Committee meetings		Investments Committee meetings		Remuneration Committee meetings		Training		Workshops		Other Scheme engagements	
A	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
				4	4			12	-	2	2	-	-
4	5	8	8	2	4			8	-	2	2	-	-
5	5							8	-	2	2	2	
4	5					4	5	10	-	2	2	-	-
		6	8					12	-	2	2	2	-
				4	4			7	-	2	2	2	-
				4	4	4	5	11	-	2	2	-	-
		8	8					11		2	2	1	-
		2	2	1	1	1	1	4	-	1	1	-	
5	5							12	-	2	2	-	-
		8	8			5	5	7	-	2	2	1	-
						5	5	11	-		2	1	-
2	5	7	8	3	4	5	5	8	-	1	1	-	-

GEMS Independent Committee Members' Attendance of Board and Committee meetings

A – Meetings attended
B – Meetings that could be attended

		Board meetings		Audit Committee meetings		Benefit Committee meetings		Clinical Governance and Ex Gratia Committee meetings		Dispute Committee	
Member	**AGM**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Davids, M										2	2
Eksteen, R				5	5						
Ford, P										2	2
Sukati, M	1	8	10	5	5						
Msiza, F				4	5						
Lungile, Z										1	1
Chikane, F										1	1

	Governance Risk and Ethics Committee meetings		Operations Committee meetings		Investments Committee meetings		Remuneration Committee meetings		Training		Workshops		Other Scheme engagements	
A	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
								-	-	-	-		
								-		-	-		
								-	-	-			
								3	-				

2017 **Remuneration** Report

The Board resolved on 28 February 2017 to adopt the King IV Report on Corporate Governance with effect from 1 January 2018. During 2017, the King IV Report was used as a best practice guide.

The Scheme has a dedicated Board Committee that is responsible for overseeing remuneration, inclusive of Trustee and Independent Committee members' remuneration, remuneration of Executives and general staff and related matters. Information on the mandate, composition and attendance of meetings held by the Remuneration Committee in 2017 is provided on page 146 of the Report.

The Board reviewed the GEMS Standing Committee Structure in 2017. The Committee was reconstituted as the GEMS Human Resources and Remuneration Committee with a revised formal Terms of Reference. The Board of Trustees finalised the Terms of Reference and the membership composition on 5 December 2017, effective 1 January 2018.

The key factors that influenced remuneration decisions during 2017:

- The financial performance of the Scheme has had an influence on the performance management process and in turn employee performance bonuses for senior managerial employees.
- The current economic climate continues to play a key role in determining annual remuneration adjustments, as this has an influence during salary benchmarking processes. The Consumer Price Index (CPI), the salary market and salary benchmarking also had an impact, as these factors are taken into consideration when determining annual remuneration adjustments.
- The responsibility of the Board to ensure that remuneration is fair, equitable and justifiable found expression in the approval of salary increases based on a sliding scale for General Staff, Senior Managers and Executive Management. Special consideration was given to the position of the lowest paid employees.
- The Board of Trustees remained considerate of views expressed by the members and Stakeholders of GEMS in respect of the trustee remuneration.

The key focus areas and key decisions of the Remuneration Committee in 2017 summarised:

- The Remuneration Committee played a key role in determining the 2018 annual salary adjustments for GEMS employees.
- The revision of the GEMS Recruitment and Employee Relations Policies was overseen by the Remuneration Committee.
- The Trustee and Independent Committee Member meeting fees were reviewed and approved for implementation in January 2018.
- In respect of the governance of remuneration, the Committee considered the application of the Principles and Business Practices as contained in the King III Report.

Future areas of focus include a comprehensive revision of the Trustee and Independent Committee Member Remuneration Policy with a view to ensure that the basis for calculating fees remains fair, equitable and justifiable.

The GEMS Employee Remuneration Policy was revised in 2015 and the new policy was approved by the Board of Trustees on 8 December 2015 for implementation on 1 January 2016. No changes were made to the policy in 2017.

Remuneration consultants were used in the remuneration benchmark analyses performed in relation to General Staff, Senior Managers, Executive Management and the Principal Officer under the auspices of the Remuneration Committee in 2017. The Remuneration Committee approved the Terms of Reference of the organisation appointed to perform the remuneration benchmark analyses. The work was allocated to an organisation that is well versed and experienced in this area and the Remuneration Committee is satisfied with their independence and objectivity.

Employee Remuneration

Meeting the stated remuneration policy objectives

The GEMS Employee Remuneration Policy has met its stated policy objectives in that it supports the Scheme's commitment to attracting and retaining highly-skilled talent. The total reward packages and benefits offered contributed to attracting and retaining key talent. This can be seen from the low staff turnover rate of 5.4% that was recorded for the 2017 financial year. The calculation of the turnover rate of 5.4% includes the seven employees who left the Scheme as a result of the tender investigation concluded in 2017 (refer to the Chairperson's Overview on page 12 of the report). The GEMS performance management process further entrenches this commitment as we continue to reward high performers within the organisation.

Future areas of focus

The GEMS Employee Remuneration Policy continues to evolve as the Scheme seeks to ensure that employees are paid according to market standards while also being cognisant of the current economic environment. The success of the new GEMS Five-year Strategic Plan is dependent on the Scheme's ability to attract and retain highly-skilled talent. GEMS strives to be an employer of choice and the policy is under review to ensure that it optimally supports the implementation of the Scheme's new Five-year Strategic Plan. Key future areas of focus are pay structuring and the review of pay scales.

Overview of GEMS Employee Remuneration Policy

The Board of Trustees determines the remuneration and reward structures of GEMS employees in keeping with the provisions of the GEMS Employee Remuneration Policy and has the duty to ensure that employees are appropriately compensated. The Board adopted a remuneration philosophy and strategy in 2013. The Scheme's remuneration philosophy reflects GEMS' commitment to attracting and retaining highly-skilled, high-performing employees that enable the Scheme to maintain and improve on its performance. The remuneration philosophy is aligned to the Scheme's business strategy, objectives, values and achieving long-term sustainability. The GEMS Employee Remuneration Policy is also aligned to the Scheme's remuneration philosophy and strategy.

GEMS is committed to developing, implementing and upholding remuneration strategies and practices which support the vision, mission, values and strategic objectives of the Scheme, while pursuing the best interests of GEMS. The Scheme seeks to ensure that remuneration is fair, equitable and justifiable.

In determining the appropriate level of remuneration for each staff member, all posts are graded based on the requirements of the position. The relevant grading is used during the annual staff remuneration benchmarking exercise to determine if the level of remuneration for each position is in line with benchmarked levels. The results of the annual benchmarking exercise are considered by the Remuneration Committee for recommendation to the Board.

Remuneration is provided to employees in the form of guaranteed and variable pay. Guaranteed remuneration includes basic salary and benefits. Variable remuneration is aligned to the achievement of business objectives and individual performance.

GEMS' targeted pay level for permanent employees is up to the 50th percentile of the benchmark used for employees who meet the required qualifications, experience and other job requirements. Where necessary, for strategic reasons, the Scheme may remunerate an employee at a remuneration package above the 50th percentile. To this end, the Principal Officer, with the approval of the Board of Trustees, may offer a package that is above the market median to a candidate considered to be of strategic importance to GEMS, or who has scarce or critical skills.

The Scheme aims to attract, retain and motivate Executives of the highest calibre, while at the same time aligning their remuneration with member interests and best practice. The Scheme rewards Executives for their contribution to the strategic, operational and financial performance of the Scheme and ensures that remuneration is conducive to developing and retaining top talent and critical skills. A decision was taken by the Board on 31 October 2017 to convert the employment contracts of GEMS Executives to fixed-term contracts of five years.

The Principal Officer's remuneration package is determined by the Board of Trustees with due consideration to the Scheme's financial performance, the Principal Officer's role and responsibilities, and the strategic imperatives of the appointment. The package may not exceed the remuneration packages attached to the upper quartile.

With effect from 1 January 2014, employees contribute to a compulsory retirement and risk arrangement in the form of a provident fund. Employees are allowed to choose their contribution rate on a scale of 5%, 6% or 7.5%. The employer matches the employee contribution rate. Under this arrangement, employees also have funeral cover, group income protection and group life cover. A medical assistance subsidy was introduced with effect from 1 August 2015 for GEMS employees. The medical assistance subsidy is adjusted on 1 January each year in accordance with medical price inflation.

The GEMS performance framework and measures

To assess the achievement of strategic objectives and positive outcomes, the Scheme uses a standardised and integrated Three-tiered Performance Management System. A standardised balanced scorecard is used to measure performance in four areas, namely:

- Internal Business Performance
- Customer/Stakeholder Management Performance
- Financial Performance
- Learning and Growth

The GEMS balanced scorecard is a key performance management tool to measure outputs and results against key performance indicators that are linked to the GEMS strategic objectives.

The system ensures that performance is measured holistically at three organisational levels i.e., Scheme level, divisional level and individual employee level as follows:

- The Principal Officer's performance is measured on the achievement of the Scheme Strategic Plan .
- Executives are measured on the achievement of Divisional Business Plans aligned to the Scheme Strategic Plan.
- Employees below Executives are measured on their job profiles and the achievement of operational business plans that are aligned to Divisional Business Plans.

Annual employee performance contracting and assessment is done on the basis of performance scorecards made up of key performance areas and competencies. Key performance areas are aligned to the Scheme's strategic objectives and competencies are based on occupational levels. The allocation of weightings in respect of key performance areas and competencies is depicted below:

Level of Management	Key Performance Areas	Core/Managerial Competencies	Total Weight in % of 100
Principal Officer	60%	40%	100
Executives	70%	30%	100
Senior Management	80%	20%	100
Other Employees	90%	10%	100

The allocation of weightings will be adjusted and 10% will be allocated to measure employees' performance in relation to the Scheme's values.

We strive to improve employee contribution to the Scheme's performance by linking rewards and recognition with performance management outputs. Employees are eligible and considered for performance rewarding in recognition of sustained performance that is significantly above expectations. For the Principal Officer and Executives, the awarding of performance bonuses is dependent upon the achievement of a minimum individual performance rating, an unqualified audit report, the achievement of a surplus and a complaints ratio approved by the Board.

An illustration of the potential consequences on the total remuneration for executive management of applying the GEMS Performance Management Policy under minimum, on-target and maximum performance outcomes is below:

Performance bonus percentage	0%	6%	20%
Total including annual remuneration	R21,368,319	R22,650,418	R25,641,982

Remuneration benchmarks

Like other organisations, GEMS strives to attract and retain key talent, thereby driving forward its business strategy with the right people. The risk of losing key talent is high in most organisations. Variations in pay is one of the key determinants in retaining or losing key individuals. It is not possible for organisations to determine if pay practices are aligned with other organisations if a benchmarking exercise is not completed. The need for benchmarking therefore becomes important in identifying pay practices in the market and aligning those to the GEMS pay practices. The GEMS benchmarking process is conducted against the healthcare, financial and national industries as our products and services compare well to these.

Executive remuneration in 2017

	Annual earnings	Bonus	Total remuneration 2016	Total remuneration 2017	Conversion package paid in Dec 2017***
Guni Goolab	R4,434,333	Not yet available	R4,223,174	**R4,434,333**	N/A
Bella Mfenyana	R2,289,588	N/A	R2,170,226	***R953,995**	N/A
Karyna Pierce	R2,966,891	R356,027	R2,812,219	**R3,322,918**	R1,255,030
Liziwe Nkonyana	R2,097,234	N/A	R1,987,899	****R699 078**	N/A
Jeannie Combrink	R2,097,234	R251,668	R1,987,899	**R2,348,902**	R967,805
Gloria Nkadimeng	R1,790,777	R214,893	R1,697,419	**R2,005,670**	R275,462
Sam Lewatle	R1,879,870	R225,584	R1,781,867	**R2,105,454**	R289,166
Molapo Masekoameng	R1,727,662	R207,319	R1,637,594	**R1,934,981**	R265,753
Vuyokazi Gqola	R2,084,730	R250,168	R1,976,047	**R2,334,898**	R240,509
	R21,368,319	**R1,505,659**	**R20,274,344**	**R20,140,229**	**R3,293,725**

* Pro-rata salary – resigned 30 April 2017
** Pro-rata salary – resigned 31 May 2017
*** A decision was taken by the Board of Trustees during 2017 to amend the Terms and Conditions of Employment of Executive Management employees. Permanent contracts of employment were converted to five-year fixed-term contracts effective 01 January 2018. This resulted in the payment of a conversion package calculated as two weeks' salary (cost to company package) in lieu of every full year worked.

Compliance statement

The Scheme complied with its approved Employee Remuneration Policy in 2017 and no deviations from the policy were reported.

The GEMS Performance Management Policy is still being implemented. The Scheme complied with the components of the policy that have been implemented and no deviations from the policy were reported.

Trustee remuneration

Overview of GEMS Trustee and Independent Committee Member remuneration policy

Trustees and Independent Committee Members are remunerated for attendance of Board of Trustees meetings and meetings of Committees of the Board.

Trustees and Independent Committee Members may also be reimbursed for costs incurred in respect of travelling and subsistence in the performance of their obligations. The Scheme commissions independent remuneration surveys to ensure that the remuneration paid is commensurate with the fiduciary obligations assumed by Trustees and the expertise of Trustees and Independent Committee members.

Trustees and Independent Committee members are remunerated for meeting preparation and attendance. Trustees and Independent Committee members are not remunerated for the following:

- Meetings not attended;
- Participating in the Scheme's Board Effectiveness Assessment;
- The attendance of training sessions;
- The attendance of Scheme events where trustees are not required to perform work; and
- The attendance of member and stakeholder information and communication sessions such as lekgotlas .

Trustees and Independent Committee Members are paid a fixed daily meeting fee for each day spent in a meeting for Quarterly and Interim Meetings. The fixed daily meeting fee is based on an average meeting duration time of 6 hours and 12 hours preparation time. Trustees are paid a reduced daily meeting fee for the attendance of ad hoc meetings.

For meetings with the Minister for the Public Service and Administration and stakeholders, the fixed meeting fee is not applied. To remunerate Trustees for the attendance of such meetings, the fixed

meeting fee is converted to an hourly fee and remuneration is calculated as follows: Number of hours in meeting +1 hour preparation time for each hour spent in the meeting.

Trustees receive a monthly stipend to cover expenses such as stationery, telephone and internet fees.

The remuneration of the Chairperson of the Board and Chairpersons of the Committees (including the Independent Chairpersons of the Audit Committee and the Dispute Committee) is calculated as the trustee fixed daily meeting fee x1.5.

The GEMS Trustee and Independent Committee Member Remuneration Policy was reviewed by the Board in 2017.

Remuneration benchmarks

Trustee Remuneration benchmarking is conducted using the comparisons of remuneration from at least 10 of the largest closed and open medical schemes in the industry.

The fixed daily meeting fee of Trustees has been increased for the first time since 2014 by means of a Board decision taken on 5 December 2017. An inflationary increase of 5% will be implemented with effect from 1 January 2018.

Trustee remuneration 2017

The remuneration paid in 2017 per Trustee is shown from page 166. Meeting fees, travel and accommodation costs, training costs and other disbursements are disclosed separately per trustee in accordance with Regulation 6A of the Regulations made under the Medical Schemes Act, 1998, as amended.

The total amount of trustee remuneration paid in 2017 was R8,632,000, representing an increase of 14.45% compared to 2016. Of the total amount paid in 2017, R7,124,000 (83%) was paid in respect of meeting fees and the monthly stipend. The balance represents travel and accommodation costs related to the attendance of meetings and fees paid to trainers.

The increase in trustee remuneration in 2017 is mainly informed by additional Board meetings to deal with the investigation into corrupt activities by Scheme employees and contracted providers. The Board conducted four ad hoc meetings for this purpose. Trustee remuneration paid in respect of the meetings was R870 000.

The GEMS Trustees undertook additional duties on a voluntary basis during the course of 2017 to represent the Scheme at important stakeholder events and to support Scheme Management in important meetings with key stakeholders such as unions, the large hospital groups and the board members of some of the Scheme's contracted administrators. Board members also attended meetings with the Council for Medical Schemes and the forensic investigators appointed to conduct the various tender and forensic investigations.

Trustees attended the Scheme's CSI events scheduled to coincide with the AGM and Symposium. Trustees did not receive remuneration for undertaking these obligations, representing an estimated cost saving of R1,374,600 in 2017 to the Scheme.

In 2017, trustee fees expressed as a percentage of contributions was 0.02%. Expressed as a percentage of the Scheme's non-healthcare costs, it was 0.43%.

The GEMS Board of Trustees and the Committees meet frequently to ensure effective oversight of the Scheme. The meetings held by the GEMS Board of Trustees and the Committees appointed by the Board are all necessary and convened in order to:

- Meet the Scheme's statutory obligations;
- Adhere to corporate governance standards;
- Address matters related to the Scheme's business model and requirements; and
- Guide Scheme Management in respect of stakeholder engagements considering the Scheme's complex stakeholder relations environment.

The close level of oversight maintained by the Board is an important factor in the Scheme's continued financial and operational performance, as evidenced by the Scheme's track record of unqualified audits, sound procurement processes, responsiveness to member concerns and sound stakeholder relationships.

A further explanation on the number of meetings held by the GEMS Board of Trustees and the Standing Committees is outlined below to provide Members with a view on the statutory obligations fulfilled and the value derived from the meetings.

Board Meetings

At least eight meetings are required each year to meet the requirements below	
Legal Requirements	Four quarterly meetings, i.e. in February, April, July and October, to review performance for the previous quarter in keeping with the registered GEMS Rules. The Board also disposes of other business requirements at the quarterly meeting, such as approving the Scheme's audited annual financial statements.
	A meeting in June every year to approve the AGM agenda as required by the registered GEMS Rules. The Board also disposes of other business requirements at the June meeting.
	A meeting in September every year to finalise benefit design and pricing for submission to the CMS, in keeping with regulated timeframes. The Board also disposes of other business requirements at the September meeting.

Business Requirements	A two-day strategic planning meeting in September every year.
	A meeting in December every year to finalise the annual revision of the Standing Committees' Terms of Reference, the Standing Committees' Composition, the revision of the Principal Officer Delegations, employees' salary adjustments for the next year and operational mandates required by the Scheme.
	In trustee election years, two additional meetings are required to approve election procedures and to receive the election reports required in keeping with the GEMS Rules.
	Tender adjudication meetings are scheduled to coincide with existing scheduled meetings.
	Special (ad hoc) meetings are scheduled from time to time to deal with urgent matters. In 2017, the Board conducted four ad hoc meetings focused on the investigations into corrupt activities by GEMS employees and contracted providers. The combined annual value of the contracts cancelled or terminated as a result of the investigations is R200 million. Thus, in dealing with these difficult matters in 2017, the Board positively impacted on the Scheme's ability to create value for Members.

Committee Meetings

In 2017, the Board of Trustees was supported by seven Committees as described on pages 140 to 147 of the Governance Report. The Committees provided for in the Scheme's Standing Committee Structure are necessary to comply with legal requirements, good corporate governance standards and to meet the Scheme's business requirements, as shown below.

Legal Requirements and King IV Report	
Audit Committee	Section 36 of the Medical Schemes Act, King IV Principle 51
Dispute Committee	Section 29(j) of the Medical Schemes Act, GEMS Rule 30
Remuneration Committee	King IV Report, Principle 8, Practice 65

Business Requirements and Good Corporate Governance Standards	
Committee	**Value Creation**
Audit Committee	The Audit Committee supported the Board in ensuring that the Scheme's control environment is sound. The Audit Committee oversees the work performed by the Scheme's assurance structures and plays an important role in protecting the interests of the Scheme's beneficiaries.
Clinical Governance and Ex Gratia Committee	The Committee met every eight weeks in 2017 and meetings took place over two days due to the Committee's high case load. The work performed by this Committee contributed significantly to value creation for members. In 2017, ex gratia payments to the value of R27.4 million were approved by the Committee. In 2017, the Committee was also responsible for overseeing the implementation of the Scheme's Strategic Plan Objectives, relating to Healthcare Management and the development of the Scheme's product development and benefit design for 2018.
Dispute Committee	The Dispute Committee supported the Board in ensuring that the Scheme's dispute resolution process is sound and is applied consistently and correctly. The Dispute Committee also plays a valuable role in ensuring that persons referring disputes for adjudication are treated fairly and equitably.
Governance, Risk and Ethics Committee	The Committee met once per quarter to oversee the Scheme's risk management function, stakeholder management activities, the Scheme's ethics performance, the Scheme's compliance to the applicable regulatory framework, trustee training and the Scheme's rule review processes. The existence of a Board Committee overseeing risk management is also in line with King IV.
Investment Committee	The effectiveness of the Scheme's investment strategy has a significant impact on the Scheme's financial performance. The Committee met once per quarter to keep the Scheme's investment activities, compliance to the relevant provisions of the Medical Schemes Act and investment performance under close review. This included the investment performance of members' personal medical savings account funds.
Operations Committee	This was a unique Committee in the Scheme's Governance Structure. The Scheme's business model, is unique in the medical schemes industry and the Committee assisted the Board by guiding and overseeing the development of the Scheme's strategic plan and by maintaining close oversight of the Scheme's services, procurement and contracting functions. The Committee also kept the implementation of the Scheme's Supply Chain Management Policy under close review and monitored the impact of the policy on the Scheme and the society within which the Scheme operates. The Committee monitored the Scheme's financial and operational performance as well as the member communication output of the Scheme. The close level of oversight maintained by the Operations Committee was instrumental in maintaining the Scheme's low non-healthcare costs.
Remuneration Committee	The Remuneration Committee assisted the Board in ensuring that the Scheme's remuneration policies and practices are fair, responsible and transparent. The Committee ensures that the Board's consideration of remuneration matters is informed by objective and independent reviews.

Five of the seven Committees – the Audit Committee, the Governance, Risk and Ethics Committee, the Investment Committee, the Operations Committee and the Remuneration Committee – met once a quarter to review performance in the quarter and to formulate recommendations for the Board's consideration. In addition, the Audit Committee, Operations Committee and Remuneration Committee each conducted additional meetings in 2017 for specified purposes such as the finalisation of the Scheme's annual financial statements and developing recommendations to the Board on annual remuneration adjustments. The Clinical Governance and Ex Gratia Committee met every eight weeks to consider member applications for ex gratia assistance. The Dispute Committee meets at least once per year. Additional meetings depend on the referral of disputes to the Committee by Members.

In summary, the value realised over time by the Scheme's corporate governance structure and practices is:

- A sophisticated ex gratia system to assist members in need.
- A 12-year track record of unqualified audits.
- The lowest non-healthcare costs in the industry.
- A unique business model and Supply Chain Management Policy that supports B-BBEE.
- A rigorous procurement system that supports the successful execution of the Scheme's business model.
- A rigorous strategic planning process.
- Corporate governance systems and processes that are in line with best practice.
- A stakeholder inclusive approach that contributes to the Scheme's sustainability over time.

Travel and accommodation expenditure

Five of the twelve Trustees do not reside in Gauteng. Travel and accommodation costs for these Trustees to attend meetings at the Scheme's Head Office are therefore higher:

- Mr CJ Booyens
- Dr JA Breed
- Mr EB de Vries
- Mr JS Roux
- Dr IJ van Zyl

The Board is also remunerated for incidental expenditure relating to the performance of their duties as trustees and for this purpose, a fixed stipend of R1,150.00 per month was paid in 2017.

Trustee remuneration paid

	Appointed or Member Elected	Attendance fees		Travel and accommodation		Reimbursement and allowances		Training (fees paid to trainers)		Total	
		2017 R'000	2016 R'000	2017 R'000	2016 R'000	2017 R'000	2016 R'000	2017 R'000	2016 R'000	2017 R'000	2016 R'000
Mr DJ de Villiers Re-elected July 2013 – term expires 29 July 2019	Elected	711	640	60	48	1	1	7	14	779	703
Mr ZC Rikhotso (Chairperson) Re-appointed September 2013 – resigned 31 July 2016	Appointed	-	214	-	59	-	1	-	11	-	285
Mr JS Roux Re-elected July 2014 – term expires 29 July 2020	Elected	658	605	367	339	15	10	9	3	1,049	957
Mr NL Theledi Re-appointed September 2013 – term expires 26 September 2019	Appointed	478	431	74	47	7	3	7	2	566	483
Mr CJ Booyens Elected July 2013 – term expires 29 July 2019	Elected	641	623	91	68	24	22	3	2	759	715
Mr EB de Vries Elected July 2013 – term expires 29 July 2019	Elected	443	397	325	278	16	17	16	5	800	697
Ms NM Ntsinde (Chairperson) Appointed July 2013 – term ended 6 Feb 2018	Appointed	924	840	91	48	12	7	12	75	1,039	970
Dr CM Mini Appointed July 2014 – resigned 15 Dec 2017	Appointed	845	814	73	23	27	17	7	54	952	908
Dr JA Breed Elected July 2014 – term expires 29 July 2020	Elected	523	466	122	95	27	15	1	3	673	579
Dr IJ van Zyl Elected July 2014 – term expires 29 July 2020	Elected	502	475	111	55	32	14	16	3	661	547
Ms NH Mkhumane (Deputy Chairperson) Appointed September 2014 – term ended 6 Feb 2018	Appointed	535	518	70	-	3	1	12	55	620	574
Mr EM Phophi Appointed September 2017 – term expires 25 September 2023	Appointed	252	-	18	-	3	-	10	-	283	-
Dr ET Moloko Appointed October 2016 – term expires 27 October 2022	Appointed	448	124	74	-	9	-	16	-	547	124
Total		**6,960**	**6,147**	**1,476**	**1,060**	**176**	**108**	**116**	**227**	**8,728**	**7,542**

Value Statement and Ethics

Good corporate governance is regarded as critical to the success of the business of the Scheme and the Board and Scheme Management is unreservedly committed to exercising ethical and effective leadership. In so doing the Board strives to cultivate and exhibit the characteristics of integrity, competence, responsibility, accountability, fairness and transparency in all dealings by, in respect of and on behalf of the Scheme.

Structures and processes

The role of the GEMS Board of Trustees: The Board is responsible for exercising ethical leadership and assumes responsibility for the governance of ethics by setting the direction for how ethics should be approached and addressed by the Scheme in all its dealings.

The Board of Trustees reviews the Scheme's vision, mission and value statements on an annual basis to ensure that the Board's commitment to building and sustaining an ethical organisation is adequately reflected therein.

The GEMS Risk Social and Ethics Committee is responsible for supporting the Board in ensuring effective oversight of, and reporting on, organisational ethics in GEMS. The Committee is specifically responsible for supporting the Board in ensuring that the Scheme's Ethics Policy, Codes of Conduct and ethics management programmes:

- Encompass the Scheme's interaction with internal and external stakeholders and society in general;
- Address the key ethical risks of the Scheme; and
- Provide for arrangements that familiarise the employees and other stakeholders with the ethical standards of the Scheme.

The Committee is further responsible for supporting the Board in exercising ongoing oversight over the management of ethics in the Scheme.

Conflict of interest, skills requirements as well as fit and proper criteria for GEMS Trustees are addressed in the registered Rules of GEMS. In the Rules, the same requirements regarding conflict of interest that are applicable to Trustees also apply to GEMS Chief Officers.

Scheme Management discuss ethics and values and is responsible for designing and implementing policies and processes to achieve sound ethics management. Scheme Management submits policies to the Board for approval and accounts to the Board in respect of the implementation of policies designed to achieve effective ethics management. In 2017, ongoing focus was placed on leadership collaboration and shared accountability.

An overarching GEMS Ethics Policy is in place which sets the tone for the various policies, measures and mechanisms used to ensure that Trustees, employees and contracted service providers meet the ethical expectations of the Scheme. These include measures on the acceptance of gifts; a GEMS Supply Chain Management ethics procedure consisting of the Supply Chain Management Code of Conduct; a declaration of interest process for all role players and the independent proactive monitoring of procurement processes above the informal quotation threshold by the Scheme's internal auditors.

GEMS applies a Procurement Conflict Matrix to specify which specific contracts may not be awarded to the same service provider. This enhances governance and is applied where there is a perception of bias if the service provider executes both contracts, where there is a conflict due to legal restrictions or conflict of interest restrictions should both contracts be executed by the same service provider. Examples hereof are the internal and external audit service providers, the GEMS procurement service provider and the GEMS vetting provider.

GEMS makes use of its appointed internal auditors to render procurement oversight to further enhance procurement governance. All procurement processes initiated and concluded during 2017 were declared free, fair, transparent and in line with the Scheme's Supply Chain Management Policy.

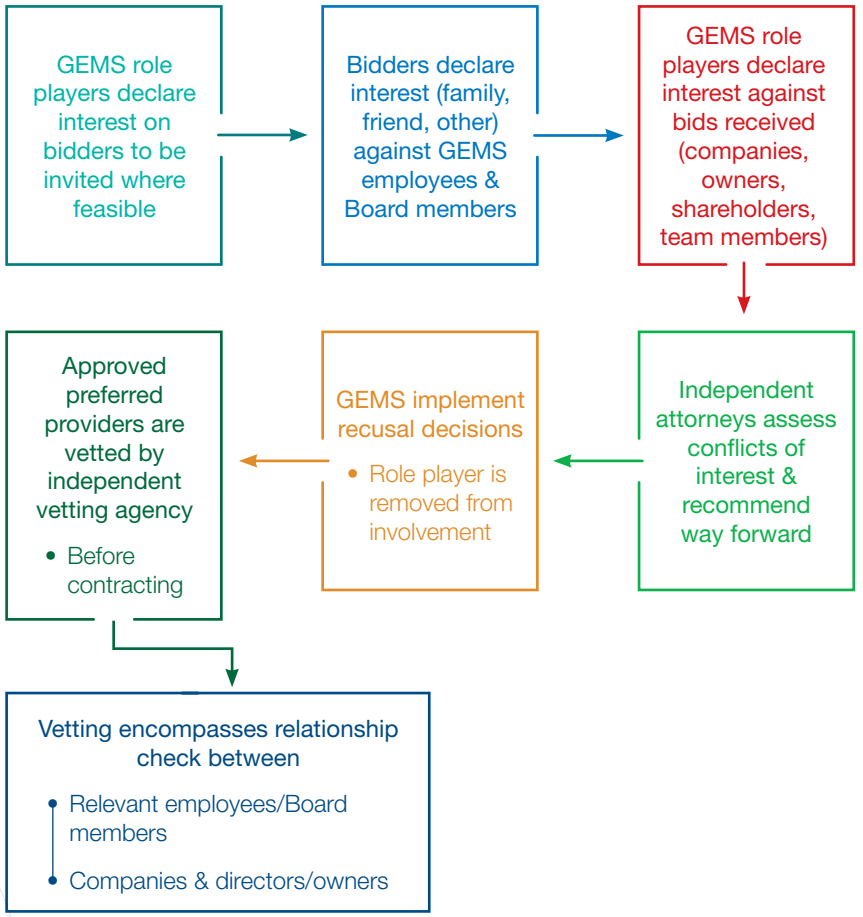
Key focus areas in 2017

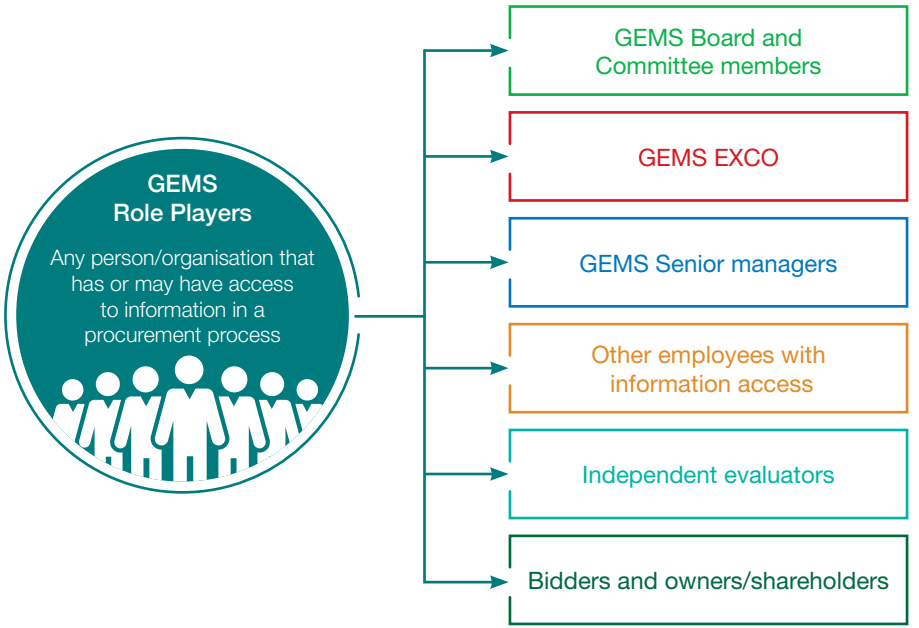
The investigation into tender irregularities which occurred in the Scheme in the period of 2014 to 2016, revealed weaknesses in the GEMS policy environment and institutional capacity for preventing, detecting and managing ethical breaches and corruption by Scheme Officers.

The main focus area in 2017 was to address shortcomings in the Scheme's policy environment and governance structure arrangements. The GEMS policies governing Supply Chain Management; Ethics Management; Vetting of Scheme Officers; and Recruitment and Selection were all revised based on an internal gap analysis as well as issues reported in the forensic tender investigation reports. The Principal Officer of GEMS engaged with employees in staff training and information sessions to provide updates on the tender investigation and to communicate the Scheme's expectations regarding ethical conduct and embracing the Scheme's values.

The Scheme's operations are based on a high level of outsourcing and this makes the GEMS Supply Chain Management Policy a critical component in ethical governance. The Board currently reviews the policy at least once annually.

The new GEMS Supply Chain Management ethics procedure is based on an extensive declaration of interest and vetting process.





Under the enhanced Supply Chain Management Policy aimed at managing specific conflicts of interest, GEMS has introduced the principle of a cooling-off period. GEMS will not consider the bid of a person who was an employee of GEMS, a GEMS Board Member or an Independent Committee member within a 12-month period prior to the closing date of the bid to which the person wanted to respond. This includes bids from organisations where such employee or Board/Committee member is an owner/shareholder or where such person is a team member for the bid submitted.

Other key changes on the GEMS policy environment:

- A new Whistle-blowing Policy was approved by the Board of Trustees on 5 December 2017.
- A key change in the GEMS Ethics Policy is an enabling provision for lifestyle audits on Scheme officers.

The Scheme commenced with the implementation of a Whistle-blowing Programme that includes the establishment of a structure for the reporting and investigation of unethical and corrupt conduct by Scheme Officers in 2017. An internal whistle-blowing hotline, managed by an independent provider, will become operational in 2018. The Board has allocated the responsibility for overseeing forensic investigations into the activities of Scheme Officers to the GEMS Audit Committee with effect from 1 January 2018.

Governance of
Data and Information

Structures and processes

The Scheme's approved Information and Communication Technology (ICT) Governance Framework encompasses two levels of decision-making, authority and accountability:

- Oversight by the Board of Trustees supported by the Finance and Investment Committee.
- Planning, implementation and monitoring are the responsibilities of Executive Management.

ICT has become an integral part of doing business, at GEMS today, as it is fundamental not only to the achievement of GEMS strategic objectives but also to the growth and sustainability of GEMS.

We recognise that ICT cuts across all aspects, functional components and processes in business. It is not only an operational enabler but an important strategic enabler that can be leveraged to create business sustainability and competitive advantage. ICT can be leveraged by the Scheme to create a platform that could form part of the blueprint for NHI.

Whilst it is a strategic enabler, ICT also presents a significant risk from a cost and implementation perspective. It is imperative to ensure that ICT risk and constraints are well governed and controlled to ensure that it does indeed support the strategic objectives of GEMS, hence the ICT Governance Framework.

The adoption of an ICT Governance Framework is based on several methodologies, standards, tools and good practices that will ensure prudent management of GEMS resources, compliance to good practice and value creation from ICT for GEMS.

The main standards and best practices that are referenced in the GEMS ICT Governance Framework are as follows:

ICT Governance

- COBIT: Control Objectives for Information and related Technology which is a good-practice framework created by international professional association ISACA for information technology (IT) management and IT governance.
- ISO 38500: Corporate Governance of IT Standards: An international standard for corporate governance of information technology, providing a framework for effective governance of IT to assist those at the highest level of the Scheme to understand and fulfil their legal, regulatory and ethical obligations in respect of the use of IT in the Scheme.

Information Security Management

- ISO 27001/2 Information Security Standard which is a specification for an information security management system (ISMS). An ISMS is a framework of policies and procedures that includes all legal, physical and technical controls involved in an organisation's information risk management processes.

Key focus areas during the reporting period

- Enabling the Scheme to be the custodian of its own data;
- Insourcing key capabilities;
- Creating a platform for access to reports and analytics;
- Sourcing of infrastructure hosting services of Intelligems test, quality assurance, pre-production and production environments;
- Procurement of Servers, Server Rack and Storage Area Network (SAN) for GEMS;
- Procurement of a Content Management Solution and implementation of a modernised GEMS website;
- Continued implementation of the ICT Governance Framework;
- Enhancing the overall member experience through implementation of the ICT Strategy: Intelligems Phase 2 by rolling out:
  - An Enterprise-wide Resource Planning solution;
  - A Customer Relationship Management solution; and
  - A Multichannel solution.

Updating the ICT Governance Framework to apply the King IV Report on Corporate Governance for South Africa 2016 is a current focus area.

The impact of digital development on GEMS' performance, current operations and future strategic objectives

The standard of services rendered by contracted service providers impacts on our performance and operations. Our contracted service providers have their own digital solutions subject to different renewal cycles and running on different technologies which are at different stages of development. Whilst by and large this environment has been functioning as required and services are being delivered to members, alignment is impacted on by technological refreshes necessitated by digital developments as well as the speed of technological change.

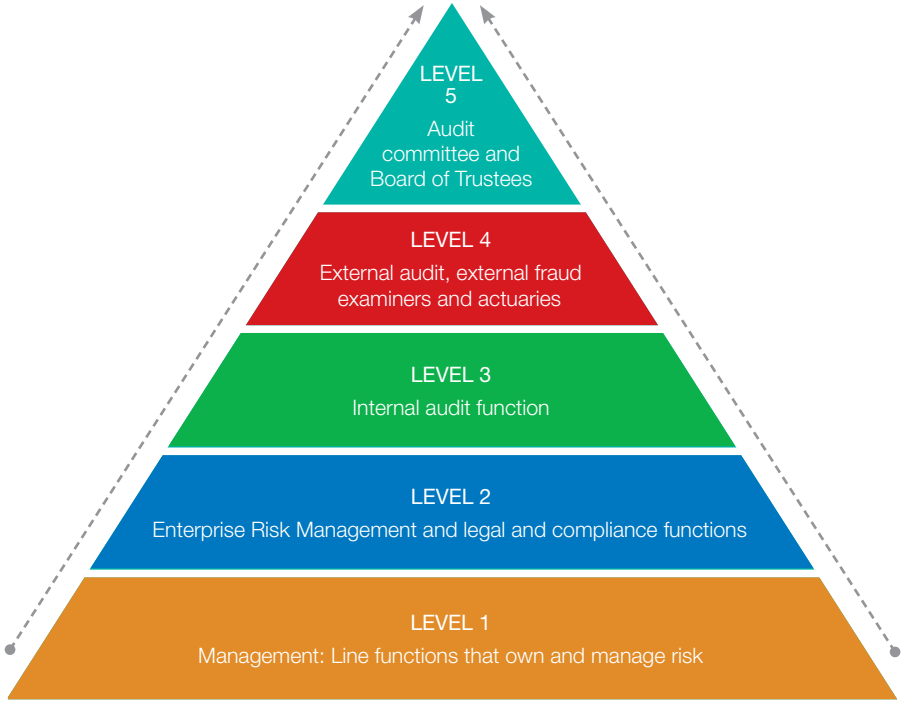
Our future strategic objectives call for a fast, flexible and collaborative approach that leverages the pace of technological developments to enable the Scheme to scale to the level of being able to address key strategic issues such as those surfaced by the imminent National Health Insurance (NHI); trends in the medical scheme industry such as increasing healthcare costs; changing member behaviour and the increased burden of disease. The approach must exploit digital developments to continue meeting member needs for quality, accessible and affordable healthcare through empowering both the Scheme and its Members with accessibility to up-to-date information anywhere, anytime, anyhow through the deployment of innovative healthcare solutions. It is imperative that the Scheme exploits the current nexus of forces: social, mobile, cloud, information and analytics to achieve the strategic objectives of the Scheme as contained in the GEMS 2017-2021 Strategy.

Structure and processes for
Compliance Management

As part of the primary responsibilities of the GEMS Board of Trustees as stipulated in the GEMS Board Charter, the Board has to set and steer the Scheme's approach to the governance of compliance. The Board must specifically ensure that compliance is understood, not only as an obligation, but also as a source of rights and protection.

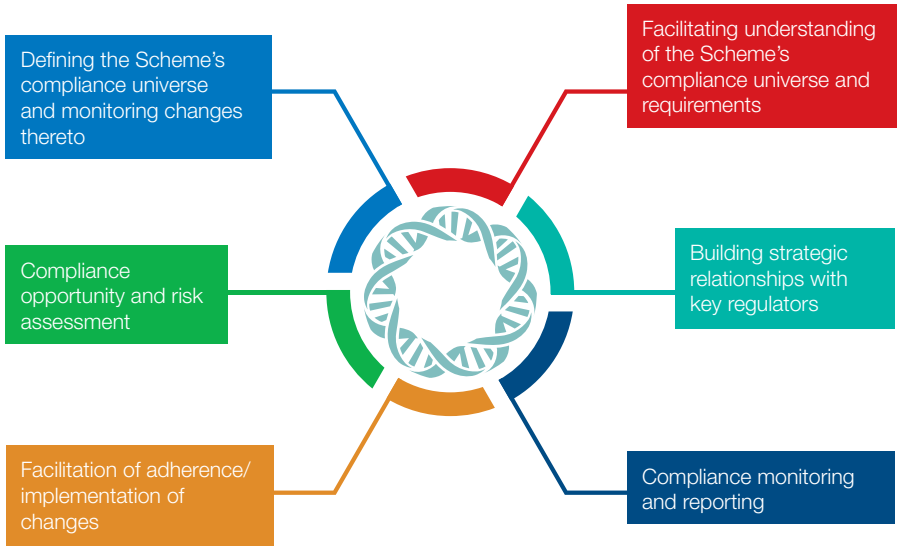
The GEMS Compliance Function reports to the Audit Committee and the Risk, Social and Ethics Committees of the GEMS Board. More information on the composition of the Audit Committee and the Risk, Social and Ethics Committee and a summary of the Committees' responsibilities can be found from page 140 of the Report.

The Compliance Function forms part of the second line of assurance in the Scheme's combined assurance framework:



The Compliance Function is located within the Governance and Compliance Division of the Scheme and is represented on the Scheme's Combined Assurance Forum that is convened by the Chief Audit Executive.

The broad approach to Compliance Management in the Scheme is outlined below:



The Scheme has established a Governance and Compliance Forum, comprising all of the members of the Scheme's Service Provider Network. The Forum supports the Scheme in monitoring and complying with its compliance universe, including (but not limited to) the GEMS Rules and applicable legislation. The Forum is convened by the Scheme on a quarterly basis.

The main key focus areas for 2017 were:

- Preparing for compliance to the Protection of Personal Information Act.
- Addressing non-compliance to the GEMS policies that regulate ethics management in the Scheme.

- Addressing the underlying causes of non-compliance to statutory obligations relating to the payment of Prescribed Minimum Benefit claims and the classification of claims as stale claims by the Scheme's Service Provider Network.
- Providing guidance to the Scheme's Service Provider Network with a view to ensure the correct application of the GEMS Rules relating to underwriting.

The adequacy and effectiveness of the Scheme's Compliance Management Function is periodically assessed by the Scheme's Internal Audit Function. The next assessment will be conducted during Quarter 1 of 2018.

Regulatory actions

Section 47(1) of the Medical Schemes Act 131 of 1998 ("the Act") states that: *"The Registrar shall, where a written complaint in relation to any matter provided for in this Act has been lodged with the Council, furnish the party complained against with full particulars of the complaint and request such party to furnish the Registrar with his or her written comments thereon within 30 days or such further period as the Registrar may allow."*

Section 66(1) of the Act states that: Any person who *"(a) contravenes any provision of this Act or fails to comply therewith" … "shall, subject to the provisions of subsection (2), be guilty of an offence, and liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and imprisonment."*

Section 66(3) of the Act states that: *"Any person who fails to furnish the Council or Registrar with a return, information, financial statement, document or a reply to an enquiry addressed to him or her, as provided for by this Act or any directive under this Act, within the prescribed period or any extension thereof, shall irrespective of any criminal proceedings instituted under this Act, be liable to a penalty as prescribed for every day which the failure continues, unless the Registrar, for good cause shown, waives the penalty or any part thereof."*

Issue

On 19 July 2017, the Scheme received a penalty notice in terms of Section 66(3) of the Act from the CMS in respect of a number of instances where the Scheme did not timeously respond to the CMS's requests to furnish the Registrar with the Scheme's written comments on the full particulars of complaints received by the CMS from third parties ("CMS Complaints") within 30 days or such further period as allowed by the Registrar, as prescribed by Section 47(1) of the Act.

Corrective action

On 16 August 2017, during a meeting between representatives of the Scheme and the CMS, the Scheme took accountability for 24 of the 26 CMS Complaints presented, as two of the complaints were addressed within the requisite time period. The Scheme provided the CMS with the necessary assurance that this matter was receiving priority attention and that the Scheme is committed to respond to CMS Complaints timeously.

Adherence to the Scheme's existing controls in respect of the processing of CMS Complaints is being enforced by the responsible Scheme Officers.

The capacity issue within the Complaints Management Function received further attention with the appointment of the new Senior Manager: Office of the Principal Officer, who has put additional control measures in place to strengthen the complaints process, i.e. weekly reconciliations of CMS Complaints and the prioritisation of stale-claims-related complaints, which currently comprise the bulk of the Scheme's complaints experience.

A new Complaints and Compliments Policy was developed, approved by the Board on 05 December 2017, and implemented from 01 January 2018.

However, it should be noted that:

- Based on the Scheme's interpretation of Section 47(1) of the Act, being that it does not place an obligation on the Scheme to comment on CMS Complaints within the prescribed 30 day period or such further period as allowed by the Registrar, but in fact places an obligation on the Registrar to provide the Scheme with such period to so comment, the Scheme lodged a formal appeal against the CMS' aforesaid penalty notice to the CMS Appeal Committee in terms of Section 49(1) of the Act on 18 August 2017, following which the matter was enrolled by the Secretary of the CMS Appeal Committee for hearing by the CMS Appeal Committee on 15 February 2018.

During December 2017 to January 2018, the Scheme responded timeously to all CMS requests received in terms of Section 47(1) of the Act.

Matters of non-compliance

To the best of the Scheme's knowledge, the compliance matters listed below cover all of the non-compliance matters for the 2017 financial year.

	Nature	Cause	Corrective action
Late-paying employer groups	In terms of Rule 13.2 of GEMS' Scheme Rules and Section 26(7) of the Medical Schemes Act members' contributions are due monthly in arrears and payable by no later than the third day of each month.	During the period under review, certain employer groups paid over contributions on behalf of their members after the third day of the month. Late payment may result in a loss of interest earned for the Scheme; however, this is not significant due to the short duration of the contributions being outstanding.	Scheme Management engaged with the employer groups concerned to ascertain the reasons for the late payment of contributions and to highlight the impact of this practice on members of the Scheme. The Council for Medical Schemes is informed quarterly of any late payers and the Auditor General is informed annually. At year-end there were nine late-paying employer groups. Subsequently these amounts have been received.
Minimum accumulated funds	In terms of Regulation 29(2), (3) or (3A) of the Medical Schemes Act of 1998, a medical scheme shall maintain a minimum accumulated funds level of 25%. As prescribed by Regulation 29(4), where a medical scheme for a period of 90 days fails to comply with sub regulations 29(2), (3) or (3A) must notify the regulator of such noncompliance.	The Scheme's minimum accumulated funds ratio throughout the year was below the required target of 25% as provided for in the Act and above what was subsequently approved by the Registrar on 27 March 2017. Reserves below the required 25% prescribed by the Act may be an indication that a Medical Scheme may have reserve concerns which would impact on the Scheme's ability to pay claims.	The Scheme is, however, accumulating funds in accordance with a business plan approved by the Registrar. The Registrar was notified of the Scheme's performance throughout 2017 with the submission of quarterly performance reports and quarterly meetings with the CMS. The Scheme's reserve ratio level at 31 December 2017 was 15.22% (2016: 6.99%).

	Nature	Cause	Corrective action
Benefit options	In terms of Section 33(2) of the Medical Schemes Act, medical scheme options shall be self-sufficient in terms of membership and financial performance.	The Scheme's Onyx option did not meet the self-sufficiency requirement in terms of Section 33(2) of the Medical Schemes Act. Loss-making options adversely affect the financial performance of the Scheme and the reserve ratio. The claims on the Onyx option were driven by the option's older demographic profile, which resulted in higher claims being incurred relating to chronic and lifestyle-related diseases. The migration of the pre-1992 pensioners to this option in prior years also resulted in the financial performance being adversely affected during the financial year.	The Scheme is, however, accumulating funds in accordance with a business plan approved by the Registrar. The Registrar was notified of the Scheme's performance throughout 2017 with the submission of quarterly performance reports and quarterly meetings with the CMS. Part of the quarterly submission is actuarial reports for these specific options in order for CMS to see progress of the options against the business plan and budget for the year.
Claims settled after 30 days	In terms of Section 59(2) of the Medical Schemes Act, the Scheme shall, in the case where an account has been rendered, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the Scheme.	During the financial year, there were instances that were identified where this regulation had not been complied with.	Additional controls have been put in place at the Administrator to mitigate the risk of noncompliance and the Scheme will ensure that these are tested as part of the Internal Audit process of the Scheme during the coming year.

Report of the **Audit Committee**

We are pleased to present our report for the financial year ended 31 December 2017.

The mandate of the Audit Committee requires it to adhere to high-quality standards of corporate accountability, to ensure the quality of the financial reporting process, control systems and to maintain a high degree of integrity in both the external and internal audit processes.

The Committee has reviewed the Annual Integrated Report and considered all factors that may impact on the integrity of the Report. We also reviewed and commented on the disclosure of sustainability issues raised in the Report to confirm that it is reliable and does not conflict with the financial information contained in the Report.

External Auditor independence and quality

The Committee was involved in the appointment of the external auditor and following the Committee's assessment of the auditor, we were satisfied that the auditor is independent of the Scheme as set out in Section 36(3) of the Medical Schemes Act, No 131 of 1998, as amended. Furthermore, the Committee approved the External Auditor's engagement letter, audit plan and budgeted fees for the year ended 31 December 2017. The Scheme maintains the Non-Audit Services and Consulting Services policy, which describes prohibited services by the External Audit and those requiring prior approval of the Audit Committee. We are satisfied that the Scheme's External Auditor has not performed any prohibited work for the 2017 financial year. Both the Scheme's audit firms (Deloitte & Touche and OMA Chartered Accountants) and the designated external audit partner have only provided external audit services to the Scheme since 2016 and as such partner rotation was not deemed necessary for the period under review.

Requisite assurance was sought and provided by the auditor that internal governance processes within the audit firm support and demonstrate its claim to independence.

Significant matters considered in relation to the Annual Financial Statements

The going concern basis has been adopted in preparing the Annual Financial Statements. Based on the forecasts and available cash resources the Trustees have no reason to believe that the Scheme will not be a going concern in the foreseeable future. These Annual Financial Statements support the viability of the Scheme.

We have reviewed and discussed with the external auditor and management the audited 2017 Annual Financial Statements, and we are of the view that they comply, in all material respects, with the Medical Schemes Act, No 131 of 1998, and International Financial Reporting Standards.

The Committee has oversight of the financial reporting risks of the Scheme and confirmed through the various audit reports throughout the year that sound financial controls are in place and that the fraud and ICT risks as they relate to financial reporting have been adequately addressed.

Effectiveness of the Chief Audit Executive and arrangements for Internal Audit

The Scheme's Chief Audit Executive reports functionally to the Audit Committee and administratively to the Principal Officer. Internal Audit forms an integral part of the Scheme's risk management process, system of internal control and leads the combined assurance coordination within the Scheme. The Internal Audit function has an appropriate and formal charter which was approved by the Audit Committee.

We are satisfied that the Internal Audit function of the Scheme is independent and has the relevant skills and resources to perform its duties. In addition to utilisation of in-house resources to deliver on the Internal Audit mandate, the Scheme's Internal Audit division is supplemented by specialists from the panel of Internal Audit service providers where required.

Internal Audit has provided quarterly reporting to the Audit Committee on assurance results and progress against its strategic objectives.

Effectiveness of the Chief Financial Officer and the finance function

The Committee has reviewed the expertise, resources and experience of the Scheme's finance function and believes that the Chief Financial Officer and other relevant finance staff have the required competence and skills. Financial reporting has been of a high standard throughout the financial year.

Design and implementation of internal financial controls

The Scheme's Internal Audit reviews for 2017 included a review of the design and effectiveness of Internal Financial Controls and, based on the report issued, it was found that controls in place achieve their objectives. Based on this assurance by Internal Audit, we are satisfied that the finances and system of internal control are appropriately managed. Furthermore, the External Auditors have issued an unqualified opinion that the 2017 Annual Financial Statements are a fair reflection of the Scheme's activities in the past financial year and accounting practices have been applied appropriately.

The Scheme requires its administrators to perform International Standard on Assurance Engagements (ISAE) 3402 – Assurance Report on controls at a service organisation. Such reports were received from the Scheme's administrators during 2017 and their findings considered accordingly.

Combined assurance

The Scheme's Chief Audit Executive is charged with the responsibility for leading the Scheme's combined assurance model. For the 2017 financial year, activities of the various assurance providers (internal and external) were coordinated to optimise assurance coverage of the Scheme's key risks, avoid duplication, prevent assurance overload and the resulting disruption to operations.

As part of the forensic investigations work performed in 2017, it was found that there were certain anomalies related to the fulfilment of roles by some of the members of the Scheme's panel of Internal Audit services providers in relation to two tenders that were processed in 2015 and 2016 respectively. The Committee provided the Board of Trustees with recommendations for remediation of the identified anomalies and such actions are in progress.

Key areas of focus during the reporting period

Review of the quarterly Internal Audit reports by the Committee identified concerns relating to remediation of audit findings as management was not meeting committed remediation dates for a significant number of findings. The concern was discussed with management and reported to the Board of Trustees. This matter will continue to receive attention as part of further strengthening of the internal control environment.

Following conclusion of the forensic investigations that were handled by the Board of Trustees in 2017 as referred to in the "Foreword by Chairperson", the Committee noted with concern control gaps and instances of fraud by certain service providers and GEMS' employees. Through Internal Audit quarterly reports, the Committee will monitor implementation of the Board-approved policy changes to remediate the identified gaps and to confirm that recommendations made by the independent investigators are actioned. The Board has allocated the responsibility for overseeing forensic investigations into the activities of Scheme Officers to the GEMS Audit Committee with effect from 1 January 2018.

Conclusion

The Committee has recommended the Annual Financial Statements to the Board of Trustees for approval which will be presented to the members at the forthcoming Annual General Meeting.

We wish to congratulate the Principal Officer and his management team on the continued adherence to good corporate governance by the Scheme. The Committee also wishes to thank the Board of Trustees for its support and the assurance providers for their value-adding contributions.

Internal Audit Assessment:
System of Internal Controls and Risk Management

Risk management is a key responsibility of management. To achieve its objectives, the Scheme has a Risk Management Policy and Standard Operating Procedure which were approved by the Board of Trustees. The Scheme further maintains a strategic risk register, which is reviewed at least annually.

The approved Internal Audit plan for GEMS 2017 focused on high- and medium-risk areas at the key service providers and the Scheme's Head Office as contained in the Scheme's risk registers. Particularly, the focus of the audits at the service providers was to confirm that controls are embedded to address cyber risk and the risk of healthcare cost increases as a result of fraudulent claims. Findings that were raised by assurance providers and remain unresolved do not present pervasive control breakdowns within the Scheme.

Procurement oversight reviews were also performed in line with the Scheme's Supply Chain Management policy by outsourced providers of Internal Audit services to confirm compliance to the Policy. Such reviews found that GEMS tender processes were generally compliant with the SCM policy, therefore providing reasonable assurance that the tender processes were fair, transparent and equitable to all the bidders. External forensic investigations were performed on some of the prior year procurement and contracts and it was identified that there were control gaps and irregularities that required attention, which are being addressed by management and will be monitored by Internal Audit for resolution.

As reliance is placed on work performed by the Scheme's administrators, their Internal Audit functions were subjected to reviews by GEMS Internal Audit during 2017 and it was found that the administrators are maintaining sound internal audit functions, which are set-up and executing work in line with the standards as prescribed by the Institute of Internal Auditors.

In conclusion, and notwithstanding control deficiencies observed during 2017 assurance work and forensic investigations, we are of the opinion that deficiencies identified are not pervasive in nature and therefore the system of internal control provides reasonable assurance over the achievement of objectives, reliability of information; effectiveness and efficiency of operations; safeguarding of assets; and compliance with laws, regulations and contracts.

AGM Notice

Notice is hereby given that the12th Annual General Meeting ("the meeting") of the Members of the Government Employees Medical Scheme ("GEMS") will be held at the Southern Sun Emnotweni Arena, Riverside Mall, Government Blvd, Nelspruit, Mpumalanga on 31 July 2018 at 15h00.

Please note that registration will commence at **13h00**.

The preliminary agenda is below

AGENDA 12th GEMS Annual General Meeting 31 July 2018, 15h00	
Item	**Speaker**
1. Opening and Welcome	Chairperson
2. Announcement of Agenda as finalised in accordance with GEMS Rules 28.1.5.1 to 28.1.5.6	Chairperson
3. Opening remarks by Chairperson followed by a presentation by the Principal Officer on the business of the Scheme for the financial year ended 31 December 2017	Chairperson Principal Officer
4. Matters for decision	
a. Confirmation and adoption of the Minutes of the 11th GEMS Annual General Meeting held on 31 July 2017 at the Steve Biko Centre, 2429 Mbeka Street, King William's Town, 5601	Chairperson

b. Receipt and adoption of the Annual Financial Statements for the year ended 31 December 2017, including the reports of the Board of Trustees and the external auditor of GEMS i. Discussion of the highlights of the Annual Financial Statements ii. Discussion of the external audit process	Chairperson Mr Motshoanedi Johannes Lesejane (Independent Chairperson of the GEMS Audit Committee) Dinesh Munu, Deloitte (GEMS external auditor)
c. Appointment of GEMS' external auditor for the year ending 31 December 2018 in terms of GEMS Rule 27.1	Chairperson Mr Motshoanedi Johannes Lesejane (Independent Chairperson of the GEMS Audit Committee)
5. Matters for noting	
a. Disclosure of Trustee Remuneration	Deputy Chairperson
b. Addressing member issues raised at the 11th GEMS Annual General Meeting	Deputy Chairperson
c. [To be confirmed]	Chairperson
d. [To be confirmed]	Chairperson
e. [To be confirmed]	Chairperson
6. Question and Answer session (General questions only please, as there is a helpdesk at the AGM for members to submit enquiries and complaints concerning personal and confidential medical scheme issues.)	Chairperson
7. Summary of decisions	Chairperson
8. Closure	Chairperson

The attention of Members who wish to place or object to matters for discussion and/or resolution on the agenda of the meeting, is respectfully drawn to the provisions of rules 28.1.5.1 to 28.1.5.7 of the Rules of GEMS as reproduced hereunder:

"28.1.5.1 such proposed resolution or objection must reach the Principal Officer no later than five (5) weeks before the date of the meeting;

28.1.5.2 the proposed resolution or objection must be accompanied by an explanatory memorandum which clearly explains why the proposed resolution or objection must be considered and the background giving rise to the proposed resolution or objection;

28.1.5.3 the proposed wording of any resolution to be passed must be submitted;

28.1.5.4 no proposed resolution which is in contravention of or in conflict with the Act, the Regulations or these Rules shall be placed on the agenda for consideration at the Annual General Meeting;

28.1.5.5 the decision as to whether or not a Member has satisfied the conditions specified in Rules 28.1.5.1 to 28.1.5.4 to allow for the inclusion, amendment or deletion of a matter or proposed resolution on/from the agenda of the Annual General Meeting, shall be that of the Principal Officer, who must make such decision in consultation and with the approval of the Board;

28.1.5.6 if the Principal Officer, in consultation and with the approval of the Board as contemplated by Rule 28.1.5.5, decides that a matter or proposed resolution should be included on, amended, or deleted from the agenda of the Annual General Meeting, then a second notice must be sent to Members, to reach them by no later than three (3) weeks prior to the date of the Annual General Meeting, recording all new, amended and deleted matters and proposed resolutions which have been placed on the agenda of the Annual General Meeting; and

28.1.5.7 Should the Principal Officer, in consultation and with the approval of the Board as contemplated by Rule 28.1.5.5, decide not to place, amend or delete a matter or proposed resolution on/from the agenda of the Annual General Meeting, he or she shall notify the Member of his or her decision and the reasons therefore, which notice shall be delivered to the Member no later than three (3) weeks prior to the date of the Annual General Meeting. Should the Member be aggrieved by the Principal Officer's decision, the Member may refer a dispute to the dispute committee in terms of these Rules or to the Council for Medical Schemes in terms of the Act."

Members wishing to propose additional agenda items or to object to any existing agenda items are required to submit proposals to the Scheme by post to Private Bag X782, Cape Town, 8000, email to enquiries@gems.gov.za or by facsimile to 0861 00 4367 for the attention of the Principal Officer under reference "**2018 AGM Agenda**". Proposed resolutions must reach the Scheme by **16h00 on 26 June 2018**. Members are further encouraged to submit additional agenda items or to object to any existing agenda items in full compliance with the GEMS Rules reproduced on the previous page. Member proposals that do not comply cannot be placed on the agenda of the AGM as we are compelled to adhere to the registered Rules of GEMS.

An updated agenda and proxy form will be sent to Members by **10 July 2018**. Please make enquiries at 0860 004 367 or enquiries@gems.gov.za if you have not received the agenda and proxy form by 10 July 2018. It is also important that Members note GEMS Rule 28.1.6 which provides that resolutions passed at any annual general meeting shall be by way of an ordinary majority vote of all members present or represented by proxy at the annual general meeting provided that only proxies received by the Scheme no later than one (1) week prior to the date of the annual general meeting will be recognised. For this purpose, completed proxy forms must reach the Scheme by **16h00 on 24 July 2018** and can either be posted to Private Bag X782, Cape Town, 8000, emailed to enquiries@gems.gov.za or sent by facsimile to 0861 00 4367 for the attention of the Principal Officer under reference "2018 GEMS AGM Proxy". To ensure timeous delivery, members are advised to fax or email their AGM proxy forms to the Scheme.

In keeping with the Rules of GEMS, attendance at annual general meetings will be limited to Members, Officers of the Scheme and individuals or organisations who are expressly invited by the Scheme to attend. A quorum of 60 members is required to ensure that the meeting may proceed.

In accordance with GEMS Rule 29.5, the Board of Trustees stipulates that members attending the AGM will be required to produce their GEMS membership card and ID or valid drivers' license at the registration desk. Individuals who are unable to produce the required confirmation of their eligibility to attend, will not be admitted to the meeting.

By order of the Board of Trustees.

Chairperson

Date

Minutes of the 11th AGM

Minutes of the 11th GEMS Annual General Meeting

31 July 2017, 15h00

**Steve Biko Centre, 2429 Mbeka Street, Ginsberg,
King William's Town, Eastern Cape**

1. Opening and Welcome

a. The Chairperson of the GEMS Board of Trustees, Ms Nontobeko Ntsinde, opened the 11th Annual General Meeting of the members of GEMS ("the meeting") at 15h00 on 31 July 2017 and welcomed the members of GEMS and the Board of Trustees present at the meeting. She also welcomed and introduced the new Trustee, Mr Mpfariseni Phophi, who was recently appointed by the Minister for Public Service and Administration, replacing Mr Colbert Rikhotso who resigned with effect from 01 August 2016.

b. The following invited guests were also welcomed:

i. Ms Mmathabo Sukati, the Independent Chairperson of the GEMS Audit Committee;

ii. Mr Dinesh Munu from Deloitte and OMA Chartered Accountants Joint Venture, the Scheme's external auditor for the year ended 31 December 2017;

iii. Mr Thamsanqa Diniso and Dr Elsabe Conradie from the Council for Medical Schemes ("**CMS**");

iv. The Scheme's stakeholders, who were attending as observers, including the representatives from the Department of Public Service and Administration ("**DPSA**") and the Public Service Coordinating Bargaining Council ("**PSCBC**"); and

v. The Scheme's internal auditors, i.e. PwC, who were there to make sure that the AGM was run in accordance with the GEMS Rules.

2. Announcement of Agenda as finalised in accordance with GEMS Rules 28.1.5.1 to 28.1.5.6

a. The Chairperson informed the meeting that the agenda was finalised in terms of the GEMS Rules and posted to members in the second week of July 2017, and that copies were handed to members at the AGM registration desk.

b. The meeting noted that two proposed motions were received by the Scheme, that both motions involved rule changes, which is something that cannot be decided at the AGM, that the two members who had proposed the motions were engaged and notified that their motions will not be added to the final agenda, and that the Board finalised the agenda at its meeting on 29 June 2017.

c. The meeting heard that the GEMS Rules require all proxies held to be declared upfront at the AGM, and that out of the 422 proxy forms received, 296 were valid.

3. Opening remarks by Chairperson followed by a presentation by the Principal Officer on the business of the Scheme for the financial year ended 31 December 2016

a. The Chairperson highlighted that the Scheme concluded its third strategic plan at the end of 2016, and that GEMS celebrated a decade of existence since its inception.

b. She gave the members an overview of the highlights and challenges experienced in 2016 and how the Board dealt with same, including the opening of additional Client Liaison Offices in some of the provinces in order to provide face-to-face interactions with more members.

c. She highlighted that GEMS made significant advances in the areas of membership growth and health risk management.

d. She mentioned that the Scheme dealt with the challenges of increased levels of fraud, waste and abuse, which led the Scheme to make serious decisions, including a far-reaching claims management programme, which was implemented in order to deal with these challenges.

e. The Chairperson also mentioned that the Board was greatly saddened to have to deal with instances of alleged fraudulent activities by some members of staff and service providers of the Scheme, which led to an extensive legal and forensic investigation process. The meeting noted that the Board implemented the recommendations of the findings, which included disciplinary action against implicated employees and the termination of the associated service provider contracts. She reiterated that the Scheme has zero tolerance for fraud and that further investigations are taking place.

f. She highlighted that, although member contributions had to be drastically increased in 2017 as a result of aforementioned matters, the impact of the increases was curtailed, to some extent, by the introduction of Emerald Value option, which had a zero percent increase for members who switched from Emerald to this new option.

g. She also highlighted that the Scheme is excited to have commenced with its new 5-year Strategic Plan and is confident that the successful implementation of this plan will provide the necessary foundation for long-term sustainability, improved product and service offerings to all stakeholders, and to contribute meaningfully to the goal of implementing universal healthcare in South Africa.

h. The Chairperson indicated that one of the matters that were raised at previous AGMs, except the 2016 AGM, was the Board Composition matter. She mentioned that this matter forms part of the PSCBC review of various aspects concerning the Scheme. She highlighted that after various discussions, recommendations were developed and that the Scheme is anticipating a transformation in its Board composition once everything is finalised.

i. She then thanked Mr Colbert Rikhotso, who served as Chairperson of the Board until 31 July 2016, the Deputy Chairperson, Ms Nombulelo Mkhomane, the Board of Trustees and the Chairperson of the Audit Committee, Ms Mabatho Sukati, for their valuable contributions towards the Scheme in 2016.

j. The Principal Officer highlighted that, whilst the mandate of GEMS remains unchanged, some changes were made to GEMS' vision, mission and values in line with the new 5-year strategy, which was approved by the Board in December 2016. GEMS' vision now acknowledges what the World Health Organisation has indicated, that all winning nations strive to have universal health coverage for all its citizens. GEMS' mission emphasises member well-being, and its values include collaboration, both internally and externally, in the way the Scheme's mandate is delivered.

k. He highlighted that the Scheme had reached its highest record of membership growth in the history of GEMS by reaching 1.83 million beneficiaries at the end of 2016, which exceeded the target of 1.79 million beneficiaries that was set.

l. He also mentioned that one of the challenges faced was the strategic pillar of healthier members, which was not achieved in 2016. The Scheme had aimed to have a claims-ratio level below 92.3%; however, due to the significant increase in hospital claims, this was not achieved.

m. He further mentioned that the Scheme had partnered with Mthatha General Hospital to assist with the pilot process of the NHI, and also indicated that the Scheme made extensive submissions to assist with the NHI White Paper and policy.

n. He indicated that, since GEMS' inception, five benefit option plans were implemented, but that during 2016, a new benefit option plan was developed and introduced in 2017, i.e. the Emerald Value option, which mirrors the Emerald option with just three differentiators, i.e. family practitioner nomination; controlled referral to specialists and the use of network hospitals.

o. He also highlighted the introduction of network specialists, including paediatricians, physicians, gynaecologists and anaethetists, as well as the addition of contracted pharmacies and the Client Liaison Officers, which are now in seven provinces, with the aim of being present in all nine provinces by the end of 2018.

p. He subsequently moved to report on the Scheme's business indicators for 2016.

q. The Principal Officer informed the meeting that some initiatives were introduced to deal with the high volumes of claims, including hospital and tariff negotiations, having on-site case managers, and the introduction of underwriting from 01 October 2016.

r. He further highlighted a number of factors that impacted on the Scheme's performance, i.e. anti-selection, increased utilisation of hospitals and fraud, waste and abuse.

s. He also highlighted that the Scheme received a complaint in respect of irregularities pertaining to the GEMS Telemarketing tender, following which a forensic investigation was initiated by the Scheme. As a result, two GEMS Executives and two other employees were charged with disciplinary action, of which three resigned and one's employment terminated. He mentioned that the impacted Scheme contracts will also be terminated, which should be concluded by the end of 2017. He further mentioned that a case will be built and handed over to the relevant prosecuting authorities to pursue criminal charges against all implicated parties.

t. The Principal Officer then mentioned the CSI Project in which the Scheme assisted the Sapphire Road Primary School in Booysen Park in Port Elizabeth by providing 20 computers, food packages for the community workers and school uniforms for the learners.

u. Finally, the Principal Officer thanked:

   i. The Minister for Public Service and Administration, Ms Faith Muthambi;

   ii. The officials at the DPSA;

   iii. The Minister of Health, Dr Aaron Motsoaledi, and the officials of the Department of Health ("DoH");

   iv. All the GEMS stakeholders, including the unions, PSCBC, CMS and Government Departments;

   v. The GEMS Board of Trustees for their continued guidance and support in running the Scheme;

   vi. The GEMS Executives and staff for their support, remaining focused and dedicating themselves to the sole purpose of pursuing the Scheme's operational plan;

   vii. The Scheme's healthcare partners and service providers that make the delivery of healthcare services possible; and

   viii. Most importantly, the members who comprise the Scheme and place their trust in GEMS.

v. The Chairperson opened the floor for questions and comments on the presentations.

w. Mr Oupa Sebiloane, representing the Deputy Chairperson of the PSCBC, acknowledged the presentations; thanked the Scheme for their commitment to the fight against fraud; welcomed the new 5-year strategy adopted by the Scheme; placed reliance on the Board to ensure the proper implementation of the new strategy; noted the PO's presentation on NHI funding; called on the DOH to engage the PSCBC on the NHI; and urged the Scheme to go further with the investigations by recovering the monies where people had unduly benefited.

x. Mr Sandisile Mxokozeli, a GEMS member, complained about service providers who indicate that the Scheme does not cover some claims and require members to pay from their pockets; then later, these members receive notifications from GEMS that these service providers had claimed for the very same thing that these members had paid in cash for.

The Principal Officer responded that more detail will be required from the member, as this matter sounded like an issue of fraud.

y. Mr Jones Garolale, a PSCBC union member, highlighted the importance of member communication and that translations into other languages are required to further members' understanding thereof. He raised the issue of the pre-1992 Medihelp-pensioners transfer to GEMS, which is placing strain on the Scheme's finances, and enquired about the Scheme's current arrangement with Treasury to soften the impact of same on the Scheme. He also raised the issue of the Scheme's 2017 average contribution increase, which was at 14% and higher than the medical aid subsidy increase negotiated between the PSCBC and DPSA, and which has negatively impacted on members' salary increases.

The Principal Officer responded by acknowledging that the Scheme has noted the issue on communication and will consider same with reference to the Scheme's various communication channels to the members. He mentioned that the Scheme has addressed the impact of the pre-1992 Medihelp pensioners transfer matter with the CMS and DPSA, and that the Scheme has the support of the Minister for Public Service and Administration to address this matter with Treasury.

z. Mr Mataitsane, a GEMS member, enquired as to why the Scheme does not allocate surplus funds accumulated during the course of a financial year to members' benefits in the following year so as to afford members greater health coverage, as members' current benefits tend to exhaust mid-year.

The Chairperson responded that the Scheme will review the cause of this surplus to understand clearly what it is.

The Principal Officer added that there are certain areas where the Scheme will continue to fund, irrespective of the availability of member benefits, i.e. in the case of Prescribed Minimum Benefits, which all medical schemes are obliged to cover.

aa. Mr Mzwandile Sijendu, a GEMS member, enquired about how the Scheme verifies and authorises clinical procedures that are performed on GEMS members at hospitals, as there are instances where members have found themselves having to pay for accounts that GEMS had refused to pay because of members not having followed the prescribed pre-authorisation procedure, despite such members not having understood the pre-authorisation communication that had been sent to them.

The PO responded that the Scheme pre-authorises what is done upfront and then communicates same in writing to both members and healthcare providers. However, going forward, such communication will comprise simpler language, which could be easily understood by members.

4. Matters for decision

a. Confirmation and adoption of the Minutes of the 10th GEMS Annual General Meeting held on 29 July 2016 at the CSIR International Convention Centre, Pretoria.

i. The Chairperson tabled the draft Minutes of the 10th GEMS Annual General Meeting held on 29 July 2016 for consideration by the meeting.

ii. The meeting heard that the draft Minutes were included in the 2016 Annual Integrated Report that was distributed to members for consideration.

iii. The Chairperson mentioned that the number of proxies that voted in favour of the adoption of the Minutes was more than the number of members in attendance at the AGM; hence, she proposed for any member at the meeting to propose and any other member at the meeting to second the adoption of the Minutes.

Decision

iv. The Minutes of the 10th GEMS Annual General Meeting held on 29 July 2016 at the CSIR International Convention Centre, Pretoria were adopted by the meeting as a true reflection of what was discussed at that meeting, after a proposal to adopt and a secondment in favour of such adoption were received from two respective members.

b. Receipt and adoption of the Annual Financial Statements for the year ended 31 December 2016, including the reports of the Board of Trustees and the external auditor of GEMS.

i. The Chairperson afforded the Chairperson of the GEMS Audit Committee, Ms Mmathabo Sukati, an opportunity to comment on the Scheme's Annual Financial Statements for the year ended 31 December 2016 ("AFS").

ii. Ms Sukati highlighted the salient features of the AFS and mentioned that they were approved by the CMS.

iii. She proposed that the members at the meeting note the overview of the AFS, as presented.

iv. The Chairperson then called upon Mr Dinesh Munu from Deloitte and OMA Chartered Accountants Incorporated Joint Venture (the Scheme's External Auditor for the year ended 31 December 2016) to present their audit opinion in respect of the AFS.

v. Mr Munu commented on the audit process followed and confirmed that the AFS received an unqualified audit opinion.

vi. He further mentioned that Deloitte and OMA Chartered Accountants Incorporated Joint Venture did not identify any material issues of non-compliance in respect of the 2016 financial year, but that the four items from 2015, reported in the 2016 GEMS Annual Integrated Report, remains.

vii. Given that the number of proxy votes in favour of the adoption of the AFS was more than the number of members in attendance at the AGM, the Chairperson proposed that any member at the meeting propose and any other member at the meeting second the adoption of the AFS.

Decision

viii. The Annual Financial Statements of the Government Employees Medical Scheme for the financial year ended 31 December 2016 were adopted by the members of the Scheme, after a proposal to adopt and a secondment in favour of the adoption were received from two respective members.

c. Appointment of GEMS' external auditor for the year ending 31 December 2017 in terms of GEMS Rule 27.1

i. The Chairperson called upon the Chairperson of the GEMS Audit Committee, Ms Mmathabo Sukati, to provide an overview on the appointment of the Scheme's external auditor.

ii. Ms Sukati informed the meeting that the external auditor was appointed in 2016 on a two-year contract, which was subject to annual renewal. The meeting heard that the GEMS Audit Committee reviewed the external auditor's performance for the 2016 financial year, found it satisfactory, and recommended the renewal of the contract for the 2017 financial year.

iii. Given that the number of proxy votes in favour of the appointment of Deloitte and OMA Chartered Accountants Incorporated Joint Venture was more than the number of members in attendance at the AGM, the Chairperson proposed that any member at the meeting propose and any other member at the meeting second the appointment of Deloitte and OMA Chartered Accountants Incorporated Joint Venture for the financial year ending 31 December 2017.

Decision

iv. The appointment of Deloitte and OMA Chartered Accountants Incorporated Joint Venture as the Scheme's external auditor for the financial year ending 31 December 2017 was approved by the members of the Scheme, after a proposal and a secondment in favour of such appointment were received from two respective members.

5. Matters for noting.

a. Disclosure of Trustee Remuneration

i. The Deputy Chairperson of the GEMS Board of Trustees, Ms Nombulelo Mkhumane, informed the meeting that, during previous AGMs, members raised concerns about the Trustees' remuneration and the GEMS Remuneration Policy.

ii. She stated that the 2016 GEMS Trustee Remuneration Report was incorporated into the 2016 GEMS Annual Integrated Report, which was distributed to members, and into the 2017 GEMS AGM Meeting Guide, which was handed out to members at this AGM.

iii. She highlighted that the Board of Trustees did not receive any increases since 2014.

iv. She also highlighted the fiduciary responsibilities of the Board in respect of the governance and strategic direction of the Scheme.

b. Addressing member issues raised at the 10th GEMS Annual General Meeting

i. Ms Mkhumane informed the meeting that, following each AGM, the Scheme compiles an action list based on the issues raised by members at the AGM. The meeting heard that the 2016 GEMS AGM Action List comprised 15 issues.

ii. She further highlighted that communication was one of the issues receiving the Scheme's attention, as already alluded to by the Chairperson.

iii. She then highlighted the other issues comprising the 2016 GEMS AGM Action List and informed the meeting on the actions taken by the Scheme in addressing these issues, as indicated in the 2016 GEMS AGM Action List section of the 2017 GEMS AGM Member Guide, which was provided to members at this AGM.

6. Question and Answer session

a. The Chairperson gave members an opportunity to ask general questions about the matters discussed in the 2017 GEMS Annual Integrated Report and at this meeting.

b. In response, a number of members raised the following concerns:

i. A member requested the Scheme to increase beneficiaries' benefits for self-medication for cases such as influenza, where members can get medication from pharmacies instead of having to visit medical practitioners first.

The Principal Officer responded that the Scheme will incorporate this matter in the Benefit Design planning for 2018.

ii. A member enquired about the implications of GEMS' proposed merger with the medical schemes indicated in the Principal Officer's earlier presentation, as required for the NHI.

The Principal Officer responded by acknowledging that it is a complex matter and that the process of engagement with all parties affected will soon start. The meeting heard that GEMS will contribute to the process and that the CMS will communicate how they anticipate supporting the process.

iii. A member raised a concern about the Scheme's wellness sessions and fitness programmes, which were introduced and then reduced and stopped respectively, to the detriment of members.

The Principal Officer indicated that GEMS' Acting Chief Communication and member Affairs Officer will address this matter outside of the meeting by providing feedback to the members.

iv. A member requested that his membership be reinstated, as it has been suspended since March 2017.

The Principal Officer indicated that a Scheme official will engage the member on this issue after the meeting, as the circumstances that led to the suspension were unknown to him.

v. A member raised a concern on the language used to communicate with members, as not all members understand English.

The Chairperson indicated that more information will be required from the member that raised this issue in order to assist the Scheme in identifying the areas of concern. The meeting, however, heard that the Scheme has call-centre agents that currently assist members in the 11 official languages.

vi. A member enquired about the criteria used to select the Scheme's auditors.

The Chairperson advised that the Scheme is guided by its policies, as approved by the GEMS Board of Trustees, and that a list, comprising the BEE firms that are rendering professional services to the Scheme, will be provided to members for comfort.

vii. A member commended the Chairperson for leading the meeting and enquired about the Board composition matter, i.e. what is being done to resolve it, and if anyone is standing in the way of the Board's transformation.

The Chairperson indicated that six of the Board members are appointed by the Minister for Public Service and Administration and that the other six are elected by members for a term of six years. She acknowledged that this matter has come up time and again, in response to which the Board has developed a formal proposal for submission to the CMS, which includes a change to the GEMS Rules, with the effect that some of the Board members be nominated from the unions within the PSCBC. The meeting also heard that the PSCBC is reviewing the Scheme's mandate with the Scheme's support.

7. Summary of Decisions

a. The Chairperson confirmed that the Minutes of the meeting shall reflect that:

i. The Minutes of the 10th Annual General Meeting of members of GEMS held on 29 July 2016 at the CSIR International Convention Centre, Pretoria were adopted by the members of the Scheme as an accurate reflection of the proceedings of that meeting;

ii. The Annual Financial Statements of the Government Employees Medical Scheme for the financial year ended 31 December 2016 were adopted by the members of the Scheme; and

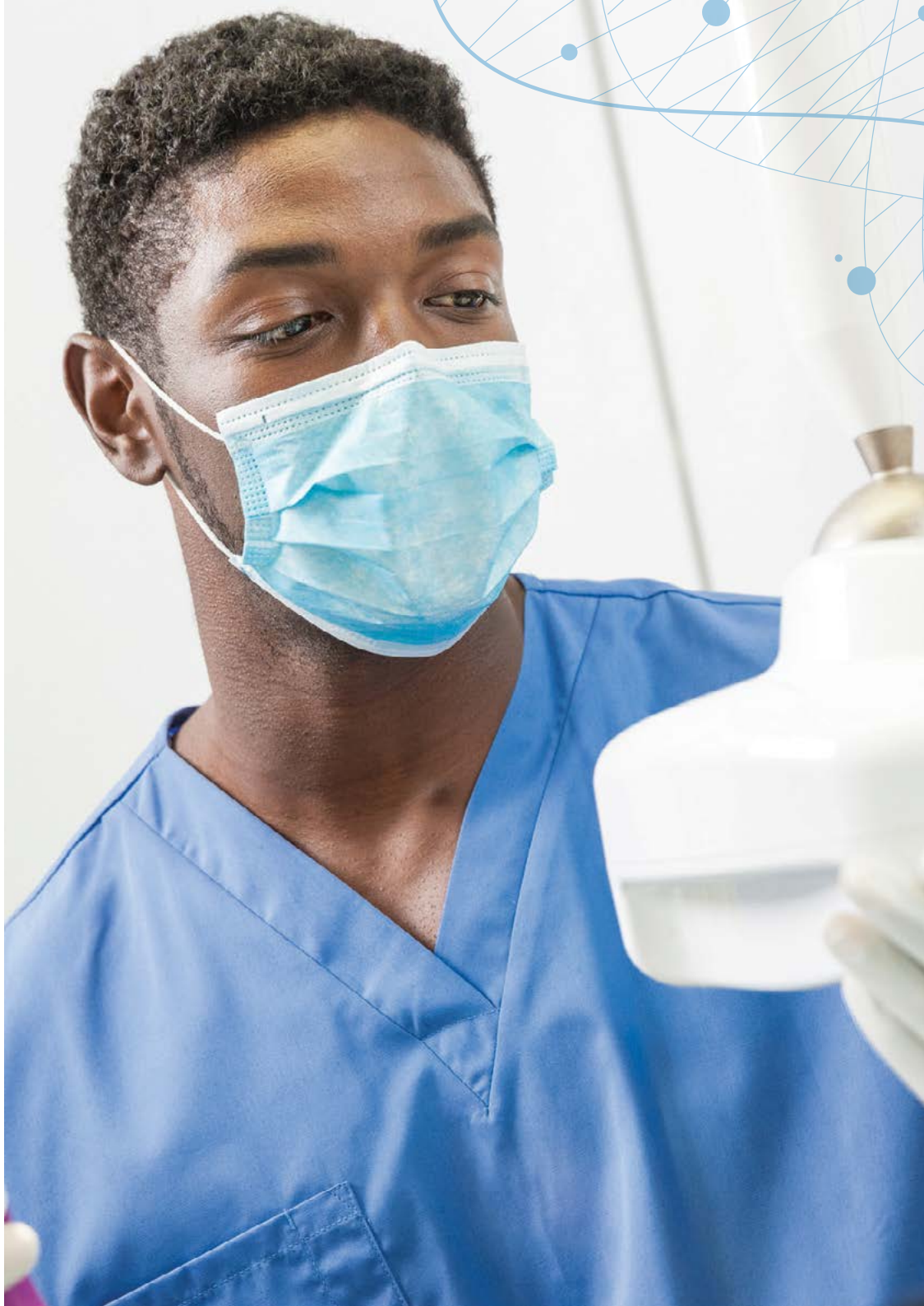
iii. Deloitte and OMA Chartered Accountants Incorporated Joint Venture was re-appointed as the external auditor of the Scheme for the financial year ending 31 December 2017.

8. Closure

a. After all matters on the 2017 GEMS AGM Agenda were duly disposed of, the Chairperson closed the 11th Annual General Meeting of the members of GEMS at 17h15 on 31 July 2017.

Date of approval by members of the Scheme:

Chairperson
Date:



Action list of the 11th AGM
held on 31 July 2017

ACTION LIST ON MEMBER ISSUES RAISED AT THE 2017 GEMS AGM

HELD AT THE STEVE BIKO CENTRE, KING WILLIAM'S TOWN ON 31 JULY 2017 AT 15h00

	Issue (short description)	Classification of issue	Scheme response/action required	Progress
1.	Members urged the Scheme to pursue the recovery of monies where people had unduly benefited, as part of the Scheme's forensic investigations into same.	Fraud/Forensic Investigations	The Scheme is seeking legal advice on the process of reporting the implicated employees to law enforcement agencies for possible prosecution and recovery of monies. The report on the outcome of the forensic investigation will be tabled at the next Board meeting.	The final report on the outcome of the investigation was presented to the Board. Charges were laid with the Directorate for Priority Crimes & Investigations (HAWKS).
2.	Members indicated that some healthcare providers informed them that GEMS does not cover claims for certain conditions and end up having to pay from their own pockets; however, members later get notifications that the Scheme will be paying or has paid the same provider for what has already been paid for. The Scheme needs to investigate this.	Fraud	The Scheme has implemented a SMS notification service for all claims transactions in order to ensure that members are aware of claims transactions and to report any suspicious and irregular claims to the Scheme on time. All SMS notifications will come through as claims being processed whether a claim is rejected or accepted. When a claim is rejected, this information will reflect on the member statement with reasons of rejection, for example, benefit depleted. Members are urged to verify claim transactions on their member statements and subsequently report any irregular or suspicious claims for investigation.	In instances where a complaint, which was not made anonymously, was referred for investigation, the complainant is engaged to provide further details. In addition, an acknowledgement is sent to the complainant when the matter is allocated for investigation and feedback is provided.

	Issue (short description)	Classification of issue	Scheme response/action required	Progress
3.	Members raised the issue of the pre-1992 members who have impacted negatively on the Scheme's finances. Members requested that the Scheme provide information in respect of the arrangements with National Treasury in terms of mitigating the impact.	Scheme Funding	The Scheme has been engaging with National Treasury since 2012 on the matter. A grant of R600 million has been paid to the Scheme to date. The Scheme is currently engaging with National Treasury for an additional grant given the ongoing financial impact on the Scheme. To this end, a submission is being prepared for the allocation of funds during the MTEF process.	The letter was drafted by the Scheme, reviewed and approved by the CFO of National Treasury, and signed by the Principal Officer on 20 March 2018 for submission to National Treasury.
4.	Members raised the issue of communication in other languages, especially at the AGM where other members do not understand the English language that is used to communicate.	Communication	The Scheme supports this and will ensure that it is incorporated in all communication strategy going forward.	Plain language posters on the new Emerald Value option were sent to employer departments. The following key member-communication documents are being translated into plain language and should be finalised by 30 June 2018: • Member Guide; • Mini Guide; • Wellness Guide; • Marketing Brochure; and • Newsletter.
5.	Members enquired about the link between the Scheme's surplus and the fact that some members' benefits are exhausted mid-year, and what the Scheme will do to assist those members.	Member Benefits	The Scheme noted this issue and will take it into consideration during the 2017/18 Product Development and Benefit Design processes, where enhancements to the current benefits are considered. Members are advised to make use of generic medication whenever they require over-the-counter or prescribed medicines. Members are also advised to nominate a General Practitioner/Family Practitioner to coordinate their care.	The Scheme discussed this matter during the 2017/18 Product Development and Benefit Design meetings, during which certain benefits were enhanced. The Benefit Schedules on the GEMS website were subsequently updated with the enhanced benefits.
6.	Members urged the Scheme to write in a language that they will understand when communicating about pre-authorisations for procedures to be undertaken in hospitals, as some of them do not always understand the communique received from the Scheme.	Member Communication	The Scheme will review all member communication as part of its Year-End process, including all pre-authorisation and hospitalisation communication sent to members. Any enhancements required will be effected through this process.	The Year-End review of all member communication was completed and communication was written in plain and simplified language. The pre-authorisation and hospitalisation information in the Member Guide was grouped together for ease of reference. Translations into other languages are underway and it is anticipated that this process will be completed by mid-year.

Issue (short description)		Classification of issue	Scheme response/action required	Progress
7.	Members raised a concern about the benefit limits for self-medication and indicated that the Scheme should consider increasing these limits as they are not enough to cover their needs. In this regard, members wish to avoid unnecessary medical practitioner consultations (i.e. to obtain a script).	Member Benefits	Kindly refer to Issue No. 5 above.	Kindly refer to Issue No. 5 above.
8.	Members requested that the Scheme continue with the Wellness and Fitness Programmes, which were introduced and then put on hold without proper communication to the members.	Member Wellness	The Scheme will consider resuming its Wellness and Fitness Programmes.	The Scheme held a meeting with the Office of the Premier in KwaZulu-Natal and Eastern Cape and addressed the issue raised. Following same, the Scheme resumed its Wellness and Fitness Programmes. Communication was sent out to stakeholders to support the changes and rationale for same. The Regional Managers and CLOs are continuously managing and supporting the Scheme's Wellness and Fitness Programmes during their engagements with members. The Scheme will review its Wellness and Fitness Programme in 2018 to identify any shortcomings, challenges, and areas of improvement identified in 2017.
9.	Members enquired on how and when the Board composition matter will be addressed.	Board Composition	The Scheme will consider lodging an application in terms of Section 8(h) of the Medical Schemes Act 131 of 1998 for an exemption from Section 57 of the Act.	The Scheme lodged an application in terms of Section 8(h) of the Act for an exemption from Section 57 of the Act. The CMS declined the exemption application on 7 November 2017. The Scheme was provided with a copy of PSCBC Resolution 4 of 2017 that would govern the election of trustees by unions in the PSCBC. The Scheme will cooperate with the PSCBC in respect of pursuing the matter further.

Other information

Principal Officer's office and postal address

Dr Gunvant Goolab

Hillcrest Office Park
177 c/o Lynnwood and Dyer Rd
Hillcrest
Pretoria
0083

Private Bag X1
Hatfield
0028

Registered office and postal address

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0083

Private Bag X1
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0028

Medical Scheme administrator during the year, office and postal address

Metropolitan Health Corporate (Pty) Ltd
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61 St George's Mall
Cape Town
8001

P O Box 4313
Cape Town
8001

Actuaries' office and postal address

Insight Actuaries and Consultants (Pty) Ltd
Block J, Central Park
400 16th Road
Midrand
1682

Auditors' office and postal address

Deloitte & Touche
Deloitte Place
Building 8
The Woodlands
20 Woodlands Drive
Woodmead
2052

AUDITED FINANCIAL STATEMENTS

The full audited Annual Financial Statements can be obtained from the Scheme's registered office, postal address, Scheme website and by email as stated below:

Registered Office
Hillcrest Office Park
177 c/o Lynwood and Dyer Road
Hillcrest
Pretoria
0083

Private Bag X1
Hatfield
0028

GEMS website: www.gems.gov.za

Email: enquiries@gems.gov.za

2017
ANNUAL FINANCIAL STATEMENTS

Annual Financial Statements
for the year ended 31 December 2017

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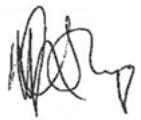
Mr NL Theledi
Chairperson



Dr SM Hlatshwayo
Deputy Chairperson

Dr G Goolab
Principal Officer

25 April 2018

Independent Auditor's Report

To the Members of the Government Employees Medical Scheme

Report on the Audit of Financial Statements

Opinion

We have audited the financial statements of the Government Employees Medical Scheme (the "Scheme") set out on pages 6 to 52, which comprise the statement of financial position as at 31 December 2017, and the statement of profit or loss and other comprehensive income, the statement of changes in equity and the statements of cash flow for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2017, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the Scheme in accordance with the Independent Regulatory Board for Auditors *Code of Professional Conduct for Registered Auditors (IRBA Code)* and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the International Ethics Standards Board for Accountants *Code of Ethics for Professional Accountants* (Parts A and B). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Outstanding risk claims provision (IBNR)	
Key Audit Matter	**How the matter was addressed in the audit**
The outstanding risk claims provision ("IBNR") comprise provisions for the Scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date. The determination of the IBNR requires the Scheme's trustees to make assumptions in the valuation thereof, which is determined with reference to an estimation of the ultimate cost of settling all claims incurred but not yet reported at the Statement of Financial Position date. The trustees make use of an independent actuarial specialists for the estimation of the IBNR. The IBNR calculation is based on the following of factors: • Previous experience in claims patterns; • Claims settlement patterns; • Changes in the nature and number of members according to gender and age; • Trends in claims frequency; • Changes in the claims processing cycle; and • Variations in the nature and average cost per claim. Certain of the above mentioned factors require judgement and assumptions to be made by the Schemes trustees and therefore we identified the valuation of the IBNR as a key audit matter. The IBNR is disclosed in note 10.	In evaluating the valuation of the IBNR, we performed various procedures including the following: • Testing the Scheme's controls relating to the preparation of the IBNR calculation; • Testing the integrity of the information used in the calculation of the IBNR by performing substantive procedures; • With the assistance of our internal actuarial specialists we performed an independent calculation of the estimate of the provision using historical claims data and trends, and using this estimate as a basis of assessing the reasonableness of the trustee's estimate of the provision; • Performing a retrospective review of the IBNR raised in the 2016 financial year based on actual claims paid in 2017 to verify the assumptions applied to determine the IBNR are reasonable; • Performing tests of detail on the current year IBNR including testing actual claims experienced subsequent to year end and to as close as possible to audit completion date; and • Assessing the presentation and disclosure in respect of the IBNR and considered whether the disclosures reflected the risks inherent in the accounting for the IBNR. The assumptions applied in the IBNR are appropriate and we are satisfied that the movement of the IBNR in the Statement of Comprehensive Income is appropriate. The related disclosure of the IBNR and assumptions are appropriate.

Other information

The trustees are responsible for the other information. The other information comprises the Report of Board of Trustees, the Statement of responsibilities of the Board of Trustees and the Statement of corporate governance by the Board of Trustees, which we obtained prior to the date of this report. The other information does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work we have performed on the other information obtained prior to the date of this auditor's report, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Trustees for the Financial Statements

The Trustees are responsible for the preparation and fair presentation of the financial statements in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the Scheme's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

Auditor's Responsibilities for the Audit of the Financial Statements

Our 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 our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We 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 our 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 Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the trustees.
- Conclude on the appropriateness of the trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Audit Committee regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

We also provide the Audit Committee with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence, and where applicable, related safeguards.

From the matters communicated with the trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. We describe these matters in our auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Scheme, we report that there were no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, that have come to our attention during the course of the audit.

Deloitte & Touche

Deloitte & Touche
Registered Auditor

Per: D. Munu
Partner

25 April 2018

Statement of Financial Position
as at 31 December 2017

	Notes	2017 R '000	2016 R '000
ASSETS			
Non-Current Assets			
Property & Equipment	3	97,906	11,943
Intangible assets	4	55,344	48,019
Financial assests at fair value through profit or loss	5	571,230	684,275
		724,480	**744,237**
Current Assets			
Financial assests at fair value through profit or loss	5	1,905,393	177,249
Trade and other receivables	6	405,117	305,114
Cash and cash equivalents	7	5,488,609	3,755,096
		7,799,119	**4,237,459**
Total Assets		**8,523,599**	**4,981,696**
FUNDS AND LIABILITIES			
MEMBERS' FUNDS			
Accumulated funds		5,446,276	2,176,075
LIABILITIES			
Current Liabilities			
Personal medical savings account liability	8	759,387	656,318
Trade and other payables	9	1,193,272	1,188,560
Outstanding risk claims provision	10	1,123,600	960,000
Lease escalation reserve		1,064	743
		3,077,323	**2,805,621**
Total Funds and Liabilities		**8,523,599**	**4,981,696**

Statement of **Comprehensive Income**

	Notes	2017 R '000	2016 R '000
Risk contribution income	12	34,703,985	30,271,405
Relevant healthcare expenditure		(29,844,481)	(29,241,001)
Risk claims incurred	13	(29,134,469)	(28,543,347)
Accredited managed healthcare services	14	(710,012)	(697,654)
Gross healthcare result		**4,859,504**	**1,030,404**
Administration expenditure	15	(1,782,952)	(1,567,415)
Marketing services		(121,718)	(120,382)
Impairment losses on healthcare receivables	17	(77,104)	(65,766)
Net healthcare result		**2,877,730**	**(723,159)**
Investment income	18	388,236	261,773
Dividends received		8,101	6,713
Interest received on financial assets at fair value through profit or loss		88,851	47,803
Net realised gain on financial assets at fair value through profit or loss		13,306	5,224
Net unrealised gain on financial assets at fair value through profit or loss		19,392	8,468
Interest received on Scheme cash invested		210,409	156,207
Interest received on Personal medical savings account monies invested		48,177	37,358
Other income		58,769	17,478
Sundry income		58,769	17,478
Other expenses		(54,534)	(40,742)
Investment management fees		(6,357)	(3,384)
Interest allocated to membersí personal medical savings accounts monies		(48,177)	(37,358)
Total comprehensive surplus/(deficit) for the year		**3,270,201**	**(484,650)**

Statement of **Changes in Funds**

	R '000	R '000
	Accumulated funds	Member funds
Balance at January 1, 2016	**2,660,725**	**2,660,725**
Total comprehensive Deficit for the year	**(484,650)**	**(484,650)**
Balance at January 1, 2017	**2,176,075**	**2,176,075**
Total comprehensive surplus for the year	**3,270,201**	**3,270,201**
Balance at December 31, 2017	**5,446,276**	**5,446,276**

Statement of **Cash Flows**

	Notes	2017 R '000	2016 R '000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members		35,373,812	31,016,559
Cash paid to suppliers, members and employees		(32,405,293)	(30,954,883)
Cash generated from operations	21	2,968,519	61,676
Net cash inflow from operating activities		**2,968,519**	**61,676**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of property & equipment	3	(91,527)	(7,798)
Purchase of other intangible assets	4	(28,195)	(37,610)
Purchase of financial assets		(1,455,343)	(350,009)
Investment income		388,236	261,773
Interest received on Scheme cash invested		210,409	156,207
Income earned on financial assets at fair value through profit or loss		129,650	68,208
Interest received on Personal medical savings account monies invested		48,177	37,358
Interest allocated to membersí personal medical savings account monies		(48,177)	(37,358)
Net cash outflow from investing activities		**(1,235,006)**	**(171,002)**
Total cash movement for the year		**1,733,513**	**(109,326)**
Cash at the beginning of the year		3,755,096	3,864,422
Total cash at end of the year	7	**5,488,609**	**3,755,096**

1. Significant Accounting Policies

The principle accounting policies applied in the preparation of the financial statements are set out below. The policies are consistent with those of the prior year. Refer to note 2 for the new standards and interpretations.

1.1 Statement of compliance

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act no. 131 of 1998, as amended (the Act). In addition the Statement of Comprehensive Income is prepared in accordance with Circulars 41 of 2012 and 56 of 2015 of the Council for Medical Schemes that sets out their interpretation of IFRS as it relates to the Statement of Comprehensive Income for Medical Schemes in South Africa.

1.2 Basis of preparation

The annual financial statements have been prepared on the going concern basis in accordance with, and in compliance with, International Financial Reporting Standards ("IFRS") and International Financial Reporting Interpretations Committee ("IFRIC") interpretations issued and effective at the time of preparing these annual financial statements.

These annual financial statements comply with the requirements of the 2017 SAICA Medical Scheme Accounting Guide as issued by the Accounting Practices Committee and the Financial Reporting Pronouncements as issued by the Financial Reporting Standards Council.

The annual financial statements have been prepared on the historic cost convention, unless otherwise stated in the accounting policies which follow and incorporate the principal accounting policies set out below. They are presented in Rands, which is the Scheme's functional currency.

These accounting policies are consistent with the previous period.

1.3 Property & Equipment

Property and Equipment is measured at historical cost less accumulated depreciation and accumulated impairment losses. Depreciation is charged on the straight line basis over the estimated useful lives of assets after taking into consideration an asset's residual value.Land will be carried at cost and not depreciated.

The useful lives of items of property & equipment have been assessed as follows:

Item	Depreciation method	Average useful life
Land		Infinite Useful Life
Buildings	Straight line	20 years
Furniture and fixtures	Straight line	5 years
Motor vehicles	Straight line	5 years
Office equipment	Straight line	5 years
Computer equipment and software	Straight line	3 years
Leasehold improvements	Straight line	Over the unexpired period of the applicable lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value, depreciation method and the estimated useful life of each asset is reviewed at the end of each reporting period and adjusted where appropriate.The effects of any changes in estimates are accounted for on a prospective basis.

The Scheme capitalises leasehold improvements, as specified in the lease contracts, and these improvements are depreciated.

Repairs and maintenance, which neither materially add to the value of assets nor appreciably prolong their useful lives, are recognised in surplus or deficit. Subsequent expenditure is capitalised only when it is probable that the future economic benefits associated with the expenditure will flow to the Scheme and the cost of the item can be measured reliably. Costs directly attributed to the acquisition, development and installation of software are capitalised.

An item of asset is derecognised upon disposal or when no future economic benefits are expected from its continued use or disposal. Any gain or loss arising from the derecognition of an item of asset, determined as the difference between the net disposal proceeds, if any, and the carrying amount of the item, is included in surplus or deficit when the item is derecognised.

1.4 Intangible assets

An intangible asset is recognised when:

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

Intangible assets are initially recognised at cost.

Expenditure on research (or on the research phase of an internal project) is recognised as an expense when it is incurred.

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.
- 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. 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 every period end.

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.

Internally generated brands, mastheads, publishing titles, customer lists and items similar in substance are not recognised as intangible assets.

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

Item	Useful life
Software	3 years

1.5 Financial instruments

Classification

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

- Financial assets at fair value through profit or loss
- Loans and receivables
- Financial liabilities measured at amortised cost

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

Initial recognition and measurement

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

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

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

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

Transaction costs on financial instruments at fair value through profit or loss are recognised in the Statement of Comprehensive Income.

Subsequent measurement

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

Dividend income is recognised in profit or loss as part of other income when the Scheme's right to receive payment is established.

Loans and receivables are subsequently measured at amortised cost, using the effective interest method, less accumulated impairment losses.

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

Derecognition

Financial assets are derecognised when the rights to receive cash flows from the investments have expired or have been transferred and the Scheme has transferred substantially all risks and rewards of ownership.

Financial instruments designated as at fair value through profit or loss

The Scheme classifies a financial asset at fair value through profit or loss when any of the following conditions are met:

- The asset is acquired principally for the purpose of selling in the near term.
- It is part of a portfolio of identified financial assets that are managed together and for which there is evidence of a recent pattern of short term profit.
- Upon initial recognition the Scheme designated the asset as at fair value through profit or loss.

A group of financial assets is designated as at fair value through profit or loss if it is managed and its performance is evaluated on a fair value basis, in accordance with the Scheme's documented risk management strategy, and information about the group of assets is provided internally on that basis to the Scheme's key management personnel.

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

Gains or losses arising from subsequent changes in fair value, including any interest or dividend income, are recognised under Investment Income in the Statement of Comprehensive Income within the period in which they arise.

Trade and other receivables

Trade receivables are measured at initial recognition at fair value, and are subsequently measured at amortised cost using the effective interest rate method. Appropriate allowances for estimated irrecoverable amounts are recognised in profit or loss when there is objective evidence that the asset is impaired. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments (more than 30 days overdue) are considered indicators that the trade receivable is impaired. The allowance recognised is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the effective interest rate computed at initial recognition.

The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in profit or loss within operating expenses. When a trade receivable is uncollectable, it is written off against the allowance account for trade receivables. Subsequent recoveries of amounts previously written off are credited against operating expenses in profit or loss.

Interest income is recognised by applying the effective interest method, except for short term receivables when the recognition of interest would be considered immaterial. In line with the Scheme Rules, no interest is charged on overdue receivable balances.

Trade and other receivables are classified as loans and receivables.

Trade and other payables

Trade payables are initially measured at fair value, and are subsequently measured at amortised cost, using the effective interest rate method.

Cash and cash equivalents

Cash and cash equivalents comprise fixed deposits held for a period of up to 12 months, deposits held on call with banks, cash on hand and other short term liquid investments. These fixed deposits are readily convertible, within a 3 month period, to a known amount of cash and are subject to an insignificant risk of changes in value. These are initially and subsequently recorded at fair value. Cash and cash equivalents are classified as loans and receivables.

Financial liabilities measured at amortised cost

Financial liabilities are initially measured at fair value, and are subsequently measured at amortised cost, using the effective interest rate method.

Offset

Financial assets and liabilities are offset and the net amount presented in the Statement of Financial Position when, and only when, the Scheme has a legally enforceable right to offset the amounts and intends either to settle on a net basis or to realise the asset and settle the liability simultaneously. No offsetting is currently applied in the financial statements.

Held to maturity

These financial assets are initially measured at fair value plus direct transaction costs.

At subsequent reporting dates these are measured at amortised cost using the effective interest rate method, less any impairment loss recognised to reflect irrecoverable amounts. An impairment loss is recognised in profit or loss when there is objective evidence that the asset is impaired, and is measured as the difference between the investment's carrying amount and the present value of estimated future cash flows discounted at the effective interest rate computed at initial recognition. Impairment losses are reversed in subsequent periods when an increase in the investment's recoverable amount can be related objectively to an event occurring after the impairment was recognised, subject to the restriction that the carrying amount of the investment at the date the impairment is reversed shall not exceed what the amortised cost would have been had the impairment not been recognised.

Financial assets that the Scheme has the positive intention and ability to hold to maturity are classified as held to maturity.

1.6 Leases

Leases in which substantially all of the risks and rewards of ownership are retained by the lessor are classified as operating leases. Operating lease payments are recognised as an expense on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset are consumed.

1.7 Insurance contracts

Contracts under which the Scheme accepts significant insurance risk from another party (the member or other beneficiaries) by agreeing to compensate the member or other beneficiaries if a specified uncertain future event (the insured event, i.e. occurrence of a medical expense) adversely affects the member or their dependents are classified as insurance contracts. In terms of these contracts the Scheme is obligated to compensate its members for the healthcare expenses they have incurred.

1.8 Risk claims incurred

Risk claims incurred comprise the total estimated cost of all claims (including claim handling costs) arising from healthcare events that have occurred in the year and for which the Scheme is responsible in terms of its registered rules, whether or not reported by the end of the year.

Net risk claims incurred comprise of the following:

- Claims submitted and accrued for services rendered during the year, net of discounts received, recoveries from members for co payments and personal medical savings accounts;
- Movements in the outstanding risk claims provision.

1.9 Impairment of assets

The Scheme assesses at each end of the reporting period whether there is any indication that an asset may be impaired. If any such indication exists, the Scheme estimates the recoverable amount of the asset.

Irrespective of whether there is any indication of impairment, the Scheme also:

- tests intangible assets with an indefinite useful life or intangible assets not yet available for use for impairment annually by comparing its carrying amount with its recoverable amount. This impairment test is performed during the annual period and at the same time every period.
- tests goodwill acquired in a business combination for impairment annually.

If there is any indication that an asset may be impaired, the recoverable amount is estimated for the individual asset. If it is not possible to estimate the recoverable amount of the individual asset, the recoverable amount of the cash generating unit to which the asset belongs is determined.

The recoverable amount of an asset or a cash generating unit is the higher of its fair value less costs to sell and its value in use.

If the recoverable amount of an asset is less than its carrying amount, the carrying amount of the asset is reduced to its recoverable amount. That reduction is an impairment loss.

An impairment loss of assets carried at cost less any accumulated depreciation or amortisation is recognised immediately in profit or loss. Any impairment loss of a revalued asset is treated as a revaluation decrease.

An entity assesses at each reporting date whether there is any indication that an impairment loss recognised in prior periods for assets other than goodwill may no longer exist or may have decreased. If any such indication exists, the recoverable amounts of those assets are estimated.

The increased carrying amount of an asset other than goodwill attributable to a reversal of an impairment loss does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior periods.

A reversal of an impairment loss of assets carried at cost less accumulated depreciation or amortisation other than goodwill is recognised immediately in profit or loss. Any reversal of an impairment loss of a revalued asset is treated as a revaluation increase.

1.10 Liabilities and related assets under liability adequacy test

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows and comparing this amount to the carrying value of the liability net of any related assets. Where a shortfall is identified, an additional provision is made and the Scheme recognises the deficit in profit or loss for the year.

1.11 Outstanding risk claims provision

Outstanding risk claims comprise provisions for the Scheme's estimate of the ultimate cost of settling all claims incurred by not yet reported at the reporting date. Outstanding risk claims are determined as accurately as possible on the basis of a number of factors, which includes previous experience in claims patterns, claims settlement patterns, changes in the number of members according to gender and age, trends in claims frequency, changes in the claims processing cycle and variations in the nature and average cost incurred per claim.

Estimated co-payments and payments from personal medical savings accounts are deducted in calculating the outstanding risk claims provision. The Scheme does not discount its outstanding risk claims provision, since the effect of the time value of money is not considered material.

A standard operating procedure governing the calculation of the provision as agreed with the Scheme is followed by the Scheme's actuaries to ensure consistency in the application and interpretation of results.

1.12 Risk Contribution Income

Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably certain. Risk contributions represent the gross contributions per the registered rules after the unbundling of savings contributions. The earned portion of risk contributions received is recognised as revenue. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight line basis. Risk contributions are presented before the deduction of broker service fees and other acquisition costs.

1.13 Employee benefits

Short-term employee benefits

Short term employee benefit obligations are measured on an undiscounted basis and are expensed as the relevant service is provided.

Post employment benefits

Obligations for contributions to post employment benefits to defined contribution plans are measured on an undiscounted basis and are expensed as the relevant service is provided.

1.14 Provisions and contingencies

Provisions are recognised when:

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

The amount of a provision is the present value of the expenditure expected to be required to settle the obligation.

Provisions are not recognised for future operating losses.

The expected future cash flows are discounted and reflects current market assessments of the time value of money and the risks specific to the liability.

The unwinding of the discount is recognised as a finance cost.

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the end of the reporting period, taking into account risks and uncertainties surrounding the obligation.

1.15 Accredited managed healthcare services

These expenses represent expenditure and amounts paid or payable to accredited managed care organisations contracted by the Scheme for management of the utilisation costs and quality of healthcare services supplied to the Scheme and its members. These fees are expensed as incurred.
The services provided by these organisations include hospital pre authorisation, disease management programmes, optical and dental managed care services and pharmaceutical benefit and network management.

1.16 Investment Income

The Scheme's investment income includes:

- Dividends on investments;
- The net realised gains or losses on financial assets at fair value through profit or loss;
- The net unrealised gains or losses on financial assets at fair value through profit or loss; and
- The net interest on investments and cash and cash equivalents.

Interest income is recognised on a yield to maturity basis, taking account of the principal outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue. Dividend income is recognised when the right to receive payment is established.

1.17 Unclaimed benefits

Unclaimed benefits are written back to income after a period of three years. Unclaimed benefits consist of member credits and unidentified deposits in line with the Scheme's debt management policy.

1.18 Impairment losses

Non-derivative financial assets

A financial asset not classified at fair value through profit or loss is assessed at each reporting date to determine whether there is objective evidence that it is impaired. A financial asset is impaired if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset, and that loss event(s) that can be estimated reliably had an impact on the estimated future cash flows of that asset.

Financial assets measured at amortised cost: Loans and receivables

The Scheme considers evidence of impairment for financial assets measured at amortised cost (loans and receivables) at both a specific and collective asset level. All individually significant assets are assessed for specific impairment. Those found not to be specifically impaired are then collectively assessed for any impairment that has been incurred but not yet identified. Assets that are not individually significant are collectively assessed for impairment by grouping together assets with similar risk characteristics.

In assessing collective impairment, the Scheme uses historical trends of the probability of default, the timing of recoveries and the amount of loss incurred, adjusted for management's judgement as to whether current economic and credit conditions are such that the actual losses are likely to be greater or less than suggested by historical trends.

An impairment loss in respect of a financial asset measured at amortised cost is calculated as the difference between its carrying amount and the present value of the estimated future cash flows discounted at the asset's original effective interest rate. Losses are recognised in profit or loss and reflected in an allowance account against loans and receivables. When an event occurring after the impairment was recognised causes the amount of impairment loss to decrease, the decrease in impairment loss is reversed through profit or loss.

Non-financial assets

The carrying amounts of the Scheme's non-financial assets are reviewed at each reporting date to determine whether there is any indication of impairment. If any such indication exists, then the asset's recoverable amount is estimated.

An impairment loss is recognised if the carrying amount of an asset exceeds its recoverable amount. Impairment losses are recognised as an expense.

The recoverable amount of other assets is the greater of their fair value less cost to sell and value in use. In assessing value in use, the estimated future cash flows are discounted to their present value using a discount rate that reflects current market assessments of the time value of money and the risk specific to the asset.

When an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised immediately in profit or loss.

1.19 Allocation of revenue and expenditure to benefit options

Revenue and expenditure is allocated to benefit options on a direct basis where this is determinable. Where revenue and expenditure is not directly attributable to a specific benefit option, the revenue or expense is allocated on the basis of the benefit option's membership proportionate to the Scheme's overall membership base. Investment income and investment management fees are allocated on the basis of the benefit option's contribution income proportionate to that of the overall Scheme.

The following items are directly allocated to benefit options:

- Risk contributions;
- Risk claims incurred;
- Savings interest.

The remaining items are apportioned based on the number of members on each option:

- Other administration expenditure;
- Other income
- Other expenditure;
- Managed care services; and
- Administration fees.

1.20 Road Accident Fund (RAF) Recoveries

Amounts received from the RAF are not recognised in profit or loss and recognised as accounts payable. These amounts are refunded to members.

1.21 Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred and managed care services.

1.22 Personal Medical Savings Accounts: Trust monies managed by the Scheme on behalf of its members

The personal medical savings account, which is managed by the Scheme on behalf of its members, represents savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings laims paid on behalf of members, in terms of the Scheme's registered rules, and bank charges.

The deposit component of the insurance contracts has been unbundled, since the Scheme can measure the deposit component separately. The deposit component is recognised in accordance with IAS 39 and is initially measured at fair value and subsequently at amortised cost using the effective interest method. The insurance component is recognised in accordance with IFRS 4, Insurance Contracts.

Unspent savings at year end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Unspent savings at year end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded from the Scheme's funds and the risk of impairment is carried by the Scheme.

The personal medical savings account trust monies are invested on behalf of members in deposits held in a call account. These monies are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method. Interest is allocated to members with positive balances in their trust accounts monthly.

2017 will be the last year that PMSA funds are dealt with in this manner due to the Constitutional Court Ruling issued during 2017 and subsequent Circulars by the CMS.

2. New Standards and Interpretations

2.1 New Standards and interpretations not yet effective

The Scheme has chosen not to early adopt the following standards and interpretations, which have been published and are mandatory for the's accounting periods beginning on or after 1 January , 2018 or later periods:

IFRS 16 Leases

IFRS 16 is a new standard which replaces IAS 17 Leases and introduces a single lessee accounting model. The new standard requires a lessee to recognize assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. IFRS 16 also contains expanded disclosure requirements for lessees. IFRS 16 is effective for annual reporting periods beginning on or after 1 January 2019 and the impact of the adoption of IFRS 16 has not yet been estimated. The Scheme will adopt the standard in the first annual period beginning on or after the mandatory effective date.

It is unlikely that the standard will have a material impact on the Scheme's Annual Financial Statements.

Amendments to IFRS 4: Insurance Contracts

The amendment provides a temporary exemption that permits, but does not require, insurers, under specified criteria, to apply IAS 39 Financial Instruments: Recognition and Measurement, rather than IFRS 9 Financial Instruments for annual periods beginning before 1 January 2021. The exemption is only available provided the insurer has not previously applied any version of IFRS 9 (with some exceptions) and that the activities are predominantly connected with insurance.

A further exemption has been provided from IAS 28 Investments in Associates and Joint Ventures. In terms of the exemption, an insurer is exempt from applying uniform accounting policies when applying the equity method, insofar as the IAS 39/IFRS 9 exemption is applied. Thus, the relevant accounting policies of the associate or joint venture are retained if the entity applies the IFRS9/IAS 39 exemption and the associate or joint venture does not apply the exemption, or visa versa.

The amendment further permits, but does not require, insurers to apply the "overlay approach" to designated financial assets when it first applies IFRS 9. The overlay approach requires the entity to reclassify between profit or loss and other comprehensive income, an amount which results in the profit or loss of the designated financial assets at the end of the reporting period being equal to what it would have been had IAS 39 been applied to the designated financial assets.

Additional disclosures are required as a result of the amendment.

The effective date of the amendment is for years beginning on or after 1 January, 2018.

The Scheme expects to adopt the standard for the first time in the 2018 Annual Financial Statements.

It is unlikely that the amendment will have a material impact on the Scheme's Annual Financial Statements.

IFRS 9 Financial Instruments

IFRS 9, published in July 2014, replaces the existing guidance in IAS 39 Financial Instruments: Recognition and Measurement. IFRS 9 includes revised guidance on the classification and measurement of financial instruments, including a new expected credit loss model for calculating impairment on financial assets, and the new general hedge accounting requirements. It also carries forward the guidance on recognition and derecognition of financial instruments from IAS 39. IFRS 9 is effective for annual reporting periods beginning on or after 1 January 2018, with early adoption permitted. The Scheme will adopt the standard in the first annual period beginning on or after the mandatory effective date. The impact of the adoption of IFRS 9 has not yet been estimated. An amendments to IFRS 4 was issued which provides a temporary exemption that permits Insurers to apply IAS 39 Financial Instruments: Recognition and Measurement rather IFRS9 Financial Instruments for annual periods beginning before 1 January 2021.

The Scheme will adopt the exemption from new IFRS 9 standards for the reporting period beginning on 1 January 2018 up until the adoption of IFRS 17 for periods beginning 1 January 2021.

IFRS 15 Revenue from Contracts with Customers

IFRS 15 supersedes IAS 11 Construction contracts; IAS 18 Revenue; IFRIC 13 Customer Loyalty Programmes; IFRIC 15 Agreements for the construction of Real Estate; IFRIC 18 Transfers of Assets from Customers and SIC 31 Revenue Barter Transactions Involving Advertising Services.

The core principle of IFRS 15 is that an entity recognises revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. An entity recognises revenue in accordance with that core principle by applying the following steps:

- Identify the contract(s) with a customer
- Identify the performance obligations in the contract
- Determine the transaction price
- Allocate the transaction price to the performance obligations in the contract
- Recognise revenue when (or as) the entity satisfies a performance obligation.

IFRS 15 also includes extensive new disclosure requirements.

The effective date of the standard is for years beginning on or after 1 January, 2018.

The Scheme expects to adopt the standard for the first time in the 2018 annual financial statements.

3. Property and Equipment

	2017			2016		
	Cost or revaluation	Accumulated depreciation	Carrying value	Cost or revaluation	Accumulated depreciation	Carrying value
Land	22,819	-	22,819	-	-	-
Furniture and fixtures	3,751	(2,117)	1,634	3,183	(1,637)	1,546
Motor vehicles	9,102	(3,282)	5,820	7,113	(1,731)	5,382
Office equipment	2,896	(1,700)	1,196	2,410	(1,464)	946
IT equipment	10,075	(5,584)	4,491	9,130	(5,372)	3,758
Leasehold improvements	3,406	(3,248)	158	3,278	(2,967)	311
Building Work in progress	61,788	-	61,788	-	-	-
Total	**113,837**	**(15,931)**	**97,906**	**25,114**	**(13,171)**	**11,943**

Reconciliation of property & equipment 2017	Opening balance	Additions	Disposals	Depreciation	Total
Land	-	22,819	-	-	22,819
Furniture and fixtures	1,546	568	-	(480)	1,634
Motor vehicles	5,382	1,989	-	(1,551)	5,820
Office equipment	946	561	(2)	(309)	1,196
Computer equipment and software	3,758	3,674	(164)	(2,777)	4,491
Leasehold improvements	311	128	-	(281)	158
Building Work in progress	-	61,788	-	-	61,788
	11,943	**91,527**	**(166)**	**(5,398)**	**97,906**

Reconciliation of property & equipment 2016	Opening balance	Additions	Depreciation	Total
Furniture and fixtures	1,173	715	(342)	1,546
Motor vehicles	2,065	4,178	(861)	5,382
Office equipment	692	476	(222)	946
Computer equipment and software	3,283	2,373	(1,898)	3,758
Leasehold improvements	634	56	(379)	311
	7,847	**7,798**	**(3,702)**	**11,943**

4. Intangible Assets

	2017			2016		
	Cost/Valuation	Accumulated amortisation	Carrying value	Cost/Valuation	Accumulated amortisation	Carrying value
Computer software	80,424	(28,218)	52,206	43,122	(7,348)	35,774
Intangible assets under development	3,138	-	3,138	12,245	-	12,245
Total	**83,562**	**(28,218)**	**55,344**	**55,367**	**(7,348)**	**48,019**

Reconciliation of intangible assets - 2017	Opening balance	Additions	Transfers	Amortisation	Total
Computer software	35,774	25,057	12,245	(20,870)	52,206
Intangible assets under development	12,245	3,138	(12,245)	-	3,138
	48,019	**28,195**	**-**	**(20,870)**	**55,344**

Reconciliation of intangible assets - 2016	Opening balance	Additions	Transfers	Amortisation	Total
Computer software	-	37,610	4,705	(6,541)	35,774
Intangible assets under development	16,950	-	(4,705)	-	12,245
	16,950	**37,610**	**-**	**(6,541)**	**48,019**

5. Financial Assets at Fair Value through Profit or Loss

	2017 R '000	2016 R '000
Opening balance	861,524	451,355
Additions to investments	1,455,343	350,009
Realised gains and interest	150,959	59,740
Unrealised gains/(losses)	20,619	8,469
Investment transaction fees*	(211)	(79)
Fair value of investments at year end	**2,488,234**	**869,494**
Less Accrued interest **	(11,611)	(7,970)
Closing balance of investments	**2,476,623**	**861,524**
Non-current assets		
Designated as at Fair value through profit (loss)	571,230	684,275
Current assets		
Designated as at Fair value through profit (loss)	1,905,393	177,249
	2,476,623	**861,524**

* Investment transaction fees are deducted directly from investment porfolio balances and are included as part of investment management fees.

** Accrued interest is not capitalised and is included with Accrued Interest on note 6, Trade and other receivables.

Financial assets at fair value through profit or loss consist of money market instruments, bonds and equities. Financial assets at fair value through profit or loss are categorised as Levels 1 and 2. Refer note 26.

6. Trade and Other Receivables

	2017 R '000	2016 R '000
Insurance receivables		
Contributions outstanding	291,867	187,892
Receivables from members and providers	129,028	110,722
Personal medical savings account advances (note 8)	1,771	1,331
Receivables balance before impairment	422,666	299,946
Less: Balance of allowance for impairment at 31 December	**(87,579)**	**(53,967)**
Balance as at 1 January	53,967	24,712
Amount recognised in the Statement of Comprehensive Income	77,104	65,766
Amounts utilised during the period	(43,492)	(36,511)
Total insurance receivables	**335,087**	**245,979**
Financial receivables		
Accrued interest	46,441	33,496
Sundry accounts receivable	23,589	25,640
Total financial receivables	**70,030**	**56,206**
Total trade and other receivables	**405,117**	**305,114**

Trade and other receivables disclosed above are classified as loans and receivables and are measured at amortised cost. The carrying amounts of receivables approximate their fair value due to the short term maturities of these assets. No interest is charged on overdue balances in line with Scheme Rules.

The Scheme has recognised an allowance for impairment of 100% against all receivables from deceased members and all categories of receivables outstanding for longer than 120 days based on historical experience.

For an analysis of the ageing of receivables refer to note 26.

7. Cash and Cash Equivalents: Scheme Cash Invested

	2017 R '000	2016 R '000
Cash and cash equivalents consist of:		
Call accounts	3,097,980	2,547,710
Current accounts	480,629	69,764
Fixed deposit	1,910,000	560,000
Personal Medical Savings Account	-	577,622
Total cash and cash equivalents: Scheme cash invested	**5,488,609**	**3,755,096**

The carrying amounts of cash and cash equivalents approximate their fair values due to the short term maturities of these assets. Fair value is determined to be equal to the carrying value of the deposit.

For an analysis of the average interest rates and maturity refer to note 26.

In 2017 it is no longer a legal requirement to separately invest PMSA (Personal Medical Savings Account) assets, the separate disclosure on the face of the Statement of Financial position is no longer required and these are included as part of the cash and cash equivalents in 2016.

8. Personal Medical Savings Account Trust Liability

	2017 R '000	2016 R '000
Gross balance of personal medical savings account trust liability at beginning of the year	656,318	493,715
Less: Advances on personal medical savings account trust liability at beginning of year	(1,333)	(1,001)
Balance of personal medical savings account trust liability at the beginning of the year	654,985	492,714
Savings account contributions received (note 12)	792,547	772,303
Transfers from other schemes in terms of Regulation 10(4)	66	201
Interest income earned on trust monies invested	48,177	37,358
Refunds on death or resignation in terms of Regulation 10(5)	(75,653)	(58,564)
Claw backs from members	5,776	4,132
Claims paid on behalf of members (note 13)	(668,282)	(593,159)
Personal medical savings account advances (note 6)	1,771	1,333
Balances due to members on personal medical savings accounts held in trust at the end of the year	**759,387**	**656,318**

In accordance with the Rules of the Scheme, the savings plan is underwritten by the Scheme.

The personal medical savings account liability contains a demand feature that any credit balance on the savings account will be transferred to the member in terms of the Medical Schemes Act and the Scheme Rules when a member registers on another benefit option or medical scheme which does not have a savings account or when a member resigns from the Scheme.

As at year end the carrying amount of the members' personal medical savings accounts were deemed to be equal to its fair value, which is the amount payable on demand. The amounts were not discounted due to the demand feature.

Interest on the members' personal medical savings accounts is calculated and allocated on a monthly basis using the effective interest method.

Advances on personal medical savings accounts are funded by the Scheme and are included in trade and other receivables (refer note 6). The Scheme does not charge interest on advances on personal medical savings accounts.

The effect of discounting is not material.

9. Trade and Other Payables

	2017 R '000	2016 R '000
Insurance liabilities		
Claims reported not yet paid		
Balance at the beginning of the year	845,515	199,678
Claims incurred	29,134,469	28,543,347
Claims settled	(29,170,431)	(27,897,510)
Total liabilities arising from insurance contracts	**809,553**	**845,515**
Financial liabilities		
Trade payables	99,591	130,017
Administration fees payable	150,924	88,530
Consulting fees payable	20,813	2,327
Accredited managed healthcare fees due	55,456	58,444
Marketing services	7,950	12,802
Sundry payables and accrued expenses	44,368	47,654
Refunds due to members	3,909	3,077
Unallocated deposits	708	194
Total arising from financial liabilities	**383,719**	**343,045**
Total trade and other payables	**1,193,272**	**1,188,560**

The carrying amounts of trade payables approximate their fair values due to the short term maturities of these liabilities. Fair value is equal to the face value of the amount invoiced by the creditor. The average payment terms for trade payables are 27.1 days (2016: 25.4 days).

The Scheme has financial risk management policies in place to ensure that all payables are paid within the pre-agreed credit terms and no interest is incurred on outstanding balances.

10. Outstanding Risk Claims Provision

	2017 R '000	2016 R '000
Outstanding risk claims provision		
Not covered by risk transfer arrangements	1,123,600	960,000

Reconciliation of provisions - 2017	Opening balance	Current year increase in provision	Payments in respect of prior year	Total
Outstanding risk claims provision	960,000	1,181,100	(1,017,500)	1,123,600

Reconciliation of provisions - 2016	Opening balance	Current year increase in provision	Payments in respect of prior year	Total
Outstanding risk claims provision	1,000,800	985,988	(1,026,788)	960,000

Analysis of outstanding risk claims provision 2017	Estimated gross claims	Balance at the end of the year
Not covered by risk transfer arrangements	1,123,600	1,123,600

Analysis of outstanding risk claims provision 2016	Estimated gross claims	Balance at the end of the year
Not covered by risk transfer arrangements	960,000	960,000

This provision, known as the outstanding risk claims provision, is determined by way of statistically sound analyses of a number of factors, which include previous experience in claim patterns, claim settlement patterns, changes in the number of members according to gender and age, trends in claim frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim. The provision is net of estimated recoveries from members for co-payments.

The actuaries followed a standard operating procedure governing the calculation of the provision as agreed with the Scheme to ensure consistency in application and interpretation of results. The Scheme does not discount its outstanding risk claims provision since the effect of the time value of money is not considered material. The adequacy of the provision is assessed on a monthly basis, through reviews of past experience and consideration of changes in fundamentals such as claims processing and composition. Furthermore, the Scheme has standardised the provision calculation methodology and any deviation to this is adequately supported. An actuarial peer review of the provision calculation is in place and the Scheme considers the outstanding risk claims provision of R1.123 billion (2016: R1 billion) to be adequate. The estimation of the provision gives an indication of whether the Scheme would have adequate assets to cover the potential liability from the Scheme's insurance contracts, as required by accounting policy. The Scheme has sufficient assets to cover any potential liability from insurance contracts as the cash and cash equivalents at year end cover the outstanding risk claims provision more than three times.

Each notified claim is assessed on a separate, case by case basis with due regard to the claim circumstances, information available from managed care organisations and historical evidence of the quantum of similar claims. The provisions are based on information currently available. However, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items affecting the ultimate cost of the loss is difficult to estimate. The provision estimation also accommodates the processing and adjudication of different categories of claims (i.e. in hospital, chronic and above threshold benefits). This is caused by differences in the underlying insurance contract, claim complexity, the volume of claims, the individual severity of claims, the determination of the occurrence date of a claim, and reporting lags.

Members must submit all claims for payment within four months of seeking medical treatment (i.e. the date of service). The cost of outstanding claims at the reporting date is estimated with reference to the actual claims submitted within the first three months after the reporting date that relates to the period before the reporting date. The claims to be submitted in the fourth month, relating to the reporting period, are then extrapolated using the bootstrapping, chain ladder, expected minus actual and the Bornheutter Ferguson method.

The Bornheutter Ferguson method was the preferred actuarial method for estimating the provision for the year under review and the prior year. This method of calculating the outstanding risk claims provision is in line with the standard operating procedure (SOP) for the Scheme. Refer to note 22 for actuarial assumptions made.

11. Financial Assets and Liability by Category

The accounting policies for financial instruments have been applied to the line items below:

2017	Financial assets at fair value through profit or loss	Loans and receivables	Financial liabilities at amortised cost	Total
Financial assests at fair value through profit or loss	2,476,623	-	-	2,476,623
Trade and other receivables	-	405,117	-	405,117
Cash and cash equivalents	-	5,488,609	-	5,488,609
Personal medical savings account trust liability	-	-	(759,387)	(759,387)
Trade and other payables	-	-	(1,193,272)	(1,193,272)
	2,476,623	**5,893,726**	**(1,952,659)**	**6,417,690**

2016	Financial assets at fair value through profit or loss	Loans and receivables	Financial liabilities at amortised cost	Total
Financial assests at fair value through profit or loss	861,523	-	-	861,523
Trade and other receivables	-	305,114	-	305,114
Cash and cash equivalents	-	3,177,474	-	3,177,474
Personal medical savings account trust monies invested	-	577,622	-	577,622
Personal medical savings account trust liability	-	-	(656,318)	(656,318)
Trade and other payables	-	-	(1,188,560)	(1,188,560)
	861,523	**4,060,210**	**(1,844,878)**	**3,076,855**

12. Risk Contribution Income

	2017 R '000	2016 R '000
Gross contributions per registered rules	35,496,532	31,043,709
Less: Personal medical savings account contributions received *	(792,547)	(772,304)
Risk contribution income per statement of comprehensive income	**34,703,985**	**30,271,405**

* The savings contributions are received by the Scheme in terms of Regulation 10(1) and the Scheme's registered Rules and held in trust on behalf of its members. Refer to note 7 for more detail on how these monies were invested and to note 8 on how the monies were utilised.

13. Risk Claims Incurred

	2017 R '000	2016 R '000
Claims incurred		
Current year claims per registered rules	28,684,825	28,139,117
Outstanding risk claims provision as at 31 December	1,123,600	998,896
Less:		
Claims paid from personal medical savings accounts**	(668,282)	(593,159)
Discount received	(5,674)	(1,507)
Total net claims incurred	**29,134,469**	**28,543,347**

The claims ratio is calculated as claims incurred expressed as a percentage of risk contributions received. The Scheme recorded a claims ratio for the current financial year of 86% (2016: 97%).

Healthcare Networks amount of R94 million (2016: R74.9 million), previously included in Administration expenditure has been reallocated to and included in Risk claims incurred.

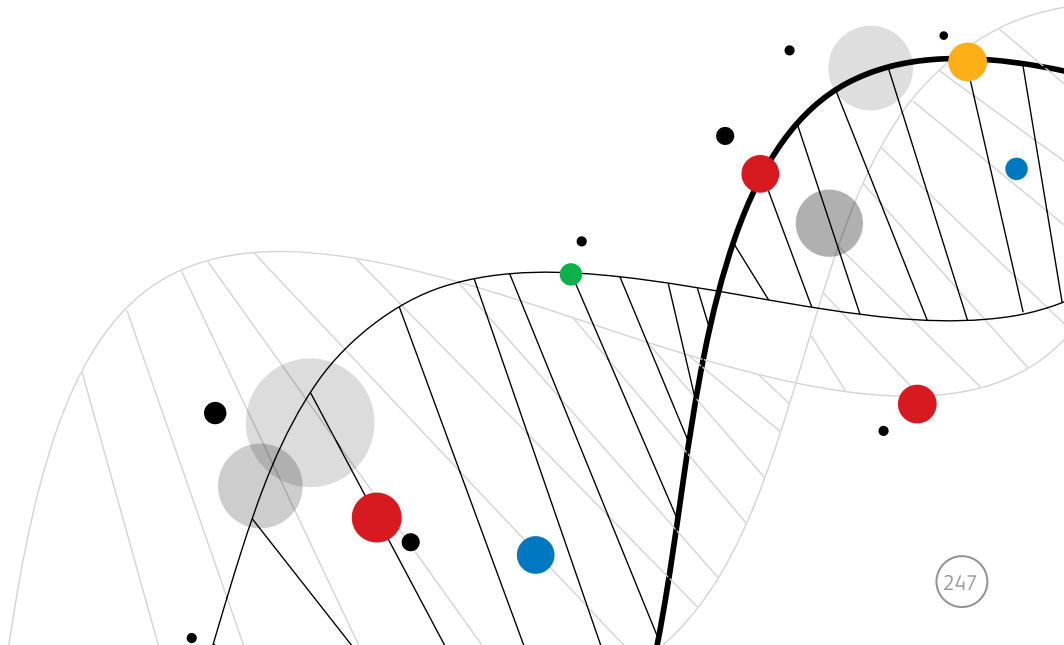
** Claims are paid on behalf of the members from their personal medical savings accounts in terms of Regulation 10(3) and the Scheme's registered benefits. Refer to note 8 for a breakdown of the movement in these balances.

14. Accredited Managed Healthcare Services

	2017 R '000	2016 R '000
Chronic medicine management services	156,100	145,299
Dental managed care	55,974	59,349
HIV management	39,850	43,259
Managed care services	356,391	335,808
Pharmaceutical benefit management	101,697	113,939
	710,012	**697,654**

Fees are contractually determined per member per month, reducing any upfront capital outlays and reducing as membership grows resulting in improved economies of scale.

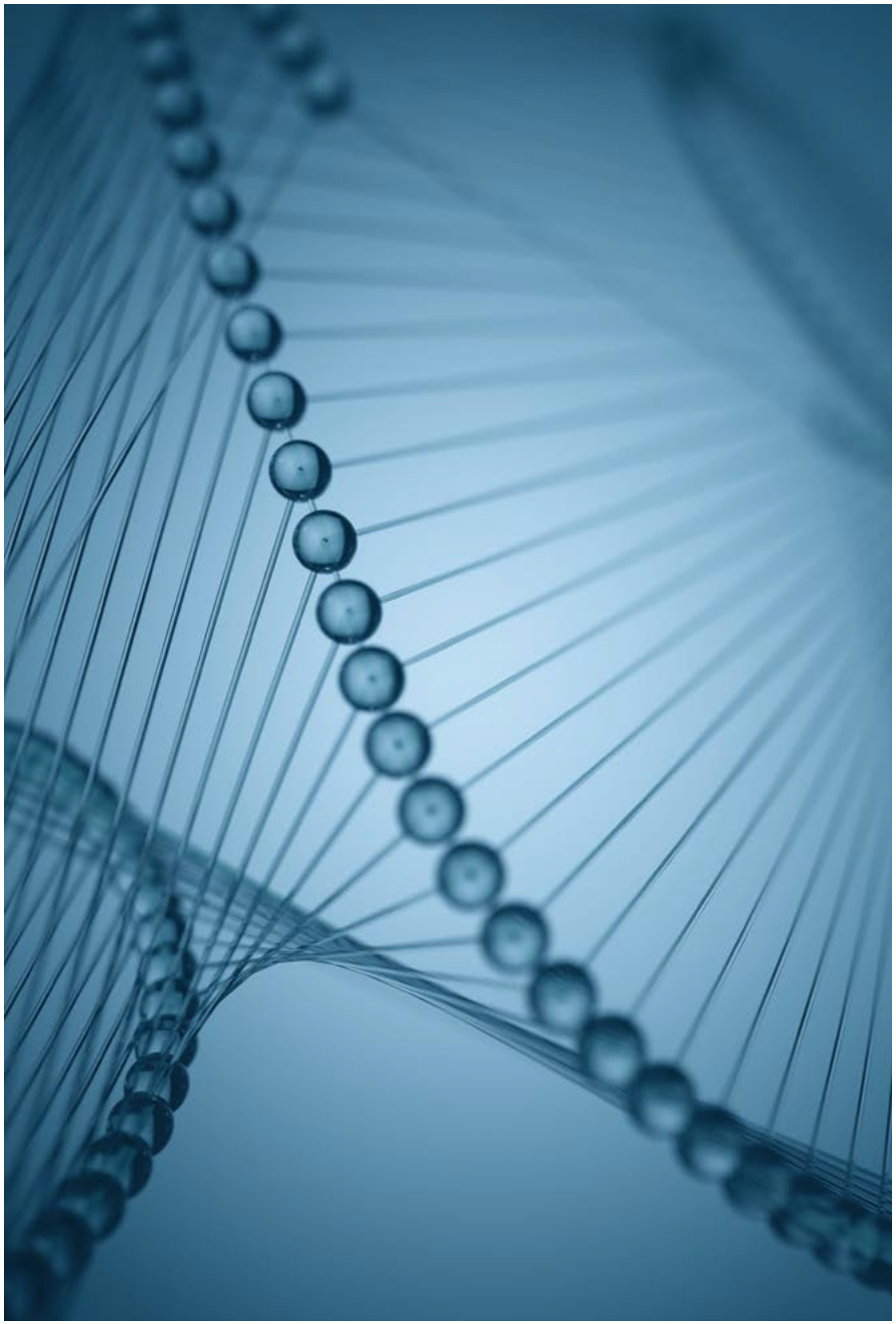
Refer to note 24 for more information on managed care agreements.



15. Administration Expenditure

	2017 R '000	2016 R '000
Actuarial fees	6,814	6,212
Administration fees	1,146,025	1,061,897
Advertising and marketing	37,824	53,703
Auditors remuneration - statutory fees	2,701	3,207
Bank charges*	3,157	170
Benefit management services (Unaccredited managed care providers)	132,221	124,714
Board and Committee fees	7,686	6,855
Conferences and workshops	3,467	3,078
Consulting fees*	144,638	96,249
Depreciation	26,268	10,256
Employee costs	166,352	124,791
Legal expenses*	17,370	7,577
Loss on disposal of assets	166	-
Motor vehicle expenses	1,166	561
Office supplies	8,086	7,069
Other expenses	10,268	5,046
Practice Code Numbering System (PCNS) fees and CMS levies	28,424	22,837
Principal Officer's fees	4,258	4,223
Rental paid	16,897	14,761
Telephone and fax	861	708
Travel and accommodation	14,999	11,660
Trustees' and Committee members' training	121	246
Trustees' and Committee members' travel and accommodation	1,621	861
Water and electricity	1,562	734
	1,782,952	**1,567,415**

* Legal fees increased mainly as a result of the fraud investigation that the Scheme initiated in 2017.
* Bank charges increased as the Scheme took over the full accounting and banking responsibility, previously included in the administrators contract.
* Consulting fees have increased mainly due to Consultants used to assist the Scheme with the development of it's new five year strategy and additional IT support costs incurred for the Intelligems project.



16. Trustees' and Independent Committee Members' Remuneration

Board of Trustees' remuneration

2017	Term End	Attendance Fees R '000	Travel and Accommodation R '000	Reimbursments and Allowances R '000	Training R '000	Total R '000
Ms NH Mkhumane: Deputy Chairperson	2018/02/05	535	70	3	12	620
Mr BE De Vries	2019/07/29	443	325	16	16	800
Mr CJ Booyens	2019/07/29	641	91	24	3	759
DR C Moloko	2022/10/28	448	74	9	16	547
Ms N Ntsinde: Chairperson	2018/02/05	924	91	12	12	1,039
Mr D de Villiers	2019/07/29	711	60	1	7	779
Mr NL Theledi	2019/09/26	478	74	7	7	566
Dr IJ Van Zyl	2020/07/29	502	111	32	16	661
Dr JA Breed	2020/07/29	523	122	27	1	673
Dr CM Mini	2020/07/29	845	73	27	7	952
Mr JS Roux	2020/07/29	658	367	15	9	1,049
Mr EM Phophi	2023/09/25	252	18	3	10	283
		6,960	**1,476**	**176**	**116**	**8,728**

2016	Term End	Attendance Fees R '000	Travel and Accommodation R '000	Reimbursments and Allowances R '000	Training R '000	Total R '000
Ms NH Mkhumane: Deputy Chairperson	2019/07/22	518	-	**1**	**55**	**574**
Mr BE De Vries	2019/07/22	397	278	**17**	**5**	**697**
Mr CJ Booyens	2019/07/22	623	68	**22**	**2**	**715**
Mr ZC Rikhotso	2019/09/26	214	59	**1**	**11**	**285**
Ms N Ntsinde: Chairperson	2019/07/31	840	48	**7**	**75**	**970**
Mr D de Villiers	2019/07/31	640	48	**1**	**14**	**703**
Mr NL Theledi	2019/09/26	431	47	**3**	**2**	**483**
Dr IJ Van Zyl	2020/07/29	475	55	**14**	**3**	**547**
Dr JA Breed	2020/07/29	466	95	**15**	**3**	**579**
Dr CM Mini	2020/07/29	814	23	**17**	**54**	**908**
Mr JS Roux	2020/07/29	605	339	**10**	**3**	**957**
Dr C Moloko	2022/10/28	124	-	**-**	**-**	**124**
		6,147	**1,060**	**108**	**227**	**7,542**

The Trustee remuneration should be seen in relation to the attendance of meetings as reported in the Board of Trustees report as well as the term of office applicable to each trustee. It is worth noting that not all Trustees reside in Gauteng and therefore travel and accommodation costs are incurred.

The total of the Trustees Fees disclosed in this note is included in the Board and Committee fee line items as disclosed in Administration Expenditure (refer note 15).

Independent Committee members' remuneration

2017	Term End	Attendance Fees R '000	Travel and Accommodation R '000	Reimbursments and Allowances R '000	Training R '000	Total R '000
Ms M Sukati (Resigned)	2017/12/31	269	48	16	5	338
Ms LR Zondi	2017/07/31	27	-	-	-	27
Ms M David	2019/03/31	35	6	1	-	42
Ms P Ford	2019/03/31	36	22	-	-	58
Ms F Msiza	2019/03/31	66	6	-	-	72
Ms RHS Eksteen	2018/11/01	83	45	-	-	128
Rev Frank Chikane	2020/07/31	18	17	-	-	35
		534	**144**	**17**	**5**	**700**

2016	Term End	Attendance Fees R '000	Travel and Accommodation R '000	Reimbursments and Allowances R '000	Training R '000	Total R '000
Ms LR Zondi	2017/07/31	39	-	-	-	39
Ms M Sukathi	2018/03/31	333	-	1	6	340
Dr F Msiza	2016/03/31	87	5	-	-	92
Mr N Mhlongo	2016/03/31	52	-	-	-	52
Dr P Ford	2016/03/31	-	9	-	-	9
Ms M David	2016/03/31	26	-	-	-	26
Mr L Jiya	2016/06/30	26	-	-	-	26
Ms RHS Eksteen	2018/10/30	104	34	1	-	139
		667	**48**	**2**	**6**	**723**

Remuneration paid to independent committee members during 2017 was based on a fixed rate per meeting.

17. Impairment Losses on Healthcare Receivables

	2017 R '000	2016 R '000
Movement in the allowance account for impairment losses	33,612	29,255
Impairment losses recognised directly in income	43,492	36,511
	77,104	**65,766**

18. Investment Income

	2017 R '000	2016 R '000
Dividend income		
From investments in financial assets measured at fair value through profit or loss:		
Listed investments – Local	8,101	6,713
Interest income		
From investments in financial assets:		
Interest received on financial assets at fair value through profit or loss	88,851	47,803
Net realised gains on financial assets at fair value through profit or loss	13,306	5,224
Net unrealised losses on financial assets at fair value through profit or loss	19,392	8,468
Interest received on Scheme cash invested	210,409	156,207
Personal medical savings account trust monies invested	48,177	37,358
	388,236	**261,773**

Interest income is comprised of interest earned from short term fixed deposits, current accounts and money market instruments. This interest is recognised on a yield to maturity basis, taking into account the principal amount outstanding and the effective interest rate over the period to maturity.

The personal medical savings account, which is managed by the Scheme on behalf of its members, represents savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered rules.

19. Commitments

	2017 R '000	2016 R '000
Operating leases – as lessee (expense)		
The future minimum lease payments under a non cancellable operating lease:		
- within one year	7,202	6,256
- in second to fifth year inclusive	21,585	18,787
	28,787	**25,043**
Lease amounts recognised in profit or loss during the year		
Rental paid	16,897	14,362

Operating lease payments represent rentals payable by the Scheme for its office properties. Leases are negotiated for an average term of five years and the lease escalation is 8% per annum over the lease period for the rental component and 8% for lease operating costs. No contingent rent is payable.

20. Net Healthcare Result per Benefit Option

2017	Sapphire R '000	Beryl R '000	Ruby R '000	Emerald Value R '000	Emerald R '000	Onyx R '000	Total R '000
Risk contribution income	1,026,181	903,992	3,170,328	1,946,923	25,406,677	2,249,884	34,703,985
Relevant healthcare expenditure	(323,649)	(687,784)	(2,073,389)	(1,710,295)	(22,271,640)	(2,777,724)	(29,844,481)
Risk claims incurred	(279,605)	(658,013)	(1,990,951)	(1,672,193)	(21,792,821)	(2,740,886)	(29,134,469)
Managed care services	(44,044)	(29,771)	(82,438)	(38,102)	(478,819)	(36,838)	(710,012)
Gross healthcare result	**702,532**	**216,208**	**1,096,939**	**236,628**	**3,135,037**	**(527,840)**	**4,859,504**
Administration expenditure	(110,765)	(74,936)	(207,093)	(96,945)	(1,200,962)	(92,251)	(1,782,952)
Marketing services	(7,551)	(5,104)	(14,132)	(6,562)	(82,055)	(6,313)	(121,718)
	584,216	**136,168**	**875,714**	**133,121**	**1,852,020**	**(626,404)**	**2,954,834**
Net impairment losses on healthcare receivables	(3,643)	(2,726)	(10,569)	(3,866)	(48,278)	(8,020)	(77,104)
Net healthcare result	**580,573**	**133,442**	**865,145**	**129,255**	**1,803,742**	**(634,424)**	**2,877,730**
Investment income	21,186	14,352	39,552	18,782	228,640	17,542	340,059
Personal medical savings account trust monies invested	-	-	(48,177)	-	-	-	48,177
Interest allocated to personal medical savings accounts	-	-	48,177	-	-	-	(48,177)
Other income	3,751	2,571	6,911	3,462	39,121	2,952	58,769
Investment management fees	(408)	(281)	(750)	(379)	(4,220)	(316)	(6,357)
Total comprehensive surplus/ (deficit) for the year	**605,102**	**150,084**	**910,858**	**151,120**	**2,067,283**	**(614,246)**	**3,270,201**
Number of members	**44,508**	**30,629**	**81,682**	**41,317**	**459,486**	**34,470**	**692,092**

* Emerald Value is a new option introduced in 2017

Net Healthcare Result per Benefit Option

2016	Sapphire R '000	Beryl R '000	Ruby R '000	Emerald R '000	Onyx R '000	Total R '000
Risk contribution income	860,678	726,371	2,316,914	24,111,513	2,255,929	30,271,405
Relevant healthcare expenditure	(277,132)	(610,698)	(1,911,734)	(23,485,498)	(2,955,939)	(29,241,001)
Risk claims incurred	(235,337)	(583,565)	(1,838,620)	(22,971,217)	(2,914,608)	(28,543,347)
Managed care services*	(41,795)	(27,133)	(73,114)	(514,281)	(41,331)	(697,654)
Gross healthcare result	**583,546**	**115,673**	**405,180**	**626,015**	**(700,010)**	**1,030,404**
Administration expenditure	(94,118)	(61,216)	(164,803)	(1,154,708)	(92,570)	(1,567,415)
Marketing services	(7,214)	(4,686)	(12,625)	(88,729)	(7,128)	(120,382)
	482,214	**49,771**	**227,752**	**(617,422)**	**(799,708)**	**(657,393)**
Net impairment losses on healthcare receivables	(2,624)	8,237	(2,614)	(63,917)	(4,849)	(65,766)
Net healthcare result	**479,590**	**58,008**	**225,138**	**(681,339)**	**(804,557)**	**(723,159)**
Investment income	6,362	5,339	17,051	178,837	16,826	224,415
Personal medical savings account trust monies invested	-	-	37,358	-	-	37,358
Interest allocated to personal medical savings accounts	-	-	(37,358)	-	-	(37,358)
Other income	1,073	705	1,888	12,803	1,009	17,478
Investment management fees	(97)	(82)	(261)	(2,693)	(251)	(3,384)
Total comprehensive surplus/ (deficit) for the year	**486,928**	**63,970**	**243,816**	**(492,392)**	**(786,973)**	**(484,650)**
Number of members	**43,197**	**28,509**	**76,118**	**506,907**	**39,531**	**694,262**

Revenue and expenditure are allocated to benefit options on a direct basis where this is determinable. Where revenue and expenditure are not directly attributable to a specific benefit option, the revenue or expense is allocated on the basis of the benefit option's membership proportionate to the Scheme's membership base. Investment income is allocated on the basis of the benefit option's contribution income proportionate to that of the overall Scheme.

The Scheme offers its members six different benefit options: Sapphire, Beryl, Ruby, Emerald Value, Emerald and Onyx.

Sapphire and Beryl are the entry level options where cover is provided by designated provider networks. Sapphire was specifically designed to be inexpensive and it achieves this by providing out of hospital care at private facilities and in hospital cover at public facilities. Beryl provides in hospital cover at both public and private facilities.

Ruby offers members a savings account for day-to-day medical expenses as well as a hospital benefit. Savings contributions portion is comprised of 20% of contribution income of the Ruby option.

Emerald Value is a new option which offers benefits through the use of the Gems networks with specific care co-ordination principles.

Emerald is the traditional option and the majority of the membership population is part of this option.

Onyx is the comprehensive option. Following engagements and approval from the Department of Public Service and Administration (DPSA) and National Treasury (NT) the Scheme migrated the pre-1992 state pensioners from Medihelp to GEMS, effective 1 April 2012. These members were registered on the Onyx option which adversely affected the financial performance of this option during the financial year.

21. Cash Generated from Operations

	2017 R '000	2016 R '000
Surplus/Deficit reported:	3,270,201	(484,650)
Adjustments for:		
Depreciation, amortisation and impairment	26,268	10,242
Investment transaction fees	211	79
Loss on disposals of assets	166	-
Investment income:		
Scheme cash invested	(210,409)	(156,207)
Income earned on financial assets at fair value through profit or loss	(129,650)	(68,208)
Interest earned on trust monies invested	48,177	37,358
Personal medical savings account trust monies invested	(48,177)	(37,358)
Other:		
Impairment losses on healthcare receivables	77,104	65,766
Movements in provisions	163,600	(40,800)
Changes in working capital:		
Trade and other receivables	(303,108)	(117,291)
Trade and other payables	4,712	689,736
Personal medical savings account liability	69,103	162,603
Lease escalation reserve	321	406
	2,968,519	**61,676**

22. Critical Accounting Judgements and Areas of Key Sources of Estimation Uncertainty

In the process of applying the Scheme's accounting policies, management has made no judgements that have a significant effect on the amounts recognised in the financial statements, other than the outstanding risk claims provision, the impairment allowance for trade and other receivables, as explained further in this note.

Impairment of trade and other receivables

Objective evidence of the impairment of trade and other receivables includes the Scheme's past experience of collecting payments, trade and other receivables outstanding for 120 days or more and receivables due from deceased members. Refer to note 1.18 for more detail with regards to the accounting policy for impairment losses.

Outstanding risk claims provision

This provision has been calculated on the standard operating procedure as agreed between the Scheme and its actuaries.

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision are the expected claims development for the most recent benefit months for the day to day, in hospital, acute and chronic benefit categories of claims.

There is some estimation uncertainty that has to be considered in the provision for the estimate of the liability arising from outstanding claims i.e. the cost of healthcare benefits that have occurred before the end of the accounting period but have not been reported to the Scheme by that date.

Sources of unreported claim payments include:

- Unknown and hence unreported claims; and
- closed claims that later become reopened and have additional payments made.

If no or insufficient allowance is made for these claims, the result is that the Scheme is likely to hold insufficient funds aside for paying claims. This in turn impacts the Scheme's cash flow and ability to honour claims.

The Scheme does not discount its outstanding risk claims provision as the effect of the time value of money is not considered material.

The following table illustrates the quantum of uncertainty inherent to the outstanding risk claims provision estimates. As opposed to claims for 2016 that have already been paid, the claims for 2017 estimate to be paid (or reopened) in future payment months are still subject to uncertainty. This quantity forms a useful basis for a sensitivity analysis. The table below illustrates the effect of a 3% increase and decrease in this amount.

	Claims for 2017 services paid from Jan 2018 to March 2018	2017 claims estimated at the time to be paid after March 2018	2017 Outstanding risk claims provision	% change in outstanding risk claims provision
	R '000	R '000	R '000	
Base Scenario	1,017,500	106,100	1,123,600	-%
3% increase	1,017,500	109,300	1,126,800	0.28%
3% decrease	1,017,500	102,900	1,120,400	(0.28)%

The same analysis appears below for 31 December 2016 financial year outstanding risk claims provision, where claims paid after March 2017 for 2016 forms the basis for the sensitivity analysis. Note that the base scenario figures below are actuals, not estimates.

	Claims for 2016 services paid from Jan 2017 to March 2017	2016 claims estimated at the time to be paid after March 2017	2016 Outstanding risk claims provision	% change in outstanding risk claims provision
	R '000	R '000	R '000	
Base Scenario	898,151	61,849	960,000	-%
3% increase	898,151	63,704	961,855	0.19%
3% decrease	898,151	59,993	958,145	(0.19)%

The Scheme monitors each month's initial outstanding risk claims provision over a four month period as subsequent claims are received. The variances have been monitored to be within a range of 1% to 3% over time.

The Board of Trustees believe that the liability for claims reported in the Statement of Financial Position is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions which could differ when claims arise.

At 31 December 2017, if the estimated component of the outstanding risk claims provision had increased by 3% with all other variables held constant, the surplus (2016: deficit) for the year would have been R3.2 million lower (2016: R1.86 million higher).

At 31 December 2017, if the estimated component of the outstanding risk claims provision had decreased by 3% with all other variables held constant, the surplus (2016: deficit) for the year would have been R3.2 million higher (2016: R1.86 million lower).

Additional comments are provided in note 10.

23. Professional Indemnity and Fidelity Insurance

In accordance with the Scheme rules, the Scheme has Professional Indemnity and Fidelity insurance to cover the events of fidelity, trustees and officers' errors and omissions and medical scheme reimbursements. On 31 December 2017 the effective cover was R1 billion (2016: R1 billion). The Scheme's insurance contracts are reviewed for adequacy and reinstated annually.

24. Related and Other Significant Parties

Related Parties with significant influence over the Scheme

The Minister for Public Service and Administration is responsible for appointing 50% of the Board of Trustees and for determining the medical subsidy policy in the public service and thus has significant influence over the Scheme, but does not control it.

The Scheme engages with the Department of Public Service and Administration (DPSA) who is responsible for implementing and maintaining the medical subsidy policy. The DPSA therefore has significant influence over the Scheme, but does not control it.

Metropolitan Health Corporate (Pty) Ltd (MHC) provides membership and claims management services, operational information and recommendations, through its administration agreement with the Scheme, on which policy decisions are based, and therefore it has significant influence over the Scheme, but does not control it.

Medscheme Holdings (Pty) Ltd provides contribution and debt management Services through its administration agreement with the Scheme from 1 January 2012, on which policy decisions are based, and therefore it has significant influence over the Scheme, but does not control it.

Medscheme Health Risk Solutions (Pty) Ltd (MHRS) and Metropolitan Health Risk Management (Pty) Ltd (MHRM) provide managed care information on which benefit design decisions are based and therefore they have significant influence over the Scheme, but do not control it.

Insight Actuaries (Pty) Ltd provides actuarial and consulting services to the Scheme and therefore has significant influence over the Scheme, but did not control it.

The Scheme has multiple other Administration and Managed care providers that it contracts with, but non of these have significant influence over the Scheme or control over the Scheme.

Key management personnel and their close family members

Key management personnel are those persons who have authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Board of Trustees, the Principal Officer and members of the Executive Committee. This disclosure deals with full time personnel that are compensated on a salary basis (Principal Officer and Executive Committee) and part time personnel that are compensated on a fee basis (Board of Trustees). Close family members include family members of the Board of Trustees, Principal Officer and members of the Executive Committee.

Transactions with related parties

The following table provides the total amount of transactions, which have been entered into with related parties for the relevant financial year.

	2017 R '000	2016 R '000
Key management personnel		
Compensation (includes remuneration and other costs)		
Short term benefits	17,480	19,167
Post employment benefit	1,154	1,107
Bonus	1,505	-
	20,139	**20,274**
Principal Officer	4,258	4,223
Chief Financial Officer	3,323	2,812
Chief Contracts and Operations Officer (Resigned)	954	2,170
Chief Communications and Member Affairs Officer (Resigned)	699	1,988
Chief Governance and Compliance Officer	2,349	1,988
Chief Healthcare Management Officer	2,335	1,977
Chief Information,Communication & Technology Officer	2,005	1,697
Chief Corporate Services Officer	2,106	1,782
Chief Audit Executive	1,934	1,637
Gross contributions received (*)		
Board of Trustees	514	448
Principal Officer	30	30
Executive Committee	364	573
Claims incurred (*)		
Board of Trustees	988	672
Principal Officer	22	11
Executive Committee	162	514

(*) Gross contributions and claims incurred include contributions and claims incurred by members and their beneficiaries.

Transaction	Nature of transactions and terms and conditions thereof
Gross contributions received	This constitutes the contributions paid by the related party as a member of the Scheme in their individual capacity. All contributions were at the same terms as applicable to third parties.
Claims incurred	This constitutes amounts claimed by the related parties in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme as applicable to third parties.

	2017 R '000	2016 R '000
Parties with significant influence over the Scheme, but not control		
Statement of Comprehensive Income		
Administration fees	1,146,025	1,061,897
Accredited managed healthcare fees	710,012	697,654
Actuarial fees	6,814	6,212
Trade and other payables		
Administration fees due	150,924	88,530
Accredited managed healthcare fees due	55,456	58,444
	206,380	**146,974**

Terms and conditions of the administration agreement

Administration fees are calculated on an arm's length basis on the number of members in good standing for the month.These contracts are renewable annually.

The outstanding balance bears no interest and is settled within 7 days.The Scheme has the right to terminate the agreements on 90 days' notice.

The services covered by these agreements include:

Service	Provider 2017	Provider 2016
Contribution and Debt Services	Medscheme (Pty) Ltd	Medscheme (Pty) Ltd
Correspondence Services	Business Collaborate Pty (Ltd)	Business Collaborate Pty (Ltd)
Administration Services	Metropolitan Health Corporate (Pty) Ltd (MHC)	Metropolitan Health Risk Management (Pty) Ltd

Terms and conditions of the managed care agreements

The Scheme has entered into managed care agreements in order to manage the costs of delivering healthcare services to its members while ensuring the highest quality of care.

All contracts are tendered for a maximum contract period of 3 to 5 years. The Scheme has the right to terminate the agreements on 90 days' notice. In respect of hospital pre authorisation and HIV and disease management, managed care and pharmaceutical benefit management fees are calculated based on the number of members in good standing for the month.The outstanding balance bears no interest and is settled within 7 days.

The services covered by these agreements include:

Service	Provider 2017	Provider 2016
Chronic medicine management services	Universal Care (Pty) Ltd	Universal Care (Pty) Ltd
Dental managed care	Denis (Pty) Ltd	Denis (Pty) Ltd
HIV disease management services	Thebe Health Risk Management	Thebe Health Risk Management
Managed health care services	Medscheme Holdings (Pty) Ltd	Medscheme Holdings (Pty) Ltd
Maternity programme services	Healthi Choices (Pty) Ltd	Healthi Choices (Pty) Ltd
Emergency medical dispatch services	Europ Assist (Pty) Ltd	Europ Assist (Pty) Ltd
Pharmaceutical benefit management services	Medikredit (Pty) Ltd	MyCare (Pty) Ltd
Telemarketing services	EOH Abantu (Pty) Ltd	Teledirect (Pty) Ltd
Health and wellness services	Healthi Choices (Pty) Ltd	Pinnacle Health Solutions (Pty) Ltd

25. Insurance Risk Management

Risk management objectives and policies for mitigating insurance risk

The primary insurance activity carried out by the Scheme is that it assumes the risk of loss by members and their dependants that are directly subject to the risk. These risks relate to the health of the Scheme's members. As such the Scheme is exposed to the uncertainty surrounding timing and severity of claims under the contract. The Scheme also has exposure to market risk through its insurance and investment activities.

The Scheme manages its insurance risk through benefit limits and sub limits, approval procedures for transactions that involve pricing guidelines, pre authorisation and case management, service provider profiling, centralised management of risk transfer arrangements as well as monitoring of emerging issues.

The Scheme uses several methods to assess and monitor insurance risk exposure both for individual types of risks insured and overall risks. The Scheme analyses the distribution of claims per category of claim, average age of members per member group, average age per benefit option, actual number of members per benefit option and the geographic distribution of members.

The Scheme uses the average age per member and claims per category of benefits to analyse its insurance risk. Income bands and geographical spread are not good indicators as the Scheme's risk is not concentrated in a specific income band or geographical location. Analyses based on the ageing of members indicate specific risks and behaviours that result in increased claims and these can be further analysed in different categories to inform the Scheme's interventions of which managed care is key.

Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

The table below summarises the concentration of risk, with reference to the carrying amount of the insurance claims incurred (before and after risk transfer arrangements), by age group and in relation to the type of cover/benefit provided where:

- Hospital benefits cover all costs incurred by members, while they are in hospital to receive pre authorised treatment for certain medical conditions.
- Specialist benefits cover the cost of all visits by members to specialists and of the out of hospital procedures performed by specialists. Specialist benefits also include radiology and pathology benefits provided to members.
- Medicine benefits cover the cost of all medicines prescribed to members.
- General Practitioner and Optometry benefits cover the cost of all visits by members to these practitioners and the procedures performed by them, up to a prescribed annual limit per member.

The Scheme profiles members' risk exposure by using their age. Of the various other indicators available, age provides a better indication of who is most likely to claim.

2017 Insurance Age Grouping (in years)	Hospitals R '000	Specialists R '000	Medicines R '000	General Practitioners R '000	Optometry R '000	Other R '000	Total R '000
<26	107,801	59,210	21,260	20,553	4,610	25,387	238,821
26 – 35	1,784,201	1,014,042	567,218	380,461	79,419	503,963	4,329,304
36 – 50	4,102,314	2,592,633	2,045,560	955,069	265,398	1,547,053	11,508,027
51 – 65	3,283,208	2,082,613	1,632,713	570,576	189,903	1,181,070	8,940,083
>65	1,616,056	952,530	650,723	126,371	40,738	468,617	3,855,035
	10,893,580	**6,701,028**	**4,917,474**	**2,053,030**	**580,068**	**3,726,090**	**28,871,270**

2016 Insurance Age Grouping (in years)	Hospitals R '000	Specialists R '000	Medicines R '000	General Practitioners R '000	Optometry R '000	Other R '000	Total R '000
<26	143,582	72,927	25,417	25,385	6,173	32,214	305,698
26 – 35	2,033,883	1,088,799	569,344	403,469	86,005	549,382	4,730,882
36 – 50	4,325,700	2,624,794	1,946,881	966,636	277,413	1,573,185	11,714,609
51 – 65	3,169,142	1,936,174	1,453,547	537,750	189,982	1,104,815	8,391,410
>65	1,461,139	852,455	581,396	116,681	38,080	424,819	3,474,570
	11,133,446	**6,575,149**	**4,576,585**	**2,049,921**	**597,653**	**3,684,415**	**28,617,169**

The information presented in this table is based on claims with a service date during the relevant year.

The Scheme's strategy seeks diversity to ensure a balanced portfolio and is based on a large portfolio of similar risks over a number of years and, as such, it is believed that this reduces the variability of the outcome.

The reporting of claims by age group is impacted by members who join and leave in the same month.

Claims development

Claims development tables are not presented since the uncertainty regarding the amount and timing of claim payments is typically resolved within one year and the majority of cases within four months. At year end, a provision is made of those claims outstanding that are not yet reported at that date. Details regarding the subsequent claim development in respect thereof have been disclosed in note 10 & 22.

26. Financial Risk Management and Capital Management

The Scheme's activities expose it to credit risk, liquidity risk and market risk, including the effects of interest rate changes. The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potentially adverse effects on the financial performance of the investments that the Scheme holds to meet its obligation to its members.

The Board of Trustees has an overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages the financial risks as follows:

- The Investment Committee, a committee of the Board of Trustees, determines, recommends, implements and maintains investment policies and procedures. The Investment Committee advises the Board of Trustees on the strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Investment strategy is guided by or within the risk appetite and risk tolerance set by the Board

Risk management and investment decisions are carried out by the executive management, under the guidance of policies approved by the Board of Trustees. The Board of Trustees approves all these written policies and there has been no change in these policies from previous financial years.

Market risk

Market risk is the risk that changes in market variables will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on investment.

The table summarises the Scheme's financial instrument exposure to market risk as at December 31, 2017 and excludes trade and other receivables and trade and other payables as they are not exposed to currency risk, price risk and interest rate risk.

As at December 31, 2017	Total value R '000	Currency risk R '000	Price risk R '000	Interest rate risk R '000
Cash and cash equivalents	5,488,609	-	-	5,488,609
Equities	281,210	-	281,210	-
Local bonds	242,791	-	242,791	-
Local money markets	1,880,847	-	-	1,880,847
Foreign money markets	4	4	-	-
Foreign bonds	71,770	71,770	-	-
	7,965,231	**71,774**	**524,001**	**7,369,456**

As at December 31, 2016	Total value R '000	Currency risk R '000	Price risk R '000	Interest rate risk R '000
Cash and cash equivalents	3,177,474	-	-	3,177,474
Equities	169,909	-	169,909	-
Local bonds	231,996	-	231,996	-
Local money markets	415,546	-	-	415,546
Foreign money markets	17,845	17,845	-	-
Foreign bonds	26,227	26,227	-	-
	4,038,997	**44,072**	**401,905**	**3,593,020**

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds in fixed accounts, call accounts and money market instruments. This risk is managed by maintaining an appropriate mix between the Scheme's money market portfolio, fixed and call account investments as guided by the investment policy

Cash and cash equivalents comprise fixed deposits held for a period of up to 12 months, deposits held on call with banks, cash on hand and other short term liquid investments. These fixed deposits are readily convertible to a known amount of cash and are subject to insignificant risk of change in value. Cash and cash equivalents are classified as loans and receivables.

The table summarises the Scheme's total exposure to interest rate risks as at 31 December. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

As at December 31, 2017	Up to 3 months R '000	3 - 12 months R '000	More than 12 months R '000	Total
Cash and cash equivalents	5,098,609	390,000	-	5,488,609
Local money markets	1,322,246	448,103	110,498	1,880,847
	6,420,855	**838,103**	**110,498**	**7,369,456**

As at December 31, 2016	Up to 3 months R '000	3 - 12 months R '000	More than 12 months R '000	Total
Cash and cash equivalents	2,967,474	210,000	-	3,177,474
Local money markets	123,333	53,004	239,209	415,546
	3,090,807	**263,004**	**239,209**	**3,593,020**

The average effective interest rates for the year ended 31 December were as follows:

	2017	2016
Current accounts	5.25%	5.46%
Call accounts	6.61%	6.69%
Fixed deposits	7.70%	7.51%
Money market instruments carried at fair value through profit or loss	8.88%	8.39%

Interest rate risk sensitivity analysis

The information below illustrates the impact that the fluctuation in investment income would have on interest income for the period and on the cash and cash equivalent balance. A rate of 0.50% interest rate variance has been used to illustrate the sensitivity.

Based on past experience and a reasonable possible change in interest rate within the life of the investment, the rate of 0.50% is considered appropriate in measuring the sensitivity of the Scheme's interest bearing instruments. The Scheme's investments are short term in nature with a maximum investment period of twelve months permitted. This sensitivity analysis assumes that all other variables remain constant.

At December 31, 2017, if interest rates had been 50 basis points higher with all other variables held constant, the surplus for the year and accumulated funds would have been R15.18 million higher (2016: deficit would have been R23.18 million higher).

At December 31, 2017, if interest rates had been 50 basis points lower with all other variables held constant, the surplus for the year and accumulated funds would have been R14.89 million lower (2016: deficit would have been R23.18 million lower).

Currency risk

The Scheme operates in South Africa and its cash flows are denominated in South African Rand. However through its investments, the Scheme is exposed to a direct currency risk.

For purpose of seeking investment diversification, the Scheme has invested 2.9% (2016: 5.12%) of its financial assets at fair value through profit or loss in offshore bond and cash portfolios. At December 31, 2017 this equated to R71.8 million (2016: R44.07 million).

The fair value of these contracts has been included in financial assets. Gains and losses on these arrangements are included in the surplus.

Currency risk sensitivity analysis

Based on past experience and a reasonable possible change in currency, 10% and 15% change in currency is considered appropriate in measuring the Scheme's currency risk sensitivity. A 10% depreciation in the Rand would result in a gain of R12.1 million (2016: R2.98 million) and a 15% depreciation in the Rand would result in a gain of R18.2 million(2016: R4.62 million). A 10% appreciation in the Rand would result in a loss of R11.9 million (2016: R2.63 million) and a 15% appreciation in the Rand would result in a loss of R17.7 million (2016: R3.80 million). This impact would be recognised in the surplus and accumulated funds. The sensitivity is based on the assumption that the Rand has strengthened or weakened against the US Dollar by 10% or 15% considered as the reasonable possible change, with all other variables held constant.

The following US Dollar exchange rate was applied.

	2017	2016
Average rate	13.27	14.70
Year-end closing rate	12.38	13.70

Price risk

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified at fair value through profit and loss. The Scheme is indirectly exposed to equity risk through its investments in listed equities. The value of the equity investments was R281.21 million (2016: R169.91 million)

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios.

Diversification of the portfolios is performed by asset managers in accordance with the mandate set by the Scheme.

Equity price risk sensitivity analysis

Based on past experience and a reasonable possible change in equity prices, 10% and 15% change in equity prices is considered appropriate in measuring the Scheme's equity price risk sensitivity. A 10% increase in the price of equities within the equity portfolios would result in a gain of R31.8 million (2016: R7.95 million) and a 15% increase would result in a gain of
R47.8 million (2016: R25.18 million). A 10% decrease in the price would result in a loss of R31.8 million (2016: R7.73 million) and a decrease of 15% would result in a loss of R47.8 million (2016: R24.62 million). This impact would be recognised in the surplus and accumulated funds. The sensitivity is based on the assumption that equity prices had increased or decreased by 10% or 15% considered as the reasonable possible change,
with all other variables held constant.

Liquidity risk

Prudent liquidity risk management implies maintaining sufficient cash and cash equivalents. The availability of liquid cash holdings positions with various financial institutions ensures that the Scheme has the ability to fund its day to day operations. The Scheme manages liquidity risk by monitoring forecast cash flows and ensuring that adequate reserves are maintained. This approach ensures that the Scheme will have sufficient liquidity to meet its obligations when due, under both normal and stressed market conditions, without incurring losses that would threaten the Scheme's going concern status. The Scheme's available funds were invested in cash products to ensure that the Scheme can meet its short term obligations. The table below reflects the Scheme's liquidity requirements to meet its financial obligations.

At December 31, 2017 Category	Less than 1 month R '000	Between 1 and 3 months R '000	Between 3 months and 1 year R '000	Over 1 year R '000	Total R '000
Insurance liabilities:					
Outstanding claims provision	621,400	398,200	104,000	-	1,123,600
Nonderivative financial liabilities:					
Amounts owing to members and providers	99,591	-	-	-	99,591
Claims reported not yet paid	809,553	-	-	-	809,553
Sundry payables and accrued expenses	283,420	-	-	-	283,420
Unallocated deposits	708	-	-	-	708
Personal medical savings accounts trust liability	759,387	-	-	-	759,387
Total liabilities	**2,574,059**	**398,200**	**104,000**	**-**	**3,076,259**
Financial assets at fair value through profit or loss	256,075	1,203,465	519,873	497,210	2,476,623
Scheme monies invested	3,578,609	1,520,000	390,000	-	5,488,609
Available cash and investments	**3,834,684**	**2,723,465**	**909,873**	**497,210**	**7,965,232**
Excess liquidity	**1,260,625**	**2,325,265**	**805,873**	**497,210**	**4,888,973**

At December 31, 2016 Category	Less than 1 month R '000	Between 1 and 3 months R '000	Between 3 months and 1 year R '000	Over 1 year R '000	Total R '000
Insurance liabilities:					
Outstanding claims provision	634,807	263,344	61,849	-	960,000
Nonderivative financial liabilities:					
Amounts owing to members and providers	130,017	-	-	-	130,017
Claims reported not yet paid	845,515	-	-	-	845,515
Sundry payables and accrued expenses	212,834	-	-	-	212,834
Unallocated deposits	194	-	-	-	194
Personal medical savings accounts trust liability	656,318	-	-	-	656,318
Total liabilities	**2,479,685**	**263,344**	**61,849**	**-**	**2,804,878**
Financial assets at fair value through profit or loss	87,324	36,920	53,004	684,275	861,523
Scheme monies invested	2,667,474	300,000	210,000	-	3,177,474
Personal medical savings account trust monies invested	577,622	-	-	-	577,622
Available cash and investments	**3,332,420**	**336,920**	**263,004**	**684,275**	**4,616,619**
Excess liquidity	**852,735**	**73,576**	**201,155**	**684,275**	**1,811,741**

Personal medical savings account trust monies managed by the Scheme on behalf of its members (note 7) is included in the liquidity risk calculation as suggested in the Medical Schemes Accounting Guide.

Credit risk

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations. Key areas where the Scheme is exposed to credit risk are:

- Financial assets at fair value through profit or loss
- Cash and cash equivalents
- Trade and other receivables

The Scheme only deposits cash with registered banks per the South African Reserve Bank's Supervision Unit with high quality credit standing and limits the exposure to any one financial institution.

Financial assets are valued at fair value through profit or loss comprise money market and bond instruments entered into to fund the obligations arising from its insurance contracts and to invest surplus funds to maintain the statutory reserve requirement. The Scheme is exposed to the issuer's credit standing on these instruments. Exposure to credit risk is monitored and minimum credit ratings for these investments are set. Reputable asset managers have been appointed to manage these instruments.

	2017 R '000	2016 R '000
Cash and cash equivalents		
ABSA Bank	1,200,000	665,000
First National Bank	488,129	77,265
Investec Bank	859,000	785,915
Nedbank	980,000	420,000
Standard Bank	545,000	300,000
South African Reserve Bank	1,416,480	789,294
Rand Merchant Bank	-	140,000
Investec Bank (Personal medical savings account)	-	577,622
	5,488,609	**3,755,096**

	2017 R '000	2016 R '000
Ratings of Banks invested with:		
ABSA Bank	BB+	BBB-
First National Bank	BB+	BBB-
Investec Bank	BB+	BBB-
Nedbank	BB+	BB-
Standard Bank	BB+	BBB-
South African Reserve Bank	A	A
Rand Merchant Bank	BB+	BBB-
The maximum exposure to credit risk for financial assets at year end were as follows:		
Other financial assets	2,476,623	861,524
Loans and receivables (Cash and cash equivalents)	5,488,609	3,755,096
Loans and receivables (Trade and other receivables)	405,117	305,114
	8,370,349	**4,921,734**

The amounts represented in the Statement of Financial Position for trade and other receivables are net of allowances for doubtful receivables.

An allowance for impairment is made where there is an identified loss event which, based on previous experience, is evidence of a reduction in the recoverability of the cash flows. The ageing of insurance receivables at year end was:

As at December 31, 2017	Not past due, not impaired R '000	Past due, not impaired R '000	Impaired R '000	Total R '000
Contribution debtors	284,940	6,892	35	291,867
Receivables from members and providers	30,058	5,760	93,211	129,029
Sundry accounts receivable	23,589	-	-	23,589

As at December 31, 2016	Not past due, not impaired R '000	Past due, not impaired R '000	Impaired R '000	Total R '000
Contribution debtors	184,791	2,609	492	187,892
Receivables from members and providers	48,141	9,107	53,475	110,723
Sundry accounts receivable	25,640	-	-	25,640

The table below provides an age analysis of the receivables that are not yet impaired.

Amounts outstanding for 30 days are not impaired, as they are within the normal expected recovery period. The credit quality of financial assets that are neither past due nor impaired has been assessed on the basis of historical information. This information indicated that the majority of debt is settled just after year end and within the rules of the Scheme. The amounts not past due have been collected shortly after year end.

The carrying amount of these financial instruments best represents the maximum exposure to credit risk.

As at December 31, 2017	3 - 30 days R '000	31 - 60 days R '000	61 - 90 days R '000	Total R '000
Contribution debtors	284,940	5,521	1,371	291,832
Receivables from members and providers	30,058	4,200	1,559	35,817

As at December 31, 2016	3 - 30 days R '000	31 - 60 days R '000	61 - 90 days R '000	Total R '000
Contribution debtors	184,791	1,398	1,211	187,400
Receivables from members and providers	48,141	7,078	2,029	57,248

Management information reported to the Scheme includes details of allowances for impairments on receivables. The table below provides an analysis of receivables that were impaired.

	2017 R '000	2016 R '000
Receivables impaired:		
Contribution debtors		
120 days	80	492
Receivables from members and providers		
120 days	87,499	53,475
Total	**87,579**	**53,967**

The amounts represented in the Statement of Financial Position are net of impairment receivables, estimated by the Scheme's management based on outcomes of recovery processes, prior experience and the current economic environment.

Fair value estimation

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value, less impairment provision of trade receivables, and payables are assumed to approximate their fair values due to their short term nature.

The members' Personal Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan, and enrols in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore the carrying values of the members' Personal Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

Fair value of financial assets by hierarchy level

At December 31, 2017	Carrying amount R '000	Total R '000	Level 1 R '000	Level 2 R '000	Level 3 R '000
Cash and cash equivalents	5,488,609	5,488,609	-	5,488,609	-
Financial assets at fair value through profit or loss	2,476,622	2,476,622	1,067,315	1,409,307	-
Equities	281,210	281,210	281,210	-	-
Local bonds	242,791	242,791	242,791	-	-
Local money markets	1,880,847	1,880,847	471,540	1,409,307	-
Foreign money markets	4	4	4	-	-
Foreign bonds	71,770	71,770	71,770	-	-
	7,965,231	**7,965,231**	**1,067,315**	**6,897,916**	**-**

At December 31, 2016	Carrying amount R '000	Total R '000	Level 1 R '000	Level 2 R '000	Level 3 R '000
Cash and cash equivalents	3,177,474	3,177,474	-	3,177,474	-
Financial assets at fair value through profit or loss	861,524	861,523	169,909	691,614	-
Equities	169,909	169,909	169,909	-	-
Local bonds	231,996	231,996	-	231,996	-
Local money markets	415,547	415,546	-	415,546	-
Foreign money markets	17,845	17,845	-	17,845	-
Foreign bonds	26,227	26,227	-	26,227	-
	4,038,998	**4,038,997**	**169,909**	**3,869,088**	**-**

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The allocation of Investments for 2017 have in some instances been amended when compared to 2016 due to new/additional information received from the Assest Managers of the Scheme.

The fair value hierarchy has the following levels:

Level 1 – These are assets measured using quoted prices in an active market

Level 2 – These are assets measured using inputs other than quoted prices included within Level 1, that are either directly or indirectly observable.

Level 3 – These are assets measured using inputs that are not based on observable market data.

Capital adequacy risk

Capital adequacy risk is the risk that there may be insufficient reserves to provide for adverse variations in actual future benefit liabilities. In terms of Regulation 29(3)A of the Medical Schemes Act, a medical scheme registered for the first time must maintain reserves of no less than:

First year of operations	10.00%
Second year of operations	13.50%
Third year of operations	17.50%
Fourth year of operations	22.00%
Fifth year of operations	25.00%

The Registrar of Medical Schemes, in terms of the business plan submitted by the Scheme in 2017, agreed to revise the required reserve levels which will apply to the Scheme for each related year of operation:

	Actual levels	CMS approved levels
31 December 2014	10.02%	8.90%
31 December 2015	9.46%	10.10%
31 December 2016	6.99%	9.90%
31 December 2017	15.22%	8.20%

The Scheme monitors and manages the capital adequacy risk through the following means:

- The capital adequacy risk is documented on the risk register that is regularly reviewed by the Board of Trustees.
- Scheme management reviews the monthly management accounts where the Scheme's financial performance is monitored.
- Monthly management accounts and the Scheme's quarterly performance reports are submitted to and discussed with the Council for Medical Schemes.
- The annual budgeting process, long term projections and planning allows the Scheme to review its capital adequacy and reserve levels to ensure continuity of operations and sustainability.

27. Events after the Reporting Period

The Minister for Public Service and Administration has made changes to the employer appointed Trustees of the GEMS Board, as per the Government Employees Medical Scheme (GEMS) Rules 19.3 and 19.15.

Ms NM Ntsinde and Ms NH Mkhumane's services as Trustees ended on 5 February 2018.

GEMS is a restricted membership medical scheme and operates under the Medical Schemes Act No. 131 of 1998 as amended and the registered Rules of GEMS. In accordance with the GEMS Rules, the Minister for Public Service and Administration, representing the Employer, appoints 50% of the Board, while the remaining 50% is elected by members of the Scheme.

In compliance with the Scheme's rules, two new Trustees commenced their term of office on 6 March 2018 at the Board meeting held.

28. Guarantees and Commitments

The Scheme held guarantees in favor of the following instructions during the year

	2017 R '000	2016 R '000
Council for Medical Scheme	2,500	2,500
South African Post Office	5,000	5,000
	7,500	**7,500**

The guarantee in favour of the Council for Medical Schemes has been issued in terms of Section 24(5) of the Medical Schemes Act, 1998. The Act prescribes that the Registrar may demand from the person who manages the business of a medical scheme such financial guarantees as will in the opinion of the Council ensure the financial stability of the medical scheme.

The guarantee in favour of the South African Post Office allows the Scheme to transact directly with the service provider for the provision of postal services, rather than procuring these services on an agency basis.

29. Regulatory Non-Compliance

To the best of the Scheme's knowledge, the compliance matters listed below cover all of the non compliance matters for the 2017 financial year.

Late paying Employer groups

Nature

In terms of Rule 13.2 of GEMS' Scheme Rules and Section 26(7) of the Medical Schemes Act members' contributions are due monthly in arrears and payable by no later than the third day of each month.

Cause

During the period under review, certain employer groups paid over contributions on behalf of their members after the third day of the month. Late payment may result in a loss of interest earned for the Scheme; however this is not significant due to the short duration of the contributions being outstanding.

Corrective action

Scheme Management engaged with the employer groups concerned to ascertain the reasons for the late payment of contributions and to highlight the impact of this practice on members of the Scheme. The Council for Medical Schemes is informed quarterly of any late payers and the Auditor General is informed annually. At year end there were nine late paying employer groups. Subsequently these amounts have been received.

Minimum accumulated funds

Nature

In terms of Regulation 29(2), (3) or (3A) of the Medical Schemes Act of 1998, a medical scheme shall maintain a minimum accumulated funds level of 25%. As prescribed by Regulation 29(4), where a medical scheme for a period of 90 days fails to comply with sub regulations 29(2), (3) or (3A) must notify the regulator of such non compliance.

Cause

The Scheme's minimum accumulated funds ratio throughout the year was below the required target of 25% as provided for in the Act and above what was subsequently approved by the Registrar on 27 March 2017. Reserves below the required 25% prescribed by the Act may be an indication that a Medical Scheme may have reserve concerns which would impact on the Scheme's ability to pay claims.

Corrective action

The Scheme is however accumulating funds in accordance with a business plan approved by the Registrar. The Registrar was notified of the Scheme's performance throughout 2017 with the submission of quarterly performance reports and quarterly meetings with the CMS. The Scheme's reserve ratio level at 31 December 2017 was 15.22% (2016: 6.99%).

Benefit Options

Nature

In terms of Section 33(2) of the Medical Schemes Act, medical scheme options shall be self sufficient in terms of membership and financial performance.

Cause

The Scheme's Onyx option did not meet the self sufficiency requirement in terms of Section 33(2) of the Medical Schemes Act. Loss making options adversely affect the financial performance of the Scheme and the reserve ratio.The claims on the Onyx option were driven by the option's older demographic profile, which resulted in higher claims being incurred relating to chronic and lifestyle related diseases. The migration

of the pre 1992 pensioners to this option in prior years also resulted in the financial performance being adversely affected during the financial year.

Corrective Action

The Scheme is however accumulating funds in accordance with a business plan approved by the Registrar. The Registrar was notified of the Scheme's performance throughout 2017 with the submission of quarterly performance reports and quarterly meetings with the CMS. Part of the quarterly submission are actuarial reports for these specific options in order for CMS to see progress of the options against the business plan and budget for the year.

Claims settled after 30 days

Nature

In terms of Section 59(2) of the Medical Schemes Act, the Scheme shall, in the case where an account has been rendered, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the Scheme.

Cause

During the financial year, there were instances that were identified where the above regulation had not been complied with.

Corrective Action

Additional controls have been put in place at the Administrator to mitigate the risk of non compliance and the Scheme will ensure that these are tested as part of the Internal Audit process of the Scheme during the coming year.

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