CMS

Council for Medical Schemes

STRATEGIC PLAN 2015 – 2020

STRATEGIC PLAN

for the fiscal years

2015/16 – 2019/20

Date of Tabling: 10 March 2016

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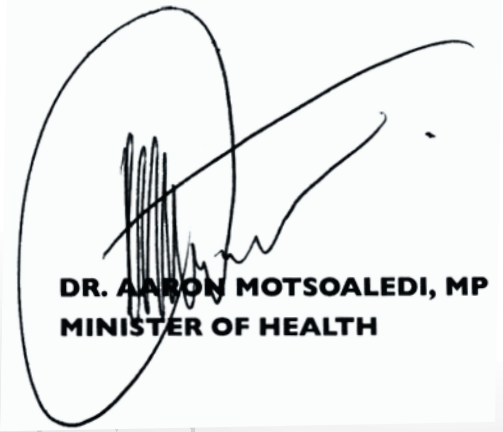
Council for Medical Schemes

FOREWORD BY MINISTER OF HEALTH

The strategic plan of the Council for Medical Schemes (CMS) for the fiscal years 2015/16 - 2019/2020 has been submitted by CMS, and received by me. In particular, I am encouraged by the strategic goal 4 of the CMS that supports development of the universal health care coverage system by the National Department of Health, and the continued pursuit to improving the efficiency and effectiveness of the healthcare system in South Africa.

The CMS has established itself as an effective and efficient regulator which can be evidenced in the execution and responsiveness to its key mandate that of the protection of the members of medical schemes and promoting access to healthcare. I am also pleased by the manner in which the finances of CMS have been managed - CMS has obtained unqualified audit reports from the office of the Auditor General of South Africa every year since its inception. Consequently, I am satisfied to endorse these strategic plans going forward.

I thank Council, the Acting Registrar and his staff for the development of this strategic plan and wish them well in the execution of these plans.



FOREWORD BY CHAIRPERSON OF COUNCIL

During its 14 years of existence, the Council for Medical Schemes (CMS) has built a proud culture of protecting beneficiaries of medical schemes by enforcing the provisions of the Medical Schemes Act (131 of 1998). The main pillars of the Act are the requirements for open enrolment, community rating and prescribed minimum benefits. Linked with the gove rnance requirements stipulated in the Act, these provisions protect beneficiaries against discrimination based on health status and other arbitrary grounds.

The healthcare system is marred by inequitable access to care and health care resources. The life expectancy of South Africans is currently 56, which is much lower than that of other upper-middle income countries which in 2012 was reported at 74 (World Development Indicators 2014). This is despite the rapid improvement in life expectancy of South Africans which improved from 51.6 in 2004 to the current age of 56. This growth is faster than that of upper-middle income countries which grew from 72.5 in 2004 to 74 in 2012. The National Department of Health (NDoH) in its strategic plan envisages the life expectancy of South Africans to reach 70 by the year 2030.

Inequality in access of health services results in lower levels of human development (Human Development Report, 2013) being attained than in countries which spend less amounts on health care as a proportion of Gross Domestic Product (GDP). Close to 23% of Human Development Index1 (HDI) globally is lost to inequality. South Africa is currently ranked as a middle human development country. This is despite South Africa's healthcare expenditure as a percentage of GDP being higher than that of the upper-middle income countries. South Africa's healthcare expenditure as a percentage of GDP is 8.8% while the upper-middle income countries expenditure as a proportion of GDP is 6.2% (2012) (World Development Indicators 2014).

The problem of access and inequality to healthcare is a source of concern for the Government of South Africa. The Government has adopted a National Development Plan (NDP), vision 2030 in order to address the problem of inequality and poverty in the country. Chapter 10 of this policy document deals with matters geared towards promoting health. The Government has therefore adopted the strategic goals for the years 2014 to 2019 to respond to the challenges of access and inequality to healthcare; these goals are highlighted under the heading of Policy Mandates in this document. The priority for the NDoH is to promote

[1] The Human Development index is a statistical tool used to measure and rank a country's overall achievement in its social and economic dimensions.

Schemes supports this health initiative by the Department and will work closely with the NDoH to make this goal a reality.

Council discharges its mandate in an increasingly litigious health care environment. The 2010 high court judgement, which set aside the Reference Price List (RPL) regulations, has left a void in the regulation of healthcare prices, and leaves many medical scheme beneficiaries unprotected. The CMS supports the NDoH in the development of an alternative mechanism for the determination of private healthcare prices. The newly established Market Inquiry by the Competition Commission will also potentially provide insight to some of these structural challenges faced by the industry.

The Prescribed Minimum Benefit (PMB) package was not designed to operate in an environment where there is no price regulation. CMS must work closely with the NDoH, the Health Professions Council of SA (HPCSA) and other stakeholders to ensure that there is a mechanism in place to determine healthcare prices as soon as possible.

Governance in medical schemes continues to be a challenge in the regulatory framework. In order to stabilise governance in medical schemes, Council frequently appoints curators for medical schemes through court action; manages insolvent schemes and institutes legal proceedings to ensure that beneficiaries are protected. These interventions, whilst critical in protecting our mandate, attract high legal costs and increase the cost of regulation.

In the ensuing period, Council plans to strengthen regulation by way of amending the Medical Schemes Act. This process is at an advanced stage as proposed amendments have been submitted to the NDOH already.

I extend my thanks and appreciation to the Acting Registrar and his team at the CMS, for the continued focus on the mandate as entrenched in the Medical Schemes Act; in particular, the development of this strategic plan. Further, I would like to wish them well in the execution of this plan.

PROF YUSUF VERIAVA

CHAIRPERSON OF THE COUNCIL

Certification

It is hereby certified that this Strategic Plan:

- Was developed by the management of the Council for Medical Schemes
- Takes into account all the relevant policies, legislation and other mandates for which the Council for Medical Schemes is responsible
- Accurately reflects the strategic outcome oriented goals and objectives which the Council for Medical Schemes will endeavour to achieve over the period 2015/16 - 2019/2020

Ms. Waheda Khan

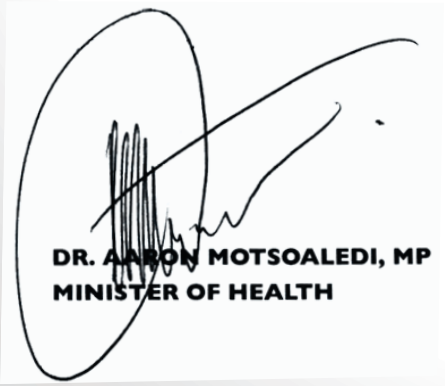
Risk and Performance Manager

Mr. Daniel Lehutjo

Acting Registrar and Chief Executive Officer

Prof. Y Veriava

Chairperson: Council for Medical Schemes



Part A
Strategic Overview

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1. Vision

Promote vibrant and affordable healthcare cover for all

2. Mission

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

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

3. Values

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

- "Ubuntu" – we need each other to achieve our goals;
- We strive to be consistent in our regulatory approach;
- We approach challenges with a "Can do" attitude;
- We are proud with our achievements; and
- We are occupied by doing something which is of value.

4. Legislative and other mandates

4.1. Legislative mandates

4.1.1. Constitutional Mandates

4.1.1.1. Section 9 of the Constitution of the Republic of South Africa, 108 of 1996 ("the Constitution"), states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care.

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

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

The Medical Schemes Act (131 of 1998) (MSA) represents such legislation, which creates the framework for non-discriminatory access to medical schemes. The MSA provides for the regulation of the private medical schemes industry to ensure synchrony and consonance with the national health objectives.

4.1.1.3. Section 27 of Chapter 2 of the Bill of Rights of the Constitution states as follows: with regards to Health care, food, water, and social security:

Everyone has the right to have access to:

- health care services, including reproductive health care;
- sufficient food and water; and
- social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
- No one may be refused emergency medical treatment.

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

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

4.1.2. The National Health Act, 61 of 2003 (NHA)

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

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

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

4.1.4. The Medical Schemes Act, 131 of 1998

The Medical Schemes Act (131 of 1998), established the Council for Medical schemes. Section 7 of the Act confers the following functions on Council:

- protect the interests of the beneficiaries at all times;
- control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy;
- make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine;
- investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act;
- collect and disseminate information about private health care;
- make rules, not inconsistent with the provisions of the Act for the purpose of the performance of its functions and the exercise of its powers;
- advise the Minister on any matter concerning medical schemes; and
- perform any other functions conferred on the Council by the Minister or by the Act.

4.1.5. Related Legislation impacting on and influencing the functioning of CMS

- Council for Medical Schemes Levy Act, 58 of 2000

Provides a legal framework for the Council to collect levies from medical schemes.

- Occupational Health and Safety Act, 85 of 1993

Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

- Employment Equity Act, 55 of 1998

Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

- Skills Development Act, 97 of 1998

Provides for the measures that employers are required to take to improve the levels of skills of employees in workplaces.

- Public Finance Management Act, 1 of 1999

Provides for the effective, efficient and economic financial management in government departments and public entities.

- Promotion of Access to Information Act, 2 of 2000 (PAIA)

Amplifies the constitutional provision pertaining to accessing information under the control of various bodies or person. It gives effect to the right of access to any information held by the state or any other entity or person.

- Protection of Personal Information Act 4 of 2013 (POPI)

This Act sets the conditions for how an organisation can process or access information and also how it approaches the aspect of privacy.

- Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000

Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

- Consumer Protection Act, 68 of 2000 (CPA)

A valuable piece of complementary legislation in the context of CMS and the medical schemes industry. The provisions involving the duty to communicate clearly and in simple, understandable language strengthens the provisions in Section 57 (4) (d) of the MSA.

- Broad-based Black Economic Empowerment Act, 53 of 2003

Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.

- Inspection of Financial Institutions Act 80 of 1998

Provides for the inspection of the affairs of financial institutions; the inspection of the affairs of unregistered entities conducting the business of financial institutions. Financial institutions include medical schemes.

- Financial Institutions (Protection of Funds) Act 28 of 2001

Provides for matters relating to the investments, safe custody and administration of funds and trust property by financial institutions. It also enables the Registrar to protect such funds and trust property.

4.2. Policy mandates

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

The following are the key priorities for the vision 2030 development plan *(extract from Chapter 10 of NDP Vision 2030):*

1. raise the life expectancy of South Africans to at least 70 years;
2. progressively improve TB prevention and cure;
3. reduce maternal, infant and child mortality;
4. significantly reduce prevalence of non-communicable diseases;
5. reduce injury, accidents and violence by 50 percent from 2010 levels;
6. complete Health system reforms;
7. primary healthcare teams provide care to families and communities;
8. universal health coverage; and
9. fill posts with skilled, committed and competent individuals.

Furthermore, the National Development Plan (NDP) Vision 2030 sets out nine priority areas that highlight the key interventions required to achieve a more effective health system, which will contribute to the achievement of the desired outcomes. These nine priorities are as follows:

1. address the social determinants that affect health and diseases;
2. strengthen the health system;
3. improve health information systems;
4. prevent and reduce the disease burden and promote health;
5. financing universal healthcare coverage;
6. improve human resources in health sector;
7. review management positions and appointments and strengthen accountability mechanisms;
8. improve quality by using evidence; and
9. meaningful public-private partnerships

The current population of South Africa is estimated at approximately 53 million lives, 8.7 million of which are covered by private healthcare. This is largely a function of the socio economic status of the majority of the South African population, with unemployment at the forefront of such factors. There is a positive correlation between employment and membership of medical schemes – even for those belonging to medical schemes, affordability remains an issue as healthcare costs continue to increase at rates that are significantly higher than inflation. A lot therefore remains to be done in increasing access to healthcare. The CMS as a regulator of the private healthcare system plays a key role in facilitating and promoting the health of all citizens in support of Vision 2030.The CMS will need to, inter alia,

Below are the five year goals[2] of the NDOH for 2014 – 2019:

1. to make progress towards universal health coverage through the development of the National Health Insurance (NHI) Scheme, and improved the readiness of health facilities for its implementation;
2. to re-engineer primary health care by: increasing the number of ward based outreach teams, contracting general practitioners and district specialists teams; and expanding school health services;
3. to improve the quality of care by setting and monitoring national norms and standards, improving systems for user feedback, increasing safety and health care and by improving clinical governance;
4. to improve health facility planning by implementing norms and standards;
5. to improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms;
6. to improve human resources for health by ensuring appropriate appointments, adequate training and accountability measures;
7. to prevent disease and reduce its burden and promote through a multi stakeholder National Health Commission; and
8. to develop an efficient health management information system for improved decision making.

The NHI as envisaged in the NDoH Strategic Plans, Green Paper published in 2011 and the recent publication of the White Paper in 2015 represents an important change in trajectory and will change the landscape of healthcare in the country, and as such will have an impact on all the role-players in the current environment.

The following are key elements in the implementation of a NHI:

- implementation of pilot projects – these have been implemented since 2012;
- the National Department of Finance (NDOF) will finalise and pass the NHI law in 2015/16;
- the National Insurance Fund will be created in 2016/17;
- set up National Quality Management and Accreditation Body. The Office of National Health Standards has been in operation since 2014.
- perform an audit of Health Information and Communications Technology (ICT) at all levels of the National Health System public sector only; and
- draft the National ICT Strategy for Health.

As legislated in Section 7 of the MSA, The CMS will continue to provide support of these health reforms and other healthcare policy matters.

The following table reflects the alignment between the NDP goals, MTSF Priorities and NDOH strategic goals with the CMS strategic goals for the period 2015 to 2020:

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2014 - 2019	CMS Strategic Goals 2015 to 2020
Average male and female life expectancy at birth increased to 70 years	HIV&AIDS and TB prevented and successfully managed Maternal, infant and child mortality reduced	Prevent disease and reduce its burden and promote health	***Access to good quality medical scheme cover is promoted*** The CMS Research and Monitoring as well as the Clinical Unit are currently engaged in the analysis of health care data with the aim to measure health quality outcomes at benefit option level. One of the pillars of the medical schemes Act is the PMB package and enforcement of Regulation 8 which makes payment of PMBs in full a requirement for all registered medical schemes. Currently the CMS is in the process of revising the PMB package with an emphasis to include more primary health care benefits.
Tuberculosis (TB) prevention and cure progressively improved			***Access to good quality medical scheme cover is promoted*** Treatment of TB is part of the PMB package and is treated in line with public sector protocol.
Maternal, infant and child mortality reduced			***Access to good quality medical scheme cover is promoted*** Vaccinations has been included in the revised PMB list as part of the development of a more primary health care focused package. CMS is working on finalising this during the course of 2016. The vaccination list is specific and includes vaccination like HPV Human papilloma virus (7 to 12 year old) hepatitis A B C D, etc.
Prevalence of non-communicable diseases reduced			***Access to good quality medical scheme cover is promoted*** The CMS through its Research and Monitoring Programme monitors the prevalence of non-communicable diseases within the medical schemes environment by analysing Scheme Risk measurement data as well as data submitted by means of the utilisation returns. This information is shared with relevant stakeholders in an effort to inform trends and advise on how best to reduce prevalence.

Health System reforms completed	Health care costs reduced	Improve financial management by improving capacity, contract management, revenue collection and supply chain management	***Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*** The CMS is currently engaged in a project to review and replace the current solvency framework with a risk based solvency framework. If implemented this framework may result in reduction of scheme contribution by members. The CMS is actively participating in the pricing enquiry currently being conducted by the Competition Commission. Once the report is finalised it is envisaged that recommendations by the Competition Commission will eventually lead to a reduction in health care costs.
	Efficient health management information system for improved decision making	Develop an efficient health management information system for improved decision making	***CMS provides strategic advice to influence and support the development and implementation of National health policy*** The CMS is currently developing a registry of all funded patients in South Africa. Once completed this system will be linked to the patient health register and will facilitate the overall improvement of the health management information system. The CMS is developing a system for the management of a single exit price for medicines on behalf of the National Department of Health (NDoH). Once completed this system will facilitate the regulation of medicine pricing in South Africa.
	Improved quality of health care	Improve the quality of care by setting an monitoring national norms and standards, improving systems for user feedback, increasing safety in health care and by improving clinical governance	***Access to good quality medical scheme cover is promoted*** The CMS fulfils an accreditation function in term of managed care organisations, administrators, brokers and broker organisations. The ongoing accreditation of these entities is dependent on inspection of their ability to render the required services at a specified health care level. In as far as accreditation of managed care entities are concerned, an evaluation of health outcomes, resources employed and price paid for such services is being undertaken to determine the clinical effectiveness and value proposition of these entities. CMS has further more also commenced work on chronic conditions (CDLs) and

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2014 - 2019	CMS Strategic Goals 2015 to 2020
			Utilisation management of services as it relates to hospitals and medicines with the aim of eliminating waste from the system. This initiative will be further developed over the next five years. The NDoH guidelines serve as a minimum benchmark for quality health outcomes. Once entry level criteria, process indicators and outcomes have been concluded, same will be incorporated in the CMS accreditation standards and applied to managed care entities for purposes of ongoing accreditation. Finally, the CMS, through its compliance inspectorate also ensures compliance with different aspects of the Medical Schemes Act some of them which relate to improving the overall quality of health care delivery.
Primary health care teams deployed to provide care to families and communities	Re-engineering of Primary health care	Re-engineer primary healthcare by: increasing the number of ward base outreach teams, contracting general practitioners, and district specialist teams and expanding school health services	***CMS provides strategic advice to influence and support the development and implementation of National health policy*** Currently the CMS is in the process of revising the PMB package with an emphasis to include more primary health care benefits.
Universal Health coverage achieved	Universal health coverage achieved through implementation of National Health Insurance	Make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation.	**CMS provides strategic advice to influence and support the development and implementation of National health policy** Resulting from the publication of the NHI white paper, the NDoH published by means Government notice no. 1231, the terms of reference of the National Health Insurance work streams in terms of Section 3 (1) of the National Health Act, 2003. Work Stream 4 will investigate and advise on the future role of medical schemes in an NHI environment. The CMS will participate fully with the Work Stream 4 team to reach their specific objectives as stated in the Government notice.

4.3. Relevant court rulings

The Guardrisk court case, which ruled that some gap-cover health insurance products are not in contravention of the Act, placed a particular burden on the Council to protect medical schemes as the preferred health insurance vehicle. This ruling has led to a proliferation of health insurance products, which threatens medical scheme risk pools, and requires extensive interventions by the office.

Since the Guardrisk judgement in 2008, the definition of the "business of a medical scheme" in the Medical Schemes Act 131 of 1998 was amended by The Financial Services Laws General Amendment Act, No. 45 of 2013 which came into operation on 28 February 2014. The effect of the amendment is to clarify each of the activities (and not all the activities collectively as per the Guardrisk Judgment). The amendment to the definition of the "business of a medical scheme" will come into effect at the same time as the finalisation of the Demarcation Regulations.

Further, close collaboration between the National Treasury and the Financial Services Board has resulted in the development of a draft set of regulations to the Long-term Insurance Act, No. 52 of 1998 and the Short-term Insurance Act, No. 53 of 1998. The first draft regulations were published for public comment in March 2012 and the second draft in April 2014. The purpose of the regulations is to clearly define and separately regulate health insurance policies from the business of medical schemes.

The July 2010 High Court ruling which set aside the National Health Reference Price List (NHRPL) regulations has left a vacuum in the determination of private health care prices. The CMS assisted the NDoH in the publication of a discussion document on the determination of health care prices in the private sector. The Minister has appointed a task team to engage with comments on the discussion document and to advise him on further options.

A key development in the understanding of the healthcare market structure is the amendment to the Competition Act, 89 of 1998 to grant the necessary powers to the competition authorities to undertake a market inquiry, such as the one in the healthcare sector. The Competition Commission is of the view that conducting this inquiry will assist in understanding how it may promote competition in the healthcare sector, in furtherance of the purpose of the Act. The CMS, as a regulator of the healthcare sector fully supports this initiative, and has been invited, amongst other stakeholders, to provide information in this regard. The CMS believes that the private health sector in South Africa is in need of an urgent reform in order to enable it to ma ximise its contribution to overall health system performance within the country. Our key concern relates to cost escalation and limited competition based on quality and price.

Therefore, it is our view that amongst other things, the Market Inquiry will facilitate the move towards the establishment of a Pricing Statutory Body to regulate price setting by private hospitals, day clinics and private primary healthcare centers; and also to address the adverse impact of vertical relationships between specialists and private hospitals.

In November 2011 the High Court dismissed the Board of Healthcare Funders (BHF) application, whereby they argued that prescribed minimum benefits (PMBs) must be paid for only at scheme tariff level and not in full as determined by Regulation Act. This amounts to an important victory for medical scheme members. If BHF were successful, the implication would have been that the effect of PMBs to ensure solidarity in healthcare would have been severely undermined. The High court denied leave to appeal this decision in May 2012, and the Supreme Court of Appeal dismissed the application for leave to appeal in September 2012.

During the past two years there have been a number of court cases where governance and the interpretation of the Medical Schemes Act was the subject of the disputes.

In the matter of Genesis v CMS and Joubert, the daughter of a member of Genesis medical scheme was involved in a motor vehicle accident in 2008 during which she sustained a broken leg. The scheme appealed a ruling of the Registrar which directed it to pay for three external prostheses which were fitted to the dependant's leg. The matter was appealed by the scheme to the level of the Appeal Board. The Appeal Board ruled that the scheme was liable to fund the medical expenses up to the amount that would be paid to a public hospital. The scheme subsequently lodged a review application in the Western Cape High Court. The court ruled in favour of the scheme on the basis that the registered rules of the scheme is binding on the Regulator as well. As the matter has huge implications for the industry and the application of PMBs, the CMS has appealed the judgement.

In the matter of the Registrar of Medical Schemes v Hosmed Medical Scheme, the Registrar instituted action in the North Gauteng High Court against the scheme, its principal officer and trustees for the recovery of penalties levied in terms of section 66(3) of the Medical Schemes Act. The scheme subsequently made an offer to pay the penalties and the legal costs of the Registrar's Office. In another matter concerning the same scheme, the CMS's decision to remove some trustees due to them not meeting fitness and propriety standards, was taken on review. The appeal by the trustees was dismissed by the Appeal Board. Such cases are significant in determining boundaries in respect of the conduct of the market.

In 2012, The Registrar of Medical Schemes had obtained a court order to place Medshield Medical Scheme under curatorship, due to governance failures at the scheme. The then trustees of the scheme who were removed by the curatorship sought to challenge this ruling by bringing an application to the Supreme Court of Appeal (SCA) which confirmed that the material irregularities at Medshield justified the appointment of a curator by the Registrar and that it was in the interest of the beneficiaries of the scheme.

The appeal by the now ejected Board of Trustees of Medshield was dismissed with costs. The court found the removal of trustees in terms of section 46 of the Medical Schemes Act 131 of 1998 is too time consuming and is not an effective alternative remedy.

This is a significant judgment for the CMS in that apart from focusing attention on the lack of good governance at the scheme the Supreme Court of Appeal has expressed its unequivocal support for the course of remedial action adopted by the Registrar in appointing a curator to assume control of Medshield, rather than invoking the remedy of removing the entire board of trustees in circumstances where the entire board of trustees had made itself guilty of impropriety.

In addressing the material governance failures faced currently in the environment, some schemes were placed under curatorship. These interventions continue to be riddled with difficulties, and governance will as such continue to be an area of key strategic focus and enhancement by the Council. To this end specific amendment to the present Act have been made to mitigate this challenge.

In Genesis v CMS and du Toit the dispute related to a member's surgical procedure following a back injury in 2007. The scheme did not fund the claims in full because the services were not provided by a state hospital. The decision was appealed to the Appeals Committee which postponed its ruling to allow the scheme to submit further documents. When these documents were not submitted, the Appeals Committee ruled that the scheme must fund the outstanding claims. The scheme lodged a review application in the North Gauteng High Court and requested exemption from the provision in the Promotion of Administrative Justice Act which would require the scheme first to exhaust internal remedies – an Appeal Board hearing – before resorting to court action. In November 2013 the court dismissed Genesis's application with costs, ruling that the Appeal Board had wide powers to hear the matter and remedy alleged irregularities by the Appeals Committee. The scheme applied to for leave to appeal and this was rejected by the same court after which its petition to the Supreme Court of Appeal was also dismissed.

The judgement reinforces the view of the CMS that internal remedies have to be exhausted before an aggrieved party can approach a court. By doing this there is a greater prospect of the matter being resolved in a less costly and less time consuming manner. The Appeals Committee and Appeal Board was put in place to ensure that tribunals who have the appropriate knowledge of the medical schemes industry adjudicate the matters before it. The court on the other hand may not have the required expertise and it is very costly to brief legal representatives to deal with a matter at that level. In conclusion the impact of the matter is that time and money is saved while the matters are being heard by panellists with the appropriate expertise and knowledge.

4.4. Planned Policy Initiatives

Applicable to Departments only.

5. Situational analysis

5.1. Performance environment

The private health system is complex, involving numerous players whose interests and goals are in constant flux and in many instances contradict both their own long-term interests as well of those of the public at large. Identifying a rational and feasible path forward consequently requires an on-going combination of leadership and intelligent engagement with the environment. The private health system organically responds to health demand, but not coherently to health needs. For this reason, public policy intervention is necessary to enhance what the private system does well, and to minimise those areas where the private system fails. If interventions are well designed and successfully implemented the private health system is capable of fully supporting the country's broader social goals. Where a coherent strategy for the private health system is absent, however, coverage will invariably diminish in both extent and quality, with knock-on effects for the public health system and the quality of life possible in South Africa.

Over the past one hundred years' health insurance of various forms evolved in South Africa along with various regulatory instruments. It was however not until 1998 that a framework was implemented to modernise and update the system with a view to maximise fair access to medical schemes along the lines of developments in Europe and South America. The central aim of these reforms, provided for in the **Medical Schemes Act No. 131 of 1998** (the Act), was to enhance the *risk pooling* potential of medical schemes and other important *regulatory and oversight mechanisms* by introducing:

- **A preferred health insurance vehicle**, which required that any person doing the business of a medical scheme must operate in terms of a single legislative framework;
- **Open enrolment**, which removed the discriminatory practice of medical schemes to select only good risk beneficiaries for membership (risk selection);
- **Community rating by option**, which removed the discriminatory practice of schemes to apply unfair charges to older and sicker members and beneficiaries (risk rating);
- **Mandatory minimum benefits**[3], which removed the ability of schemes to discriminate against older and sicker members through the selective non-provision of key benefits;
- **Waiting periods and late joiner penalties**, to eliminate any significant application of penalties for member movement between medical schemes and options, while substantially removing the opportunities for anti-selection where a member joins only when sick and then leaves or only joins for the first time later in life;
- **Improved governance**, which removed the historical conflicts of interest embedded in the oversight of medical schemes;
- **Regulation of intermediaries**, which implemented accreditation and more stringent regulatory oversight of medical scheme brokers, administrators, and managed care organisations;
- **Improved oversight**, through the implementation of a substantially enhanced special-purpose regulator to oversee the Act; and
- **Member protection,** which includes the complaints resolution mechanisms at scheme level and providing members access to the complaints resolution mechanisms at the Registrar's office and appeals processes.

The introduction of the above measures ensures that all health insurers operate on a level playing field, which maximises the advantages and minimise the disadvantages of a competing and highly commercialised multi-fund health system. However, many facets of the funding and provision of private health services are not adequately regulated resulting in systemic shortfalls in coverage, the quality of coverage, cost containment, and impact on the public health system. Certain of these inadequacies pertain to the public health service as well, which contributes to private sector costs, coverage, and unfair access to the health system for low-income groups. Understanding where these gaps are located and how health policy should respond remains a major challenge for the CMS and Government, and that all role players respond appropriately to these deficiencies. The regulation of private hospitals is an example of a key policy intervention required to allow for the stabilisation of healthcare costs.

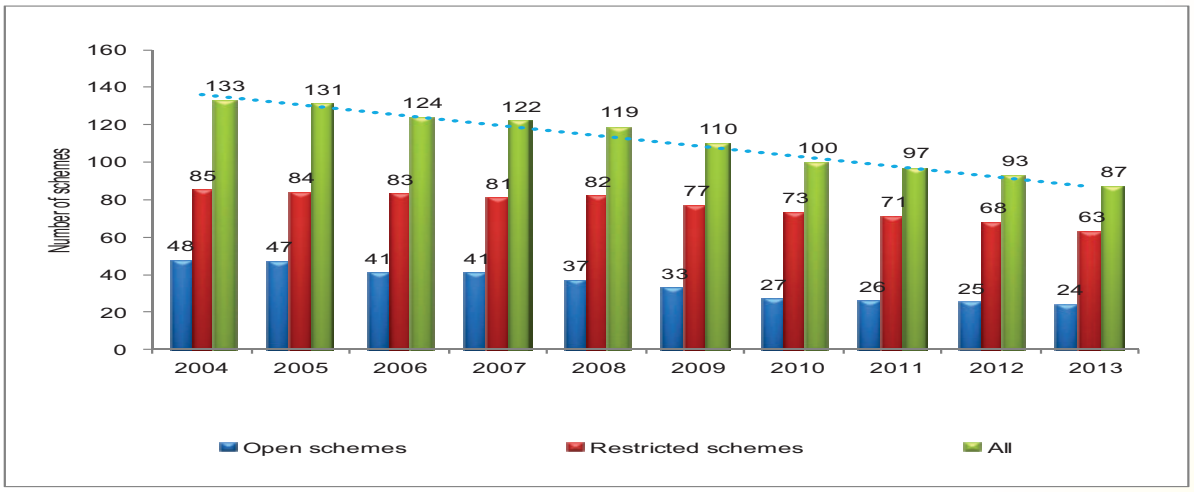
[3] Note that the term "Mandatory minimum benefits" is generic in nature, in our context this refers to the prescribed minimum benefits (PMBs).

5.1.1. Progress since 2004

Without addressing all possible matters, the powers given to Council through the Medical Schemes Act has stabilised many of the negative tendencies of the private health sector. Successes over the past decade include:

- Improving coverage and the quality of coverage, which was in decline during the 1990s;
- Containment of the upward trend in private provider costs experienced by medical schemes, with 2010 costs per beneficiary per month only slightly higher than the 2006 levels (See figure 4 -5)
- Containing non-health costs in medical schemes which increased dramatically post the de-regulation of January 1994 and only ended after the full implementation of the CMS in 2002 (see Figure 7, Page 22)
- Introduction of new solvency requirements which reduced the risk of rapid unforeseen insolvencies in schemes;
- Introduction of web-based reporting of annual financial returns, with quarterly reporting introduced from around 2004, which improved the early warning and response capability of the office;
- substantially improved transparency in the system through an upgrading of the South African Institute of Chartered Accountants (SAICA) guidelines and the public reporting of medical scheme financials and data through the annexures to the annual report which are published annually on the website; and
- Establishment of a robust complaints system and a call centre which afforded easy communication with the public.
- Real Time Monitoring system, which is a web based application that collects a limited data set via direct mapping to the systems of medical schemes, was introduced. This is to allow for better understanding of the risk profiles of schemes and thus more holistic regulatory and policy interventions.
- In 2013, the Council for Medical Schemes introduced a process for Alternative Disputes Resolution (ADR) and facilitation of pro-bono legal assistance in 2014, to alleviate both administrative and financial pressures from the beneficiaries, schemes and the regulator. Although in their initial stages, these interventions have been welcomed by stakeholders and are certainly a move in the right direction.

Figure 1: Trends in the number of medical schemes, 2004 -2013



The downward trend in the total number of medical schemes that has been noted for several years continued in 2013. As evidenced by Figure 1, it was most pronounced among small restricted schemes. The sustained reduction in the number of schemes has been occurring for the past 10 years. There is a clear trend of consolidation in the private medical scheme industry. The challenge to have an industry that is competitive, financially sound and not dominated by a few schemes as this will have adverse implication for the entire industry remains.

Figure 2 shows an overall increase in the number of medical schemes beneficiaries between 2004 and 2013. Within the restricted schemes market, the high increase in beneficiaries from 2006 can largely be attributed to the impact of GEMS when it started operations. It however appears that the growth in GEMS has stabilised and hence the trend in number of beneficiaries in restricted schemes also stabilised. This trend points to the need for the CMS to continue its endeavours in ensuring that the industry remains sustainable with emphasis on increasing coverage.

Figure 2: Trends in number of beneficiaries, 2004 - 2013

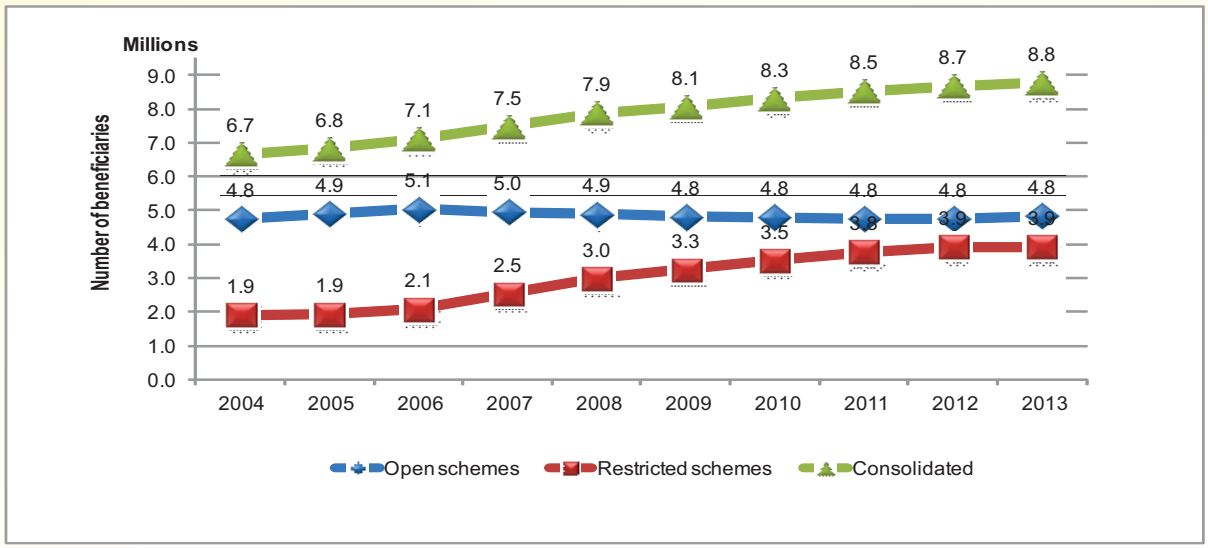


Figure 3: Trends in the Average Age of Beneficiaries, 2000 – 2013

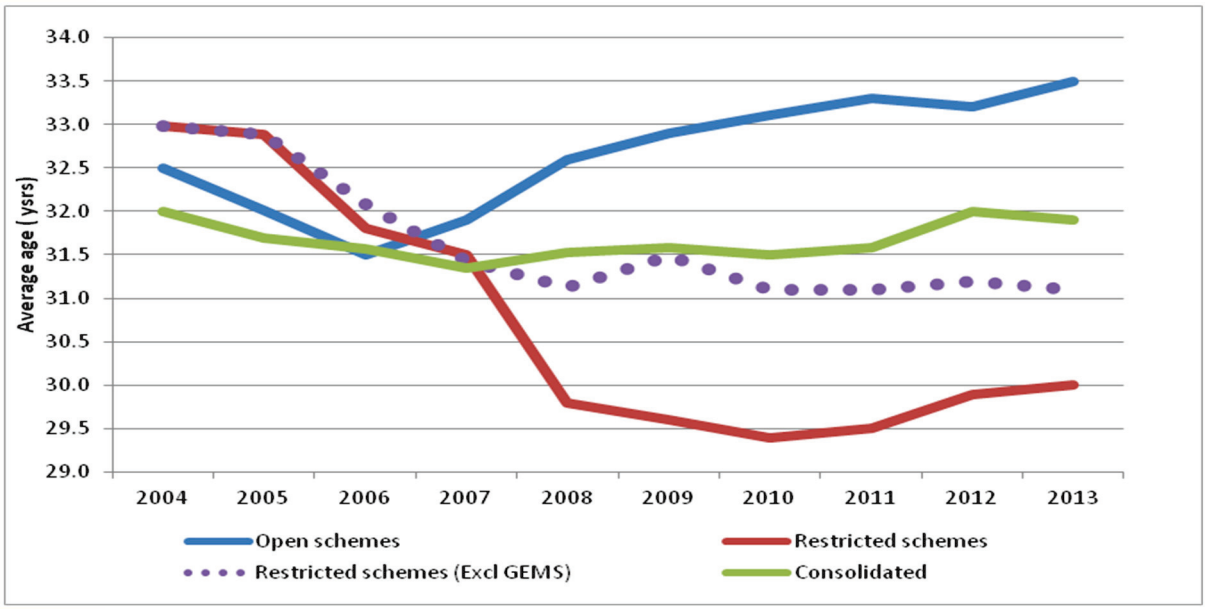


Figure 3 shows that there is a large difference in the average age of beneficiaries between open and restricted schemes; this is the result of the growth of the Government Employees Medical Scheme (GEMS). The increasing average age of the open schemes places a heavy burden on these schemes, and unless a risk adjustment mechanism is considered, the unequal distribution of risk will result in continued failure of smaller schemes at the expense of older and sicker beneficiaries.

Trends in total healthcare benefits paid

Hospitals and medical specialists continue to constitute the majority of benefits paid by medical schemes. In the 2013 benefit year, benefits paid to hospitals and medicals specialists amounted to a combined proportion of 59.8% with hospitals making up 35.3% of the total benefits, while medical specialists make up 24.5% of the total benefits paid in the year. This is a continuation of observed trends in the last several years. Figure 4 refers.

Figure 4: Trends in benefits paid by discipline, 2013

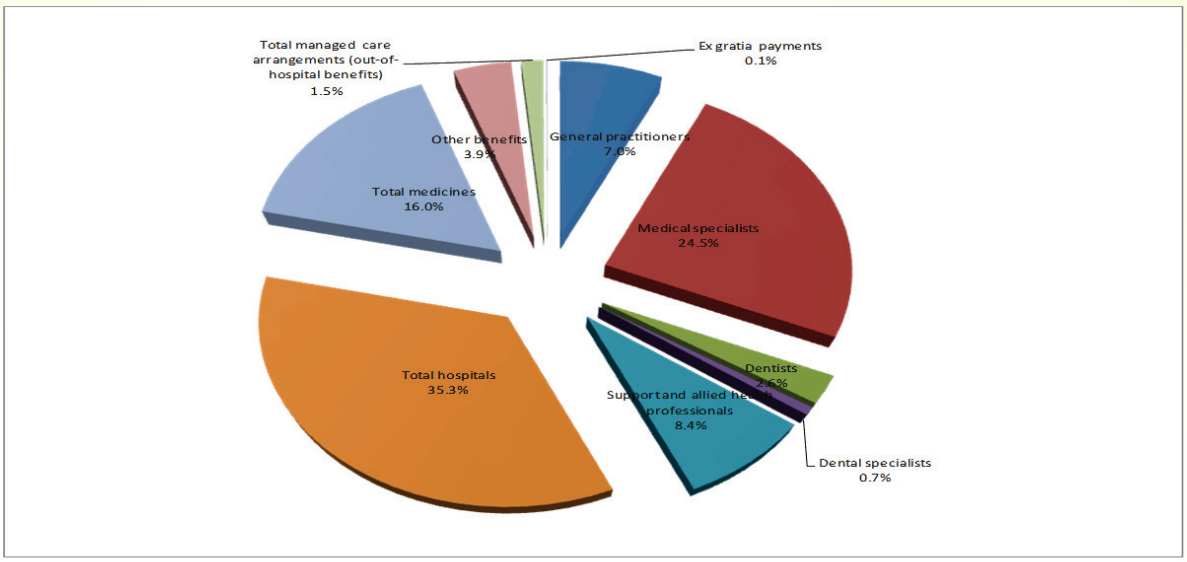
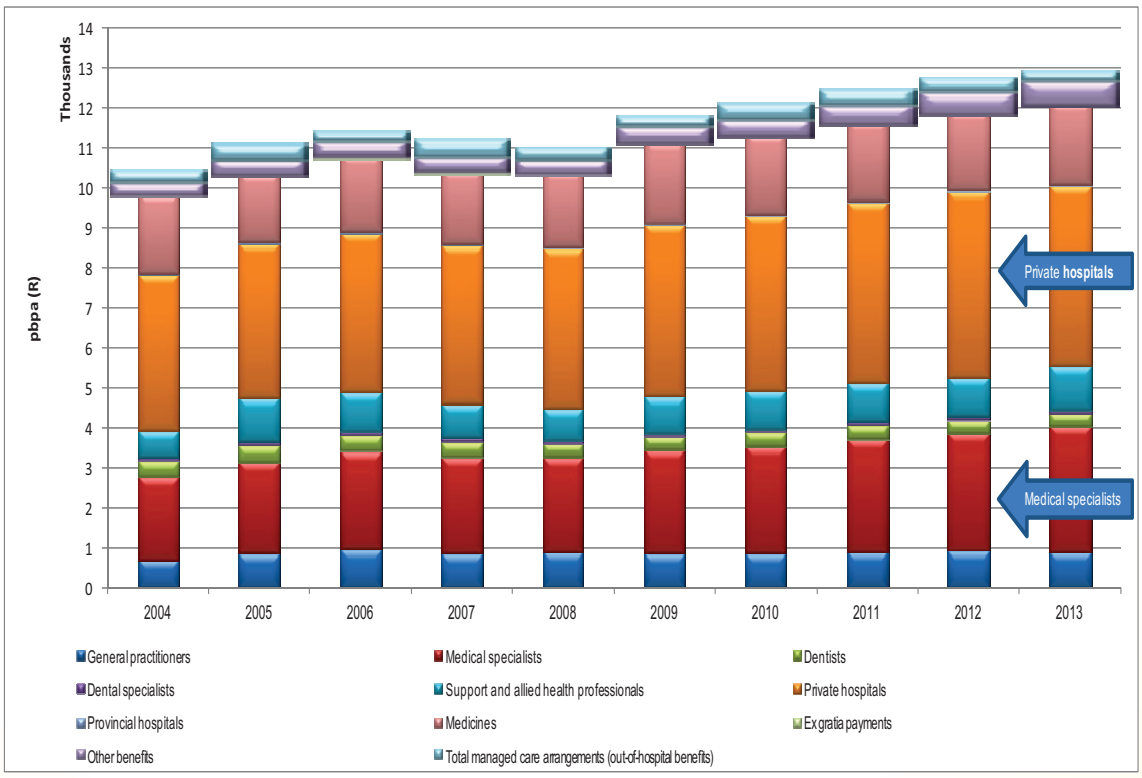


Figure 5 shows trends in the distribution of healthcare benefits that medical schemes paid to various categories of service providers since 2004, adjusted for inflation to 2013 prices. These figures are reflected per beneficiary per annum.

Figure 5: Trends in benefits paid by discipline per beneficiary per annum, 2004 - 2013

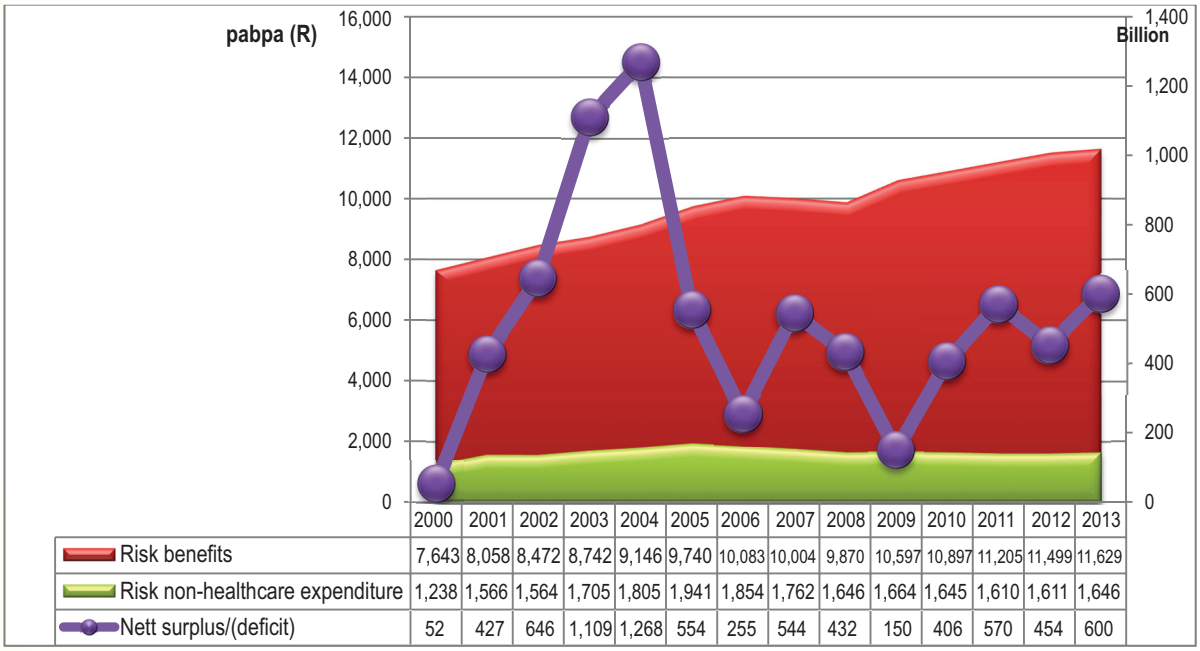


Overall medical schemes' expenditure on private hospitals decreased slightly in real terms by -0.8% to R39.4 billion in 2013, compared to R39.7 billion in 2012, representing the first year since 2005 in which there was no significant increase in expenditure paid to hospitals.

However, over the ten years from 2004 to 2013, there has been a historical sustained increase in expenditure on private hospitals, rising from R25.7billion in 2004 to R39.4 billion in 2013 – in the long run; this will have a negative impact on the affordability of medical schemes. Affordability is a big challenge on the growth of the private medical scheme industry, but also on access of healthcare. It is important for CMS needs monitor these costs and develop strategies to ensure that the beneficiaries are receiving value for money. One such intervention is ensuring that the value proposition of the various managed care initiatives implemented by schemes is heightened. Managed care programs are designed to keep the beneficiaries out of the hospital. When successfully implemented and managed, such programs have not only the potential to save medical schemes and beneficiaries' money, but also improve the quality of life of the beneficiaries.

Measuring the value add of managed healthcare, including patient satisfaction will be an important area of focus for the CMS over the next five years. The imperative of measuring, monitor and improving the quality of health and the effectiveness of health care system is an important one which must be pursued vigorously. However, overall, many structural problems remain in the private health system, which, if not addressed will result in an erosion of both coverage and the quality of coverage.

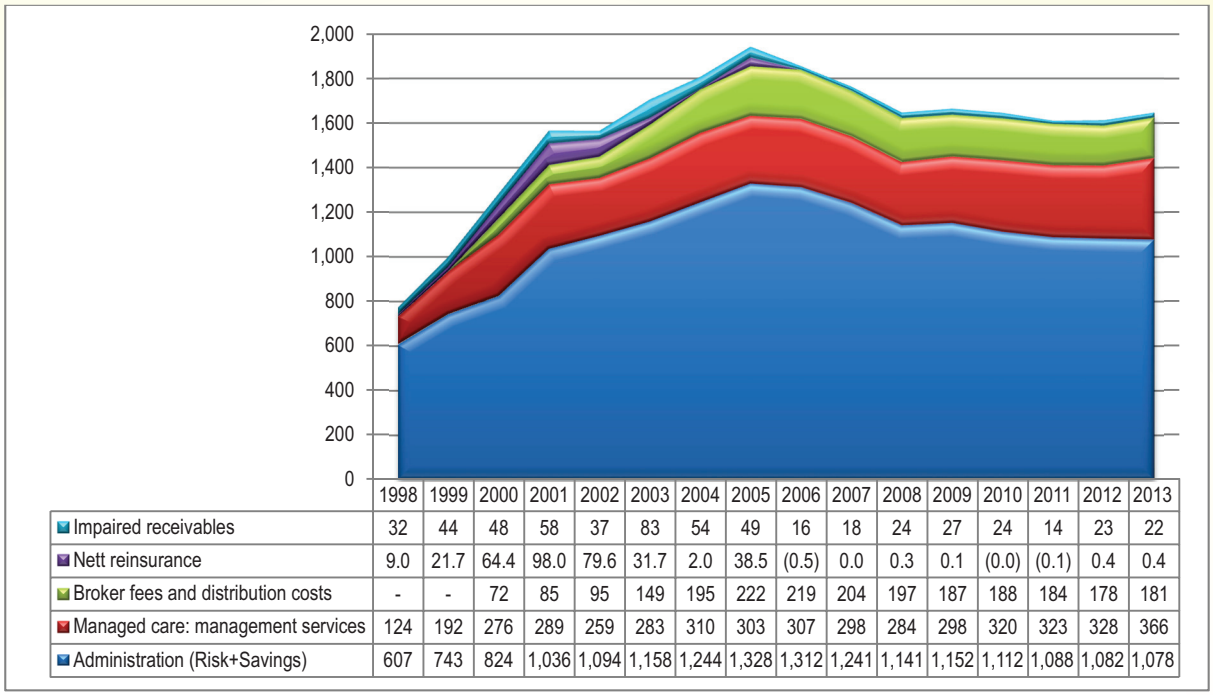
Figure 6: Trends in claims, non-healthcare expenditure and net results, 2013 prices



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Risk benefits	7,643	8,058	8,472	8,742	9,146	9,740	10,083	10,004	9,870	10,597	10,897	11,205	11,499	11,629
Risk non-healthcare expenditure	1,238	1,566	1,564	1,705	1,805	1,941	1,854	1,762	1,646	1,664	1,645	1,610	1,611	1,646
Nett surplus/(deficit)	52	427	646	1,109	1,268	554	255	544	432	150	406	570	454	600

Figure 6 above shows trends in claims, non-healthcare expenditure and the net results of all medical schemes since 2000 to 2013. In the earlier years when all medical schemes were required to build up reserves following the promulgation of the MSA, the overall net results, after the inclusion of investment income, were positive and increasing. The surpluses per beneficiary per annum were subsequently volatile, coupled with an increase in the claims cost per life. This trend has stabilised in the last few years.

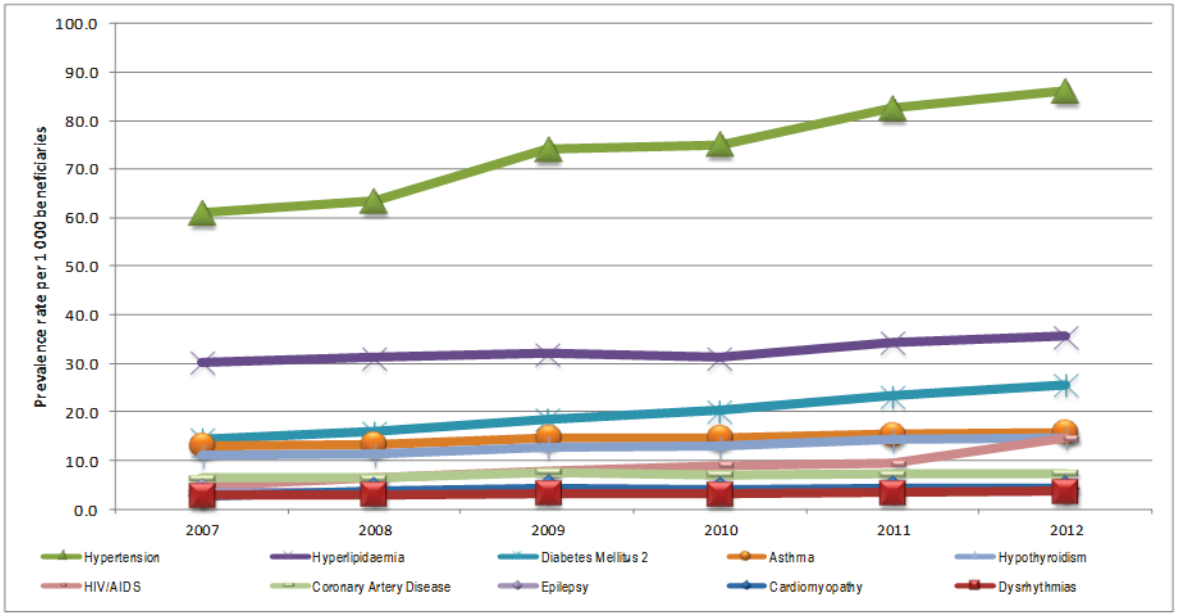
Figure 7: Trends in non-healthcare expenditure, 2013 prices



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Impaired receivables	32	44	48	58	37	83	54	49	16	18	24	27	24	14	23	22
Nett reinsurance	9.0	21.7	64.4	98.0	79.6	31.7	2.0	38.5	(0.5)	0.0	0.3	0.1	(0.0)	(0.1)	0.4	0.4
Broker fees and distribution costs	-	-	72	85	95	149	195	222	219	204	197	187	188	184	178	181
Managed care: management services	124	192	276	289	259	283	310	303	307	298	284	298	320	323	328	366
Administration (Risk+Savings)	607	743	824	1,036	1,094	1,158	1,244	1,328	1,312	1,241	1,141	1,152	1,112	1,088	1,082	1,078

Figure 8 below depicts the trends in the 10 most commonly diagnosed and treated conditions from 2007 to 2012. Due to data limitation, it is currently not possible to isolate the reason for the generally upward trend shown in Figure 8, but generally it could be attributed to improved data management systems of medical schemes and administrators, the deteriorating disease profile and higher average age of beneficiaries, increased beneficiary awareness of entitlements and changes in care-seeking behaviour. The higher prevalence of beneficiaries with chronic diseases could translate to an increase in visits to general practitioners and specialists, a growth in the use of medicines, and a possible rise in hospital events. Without population-wide interventions to address the root causes of these chronic diseases the upward trend is expected to continue with increasingly severe impacts on schemes. Protection of risk pools and growth in younger, healthier beneficiaries are critical for long-term sustainability of the industry. These interventions must be coupled with increased utilisation of properly structured disease managed care programmes and the measurement of the outcomes thereof.

Figure 8: The trend in the prevalence of the top 10 diagnosed and treated chronic conditions (2007 – 2012)



Whilst there has been significant progress in some areas of regulation, there is a lot still to be done as structural deficiencies remain with an adverse impact on the industry as a whole. A proposal to address these deficiencies should include the following:-

- A standardisation of the process involved in issuing licenses to hospitals in all the provinces throughout our country. It is important to have these processes in place with immediate effect.
- A Statutory Pricing Authority that will play a significant role in terms of its impact on the cost factor in the private health care industry.
- The regulation of the supply side of the market needs urgent attention – the lack thereof creates imbalances in the current environment.

5.1.2. Benefit coverage (Prescribed Minimum Benefits)

PMB level of care is best described as health care that is essential, fair and ensures that all members of a medical scheme have access to a basic level of health protection irrespective of health risk and benefit option status. The overall objective of the PMB Package is to protect medical scheme members against severe financial/economic disaster related to access to services. All medical schemes are required by law to provide for PMBs. In addition, schemes can also provide for varying levels of discretionary benefits.

Some medical schemes tend to manipulate these entitlements. Many members do not fully comprehend scheme rules. These rules need to be simplified especially in terms of these entitlements. Measures that need to be in place in order to protect access will include:

- PMBs need to be defined as benefit packages and not as diagnosis treatment pairs which can be simply expressed in the rules.
- Benefit designs need to be standardised and simplified and clearly show benefit exclusions.
- Rules relating to benefits ought to be filed electronically.
- Rules regarding Designated Service Providers (DSPs) and protocols need to be clearly laid out in simple language.
- Price regulation to be introduced for funding PMBs and regulating the extent of balance billing and the use of co-payments.

Furthermore, the PMB package needs to be reviewed to incorporate preventative care initiatives. This will assist in reducing healthcare costs by introducing co-ordinated referrals and limiting downstream costs at higher levels of care. Additionally, such a package should be responsive to the quadruple burden of disease as identified by the Minister of Health and national preventative care policies; and be cost effective.

5.1.3. Open enrolment

Open enrolment is a cornerstone of the medical schemes system ensuring free movement between schemes and options without penalty. Recently, there have been signif icant challenges to this provision, with some medical schemes refusing members cover for a myriad of reasons.

In large measure, this set of circumstances has arisen because of the absence of a system of risk adjustment.

Therefore, strengthening the system of open enrolment requires consideration of the following:

- Further preparations for the implementation of full community rating system that would remove scheme disincentives to accept poor risks;
- The introduction of strong penalties for any risk selective conduct of this nature; and
- Further clarification of provisions governing restricted membership schemes, which presently are not explicitly spelt out in the law, to prohibit the granting of such status subject to compliance with strict criteria.

Access to medical schemes for many is the means by which they access private services and public services which require payment. Access is reduced where applicants and beneficiaries are discriminated against based on their health status or any factor correlated with it (such as age). High costs and low income are also barriers to access. Systemic barriers to access can also arise due to the multi-scheme nature of coverage.

Besides the Regulation 8 challenge which was set aside by the Supreme Court of appeal, other assaults on risk pooling include the instance where both GEMS and Discovery refused membership to Transmed members. In the GEMS case, both the Appeal Committee and Appeal board ruled in favour of the Transmed members, but GEMS has taken the matter to the high court for review. The Appeal Committee ruled in favour of the Transmed members in the Discovery case. The underlying structural problem in both these cases is the absence of a system of risk adjustment. The absence of such a system is dire as it results in an unequal playing field between schemes and the resultant distortion of claims due to deteriorating risk pools.

In relation to the Discovery Medical Scheme's refusal to accept Transmed members, the matter has since been resolved. The scheme has agreed to accept these Transmed members after engagement with the Office. It however remains critical that an industry wide solution be developed such that the important principle of open enrolment as entrenched in the MSA is protected.

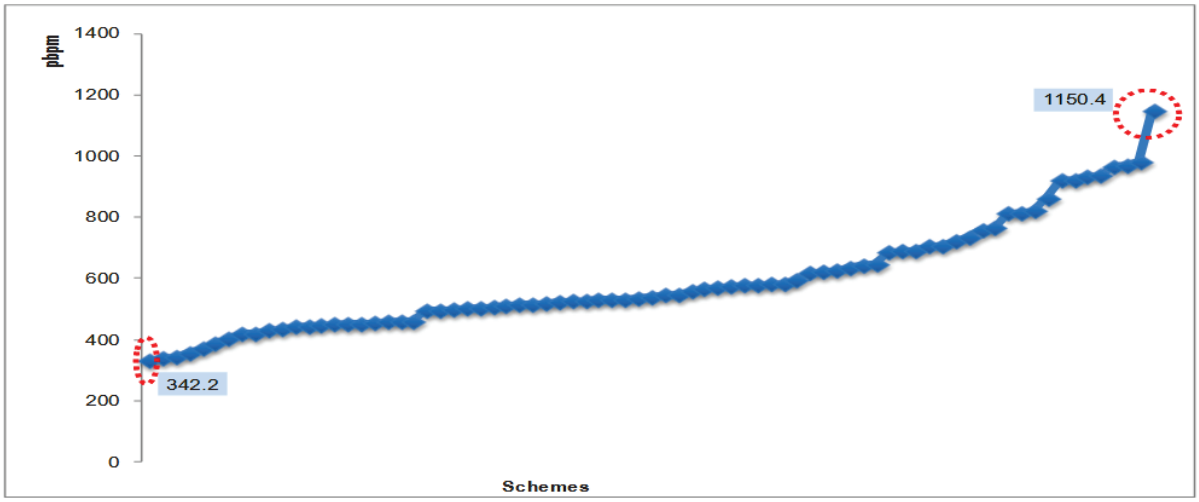
5.1.4. Full community rating

Presently community rating only exists within options within schemes. As a consequence a degree of risk rating for essential benefits continues to exist. This occurs because different option designs deliberately attract different risk groups.

Figure 9 shows the difference between the medical schemes in the estimated cost of the PMB's per month per beneficiary. The amounts and variation are very similar for the other months of 2013. The expected PMB cost for 2013 was R508.20 per beneficiary per month (pbpm).

It is clear from Figure 9 that schemes do not compete at the same level. Competition amongst schemes is currently not fair and a system of risk adjustment could equalise the cost of providing benefits to members across medical schemes. This would encourage schemes to compete in terms of efficiency rather than on their membership profile.

Figure 9: Scheme community rate, December 2013



The absence of the system of risk adjustment perpetuates this phenomenon in medical schemes. The medical schemes environment is divided into many separate risk pools, which has a number of avoidable systemic consequences. These include:

- Anti-selective behaviour by members, who buy less cover when healthy and more cover when sick or sicker;
- Medical schemes have an incentive to avoid poor risks and attract only good risks, in part to avoid anti-selection, but also to price compete with other schemes for equivalent levels of cover;
- Medical schemes have an incentive to unfairly deny access to MMBs or to shift these expenses into self-insurance pools; and
- Medical schemes have an incentive to compete on risk profiles instead of underlying health service costs, as measures targeting the former are easier to implement.

It would require a considerable amount of time for the implementation of a system of full community rating including a beneficiary registry, with material implications for the evolution of the medical schemes system. These changes should occur in conjunction with appropriate changes to the benefit framework.

5.1.5. Affordability – healthcare costs

Figure 5 above deals with the increasing cost burden of healthcare benefits on members.

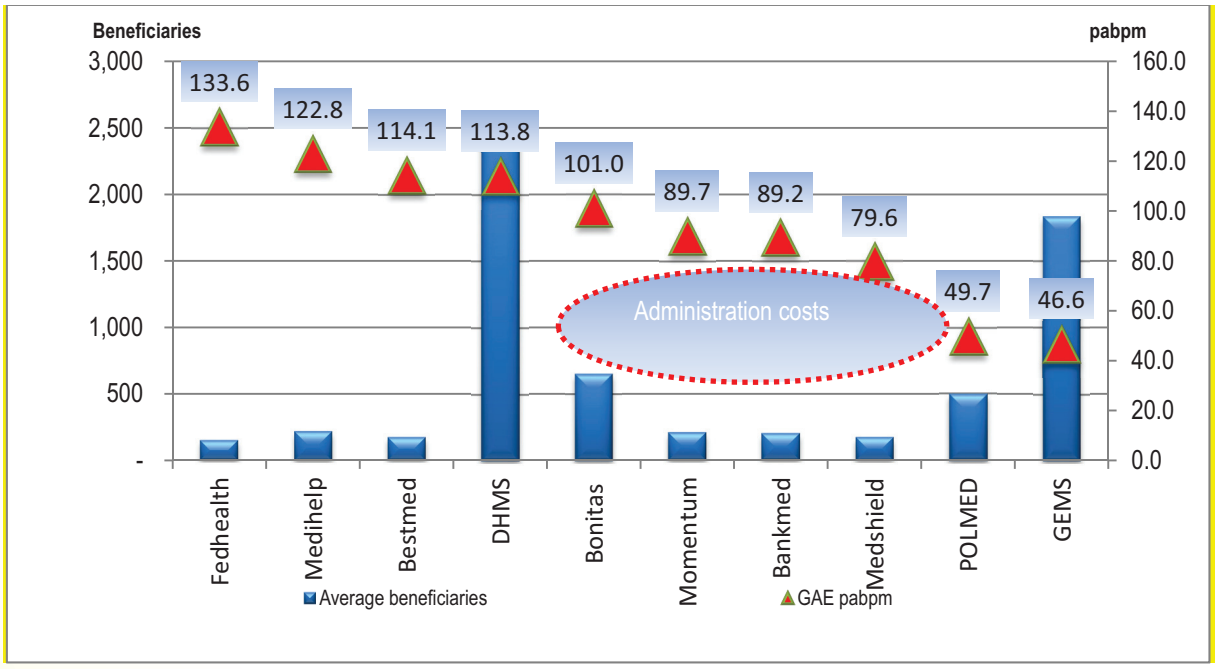
Further, the estimated cost of the PMB benefit package for 2013 is R508,20 pbpm. The current PMB package involves full cost cover for 26 chronic conditions and 271 diagnosis-treatment pairs – mainly, but not exclusively, related to serious conditions usually requiring hospitalisation and highly specialised and costly out of hospital care. The PMB package therefore focuses largely on tertiary care, and there seems to be a need for including primary care elements in the package, as indicated by the NDoH.

However, this could mean that the introduction of further PMB benefits may place further cost pressure on medical schemes, pushing scheme membership even further out of reach for a larger number of low income individuals, due to continued increases in costs, especially in the absence of any price regulation.

Given the cost pressures in the environment, an alternative framework may need to be considered. This package will need to have well defined and standardise preventative care benefits, amongst other. Such a benefit framework will only be viable when coupled with a system that would adjust for risk in order to address the potential anti-selective behaviour that may arise due to differentiated benefit packages.

Over the last decade or so, the Council has placed increased emphasis on the need to curb both the spiralling healthcare costs and inordinate expenditure on non-healthcare, particularly where there is no demonstrable value proposition. Whilst non healthcare as whole has reduced in real terms, it should be acknowledged that it was coming off a very high base from the pre regulation era. Further, some constituents of non-healthcare expenditure are still presenting problems, such as administration fees, broker fees and managed care. The universally accepted principle of economies of scale does not seem to be evident, where administration costs do not vary with scale. This is also due to structural problems that exist in the governance frameworks adopted by medical schemes.

Figure 10: Administration costs of the top ten largest schemes, 2013



GAE= Gross administration expenditure

As shown in Figure 10, it is clear that there is no expected relationship between costs and scale in the current environment. This may have an impact on efficiencies as operational efficiencies are often greater with increasing scale. The cost of administration to a medical scheme furthermore depends on the nature and extent of the services contracted to administrators against payment of a fee which is influenced by the complexity of benefit options provided for by the scheme.

A factor contributing to increased cost of administration may involve the existence of brokers who render services which are paid for by medical schemes as a business expense. The Act presently permits a scheme to remunerate brokers for services rather than members or employers who appoint brokers to advise them on medical scheme matters. This practice fails to discount medical scheme contributions where no use is made of a broker, thereby adding costs to the scheme.

A fairly significant long-term impact on scheme costs is possible if the following are implemented:

- A central bargaining process for negotiating provider charges outside of bilateral contracts;
- Promoting alternative reimbursement structures for schemes and managed care entities with providers of service to incentivise price competition between schemes on claims costs;
- The implementation of governance reforms for schemes (discussed below);
- The introduction of broker reforms which would include:
- A clear indication that members or employers who appoint brokers must pay for such services in addition to their contributions payable;
- Separating broker fees from scheme contributions and requiring that brokers contract directly with beneficiaries and employers; and
- Distinguishing between advice and marketing, creating separate markets for each, and disallowing any broker offering advice from marketing a scheme or any related party.

5.1.6. Affordability – income

Significant unfairness exists for low-income groups wishing to join a medical scheme, as many of them must pay for cover without access to a tax subsidy or to the implicit subsidy made available through the means tested public health system. They are further disadvantaged where the means test excludes them from free public health services, despite not being able to afford a medical scheme. This difficulty also applies to many pensioners whose incomes drop significantly when going into retirement.

Aside from the above there is the problem generated by the necessary PMB framework (needed for risk pooling purposes) which could end up excluding low-income groups.

The following must therefore be considered to deal with income-related affordability concerns:

The means test for access to public sector hospital services may be adjusted or entirely removed, except for people covered by a medical scheme;

- The tax subsidy needs to be adjusted to favour lower income contributors;
- An alternative benefit framework must be considered for persons in lower income bands. Given the recent proliferation of health insurance products some of which are referred to as gap cover products, coupled with the rising cost of healthcare (in the absence of structural interventions such as, amongst others, a centralised bargaining mechanism and a Reference Price List i.e. price regulation, system of risk adjustments) the need for such a framework has become even more urgent. The high cost of healthcare frequently results in members being required to make co-payments and be subjected to deductibles. Such a framework would also allow extended coverage to include the uninsured market; and
- The Act needs to be adjusted to guarantee the full reimbursement of public health services, outside of bilateral agreements, where the public sector is used to cover medical scheme benefits of any form.

5.1.7. Access to schemes

Access to medical schemes typically occurs through employers or brokers advising on individual cover. Given that brokers may have conflict of interests due to the current remuneration model and the role that employers play in the selection of brokers for their employees, access may be restricted through incentives provided by schemes or employers. It is therefore necessary to introduce a framework whereby members who appoint brokers or employers who do so on employees' behalf, remunerate any and all broker fees from their own pocket rather than to incur a general scheme expense. It is anticipated that a shift in payment towards broker fees may result in greater transparency and in addition to a reduction in administration costs of schemes, cause clients to opt for direct access to medical schemes. Medical schemes ought to take a more active role in marketing cover with a view to attract direct members and provide factual advice to the public. It is worth noting that GEMS does not make use of brokers and yet has the ability to handle direct applications without any difficulty, while having the lowest administration costs in the market. Protecting access to schemes requires that the broker framework, discussed above, be implemented by means of legislative changes to enforce a restriction on liability for payment of broker fees. It also requires that administrators and schemes have the capacity to deal directly with member applications.

5.1.8. Challenges in the medical scheme environment

5.1.8.1. Complaints direct to schemes

The Act does require that schemes establish dispute committees to resolve complaints made directly to schemes, before being escalated to the CMS. However, this framework is not adequately provided for in legislation and more substantive mechanism needs to be put in place.

It is therefore important that the framework governing scheme disputes be properly provided for through:

- requirements that schemes implement independent dispute resolution committees;
- that schemes resolve disputes within a maximum time period of 30 working days;
- that a specific dispensation be required for urgent medical conditions, whereby complaints must be resolved quicker; and
- that schemes must afford members the opportunity to appeal decisions made in respect of those complaints.

5.1.8.2. Complaints process and appeals

The CMS deals directly with the public where complaints and appeals are concerned. The efficient functioning of these mechanisms is in many respects a measure of responsiveness. However, there are concerns that the office takes too long to deal with complaints, and that the appeals processes are very slow. The slow pace of complaints determinations and appeals is sometimes used by some schemes to delay having to comply with the law.

Among others, Council will therefore consider:

- to provide a mechanisms for urgent appeals;
- frequent sitting of appeals;
- amending the Act to compel members to exhaust internal avenues first before escalating complaints to CMS;
- amending the Act to enable penalty awards against schemes appealing against rulings for frivolous reasons; and
- the public dissemination of complaint and appeal determinations to maximise systemic governance effects.

In addressing the issues raised above, the CMS has implemented an Alternative Dispute Resolution (ADR) process. The primary purpose of this intervention is to establish the extent to which costs can be saved on unnecessary litigation by members against their schemes, in addition to mitigating the ever increasing volume of complaints being raised by members of medical schemes directly with the CMS.

5.1.8.3. Accessibility of rules

Although much has been done to ensure that members have access to the rules, they remain complex documents with language that is not easily understood by members. The proliferation of scheme benefit designs, most of which differ only in the detail rather than substance, make it difficult for members to know in advance whether they are properly protected.

The framework for presenting and filing rules needs to be updated to allow for more streamlined rules that clearly indicate the benefits and rights to which beneficiaries are entitled. Further, the CMS must develop a framework for the electronic filing of rules.

5.1.8.4. Transformation of medical scheme industry

The medical aid industry is far from being transformed. Processes must be put in place to encourage medical schemes to transform their operations and board representations to reflect the demographics of the South African population. The procurement of services must also be geared towards promoting empowerment initiatives of government.

The schemes must be encouraged to adopt best corporate governance practices such as those expressed in the King Code of Governance.

5.1.8.5. Monitoring and evaluation

Collecting strategic information routinely from schemes and the industry is an important aid to diagnosing systemic concerns, researching policy, and understanding the impact of reforms. CMS must evaluate the current systems and processes to collect data. The data must be relevant, reliable and available at the schemes, administrators and managed care organisations. However, in order to allow for meaningful comparisons between, inter alia schemes, administrators, disease management programs it is important to start with the definition of data variables to ensure consistency in the data extraction processes in the industry. CMS will require increased investment in the IT infrastructure to ensure that we have systems in place that will enhance the efficiency of the data collection and analysis.

5.1.8.6. Council contribution to Policy development

Government intervention in the private health system occurs through regulation rather than direct funding, pooling, or service provision. This consequently forms part of a suite of interventions, which do involve direct provision, and social insurance of various forms. In addition, the system forms part of a broader system of social security, which extends beyond health care. It is consequently necessary to at all times ensure that policy is harmonised across all state players to ensure that interventions designed for medical schemes serve to strengthen the overall government response framework. Government has introduced reforms aimed at providing universal access to health care to all through a system of NHI. A green paper on this reform was introduced in 2012 and Council contributed to this paper and we are looking to make a meaningful contribution into the recently published white paper on NHI.

5.1.8.7. General research and advice

The CMS has been instrumental in advising on a range of policy areas outside its immediate policy brief, most notably in the area of private healthcare costs, utilisation and risk adjustment.

5.1.8.8. Support to government processes

The CMS presently provides support to the Minister and Department of Health in a number of areas. These include:

- The full community rating strategy;
- The establishment of a pricing regulator;
- The implementation of system to monitor the private health workforce;
- The establishment of an IT platform for the single exit pricing framework;
- The establishment of a website for managing the single exit pricing framework for medicines;
- Regular interaction with the Ministry in respect of the development of NHI.

5.1.8.9. Regulatory response

The CMS as a regulator can broadly break down its response framework into the following elements:

- **Prospective regulation**, which deals with registration and accreditation functions, and any other activity, which provides some form of prior approval. This part of the regulator seeks to prevent problems from occurring in advance. Over-regulation occurs where the activities are so onerous and poorly designed that they stifle innovation and market entry. Within CMS the following activities fall into this framework:
    - Registration of schemes;
    - Registration of scheme rules;
    - Registration of new options;
    - Accreditation of administrators;
    - Accreditation of managed care companies;
    - Accreditation of brokers;
    - Review of reinsurance agreements; and
    - Approval of expositions for amalgamations and transfers of business.

The prospective regulatory measures, although well developed in CMS, and substantially better than what was in place prior to 2000, still suffers from a number of shortcomings. These include:

- Filing of rules is still paper-driven;
- The rules are complex and often poorly framed rules are registered;
- The lack of review of old registered rules as the attention is given to new rules and/or amendments;
- Benefit designs are too complex and naming conventions are not standardised;
- There is no structured approach to deal with marketing material;
- At present the accreditation of administrators and brokers does not adequately respond to predictable perverse arrangements;
- There is no standardised test required for the appointment of actuaries and auditors of schemes.
- There are gaps that exist in the education and training strategy

- **Concurrent regulation**, which focuses primarily on reporting arrangements and ongoing reviews. Within CMS the following activities fall into this framework:
    - Financial and associated reporting (annual and quarterly);
    - Requirements for schemes to submit information related to key triggers (e.g. solvency thresholds);
    - Real-time financial monitoring; and
    - Routine inspections.

This framework is now quite advanced and mainly focuses on monitoring indicators of scheme risk but operates in silos. However, the development of triggers, using compos ite indicators of scheme risk, to ensure a coordinated response within CMS, has not yet been implemented. The implemented framework would weigh the risk of a scheme based on a composite set of indicators incorporating: demographic and health risk, finances, solvency, and governance, and should be substantially automated.

- **Retrospective regulation**, which involves reactive regulatory interventions once problems become apparent. If the prospective framework is inadequate, or the concurrent framework is delayed in identifying problems, then a great, and possibly impossible, burden can be placed on these functions. Furthermore, where retrospective actions are not fully carried through or successful actions not properly communicated, the preventive or knock-on governance effects may be lost and thereby increasing the probability those problems requiring retrospective interventions will recur. Within CMS the following activities fall into this framework:
    - Complaints adjudication;
    - Compliance and investigation;
    - Council appeal committee; and
    - Appeal board.

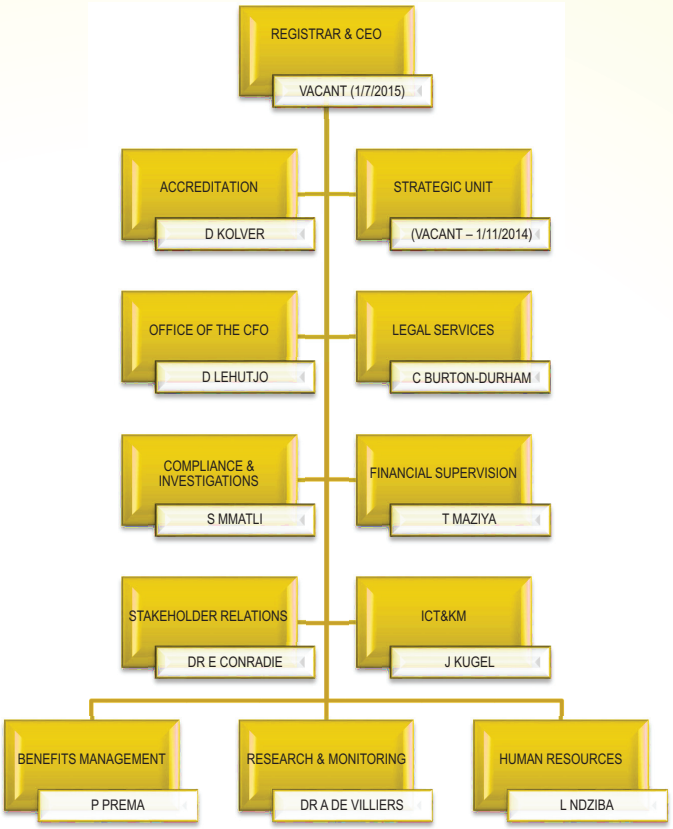
The retrospective regulatory framework is presently hampered by the inability of the CMS to control prosecutions. The complaints process appears to be adequately capacitated for existing volumes but potentially underutilises the information from complaints to achieve systemic change. Major changes required here potentially involve the collation and use of the complaints database to:

- Name and shame problematic schemes through the public dissemination of complaint determinations;
- Identify and channel information to the prospective regulatory system to prevent future conduct; and
- The collation of complaints information for researching legislative and policy reforms.

The appeals processes are necessary, but extremely time consuming and burdensome. The Council has started with the programme of Alternative Dispute Resolution (ADR) and a pro-bono legal assistance in order to alleviate the burden on the appeals process.

The weak penalty framework provided for in the Act removes the deterrent effect of the retrospective framework and an enhanced and more severe framework is needed. Provision should also be made for the awarding of costs against schemes for wasting the CMS's time with frivolous appeals.

5.2. Organisational Environment



Programme 1: Administration
The Administrative Programmes of CMS are effectively focused on the efficient functioning of the office and provide support to the core programmes to efficiently carry out their mandates. The programme is made up of the following sub-programmes:

Sub-programme 1.1: Registrar and CEO
Purpose: The CEO is the executive officer of Council for Medical Schemes delegated with the mandate of exercising overall management of the office, and as Registrar, exercises legislated powers to regulate medical schemes, administrators, brokers, and managed care organisations.

Sub-programme 1.2: Office of the CFO
The purpose of the sub-programme is to serve all business units in CMS, the executive management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The Internal Finance unit also serves the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, the sub-programme helps Council to be a reputable Regulator.

Sub-programme 1.3: Information and Communication Technology (ICT) and Knowledge Management (KM)
The purpose of the sub-programme is to serve the CMS business units and external stakeholders by providing technology enablers and making information available and accessible.

Sub-programme 1.4: Human Resources
The purpose of the sub-programme is to provide high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programmes that promote and support Council's vision.
We will fulfil this mission with professionalism, integrity, and responsiveness by:

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

By doing this the sub-programme helps the Council for Medical Schemes by supporting its administration and staff through Human Resources Management advice and assistance, enabling them to make decisions that maximise its most important asset: its people and to continue the development of CMS as an employer of choice.

Sub-programme 1.5: Legal Services
The purpose of the sub-programme is to provide legal advice and representation to the CMS and business units to ensure the integrity of regulatory decisions.The legal services sub-programme was moved to fall under administration as this forms part of our support programmes.

The Core Programmes of CMS are mainly concerned with the regulation and stability of the industry. The following programmes make up these:

Programme 2: Strategy Office
The purpose of this programme is to engage in projects to provide information to the Ministry on strategic health reform matters to achieve government's objective of an equitable and sustainable healthcare financing system in support of universal access and to provide support to the office on clinical matters. The purpose of the Clinical Unit is to ensure that access to good quality medical scheme cover is maximised and that regulated entities are properly governed, through prospective and retrospective regulation.

Programme 3: Accreditation
The purpose of the programme is to ensure brokers and broker organisations, administrators and managed care organisations are accredited in line with the accreditation requirements as set out in the Medical Schemes Act, including whether applicants are fit and proper, have the necessary resources, skills, capacity, and infrastructure and are financially sound.

Programme 4: Research and Monitoring
The purpose of the programme is to serve beneficiaries of medical schemes and members of the public by collecting and analysing data to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes and develop recommendations to improve regulatory policy and practice. By doing this the programme helps the Council for Medical Schemes to contribute to development of policy that enhances the protection of the interests of beneficiaries and members of public.

Programme 5: Stakeholder Relations
The purpose of the programme is to create and promote optimal awareness and understanding of the medical schemes environment by all regulated entities, the media, Council members and staff, through communication, education, training and customer care interventions.

Programme 6: Compliance and Investigation
The purpose of the programme is to serve members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act.

Programme 7: Benefit Management
The purpose of the programme is to serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. The programme helps analyse and approve all other rules to ensure consistency with the Medical Schemes Act. This ensures that the beneficiaries have access to affordable and appropriate quality health care. By doing this the programme helps the Council for Medical Schemes ensure that the rules of medical schemes are fair to beneficiaries and are consistent with the Act.

Programme 8: Financial Supervision
The purpose of the programme is to serve the beneficiaries of medical schemes, the Registrar's Office and Trustees by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Act. By doing this, the programme helps the Council for Medical Schemes monitor and promote the financial performance of schemes in order to achieve an industry that is financially sound.

Programme 9: Complaints Adjudication
The purpose of the programme is to serve the beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. By doing this, the programme ensures that beneficiaries are treated fairly by their medical schemes.

5.2.1. Flowing from the general policy direction in healthcare as set out in the NDoH Strategic Plan 2014/15 – 2018/19, as well as imperatives outlined in NDP Vision 2030, the CMS has identified the following as strategic focus areas for the next five years:

5.2.1.1. Strengthening regulatory mandate, amendment of the Medical Schemes Act and regulations, measuring the quality and outcomes of healthcare in medical aid schemes

CMS, as a regulatory authority, can only be as effective as the legislation (MSA) enables it to do so. The last amendments to the MSA occurred ten years ago. Gaps in the current framework have been identified since then as well as structural deficiencies which impact on the sustainability of the medical schemes environment and their role in the wider health policy framework. These challenges include mandatory membership for all who are employed, issues relating to open enrolment, strengthening the provisions relating to the PMB review process and associated improvements and enhancing governance aspects of medical schemes.

There are also challenges with respect to the transfer of members to open schemes, re-enrolment of members following termination due to non-disclosure, community rating and PMB payment shortfalls.

A draft MSAB was submitted to the NDoH in October 2013. A fully functional medical schemes industry requires that these essential legislative reforms be pursued and adopted diligently.

The CMS submitted draft regulations on the review of PMBs to the NDoH in 2010. Since then, work has commenced to include the following aspects in the PMB package:

- Introducing a preventative component to the PMB regulations providing for a more broader package;
- Decreasing the emphasis on the component that is largely curative and hospicentric; and
- Costing of the preventative add-on component and also the entire PMB package as a whole by embarking on a costing analysis project.

A proposal that fits in with the progress towards the evolving NHI will be submitted by the CMS to the NDoH.
The CMS has been working with the NDoH on the social impact analysis of the Medical Schemes Amendment Bill.

Governance in Medical schemes

As medical schemes operate in the private sphere, and are owned by their members, corporate governance arrangements determine whether the scheme acts in the interests of beneficiaries or in the interests of office bearers and commercial interests. The Act as introduced in 1998 and amended in 2003 removed some of the more flagrant failures in the corporate governance framework. However, the present framework falls far short of the appropriate standards required to avoid predictable principal – agent problems.

The policy and legislated framework needs to be enhanced with a view to having a more comprehensive model in place. The aim is to have appropriate standards to avoid predictable principal-agent issues and problems. Reforms in terms of governance principles and policy contained in the MSAB have been submitted to NDoH already. These include, amongst other aspects, the following: introducing greater oversight of board elections, introducing fit and proper criteria, clearly delineating the roles and responsibilities of the board vis-à-vis the principal officer (PO), designating the PO as the Chief Executive Officer (CEO), limiting the terms of board members, introducing benchmark governance guidelines, introducing a stringent definition of conflict of interest, and increase the percentage of elected trustees.

Corporate governance failures, exacerbated by a weak legislative framework, are further deepened by the inability of the CMS to criminally prosecute scheme office bearers for fraud and contraventions of the Act. Collaboration with the National Prosecution Authority (NPA) has failed in a number of instances. This failure has systemic consequences for the industry because it may create the impression that acts of fraud will not lead to criminal prosecution or do not carry serious criminal consequences.

The failure of collaboration between the CMS and the NPA, resulting in an inadequate response to criminal cases involving substantial funds needs to be taken up at two levels: The matter needs to be raised with the Minister of Health and the Minister of Justice; and mechanisms to support the NPA with CMS resources need to be explored.

Assessment of the value add of managed care in the medical scheme environment

Managed care as a health and quality intervention has evolved in South Africa over time. There are also different permutations of this intervention; the question remains whether there is any value? Is managed care the strategy that will fix healthcare?

The value in terms of health care delivery is fast becoming the over-arching goal in health for the future in our country. There is a need to demonstrate that cost effective interventions also provide value for members, in terms of quality health outcomes. Achieving best outcomes at the lowest cost is the goal, as it also creates the foundation for improved clinical governance.

There is a shifting focus throughout the world to the patient outcomes achieved. This is known as value-based **health care**, also known as the **"value agenda"**.

In contributing to the value agenda, the CMS has made progress towards establishing Task Teams with stakeholder's to respond to the important questions relating to the value proposition of managed health care being funded by medical schemes.

In line with the emphasis on quality of care as outlined the "NDP Vision 2030" and in the NDoH Strategic Plan 2014/15 to 2018/19, the CMS has already commenced work in this area, specifically on chronic conditions (CDLs) and Utilisation management of services: hospitals and medicines – eliminating waste from the system, which will be further developed in the next five years. The NDoH guidelines serve as a minimum benchmark for quality health outcomes.

5.2.1.2. The development of a beneficiary registry to facilitate the collection of data

The mission of CMS is "*Protecting the public and informing them about their rights, obligations, and other matters in respect of medical schemes"*. Currently, CMS has no database of beneficiaries and is unable to efficiently communicate and reach out to beneficiaries effectively in order to meet the mission statement above.

The Beneficiary Registry Project (BRP) entails the development of a system for the registration of a set of information/data from medical schemes about a beneficiary in terms of entering/exiting a scheme and when other details change.

Sections 7(c) and 42(3) of the Medical Schemes Act 131 of 1998 make provision for CMS to collect the relevant data per beneficiary from medical schemes.

The strategic benefits of the BRP are as follows:

- The ability to track the movement of a member between schemes and options. This will enable CMS to verify anti-selection member behaviour alluded to by medical schemes whereby members buy less cover when healthy and more cover when sick. Hence, a better understanding of health-seeking behaviour by members will be obtained.
- BRP will collect membership data by districts and hence its relevance to the evolving NHI. A combination of data from the BRP and PCNS databases will provide a geospatial analysis that can assist the NDoH in resource planning activities.
- BRP will play a vital role in education of members and in doing surveys to access patient satisfaction (managed care). Beneficiaries will become more aware of their rights as well as get educated on aspects relating to medical aid benefits they pay for. This will also benefit schemes, as better educated members will lodge fewer complaints.
- The BRP may assist SARS in the verification of member data for tax purposes.
- Ability to obtain data on specific variables such as whether a member has additional top-up hospital cover. This is of strategic significance in view of the Demarcation Regulations and its implications for the industry.
- It will be easier to enhance marketing of CMS services and to obtain feedback from members.
- The allocation of a unique beneficiary identity number for life. This will allow administrators to verify previous membership and access membership history.
- Assist in the prevention of fraudulent member activity, such as accessing state facilities claiming benefits or belonging to more than one scheme.
- BRP will lay the foundation to implement a system of risk adjustment.

The BRP will also go a long way in improving health information systems of the CMS in its role as regulator, and the country in general.

As the beneficiary registry project unfolds over the next five years, the industry will be engaged and consulted through an inclusive collaborative process and by ensuring that the most relevant and up to date information security methods and technology is used to protect the confidentiality of data being collected. Measuring quality of healthcare in medical aid schemes

5.2.1.3. Demarcation Regulations

Treasury published Draft Demarcation Regulations to the Short Term insurance Act of 1998 and Long Term Insurance Act of 1998 in March 2012 and April 2014 respectively. The public comments have been considered with Treasury and FSB. Most commentators argue that in favour of short-term insurance. In spite of not being accessible to vulnerable groups, Gap Cover products are particularly preferred by brokers and members of the public who currently have no such cover.

The commentators have argued that Medical Scheme cover is insufficient, that there are many gaps in cover and that members frequently have to make co-payments and face deductibles. The high cost of medical schemes was also raised by many commentators. Many commentators argued that the underlying reason for the need for Gap Cover was due to the fact that professional fees charged by specialists and hospital fees were very high and that these needed to be regulated. Other commentators raised systemic problems in medical schemes environment such as that there is no risk adjustment system in place, or the absence of mandatory membership of medical schemes, as underlying problems which necessitated the existence of Gap Cover products.

Development Capacity / Resource Requirements

Treasury has advised of its intention to promulgate the Demarcation regulations from the beginning of 2015. The draft Regulations are structured in such a manner that all the products that were registered before 2008 must be resubmitted for adjudication by both CMS and FSB to determine whether they are not in contravention of the Medical Schemes Act and the Demarcation regulations. In addition, all prospective applicants will similarly undergo scrutiny by both regulators for the same purpose. It should also be noted that the definition of the business of a medical scheme has been amended by Treasury in consultation with CMS through the Financial Laws General Amendment Act. The amended definition will only come into effect at the same time as the promulgation of the draft Demarcation regulations.

Since the ruling of the Supreme Court of Appeal in 2008 which allowed Gap Covers in the matter of Guardrisk, products that purport to be Gap Covers have flooded the market. Most of these products are in actual fact doing the business of a medical scheme without being registered. Our strategy is to commence with full scale enforcement action as soon as the draft Demarcation regulations are promulgated.

Since the second publication of the draft Demarcation regulations, some providers of Gap Covers have approached CMS and some schemes with a view to enter our regulated space.

CMS will continue engaging FSB specifically on their ideas and suggestions of our recommended resource and capacity requirements.

5.2.1.4. An Evaluation of the Adequacy of the Current Solvency Framework

Currently, Regulation 29 of the Medical Schemes Act details the following:-

- How much reserves i.e. accumulated funds medical schemes should have; and
- The definition of accumulated funds

Medical schemes are currently required to maintain accumulated funds expressed as a percentage of gross annual contributions which may not be less than 25%. There have often been debates and challenges to this regulation and the somewhat undesirable effects of the manner in which the solvency ratio is calculated.

In order to fully understand the matter and related consequences, the CMS should undertake a research project that will begin to respond to the challenges. The following are concerns that will need to be catered for in the research project:-

- Impact on affordability aspect of health care
- Effect on market concentration
- Implementation challenges of an alternative framework and the impact on the industry as a whole
- The resultant solvency framework should be one that strengthens the sustainability of medical schemes, and is in line with prudential regulatory developments both nationally and internationally.

5.2.1.5. *Enhancing the effectiveness of Council and its Committees*

Council as an oversight authority is charged with providing strategic direction to the operations of CMS.
In order to enhance the effectiveness and functioning of Council the following needs to be put in place:

- Rules governing the functioning of Council and its Committees, the purpose of which is to set out clear roles and responsibilities and general rules on the functioning of Council, must be finalised and approved -
  - CMS has embarked on a process of drafting and publishing rules of the Appeals Committee to streamline the appeals procedure. Members of the public were invited to make comments on the draft rules in Circular 48 of 2013. The updated and final version is being considered for approval and publication.
- Council should adopt a code of conduct that deals with areas of fiduciary responsibilities, conflict of interest, ethics and attendance of meetings – CMS will develop a code of conduct with input from Council for their adoption.
- Proper records of the deliberations of Council and Resolutions should be enhanced and properly documented – the Secretariat will be guided on recording of Council deliberations and resolutions.
- Annual assessment of the functioning of Council, its Committees and members must be undertaken – CMS has appointed a service provider to assist Council with the annual assessment of members and Committees.

5.2.1.6. *Improving the Visibility and Reach of CMS brand*

Organisations that have developed successful brands have created a culture in which all areas of the organisation are committed to the branding process. Therefore, employees are viewed as playing a crucial role in creating brand awareness as they facilitate the interface between the organisation and industry (Eisingerich & Rubera, 2010:65), thus making a significant contribution to the organisation's reputation.

Below are challenges facing brand awareness:

- There is a lack of information and knowledge amongst stakeholders, in particular employer groups and medical scheme members, as to the role of and the support provided by CMS.
- There are different interpretations and implications of the Medical Schemes Act as to the roles and responsibilities of the various stakeholders.
- The communication and information efforts of medical schemes and other stakeholders at times misinforming medical scheme members of their rights.
- Communication to individual members, employer groups and rural areas is not sufficient.
- There is a lack of overall awareness of the CMS, i.e. the brand of CMS.
- The reputation of the CMS is at stake due to the lack of proper stakeholder relationships.

These challenges will change as and when circumstances and perceptions change.

In order to improve the reputation of CMS, the following has to be implemented:

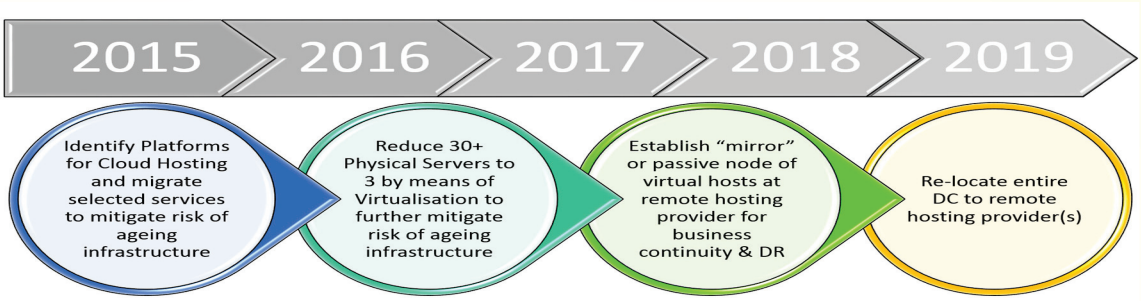
- Facilitate information flow about the Medical Schemes Act and the functioning of the CMS;
- Ensure that communication and information addresses stakeholders' needs with regards to their requirements of the Medical Schemes Act and interpretation thereof;
- Create the opportunity for stakeholder participation;
- Clarify and enhance awareness of the objectives and functions of the CMS
- Improve the brand of the CMS; and
- Improve relationship with the Executive Authority

Effective stakeholder relationships and involvement is critical to the success of complying with the Act and its regulations regulated by the CMS. CMS has a duty to create optimal awareness and understanding of regulatory and policy developments and industry trends in the medical schemes environment.

5.2.1.7. Development of Information Technology (IT) information systems and Knowledge Management to improve efficiencies in the Organisation

Over the next five years, the following Information and Communication Technology (ICT) strategic roadmaps will be followed for each of the various domains (ICT infrastructure, software development and knowledge management) in order to strategically align ICT with business.

ICT Infrastructure

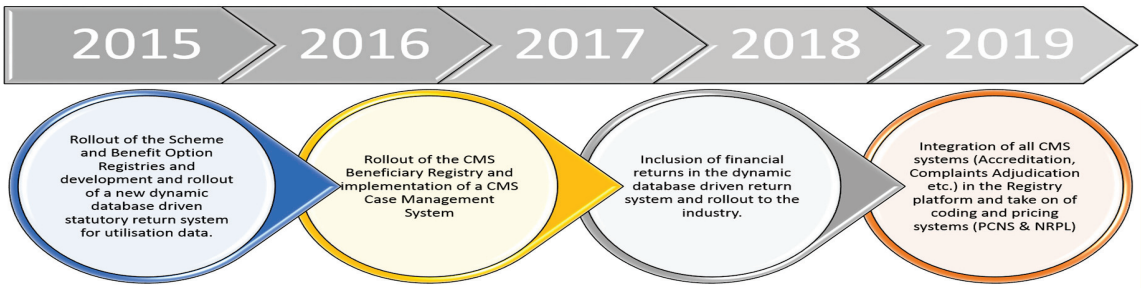


Given the complexity, challenges and risks associated with physical servers that the CMS had procured over time, a new server hosting facility and network cabling/switching infrastructure was acquired. The main drive over the next five years will be to:

- Reduce the complexity and mitigate the risks associated with an ageing server environment by identifying servers which can be outsourced to cloud hosting providers (mail and mail archiving).
- Virtualisation of the existing physical server environment, thereby reducing the number of physical machines from 30+ to just 3, thus enabling a much more manageable infrastructure.
- Ensuring a proper business continuity and disaster recovery solution by establishing a passive node of the virtualized servers at a remote hosting site, and
- Eventually completely relocating the entire on premise virtualized infrastructure to a hosted environment.

Further to the above, we will implement a unified communications solution and upgrade our data link and information security solutions to accommodate anticipated ICT solutions such as the beneficiary registry and other data intensive applications.

Software Development



Our software development drive will further exploit and expand the Microsoft Dynamics Extensible Relationship Management (XRM) platform by introducing the scheme, benefit option and beneficiary registries as well as a case management system which will be driven by the XRM platform, including the integration of CMS legacy systems into this system. This platform will enable agility and enhance the responsiveness of IT infrastructure to rapidly changing business needs. Our statutory return system will also be updated in close collaboration with schemes and administrators and will be a dynamic database driven system which will allow for faster and more accurate collection of data whilst reducing the administrative burden on users.

Further to the above, we will continue to exploit the recently acquired business process management software suite to automate all major business processes within the CMS.

Knowledge Management

The CMS will continue with its drive to unlock information within the organisation thereby creating and maintaining an environment where information and knowledge becomes paramount. A crucial part of this "unlocking" of information is the scanning of CMS records, the process of object character recognition and the storing of such records on a proper electronic document management system. The drive to expand the electronic capturing of all CMS records will be continued. We also intend further enhancing and integrating our electronic document management system.

Apart from the above we further intend:

- Making our E-library an even more effective information tool, that provides up to date information to CMS, by creating an E-Library which will provide
  - A baseline of access tools for both archival and latest books and articles contents in the Resources Centre repository, where users are able to perform a Bibliographic searching through either a title, author, subject, ISBN, publisher, and year of publication.
  - Universal access to all relevant online databases to CMS staff
- Establishing a fully functional Registry Office which will eventually perform a bureau scanning, indexing and retrieval service for CMS.

5.2.1.8. Continuous improvement of CMS as Employer of Choice

In line with other service organisations throughout the world, the CMS's biggest resource is its human capital and it is essential to ensure that employees are well looked after. The challenge is always to retain talent within the organisation. CMS has identified a succession planning project in order to mitigate the challenge of staff retention. Key positions have been identified and possible successors are now being mentored and coached. This project will be completed in 2016.In order to remain employer of choice, succession planning, benchmarking of benefits, improvement of the performance and development system must receive special attention in this planning cycle.

The CMS has recently experienced a high staff turnover which is a trend that could potentially harm the operations of the organisation due to the specialised nature of skills required. CMS continues to benchmark its benefits with similar entities in the market in order to remain competitive. The performance and development systems are in place to encourage outstanding performance. The CMS also pays particular attention to relevant labour legislation such as the Labour Relations Act, Basic Conditions of Employment Act and the Employment Equity Act. An employment equity plan is in place and is reviewed from time to time.

5.2.1.9. Adequate and Sustainable Funding of the operations of CMS

Council for medical schemes receives its funding mainly from levies on medical schemes. The challenge is that Council is not able to charge more than the inflation rate because the burden goes to the members of medical schemes. It is increasingly difficult to regulate adequately within the confines of the current funding structure. Furthermore National Treasury provides guidelines for expenditure increase for all public entities. This is often limited to inflation or below inflation. The challenge is that Council is not able to undertake major strategic projects which require substantial funding e.g. The IT infrastructure requires upgrading and therefore more funding. The legal fees in our operation are a case in point where the budget is always limited and the legal challenges are growing each year.

Additionally, remuneration of employees must also be competitive and market related in order to retain experienced and specialist staff for purposes of institutional memory and to also facilitate the carrying out of our mandate in this ever evolving and complex environment. The CMS must therefore consider alternative funding models, in line with relevant legislative requirements.

5.3. Strategic Planning process

Strategic and Annual performance plan - January 2016

The strategic plan 2015 to 2020 and annual performance plan 2016/17 was developed taking into account the vision of the National Department of Health as our Executive Authority. Management held a workshop to identify key strategic matters which have been elaborated in this document. A consultation was also held with Council in the form of the Chairperson and the Department of Health to discuss further strategic matters for incorporation into this strategic document. The Executive Authority advised us that we needed to further align our plans with the Framework for strategic and annual performance plans.

Portfolio Committee feedback

At the Portfolio Committee meeting of 15 April 2015 the Committee raised a number of issues concerning CMS strategic plans. Taking the comments of the Committee into consideration CMS has revised the strategic plans 2015 to 2020 as per the inputs received. Below are the comments received together with CMS response:

1. CMS should comment on Transfer from National Treasury
    - CMS does not receive a transfer from National Treasury. CMS is funded through the raising of levies. CMS does however receive a grant from Department of Health and this is explained in the budget write up in the annual performance plan.
2. CMS did not follow the framework format
    - The format of the plans have been corrected as per the framework
3. There were no explanation on programme structures
    - Organogram of the organisation has been included in strategic plan under the heading Organisational environment together with the purpose of each of the programmes.
4. There is no Oriented Goals
    - The strategic goals did not appear under the heading Strategic Oriented Goals but was included in the strategic plans. The heading has now been added with the strategic goals now featuring under this heading.
5. There is no baseline information provided for strategic objectives and indicators
    - baseline information has been provided, the baseline figures have been updated to 2014/15

The contents of the situational analysis has not been changed and will remain as per the submission made for 2015-2020.

6. Strategic Outcome Oriented Goals

Strategic Outcome Oriented Goal 1	Access to good quality medical scheme cover is promoted
Goal Statement	The aim of this goal is to ensure that beneficiaries of medical schemes receives adequate and quality health care cover. To grow membership of medical schemes in order to increase the percentage of the population covered by medical schemes. As CMS we create **an enabling environment** that is conducive for schemes to **grow membership**. Currently only about 17% of the population is covered by medical schemes. If membership of schemes is increased the burden in public sector facilities will be alleviated. CMS will ensure that at all times **barriers to scheme access are minimized** and that coverage provided by schemes is of a high standard. Improved risk pooling is achieved through **enhanced community rating, open enrolment, and prescribed minimum benefits.** The process of evaluating the **clinical effectiveness and value proposition of managed care** activities provided to medical schemes is in the process of being strengthened by introducing entry level criteria, process indicators and outcomes for treatment of patients with one or more **chronic disease conditions**. The process provides for participation by role-players and once introduced, will significantly enhance the ability to **evaluate the health outcomes** in terms of resources employed and price paid for such services. CMS will publish **Prescribed Minimum benefit definitions and CMScript** articles as **guidelines to inform the industry** and members of appropriate treatment plans. These guidelines will clarify what PMB entitlements entail and as such provide guidance to the healthcare industry on funding of PMBs with the resultant effect that complaints with regards to these conditions are minimized CMS must ensure that **scheme rules are registered to cover the required health care benefits** and contribution increases and are reviewed to ensure cost effectiveness and affordability. CMS will collect process and outcomes indicator data through the **Annual Statutory system** for various chronic diseases at benefit option level. The analysis of the data will aim to **measure health quality outcomes at benefit option** level that could be linked to the **performance of specific managed care entities.** CMS will also continue to put measures in place to measure and **monitor financial soundness** of medical schemes. This ensures that schemes will be able to meet their financial obligations.

Strategic Outcome Oriented Goal 2	Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected
Goal Statement	Ensure that at all times **medical schemes are governed** in the interests of beneficiaries by ensuring that the principles of good corporate governance are fully adhered to and that appropriate action is taken against **corporate governance** failures. Ensure that Medical Schemes and other regulated entities are compliant with the Medical Schemes Act and other relevant legislation. Create an environment where **members actively participate** in the affairs of their scheme. By 2020, **amendments to the Medical Schemes Act** must be in place to strengthen governance provisions, appeals processes, enforcement powers and complaints resolution processes. Ensure that at all times medical schemes are sensitive to the **specific needs of beneficiaries, are financially sound**, offers **protection against catastrophic financial incidents**. Schemes must also be sensitive to broader social considerations through the introduction of appropriate regulatory measures such as **fair treatment of beneficiaries.** CMS is looking at a **risk based solvency framework** that will go a long way in changing the landscape in medical scheme environment. Medical schemes are currently required to maintain accumulated funds expressed as a percentage of gross annual contributions which may not be less than 25%. There have often been debates and challenges to this regulation and the somewhat undesirable effects of the manner in which the solvency ratio is calculated. In order to fully understand the matter and related consequences, the **CMS will undertake a research project that would begin to respond to these challenges.** By 2020 the Council must have a well-functioning system to cater for the **electronic filing of scheme rules, and a well-functioning composite risk index system.** Through the control and coordination of the **availability of information** emanating from regulated entities, **their education and training activities,** participation in public discussions, and the publication of material in lay and official publications, the CMS will contribute to ensure that members, their dependents, and the public are informed of their rights. **Enhance visibility of CMS as a brand through campaigns and advertising.** The **communication guidelines** and **model rules** have been developed are continuously being **enhanced to ensure that schemes are aware of the information** that must be sent to members. The model rules are a guide to the form and structure of the rule which schemes are encouraged to adhere

	to; to ensure the protection of members rights through clarity of disclosure. The communication guidelines will ensure that there is improved communication between CMS and the schemes such that **information is disseminated with ease to members.** CMS has issued **trustee remuneration guidelines**, this will go a long way to guide trustees in their fiduciary responsibilities. CMS further conducts investigations where governance irregularities are identified and in some instances this leads to some schemes being put under curatorship. CMS will also have to ensure that a **Practice Code Numbering system** is administered by an approved entity in order to facilitate claims payment and resource planning CMS will ensure that **brokers and broker organisations, administrators and managed care organisations are accredited in line with the accreditation requirements** as set out in the Medical Schemes Act, ensuring that applicants are fit and proper, have the necessary resources, skills, capacity, and infrastructure and are financially sound. **Protection of beneficiaries is key to our regulatory function** and the **complaints resolution** process must be improved continuously to instill confidence in beneficiaries that their complaints will be resolved timeously. A system of **alternative dispute resolution** has been put in place to assist in the complaints resolution. This will be monitored in the MTE years to ascertain the impact this has on the complaints resolution process.

Strategic Outcome Oriented Goal 3	**CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation**
Goal Statement	Through the improvement of: • **business processes and business process automation** • **information** collection and dissemination, • **financial** and other best practice **monitoring systems**, • Information Technology (IT) **systems**, • **human resource** policies and procedures and strategies developed for staff retention and human capital investment, • **financial** management, • **legal advisory** services, • **operational** efficiency, the CMS will constantly adapt to the ever changing environment and will improve its way of doing business. To improve its efficiency over the MTE period, the CMS will invest in its IT infrastructure. The area of supply chain management will be strengthened. CMS will ensure that it applies corporate governance principles in its operations. CMS will ensure that it deals with stakeholders in a fair and transparent manner.

Strategic Outcome Oriented Goal 4	**CMS provides strategic advice to influence and support the development and implementation of National health policy**
Goal Statement	Through **reviewing the needs of the environment**, the CMS, will constantly **collect and upgrade the collection of information** for the purposes of ongoing and **strategic review of the private health system including advising on relevant legislative reform.** **Research** is conducted on **aspects of the health system** that have an **impact on medical schemes and beneficiaries**. CMS collects and analyses **healthcare utilisation data** through the Annual Statutory Returns and makes **recommendations to the Registrar** on **significant trends** in the industry which may have an **impact on National Health Policy.** Through the development of application systems such as the **Single Exit Price (SEP) and Beneficiary Registry** the CMS will assist **NDoH to attain its objective** of an efficient health management information system for improved decision making, planning and policy implementation. Through its strategic position in the health system, the CMS will form **strategic relations** with re**gional and international institutions**, **consult, research, and collate information** for the purposes of **influencing** stakeholders and to provide **strategic advice to Government**; as well as provide **technical assistance** to major strategic health reforms like the **NHI.**

Part B
Strategic Objectives

CONTENTS

1. Programme 1 (Administration)

The Administration programme consists of five sub-programmes, each of these sub-programmes provide support services for the core business units of CMS. These sub-programmes allow CMS to carry out its operations in an efficient and effective manner.

1.1. Sub-Programme 1.1 (CEO and Registrar)

Purpose (CEO and Registrar)

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

1.1.1. Resource considerations (CEO and Registrar)

1.1 Registrar and CEO	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**4**	**4**	**4**	**4**	**4**	**4**	**4**
Total	**11,285,348**	**9,521,012**	**15,352,454**	**8,561,731**	**9,395,051**	**10,004,350**	**9,774,806**
Compensation of employees	5,828,526	3,254,991	3,355,588	3,434,051	4,049,405	4,348,888	3,791,560
Salaries & wages	5,828,526	3,254,991	3,355,588	3,432,851	4,048,151	4,347,562	3,790,157
Social contributions	-	-	-	1,200	1,254	1,326	1,403
Goods and services	5,456,822	6,266,021	11,996,866	5,127,680	5,345,646	5,655,462	5,983,246
Agency and support / outsourced services	-	109,406	70,226	73,620	76,933	81,395	86,116
Consultants	1,134,486	1,623,197	9,550,016	2,403,060	2,511,198	2,656,847	2,810,944
Transfers to households	-	-	-	4,000	4,000	4,000	4,000
Training and staff development	200,711	191,800	60,175	80,000	80,000	84,640	89,549
Travel and subsistence	898,888	860,396	490,423	694,400	716,648	758,214	802,190
Venue and facilities	277,034	800,990	192,910	224,000	234,080	247,657	262,021
Other	2,945,703	2,680,232	1,633,116	1,648,600	1,722,787	1,822,709	1,928,426

The Office of the CEO and Registrar is currently adequately resourced in order to meet its objectives for the ensuing financial years. There will be no need for further human resource requirements for the office.

1.2. Sub-Programme 1.2 (Office of the CFO)

Purpose (Office of the CFO)

The purpose of the sub-programme is to serve all business units in CMS, the senior management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The Internal Finance unit also serves the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, we help Council to be a reputable Regulator.

1.2.1. Strategic Objectives (Office of the CFO)

Goal 3 *CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

Strategic Objective 1.2.3.1	**Ensure effective financial management and alignment of budget allocation with strategic priorities**
Objective statement	Ensure that internal controls are always adhered to in the financial management processes. An effective performance and budgeting management environment is maintained in the Council.
Baseline	Achieved unqualified audit opinion for 2014/15
Links	PFMA, Treasury Regulations, CMS policies and procedures, Supply Chain Management, CMS Performance Information Framework
Strategic Objective 1.2.3.2	**An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS**
Objective statement	An effective, efficient and transparent system of risk management is maintained. To ensure that CMS achieves its strategic goals by economic application of resources to minimize, monitor, and control the probability and/or impact of adverse events.
Baseline	A risk management framework was approved by Council during 2014/15 A new indicator has been developed for this objective for 2015/16
Links	PFMA, King III Corporate governance guidelines, CMS Risk Management Framework

1.2.2. Resource considerations (Office of the CFO)

1.2 Office of the CFO	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**7**	**9**	**10**	**10**	**10**	**10**	**10**
Total	**16,711,507**	**20,486,943**	**24,641,623**	**27,820,026**	**30,031,129**	**31,902,710**	**33,915,567**
Compensation of employees	7,558,174	7,654,833	9,107,930	9,323,453	10,350,059	11,080,138	11,885,286
Salaries & wages	6,069,083	6,072,455	7,280,330	7,361,016	8,148,010	8,750,370	9,420,392
Social contributions	1,489,091	1,582,378	1,827,600	1,962,437	2,202,049	2,329,768	2,464,894
Goods and services	9,153,333	12,832,110	15,533,693	18,496,573	19,681,070	20,822,572	22,030,281
Audit costs	1,678,370	1,600,961	1,897,016	2,080,470	2,201,136	2,328,802	2,463,873
Bank charges	39,545	41,012	46,100	48,312	48,775	51,604	54,597
Consultants	111,753	404,649	96,977	254,085	291,929	308,861	326,775
Lease Payments	4,496,986	6,325,553	9,304,905	11,059,817	11,652,002	12,327,818	13,042,832
Non-life insurance	176,368	274,398	295,217	332,610	339,406	359,092	379,919
Property payments	1,897,370	3,311,973	3,438,507	4,138,944	4,478,421	4,738,170	5,012,983
Repairs and maintenance	274,217	285,312	143,894	150,000	150,000	158,700	167,905
Training and staff development	340,643	125,245	140,223	200,000	200,000	211,600	223,873
Travel and subsistence	36,430	16,549	2,584	5,600	5,600	5,925	6,268
Venue and facilities	-	51,689	7,840	35,000	52,000	55,016	58,207
Other	101,651	394,769	160,430	191,735	261,801	276,984	293,049
Payments for capital assets	2,802,866	2,637,058	3,771,627	3,771,627	2,424,248	2,564,854	2,713,616
Amortization	941,811	895,309	765,040	765,040	533,810	564,771	597,528
Depreciation	1,861,055	1,741,749	3,006,587	3,006,587	1,890,438	2,000,083	2,116,088
Total	19,514,373	23,124,001	28,413,250	31,591,653	32,455,377	34,467,564	36,629,183

In order to strengthen the unit to deal with the demands of Supply Chain Management, a Supply Chain officer was appointed in 2014/15. The unit has noted that the area of supply chain management may need further capacity – this will be considered in the financial year 2017/18. The area of risk and performance management would also need further capacity in the next financial year. Currently there is only one person responsible for both risk and performance management in the organisation.

The unit will be implementing a risk management software tool, allowing for more effective tracking of CMS risks. Currently the unit uses a manual excel spreadsheet to capture the risks. To further strengthen the risk management processes the risk management software tool is needed to assist the CMS to manage the critical elements of the entity – compliance, financial and operational risk management initiatives – in a more effective and efficient way. Processes assessing risks and object ives across CMS, linking risks to strategic objectives, monitoring risks and managing risk response strategies will be automated. Executives will be able to quickly assess problem areas, proactively adjust processes to respond to issues and track progress through reports and automated alerts.

The unit will be embarking on a project of business process mapping. Business process mapping refers to activities involved in defining what a business entity does, who is responsible, to what standard a business process should be completed, and how the success of a business process can be determined.

The main purpose behind business process mapping is to assist organisations in becoming more efficient. A clear and detailed business process map or diagram allows anyone externally or internally to look at whether or not improvements can be made to the current process.

Business process mapping takes a specific objective and helps to measure and compare that objective alongside the entire organisation's objectives to make sure that all processes are aligned with the company's values and capabilities. As the project will be taken up in house and will not be seeking the help of service providers it is estimated that the project will take a period of two years to complete.

1.2.3. Risk Management

Risk Name: Supply Chain Management

Risk impact on the strategic objectives

The area of supply chain management has been identified as a risk area within the internal finance unit which requires close monitoring. There have been a number of findings from the Auditor General on non-compliance to Treasury Regulations relating to the supply chain. In order to enhance the internal controls the unit recently appointed a Supply Chain Officer. Policies regarding SCM have to be further developed as well as monitoring systems needs to be implemented to ensure compliance.

Risk name: Asset Management

Risk Impact on the strategic objectives

Asset management has been identified as one of the high risk areas within the internal finance unit. AG has raised a number of findings around this area in the past years ranging from asset verification, assets no longer in use but still listed on the asset register, asset review of useful lives. All these findings are generally around IT assets. The unit has resolved that asset quarterly verification should focus more on IT assets as it is the risk area, review of asset useful lives will be performed early in the year and this process will also identify assets which are no longer in use.

1.3. Sub-Programme 1.3 (Information and Communication Technology (ICT) and Knowledge Management (KM))

Purpose (ICT & KM)

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

1.3.1. Strategic Objectives (ICT & KM)

Goal 3 *CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

Strategic Objective 1.3.3.1	**An established ICT Infrastructure that ensures information is available, accessible and protected**
Objective statement	Diligently maintain, renew and secure the computer network, systems, operating system software and hardware of the organisation to ensure the availability of ICT infrastructure. The Unit will achieve a network and server uptime of 99% whilst reducing security incidents to 0% per annum by 2020.
Baseline	This was a new Indicator from 2015/16 therefore there will be no baseline for security incidents for 2014/15
Links	Information Technology Infrastructure Library (ITIL)& Control Objectives for Information Technology(COBIT)
Strategic Objective 1.3.3.2	**Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance**
Objective statement	Focus development responsibilities on creating, editing, and maintaining the custom software applications in use at CMS as well as procuring off-the-shelf applications. In performing this function, the unit will also render business analysis and advisory services according to enterprise architecture principles to CMS Units as well as external stakeholders where applicable. This objective will enable business units to improve their processes and ultimately their performance. The unit will increase the uptime percentage of all installed applications, to 99% by 2020
Baseline	98.23% uptime in 2014/15
Links	COBIT, Protection Of Personal Information (POPI), The Open Group Architecture Framework (TOGAF)
Strategic Objective 1.3.3.3	**Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing**
Objective statement	Create and maintain an environment where information, knowledge and records are effectively managed, and easily accessible to our stakeholders. The Unit will respond to 100% (400) of all requests for information received within 30 days, by 2020.
Baseline	274 requests for information received and attended to in 2014/15
Links	PAIA, POPI, South African National Archives and Record Services Act

1.3.2. Resources considerations (ICT & KM)

1.3 ICT and KM	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**14**	**11**	**11**	**12**	**12**	**12**	**12**
Total	**9,926,241**	**11,242,275**	**12,212,537**	**14,059,053**	**15,898,425**	**17,001,180**	**18,283,931**
Compensation of employees	6,562,292	6,959,751	7,535,771	8,355,217	9,337,799	10,060,037	10,940,202
Salaries & wages	6,562,292	6,959,751	7,535,771	8,351,617	9,334,199	10,056,228	10,936,172
Social contributions	-	-	-	3,600	3,600	3,809	4,030
Goods and services	3,363,949	4,282,524	4,676,766	5,703,836	6,560,626	6,941,143	7,343,729
Communication	1,155,215	1,212,222	923,279	923,850	965,418	1,021,412	1,080,654
Computer services	1,856,669	2,240,393	2,857,753	3,782,686	4,486,051	4,746,242	5,021,524
Consultants	55,984	50,826	200,699	112,500	190,000	201,020	212,679
Lease Payments	119,702	243,655	248,182	264,000	275,004	290,954	307,830
Training and staff development	95,537	148,194	106,687	180,000	180,000	190,440	201,486
Travel and subsistence	9,603	4,654	23,662	10,800	11,286	11,941	12,633
Venue and facilities	53,704	368,070	300,973	419,000	441,392	466,993	494,078
Other	17,535	14,510	15,531	11,000	11,475	12,141	12,845

Strategic Objective 1.3.3.1 - An established ICT Infrastructure that ensures information is available, accessible and protected

The following diagram provides a roadmap of the intended operations for the next 3 years:

Server and Desktop Virtualisation

The server and desktop virtualisation drive is proceeding at a slower pace than anticipated, mainly due the time and effort required to make logistical arrangements for the relocation of the CMS Server Farm and ICT Infrastructure from the previous offices in Hatfield to the new location in Centurion during 2013 and the planning and selection process for the right virtualisation platforms and software during 2014. The unit is therefore still in the planning phase of the virtualisation rollout. The intention remains to reduce the number of physical servers from the current 30 plus to no more than 3. This will make it easier for the unit to perform remote online backups as well as introduce a remote disaster recovery (DR) site which will allow for real-time failovers in case of an emergency situation or disaster which warrants the evacuation of the current building/premises (a hot site).

Network connectivity

A new 8Mb Fibre internet link was acquired in line with the CMS requirement to increase bandwidth over the next three years to accommodate our linkage to remote backup and DR sites as well as other hosted solutions. It has however become clear that this link may not be adequate to accommodate our real-time linkage and replication requirements as well as the anticipated demands which new systems such as the beneficiary registry and dynamic database driven returns may require going forward. To address this anticipated bandwidth issue, the CMS intend to increase the bandwidth of this link from 7Mbps to 20Mbps in the next three years.

Telephony

The unit will continue with telephony and data convergence and will investigate various solutions such as Microsoft Lync Server. This will ensure that the CMS workforce mobility and "bring your own device" (BOYD) drive is further enhanced.

Disaster Recovery (DR)

The unit's roadmap from server virtualisation to remote backup and DR will ensure that the CMS can remain fully operational even if the physical premises is compromised. Various solutions will be investigated. These solutions will ensure that there is always a workable virtual instance of any of the CMS core servers at a remote site which can be started up in case of a disaster occurring. A final decision on exactly which solution to deploy will depend on the outcome of a comprehensive disaster recovery assessment which is currently being undertaken internally with the participation of all business units within CMS.

Network Security

The unit will continue to expand on the security modules at firewall level. Some of the modules likely to be acquired will improve the management of different devices which link to the CMS network and include modules for data loss prevention (DLP) as well as full disk encryption and mail encryption. This will not only enhance network security but will also ensure the CMS complies with relevant legislative requirements such as the POPI Act. The anticipated rollout of a beneficiary registry will demand that the CMS can provide assurance of privacy and confidentiality of member data at all times.

Helpdesk Support

The unit has over the past year embarked on an improvement of the IT Helpdesk function by acquiring the temporary services of a dedicated Helpdesk Technician. This has allowed the CMS IT Helpdesk Coordination function to render a much improved call logging and follow up service to end-users and to implement several measures grounded in the Information Technology Infrastructure Library (ITIL) framework, which focusses on improving IT service delivery. Going forward, the unit intends to solidify this arrangement by the permanent filling of the Helpdesk Technician post. The unit intends to acquire an ITIL module for the automated helpdesk management system allowing end users to complete required forms related to the CMS ICT Policies and Procedures online. This will reduce the administrative burden related to these policies while aligning these policies and procedures with specific service requests.

Strategic Objective 1.3.3.2 - Provide software applications that improve business operations and performance

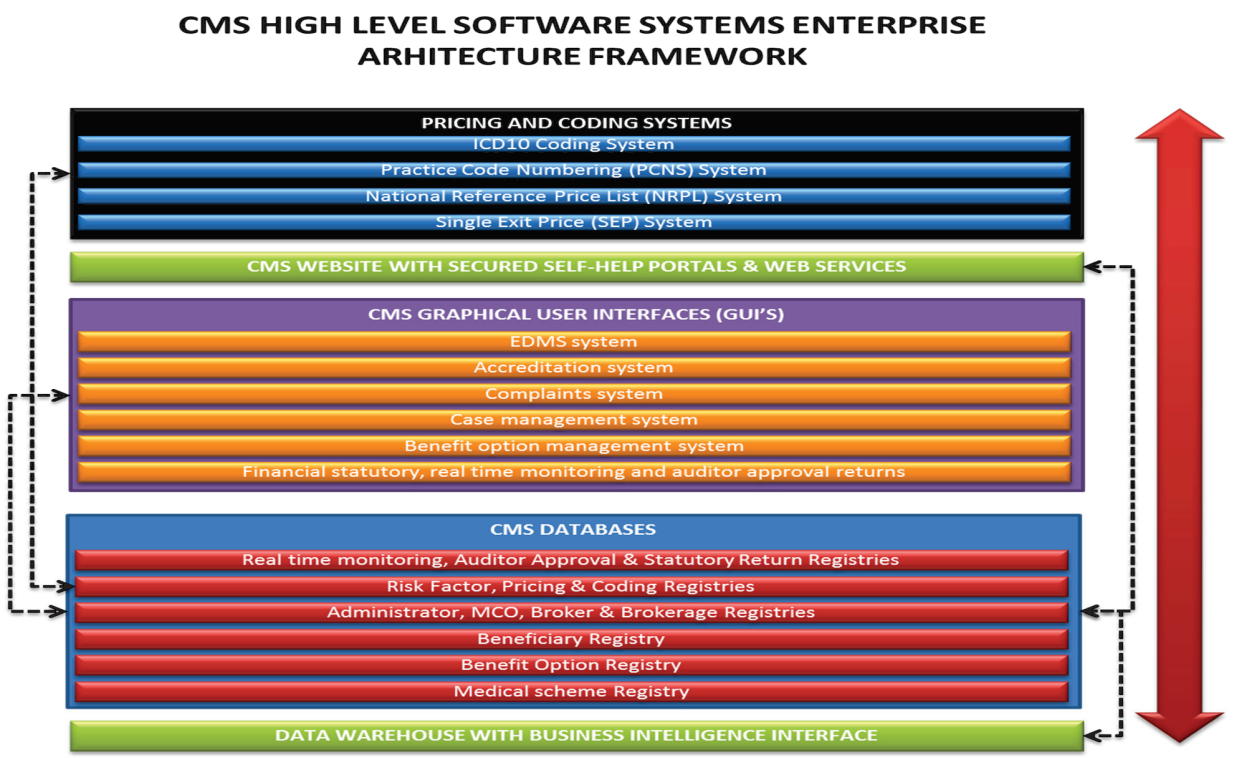
The software development sub-unit will embark on the following software development projects in the next three years. All of these projects strategically complement the overall healthcare goals. These projects include but are not limited to:

- The rollout of a benefit option and scheme registration system (2014/15 – 2015/16)
- The Development of a new system for the collection of Statutory Return Utilisation Data using a Dynamic Database Driven Metadata approach (2015/16 – 2016/17)
- A medical scheme beneficiary registry (2014/15 – 2017/18)

Apart from the above internal demands, the CMS has engaged with the National Department of Health to assist with the development and hosting of:

- A Single Exit Price System for drugs (medicines) (2015/16)

The following diagram provides an overview of the high level Enterprise Architecture Framework, - to address these demands - which the CMS aims to fully implement in the next 5 years. The framework indicates interfacing with various pricing and coding systems which will not necessarily reside with or be hosted by the CMS:



The sub-unit used Microsoft Dynamics XRM to develop a new medical scheme registry and benefit option registry. Both these registries will go live in November of this year (2014). The new beneficiary registry will also be based on this platform.

The sub-unit will utilise the built in Reporting Services functionality of Microsoft SQL 2008 R2 as well as the Tableau Business Intelligence tool to produce meaningful management dashboards to aid in risk based decision making. To achieve meaningful reports the unit wishes to establish a proper business intelligence environment over the next 3 years. This will enable management to access different dashboards of their data for better decision making.

In order to meet the software development skills required to build the new applications outlined above, the capacity of the software development unit will need to be enhanced. To this effect, a process has been set in motion to fill two additional Senior Software Developer positions over the next two years.

In addition to filling these positions, the CMS will also acquire the skills of two temporary developers to finalise development of the long anticipated Single Exit Price (SEP) System for Medicines. The development is being undertaken for the National Department of Health and the funding for these temporary positions will be acquired from surplus funds realised through savings incurred on the National Department of Health annual grant.

Finally, the CMS has invested in an Enterprise Business Process Workflow solution called FlowCentric. The intention is to digitise all the critical workflow processes in CMS over the next three years. To this end, the CMS Procurement process has now been developed as the first major workflow process and it will be rolled out across the CMS during August 2014. It is believed that the successful digitisation and rollout of our critical workflow processes will not only assist in making the CMS more responsive and administratively agile but should also improve audit compliance.

Strategic Objective 1.3.3.3 - Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing

Part of this sub-unit's main objective is to unlock information within CMS, creating and maintaining an environment where information and knowledge becomes paramount. The web based E-library should be viewed as a positive step in unlocking new information and the sharing of it within the organisation. The sub-unit will endeavour to continue improving this E-library.

The scanning of CMS records is continuing. So far, the sub-unit has been able to scan all documents located in the local filing room, as well as all the records of the Benefits Management Unit located at Metrofile, using a bureau scanning service. A process of unlocking information from the CMS scanned documents by batch object character resolution (OCR) processing also continues.

A more robust electronic document management (EDMS) solution in the form of M-files has been acquired, and has been deployed throughout CMS. This system has been enhanced and now allows users remote access either through a mobile application or via the native M-Files client. The sub-unit intends to further improving this system while integration with other CMS systems will continue over the next three years.

The next three years will place the following requirements on Knowledge and Records Management:

To make the E-library an even more effective information tool, that provides up to date information to CMS

Establish a fully functional Registry Office which will perform a bureau scanning and indexing service for CMS using outsourced bureau scanning services to continue to scan all documents of significance at our offsite location.

Human Resource requirements

In order to meet the demands outlined above, the following human resource requirements will have to be met.

Objective &Position	Current	Proposed
Snr Software Developer 1	Vacant and not on post establishment	To be created and advertised during 2015/16.
Snr Software Developer 2	Vacant and not on post establishment	To be created and advertised during 2017/18 due to moratorium on filling of positions for 2016/17
IT Helpdesk Technician	Vacant and not on post establishment	To be created and advertised during 2017/18 due to moratorium on filling of positions for 2016/17
Registry Clerk	Vacant and not on post establishment	On hold

1.3.3. Risk Management

Risk Name: Human Resources

Risk impact on the strategic objectives

Although the CMS has grown exponentially in the last 5 years, IT has remained unchanged with regards to the staff compliment in the network and software sub-units. The unit has a substantial increase in projects, maintenance and enhancements to legacy systems as well as increased workload on the helpdesk and networks. In order for the unit to meet its strategic goal all operational requirements that arise from the different units we support at CMS have to be fulfilled and satisfied.

In order to try and mitigate this risk, a motivation was submitted to the HR sub-committee for the addition of 2 new developers in the software sub-unit. In the network sub-unit a temporary IT technician has been appointed while a motivation has been submitted to the HR sub-committee for a permanent post to be created.

1.4. Sub Programme 1.4 (Human Resources Management unit)

Purpose (Human Resources Management unit)

The purpose of the sub-programme is to provide high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programs that promote and support Council's vision.

We will fulfil this mission with professionalism, integrity, and responsiveness by:

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

By doing this we help the CMS by supporting its administration and staff through Human Resources Management advice and assistance, enabling them to make decisions that maximise its most important asset: its people and to continue the development of CMS as an employer of choice.

1.4.1. Strategic Objectives (Human Resources Management Unit)

Goal 3 *CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

Strategic Objective 1.4.3.1	**Build competencies and retain skilled employees**
Objective statement	Effective and efficient development and retention of employees to enable CMS to meet its objectives by retaining scarce, critical, professional and technical skills and maintaining a staff turnover rate of less than 5% by 2020. CMS shall ensure continuous development of staff to in line with succession planning framework. Staff are continuously engaged to assess the levels of commitment and motivation to CMS. This will be conducted through a survey and findings will be implemented upon completion of survey. CMS will ensure that vacancies are filled within 90 working days.
Baseline	Staff turnover rate was reduced to 3.88% in 2014/2015 Turnaround time to fill vacancy, 7 vacancies out of the 10 took longer than the 90days to fill in 2014/15 88% of employment equity targets were achieved during 2014/15
Link	Employment Equity Act; Recruitment, selection and retention policy; Succession planning strategy
Strategic Objective 1.4.3.2	**Maximise performance to improve organisational efficiency and maintain high performance culture**
Objective statement	Measure 100% of organisational efficiency by aligning employee performance contracts and reviewing performance against achievement of organisational objectives. The unit shall ensure that 95% of employees participate in training in accordance with Personal Development Plans that are aligned with outcomes of performance assessments where specific skills and abilities have been identified. By 2020 the unit will implement a 360 degree assessment tool
Baseline	100% of performance agreements were signed by 30 May 2015 Conclusion of employee performance assessments is a new indicator for 2016/17
Link	Skills Development Act; Skills Development Levies Act; Education and Training policy

1.4.2. Resources considerations (Human Resources Management Unit)

1.4 Human Resource	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**5**	**5**	**5**	**5**	**5**	**5**	**5**
Total	**5,913,523**	**6,526,219**	**5,473,200**	**5,842,813**	**5,733,347**	**6,207,208**	**6,563,818**
Compensation of employees	3,619,242	3,723,106	3,862,586	4,293,964	4,589,998	4,997,546	5,283,996
Salaries & wages	3,177,361	3,242,973	3,390,115	3,715,502	3,972,148	4,343,861	4,592,397
Social contributions	441,881	480,133	472,471	578,462	617,850	653,685	691,599
Goods and services	2,294,281	2,803,113	1,610,614	1,548,849	1,143,349	1,209,662	1,279,822
Consultants	873,236	897,063	376,101	820,047	551,861	583,869	617,733
Legal fees	-	111,217	15,714	-	-	-	-
Other transfers to households	3,733	6,500	20,328	48,300	50,474	53,401	56,498
Training and staff development	167,257	127,496	141,956	100,000	100,000	105,800	111,936
Travel and subsistence	193,344	14,002	11,075	20,000	20,900	22,112	23,395
Venue and facilities	901,706	1,460,596	920,465	416,290	320,000	338,560	358,196
Other	155,005	186,239	124,975	144,212	100,114	105,920	112,064

A new approach has been adopted by the organisation to look into repurposing all employees in the organisation to allow for rotation within the units and across units. This will improve on skills development and career pathing. Resource requirements will therefore be looked into in the year after this decision has been revised. A principal in sharing Executive Assistant was adopted by the organisation.

1.4.3. Risk Management

Risk name: Low staff morale

Risk impact on the strategic objectives

Low staff morale was identified in 2014 as a risk and that it can lead to compromised service delivery through increased employee turnover, increased employee conflicts, excessive stakeholder complaints, lack of trust and inadequate communication. Unfortunately for all of the above reasons and more, this translate to the negative attitude and perception towards the employees' job, work environment, team members, management and the organisation as a whole.

From 2014 the unit commenced with various programmes to mitigate this risk. These include, improvement of staff and management engagement through mentoring and coaching programmes, benchmarking staff benefits and making sure that the CMS benefits are competitive with other organisations. We plan to continue with the Executive Management development programmes/workshops, team building exercises and motivational talks. We have also introduced staff consultation meetings facilitated through the Employment Equity Forum which has created a platform for engagement between staff and management.

1.5. Sub - Programme 1.5 (Legal Services Unit)

Purpose (Legal Services Unit)

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

1.5.1. Strategic Objectives (Legal Services Unit)

Goal 3 *CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

Strategic Objective 1.5.3.1	**Legal advisory service for effective regulation of the industry and operations of the office**
Objective statement	To provide written and verbal legal opinions, and representations to the Office of the Registrar, Council and external stakeholders to protect the integrity of regulatory decisions. The unit will provide 85% (200) written & verbal legal opinions generated internally by 2019.
Baseline	227 written and verbal legal opinions were provided to the CMS or business units in 2014/15
Link	Medical Schemes Act, FI Act, PAJA, PAIA
Strategic Objective 1.5.3.2	**Support CMS mandate by defending decisions of Council and the Registrar**
Objective statement	To provide a legal support service to the Office of the Registrar, the Council and external stakeholders to ensure the integrity of regulatory decisions taken in terms of the Act and other relevant legislation and to ensure that schemes are properly governed in terms of scheme rules, good governance and tribunal decisions. The unit will attend to all court and tribunal cases referred to it.
Baseline	In 24 cases papers were filed in court and other tribunals in 2014/15
Link	Medical Schemes Act, FI Act, PAJA, PAIA

1.5.2. Resource considerations (Legal Services Unit)

1.5 Legal Services	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**4**	**4**	**4**	**4**	**4**	**4**	**4**
Total	**12,806,218**	**12,700,754**	**10,896,098**	**11,653,762**	**11,885,993**	**15,010,178**	**15,690,166**
Compensation of employees	3,211,418	3,097,112	3,092,838	3,504,282	3,737,989	4,014,395	4,321,842
Salaries & wages	3,211,418	3,097,112	3,092,838	3,503,082	3,736,789	4,013,125	4,320,499
Social contributions	-	-	-	1,200	1,200	1,270	1,343
Goods and services	9,594,800	9,603,642	7,803,260	8,149,480	8,148,004	10,995,783	11,368,324
Agency and support / outsourced services	45,657	-	-	-	-	-	-
Consultants	89,050	-	-	-	-	-	-
Legal fees	9,304,908	9,437,832	7,683,467	8,000,000	8,000,004	10,839,200	11,202,658
Training and staff development	74,817	112,726	69,980	80,000	74,000	78,292	82,833
Travel and subsistence	47,312	38,487	40,767	60,000	60,000	63,480	67,162
Venue and facilities	3,070	-	-	-	2,000	2,116	2,239
Other	29,986	14,597	9,046	9,480	12,000	12,695	13,432

There has been an upward trend in unplanned litigation against the CMS, in reaction to our regulatory interventions. This has placed strain on the legal fees budget and available resources. This trend is expected to continue going forward, with the resultant upward expenditure on legal fees. The staff complement in the Unit will need to be increased going forward, to accommodate this trend.

1.5.3. Risk Management

Risk Name: Delay in approval of Medical Schemes Amendment Bill

Risk impact on the strategic objectives

Overlapping and conflicting legislation and delay in the amendment bill to address gaps identified in the Medical Schemes Act (MSA) are major challenges to the CMS. The Medical Schemes Amendment Bill has been submitted to the Department of Health. The Council and the Registrar will continue to face challenges to the Act from the schemes and the public until such time that the bill is made into law.

To mitigate this risk the unit does continuous follow up with the Department of Health on the Medical Schemes Amendment Bill.

2. Programme 2 (Strategy Office)

Purpose (Strategy Office)

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

2.1. Strategic Objectives (Strategy Office)

Goal 1 *Access to good quality medical scheme cover is promoted*

Strategic Objective 2.1.1	**Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected**
Objective statement	The formulation of new and revision of existing PMB definitions in consultation with stakeholders with a view to ensure that members are adequately protected. The unit will publish 4 Benefit Definitions for PMB conditions and 10 CMS scripts per year by 2020
Baseline	There were 3 PMB definitions published in 2014/15
Link	Explanatory Note 2 of Annexure A of the Regulations to the Medical Schemes Act 131 of 1998

Goal 2 *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 2.2.2	**Provide clinical opinions to resolve complaints and enquiries**
Objective statement	The formulation of clinical opinions on formal complaints received from the Complaints Adjudication Unit and via e-mail and telephonic enquiries with the view to ensure that member' s complaints and enquiries are resolved so that members and providers receive rightful payment of claims.
Baseline	623 clinical opinions were completed in 2014/15
Link	Regulation 15D 2(d)(ii) - where provision is made by a managed care provider for complaints or appeals procedures or mechanisms, such provision shall in no way impact upon the entitlement of a beneficiary to- (ii) lodge a complaint with Council;

2.2. Resource considerations (Strategy Office)

2 Strategy office	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**6**	**6**	**6**	**9**	**9**	**9**	**9**
Total	**52,726**	**3,823,404**	**4,934,874**	**6,758,615**	**8,337,149**	**8,939,428**	**9,606,574**
Compensation of employees	-	3,645,434	4,785,622	6,147,615	7,455,699	8,006,854	8,619,910
Salaries & wages	-	3,645,434	4,785,622	6,144,915	7,452,877	8,003,869	8,616,752
Social contributions	-	-	-	2,700	2,822	2,985	3,158
Goods and services	52,726	177,970	149,252	611,000	881,450	932,574	986,664
Consultants	-	-	-	250,000	505,500	534,819	565,839
Training and staff development	50,811	147,831	118,339	180,000	180,000	190,440	201,486
Travel and subsistence	1,915	25,495	16,007	171,000	185,500	196,259	207,642
Venue and facilities	-	-	9,070	-	-	-	-
Other	-	4,644	5,836	10,000	10,450	11,056	11,697

The Clinical Unit is a structure in the Council for Medical Schemes that was formalised in the 2013/2014 financial year through a restructuring process commenced in 2012. Its main objective is to ensure access to quality health care for members of medical schemes and their funding protection thereof. It incorporates the 2010 constituted Clinical Review Committee (CRC).
The Clinical unit is part of the office of the Senior Strategist (OSS) of CMS. The post of the Senior Strategist has been vacant since December 2014. The unit is currently running at minimal capacity. This capacity is therefore not adequate to meet the targets and expectations over a number of financial cycles.
The unit saw a substantial rise in the complexity of clinical requests that require clinical adjudication per year. There is an inevitable increased demand to analyse new technologies as part of the clinical enquiries referred to the team producing clinical opinions and to the team developing PMB Definitions. Thus, there is a need to consolidate the skills set within the unit with pharmacology, medical technology, Pharmaco-economics or Health Technology Assessment experience. These cases are typically intensive and time-consuming analysis.
There are increasing demands to support the Stakeholder Relations Unit with training on PMBs. This forms a critical part of prospective regulation and ensures that the CMS objective to ensure access to quality healthcare is realized.
Increased requests to support Strategic objectives require that the unit is strengthened. These requests include support of the PMB Review process, ad hoc Projects, Low cost Benefit Options development to name a few.

Requests for additional staff will be based on the work load of the clinical unit during the period leading up to 2020. Resources that may be required includes
1. Additional Clinical Analyst to staff (Professional Nurse)
2. Additional Clinical Analyst (Pharmacologist/Post graduate Scientist)
3. Medical Advisor (Medical Doctor)

2.3. Risk Management

Risk Name: Clinical Opinion

Risk impact on the strategic objectives

The clinical unit is actually seeing a reduction in formal complaints rather than an increase this is due to measures put in place during 2014/15 and 15/16. E.g. PMB benefit definitions, CMS script articles and PMB training sessions. Last year the unit in total received 494 new clinical opinions and had to deal with the backlog from previous years which pushed up the figures. The unit has reduced the backlog drastically so this will reduce the projected figures. Taking this into account we had to revisit the projected figures. The unit is seeing an increase in complaints on very rare conditions that are clinically complex to diagnose and treat e.g. Goucher disease and other metabolic diseases.

The unit last year identified conditions where there was a high number of complaints and enquiries received and published scripts on these conditions thereby reducing the number of formal complaints and enquiries. The unit has confirmed that there may be a reduction in complaints due to the initiatives they will be taking.

The Clinical Unit is also responsible for the development of PMB Benefit Definitions, PMB review and input into the low cost benefit option project to the industry, with the Health Economist taking project lead. The PMB benefit definitions provide guidance to the medical schemes industry and healthcare professionals on the clinical diagnostic and treatment aspects of the conditions. It further specify the diagnostic, treatment and care modalities that are included in the PMB level if care. As such the benefit definitions minimise complaints to CMS.

The unit has commissioned a Knowledge Management System Project. The objective is to ensure that the information used to formulate clinical opinions is available for subsequent opinions. This guarantees consistency of quality, and rulings throughout the unit. This will improve efficiency in producing subsequent opinions without a need for *de novo* literature searches.

3. Programme 3 (Accreditation Unit)

Purpose (Accreditation Unit)

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

3.1. Strategic Objectives (Accreditation Unit)

Goal 2 *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 3.2.1	**Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services**
Objective statement	Ensure that the brokers that are accredited are compliant with the accreditation requirements. Accredit 100% (4 980) of individual brokers and broker organisation applications that meet the requirements of accreditation within 21 working days of receipt of all relevant information by 2019
Baseline	A total of 5 027 broker and broker organisations were accredited during 2014/15
Link	Medical Schemes Act and FAIS Act, 2002
Strategic Objective 3.2.2	**Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined**
Objective statement	Ensure that the MCOs that are accredited are compliant with the accreditation requirements. 26 New and renewal accreditation applications accredited within 3 months of receipt of all relevant information by 2019
Baseline	26 MCOs accredited in 2014/15
Link	Medical Schemes Act
Strategic Objective 3.2.3	**Accredit administrators and issue compliance certificates to self-administered schemes based on their compliance with the accreditation requirements in order to provide administration services**
Objective statement	Ensure that the administrators that are accredited and self-administered schemes that are issued with compliance certificates are compliant with the requirements for accreditation. Accredit/approve 15 administrator accreditation and self-administered applications by 2019, within three months of receipt of all relevant information.
Baseline	9 applications accredited in 2014/15
Link	Medical Schemes Act

3.2. Resource considerations (Accreditation Unit)

3 Accreditation	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**9**	**9**	**10**	**10**	**10**	**10**	**10**
Total	**5,792,595**	**6,115,769**	**7,165,575**	**8,060,888**	**8,499,546**	**9,150,042**	**9,596,799**
Compensation of employees	5,397,145	5,750,730	6,603,587	7,240,940	7,631,771	8,231,936	8,625,443
Salaries & wages	5,397,145	5,750,730	6,603,587	7,237,940	7,628,636	8,228,619	8,621,934
Social contributions	-	-	-	3,000	3,135	3,317	3,509
Goods and services	395,450	365,039	561,988	819,948	867,775	918,106	971,356
Consultants	-	-	-	80,000	-	-	-
Training and staff development	41,749	56,404	28,060	100,000	200,000	211,600	223,873
Travel and subsistence	289,155	240,272	481,057	498,948	521,400	551,641	583,636
Venue and facilities	-	5,080	3,615	6,000	6,000	6,348	6,716
Other	64,546	63,283	49,256	135,000	140,375	148,517	157,131

The Unit currently accommodates 10 members of staff in terms of the approved structure. The Clinical Analyst vacancy has been budgeted for and has been filled.

Accreditation Analysts perform desk based analysis of all applications received in the Unit and evaluate compliance by applicants in terms of relevant legal requirements as well as accreditation standards applicable to the relevant entities. Financial soundness is a critical component incorporated in all criteria for accreditation. On-site evaluations are carried out in respect of administrators and managed care organisations to assess their compliance with pre-determined standards to assess infrastructure, skills, capacity and performance.

There are currently two persons responsible for evaluating the fitness and propriety of administrators. The responsible Manager and one Senior Analyst conduct extensive and detailed analysis of the process to perform on-site and desk based evaluations and all related functions to conclusion of such applications. The complexity and time spent on this task warrants an additional Senior Analyst post to be provided for in the structure. This will allow the manager to spend quality time in overseeing the processes.

Measures introduced to ensure that strategic objectives are realised, was the introduction of a system to verify that brokers applying for accreditation comply with legislation supervised by the Financial Services Board to the extent that Financial Services Providers are required to be licensed. Should they fail to do so, accreditation is refused with the result that brokers are accredited only if they are fit and proper in terms of relevant legislation. Similarly, if either office suspends or withdraws accreditation or license to practice, the other office is notified and steps are taken to invoke similar penalty clauses against the perpetrators. This is essential to prevent disqualified brokers to operate whilst not accredited or licensed. We similarly introduced a mechanism to verify the qualifications of persons applying for accreditation as brokers. This will strengthen our ability to prevent accreditation of persons who are not fit and proper or who defraud the system. The additional workload as a result of more involved administrative tasks may in future warrant an Administrator position to maintain turnaround times based on proven statistics to be obtained during the period in question.

3.3. Risk Management

Risk Name: Accuracy, integrity and reliability of information - Administrators / MCOs/ brokers application forms submitted with incomplete or inaccurate information and insufficient supporting documentation.

Risk impact on the strategic objectives

The core business of the Unit is to ensure that entities (Administrators/ MCOs/ Brokers) are properly accredited in terms of the Act. Our core business supports strategic goal 2 which states that Medical Schemes are properly governed, are responsive to the environment and beneficiaries are informed and protected. If the information received from entities is inaccurate and unreliable, this can lead to entities that are not fit and proper receiving accreditation resulting in beneficiaries not being protected. For example; by accrediting a MCO that is not fit and proper can result in members' access to quality of health care being compromised. Again, by accrediting an Administrator that is not fit and proper can lead to the inappropriate maintenance of members' records, inadequate management of members' contributions and incorrect payment of claims.

In order to mitigate this risk the accreditation process flows for each activity (Administrators, MCOs and Brokers) are in place. An accreditation checklist has been developed to ensure that information provided by the entities is complete.

For brokers' accreditation, accreditation analysts have access to the FSB database to verify if the broker is licensed by them prior to the application for accreditation to our office.

On-site evaluation is done on the accredited MCOs and Administrators to determine if the entity has the necessary infrastructure, skills and resources to perform the services.

4. Programme 4 (Research and Monitoring Unit)

Purpose (Research and Monitoring Unit)

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

4.1. Strategic Objectives (Research and Monitoring Unit)

Goal 2 *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 4.2.1	**To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning**
Objective statement	Monitor compliance to Regulation 5 (e) with regards to ensuring that the practice code number of a treating provider is provided for on the billing statement to medical scheme for services rendered to the members. Full access to the database for analyses of data to feed into the NHI process and general resource planning. Ensure a streamlined and freely accessible practice code numbering system by 2020.
Baseline	4 quarterly reports were received in 2014/15
Link	Medical Schemes Act 131 of 1998, Regulation 5 (e)

Goal 4 *CMS provides strategic advice to influence and support the development and implementation of National health policy*

Strategic Objective 4.4.1	**Conduct research to inform appropriate policy interventions**
Objective statement	Research is conducted on aspects of the health system that have an impact on medical schemes and beneficiaries. The unit envisions doing 9 projects (research and support projects) by 2020. The research includes the evaluation of the solvency framework, measuring medical scheme inflation and health quality outcomes.
Baseline	A total of 11 research projects were completed in 2014/15
Link	CMS Annual Reports and Operational Plans of the unit.
Strategic Objective 4.4.2	**Monitoring trends to improve regulatory policy and practice**
Objective statement	The Unit provides input into the Registrar' s review, compiles the review of operations and analyses demographic, geographic, expenditure and health care utilisation data for inclusion in the Annual Report of the Registrar of Medical Schemes. The analysis includes risk profiling of the medical schemes, classification of benefit options and costing of the PMB' s.
Baseline	In 2014/15 one non-financial report was submitted for inclusion in the annual report
Link	CMS Annual Reports and Operational Plans of the unit.

4.2. Resource considerations (Research and Monitoring Unit)

4 Research and Monitoring	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**8**	**8**	**8**	**8**	**8**	**8**	**8**
Total	**5,653,841**	**5,683,458**	**6,044,616**	**6,916,990**	**7,565,324**	**7,996,551**	**8,638,119**
Compensation of employees	5,364,130	5,084,693	5,598,812	6,411,158	6,953,906	7,349,671	7,953,719
Salaries & wages	5,364,130	5,084,693	5,598,812	6,408,758	6,951,398	7,347,018	7,950,912
Social contributions	-	-	-	2,400	2,508	2,653	2,807
Goods and services	289,711	598,765	445,804	505,832	611,418	646,880	684,400
Consultants	114,648	396,522	250,800	265,000	276,925	292,987	309,980
Training and staff development	130,700	171,366	129,916	160,000	160,000	169,280	179,098
Travel and subsistence	31,251	18,449	42,041	42,800	134,750	142,566	150,834
Venue and facilities	5,663	5,063	19,368	25,000	26,125	27,640	29,243
Other	7,449	7,365	3,679	13,032	13,618	14,407	15,245

The South African health system will over the next 5 to 20 years undergo significant reforms that will have an important bearing on the private healthcare sector. The Research and Monitoring Unit will need to maintain existing capacity and consider some adjustments in other areas to strengthen its ability to make a contribution in the health systems reforms process. The appointment of one additional resource is planned for 2017/18 to assist the unit with the analysis and monitoring of health quality outcomes. Other needs may arise to employ specialised research experts from time to time and the Unit will engage external consultants to support implementation of key objectives.

4.3. Risk management

Risk Name: Annual Report - Access to quality data

Risk impact on the strategic objectives

Poor data quality can have a negative impact on the unit's ability to advise the Minister of Health on urgent health policy reforms. If the unit do not have access to good quality data, it can impact on the accuracy of the statistics reported in the Annual Report. It can harm the reputation of the unit and CMS.

The unit has completed a project in 2014/15 to redesign and enhance the system it uses to collect the healthcare utilisation data. The purpose of the project was to improve the quality of data submitted by medical schemes as well as lessen the burden on schemes due to the manual submission process the previous system required. The new data collection system will ensure that healthcare utilisation measures in the Healthcare Utilisation Annual Statutory Returns (ASR) are adequately defined and not open to different interpretation by medical schemes. The standard in the specification documents will be gradually raised to allow for the collection of healthcare indicators that are currently not in a collectable form across medical schemes. The updated guidelines and specification documents are not meant to change the definitions of historical healthcare utilisation indicators, but to strengthen them and improve consistency in the collection of healthcare utilisation data. The new system was well received by medical schemes and administrators. The CMS will continue to work on improving the healthcare utilisation data collection system. Schemes and administrators will be consulted in this process. Furthermore, the unit will engage with medical schemes that submitted poor quality ASR data.

5. Programme 5: Stakeholder Relations

Purpose (Stakeholder Relations Unit)

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

5.1. Strategic Objectives (Stakeholder Relations Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 5.2.1	**Create awareness and provide training in order to enhance the visibility and reputation of CMS**
Objective statement	Create consumer awareness and provide training to members to understand their rights and responsibilities. Provide training to trustees, schemes and brokers to enhance correct interpretation of the Medical Schemes Act, governance and compliance in the medical scheme environment.
Baseline	This is a revised indicator for 2016/17, therefore there is no baseline for 2014/15
Link	Medicals Schemes Act
Strategic objective 5.2.2	**Communication and engagement to inform and to empower stakeholders**
Objective statement	The SHR unit aims to inform and empower stakeholders through the publication of the Annual Report, newsletters, advertisements and media engagement
Baseline	CMS' Annual Report published and launched by 31 August every year. Communication with stakeholders was revised and therefore there is no baseline for 2014/15. Baseline for media monitoring is 72.9% positive/neutral media reporting received in 2014/15
Link	Medical Schemes Act

5.2. Resource considerations (Stakeholder Relations Unit)

5 Stakeholder Relations	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**8**	**11**	**11**	**11**	**11**	**11**	**11**
Total	**7,054,848**	**7,670,297**	**8,596,417**	**9,064,568**	**9,728,142**	**10,404,043**	**11,147,389**
Compensation of employees	5,029,383	5,089,157	5,948,752	6,591,816	7,036,469	7,556,253	8,134,425
Salaries & wages	5,029,383	5,089,157	5,948,752	6,588,516	7,033,020	7,552,604	8,130,565
Social contributions	-	-	-	3,300	3,449	3,649	3,860
Goods and services	2,025,465	2,581,140	2,647,665	2,472,752	2,691,673	2,847,790	3,012,964
Communication	170,976	454,737	335,822	610,412	621,324	657,361	695,488
Consultants	-	82,141	146,861	-	-	-	-
Training and staff development	119,549	130,082	227,278	200,000	220,000	232,760	246,260
Travel and subsistence	718,348	550,837	587,142	588,000	655,000	692,990	733,183
Venue and facilities	557,862	502,214	514,756	424,340	395,000	417,910	442,149
Other	458,730	861,129	835,806	650,000	800,349	846,769	895,884

Education & Training

Consumer and member awareness of CMS became a huge concern and was raised several times in the Health Portfolio Committee in Parliament. In order to increase awareness, more activities are required, which require human resources to take care of these activities, especially also with the implementation of the Low Cost Benefit Option and demarcation regulations.

In addition to these developments, the new direction the Education and Training sub-unit has embarked on resulted in more training programmes offered to Board of Trustees and other stakeholders. *The Unit offers the following* programmes as part of Consumer Awareness and Education Initiatives:

- Capacity building workshops,
- General public awareness drives, and
- Awareness presentations.

More often members of the public and other stakeholders and consumer groups complain that not many consumers, especially medical scheme members, know their rights and obligations and many more are not aware of the existence of the CMS. The challenge also remains that more stakeholder groups get added to the unit's list of stakeholders that require training and result in a need for additional human resources in order to perform the unit's functions.

The Education and Training sub-unit also offers the following trustee training interventions:

- Induction Trustee Training (mandatory);
- In-Depth Trustee Training;
- Accredited Trustee Training; and
- Response-upon-request Training.

Due to the increased number of training programmes and the high demand from stakeholders for training, a senior educator is required to assist with the increasing workload. The resource required should have a qualification as assessor and moderator with preferably the INSETA.

The appointment of such a *Senior Education and Training Specialist* will alleviate the workload and will result in a cost saving for the CMS, since outside service providers for the accredited programme will no longer be required.

Furthermore, it will alleviate duties of the current employees to focus more on consumer awareness activities and thereby enhancing the brand of CMS.

Customer Care Service Centre (CCSC)

- The CMS customer care service centre is different to other call centres where answers are provided on screen. The CMS consultants render a consulting service, interpreting the MSA and attending to frontline calls on behalf of units such as the Accreditation and Complaints Units. They therefore take longer to finalise calls than would a simpler call centre resulting in high volumes for three available consultants.
- The increase in call volume means that we will need to beef up the Customer Care Services Centre's function to keep our other indicators (average talk time and abandon rate) within permissible limits. We will therefore need an additional call centre consultant in order to effectively deal with all incoming calls and to give the Call Centre Manager an opportunity to monitor calls for quality, ongoing training and improvement and to intervene where difficult calls are experienced. Currently, the manager has to also deal with calls at peak times, whilst also attending to incoming written enquiries which get directed to information@medicalschemes.com and support@medicalschemes.com.
- In instances where existing staff have to take leave, we are normally compelled to utilise temping services which compromise the quality of our service as time to train them is limited. It is also not cost effective. Furthermore, Labour Law has placed restrictions on the duration of utilising temps over a certain period of time thus we have to change them now and then.
- Lastly, in line with servicing all our callers, there is an identified ongoing need to bridge the language gap (preferably, an Afrikaans proficient consultant) to fully complement our staff.

Provision was made for one more customer care consultant, which we urgently require to improve our services to customers.

Communication and Stakeholder Relations

The Communication sub-unit has currently only a manager responsible for communication issues, such as media releases, proofreading and editing of communication documentation and publications and the Annual Report project.

Stakeholder relations remain a critical component to build relationships with all stakeholders in the medical scheme industry and to ensure a positive reputation of the CMS. Currently only the Customer Relations Officer is assisting with the responsibilities ensuring the reputation and brand of CMS are maintained.

With the implementation of the Low Cost Benefit Option and demarcation regulations, awareness and marketing efforts will increase. There is furthermore pressure from the Health Portfolio Committee to create awareness of CMS.

These additional demands being placed on the Unit cause increased workload and in order to increase awareness, build and maintain a positive CMS reputation, very quick responses to social media are required and a resource to maintain the social media sites effectively is urgently required.

Therefore, a resource to manage awareness activities, conducting surveys, manage the content of the website, social media sites and hellopeter.com queries are urgently required.

5.3. Risk Management

Risk Name: Reputation of CMS

Risk impact on the strategic objectives

The most inherent risk of the unit pertains to the reputation of the CMS. All three sub-units deal with various stakeholders, which poses risk to the organisation if stakeholders feel they have not been treated fairly.

In order to determine the risk, measurement of satisfactory outcomes is done through the media monitoring tool, the customer satisfaction survey and training evaluation forms.

The risk of disgruntled stakeholders is mitigated through continuous training of staff in treating customers fairly and ensuring they are well informed of changes in the organisation that might affect customers.

The production of the Annual Report also contains a risk if the Annual Report is not produced and delivered as per the PFMA regulations. To mitigate the risk, a production schedule is established by the Annual Report Committee and designers and printers have to sign service level agreements with penalties included, should they not meet the deadlines.

6. Programme 6 (Compliance and Investigation Unit)

Purpose (Compliance and Investigation Unit)

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

6.1. Strategic Objectives (Compliance and Investigation Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 6.2.1	**Regulated entities comply with Legislation**
Objective statement	To institute enforcement action of against regulated entities where non-compliance is identified, this is to ensure compliance with legislation
Baseline	52 enforcement actions were taken during 2014/15
Link	Medical Schemes Act and other relevant legislation
Strategic Objective 6.2.2	**Strengthen and Monitor governance systems**
Objective statement	Ensure that good governance is maintained by medical schemes and other regulated entities
Baseline	88 governance interventions implemented during 2014/15
Link	Medical Schemes Act and other relevant legislation

6.2. Resource considerations (Compliance and Investigation Unit)

6 Compliance & Investigation	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**6**	**7**	**7**	**8**	**8**	**8**	**8**
Total	**4,979,191**	**5,307,134**	**6,719,225**	**7,428,614**	**8,437,551**	**9,041,327**	**9,768,575**
Compensation of employees	4,537,673	4,746,730	5,353,975	6,428,594	7,177,639	7,708,340	8,358,275
Salaries & wages	4,537,673	4,746,730	5,353,975	6,426,194	7,175,131	7,705,687	8,355,468
Social contributions	-	-	-	2,400	2,508	2,653	2,807
Goods and services	441,518	560,404	1,365,250	1,000,020	1,259,912	1,332,987	1,410,300
Communication	-	19,309	45,973	48,180	50,340	53,260	56,349
Consultants	126,073	217,591	1,015,730	500,000	795,000	841,110	889,894
Training and staff development	97,864	105,843	148,992	160,000	160,000	169,280	179,098
Travel and subsistence	195,626	146,554	121,335	147,840	154,493	163,454	172,934
Venue and facilities	-	19,920	-	20,000	21,995	23,271	24,620
Other	21,955	51,187	33,220	124,000	78,084	82,612	87,405

In order to further capacitate the unit, it was decide that the inspection function be outsourced to bigger forensic firms. Due to costs associated with such appointments, the regulated entities whose inspection is outsourced are directed to pay for the costs of such inspections. The difficulty with this approach is that most of these entities refuse to pay and unfortunately the registrar has no authority to compel them to pay. It is also difficult to budget appropriately for investigation costs as most of them are unpredictable in nature and duration.

It is now proposed that additional staff (Compliance officer) be employed for the 2015/16 fiscal year in order to further strengthen the capacity of the unit. It is intended that the unit be split into two sub-units, one focusing on general non-compliance functions and the other focusing on Inspections and Investigations. This separation will ensure that the different expertise in the unit is appropriately located within the unit in order to maximise the delivery of its mandate.

A further strategic objective has been added for the reporting period 2014/15 going with a view to strengthen and monitor governance systems. This will have an added effect on our resources. The vetting of trustees will require a dedicated person to manage the process and evaluate the reports generated by the systems used for

vetting. Our Act requires officers of regulated entities to be fit and proper, and the vetting process is aimed at achieving this. This process will also contribute towards the strategic goal of prospective regulation.

Another indicator that will impact on the Unit's resources is the attendance and participation as observers by unit representatives at scheme AGM (Annual General Meetings) and SGM (Special General Meeting). In addition there will be monitoring of scheme elections in order to determine the fairness of the process. The office is regularly faced with complaints by the beneficiaries of schemes pertaining to irregularities that take place at member meetings and in instances where there are scheme elections for trustees. Scheme meetings are held across various provinces, which necessitate the office representatives to travel long distances and thereby incurring associated costs.

During the 2015/16 financial year, it is anticipated that the mandate and accountabilities of the unit will expand drastically as a result of the expected promulgation of the proposed amendments of the Short and Long term Insurance act. The effect of the promulgation is to demarcate medical scheme products and insurance products. Also; the regulation will finally outlaw products that purport to offer health insurance products whereas they do the business of a medical scheme.

The Compliance unit in collaboration with FSB will be required to review products that were registered prior to the promulgation date and new applications for registration with the FSB as health insurance. Secondly, the department of labour and the CMS are about to finalise the audit of Bargaining council schemes that do the business of a medical scheme without being registered. These sick funds will have to be registered in terms of the rules, benefits and governance structure.

In addition to inspections/investigation costs, there are those costs that arise from expert advice sought and advanced technological expert assistance. This includes instances where specialised skills are required to download information from computers or electronic material. The costs have to date been funded out of investigation/inspection costs.

6.3. Risk Management

Risk Name: Compliance with legal framework

Risk impact on the strategic objectives

The units' most critical risk relates to regulated entities failing to comply with the legal framework, by applying legal resistance due to a poorly drafted Medical Schemes Act. The main issue is that there is a conflict in the way the Act is interpreted within internal business units as well as external stakeholders. As such medical schemes tend to oppose the offices view by going through lengthy litigations which affect the CMS in terms of legal budget and affects our ability to carry out or strategic objectives, which is to ensure compliance with the Act.

In order to mitigate factors such as reputational loss due to legal resistance from regulated entities, we have endeavoured to engage the Stakeholder Relations Unit on enhancing the existing stakeholder management strategy, increase interaction with the Department of Health to expedite the finalisation of the Amendment Bill, engage the education and training unit to consistently perform training on the interpretation of the Act for business units so as to avoid conflicting views of the Act given to stakeholders. Failure to mitigate this critical risk will further affect our unit's ability to reach set targets, as per the performance plans, and carry out our mandate.

7. Programme 7 (Benefits Management Unit)

Purpose (Benefits Management Unit)

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

7.1. Strategic Objectives (Benefits Management Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 7.2.1	**To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act**
Objective statement	Percentage of rule amendments (interim and annual rule amendments) by medical scheme are analysed within timeframes, to ensure that medical scheme rule amendments are fair and compliant with the Medical Schemes Act and to ensure that beneficiaries are protected.
Baseline	242 amendments analysed in 2014/15
Link	Section 31(3) requires that any rule amendment or rescission can only be approved such that it will not be unfair to members and will not render the rules inconsistent with the Medical Schemes Act.

7.2. Resource considerations (Benefits Management Unit)

7 Benefits Management	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**7**	**8**	**8**	**8**	**8**	**8**	**8**
Total	**4,363,969**	**4,574,964**	**4,757,882**	**5,589,803**	**6,275,854**	**6,721,673**	**7,193,849**
Compensation of employees	4,178,018	4,373,150	4,694,972	5,405,013	6,079,871	6,514,322	6,974,471
Salaries & wages	4,178,018	4,373,150	4,694,972	5,402,313	6,077,049	6,511,337	6,971,313
Social contributions	-	-	-	2,700	2,822	2,985	3,158
Goods and services	185,951	201,814	62,910	184,790	195,983	207,351	219,378
Training and staff development	146,904	164,061	34,484	150,000	160,000	169,280	179,098
Travel and subsistence	-	1,347	-	5,000	5,225	5,528	5,849
Other	39,047	36,406	28,426	29,790	30,758	32,543	34,431

The largest part of the Unit's budget is its salaries (94% of total budget). The activities of the Unit do not require any specific projects that require separate budgeting. The Unit has increased its focus on training and hence increased its training budget to accommodate the areas of skills identified.

The Unit comprises of a General Manager, 4 senior analysts and 3 analysts. The Unit is responsible for the following strategic objectives for which the following resources are applied.

The trend in the expenditure of the Unit comprises mainly of salary inflation as this is the units major expenditure item. The trend over the next five years is expected to remain stable in terms of the salary increases applied.

There are 4 Senior Analysts and 3 Analysts responsible for the registration of schemes and scheme rules/options, management of amalgamations/liquidations and monitoring of marketing material. The unit is also involved in developing guidance to the industry on communication to members, treating customers fairly, content of rules and implementing low cost benefit options and demarcation.

7.3. Risk Management

Risk Name: Business Efficiency

Risk impact on the strategic objectives

The unit's inability to process schemes' rule amendments will cause the organisation to be exposed to reputational harm as the beneficiaries' interests will not be protected. The organisation will not be able to respond to the needs of the environment effectively and efficiently as access to quality health would not be ensured. To ensure that this risk is mitigated or eliminated, there are series' of monthly meetings where amendments received that are potentially in conflict with section 31(3)(a) are deliberated upon with a view to ensure that non-compliant amendments are swiftly attended to and do not find their way in the registration process. Some of the amendments will be sent to relevant units for reviewing to ensure compliance. The unit also does peer reviewing of amendments prior to these being submitted for registration to ensure that there is consistency in the evaluation of amendments.

8. Programme 8 (Financial Supervision Unit)

Purpose (Financial Supervision Unit)

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

8.1. Strategic Objectives (Financial Supervision Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 8.2.1	**Monitor and Promote the financial soundness of medical schemes**
Objective statement	Secure an appropriate level of protection for beneficiaries of medical schemes by monitoring and analysing the financial performance and soundness of medical schemes.
Baseline	2 recommendations were made in respect of schemes with rapidly reducing solvencies (Suremed and Topmed) and Liberty was requested to submit a new revised business plan for 2014/15 3 Quarterly Reports published in 2014/15 1 set of input in respect of the financial sections of the Annual Return in 2014/2015
Link	Medical Schemes Act

8.2. Resource considerations (Financial Supervision Unit)

8 Financial Supervision	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**10**	**11**	**11**	**11**	**11**	**11**	**11**
Total	**8,088,903**	**8,815,543**	**9,742,148**	**10,394,899**	**11,080,850**	**11,964,136**	**12,866,543**
Compensation of employees	7,816,597	8,430,518	9,505,182	10,011,497	10,714,516	11,576,555	12,456,482
Salaries & wages	7,816,597	8,430,518	9,505,182	10,008,197	10,711,067	11,572,906	12,452,622
Social contributions	-	-	-	3,300	3,449	3,649	3,860
Goods and services	272,306	385,025	236,966	383,402	366,334	387,581	410,061
Consultants	6,535	-	-	80,000	50,000	52,900	55,968
Training and staff development	198,249	263,858	179,452	188,000	199,932	211,529	223,797
Travel and subsistence	35,027	19,089	27,333	35,000	36,000	38,088	40,297
Venue and facilities	-	63,800	-	50,000	50,000	52,900	55,968
Other	32,495	38,278	30,181	30,402	30,402	32,164	34,031

The biggest expenditure items for the unit are salaries and training. This can be expected to increase over the next five years to cater for the specialised skills required in the unit in order to carry out our functions. As the industry, and accounting standards continue to evolve and become more complex, more specialised training will be required resulting in an increase of the expenditure in relation to training. Specifically, there is a lot of specialised finance/accounting work that the unit is unable to carry out due to current excessive workloads.

There are also fairly large pieces of legislation which directly impact on the work carried out by the unit which will need to be revised e.g. Annexure B of the regulations which deals with investments by medical schemes. As this is an area outside of our ordinary scope of work, the unit will need to consult investment experts in this regard. The amount of money spent on consultancy can therefore be expected to increase over the five year period.

In providing an oversight function over medical schemes, the unit has to, amongst other things; ensure that reporting by medical schemes is in line with international accounting and reporting standards. However, some of the standards are proving to be quite onerous and/or impractical for medical schemes, suggesting that there may be a need to look into developing our own set of standards as is the case with other regulators.

Other areas that need to be explored to strengthen our regulation and interventions are inter alia Non Healthcare Expenditure NHE (Industry wide in debt analysis and recommendations), overall analysis on sustainability of medical schemes. Both these matters are aligned with the regulatory objective of understanding cost drivers and responding appropriately i.e. cost containment.

The unit may require an additional resource in the form of senior analysts to respond to increasing complexity and emerging trends. This will have the resultant increase on salaries in the unit.

8.3. Risk Management

Risk Name: Statutory Return tool

Risk impact on the strategic objectives

The unit's biggest risk is the IT Infrastructure relating to the statutory return tool, which may result in an unstable IT Platform, mostly due to many different developers who programmed the system as it evolved over a period of time. It is also our single largest data collection tool, and is as such central to our ability to carry out our mandate and operations. Consequences of this system collapsing are dire, as this will result in inaccurate data collection and inefficient service, and ultimately the inability to efficiently monitor the financial soundness of medical schemes. The current controls to mitigate against the collection of incorrect data is to manually recalibrate the built in validation rules to ensure accuracy.

9. Programme 9 (Complaints Adjudication Unit)

Purpose (Complaints Adjudication Unit)

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

9.1. Strategic Objectives (Complaints Adjudication Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 9.2.1	**Resolve complaints with the aim of protecting beneficiaries of medical schemes**
Objective statement	Increase the adjudication of complaints to 85%, within 120 days, in an efficient and effective manner by 2020.
Baseline	73% of complaints were resolved within 120 working days in 2014/15
Link	Medicals schemes Act S47

9.2. Resource considerations (Complaints Adjudication Unit)

9 Complaints Adjudication	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**8**	**9**	**9**	**9**	**9**	**9**	**9**
Total	**4,045,094**	**4,435,046**	**5,010,223**	**5,424,736**	**5,863,918**	**6,294,246**	**6,713,843**
Compensation of employees	3,959,090	4,387,838	4,910,359	5,264,736	5,673,918	6,093,226	6,501,164
Salaries & wages	3,959,090	4,387,838	4,910,359	5,262,036	5,671,097	6,090,241	6,498,006
Social contributions	-	-	-	2,700	2,821	2,985	3,158
Goods and services	86,004	47,208	99,864	160,000	190,000	201,020	212,679
Training and staff development	45,356	25,551	98,730	150,000	180,000	190,440	201,486
Travel and subsistence	29,749	12,334	-	8,000	8,000	8,464	8,955
Venue and facilities	6,075	2,825	-	-	-	-	-
Other	4,824	6,498	1,134	2,000	2,000	2,116	2,238

Measures have been put in place to improve the complaints process. The alternative dispute resolution process has gone a long way to alleviate the backlog in respect of complaints resolution. This will require further resourcing in the ensuing MTE years. The unit was further restructured to allocate more responsibilities to promoted Senior Legal officers in order to improve the internal processes. Further improvements was to have regular meeting with schemes in order to emphasise their obligations towards complaints resolution prior to referral to the CMS.

9.3. Risk Management

Risk Name: Complaints Resolution

Risk impact on the strategic objectives

The failure to timeously resolve complaints will have an impact on the effectiveness of the CMS. The delay in resolving complaints will further have a negative impact on the protection of beneficiaries as they will not be able to access their benefits. The backlog in respect of complex clinical complaints remains a major risk in achieving the objective of the unit. Measures have been put in place in the Clinical unit to address this.

Part C
Annual Performance Plans 2016/17

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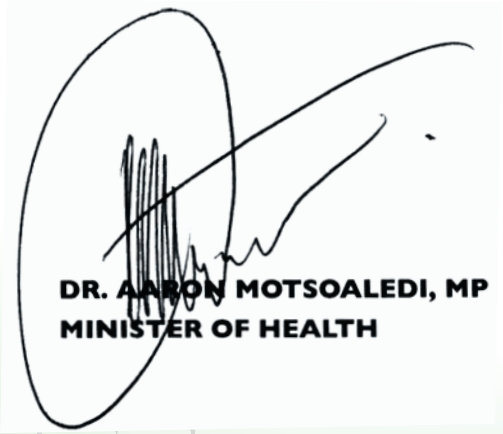
FOREWORD BY MINISTER OF HEALTH

The strategic plan of the Council for Medical Schemes (CMS) for the fiscal years 2015/16 - 2019/2020 has been submitted by CMS, and received by me. In particular, I am encouraged by the strategic goal 4 of the CMS that supports development of the universal health care coverage system by the National Department of Health, and the continued pursuit to improving the efficiency and effectiveness of the healthcare system in South Africa.

The CMS has established itself as an effective and efficient regulator which can be evidenced in the execution and responsiveness to its key mandate that of the protection of the members of medical schemes and promoting access to healthcare. I am also pleased by the manner in which the finances of CMS have been managed - CMS has obtained unqualified audit reports from the office of the Auditor General of South Africa every year since its inception. Consequently, I am satisfied to endorse these strategic plans going forward.

I thank Council, the Acting Registrar and his staff for the development of this strategic plan and wish them well in the execution of these plans.



FOREWORD BY CHAIRPERSON OF COUNCIL

During its 14 years of existence, the Council for Medical Schemes (CMS) has built a proud culture of protecting beneficiaries of medical schemes by enforcing the provisions of the Medical Schemes Act (131 of 1998). The main pillars of the Act are the requirements for open enrolment, community rating and prescribed minimum benefits. Linked with the gove rnance requirements stipulated in the Act, these provisions protect beneficiaries against discrimination based on health status and other arbitrary grounds.

The healthcare system is marred by inequitable access to care and health care resources. The life expectancy of South Africans is currently 56, which is much lower than that of other upper-middle income countries which in 2012 was reported at 74 (World Development Indicators 2014). This is despite the rapid improvement in life expectancy of South Africans which improved from 51.6 in 2004 to the current age of 56. This growth is faster than that of upper-middle income countries which grew from 72.5 in 2004 to 74 in 2012. The National Department of Health (NDoH) in its strategic plan envisages the life expectancy of South Africans to reach 70 by the year 2030.

Inequality in access of health services results in lower levels of human development (Human Development Report, 2013) being attained than in countries which spend less amounts on health care as a proportion of Gross Domestic Product (GDP). Close to 23% of Human Development Index1 (HDI) globally is lost to inequality. South Africa is currently ranked as a middle human development country. This is despite South Africa's healthcare expenditure as a percentage of GDP being higher than that of the upper-middle income countries. South Africa's healthcare expenditure as a percentage of GDP is 8.8% while the upper-middle income countries expenditure as a proportion of GDP is 6.2% (2012) (World Development Indicators 2014).

The problem of access and inequality to healthcare is a source of concern for the Government of South Africa. The Government has adopted a National Development Plan (NDP), vision 2030 in order to address the problem of inequality and poverty in the country. Chapter 10 of this policy document deals with matters geared towards promoting health. The Government has therefore adopted the strategic goals for the years 2014 to 2019 to respond to the challenges of access and inequality to healthcare; these goals are highlighted under the heading of Policy Mandates in this document. The priority for the NDoH is to promote

[1] The Human Development index is a statistical tool used to measure and rank a country's overall achievement in its social and economic dimensions.

Schemes supports this health initiative by the Department and will work closely with the NDoH to make this goal a reality.

Council discharges its mandate in an increasingly litigious health care environment. The 2010 high court judgement, which set aside the Reference Price List (RPL) regulations, has left a void in the regulation of healthcare prices, and leaves many medical scheme beneficiaries unprotected. The CMS supports the NDoH in the development of an alternative mechanism for the determination of private healthcare prices. The newly established Market Inquiry by the Competition Commission will also potentially provide insight to some of these structural challenges faced by the industry.

The Prescribed Minimum Benefit (PMB) package was not designed to operate in an environment where there is no price regulation. CMS must work closely with the NDoH, the Health Professions Council of SA (HPCSA) and other stakeholders to ensure that there is a mechanism in place to determine healthcare prices as soon as possible.

Governance in medical schemes continues to be a challenge in the regulatory framework. In order to stabilise governance in medical schemes, Council frequently appoints curators for medical schemes through court action; manages insolvent schemes and institutes legal proceedings to ensure that beneficiaries are protected. These interventions, whilst critical in protecting our mandate, attract high legal costs and increase the cost of regulation.

In the ensuing period, Council plans to strengthen regulation by way of amending the medical schemes Act. This process is at an advanced stage as proposed amendments have been submitted to the NDOH already.

I extend my thanks and appreciation to the Acting Registrar and his team at the CMS, for the continued focus on the mandate as entrenched in the Medical Schemes Act; in particular, the development of this strategic plan. Further, I would like to wish them well in the execution of this plan.

PROF YUSUF VERIAVA

CHAIRPERSON OF THE COUNCIL

Certification

It is hereby certified that this Strategic Plan:

- Was developed by the management of the Council for Medical Schemes
- Takes into account all the relevant policies, legislation and other mandates for which the Council for Medical Schemes is responsible
- Accurately reflects the strategic outcome oriented goals and objectives which the Council for Medical Schemes will endeavour to achieve over the period 2015/16 - 2019/2020

Ms. Waheda Khan

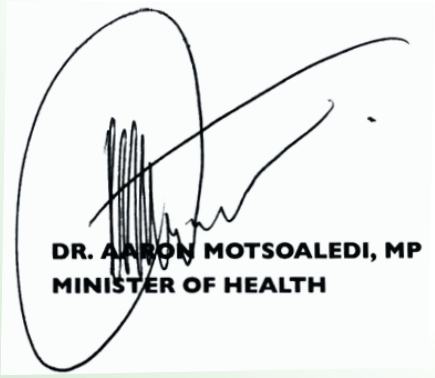
Risk and Performance Manager

Mr. Daniel Lehutjo

Acting Registrar and Chief Executive Officer

Prof. Y Veriava

Chairperson: Council for Medical Schemes



1. Updated situational Analysis

1.1. Performance Delivery environment

Resolution of complex clinical complaints still remain a challenge for the unit. Due to the complexity of the complaints these are sometimes resolved after the specified 120 days as per the standard operating procedures. To address this challenge CMS will further resource the Clinical unit with an additional Clinical Analyst and Medical Advisor during 2015/16.

The Information and Communication Technology programme (ICT) also experienced some challenges during the 2014/15 financial year this was due to electrical interruptions and ageing infrastructure which resulted in the downtime of servers and application systems. The ageing ICT infrastructure will be upgraded during the ensuing financial year. CMS has during the 2014/15 financial period invested in a larger generator to mitigate against the effect of load shedding.

There were challenges experienced in the Human Resources programme this has been attributed to the fact that vacant positions were not filled within the 90 day period as required by the standard operating procedure. The unit has revised their target to 120 days this takes into account the notice period that successful candidates have to serve before their resignation. The unit will strive to ensure that vacant positions are filled within the stipulated time frames.

The CMS has managed to stabilise governance within medical schemes despite some serious challenges from the industry. There were a number of inspections undertaken, however some schemes have resisted these interventions.

In terms of governance of schemes there were three schemes put under curatorship, namely Sizwe, Medshield and Hosmed. Of these three, two curatorships were uplifted as CMS was satisfied that governance problems that were identified were now resolved.

Alignment CMS goals to DOH and NDP

The following table reflects the alignment between the NDP goals, MTSF Priorities and NDOH strategic goals with the CMS strategic goals for the period 2015 to 2020:

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2014 - 2019	CMS Strategic Goals 2015 to 2020
Average male and female life expectancy at birth increased to 70 years	HIV&AIDS and TB prevented and successfully managed Maternal, infant and child mortality reduced	Prevent disease and reduce its burden and promote health	***Access to good quality medical scheme cover is promoted*** The CMS Research and Monitoring as well as the Clinical Unit are currently engaged in the analysis of health care data with the aim to measure health quality outcomes at benefit option level. One of the pillars of the medical schemes Act is the PMB package and enforcement of Regulation 8 which makes payment of PMBs in full a requirement for all registered medical schemes. Currently the CMS is in the process of revising the PMB package with an emphasis to include more primary health care benefits.
Tuberculosis (TB) prevention and cure progressively improved			***Access to good quality medical scheme cover is promoted*** Treatment of TB is part of the PMB package and is treated in line with public sector protocol.
Maternal, infant and child mortality reduced			***Access to good quality medical scheme cover is promoted*** Vaccinations has been included in the revised PMB list as part of the development of a more primary health care focused package. CMS is working on finalising this during the course of 2016. The vaccination list is specific and includes vaccination like HPV Human papilloma virus (7 to 12 year old) hepatitis A B C D, etc.
Prevalence of non-communicable diseases reduced			***Access to good quality medical scheme cover is promoted*** The CMS through its Research and Monitoring Programme monitors the prevalence of non-communicable diseases within the medical schemes environment by analysing Scheme Risk measurement data as well as data submitted by means of the utilisation returns. This information is shared with relevant stakeholders in an effort to inform trends and advise on how best to reduce prevalence.

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2014 - 2019	CMS Strategic Goals 2015 to 2020
Health System reforms completed	Health care costs reduced	Improve financial management by improving capacity, contract management, revenue collection and supply chain management	***Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*** The CMS is currently engaged in a project to review and replace the current solvency framework with a risk based solvency framework. If implemented this framework may result in reduction of scheme contribution by members. The CMS is actively participating in the pricing enquiry currently being conducted by the Competition Commission. Once the report is finalised it is envisaged that recommendations by the Competition Commission will eventually lead to a reduction in health care costs.
	Efficient health management information system for improved decision making	Develop an efficient health management information system for improved decision making	***CMS provides strategic advice to influence and support the development and implementation of National health policy*** The CMS is currently developing a registry of all funded patients in South Africa. Once completed this system will be linked to the patient health register and will facilitate the overall improvement of the health management information system. The CMS is developing a system for the management of a single exit price for medicines on behalf of the National Department of Health (NDoH). Once completed this system will facilitate the regulation of medicine pricing in South Africa.
	Improved quality of health care	Improve the quality of care by setting an monitoring national norms and standards, improving systems for user feedback, increasing safety in health care and by improving clinical governance	***Access to good quality medical scheme cover is promoted*** The CMS fulfils an accreditation function in term of managed care organisations, administrators, brokers and broker organisations. The ongoing accreditation of these entities is dependent on inspection of their ability to render the required services at a specified health care level. In as far as accreditation of managed care entities are concerned, an evaluation of health outcomes, resources employed and price paid for such services is being

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2014 - 2019	CMS Strategic Goals 2015 to 2020
			undertaken to determine the clinical effectiveness and value proposition of these entities. CMS has further more also commenced work on chronic conditions (CDLs) and Utilisation management of services as it relates to hospitals and medicines with the aim of eliminating waste from the system. This initiative will be further developed over the next five years. The NDoH guidelines serve as a minimum benchmark for quality health outcomes. Once entry level criteria, process indicators and outcomes have been concluded, same will be incorporated in the CMS accreditation standards and applied to managed care entities for purposes of ongoing accreditation. Finally, the CMS, through its compliance inspectorate also ensures compliance with different aspects of the Medical Schemes Act some of them which relate to improving the overall quality of health care delivery.
Primary health care teams deployed to provide care to families and communities	Re-engineering of Primary health care	Re-engineer primary healthcare by: increasing the number of ward base outreach teams, contracting general practitioners, and district specialist teams and expanding school health services	***CMS provides strategic advice to influence and support the development and implementation of National health policy*** Currently the CMS is in the process of revising the PMB package with an emphasis to include more primary health care benefits.
Universal Health coverage achieved	Universal health coverage achieved through implementation of National Health Insurance	Make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation.	**CMS provides strategic advice to influence and support the development and implementation of National health policy** Resulting from the publication of the NHI white paper, the NDoH published by means Government notice no. 1231, the terms of reference of the National Health Insurance work streams in terms of Section 3 (1) of the National Health Act, 2003. Work Stream 4 will investigate and advise on the future role of medical schemes in an NHI environment. The CMS will participate fully with the Work Stream 4 team to reach their specific objectives as stated in the Government notice.

Flowing from the general policy direction in healthcare as set out in the NDoH Strategic Plan 2014/15 – 2018/19, as well as imperatives outlined in NDP Vision 2030, the CMS has identified the following as strategic focus areas for the next five years:

1.1.1. Strengthening regulatory mandate, amendment of the Medical Schemes Act and regulations, measuring the quality and outcomes of healthcare in medical aid schemes

CMS, as a regulatory authority, can only be as effective as the legislation (MSA) enables it to do so. The last amendments to the MSA occurred ten years ago. Gaps in the current framework have been identified since then as well as structural deficiencies which impact on the sustainability of the medical schemes environment and their role in the wider health policy framework. These challenges include mandatory membership for all who are employed, issues relating to open enrolment, strengthening the provisions relating to the PMB review process and associated improvements and enhancing governance aspects of medical schemes.

There are also challenges with respect to the transfer of members to open schemes, re-enrolment of members following termination due to non-disclosure, community rating and PMB payment shortfalls.

A draft MSAB was submitted to the NDoH in October 2013. A fully functional medical schemes industry requires that these essential legislative reforms be pursued and adopted diligently.

The CMS submitted draft regulations on the review of PMBs to the NDoH in 2010. Since then, work has commenced to include the following aspects in the PMB package:

Introducing a preventative component to the PMB regulations providing for a broader package;
Decreasing the emphasis on the component that is largely curative and hospicentric; and
Costing of the preventative add-on component and also the entire PMB package as a whole by embarking on a costing analysis project.

A proposal that fits in with the progress towards the evolving NHI will be submitted by the CMS to the NDoH.

The CMS has been working with the NDoH on the social impact analysis of the Medical Schemes Amendment Bill.

Governance in Medical schemes

As medical schemes operate in the private sphere, and are owned by their members, corporate governance arrangements determine whether the scheme acts in the interests of beneficiaries or in the interests of office bearers and commercial interests. The Act as introduced in 1998 and amended in 2003 removed some of the more flagrant failures in the corporate governance framework. However, the present framework falls far short of the appropriate standards required to avoid predictable principal – agent problems.

The policy and legislated framework needs to be enhanced with a view to having a more comprehensive model in place. The aim is to have appropriate standards to avoid predictable principal-agent issues and problems. Reforms in terms of governance principles and policy contained in the MSAB have been submitted to NDoH already. These include, amongst other aspects, the following: introducing greater oversight of board elections, introducing fit and proper criteria, clearly delineating the roles and responsibilities of the board vis-à-vis the principal officer (PO), designating the PO as the Chief Executive Officer (CEO), limiting the terms of board members, introducing benchmark governance guidelines, introducing a stringent definition of conflict of interest, and increase the percentage of elected trustees.

Corporate governance failures, exacerbated by a weak legislative framework, are further deepened by the inability of the CMS to criminally prosecute scheme office bearers for fraud and contraventions of the Act. Collaboration with the National Prosecution Authority (NPA) has failed in a number of instances. This failure has systemic consequences for the industry because it may create the impression that acts of fraud will not lead to criminal prosecution or do not carry serious criminal consequences.

The failure of collaboration between the CMS and the NPA, resulting in an inadequate response to criminal cases involving substantial funds needs to be taken up at two levels: The matter needs to be raised with the Minister of Health and the Minister of Justice; and mechanisms to support the NPA with CMS resources need to be explored.

Assessment of the value add of managed care in the medical scheme environment

Managed care as a health and quality intervention has evolved in South Africa over time. There are also different permutations of this intervention; the question remains whether there is any value? Is managed care the strategy that will fix healthcare?

The value in terms of health care delivery is fast becoming the over-arching goal in health for the future in our country. There is a need to demonstrate that cost effective interventions also provide value for members, in terms of quality health outcomes. Achieving best outcomes at the lowest cost is the goal, as it also creates the foundation for improved clinical governance.

There is a shifting focus throughout the world to the patient outcomes achieved. This is known as value-based **health care**, also known as the **"value agenda"**.

In contributing to the value agenda, the CMS has made progress towards establishing Task Teams with stakeholder's to respond to the important questions relating to the value proposition of managed health care being funded by medical schemes.

In line with the emphasis on quality of care as outlined the "NDP Vision 2030" and in the NDoH Strategic Plan 2014/15 to 2018/19, the CMS has already commenced work in this area, specifically on chronic conditions (CDLs) and Utilisation management of services: hospitals and medicines – eliminating waste from the system, which will be further developed in the next five years. The NDoH guidelines serve as a minimum benchmark for quality health outcomes. Once entry level criteria, process indicators and outcomes have been concluded, same will be incorporated in the Accreditation standards and applied to managed care entities for ongoing accreditation.

1.1.2. The development of a beneficiary registry to facilitate the collection of data

The mission of CMS is "*Protecting the public and informing them about their rights, obligations, and other matters in respect of medical schemes"*. Currently, CMS has no database of beneficiaries and is unable to efficiently communicate and reach out to beneficiaries effectively in order to meet the mission statement above.

The Beneficiary Registry Project (BRP) entails the development of a system for the registration of a set of information/data from medical schemes about a beneficiary in terms of entering/exiting a scheme and when other details change.

Sections 7(c) and 42(3) of the Medical Schemes Act 131 of 1998 make provision for CMS to collect the relevant data per beneficiary from medical schemes.

The strategic benefits of the BRP are as follows:

- The ability to track the movement of a member between schemes and options. This will enable CMS to verify anti-selection member behaviour alluded to by medical schemes whereby members buy less cover when healthy and more cover when sick. Hence, a better understanding of health-seeking behaviour by members will be obtained.
- BRP will collect membership data by districts and hence its relevance to the evolving NHI. A combination of data from the BRP and PCNS databases will provide a geospatial analysis that can assist the NDoH in resource planning activities.
- BRP will play a vital role in education of members and in doing surveys to access patient satisfaction (managed care). Beneficiaries will become more aware of their rights as well as get educated on aspects relating to medical aid benefits they pay for. This will also benefit schemes, as better educated members will lodge fewer complaints.
- The BRP may assist SARS in the verification of member data for tax purposes.
- Ability to obtain data on specific variables such as whether a member has additional top-up hospital cover. This is of strategic significance in view of the Demarcation Regulations and its implications for the industry.
- It will be easier to enhance marketing of CMS services and to obtain feedback from members.
- The allocation of a unique beneficiary identity number for life. This will allow administrators to verify previous membership and access membership history.
- Assist in the prevention of fraudulent member activity, such as accessing state facilities claiming benefits or belonging to more than one scheme.
- BRP will lay the foundation to implement a system of risk adjustment.

The BRP will also go a long way in improving health information systems of the CMS in its role as regulator, and the country in general.

The financial year 2015/16 will see further research being conducted on the feasibility of the beneficiary registry, following a directive by Council aimed at ensuring that there is no duplication between the work being conducted on the BRP and the development of systems aimed at the successful implementation of the NHI. The findings of this feasibility study will be submitted to Council at its strategic planning session during the latter part of 2015 with a view to give approval for the development of the system.

Subject to final approval by Council, as the beneficiary registry project unfolds over the next five years, the industry will be engaged and consulted through an inclusive collaborative process and by ensuring that the most relevant and up to date information security methods and technology is used to protect the confidentiality of data being collected.

Council will be undertaking a feasibility research during 2015/16 in conjunction with other state entities in order to assess the viability of this system.

1.1.3. Demarcation Regulations

Treasury published Draft Demarcation Regulations to the Short Term insurance Act of 1998 and Long Term Insurance Act of 1998 in March 2012 and April 2014 respectively. The public comments have been considered with Treasury and FSB. Most commentators argue that in favour of short-term insurance. In spite of not being accessible to vulnerable groups, Gap Cover products are particularly preferred by brokers and members of the public who currently have no such cover.

The commentators have argued that Medical Scheme cover is insufficient, that there are many gaps in cover and that members frequently have to make co-payments and face deductibles. The high cost of medical schemes was also raised by many commentators. Many commentators argued that the underlying reason for the need for Gap Cover was due to the fact that professional fees charged by specialists and hospital fees were very high and that these needed to be regulated. Other commentators raised systemic problems in medical schemes environment such as that there is no risk adjustment system in place, or the absence of mandatory membership of medical schemes, as underlying problems which necessitated the existence of Gap Cover products.

Capacity / Resource Requirements

Treasury has advised of its intention to promulgate the Demarcation regulations from the beginning of 2015. The draft Regulations are structured in such a manner that all the products that were registered before 2008 must be resubmitted for adjudication by both CMS and FSB to determine whether they are not in contravention of the Medical Schemes Act and the Demarcation regulations. In addition, all prospective applicants will similarly undergo scrutiny by both regulators for the same purpose. It should also be noted that the definition of the business of a medical scheme has been amended by Treasury in consultation with CMS through the Financial Laws General Amendment Act. The amended definition will only come into effect at the same time as the promulgation of the draft Demarcation regulations.

Since the ruling of the Supreme Court of Appeal in 2008 which allowed Gap Covers in the matter of Guardrisk, products that purport to be Gap Covers have flooded the market. Most of these products are in actual fact doing the business of a medical scheme without being registered. Our strategy is to commence with full scale enforcement action as soon as the draft Demarcation regulations are promulgated.

Since the second publication of the draft Demarcation regulations, some providers of Gap Covers have approached CMS and some schemes with a view to enter our regulated space.

CMS will continue engaging FSB specifically on their ideas and suggestions of our recommended resource and capacity requirements.

1.1.4. An Evaluation of the Adequacy of the Current Solvency Framework

Currently, Regulation 29 of the Medical Schemes Act details the following:-

- How much reserves i.e. accumulated funds medical schemes should have; and
- The definition of accumulated funds

Medical schemes are currently required to maintain accumulated funds expressed as a percentage of gross annual contributions which may not be less than 25%.

There have often been debates and challenges to this regulation and the somewhat undesirable effects of the manner in which the solvency ratio is calculated.

In order to fully understand the matter and related consequences, the CMS should undertake a research project that will begin to respond to the challenges. The following are concerns that will need to be catered for in the research project:-

- Impact on affordability aspect of health care
- Effect on market concentration
- Implementation challenges of an alternative framework and the impact on the industry as a whole
- The resultant solvency framework should be one that strengthens the sustainability of medical schemes, and is in line with prudential regulatory developments both nationally and internationally.

1.1.5. Enhancing the effectiveness of Council and its Committees

Council as an oversight authority is charged with providing strategic direction to the operations of CMS.

In order to enhance the effectiveness and functioning of Council the following needs to be put in place:

- Rules governing the functioning of Council and its Committees, the purpose of which is to set out clear roles and responsibilities and general rules on the functioning of Council, must be finalised and approved -
  - CMS has embarked on a process of drafting and publishing rules of the Appeals Committee to streamline the appeals procedure. Members of the public were invited to make comments on the draft rules in Circular 48 of 2013. The updated and final version is being considered for approval and publication.
- Council should adopt a code of conduct that deals with areas of fiduciary responsibilities, conflict of interest, ethics and attendance of meetings – CMS will develop a code of conduct with input from Council for their adoption.
- Proper records of the deliberations of Council and Resolutions should be enhanced and properly documented – the Secretariat will be guided on recording of Council deliberations and resolutions.
- Annual assessment of the functioning of Council, its Committees and members must be undertaken – CMS has appointed a service provider to assist Council with the annual assessment of members and Committees.

1.1.6. Improving the Visibility and Reach of CMS brand

Organisations that have developed successful brands have created a culture in which all areas of the organisation are committed to the branding process. Therefore, employees are viewed as playing a crucial role in creating brand awareness as they facilitate the interface between the organisation and industry (Eisingerich & Rubera, 2010:65), thus making a significant contribution to the organisation's reputation.

Below are challenges facing brand awareness:

- There is a lack of information and knowledge amongst stakeholders, in particular employer groups and medical scheme members, as to the role of and the support provided by CMS.
- There are different interpretations and implications of the Medical Schemes Act as to the roles and responsibilities of the various stakeholders.
- The communication and information efforts of medical schemes and other stakeholders at times misinforming medical scheme members of their rights.
- Communication to individual members, employer groups and rural areas is not sufficient.
- There is a lack of overall awareness of the CMS, i.e. the brand of CMS.
- The reputation of the CMS is at stake due to the lack of proper stakeholder relationships.

These challenges will change as and when circumstances and perceptions change.
In order to improve the reputation of CMS, the following has to be implemented:

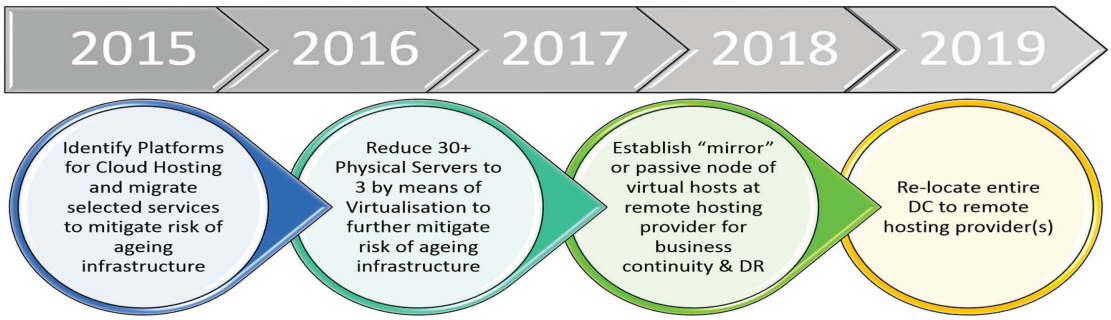
- Facilitate information flow about the Medical Schemes Act and the functioning of the CMS;
- Ensure that communication and information addresses stakeholders' needs with regards to their requirements of the Medical Schemes Act and interpretation thereof;
- Create the opportunity for stakeholder participation;
- Clarify and enhance awareness of the objectives and functions of the CMS
- Improve the brand of the CMS; and
- Improve relationship with the Executive Authority

Effective stakeholder relationships and involvement is critical to the success of complying with the Act and its regulations regulated by the CMS. CMS has a duty to create optimal awareness and understanding of regulatory and policy developments and industry trends in the medical schemes environment.

1.1.7. Development of Information Technology (IT) information systems and Knowledge Management to improve efficiencies in the Organisation

Over the next five years, the following Information and Communication Technology (ICT) strategic roadmaps will be followed for each of the various domains (ICT infrastructure, software development and knowledge management) in order to strategically align ICT with business.

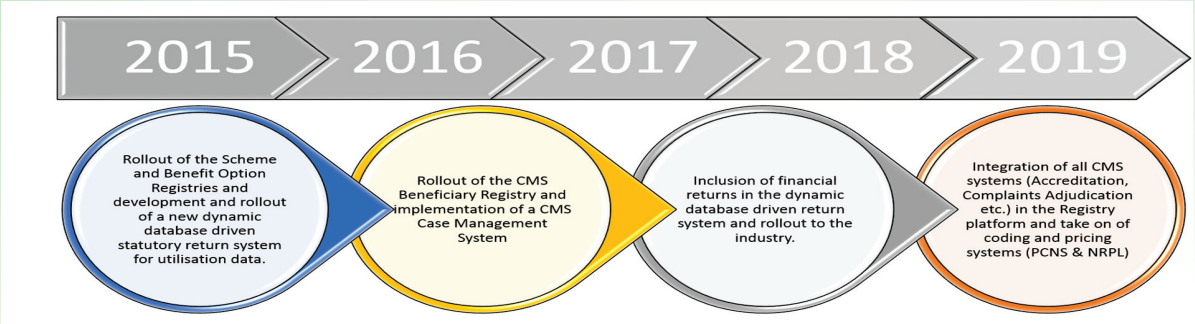
ICT Infrastructure



Given the complexity, challenges and risks associated with outdated physical servers in use at the CMS, the main drive over the next five years will be to:

- Reduce the complexity and mitigate the risks associated with the ageing server environment by identifying servers which can be outsourced to cloud hosting providers (mail and mail archiving).
- Virtualisation of the existing physical server environment, thereby reducing the number of physical machines from 30+ to just 3, thus enabling a much more manageable physical infrastructure.
- Ensuring a proper business continuity and disaster recovery solution by establishing a passive node of the virtualized servers at a remote hosting site, and
- Eventually consider completely relocating the entire on premise virtualized infrastructure to a hosted environment. Further to the above, we will implement a unified communications solution and upgrade our data link and information security solutions to accommodate anticipated ICT solutions such as the beneficiary registry and other data intensive applications.

Software Development



Our software development drive will further exploit and expand the Microsoft Dynamics Extensible Relationship Management (XRM) platform by integrating the CMS legacy systems into this system and by introducing the scheme and benefit option registries. A case management system will also be developed on our M-Files content management platform. These platforms will enable agility and enhance the responsiveness of IT systems development to rapidly changing business needs. Our statutory return system will also be updated in close collaboration with schemes and administrators and will be a dynamic database driven system which will allow for faster and more accurate collection of data whilst reducing the administrative burden on users. Further to the above, we will continue to exploit the recently acquired business process management software suite to automate all major business processes within the CMS.

Knowledge Management

The CMS will continue with its drive to unlock information within the organisation thereby creating and maintaining an environment where information and knowledge becomes paramount. A crucial part of this "unlocking" of information is the scanning of CMS records, the process of object character recognition and the storing of such records on a proper electronic document management system. The drive to expand the electronic capturing of all CMS records will be continued. We also intend further enhancing and integrating our electronic document management system.

Apart from the above we further intend:

- Making our E-library an even more effective information tool, that provides up to date information to CMS, by creating an E-Library which will provide:
  - A baseline of access tools for both archival and latest books and articles contents in the Resources Centre repository, where users are able to perform a Bibliographic searching through either a title, author, subject, ISBN, publisher, and year of publication.
  - Universal access to all relevant online databases to CMS staff
- Establishing a fully functional Registry Office which will eventually perform a bureau scanning, indexing and retrieval service for CMS.

1.1.8. Continuous improvement of CMS as Employer of Choice

In line with other service organisations throughout the world, the CMS's biggest resource is its human capital and it is essential to ensure that employees are well looked after. The challenge is always to retain talent within the organisation. CMS has identified a succession planning project in order to mitigate the challenge of staff retention. Key positions have been identified and possible successors are now being mentored and coached. Thisprojectwillbecompletedin2016.Inordertoremainemployerofchoice,successionplanning, benchmarking of benefits, improvement of the performance and development system must receive special attention in this planning cycle.

The CMS has recently experienced a high staff turnover which is a trend that could potentially harm the operations of the organisation due to the specialised nature of skills required. CMS continues to benchmark its benefits with similar entities in the market in order to remain competitive. The performance and development systems are in place to encourage outstanding performance. The CMS also pays particular attention to relevant labour legislation such as the Labour Relations Act, Basic Conditions of Employment Act and the Employment Equity Act. An employment equity plan is in place and is reviewed from time to time.

1.1.9. Adequate and Sustainable Funding of the operations of CMS

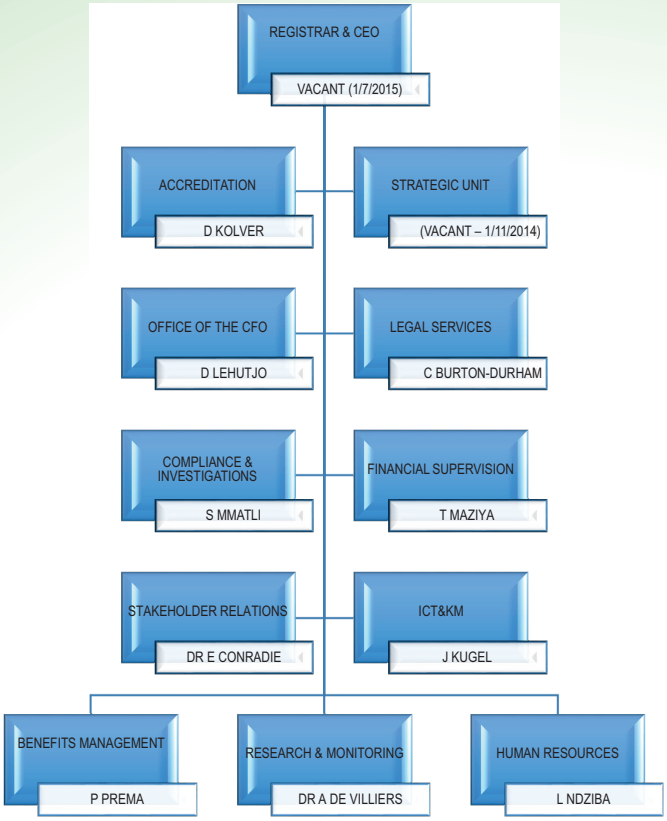
Council for medical schemes receives its funding mainly from levies on medical schemes. The challenge is that Council is not able to charge more than the inflation rate because the burden goes to the members of medical schemes. It is increasingly difficult to regulate adequately within the confines of the current funding structure. Furthermore National Treasury provides guidelines for expenditure increase for all public entities. This is often limited to inflation or below inflation. The challenge is that Council is not able to undertake major strategic projects which require substantial funding e.g. The IT infrastructure requires upgrading and therefore more funding. The legal fees in our operation are a case in point where the budget is always limited and the legal challenges are growing each year.

Additionally, remuneration of employees must also be competitive and market related in order to retain experienced and specialist staff for purposes of institutional memory and to also facilitate the carrying out of our mandate in this ever evolving and complex environment.

1.1.10. Policy Development

The CMS has previously made input in the development of Green Paper on NHI. During that time the CMS made 46 recommendations towards the development of the NHI. The CMS was also represented through the Chairperson at that time, Prof Pick, on the Ministerial Task Team on NHI. Since then the CMS has written to request representation in the evolution of NHI but was not accommodated in the process. CMS has taken note that one of the work teams in the White Paper recently released is dealing with the role of medical aid schemes in the NHI environment. It is here that the CMS identifies the need to make a meaningful contribution as this policy is being developed. This task team will have a bearing on how the CMS will need to develop its strategy and annual performance plans going forward. The CMS further believes that it has information that can be utilised.

1.2. Organisational environment



Programme 1: Administration

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

Sub-programme 1.1: Registrar and CEO

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

Sub-programme 1.2: Office of the CFO

The purpose of the sub-programme is to serve all business units in CMS, the executive management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The sub-programme also serves the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, the sub-programme helps Council to be a reputable Regulator.

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

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

Sub-programme 1.4: Human Resources

The purpose of the sub-programme is to provide high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programmes that promote and support Council's vision.

We will fulfil this mission with professionalism, integrity, and responsiveness by:

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

By doing this the sub-programme helps the Council for Medical Schemes by supporting its administration and staff through Human Resources Management advice and assistance, enabling them to make decisions that maximise its most important asset: its people and to continue the development of CMS as an employer of choice.

Sub-programme 1.5: Legal Services
The purpose of the sub-programme is to provide legal advice and representation to the CMS and business units to ensure the integrity of regulatory decisions.

The legal services sub-programme was moved to fall under administration as this forms part of our support programmes.

The Core Programmes of CMS are mainly concerned with the regulation and stability of the industry. The following programmes make up these:

Programme 2: Strategy Office
The purpose of this programme is to engage in projects to provide information to the Ministry on strategic health reform matters to achieve government's objective of an equitable and sustainable healthcare financing system in support of universal access and to provide support to the office on clinical matters. The purpose of the Clinical Unit is to ensure that access to good quality medical scheme cover is maximised and that regulated entities are properly governed, through prospective and retrospective regulation.

Programme 3: Accreditation
The purpose of the programme is to ensure brokers and broker organisations, administrators and managed care organisations are accredited in line with the accreditation requirements as set out in the Medical Schemes Act, including whether applicants are fit and proper, have the necessary resources, skills, capacity, and infrastructure and are financially sound.

Programme 4: Research and Monitoring
The purpose of the programme is to serve beneficiaries of medical schemes and members of the public by collecting and analysing data to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes and develop recommendations to improve regulatory policy and practice. By doing this the programme helps the Council for Medical Schemes to contribute to development of policy that enhances the protection of the interests of beneficiaries and members of public.

Programme 5: Stakeholder Relations
The purpose of the programme is to create and promote optimal awareness and understanding of the medical schemes environment by all regulated entities, the media, Council members and staff, through communication, education, training and customer care interventions.

Programme 6: Compliance and Investigation
The purpose of the programme is to serve members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act.

Programme 7: Benefit Management
The purpose of the programme is to serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. The programme analyses and approve all other rules to ensure consistency with the Medical Schemes Act. This ensures that the beneficiaries have access to affordable and appropriate quality health care. By doing this the programme helps the Council for Medical Schemes ensure that the rules of medical schemes are fair to beneficiaries and are consistent with the Act.

Programme 8: Financial Supervision
The purpose of the programme is to serve the beneficiaries of medical schemes, the Registrar's Office and Trustees by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Act. By doing this, the programmes helps the Council for Medical Schemes monitor and promote the financial performance of schemes in order to achieve an industry that is financially sound.

Programme 9: Complaints Adjudication
The purpose of the programme is to serve the beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. By doing this, the programme ensures that beneficiaries are treated fairly by their medical schemes.

2. Revisions to legislative and other mandates

There have been no significant changes to the Council for Medical Schemes legislative and other mandates.

3. Overview of 2016/17 draft budget and MTEF estimates

3.1. Expenditure Estimates

Programme	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
1.1 CEO and Registrar	11,285,348	9,521,012	15,352,454	8,561,731	9,395,051	10,004,350	9,774,806
1.2 Office of the CFO	19,514,373	23,124,000	28,413,250	31,591,653	32,455,377	34,467,564	36,629,183
1.3 ICT and KM	9,926,241	11,242,275	12,212,536	14,059,054	15,898,426	17,001,181	18,283,930
1.4 Human Resource Management	5,913,523	6,526,219	5,473,200	5,842,813	5,733,347	6,207,208	6,563,818
1.5 Legal Services	12,806,218	12,700,754	10,896,098	11,653,762	11,885,993	15,010,178	15,690,166
2 Strategy office	52,726	3,823,404	4,934,874	6,758,615	8,337,149	8,939,428	9,606,574
3 Accreditation	5,792,595	6,115,769	7,165,575	8,060,888	8,499,546	9,150,042	9,596,799
4 Research and Monitoring	5,653,841	5,683,458	6,044,616	6,916,990	7,565,324	7,996,551	8,638,119
5 Stakeholder Relations	7,054,848	7,670,297	8,596,417	9,064,568	9,728,142	10,404,043	11,147,389
6 Compliance & Investigation	4,979,191	5,307,134	6,719,225	7,428,614	8,437,551	9,041,327	9,768,575
7 Benefits Management	4,363,969	4,574,964	4,757,882	5,589,803	6,275,854	6,721,673	7,193,849
8 Financial Supervision	8,088,903	8,815,543	9,742,148	10,394,899	11,080,850	11,964,136	12,866,543
9 Complaints Adjudication	4,045,094	4,435,046	5,010,223	5,424,736	5,863,918	6,294,246	6,713,843
	99,476,870	**109,539,875**	**125,318,498**	**131,348,126**	**141,156,528**	**153,201,927**	**162,473,594**
Capital expenditure	**8,857,651**	**1,958,320**	**7,163,952**	**6,102,001**	**2,424,248**	**2,564,854**	**2,713,616**
Income	**103,739,562**	**114,864,797**	**121,152,746**	**130,913,576**	**141,156,528**	**153,201,927**	**162,473,594**
Accreditation Fees	5,497,000	6,263,716	5,612,000	5,876,000	9,315,016	9,855,287	10,426,894
Levy on Medical Schemes	90,775,193	99,176,566	107,841,009	120,081,576	127,526,634	134,992,053	143,207,315
Registration Fees	376,650	393,750	335,600	400,000	356,407	377,079	398,949
Other income	1,310,343	2,130,318	299,164	-	-	-	-
Grants Received	4,340,569	4,935,285	4,856,431	2,556,000	1,613,000	5,496,000	5,815,000
Interest Received	1,439,807	1,965,162	2,208,542	2,000,000	2,345,471	2,481,508	2,625,436
Internal funding	**4,594,959**	**-3,366,602**	**11,329,704**	**6,536,551**	**2,424,248**	**2,564,854**	**2,713,616**
Surplus funds	4,594,959	-3,366,602	11,329,704	6,536,551	2,424,248	2,564,854	2,713,616
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Economic Classification

Economic classification	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Current payments	**96,674,004**	**106,902,817**	**121,546,871**	**127,576,499**	**138,732,280**	**150,637,073**	**159,759,978**
Compensation of employees	63,061,690	66,198,042	74,355,974	82,412,336	90,789,040	97,538,161	103,846,777
Salaries and wages	61,130,718	64,135,532	72,055,903	79,842,937	87,939,575	94,523,427	100,657,188
Social contributions	1,930,972	2,062,510	2,300,071	2,569,399	2,849,465	3,014,734	3,189,589
Goods and services	33,612,314	40,704,775	47,190,897	45,164,163	47,943,240	53,098,912	55,913,201
Agency and support / outsourced services	45,657	109,406	70,226	73,620	76,933	81,395	86,116
Audit costs	1,678,369	1,600,961	1,897,016	2,080,470	2,201,136	2,328,802	2,463,873
Bank charges	39,545	41,012	46,100	48,312	48,775	51,604	54,597
Communication	1,326,192	1,686,267	1,305,075	1,582,442	1,637,082	1,732,033	1,832,491
Computer services	1,890,916	2,288,375	2,891,693	3,824,686	4,528,051	4,790,678	5,068,537
Consultants	2,511,765	3,671,989	11,637,185	4,764,692	5,172,413	5,472,413	5,789,813
Lease Payments	4,616,688	6,569,208	9,553,087	11,323,817	11,927,006	12,618,773	13,350,661
Legal fees	9,304,908	9,549,049	7,699,181	8,000,000	8,000,004	10,839,200	11,202,658
Non-life insurance	176,368	274,398	295,217	332,610	339,406	359,092	379,919
Other transfers to households	3,733	6,500	20,328	52,300	54,474	57,401	60,498
Property payments	1,897,370	3,311,973	3,438,507	4,138,944	4,478,421	4,738,170	5,012,983
Repairs and maintenance	274,217	285,312	143,894	150,000	150,000	158,700	167,905
Training and staff development	1,710,148	1,770,455	1,484,271	1,928,000	2,093,932	2,215,380	2,343,872
Travel and subsistence	2,486,647	1,948,464	1,843,427	2,287,388	2,514,802	2,660,661	2,814,979
Venue and facilities	1,805,113	3,280,248	1,968,997	1,619,630	1,548,592	1,638,410	1,733,438
Other	3,844,678	4,311,158	2,896,693	2,957,252	3,172,213	3,356,200	3,550,861
Payments for capital assets	**2,802,866**	**2,637,058**	**3,771,627**	**3,771,627**	**2,424,248**	**2,564,854**	**2,713,616**
Amortization	941,811	895,309	765,040	765,040	533,810	564,771	597,528
Depreciation	1,861,055	1,741,749	3,006,587	3,006,587	1,890,438	2,000,083	2,116,088
Total	**99,476,870**	**109,539,875**	**125,318,498**	**131,348,126**	**141,156,528**	**153,201,927**	**162,473,594**

3.2. Relating expenditure trends to strategic outcome oriented goals

Addressing the problems of access to health care and inequities in its quality and provision are priorities of Government. The National Development Plan envisages stronger primary health care services, and outcome 2 (a long and healthy life for all South Africans) of government's 2014-2019 medium term strategic framework seeks to address shortcomings in the sector through the introduction of National Health Insurance. Council for Medical Schemes (CMS) has prepared a preventative primary health care package for consideration by the National Department of Health (NDoH) in order to strengthen this objective. The CMS will work closely with the NDoH to achieve this, to this end we aim to contribute meaningfully to the recently published White Paper on NHI

The focus over the medium term will be on strengthening the monitoring and compliance activities of accredited entities to ensure compliance with fit and proper requirements which requires the Board of Trustees to exercise their fiduciary duties and responsibilities. The resolution of complaints and more importantly complex clinical complaints continues to be our focal point in our quest to achieve the objective of protecting beneficiaries of medical aid schemes.

The CMS was given a directive by the Minister of Health to develop a transparent pricing system for the Pharmaceutical Economic Evaluation directorate (PEED) that will enable the directorate to comply with provisions of section 22G of the medicines and related substances Act 101 of 1965. This system will ensure that the PEED conducts its day to day activities electronically instead of the current manual process. The Medicine Price Registry (MPR) or Single Exit Price (SEP) System will ensure transparency in prices of medicines for the general public to have access to authorised and up to date single exit prices in the South African pharmaceutical market. The PEED will utilise the MPR/SEP system to conduct price manipulations that would inform future amendments to pricing policies. The project is due to be completed by 2016.

Government recognises the importance and need for a central repository containing all funded (Medical Scheme) patients in South Africa. For this reason the Minister of Health has conferred the function of establishing and administering a Beneficiary Registry on the CMS. The data collected will be used for health resource planning and claim verification amongst other regulatory functions.

Information to be collected by the CMS will include but not be limited to:

a) Basic demographic details of members, including their domicile.
b) The verification of membership of patients that have medical scheme cover, visiting state facilities.
c) The join date of a new beneficiary and the date on which he/she is eligible to receive benefits.
d) The relationship between principal members and dependents.
e) The movement of beneficiaries between different benefit options.
f) The termination date of the beneficiary.

Both the SEP and the Beneficiary Registry projects are funded from the grant received from NDoH.

The project on the revision of prescribed minimum benefit definitions has proceeded slower than anticipated. CMS is exploring alternative mechanism including collaborations with academic institutions as well experts in this field in order to fast track the project but this will however require further funding for the purpose. The completion of this project is very important in that it will assist in the reduction of complex clinical complaints which is currently a challenge in our operations.

The Demarcation regulations promulgated by National Treasury will have an impact on the operations of CMS. CMS will have to adjudicate on these products that purport to be health insurance, whereas they do the business of a medical schemes without being registered in terms of the Medical Schemes Act.

Governance in medical schemes continues to be a challenge in the regulatory framework. As a consequence the CMS is always faced with a number of investigations into areas of irregularities in the governance of medical schemes. The results of these investigation sometimes lead to the appointment of Curators in medical schemes in order to stabilise the governance in schemes. The process attracts high legal costs but is necessary to ensure that the beneficiaries are protected. As a result, the Legal Services unit is a key cost driver in the *administration* programme, the entity's largest programme. As a preventative measure CMS has published a trustee guideline which serves as a framework for governance in medical schemes.

The CMS discharges its mandate in an increasingly litigious health care environment. The 2010 high court judgment that set aside the reference price list regulations has left a void in the regulation of health care prices, this meant that there was no guidelines on the prices which service providers could refer in charging for the services they provide, leaving many medical scheme beneficiaries unprotected. The CMS supports the NDoH in the development of an alternative mechanism for the determination of private health care prices. The newly established market inquiry by the Competition Commission will also potentially provide insight into some of the structural challenges the industry faces, improving access to the current risk pool of beneficiaries and making access more affordable to those who do not have medical scheme cover.

Over the MTEF period, the CMS plans to strengthen regulation by amending the Medical Schemes Act (1998). The aim of these amendments is to strengthen regulation in the current atmosphere whilst the NDoH is working on the bigger health reform for the country.

In order to support the efficient and effective functioning of CMS, the Information and Communication Technology unit is looking into virtualisation of the existing server environment thus enabling a much more manageable infrastructure. CMS is currently developing its business continuity and disaster recovery solution, to ensure that a full solution will be implemented by 2017/18, these will incur further budget requirements over the ensuing period.

The CMS is mainly a service organisation, spending on compensation of employees is a bigger portion of total expenditure over the medium term which is estimated at 63.8%. The CMS is attracting highly specialised skills including actuaries, accountants, lawyers, doctors and clinicians. The *financial supervision* unit is one of the CMS's largest spending programmes with an allocation of R36.3 million over the medium term, as they attract a high number of Chartered accountants who deals with complex financial information from medical schemes. The Human Resource unit is looking into strategies including succession planning that will enable CMS to retain and empower highly skilled personnel to ensure continuity in its operations.

The number of employees at CMS is expected to increase slightly to 109 in 2016/17 from 105 in 2014/15, after which it will remain stable over the medium term. During this period, total expenditure is expected to increase by 7.0 per cent annually, reaching R162.411illion by 2018/19.

The CMS is expected to derive 95.8 per cent or R430.0million of its revenue over the medium term from levies imposed on medical schemes according to the total number of members each scheme has. It also receives an annual transfer from the NDoH which amounts to R12.9 million over the medium term. Between 2012/13 and 2014/15, the significant increase of 9.3 per cent per year in total revenue was mainly due to increased medical scheme membership, covering 8.8 million beneficiaries in 2014. To effect baseline reductions approved by Cabinet, transfers from the NDoH have been reduced by R2.4 million in 2015/16 and R3.6 million in 2016/17, but it is estimated that total revenue will continue to grow annually by 6.4 per cent over the medium term.

The CMS continues to monitor development in the area of PFMA and Supply Chain Management guidelines in order to maintain an efficient an effective financial management environment. CMS also applies the guidelines of National Treasury as it relates to budgeting.

3.3. Materiality and Significance Framework 2016/17

The proposed Materiality and Significance Framework for the CMS, in terms of the Treasury Regulation 28.3.1 and the National Treasury Practice Note on Applications under of Section 54 of the Public Finance Management Act (PFMA), is as follows –

***Section 50:* Fiduciary duties of accounting authorities:**

1) The Accounting Authority for a public entity must –

PFMA Section	Quantitative [Amount]	Qualitative [Nature]
c) on request, disclose to the Executive Authority responsible for that public entity or the legislature to which the public entity is accountable, all material facts, including those reasonably discoverable, which in any way may influence the decisions or action of the Executive Authority or that legislature;	Disclose all material facts.	The Council will disclose to the National Department of Health all material facts as requested and all material facts not requested, including those reasonably discoverable, which in any way may influence the decisions or action of the National Department of Health, at the discretion of the Council.

Section 51: General responsibilities of accounting authorities:

1) An Accounting Authority for a public entity –

PFMA Section	Quantitative [Amount]	Qualitative [Nature]
g) must promptly inform the National Treasury on any new entity which that public entity intends to establish or in the establishment of which it takes the initiative, and allow the National Treasury a reasonable time to submit its decision prior to formal establishment; and	Disclose all material facts timeously.	Full particulars to be disclosed to the Minister of Health for approval after which it is to be presented to Treasury.

Section 54: Information to be submitted by accounting authorities:

2) Before a public entity concludes any of the following transactions, the Accounting Authority for the public entity must promptly and in writing inform the relevant Treasury of the transaction and submit relevant particulars of the transaction to its Executive Authority for approval of the transaction:

PFMA Section	Quantitative [Amount]	Qualitative [Nature]
a) establishment of a company;	Any proposed establishment of a legal entity.	Full particulars to be disclosed to the Minister of Health and Minister of Finance (National Treasury) for approval (simultaneous submission).
b) participation in a significant partnership, trust, unincorporated joint venture or similar arrangement;	Qualifying transactions exceeds R1.2m (based on 1% of total CMS Revenue, as at 31 March 2015).	
c) acquisition or disposal of a significant shareholding in a company;	Greater than 20% of shareholding.	
d) acquisition or disposal of a significant asset;	Qualifying transactions exceeds R1.2m (based on 1% of total CMS Revenue, as at 31 March 2015) including financial leases.	Any asset that would increase or decrease the overall operational functions of the CMS.
e) commencement or cessation of a significant business activity; and	Any activity not covered by the mandate/core business of the CMS and qualifying transactions exceeds R1.2m (based on 1% of total CMS Revenue, as at 31 March 2015).	Full particulars to be disclosed to the Minister of Health and Minister of Finance (National Treasury) for approval (simultaneous submission).
f) a significant change in the nature or extent of its interest in a significant partnership, trust, unincorporated joint venture or similar arrangement.	Qualifying transactions exceeds R1.2m (based on 1% of total CMS Revenue, as at 31 March 2015)	

Section 55: Annual report and financial statements

2) The annual report and financial statements referred to in subsection (1) (d) ("financial statements") must –

a) fairly present the state of affairs of the public entity, its business, its financial results, its performance against predetermined objectives and its financial position as at the end of the financial year concerned;

b) include particulars of –

PFMA Section	Quantitative [Amount]	Qualitative [Nature]
(i) any material losses through criminal conduct and any irregular expenditure and fruitless and wasteful expenditure that occurred during the financial year:	All instances.	Report quarterly to the Minister of Health. Report annually in the Annual Financial Statements.
(ii) any criminal or disciplinary steps taken as a consequence of such losses or irregular expenditure or fruitless and wasteful expenditure;		
(iii) any losses recovered or written off;		
(iv) any financial assistance received from the state and commitments made by the state on its behalf; and		
(v) any other matters that may be prescribed.	All instances, as prescribed.	

Section 56: Assignment of powers and duties by Accounting Authorities

PFMA Section	Quantitative [Amount]	Qualitative [Nature]
1) The Accounting Authority for a public entity may— (a) In writing delegate any of the powers entrusted or delegated to the Accounting Authority in terms of this Act, to an official in that public entity; (b) Instruct an official in that public entity to perform any of the duties assigned to the Accounting Authority in terms of this Act.	Values excluded from the Delegation of Authority Framework Policy.	Instances that are excluded from the Delegation of Authority Framework Policy.
2) A delegation or instruction to an official in terms of subsection (1)— (c) Is subject to any limitations and conditions the Accounting Authority may impose; (d) May either be to a specific individual or to the holder of a specific post in the relevant public entity; and (e) Does not divest the Accounting Authority of the responsibility concerning the exercise of the delegated power or the performance of the assigned duty.	Values excluded from the Delegation of Authority Framework Policy.	Instances that are excluded from the Delegation of Authority Framework Policy.

Treasury Circulars and Guidelines related to Supply Chain Management

National Department of Health and National Treasury are to:

1 be notified of procurement transactions exceeding R10m;

The materiality level mentioned above was calculated using the guidance practice note of the National Treasury. Using these parameters, the CMS materiality level calculation outcomes were as follows:

Element	Percentage (%) rand to be applied against R value	audited value at 31 March 2015	Calculated Materiality and Significance Value
Total Revenue (0.5-1%)	1%	R120, 095, 000.00	R1,200,950.00

The CMS Materiality and Significant Value will be R1.2m based on the highest percentage of the total revenue element and the significant fluctuations in the month-to-month total revenue value.

4. Programme 1 (Administration)

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

4.1. Sub-Programme 1.1 (CEO and Registrar)

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

4.1.1. Reconciling performance targets with the Budget and MTEF (CEO and Registrar)

1.1 Registrar and CEO	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**4**	**4**	**4**	**4**	**4**	**4**	**4**
Total	**11,285,348**	**9,521,012**	**15,352,454**	**8,561,731**	**9,395,051**	**10,004,350**	**9,774,806**
Compensation of employees	5,828,526	3,254,991	3,355,588	3,434,051	4,049,405	4,348,888	3,791,560
Salaries & wages	5,828,526	3,254,991	3,355,588	3,432,851	4,048,151	4,347,562	3,790,157
Social contributions	-	-	-	1,200	1,254	1,326	1,403
Goods and services	5,456,822	6,266,021	11,996,866	5,127,680	5,345,646	5,655,462	5,983,246
Agency and support / outsourced services	-	109,406	70,226	73,620	76,933	81,395	86,116
Consultants	1,134,486	1,623,197	9,550,016	2,403,060	2,511,198	2,656,847	2,810,944
Transfers to households	-	-	-	4,000	4,000	4,000	4,000
Training and staff development	200,711	191,800	60,175	80,000	80,000	84,640	89,549
Travel and subsistence	898,888	860,396	490,423	694,400	716,648	758,214	802,190
Venue and facilities	277,034	800,990	192,910	224,000	234,080	247,657	262,021
Other	2,945,703	2,680,232	1,633,116	1,648,600	1,722,787	1,822,709	1,928,426

Resource requirements

The Office of the CEO and Registrar is currently adequately resourced in order to meet its objectives for the financial year. There will be no need for further human resource requirements for the office.

4.2. Sub-Programme 1.2 (Office of the CFO)

The purpose of the sub-programme is to serve all business units in CMS, the executive management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The Internal Finance unit also serves the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, we help Council to be a reputable Regulator.

4.2.1. Strategic Objectives Annual Targets for 2014 to 2019 (Office of the CFO)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.2.3.1: Ensure effective financial management and alignment of budget allocation with strategic prioriti es								
1.2.3.1	An unqualified opinion issued by the Auditor General on the annual financial statements by 31 July each year	New indicator	New indicator	1	1	1	1	1
	An unqualified opinion issued by the Auditor General on the annual performance information by 31 July each year	New indicator	New indicator	1	1	1	1	1
Strategic Objective 1.2.3.2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS								
1.2.3.2	Number of strategic risk register reports submitted to Council for monitoring, per year	New indicator	New indicator	New indicator	4	4	4	4

4.2.2. Quarterly targets for 2016/17 (Office of the CFO)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 1.2.3.1: Ensure effective financial management and alignment of budget allocation with strategic priorities							
1.2.3.1	An unqualified opinion issued by the Auditor General on the annual financial statements by 31 July each year	Annually	1	-	1	-	-
	An unqualified opinion issued by the Auditor General on the annual performance information by 31 July each year	Annually	1	-	1	-	-
Strategic Objective 1.2.3.2: An effective, efficient and transparent system of risk management is maintained in order to miti gate the risks exposure of the CMS							
1.2.3.2	Number of strategic risk register reports submitted to Council for monitoring, per quarter	Quarterly	4	1	1	1	1

4.2.3. Reconciling performance targets with the Budget and MTEF (Office of the CFO)

1.2 Office of the CFO	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**7**	**9**	**10**	**10**	**10**	**10**	**10**
Total	**16,711,507**	**20,486,943**	**24,641,623**	**27,820,026**	**30,031,129**	**31,902,710**	**33,915,567**
Compensation of employees	7,558,174	7,654,833	9,107,930	9,323,453	10,350,059	11,080,138	11,885,286
Salaries & wages	6,069,083	6,072,455	7,280,330	7,361,016	8,148,010	8,750,370	9,420,392
Social contributions	1,489,091	1,582,378	1,827,600	1,962,437	2,202,049	2,329,768	2,464,894
Goods and services	9,153,333	12,832,110	15,533,693	18,496,573	19,681,070	20,822,572	22,030,281
Audit costs	1,678,370	1,600,961	1,897,016	2,080,470	2,201,136	2,328,802	2,463,873
Bank charges	39,545	41,012	46,100	48,312	48,775	51,604	54,597
Consultants	111,753	404,649	96,977	254,085	291,929	308,861	326,775
Lease Payments	4,496,986	6,325,553	9,304,905	11,059,817	11,652,002	12,327,818	13,042,832
Non-life insurance	176,368	274,398	295,217	332,610	339,406	359,092	379,919
Property payments	1,897,370	3,311,973	3,438,507	4,138,944	4,478,421	4,738,170	5,012,983
Repairs and maintenance	274,217	285,312	143,894	150,000	150,000	158,700	167,905
Training and staff development	340,643	125,245	140,223	200,000	200,000	211,600	223,873
Travel and subsistence	36,430	16,549	2,584	5,600	5,600	5,925	6,268
Venue and facilities	-	51,689	7,840	35,000	52,000	55,016	58,207
Other	101,651	394,769	160,430	191,735	261,801	276,984	293,049
Payments for capital assets	2,802,866	2,637,058	3,771,627	3,771,627	2,424,248	2,564,854	2,713,616
Amortization	941,811	895,309	765,040	765,040	533,810	564,771	597,528
Depreciation	1,861,055	1,741,749	3,006,587	3,006,587	1,890,438	2,000,083	2,116,088
Total	19,514,373	23,124,001	28,413,250	31,591,653	32,455,377	34,467,564	36,629,183

Resource Consideration

The organisation is growing and the volume of transactions is increasing concomitantly. In order to strengthen the unit to deal with the demands of Supply Chain Management, a Supply Chain officer was appointed in 2014/15.The unit has noted that the area of supply chain management will need further capacity. This will be considered in the financial year 2017/18. The area of risk and performance management would also need further capacity in the next financial year. Currently there is only one person responsible for both risk and performance management in the organisation.

The unit will be implementing a risk management software tool during the financial year, this will allow for more effective tracking of CMS risks. Currently the unit uses a manual excel spreadsheet to capture the risks. To further strengthen the risk management processes a risk management software tool is needed. This will help CMS manage the critical elements of the entity, compliance, financial and operational risk management initiatives in a more effective and efficient way. Proc esses assessing risks and objectives across CMS, linking risks to strategic objectives, monitoring risks and managing risk response strategies will be automated. Executives will be able to quickly assess problem areas, proactively adjust processes to respond to issues and track progress through reports and automated alerts.

The unit will be embarking on a project on business process mapping during the financial year. Business process mapping refers to activities involved in defining what a business entity does, who is responsible, to what standard a business process should be completed, and how the success of a business process can be determined.

The main purpose behind business process mapping is to assist organisations in becoming more efficient. A clear and detailed business process map or diagram allows anyone externally or internally to look at whether or not improvements can be made to the current process.

Business process mapping takes a specific objective and helps to measure and compare that objective alongside the entire organisation's objectives to make sure that all processes are aligned with the company's values and capabilities.

The CMS can then work towards ensuring its processes are effective (the right process is followed the first time), and efficient (continually improved to ensure processes use the correct resources).

4.3. Sub-Programme 1.3 (Information and Communication Technology (ICT) and Knowledge Management (KM))

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

4.3.1. Strategic Objective Annual Targets for 2015 to 2019 (ICT & KM)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.3.3.1: An established ICT Infrastructure that ensures information is available, accessible and protected.								
1.3.3.1	Percentage of network and server uptime, per year	New indicator	New indicator	97.05%	93%	95%	97%	100%
	Percentage of IT security incidents, per year	New indicator	New indicator	New indicator	New indicator	0%	0%	0%
Strategic Objective 1.3.3.2: Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance								
1.3.3.2	Percentage of uptime, of all installed application systems where network access exists, per year	98,8%	96%	98.23%	99%	99%	99%	100%
Strategic Objective 1.3.3.3: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing								
1.3.3.3	Percentage of physical requests for information responded to within 30 days, per year	New indicator	279	274	350	100% (300)	100% (250)	100% (200)

4.3.2. Quarterly targets for 2016/17 (ICT & KM)

Strategic objective	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 1.3.3.1: An established ICT Infrastructure that ensures information is available, accessible and protected							
1.3.3.1	Percentage of network and server uptime, per quarter	Quarterly	95%	90%	90%	92%	99%
	Percentage of IT security incidents, per quarter	Quarterly	0%	0%	0%	0%	0%
Strategic Objective 1.3.3.2: Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance							
1.3.3.2	Percentage of Uptime, of custom developed application systems where network access exists, per quarter	Quarterly	99%	96%	99%	99%	99%
Strategic Objective 1.3.3.3: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing							
1.3.3.3	Percentage of physical requests for information responded to within 30 days, per quarter	Quarterly	100% (300)	100% (75)	100% (75)	100% (75)	100% (75)

Adjusted

4.3.3. Reconciling performance targets with the Budget and MTEF (ICT and KM)

1.3 ICT and KM	Audited outcomes			appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**14**	**11**	**11**	**12**	**12**	**12**	**12**
Total	**9,926,241**	**11,242,275**	**12,212,537**	**14,059,053**	**15,898,425**	**17,001,180**	**18,283,931**
Compensation of employees	6,562,292	6,959,751	7,535,771	8,355,217	9,337,799	10,060,037	10,940,202
Salaries & wages	6,562,292	6,959,751	7,535,771	8,351,617	9,334,199	10,056,228	10,936,172
Social contributions	-	-	-	3,600	3,600	3,809	4,030
Goods and services	3,363,949	4,282,524	4,676,766	5,703,836	6,560,626	6,941,143	7,343,729
Communication	1,155,215	1,212,222	923,279	923,850	965,418	1,021,412	1,080,654
Computer services	1,856,669	2,240,393	2,857,753	3,782,686	4,486,051	4,746,242	5,021,524
Consultants	55,984	50,826	200,699	112,500	190,000	201,020	212,679
Lease Payments	119,702	243,655	248,182	264,000	275,004	290,954	307,830
Training and staff development	95,537	148,194	106,687	180,000	180,000	190,440	201,486
Travel and subsistence	9,603	4,654	23,662	10,800	11,286	11,941	12,633
Venue and facilities	53,704	368,070	300,973	419,000	441,392	466,993	494,078
Other	17,535	14,510	15,531	11,000	11,475	12,141	12,845

Resource Considerations

The main focus of the CMS going forward will be to produce user friendly application systems that not only meet the needs of the various business units within the CMS but also the needs of external stakeholders such as the National Department of Health. In order to fulfil this mandate, additional software development skills will need to be obtained. To this effect, a process has been set in motion to fill two additional Snr. Software Developer positions over the next two years, the first of which will be advertised in August 2015. Unfortunately, a moratorium on the filling of all positions for 2016/17 will only see the second senior developer position filled at the earliest in 2017/18. This will negatively impact the ability of the CMS to deliver on its software development mandate.

The software application systems need a solid and dependable IT Infrastructure on which to run. End-users also require a dependable IT Helpdesk as part of the IT Infrastructure support function. An IT Helpdesk Technician is required to complement the IT Helpdesk and to facilitate the execution of specific Standard Operating Procedures aimed at maintaining the IT Infrastructure. A position of IT Helpdesk has therefore been motivated to be filled during 2015/16. Unfortunately the filling of the position had to be held in abeyance due to budget constraints and therefore the position could not be filled. A further moratorium has now also been placed on filling of positions in the 2016/17 financial year. This may hurt service delivery of the IT Helpdesk going forward whilst the services of temporary staff members are utilised.

Finally, the ongoing drive to digitise all our paper based documentation in an effort to enhance knowledge sharing in the CMS will be enhanced by the addition of a Registry Clerk position which will lessen our reliance on external bureau scanning services. Due to budget constraints, this position has been placed on hold until further notice. Until the services of such a resource can be obtained, we will have to budget separately for ongoing use of bureau scanning services.

Human Resource requirements

In order to meet the demands outlined above, the following human resource requirements will have to be met.

Objective &Position	Current	Proposed
Snr Software Developer 1	Vacant and not on post establishment	To be created and advertised during 2015/16.
Snr Software Developer 2	Vacant and not on post establishment	To be created and advertised during 2017/18 due to moratorium on filling of positions for 2016/17
IT Helpdesk Technician	Vacant and not on post establishment	To be created and advertised during 2017/18 due to moratorium on filling of positions for 2016/17
Registry Clerk	Vacant and not on post establishment	On hold

4.4. Sub-Programme 1.4 (Human Resources Management)

The purpose of the sub-programme is to provide high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programmes that promote and support Council's vision.

We will fulfil this mission with professionalism, integrity, and responsiveness by:

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

By doing this we help the Council for Medical Schemes by supporting its administration and staff through Human Resources Management advice and assistance, enabling them to make decisions that maximise its most important asset: its people and to continue the development of CMS as an employer of choice.

4.4.1. Strategic Objectives Annual Targets for 2015 to 2019 (Human Resource Management)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.4.3.1: Build competencies and retain skilled employees								
1.4.3.1	Minimise staff turnover rate to less than 5% per annum	3.19%	6.12%	3.88%	5%	<5%	<5%	<5%
	Average turnaround time to fill a vacancy (average turnaround time of 90 working days for each vacancy that exists during the year)	New indicator	New indicator	There were 7 out of 10 positions that took longer than the 90days to fill	90 days	90 days	90 days	90days
	Achievement of Employment equity targets (85% optimal in terms of Employment Equity Act), annually	New indicator	New indicator	88%	85%	85%	85%	85%
Strategic Objective 1.4.3.2: Maximise performance to improve organisational efficiency and maintain high performance culture								
1.4.3.2	100% of employee performance agreements are signed by no later than 31 May of each year	New indicator	New indicator	New indicator	New indicator	100%	100%	100%
	Percentage of employee performance assessment concluded, bi annually	New indicator	New indicator	New indicator	New indicator	100%	100%	100%

4.4.2. Quarterly targets for 2016/17 (Human Resource Management)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic objective 1.4.3.1: Build competencies and retain skilled employees							
1.4.3.1	Minimise staff turnover rate to less than 5% per annum	Annual	<5%	-	-	-	<5%
	Average turnaround time to fill a vacancy (Average turnaround time of 90 working days to fill a vacancy that exists during the year)	Quarterly	90 days	90 days	90 days	90 days	90 days
	Achievement of Employment equity targets (85% optimal in terms of Employment Equity Act), annually	Annual	85%	-	-	-	85%
Strategic Objective 1.4.3.2: Maximise performance to improve organisational efficiency and maintain high performance culture							
1.4.3.2	100% of employee performance agreements are signed by no later than 31 May of each year	Annual	100%	100%	-	-	-
	Percentage of employee performance assessment concluded, bi annually	Bi annually	100%	-	100%	-	100%

4.4.3. Reconciling performance targets with the Budget and MTEF (Human Resource Management)

1.4 Human Resource	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**5**	**5**	**5**	**5**	**5**	**5**	**5**
Total	**5,913,523**	**6,526,219**	**5,473,200**	**5,842,813**	**5,733,347**	**6,207,208**	**6,563,818**
Compensation of employees	3,619,242	3,723,106	3,862,586	4,293,964	4,589,998	4,997,546	5,283,996
Salaries & wages	3,177,361	3,242,973	3,390,115	3,715,502	3,972,148	4,343,861	4,592,397
Social contributions	441,881	480,133	472,471	578,462	617,850	653,685	691,599
Goods and services	2,294,281	2,803,113	1,610,614	1,548,849	1,143,349	1,209,662	1,279,822
Consultants	873,236	897,063	376,101	820,047	551,861	583,869	617,733
Legal fees	-	111,217	15,714	-	-	-	-
Other transfers to households	3,733	6,500	20,328	48,300	50,474	53,401	56,498
Training and staff development	167,257	127,496	141,956	100,000	100,000	105,800	111,936
Travel and subsistence	193,344	14,002	11,075	20,000	20,900	22,112	23,395
Venue and facilities	901,706	1,460,596	920,465	416,290	320,000	338,560	358,196
Other	155,005	186,239	124,975	144,212	100,114	105,920	112,064

Resource Considerations

A new approach has been adopted by the organisation to look into repurposing all employees in the organisation to allow for rotation within the units and across units. This will improve on skills development and career pathing. Resource requirements will therefore be looked into in the year after this decision has been revised. A principal in sharing Executive Assistant was adopted by the organisation.

Staff turnover rates

In recent years, CMS has experienced turnover in key strategic areas. To counter this trend, the salary benchmark exercise was conducted during the financial year 2014/2015 to ensure that positions at CMS are correctly remunerated. The recommendations of the exercise were tabled to the HR Sub-Committee in February 2015, the previous financial year. However, at the time, the committee took a decision not to consider the report until CMS had obtained approval of the budget. The Report will be re-tabled on 6 August 2015.

A review of employee benefits resulted in the approval and implementation of the following policies; performance management and incentive policy section regarding the "eligibility to participate" in the performance incentive policy regarding members of staff who are in the employment of council for a period of less than 6 months during the first performance appraisal period, study, health and safety, family responsibility, compassionate, maternity and paternity. Positive results are starting to show with a low staff turnover rate of 3.88% in 2014/2015.

Tables illustrating turnover at of strategic personnel (Paterson salary band D to F):

RESIGNATIONS – 2012/2013	MALES				FEMALES				TOTAL
POSITIONS	A	C	I	W	A	C	I	W	
General Manager: Research & Monitoring	1	0	0	0	0	0	0	0	**1**
Deputy Chief Financial Officer	0	0	0	0	0	0	0	1	**1**
Council Secretariat	0	0	0	0	1	0	0	0	**1**
TOTAL PERMANENT	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**3**

RESIGNATIONS – 2013/2014	MALES				FEMALES				TOTAL
POSITIONS	A	C	I	I	A	C	I	W	
Education & Training Manager	0	0	0	0	0	1	0	0	**1**
Senior Strategist	0	0	0	1	0	0	0	0	**1**
Assistant Senior Financial Analyst	0	0	0	0	1	0	0	0	**1**
Communications Manager	0	0	0	0	0	0	0	1	**1**
TOTAL PERMANENT	**0**	**0**	**0**	**1**	**1**	**1**	**0**	**1**	**4**

RESIGNATIONS – 2014/2015	MALES				FEMALES				TOTAL
POSITIONS	A	C	I	W	A	C	I	W	
Legal Advisor	1	0	0	0	0	0	0	0	**1**
Senior Researcher	1	0	0	0	0	0	0	0	**1**
Senior Investigator	0	0	0	1	0	0	0	0	**1**
Senior Strategist	0	0	1	0	0	0	0	0	**1**
TOTAL PERMANENT	**2**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**4**

4.5. Programme 1.5 (Legal Services Unit)

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

4.5.1. Strategic objective annual targets for 2015 to 2019 (Legal Services Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.5.3.1: Legal advisory service for effective regulation of the industry and operations of the office								
1.5.3.1	Percentage of written and verbal legal opinions generated internally to internal and external stakeholders, per year	new indicator	new indicator	new indicator	100	85% (180)	85% (190)	85% (200)
Strategic Objective 1.5.3.2: Support CMS mandate by defending decisions of Council and the Registrar								
1.5.3.2	Percentage of court and tribunal appearances in legal matters received and handled by the unit, per year	23	17	24	20	100% (23)	100% (25)	100% (25)

4.5.2. Quarterly targets for 2016/17 (Legal Services Unit)

Strategic Objective	Performance Indicator	Reporting period 2016/17	Annual target 2016/17	Quarterly targets			
				1st	2nd	3rd	4th
Strategic Objective 1.5.3.1: Legal advisory service for effective regulation of the industry and operations of the office							
1.5.3.1.	Percentage of written and verbal legal opinions generated internally to internal and external stakeholders, per year	Quarterly	85%	85%	85%	85%	85%
Strategic Objective 1.5.3.2: Support CMS mandate by defending decisions of Council and the Registrar							
1.5.3.2	Percentage of court and tribunal appearances in legal matters received and handled by the unit, per quarter	Quarterly	100% (23)	100% (5)	100% (6)	100% (7)	100% (5)

4.5.3. Reconciling performance targets with the Budget and MTEF (Legal Services Unit)

1.5 Legal Services	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**4**	**4**	**4**	**4**	**4**	**4**	**4**
Total	**12,806,218**	**12,700,754**	**10,896,098**	**11,653,762**	**11,885,993**	**15,010,178**	**15,690,166**
Compensation of employees	3,211,418	3,097,112	3,092,838	3,504,282	3,737,989	4,014,395	4,321,842
Salaries & wages	3,211,418	3,097,112	3,092,838	3,503,082	3,736,789	4,013,125	4,320,499
Social contributions	-	-	-	1,200	1,200	1,270	1,343
Goods and services	9,594,800	9,603,642	7,803,260	8,149,480	8,148,004	10,995,783	11,368,324
Agency and support / outsourced services	45,657	-	-	-	-	-	-
Consultants	89,050	-	-	-	-	-	-
Legal fees	9,304,908	9,437,832	7,683,467	8,000,000	8,000,004	10,839,200	11,202,658
Training and staff development	74,817	112,726	69,980	80,000	74,000	78,292	82,833
Travel and subsistence	47,312	38,487	40,767	60,000	60,000	63,480	67,162
Venue and facilities	3,070	-	-	-	2,000	2,116	2,239
Other	29,986	14,597	9,046	9,480	12,000	12,695	13,432

Resource Considerations

There has been an upward trend in unplanned litigation against the CMS, in reaction to our regulatory interventions. This has placed strain on the legal fees budget and available resources. This trend is expected to continue going forward, with the resultant upward expenditure on legal fees. The staff complement in the Unit will need to be increased going forward, to accommodate this trend.

5. Programme 2 (Strategy Office)

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

5.1. Strategic Objectives Annual Targets for 2015 to 2019 (Strategy Office)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 1: Access to good quality medical scheme cover is promoted								
Strategic Objective 2.1.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected								
2.1.1	The number of benefit definitions and CMS Scripts published, per year	New indicator	New indicator	11	12	14	14	14
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 2.2.1: Provide clinical opinions to resolve complaints and enquiries								
2.2.1	Percentage of clinical opinions reviewed within 30 days of receipt from Complaints Adjudication	758	839	623	1472	90% (550)	95% (500)	100% (450)
	Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days	New indicator	New indicator	New indicator	New indicator	90% (480)	95% (480)	95% (480)

5.2. Quarterly targets for 2016/17 (Strategy Office)

Strategic Objective	Performance Indicator	Reporting period 2016/17	Annual target 2016/17	Quarterly targets 2016/17			
				1st	2nd	3rd	4th
Strategic Objective 2.1.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected							
2.1.1	The number of benefit definitions and CMS scripts published, per quarter	Quarterly	14	3 CMScripts published	3 CMScripts published 2 PMB Definition published	2 CMScripts published	2 CMScripts published 2 PMB Definition published
Strategic Objective 2.2.1: Provide clinical opinions to resolve complaints and enquiries							
2.2.1	Percentage of clinical opinions reviewed within 30 days of receipt from Complaints Adjudication	Quarterly	90%	90% Complaints within 30 days	90% Complaints within 30 days	90% Complaints within 30 days	90% Complaints within 30 days
	Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days	Quarterly	90%	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days

5.3. Reconciling performance targets with the Budget and MTEF (Strategy Office)

2 Strategy office	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**6**	**6**	**6**	**9**	**9**	**9**	**9**
Total	**52,726**	**3,823,404**	**4,934,874**	**6,758,615**	**8,337,149**	**8,939,428**	**9,606,574**
Compensation of employees	-	3,645,434	4,785,622	6,147,615	7,455,699	8,006,854	8,619,910
Salaries & wages	-	3,645,434	4,785,622	6,144,915	7,452,877	8,003,869	8,616,752
Social contributions	-	-	-	2,700	2,822	2,985	3,158
Goods and services	52,726	177,970	149,252	611,000	881,450	932,574	986,664
Consultants	-	-	-	250,000	505,500	534,819	565,839
Training and staff development	50,811	147,831	118,339	180,000	180,000	190,440	201,486
Travel and subsistence	1,915	25,495	16,007	171,000	185,500	196,259	207,642
Venue and facilities	-	-	9,070	-	-	-	-
Other	-	4,644	5,836	10,000	10,450	11,056	11,697

Resource consideration

The Clinical Unit is a structure in the Council for Medical Schemes that was formalised in the 2013/2014 financial year through a restructuring process commenced in 2012. Its main objective is to ensure access to quality health care for members of medical schemes and their funding protection thereof. It incorporates the 2010 constituted Clinical Review Committee (CRC).

The Clinical unit is part of the office of the Senior Strategist (OSS) of CMS. The post of the Senior Strategist has been vacant since December 2014. The unit is currently running at minimal capacity. Th is capacity is therefore not adequate to meet the targets and expectations over a number of financial cycles.

The unit saw a substantial rise in the complexity of clinical requests that require clinical adjudication per year. There is an inevitable increased demand to analyse new technologies as part of the clinical enquiries referred to the team producing clinical opinions and to the team developing PMB Definitions. Thus, there is a need to consolidate the skills set within the unit with pharmacology, medical technology, Pharmaco-economics or Health Technology Assessment experience. These cases are typically intensive and time-consuming analysis.

There are increasing demands to support the Stakeholder Relations Unit with training on PMBs. This forms a critical part of prospective regulation and ensures that the CMS objective to ensure access to quality healthcare is realized.

Increased requests to support Strategic objectives require that the unit is strengthened. These requests include support of the PMB Review process, ad hoc Projects, Low cost Benefit Options development to name a few.

Requests for additional staff will be based on the work load of the clinical unit during the period leading up to 2020. Resources that may be required includes

1. Additional Clinical Analyst to staff (Professional Nurse)
2. Additional Clinical Analyst (Pharmacologist/Post graduate Scientist)
3. Medical Advisor (Medical Doctor)

6. Programme 3 (Accreditation Unit)

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

6.1. Strategic objective annual targets for 2015 to 2019(Accreditation Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 3.2.1: Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services								
3.2.1	Number of brokers and broker organisations that comply with the accreditation requirements accredited within 21 working days of receipt of complete applications	4259	5564	5 027	5 192	3980	4045	4980
Strategic Objective 3.2.2: Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined								
3.2.2	Number of managed care organisation applications, accredited within 3 months of receipt of all relevant information	29	14	26	16	26	16	26
Strategic Objective 3.2.3: Accredit Administrators and issue Compliance Certificates to Self-Administered schemes based on their compliance with the accreditation requirements in order to provide administration services								
3.2.3	Number of applications by administrators and self-administered schemes accredited within 3 months of receipt of all relevant information	14	16	9	13	15	11	15

6.2. Quarterly targets for 2016/17 (Accreditation Unit)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 3.2.1: Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services							
3.2.1	Number of brokers and broker organisations that comply with the accreditation requirements accredited within 21 working days of receipt of complete applications	Quarterly	3980	1000	984	991	1005
Strategic Objective 3.2.2: Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined							
3.2.2.	Number of managed care organisation applications accredited within 3 months of receipt of all relevant information	Quarterly	26	2	1	22	1
Strategic Objective 3.2.3: Accredit Administrators and issue Compliance Certificates to Self-Administered schemes based on their compliance with the accreditation requirements in order to provide administration services							
3.2.3.	Number of applications by administrators and self-administered schemes accredited within 3 months of receipt of all relevant information	Quarterly	15	7	1	7	-

6.3. Reconciling performance targets with the Budget and MTEF (Accreditation Unit)

3 Accreditation	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**9**	**9**	**10**	**10**	**10**	**10**	**10**
Total	**5,792,595**	**6,115,769**	**7,165,575**	**8,060,888**	**8,499,546**	**9,150,042**	**9,596,799**
Compensation of employees	5,397,145	5,750,730	6,603,587	7,240,940	7,631,771	8,231,936	8,625,443
Salaries & wages	5,397,145	5,750,730	6,603,587	7,237,940	7,628,636	8,228,619	8,621,934
Social contributions	-	-	-	3,000	3,135	3,317	3,509
Goods and services	395,450	365,039	561,988	819,948	867,775	918,106	971,356
Consultants	-	-	-	80,000	-	-	-
Training and staff development	41,749	56,404	28,060	100,000	200,000	211,600	223,873
Travel and subsistence	289,155	240,272	481,057	498,948	521,400	551,641	583,636
Venue and facilities	-	5,080	3,615	6,000	6,000	6,348	6,716
Other	64,546	63,283	49,256	135,000	140,375	148,517	157,131

Resource Considerations

The Unit currently accommodates 10 members of staff in terms of the approved structure. The Clinical Analyst vacancy has been budgeted for and has been filled.

Accreditation Analysts perform desk based analysis of all applications received in the Unit and evaluate compliance by applicants in terms of relevant legal requirements as well as accreditation standards applicable to the relevant entities. Financial soundness is a critical component incorporated in all criteria for accreditation. On-site evaluations are carried out in respect of administrators and managed care organisations to assess their compliance with pre-determined standards to assess infrastructure, skills, capacity and performance.

There are currently two persons responsible for evaluating the fitness and propriety of administrators. The responsible Manager and one Senior Analyst conduct extensive and detailed analysis of the process to perform on-site and desk based evaluations and all related functions to conclusion of such applications. The complexity and time spent on this task warrants an additional Senior Analyst post to be provided for in the structure. This will allow the manager to spend quality time in overseeing the processes.

Measures introduced to ensure that strategic objectives are realised, was the introduction of a system to verify that brokers applying for accreditation comply with legislation supervised by the Financial Services Board to the extent that Financial Services Providers are required to be licensed. Should they fail to do so, accreditation is refused with the result that brokers are accredited only if they are fit and proper in terms of relevant legislation. Similarly, if either office suspends or withdraws accreditation or license to practice, the other office is notified and steps are taken to invoke similar penalty clauses against the perpetrators. This is essential to prevent disqualified brokers to operate whilst not accredited or licensed. We similarly introduced a mechanism to verify the qualifications of persons applying for accreditation as brokers. This will strengthen our ability to prevent accreditation of persons who are not fit and proper or who defraud the system. The additional workload as a result of more involved administrative tasks may in future warrant an Administrator position to maintain turnaround times based on proven statistics to be obtained during the period in question.

7. Programme 4 (Research and Monitoring Unit)

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

7.1. Strategic objective annual targets for 2015 to 2019 (Research and Monitoring Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 4.2.1: To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning								
4.2.1	Number of quarterly reports received from the PCNS service provider reflecting active practice code numbers, per year	New indicator	4	4	4	4	4	4
Strategic Goal 4: CMS provides strategic advice to influence and support the development and implementation of National health policy								
Strategic Objective 4.4.1: Conduct research to inform appropriate policy interventions								
4.4.1	Number of research projects and support projects finalised, per year	New indicator	13	11	8	8	8	9
Strategic Objective 4.4.2: Monitoring trends to improve regulatory policy and practice								
4.4.2	Non-financial report submitted for inclusion in the annual report, per year	1	1	1	1	1	1	1

7.2. Quarterly targets for 2016/17 (Research and Monitoring Unit)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 4.2.1: To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning							
4.2.1	Number of quarterly reports received from the PCNS service provider reflecting active practice code numbers, per quarter	Quarterly	4	1	1	1	1
Strategic Objective 4.4.1: Conduct research to inform appropriate policy interventions							
4.4.1	Number of research projects and support projects finalised, per quarter	Quarterly	8	-	1	4	3
Strategic Objective 4.4.2: Monitoring trends to improve regulatory policy and practice							
4.4.2	Non-financial report submitted for inclusion in the annual report, per quarter	Annual	1	-	1	-	-

7.3. Reconciling performance targets with the Budget and MTEF (Research and Monitoring Unit)

4 Research and Monitoring	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**8**	**8**	**8**	**8**	**8**	**8**	**8**
Total	**5,653,841**	**5,683,458**	**6,044,616**	**6,916,990**	**7,565,324**	**7,996,551**	**8,638,119**
Compensation of employees	5,364,130	5,084,693	5,598,812	6,411,158	6,953,906	7,349,671	7,953,719
Salaries & wages	5,364,130	5,084,693	5,598,812	6,408,758	6,951,398	7,347,018	7,950,912
Social contributions	-	-	-	2,400	2,508	2,653	2,807
Goods and services	289,711	598,765	445,804	505,832	611,418	646,880	684,400
Consultants	114,648	396,522	250,800	265,000	276,925	292,987	309,980
Training and staff development	130,700	171,366	129,916	160,000	160,000	169,280	179,098
Travel and subsistence	31,251	18,449	42,041	42,800	134,750	142,566	150,834
Venue and facilities	5,663	5,063	19,368	25,000	26,125	27,640	29,243
Other	7,449	7,365	3,679	13,032	13,618	14,407	15,245

Resource Considerations

The Research and Monitoring Unit will need to maintain existing capacity and consider some adjustments in other areas to strengthen its ability to make a contribution in the health systems reforms process. The appointment of one additional resource is planned for 2017/18 to assist the unit with the analysis and monitoring of health quality outcomes. Other needs may arise to employ specialised research experts from time to time and the Unit will engage external consultants to support implementation of key objectives.

8. Programme 5 (Stakeholder Relations Unit)

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

8.1. Strategic objective annual targets for 2015 to 2019 (Stakeholder Relations Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 5.2.1 Create awareness and provide training in order to enhance the visibility and reputation of CMS								
5.2.1	Percentage of member awareness of CMS resulted from survey	New indicator	New indicator	New indicator	New indicator	30%	n/a	50%
	Number of stakeholder training and awareness sessions, per year	New indicator	New indicator	New indicator	18	18	20	22
Strategic Objective 5.2.2 Communication and engagement to inform and empower stakeholders								
5.2.2	Publication of CMS' Annual Report by 31 August	1	1	1	1	1	1	1
	Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per year	New indicator	New indicator	72.9%	75%	75%	75%	75%

8.2. Quarterly targets for 2016/17 (Stakeholder Relations Unit)

Strategic Objective	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 5.2.1: Create awareness and provide training in order to enhance the visibility and reputation of CMS							
5.2.1.	Percentage of member awareness of CMS resulted from survey	Annual	30%	-	-	30%	-
	Number of stakeholder training and awareness sessions, per quarter	Quarterly	18	2	4	6	6
Strategic Objective 5.2.2: Communication and engagement to inform and empower stakeholders							
5.2.2	Publication of CMS' Annual Report by 31 August	Annual	1	-	1	-	-
	Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per quarter	Quarterly	75%	75%	75%	75%	75%

8.3. Reconciling performance targets with the Budget and MTEF (Stakeholder Relations Unit)

5 Stakeholder Relations	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**8**	**11**	**11**	**11**	**11**	**11**	**11**
Total	**7,054,848**	**7,670,297**	**8,596,417**	**9,064,568**	**9,728,142**	**10,404,043**	**11,147,389**
Compensation of employees	5,029,383	5,089,157	5,948,752	6,591,816	7,036,469	7,556,253	8,134,425
Salaries & wages	5,029,383	5,089,157	5,948,752	6,588,516	7,033,020	7,552,604	8,130,565
Social contributions	-	-	-	3,300	3,449	3,649	3,860
Goods and services	2,025,465	2,581,140	2,647,665	2,472,752	2,691,673	2,847,790	3,012,964
Communication	170,976	454,737	335,822	610,412	621,324	657,361	695,488
Consultants	-	82,141	146,861	-	-	-	-
Training and staff development	119,549	130,082	227,278	200,000	220,000	232,760	246,260
Travel and subsistence	718,348	550,837	587,142	588,000	655,000	692,990	733,183
Venue and facilities	557,862	502,214	514,756	424,340	395,000	417,910	442,149
Other	458,730	861,129	835,806	650,000	800,349	846,769	895,884

Resource Considerations

Education & Training

The new direction the Education and Training sub-unit has embarked on resulted in more training programmes offered to Board of Trustees and other stakeholders. The Unit offers the following programmes as part of Consumer Awareness and Education Initiatives:

Capacity building workshops,
General public awareness drives, and
Awareness presentations.

More often members of the public and other stakeholders and consumer groups complain that not many consumers, especially medical scheme members, know their rights and obligations and many more are not aware of the existence of CMS. The challenge also remains that more stakeholder groups get added to the unit's list of stakeholders that require training and result in a need for additional human resources in order to perform the unit's functions.

The Education and Training sub-unit also offers the following trustee training interventions:

Induction Trustee Training (mandatory);
In-Depth Trustee Training;
Accredited Trustee Training; and
Response-upon-request Training.

Due to the increased number of training programmes and the high demand from stakeholders for training, a senior educator is required to assist with the increasing workload. The resource required should have a qualification as assessor and moderator with preferably the INSETA.

The appointment of such a senior Education and Training Specialist *will alleviate the workload and will result in a cost saving for CMS, since outside service providers for the accredited programme will no longer be required.*

Communication

The Communication sub-unit has currently only a manager responsible for communication issues, such as media releases, proofreading and editing of communication documentation and publications and the Annual Report project.

Customer Care Service Centre (CCSC)

The CMS customer care service centre is different to other call centres where answers are provided on screen. The CMS consultants render a consulting service, interpreting the MSA and attending to frontline calls on behalf of units such as the Accreditation and Complaints Units. They therefore take longer to finalise calls than would a simpler call centre resulting in high volumes for three available consultants.

The increase in call volume means that we will need to beef up the Customer Care Services Centre's function to keep our other indicators (average talk time and abandon rate) within permissible limits. We will therefore need an additional call centre consultant in order to effectively deal with all incoming calls and to give the Call Centre Manager an opportunity to monitor calls for quality, ongoing training and improvement and to intervene where difficult calls are experienced. Currently, the manager has to also deal with calls at peak times, whilst also attending to incoming written enquiries which get directed to information@medicalschemes.com and support@medicalschemes.com.

In instances where existing staff have to take leave, we are normally compelled to utilise temping services which compromise the quality of our service as time to train them is limited. It is also not cost effective. Furthermore, Labour Law has placed restrictions on the duration of utilising temps over a certain period of time thus we have to change them now and then.

Lastly, in line with servicing all our callers, there is an identified ongoing need to bridge the language gap (preferably, an Afrikaans proficient consultant) to fully complement our staff.

Provision was made for one more customer care consultant, which we urgently require to improve our services to customers.

Stakeholder Relations

Stakeholder relations remain a critical component to build relationships with all stakeholders in the medical scheme industry and to ensure a positive reputation of the CMS. Currently only the Customer Relations Officer is assisting with the responsibilities ensuring the reputation and brand of CMS are maintained.

Additional demands are being placed on the Unit due to the increased use of the CMS website, social media and the subscription to Hellopeter.com. In order to build and maintain a positive CMS reputation, very quick responses to social media are required and a resource to maintain the social media sites effectively is urgently required. Therefore, a resource to manage the content of the website, social media sites and hellopeter.com queries are urgently required.

9. Programme 6 (Compliance and Investigation Unit)

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

9.1. Strategic objective annual targets for 2015 to 2019(Compliance and Investigation Unit)

Strategic Objective		Audited Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 6.2.1: Regulated entities comply with Legislation								
6.2.1	Percentage of non-compliance cases against regulated entities undertaken, per year	New indicator	New indicator	52	45	100% (40)	100% (35)	100% (30)
Strategic Objective 5.2.2: Strengthen and monitor governance systems								
6.2.2	Percentage of governance interventions implemented, per year	New indicator	New indicator	88	72	100% (75)	100% (82)	100% (85)

9.2. Quarterly targets for 2016/17(Compliance and Investigation Unit)

Strategic Objective	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 6.2.1: Regulated entities comply with Legislation							
6.2.1	Percentage of non-compliance cases against regulated entities undertaken, per quarter	Quarterly	100% (40)	100% (10)	100% (10)	100% (10)	100% (10)
Strategic Objective 6.2.2:Strengthen and monitor governance systems							
6.2.2	Percentage of governance interventions implemented, per quarter	Quarterly	100% (75)	100% (30)	100% (15)	100% (15)	100% (15)

9.3. Reconciling performance targets with the Budget and MTEF (Compliance and Investigation Unit)

6 Compliance & Investigation	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**6**	**7**	**7**	**8**	**8**	**8**	**8**
Total	**4,979,191**	**5,307,134**	**6,719,225**	**7,428,614**	**8,437,551**	**9,041,327**	**9,768,575**
Compensation of employees	4,537,673	4,746,730	5,353,975	6,428,594	7,177,639	7,708,340	8,358,275
Salaries & wages	4,537,673	4,746,730	5,353,975	6,426,194	7,175,131	7,705,687	8,355,468
Social contributions	-	-	-	2,400	2,508	2,653	2,807
Goods and services	441,518	560,404	1,365,250	1,000,020	1,259,912	1,332,987	1,410,300
Communication	-	19,309	45,973	48,180	50,340	53,260	56,349
Consultants	126,073	217,591	1,015,730	500,000	795,000	841,110	889,894
Training and staff development	97,864	105,843	148,992	160,000	160,000	169,280	179,098
Travel and subsistence	195,626	146,554	121,335	147,840	154,493	163,454	172,934
Venue and facilities	-	19,920	-	20,000	21,995	23,271	24,620
Other	21,955	51,187	33,220	124,000	78,084	82,612	87,405

Resource Consideration

Budget allowances in respect of inspections or investigations are a concern for the Unit. Inspections and Investigations are usually unpredictable and as a result it becomes difficult to indicate expenditure trends.

In addition to inspections/investigation costs, there are those costs that arise from expert advice sought and advanced technological expert assistance. This includes instances where specialised skills are required to download information from computers or electronic material. The costs have to date been funded out of investigation/inspection costs.

10. Programme 7 (Benefits Management Unit)

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

10.1. Strategic objective annual targets for 2015 to 2019 (Benefits Management Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 7.2.1: To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act								
7.2.1	Percentage interim rule amendments processed within 14 days of receipt of all information per year	New indicator	New indicator	New indicator	New indicator	100% (129)	100% (129)	100% (129)
	Percentage of annual rule amendments processed before 31 December of each year	New indicator	New indicator	New indicator	New indicator	100% (83)	100% (83)	100% (83)

10.2. Quarterly targets for 2016/17 (Benefits Management Unit)

Strategic objective	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objectives 7.2.1: To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act							
7.2.1	Percentage interim rule amendments processed within 14 days of receipt of all information, per quarter	Quarterly	100% (129)	100% 35	100% 33	100% 21	100% 40
	Percentage of annual rule amendments processed before 31 December of each year	Quarterly	100% (83)	-	-	100% (83)	-

10.3. Reconciling performance targets with the Budget and MTEF (Benefits Management Unit)

7 Benefits Management	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**7**	**8**	**8**	**8**	**8**	**8**	**8**
Total	**4,363,969**	**4,574,964**	**4,757,882**	**5,589,803**	**6,275,854**	**6,721,673**	**7,193,849**
Compensation of employees	4,178,018	4,373,150	4,694,972	5,405,013	6,079,871	6,514,322	6,974,471
Salaries & wages	4,178,018	4,373,150	4,694,972	5,402,313	6,077,049	6,511,337	6,971,313
Social contributions	-	-	-	2,700	2,822	2,985	3,158
Goods and services	185,951	201,814	62,910	184,790	195,983	207,351	219,378
Training and staff development	146,904	164,061	34,484	150,000	160,000	169,280	179,098
Travel and subsistence	-	1,347	-	5,000	5,225	5,528	5,849
Other	39,047	36,406	28,426	29,790	30,758	32,543	34,431

Resource Considerations

The largest part of the Unit's budget is its salaries (94% of total budget). The activities of the Unit do not require any specific projects that require separate budgeting. The Unit has increased its focus on training and hence increased its training budget to accommodate the areas of skills identified.

The Unit comprises of a General Manager, 4 Senior Analysts and 3 Analysts.

The trend in the expenditure of the Unit comprises mainly of salary inflation as this is the units major expenditure item. The trend over the next five years is expected to remain stable in terms of the salary increases applied.

There are 4 Senior Analysts and 3 Analysts responsible for the registration of schemes and scheme rules/options, management of amalgamations/liquidations and monitoring of marketing material. The unit is also involved in developing guidance to the industry on communication to members, treating customers fairly, content of rules and implementing low cost benefit options and demarcation.

11. Programme 8 (Financial Supervision Unit)

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

11.1. Strategic Objectives Annual Targets 2015 to 2019 (Financial Supervision Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 8.2.1: Monitor and promote the financial soundness of medical schemes								
8.2.1	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan received, per year	100% (8/8)	100%	100%	100%	100%	100%	100%
	Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per year	New indicator	New indicator	New indicator	100%	100%	100%	100%
	Number of Quarterly financial return reports published (excluding quarter 4), per year	3	3	3	3	3	3	3
	Number of financial sections prepared for the Annual Report	1	1	1	1	1	1	1

11.2. Quarterly targets for 2016/17 (Financial Supervision Unit)

Strategic Objective	Performance Indicators	Reporting Period	Annual Target	Quarterly Targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 8.2.1: Monitor and promote the financial soundness of medical schemes							
8.2.1	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan received, per quarter	Quarterly	100%	100%	100%	100%	100%
	Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per quarter	Quarterly	100%	100%	100%	100%	100%
	Number of Quarterly financial return reports published (excluding quarter 4), per quarter	Quarterly	3	-	1	1	1
	Number of financial sections prepared for the Annual Report	Annual	1	-	1	-	-

11.3. Reconciling performance targets with the Budget and MTEF (Financial Supervision Unit)

8 Financial Supervision	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of employees	**10**	**11**	**11**	**11**	**11**	**11**	**11**
Total	**8,088,903**	**8,815,543**	**9,742,148**	**10,394,899**	**11,080,850**	**11,964,136**	**12,866,543**
Compensation of employees	7,816,597	8,430,518	9,505,182	10,011,497	10,714,516	11,576,555	12,456,482
Salaries & wages	7,816,597	8,430,518	9,505,182	10,008,197	10,711,067	11,572,906	12,452,622
Social contributions	-	-	-	3,300	3,449	3,649	3,860
Goods and services	272,306	385,025	236,966	383,402	366,334	387,581	410,061
Consultants	6,535	-	-	80,000	50,000	52,900	55,968
Training and staff development	198,249	263,858	179,452	188,000	199,932	211,529	223,797
Travel and subsistence	35,027	19,089	27,333	35,000	36,000	38,088	40,297
Venue and facilities	-	63,800	-	50,000	50,000	52,900	55,968
Other	32,495	38,278	30,181	30,402	30,402	32,164	34,031

Resource Consideration

The biggest expenditure items for the unit are salaries and training. This can be expected to increase over the next five years to cater for the specialised skills required in the unit in order to carry out our functions. As the industry, and accounting standards continue to evolve and become more complex, more specialised training will be required resulting in an increase of the expenditure in relation to training. Specifically, there is a lot of specialised finance/accounting work that the unit is unable to carry out due to current excessive workloads.

There are also fairly large pieces of legislation which directly impact on the work carried out by the Financial Supervision Unit which will need to be revised e.g. Annexure B of the regulations which deals with investments by medical schemes. As this is an area outside of our ordinary scope of work, the unit will need to consult investment experts in this regard. The amount of money spent on consultancy can therefore be expected to increase over the five year period.

In providing an oversight function over medical schemes, the unit has to, amongst other things; ensure that reporting by medical schemes is in line with international accounting and reporting standards. However, some of the standards are proving to be quite onerous and/or impractical for medical schemes, suggesting that there may be a need to look into developing our own set of standards as is the case with other regulators.

Other areas that need to be explored to strengthen our regulation and interventions are inter alia Non Healthcare Expenditure NHE (Industry wide in-depth analysis and recommendations), overall analysis on sustainability of medical schemes. Both these matters are aligned with the regulatory objective of understanding cost drivers and responding appropriately i.e. cost containment.

The unit may require an additional resource in the form of senior analysts to respond to increasing complexity and emerging trends. This will have the resultant increase on salaries in the unit.

12. Programme 9 (Complaints Adjudication Unit)

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

12.1. Strategic objective annual targets for 2015 to 2019 (Complaints Adjudication Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic objective 9.2.1: Resolve complaints with the aim of protecting beneficiaries of medical schemes								
9.2.1	Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per year	76%	63%	73%	73%	76%	79%	85%

12.2. Quarterly targets for 2016/17 (Complaints Adjudication Unit)

Strategic Objective	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 9.2.1: Resolve complaints with the aim of protecting beneficiaries of medical schemes							
9.2.1	Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per quarter	Quarterly	76%	76%	76%	76%	76%

12.3. Reconciling performance targets with the Budget and MTEF (Complaints Adjudication Unit)

9 Complaints Adjudication	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Number of Employees	**8**	**9**	**9**	**9**	**9**	**9**	**9**
Total	**4,045,094**	**4,435,046**	**5,010,223**	**5,424,736**	**5,863,918**	**6,294,246**	**6,713,843**
Compensation of employees	3,959,090	4,387,838	4,910,359	5,264,736	5,673,918	6,093,226	6,501,164
Salaries & wages	3,959,090	4,387,838	4,910,359	5,262,036	5,671,097	6,090,241	6,498,006
Social contributions	-	-	-	2,700	2,821	2,985	3,158
Goods and services	86,004	47,208	99,864	160,000	190,000	201,020	212,679
Training and staff development	45,356	25,551	98,730	150,000	180,000	190,440	201,486
Travel and subsistence	29,749	12,334	-	8,000	8,000	8,464	8,955
Venue and facilities	6,075	2,825	-	-	-	-	-
Other	4,824	6,498	1,134	2,000	2,000	2,116	2,238

Resource Considerations

Measures have been put in place to improve the complaints process. The alternative dispute resolution process has gone a long way to alleviate the backlog in respect of complaints resolution. This will require further resourcing in the ensuing MTE years. The unit was further restructured to allocate more responsibilities to promoted Senior Legal officers in order to improve the internal processes. Further improvements was to have regular meeting with schemes in order to emphasise their obligations towards complaints resolution prior to referral to the CMS.

Part D

Annexure D

2016/17

CONTENTS - Part D

Vision

Promote vibrant and affordable healthcare cover for all

Mission

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

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

Values

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

"Ubuntu" – we need each other to achieve our goals;
We strive to be consistent in our regulatory approach;
We approach challenges with a "Can do" attitude;
We are proud with our achievements; and
We are occupied by doing something which is of value.

Strategic Outcome Oriented Goals

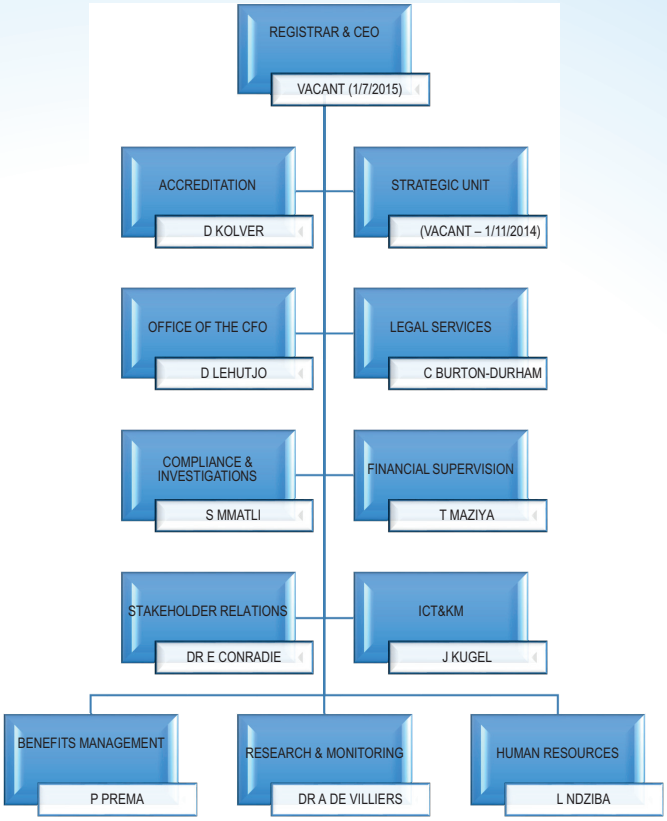
Strategic Outcome Oriented Goal 1	**Access to good quality medical scheme cover is promoted**
Goal Statement	The aim of this goal is to ensure that beneficiaries of medical schemes receives adequate and quality health care cover. To grow membership of medical schemes in order to increase the percentage of the population covered by medical schemes. As CMS we create **an enabling environment** that is conducive for schemes to **grow membership**. Currently only about 17% of the population is covered by medical schemes. If membership of schemes is increased the burden in public sector facilities will be alleviated. CMS will ensure that at all times **barriers to scheme access are minimized** and that coverage provided by schemes is of a high standard. Improved risk pooling is achieved through **enhanced community rating, open enrolment, and prescribed minimum benefits.** The process of evaluating the **clinical effectiveness and value proposition of managed care** activities provided to medical schemes is in the process of being strengthened by introducing entry level criteria, process indicators and outcomes for treatment of patients with one or more **chronic disease conditions**. The process provides for participation by role-players and once introduced, will significantly enhance the ability to **evaluate the health outcomes** in terms of resources employed and price paid for such services. CMS will publish **Prescribed Minimum benefit definitions and CMScript** articles as **guidelines to inform the industry** and members of appropriate treatment plans. These guidelines will clarify what PMB entitlements entail and as such provide guidance to the healthcare industry on funding of PMBs with the resultant effect that complaints with regards to these conditions are minimized CMS must ensure that **scheme rules are registered to cover the required health care benefits** and contribution increases and are reviewed to ensure cost effectiveness and affordability. CMS will collect process and outcomes indicator data through the **Annual Statutory system** for various chronic diseases at benefit option level. The analysis of the data will aim to **measure health quality outcomes at benefit option** level that could be linked to the **performance of specific managed care entities**. CMS will also continue to put measures in place to measure and **monitor financial soundness** of medical schemes. This ensures that schemes will be able to meet their financial obligations.

Strategic Outcome Oriented Goal 2	**Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected**
Goal Statement	Ensure that at all times **medical schemes are governed** in the interests of beneficiaries by ensuring that the principles of good corporate governance are fully adhered to and that appropriate action is taken against **corporate governance** failures. EnsurethatMedical Schemes and other regulated entities are compliant with the Medical Schemes Act and other relevant legislation. Create an environment where **members actively participate** in the affairs of their scheme. By 2020, **amendments to the Medical Schemes Act** mustbeinplacetostrengthen governance provisions, appeals processes, enforcement powers and complaints resolution processes. Ensure that at all times medical schemes are sensitive to the **specific needs of beneficiaries, are financially sound**, offers **protection against catastrophic financial incidents**. Schemes must also be sensitive to broader social considerations through the introduction of appropriate regulatory measures such as **fair treatment of beneficiaries**. CMS is looking at a **risk based solvency framework** that will go a long way in changing the landscape in medical scheme environment. Medical schemes are currently required to maintain accumulated funds expressed as a percentage of gross annual contributions which may not be less than 25%. There have often been debates and challenges to this regulation and the somewhat undesirable effects of the manner in which the solvency ratio is calculated. In order to fully understand the matter and related consequences, the **CMS will undertake a research project that would begin to respond to these challenges.** By 2020 the Council must have a well-functioning system to cater for the **electronic filing of scheme rules, and a well-functioning composite risk index system.** Through the control and coordination of the **availability of information** emanating from regulated entities, **their education and training activities,** participation in public discussions, and the publication of material in lay and official publications, the CMS will contribute to ensure that members, their dependents, and the public are informed of their rights. **Enhance visibility of CMS as a brand through campaigns and advertising**. The **communication guidelines** and **model rules** have been developed are continuously being e**nhanced to ensure that schemes are aware of the information** that must be sent to members. The model rules are a guide to the form and structure of the rule which schemes are encouraged to adhere to; to ensure the protection of members rights through clarity of disclosure. The communication guidelines will ensure that there is improved communication between CMS and the schemes such that **information is disseminated with ease to members**. CMS has issued **trustee remuneration guidelines**, this will go a long way to guide trustees in their fiduciary responsibilities. CMS further conducts investigations where governance irregularities are identified and in some instances this leads to some schemes being put under curatorship. CMS will also have to ensure that a **Practice Code Numbering system** is administered by an approved entity in order to facilitate claims payment and resource planning CMS will ensure that **brokers and broker organisations, administrators and managed care organisations are accredited in line with the accreditation requirements** as set out in the Medical Schemes Act, ensuring that applicants are fit and proper, have the necessary resources, skills, capacity, and infrastructure and are financially sound. **Protection of beneficiaries is key to our regulatory function** and the **complaints resolution** process must be improved continuously to instill confidence in beneficiaries that their complaints will be resolved timeously. A system of **alternative dispute resolution** has been put in place to assist in the complaints resolution. This will be monitored in the MTE years to ascertain the impact this has on the complaints resolution process.

Strategic Outcome Oriented Goal 3	**CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation**
Goal Statement	Through the improvement of: **business processes and business process automation** **information** collection and dissemination, **financial** and other best practice **monitoring systems**, Information Technology (IT) **systems**, **human resource** policies and procedures and strategies developed for staff retention and human capital investment, **financial** management, **legal advisory** services, **operational** efficiency, the CMS will constantly adapt to the ever changing environment and will improve its way of doing business. To improve its efficiency over the MTE period, the CMS will invest in its IT infrastructure. The area of supply chain management will be strengthened. CMS will ensure that it applies corporate governance principles in its operations. CMS will ensure that it deals with stakeholders in a fair and transparent manner.

Strategic Outcome Oriented Goal 4	**CMS provides strategic advice to influence and support the development and implementation of National health policy**
Goal Statement	Through **reviewing the needs of the environment**, the CMS, will constantly **collect and upgrade the collection of information** for the purposes of ongoing and **strategic review of the private health system including advising on relevant legislative reform**. **Research** is conducted on **aspects of the health system** that have an **impact on medical schemes and beneficiaries**. CMS collects and analyses **healthcare utilisation data** through the Annual Statutory Returns and makes **recommendations to the Registrar** on **significant trends** in the industry which may have an **impact on National Health Policy.** Through the development of application systems such as the **Single Exit Price (SEP) and Beneficiary Registry** the CMS will assist **NDoH to attain its objective** of an efficient health management information system for improved decision making, planning and policy implementation. Through its strategic position in the health system, the CMS will form **strategic relations** with re**gional and international institutions**, **consult, research, and collate information** for the purposes of **influencing** stakeholders and to provide **strategic advice to Government**; as well as provide **technical assistance** to major strategic health reforms like the **NHI**.

CMS Organogram



Programme 1: Administration

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

Sub-programme 1.1: Registrar and CEO

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

Sub-programme 1.2: Office of the CFO

The purpose of the sub-programme is to serve all business units in CMS, the executive management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The sub-programme also serves the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, the sub-programme helps Council to be a reputable Regulator.

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

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

Sub-programme 1.4: Human Resources

The purpose of the sub-programme is to provide high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programmes that promote and support Council's vision.

We will fulfil this mission with professionalism, integrity, and responsiveness by:

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

By doing this the sub-programme helps the Council for Medical Schemes by supporting its administration and staff through Human Resources Management advice and assistance, enabling them to make decisions that maximise its most important asset: its people and to continue the development of CMS as an employer of choice.

Sub-programme 1.5: Legal Services
The purpose of the sub-programme is to provide legal advice and representation to the CMS and business units to ensure the integrity of regulatory decisions.

The legal services sub-programme was moved to fall under administration as this forms part of our support programmes.

The Core Programmes of CMS are mainly concerned with the regulation and stability of the industry. The following programmes make up these:

Programme 2: Strategy Office
The purpose of this programme is to engage in projects to provide information to the Ministry on strategic health reform matters to achieve government's objective of an equitable and sustainable healthcare financing system in support of universal access and to provide support to the office on clinical matters. The purpose of the Clinical Unit is to ensure that access to good quality medical scheme cover is maximised and that regulated entities are properly governed, through prospective and retrospective regulation.

Programme 3: Accreditation
The purpose of the programme is to ensure brokers and broker organisations, administrators and managed care organisations are accredited in line with the accreditation requirements as set out in the Medical Schemes Act, including whether applicants are fit and proper, have the necessary resources, skills, capacity, and infrastructure and are financially sound.

Programme 4: Research and Monitoring
The purpose of the programme is to serve beneficiaries of medical schemes and members of the public by collecting and analysing data to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes and develop recommendations to improve regulatory policy and practice. By doing this the programme helps the Council for Medical Schemes to contribute to development of policy that enhances the protection of the interests of beneficiaries and members of public.

Programme 5: Stakeholder Relations
The purpose of the programme is to create and promote optimal awareness and understanding of the medical schemes environment by all regulated entities, the media, Council members and staff, through communication, education, training and customer care interventions.

Programme 6: Compliance and Investigation
The purpose of the programme is to serve members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act.

Programme 7: Benefit Management
The purpose of the programme is to serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. The programme analyses and approve all other rules to ensure consistency with the Medical Schemes Act. This ensures that the beneficiaries have access to affordable and appropriate quality health care. By doing this the programme helps the Council for Medical Schemes ensure that the rules of medical schemes are fair to beneficiaries and are consistent with the Act.

Programme 8: Financial Supervision
The purpose of the programme is to serve the beneficiaries of medical schemes, the Registrar's Office and Trustees by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the Act. By doing this, the programmes helps the Council for Medical Schemes monitor and promote the financial performance of schemes in order to achieve an industry that is financially sound.

Programme 9: Complaints Adjudication
The purpose of the programme is to serve the beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. By doing this, the programme ensures that beneficiaries are treated fairly by their medical schemes.

Budget Programmes

1. Programme 1 (Administration)

The Administration programme consists of five sub-programmes, each of these sub-programmes provide support services for the core business units of CMS. These sub-programmes allow CMS to carry out its operations in an efficient and effective manner.

1.1. Sub-Programme 1.1 (CEO and Registrar)

1.1.1. Purpose (CEO and Registrar)

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

1.2. Sub-Programme 1.2 (Office of the CFO)

1.2.1. Purpose (Office of the CFO)

The purpose of the sub-programme is to serve all business units in CMS, t he senior management team and Council by maintaining an efficient, effective and transparent system of financial, performance and risk management that complies with the applicable legislation. The Internal Finance unit also serves the Audit and Risk Committee, Internal Auditors, National Department of Health, National Treasury and Auditor-General by making available to them information and reports that allow them to carry out their statutory responsibilities. By doing this, we help Council to be a reputable Regulator.

1.2.2. Strategic Objectives (Office of the CFO)

Strategic Objective 1.2.3.1	**Ensure effective financial management and alignment of budget allocation with strategic priorities**
Objective statement	Ensure that internal controls are always adhered to in the financial management processes. An effective performance and budgeting management environment is maintained in the Council.
Baseline	Achieved unqualified audit opinion for 2014/15
Links	PFMA, Treasury Regulations, CMS policies and procedures, Supply Chain Management, CMS Performance Information Framework
Strategic Objective 1.2.3.2	**An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS**
Objective statement	An effective, efficient and transparent system of risk management is maintained. To ensure that CMS achieves its strategic goals by economic application of resources to minimize, monitor, and control the probability and/or impact of adverse events.
Baseline	A risk management framework was approved by Council during 2014/15 A new indicator has been developed for this objective for 2015/16
Links	PFMA, King III Corporate governance guidelines, CMS Risk Management Framework

1.2.3.Strategic Objectives Annual Targets for 2014 to 2019 (Office of the CFO)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.2.3.1: Ensure effective financial management and alignment of budget allocation with strategic prioriti es								
1.2.3.1	An unqualified opinion issued by the Auditor General on the annual financial statements by 31 July each year	New indicator	New indicator	1	1	1	1	1
	An unqualified opinion issued by the Auditor General on the annual performance information by 31 July each year	New indicator	New indicator	1	1	1	1	1
Strategic Objective 1.2.3.2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS								
1.2.3.2	Number of strategic risk register reports submitted to Council for monitoring, per year	New indicator	New indicator	New indicator	4	4	4	4

1.2.4. Quarterly targets for 2016/17 (Office of the CFO)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 1.2.3.1: Ensure effective financial management and alignment of budget allocation with strategic priorities							
1.2.3.1	An unqualified opinion issued by the Auditor General on the annual financial statements by 31 July each year	Annually	1	-	1	-	-
	An unqualified opinion issued by the Auditor General on the annual performance information by 31 July each year	Annually	1	-	1	-	-
Strategic Objective 1.2.3.2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS							
1.2.3.2	Number of strategic risk register reports submitted to Council for monitoring, per quarter	Quarterly	4	1	1	1	1

1.3. Sub-Programme 1.3 (Information and Communication Technology (ICT) and Knowledge Management (KM))

Purpose (ICT & KM)

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

1.3.1. Strategic Objectives (ICT & KM)

Goal 3 *CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

Strategic Objective 1.3.3.1	**An established ICT Infrastructure that ensures information is available, accessible and protected**
Objective statement	Diligently maintain, renew and secure the computer network, systems, operating system software and hardware of the organisation to ensure the availability of ICT infrastructure. The Unit will achieve a network and server uptime of 99% whilst reducing security incidents to 0% per annum by 2020.
Baseline	This was a new Indicator from 2015/16 therefore there will be no baseline for security incidents for 2014/15
Links	Information Technology Infrastructure Library (ITIL)& Control Objectives for Information Technology(COBIT)
Strategic Objective 1.3.3.2	**Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance**
Objective statement	Focus development responsibilities on creating, editing, and maintaining the custom software applications in use at CMS as well as procuring off-the-shelf applications. In performing this function, the unit will also render business analysis and advisory services according to enterprise architecture principles to CMS Units as well as external stakeholders where applicable. This objective will enable business units to improve their processes and ultimately their performance. The unit will increase the uptime percentage of all installed applications, to 99% by 2020
Baseline	98.23% uptime in 2014/15
Links	COBIT, Protection Of Personal Information (POPI), The Open Group Architecture Framework (TOGAF)
Strategic Objective 1.3.3.3	**Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing**
Objective statement	Create and maintain an environment where information, knowledge and records are effectively managed, and easily accessible to our stakeholders. The Unit will respond to 100% (400) of all requests for information received within 30 days, by 2020.
Baseline	274 requests for information received and attended to in 2014/15
Links	PAIA, POPI, South African National Archives and Record Services Act

1.3.2.Strategic Objective Annual Targets for 2015 to 2019 (ICT & KM)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.3.3.1: An established ICT Infrastructure that ensures information is available, accessible and protected.								
1.3.3.1	Percentage of network and server uptime, per year	New indicator	New indicator	97.05%	93%	95%	97%	100%
	Percentage of IT security incidents, per year	New indicator	New indicator	New indicator	New indicator	0%	0%	0%
Strategic Objective 1.3.3.2: Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance								
1.3.3.2	Percentage of uptime, of all installed application systems where network access exists, per year	98,8%	96%	98.23%	99%	99%	99%	100%
Strategic Objective 1.3.3.3: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing								
1.3.3.3	Percentage of physical requests for information responded to within 30 days, per year	New indicator	279	274	350	100% (300)	100% (250)	100% (200)

1.3.3. Quarterly targets for 2016/17 (ICT & KM)

Strategic objective	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 1.3.3.1: An established ICT Infrastructure that ensures information is available, accessible and protected							
1.3.3.1	Percentage of network and server uptime, per quarter	Quarterly	95%	90%	90%	92%	99%
	Percentage of IT security incidents, per quarter	Quarterly	0%	0%	0%	0%	0%
Strategic Objective 1.3.3.2: Provide software applications that serve both internal as well as external stakeholders, that improve business operations and performance							
1.3.3.2	Percentage of Uptime, of custom developed application systems where network access exists, per quarter	Quarterly	99%	96%	99%	99%	99%
Strategic Objective 1.3.3.3: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing							
1.3.3.3	Percentage of physical requests for information responded to within 30 days, per quarter	Quarterly	100% (300)	100% (75)	100% (75)	100% (75)	100% (75)

1.4. Sub Programme 1.4 (Human Resources Management unit)

Purpose (Human Resources Management unit)

The purpose of the sub-programme is to provide high quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resources programs that promote and support Council's vision.

We will fulfil this mission with professionalism, integrity, and responsiveness by:

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

By doing this we help the CMS by supporting its administration and staff through Human Resources Management advice and assistance, enabling them to make decisions that maximise its most important asset: its people and to continue the development of CMS as an employer of choice.

1.4.1. Strategic Objectives (Human Resources Management Unit)

Goal 3 *CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

Strategic Objective 1.4.3.1	**Build competencies and retain skilled employees**
Objective statement	Effective and efficient development and retention of employees to enable CMS to meet its objectives by retaining scarce, critical, professional and technical skills and maintaining a staff turnover rate of less than 5% by 2020. CMS shall ensure continuous development of staff to in line with succession planning framework. Staff are continuously engaged to assess the levels of commitment and motivation to CMS. This will be conducted through a survey and findings will be implemented upon completion of survey. CMS will ensure that vacancies are filled within 90 working days.
Baseline	Staff turnover rate was reduced to 3.88% in 2014/2015 Turnaround time to fill vacancy, 7 vacancies out of the 10 took longer than the 90days to fill in 2014/15 88% of employment equity targets were achieved during 2014/15
Link	Employment Equity Act; Recruitment, selection and retention policy; Succession planning strategy
Strategic Objective 1.4.3.2	**Maximise performance to improve organisational efficiency and maintain high performance culture**
Objective statement	Measure 100% of organisational efficiency by aligning employee performance contracts and reviewing performance against achievement of organisational objectives. The unit shall ensure that 95% of employees participate in training in accordance with Personal Development Plans that are aligned with outcomes of performance assessments where specific skills and abilities have been identified. By 2020 the unit will implement a 360 degree assessment tool
Baseline	100% of performance agreements were signed by 30 May 2015 Conclusion of employee performance assessments is a new indicator for 2016/17
Link	Skills Development Act; Skills Development Levies Act; Education and Training policy

1.4.2. Strategic Objectives Annual Targets for 2015 to 2019 (Human Resource Management)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.4.3.1: Build competencies and retain skilled employees								
1.4.3.1	Minimise staff turnover rate to less than 5% per annum	3.19%	6.12%	3.88%	5%	<5%	<5%	<5%
	Average turnaround time to fill a vacancy (average turnaround time of 90 working days for each vacancy that exists during the year)	New indicator	New indicator	There were 7 out of 10 positions that took longer than the 90days to fill	90 days	90 days	90 days	90days
	Achievement of Employment equity targets (85% optimal in terms of Employment Equity Act), annually	New indicator	New indicator	88%	85%	85%	85%	85%
Strategic Objective 1.4.3.2: Maximise performance to improve organisational efficiency and maintain high performance culture								
1.4.3.2	100% of employee performance agreements are signed by no later than 31 May of each year	New indicator	New indicator	New indicator	New indicator	100%	100%	100%
	Percentage of employee performance assessment concluded, bi annually	New indicator	New indicator	New indicator	New indicator	100%	100%	100%

1.4.3. Quarterly targets for 2016/17 (Human Resource Management)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic objective 1.4.3.1: Build competencies and retain skilled employees							
1.4.3.1	Minimise staff turnover rate to less than 5% per annum	Annual	<5%	-	-	-	<5%
	Average turnaround time to fill a vacancy (Average turnaround time of 90 working days to fill a vacancy that exists during the year)	Quarterly	90 days	90 days	90 days	90 days	90 days
	Achievement of Employment equity targets (85% optimal in terms of Employment Equity Act), annually	Annual	85%	-	-	-	85%
Strategic Objective 1.4.3.2: Maximise performance to improve organisational efficiency and maintain high performance culture							
1.4.3.2	100% of employee performance agreements are signed by no later than 31 May of each year	Annual	100%	100%	-	-	-
	Percentage of employee performance assessment concluded, bi annually	Bi annually	100%	-	100%	-	100%

1.5. Sub - Programme 1.5 (Legal Services Unit)

Purpose (Legal Services Unit)

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

1.5.1. Strategic Objectives (Legal Services Unit)

Goal 3 *CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation*

Strategic Objective 1.5.3.1	**Legal advisory service for effective regulation of the industry and operations of the office**
Objective statement	To provide written and verbal legal opinions, and representations to the Office of the Registrar, Council and external stakeholders to protect the integrity of regulatory decisions. The unit will provide 85% (200) written & verbal legal opinions generated internally by 2019.
Baseline	227 written and verbal legal opinions were provided to the CMS or business units in 2014/15
Link	Medical Schemes Act, FI Act, PAJA, PAIA
Strategic Objective 1.5.3.2	**Support CMS mandate by defending decisions of Council and the Registrar**
Objective statement	To provide a legal support service to the Office of the Registrar, the Council and external stakeholders to ensure the integrity of regulatory decisions taken in terms of the Act and other relevant legislation and to ensure that schemes are properly governed in terms of scheme rules, good governance and tribunal decisions. The unit will attend to all court and tribunal cases referred to it.
Baseline	In 24 cases papers were filed in court and other tribunals in 2014/15
Link	Medical Schemes Act, FI Act, PAJA, PAIA

1.5.2. Strategic objective annual targets for 2015 to 2019 (Legal Services Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 3: CMS is responsive to the environment by being a fair, transparent, effective and efficient organisation								
Strategic Objective 1.5.3.1: Legal advisory service for effective regulation of the industry and operations of the office								
1.5.3.1	Percentage of written and verbal legal opinions generated internally to internal and external stakeholders, per year	new indicator	new indicator	new indicator	100	85% (180)	85% (190)	85% (200)
Strategic Objective 1.5.3.2: Support CMS mandate by defending decisions of Council and the Registrar								
1.5.3.2	Percentage of court and tribunal appearances in legal matters received and handled by the unit, per year	23	17	24	20	100% (23)	100% (25)	100% (25)

1.5.3. Quarterly targets for 2016/17 (Legal Services Unit)

Strategic Objective	Performance Indicator	Reporting period 2016/17	Annual target 2016/17	Quarterly targets			
				1st	2nd	3rd	4th
Strategic Objective 1.5.3.1: Legal advisory service for effective regulation of the industry and operations of the office							
1.5.3.1.	Percentage of written and verbal legal opinions generated internally to internal and external stakeholders, per year	Quarterly	85%	85%	85%	85%	85%
Strategic Objective 1.5.3.2: Support CMS mandate by defending decisions of Council and the Registrar							
1.5.3.2	Percentage of court and tribunal appearances in legal matters received and handled by the unit, per quarter	Quarterly	100% (23)	100% (5)	100% (6)	100% (7)	100% (5)

2. Programme 2 (Strategy Office)

Purpose (Strategy Office)

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

2.1. Strategic Objectives (Strategy Office)

Goal 1 *Access to good quality medical scheme cover is promoted*

Strategic Objective 2.1.1	**Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected**
Objective statement	The formulation of new and revision of existing PMB definitions in consultation with stakeholders with a view to ensure that members are adequately protected. The unit will publish 4 Benefit Definitions for PMB conditions and 10 CMS scripts per year by 2020
Baseline	There were 3 PMB definitions published in 2014/15
Link	Explanatory Note 2 of Annexure A of the Regulations to the Medical Schemes Act 131 of 1998

Goal 2 *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 2.2.2	**Provide clinical opinions to resolve complaints and enquiries**
Objective statement	The formulation of clinical opinions on formal complaints received from the Complaints Adjudication Unit and via e-mail and telephonic enquiries with the view to ensure that member' s complaints and enquiries are resolved so that members and providers receive rightful payment of claims.
Baseline	623 clinical opinions were completed in 2014/15
Link	Regulation 15D 2(d)(ii) - where provision is made by a managed care provider for complaints or appeals procedures or mechanisms, such provision shall in no way impact upon the entitlement of a beneficiary to- (ii) lodge a complaint with Council;

2.2. Strategic Objectives Annual Targets for 2015 to 2019 (Strategy Office)

Strategic Objective		**Audited/Actual performance**			**Estimated performance**	**Medium-term targets**		
		2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Strategic Goal 1: Access to good quality medical scheme cover is promoted								
Strategic Objective 2.1.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected								
2.1.1	The number of benefit definitions and CMS Scripts published, per year	New indicator	New indicator	11	12	14	14	14
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 2.2.1: Provide clinical opinions to resolve complaints and enquiries								
2.2.1	Percentage of clinical opinions reviewed within 30 days of receipt from Complaints Adjudication	758	839	623	1472	90% (550)	95% (500)	100% (450)
	Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days	New indicator	New indicator	New indicator	New indicator	90% (480)	95% (480)	95% (480)

2.3. Quarterly targets for 2016/17 (Strategy Office)

Strategic Objective	Performance Indicator	Reporting period 2016/17	Annual target 2016/17	Quarterly targets 2016/17			
				1st	2nd	3rd	4th
Strategic Objective 2.1.1: Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected							
2.1.1	The number of benefit definitions and CMS scripts published, per quarter	Quarterly	14	3 CMScripts published	3 CMScripts published 2 PMB Definition published	2 CMScripts published	2 CMScripts published 2 PMB Definition published
Strategic Objective 2.2.1: Provide clinical opinions to resolve complaints and enquiries							
2.2.1	Percentage of clinical opinions reviewed within 30 days of receipt from Complaints Adjudication	Quarterly	90%	90% Complaints within 30 days	90% Complaints within 30 days	90% Complaints within 30 days	90% Complaints within 30 days
	Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days	Quarterly	90%	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days

3. Programme 3 (Accreditation Unit)

Purpose (Accreditation Unit)

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

3.1. Strategic Objectives (Accreditation Unit)

Goal 2 *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 3.2.1	**Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services**
Objective statement	Ensure that the brokers that are accredited are compliant with the accreditation requirements. Accredit 100% (4 980) of individual brokers and broker organisation applications that meet the requirements of accreditation within 21 working days of receipt of all relevant information by 2019
Baseline	A total of 5 027 broker and broker organisations were accredited during 2014/15
Link	Medical Schemes Act and FAIS Act, 2002
Strategic Objective 3.2.2	**Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined**
Objective statement	Ensure that the MCOs that are accredited are compliant with the accreditation requirements. 26 New and renewal accreditation applications accredited within 3 months of receipt of all relevant information by 2019
Baseline	26 MCOs accredited in 2014/15
Link	Medical Schemes Act
Strategic Objective 3.2.3	**Accredit administrators and issue compliance certificates to self-administered schemes based on their compliance with the accreditation requirements in order to provide administration services**
Objective statement	Ensure that the administrators that are accredited and self-administered schemes that are issued with compliance certificates are compliant with the requirements for accreditation. Accredit/approve 15 administrator accreditation and self-administered applications by 2019, within three months of receipt of all relevant information.
Baseline	9 applications accredited in 2014/15
Link	Medical Schemes Act

3.2. Strategic objective annual targets for 2015 to 2019(Accreditation Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 3.2.1: Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services								
3.2.1	Number of brokers and broker organisations that comply with the accreditation requirements accredited within 21 working days of receipt of complete applications	4259	5564	5 027	5 192	3980	4045	4980
Strategic Objective 3.2.2: Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined								
3.2.2	Number of managed care organisation applications, accredited within 3 months of receipt of all relevant information	29	14	26	16	26	16	26
Strategic Objective 3.2.3: Accredit Administrators and issue Compliance Certificates to Self-Administered schemes based on their compliance with the accreditation requirements in order to provide administration services								
3.2.3	Number of applications by administrators and self-administered schemes accredited within 3 months of receipt of all relevant information	14	16	9	13	15	11	15

3.3. Quarterly targets for 2016/17 (Accreditation Unit)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 3.2.1: Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services							
3.2.1	Number of brokers and broker organisations that comply with the accreditation requirements accredited within 21 working days of receipt of complete applications	Quarterly	3980	1000	984	991	1005
Strategic Objective 3.2.2: Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined							
3.2.2.	Number of managed care organisation applications accredited within 3 months of receipt of all relevant information	Quarterly	26	2	1	22	1
Strategic Objective 3.2.3: Accredit Administrators and issue Compliance Certificates to Self-Administered schemes based on their compliance with the accreditation requirements in order to provide administration services							
3.2.3.	Number of applications by administrators and self-administered schemes accredited within 3 months of receipt of all relevant information	Quarterly	15	7	1	7	-

4. Programme 4 (Research and Monitoring Unit)

Purpose (Research and Monitoring Unit)

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

4.1. Strategic Objectives (Research and Monitoring Unit)

Goal 2 *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 4.2.1	**To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning**
Objective statement	Monitor compliance to Regulation 5 (e) with regards to ensuring that the practice code number of a treating provider is provided for on the billing statement to medical scheme for services rendered to the members. Full access to the database for analyses of data to feed into the NHI process and general resource planning. Ensure a streamlined and freely accessible practice code numbering system by 2020.
Baseline	4 quarterly reports were received in 2014/15
Link	Medical Schemes Act 131 of 1998, Regulation 5 (e)

Goal 4 *CMS provides strategic advice to influence and support the development and implementation of National health policy*

Strategic Objective 4.4.1	**Conduct research to inform appropriate policy interventions**
Objective statement	Research is conducted on aspects of the health system that have an impact on medical schemes and beneficiaries. The unit envisions doing 9 projects (research and support projects) by 2020. The research includes the evaluation of the solvency framework, measuring medical scheme inflation and health quality outcomes.
Baseline	A total of 11 research projects were completed in 2014/15
Link	CMS Annual Reports and Operational Plans of the unit.
Strategic Objective 4.4.2	**Monitoring trends to improve regulatory policy and practice**
Objective statement	The Unit provides input into the Registrar' s review, compiles the review of operations and analyses demographic, geographic, expenditure and health care utilisation data for inclusion in the Annual Report of the Registrar of Medical Schemes. The analysis includes risk profiling of the medical schemes, classification of benefit options and costing of the PMB' s.
Baseline	In 2014/15 one non-financial report was submitted for inclusion in the annual report
Link	CMS Annual Reports and Operational Plans of the unit.

4.2. Strategic objective annual targets for 2015 to 2019 (Research and Monitoring Unit)

Strategic Objective		Audited/Actual performance			Estimated performance	Medium-term targets		
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 4.2.1: To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning								
4.2.1	Number of quarterly reports received from the PCNS service provider reflecting active practice code numbers, per year	New indicator	4	4	4	4	4	4
Strategic Goal 4: CMS provides strategic advice to influence and support the development and implementation of National health policy								
Strategic Objective 4.4.1: Conduct research to inform appropriate policy interventions								
4.4.1	Number of research projects and support projects finalised, per year	New indicator	13	11	8	8	8	9
Strategic Objective 4.4.2: Monitoring trends to improve regulatory policy and practice								
4.4.2	Non-financial report submitted for inclusion in the annual report, per year	1	1	1	1	1	1	1

4.3. Quarterly targets for 2016/17 (Research and Monitoring Unit)

Strategic Objectives	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 4.2.1: To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning							
4.2.1	Number of quarterly reports received from the PCNS service provider reflecting active practice code numbers, per quarter	Quarterly	4	1	1	1	1
Strategic Objective 4.4.1: Conduct research to inform appropriate policy interventions							
4.4.1	Number of research projects and support projects finalised, per quarter	Quarterly	8	-	1	4	3
Strategic Objective 4.4.2: Monitoring trends to improve regulatory policy and practice							
4.4.2	Non-financial report submitted for inclusion in the annual report, per quarter	Annual	1	-	1	-	-

5. Programme 5: Stakeholder Relations

Purpose (Stakeholder Relations Unit)

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

5.1. Strategic Objectives (Stakeholder Relations Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 5.2.1	**Create awareness and provide training in order to enhance the visibility and reputation of CMS**
Objective statement	Create consumer awareness and provide training to members to understand their rights and responsibilities. Provide training to trustees, schemes and brokers to enhance correct interpretation of the Medical Schemes Act, governance and compliance in the medical scheme environment.
Baseline	This is a revised indicator for 2016/17, therefore there is no baseline for 2014/15
Link	Medicals Schemes Act
Strategic objective 5.2.2	**Communication and engagement to inform and to empower stakeholders**
Objective statement	The SHR unit aims to inform and empower stakeholders through the publication of the Annual Report, newsletters, advertisements and media engagement
Baseline	CMS' Annual Report published and launched by 31 August every year. Communication with stakeholders was revised and therefore there is no baseline for 2014/15. Baseline for media monitoring is 72.9% positive/neutral media reporting received in 2014/15
Link	Medical Schemes Act

5.2. Strategic objective annual targets for 2015 to 2019 (Stakeholder Relations Unit)

Strategic Objective		**Audited/Actual performance**			**Estimated performance**	**Medium-term targets**		
		2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 5.2.1 Create awareness and provide training in order to enhance the visibility and reputation of CMS								
5.2.1	Percentage of member awareness of CMS resulted from survey	New indicator	New indicator	New indicator	New indicator	30%	n/a	50%
	Number of stakeholder training and awareness sessions, per year	New indicator	New indicator	New indicator	18	18	20	22
Strategic Objective 5.2.2 Communication and engagement to inform and empower stakeholders								
5.2.2	Publication of CMS' Annual Report by 31 August	1	1	1	1	1	1	1
	Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per year	New indicator	New indicator	72.9%	75%	75%	75%	75%

5.3. Quarterly targets for 2016/17 (Stakeholder Relations Unit)

Strategic Objective	Performance Indicator	Reporting period	Annual target	Quarterly targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 5.2.1: Create awareness and provide training in order to enhance the visibility and reputation of CMS							
5.2.1.	Percentage of member awareness of CMS resulted from survey	Annual	30%	-	-	30%	-
	Number of stakeholder training and awareness sessions, per quarter	Quarterly	18	2	4	6	6
Strategic Objective 5.2.2: Communication and engagement to inform and empower stakeholders							
5.2.2	Publication of CMS' Annual Report by 31 August	Annual	1	-	1	-	-
	Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool, per quarter	Quarterly	75%	75%	75%	75%	75%

6. Programme 6 (Compliance and Investigation Unit)

Purpose (Compliance and Investigation Unit)

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

6.1. Strategic Objectives (Compliance and Investigation Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 6.2.1	**Regulated entities comply with Legislation**
Objective statement	To institute enforcement action of against regulated entities where non-compliance is identified, this is to ensure compliance with legislation
Baseline	52 enforcement actions were taken during 2014/15
Link	Medical Schemes Act and other relevant legislation
Strategic Objective 6.2.2	**Strengthen and Monitor governance systems**
Objective statement	Ensure that good governance is maintained by medical schemes and other regulated entities
Baseline	88 governance interventions implemented during 2014/15
Link	Medical Schemes Act and other relevant legislation

6.2. Strategic objective annual targets for 2015 to 2019(Compliance and Investigation Unit)

Strategic Objective		**Audited Actual performance**			**Estimated performance**	**Medium-term targets**		
		2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 6.2.1: Regulated entities comply with Legislation								
6.2.1	Percentage of non-compliance cases against regulated entities undertaken, per year	New indicator	New indicator	52	45	100% (40)	100% (35)	100% (30)
Strategic Objective 5.2.2: Strengthen and monitor governance systems								
6.2.2	Percentage of governance interventions implemented, per year	New indicator	New indicator	88	72	100% (75)	100% (82)	100% (85)

6.3. Quarterly targets for 2016/17(Compliance and Investigation Unit)

Strategic Objective	**Performance Indicators**	**Reporting period**	**Annual target**	**Quarterly targets**			
		2016/17	**2016/17**	**1st**	**2nd**	**3rd**	**4th**
Strategic Objective 6.2.1: Regulated entities comply with Legislation							
6.2.1	Percentage of non-compliance cases against regulated entities undertaken, per quarter	Quarterly	100% (40)	100% (10)	100% (10)	100% (10)	100% (10)
Strategic Objective 6.2.2:Strengthen and monitor governance systems							
6.2.2	Percentage of governance interventions implemented, per quarter	Quarterly	100% (75)	100% (30)	100% (15)	100% (15)	100% (15)

7. Programme 7 (Benefits Management Unit)

Purpose (Benefits Management Unit)

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

7.1. Strategic Objectives (Benefits Management Unit)

Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected

Strategic Objective 7.2.1	**To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act**
Objective statement	Percentage of rule amendments (interim and annual rule amendments) by medical scheme are analysed within timeframes, to ensure that medical scheme rule amendments are fair and compliant with the Medical Schemes Act and to ensure that beneficiaries are protected.
Baseline	242 amendments analysed in 2014/15
Link	Section 31(3) requires that any rule amendment or rescission can only be approved such that it will not be unfair to members and will not render the rules inconsistent with the Medical Schemes Act.

7.2. Strategic objective annual targets for 2015 to 2019 (Benefits Management Unit)

Strategic Objective		**Audited/Actual performance**			**Estimated performance**	**Medium-term targets**		
		2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 7.2.1: To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act								
7.2.1	Percentage interim rule amendments processed within 14 days of receipt of all information per year	New indicator	New indicator	New indicator	New indicator	100% (129)	100% (129)	100% (129)
	Percentage of annual rule amendments processed before 31 December of each year	New indicator	New indicator	New indicator	New indicator	100% (83)	100% (83)	100% (83)

7.3. Quarterly targets for 2016/17 (Benefits Management Unit)

Strategic objective	**Performance Indicators**	**Reporting period**	**Annual target**	**Quarterly targets**			
		2016/17	**2016/17**	**1st**	**2nd**	**3rd**	**4th**
Strategic Objectives 7.2.1: To ensure that rules of the schemes are fair and compliant with the Medical Schemes Act							
7.2.1	Percentage interim rule amendments processed within 14 days of receipt of all information, per quarter	Quarterly	100% (129)	100% 35	100% 33	100% 21	100% 40
	Percentage of annual rule amendments processed before 31 December of each year	Quarterly	100% (83)	-	-	100% (83)	-

8. Programme 8 (Financial Supervision Unit)

Purpose (Financial Supervision Unit)

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

8.1. Strategic Objectives (Financial Supervision Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 8.2.1	**Monitor and Promote the financial soundness of medical schemes**
Objective statement	Secure an appropriate level of protection for beneficiaries of medical schemes by monitoring and analysing the financial performance and soundness of medical schemes.
Baseline	2 recommendations were made in respect of schemes with rapidly reducing solvencies (Suremed and Topmed) and Liberty was requested to submit a new revised business plan for 2014/15 3 Quarterly Reports published in 2014/15 1 set of input in respect of the financial sections of the Annual Return in 2014/2015
Link	Medical Schemes Act

8.2. Strategic Objectives Annual Targets 2015 to 2019 (Financial Supervision Unit)

Strategic Objective		**Audited/Actual performance**			**Estimated performance**	**Medium-term targets**		
		2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic Objective 8.2.1: Monitor and promote the financial soundness of medical schemes								
8.2.1	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan received, per year	100% (8/8)	100%	100%	100%	100%	100%	100%
	Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per year	New indicator	New indicator	New indicator	100%	100%	100%	100%
	Number of Quarterly financial return reports published (excluding quarter 4), per year	3	3	3	3	3	3	3
	Number of financial sections prepared for the Annual Report	1	1	1	1	1	1	1

8.3. Quarterly targets for 2016/17 (Financial Supervision Unit)

Strategic Objective	Performance Indicators	Reporting Period	Annual Target	Quarterly Targets			
		2016/17	2016/17	1st	2nd	3rd	4th
Strategic Objective 8.2.1: Monitor and promote the financial soundness of medical schemes							
8.2.1	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan received, per quarter	Quarterly	100%	100%	100%	100%	100%
	Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified, per quarter	Quarterly	100%	100%	100%	100%	100%
	Number of Quarterly financial return reports published (excluding quarter 4), per quarter	Quarterly	3	-	1	1	1
	Number of financial sections prepared for the Annual Report	Annual	1	-	1	-	-

9. Programme 9 (Complaints Adjudication Unit)

Purpose (Complaints Adjudication Unit)

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

9.1. Strategic Objectives (Complaints Adjudication Unit)

Goal 2: *Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected*

Strategic Objective 9.2.1	**Resolve complaints with the aim of protecting beneficiaries of medical schemes**
Objective statement	Increase the adjudication of complaints to 85%, within 120 days, in an efficient and effective manner by 2020.
Baseline	73% of complaints were resolved within 120 working days in 2014/15
Link	Medicals schemes Act S47

9.2. Strategic objective annual targets for 2015 to 2019 (Complaints Adjudication Unit)

Strategic Objective		**Audited/Actual performance**			**Estimated performance**	**Medium-term targets**		
		2012/13	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Strategic Goal 2: Medical schemes and related regulated entities are properly governed, responsive to the environment and beneficiaries are informed and protected								
Strategic objective 9.2.1: Resolve complaints with the aim of protecting beneficiaries of medical schemes								
9.2.1	Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per year	76%	63%	73%	73%	76%	79%	85%

9.3. Quarterly targets for 2016/17 (Complaints Adjudication Unit)

Strategic Objective	**Performance Indicators**	**Reporting period**	**Annual target**	**Quarterly targets**			
		2016/17	**2016/17**	**1st**	**2nd**	**3rd**	**4th**
Strategic Objective 9.2.1: Resolve complaints with the aim of protecting beneficiaries of medical schemes							
9.2.1	Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per quarter	Quarterly	76%	76%	76%	76%	76%

Part E
(Annexure E)
Technical Indicator Descriptions 2016/17

CONTENTS - Part E

1. Programme 1 (Administration)

1.1. Sub-programme 1.1 (CEO and Registrar)

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

1.2. Sub-Programme 2.1 (Office of the CFO)

1.2.1. Strategic Objective 1.2.3.1 - Maintain an effective, efficient and transparent financial management environment to support the CMS in achieving its objectives

Indicator title	An unqualified opinion issued by the Auditor General on the annual financial statements by 31 July each year
Short definition	This means that our financials are prepared in accordance with GRAP and our internal policies and the information is presented to the public in the required framework and timeframes
Purpose/importance	This is to ensure that a transparent financial management system is maintained
Source/collection of data	Financial management system and budget cycle in place (Accountmate, Sage).
Method of calculation	Audit opinion issued by Auditor General on 31 July.
Data limitations	Not applicable
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Annual
New indicator	None
Desired performance	An unqualified annual financial statement with no material findings by the Auditor General
Indicator responsibility	Chief Financial Officer

Indicator title	An unqualified opinion issued by the Auditor General on the annual performance information 31 July each year
Short definition	Reporting of actual performance against stated objectives and targets. To ensure that CMS operates in line with their approved plans
Purpose/importance	To ensure that Council achieves its performance targets as set out in the annual performance plans for the year.
Source/collection of data	Quarterly reports with audit evidence from units and annual performance report.
Method of calculation	Audit opinion issued by Auditor General by 31 July
Data limitations	Not applicable
Type of indicator	Outputs
Calculation type	Cumulative
Reporting cycle	Quarterly
New indicator	None
Desired performance	An unqualified annual performance information opinion with no material findings by the Auditor General
Indicator responsibility	Chief Financial Officer

1.2.2. Strategic Objective 1.2.3.2 - An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS

Indicator title	Number of strategic risk register reports submitted to Council for monitoring, per year
Short definition	To ensure that the risks of the Council are mitigated to an acceptable risk tolerance level
Purpose/importance	Risk Management will ultimately help CMS to achieve: Greater organisational clarity of purpose by clearly identifying policy needs and actions required to meet strategic objectives, More cohesiveness of effort through organisational consistency and clear role definition, better decisions through thorough consideration of issues, Faster reactions through concentration on key performance trends, and Accountability by recording decisions in context and allocating responsibility for action.
Source/collection of data	Quarterly strategic risk register reports to Council / Council minutes
Method of calculation	Count
Data limitations	Not applicable
Type of indicator	Outputs
Calculation type	Cumulative
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	To ensure that risks are at an acceptable risk tolerance level or are mitigated.
Indicator responsibility	Risk and Performance Manager

1.3. Sub-Programme 1.3 (Information and Communication Technology (ICT) and Knowledge Management (KM) Unit)

1.3.1. Strategic Objective 1.3.3.1 - An established ICT Infrastructure that ensures information is available, accessible and protected

Indicator title	Percentage of network and server uptime, per year
Short definition	This indicator measures the percentage of network uptime reported over a period The more network incidents reported during the year, less the percentage uptime (Network Incidents/365 * 100). These network incidents include switch and router failures, failure in ISP connectivity and general line outages. This indicator also measures the % uptime experienced on all the server systems deployed in the CMS Server Farm. The higher the number of days where access to server systems was totally interrupted, the lower the % uptime (number of server incidents / 365 * 100). This indicator does not take into account planned outages needed for purpose of maintenance. These planned outages will be recorded separately as part of the IT Change Management process on M-Files. Days: Days of the year. Incidents: The number of incidents calculated in days. These exclude planned maintenance incidents. Formula: (Days minus Incidents)/days) multiplied by 100 Annual: ((365 – Incidents)/365) * 100 Q1: ((91 – Incidents) / 91) * 100 Q2: ((92 – Incidents) / 92) * 100 Q3: ((91 – Incidents) / 91) * 100 Q4: ((91 – Incidents) / 91) * 100
Purpose/importance	A reduced network uptime may be indicative of serious network/IT infrastructure related issues which need to be addressed to prevent connectivity issues and possible data loss. A reduced network uptime may seriously affect and compromise the ability of the CMS to run software application systems to support business operations.
Source/collection of data	Advent Net Helpdesk System Software and change management process on M-Files content management system. Data is collected by the Helpdesk Coordinator.
Method of calculation	System Generated Reports
Data limitations	None
Type of indicator	Impact
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	Changed
Desired performance	Higher. A 100 % uptime should be strived for.
Indicator responsibility	Network Manager

Indicator title	Percentage of IT security incidents, per year
Short definition	This indicator measures the percentage of IT security events reported over a period The more security incidents reported during the year, the more the percentage of incidents (Security Incidents/365 * 100). These security incidents include external penetration attempts through the CMS firewall as well as attempts internally to by both staff as well as visitors to access information which they are not entitled to access. This indicator does not take into account planned penetration attempts as part of annual security audits performed. These planned penetration attempts will be recorded separately as part of the IT Change Management process on M-Files. Incidents: The number of security incidents calculated in days. These do not include planned attempts. Formula: (Security incidents/days) multiplied by 100 Annual: ((Security incidents/365) * 100 Q1: (Security incidents) / 91) * 100 Q2: ((Security incidents) / 92) * 100 Q3: ((Security incidents) / 91) * 100 Q4: ((Security incidents) / 91) * 100
Purpose/importance	Security incidents may seriously affect and compromise the ability of the CMS to act as custodian of beneficiary and scheme data which it is required to collect as part of its regulatory mandate. It may also cause the CMS to be in default in terms of current legislation aimed at protecting the privacy of information such as the Promotion of Personal Information Act (POPI) as well as the Electronic Communication and Transactions Act (ECT Act).
Source/collection of data	Firewall reports submitted monthly to CMS by the Security Service Provider. Data is collected by the Network Manager.
Method of calculation	System Generated Reports
Data limitations	None
Type of indicator	Impact
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	Changed
Desired performance	Lower. A zero percent (0 %) incident rate should be strived for.
Indicator responsibility	Network Manager

1.3.2. Strategic Objective 1.3.3.2 - Provide software applications that improve business operations and performance

Indicator title	Percentage of uptime, of all installed application systems where network access exists, per year
Short definition	This indicator measures the % uptime of all installed applications deployed in CMS. This indicator does not take into account planned outages needed for purpose of maintenance. These planned outages will be recorded separately as part of the IT Change Management process on M-Files. This indicator also assumes a 24/7 network availability. Incidents: The number of incidents calculated in days. Formula: (Days minus Incidents)/days) multiplied by 100 Annual: (365 – Incidents)/365) * 100 Q1: (91 – Incidents) / 91) * 100 Q2: (92 – Incidents) / 92) * 100 Q3: (91 – Incidents) / 91) * 100 Q4: (91 – Incidents) / 91) * 100
Purpose/importance	A lowering of the total number of days during which interruptions occurred, will result in a higher % uptime which may indicate that the application systems were developed using sound software development methodologies and that the software development environment produces stable applications which are able to support business processes and operations.
Source/collection of data	Advent Net Helpdesk System Software as well as the change management process on the M-Files content management system. Data is collected by the Helpdesk Administrator and the Manager: Software Development.
Method of calculation	System generated reports.
Data limitations	None
Type of indicator	Impact
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	New
Desired performance	Higher. A 100% uptime should be strived for.
Indicator responsibility	Manager: Software Development

1.3.3. Strategic Objective 1.3.3.3 - Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing

Indicator title	Percentage of physical requests for information responded to within 30 days, per year
Short definition	This indicator measures the percentage of physical requests for information received by the knowledge management officer for a specific period and dealt with within a period of 30 days. These requests include requests received for PAIA material, books, articles, legislative research, case law research, interlibrary loan requests and Metrofile archival requests. This indicator does not measure self-help actions performed by stakeholders through the various portals on our website and elsewhere. The aim is to lower the number of physical requests but to maintain a 100% resolution rate within 30 days in respect of physical requests for information received. Physical requests: The number of physical requests lodged with the Knowledge management Officer and responded to within 30 days. This excludes self-help actions performed on the electronic portals. Formula: (physical requests dealt with <30 days /Physical requests received) multiplied by 100 Annual & Quarterly: (physical requests dealt with <30 days /Physical requests received) * 100
Purpose/importance	A decrease in physical requests for information is indicative of a well utilised and fully resourced electronic based knowledge management function (through the various portals) as well as repository and a need for information contained therein. Increased access to tacit information stored on CMS systems will lead to better informed decision making.
Source/collection of data	A register of physical access requests is maintained by the knowledge management officer
Method of calculation	Simple count
Data limitations	None
Type of indicator	output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	New
Desired performance	Lower count whilst maintaining a 100% resolution rate within 30 days of those physical requests received.
Indicator responsibility	Knowledge Management Officer

1.4. Sub-Programme 1.4 (Human Resources Unit)

1.4.1. Strategic objective 1.4.3.1 Build competencies and retain skilled employees

Indicator title	Minimise staff turnover rate to less than 5% per annum
Short definition	The percentage rate at which an employer attracts and loses employees.
Purpose/importance	Ensure that a CMS has the right talent with the right skills at the right time. Retain scarce, critical, professional and technical skills and maintaining a staff turnover rate of less than 5% by 2020.
Source/collection of data	Excel spreadsheet. List of key staff members as per succession planning framework
Method of calculation	Divide the number of terminations by employees by the total number of employees at the end of the reporting period, expressed as a percentage (e.g. 2/20 x 100= XX)
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	Retaining competent employees with the right skills at the right time
Indicator responsibility	General Manager: Human Resources/Manager HR

Indicator title	Average turnaround time to fill a vacancy (average turnaround time of 90 working days to fill a vacancy that exists during the year)
Short definition	Time spent in filling a vacancy
Purpose/importance	Ensuring that no gap exists for longer periods of time after resignation thereby ensuring that units are able to achieve their objectives.
Source/collection of data	Council resolution for new positions. Annual performance plans and budget. Resignation and appointment letter.
Method of calculation	Count the number of calendar days from resignation of the vacancy to the date the appointment is made (a vacancy should not take more than 90 working days to fill) Number of days from date of approval of new position or approval of budget should not be more than 90 working days.
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Quarterly
New indicator	New
Desired performance	Maintain continuity in employment
Indicator responsibility	General Manager: Human Resources/Manager HR

Indicator title	Achievement of Employment equity targets (85% optimal in terms of Employment Equity Act), annually
Short definition	To ensure that CMS achieves its targets according to its approved employment equity plan.
Purpose/importance	To achieve equity in the workplace by promoting equal opportunity and fair treatment in employment through elimination of unfair discrimination and implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups, in order to ensure equitable representation in all occupational categories and levels in the workforce.
Source/collection of data	Employment equity and income differential reports to the Department of Labour
Method of calculation	Spreadsheet
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Annually
New indicator	New
Desired performance	Higher
Indicator Responsibility	General Manager: Human Resources

1.4.2. Strategic Objective 1.4.3.2: Maximise performance to improve organisational efficiency and maintain high performance culture

Indicator title	100% of employee performance agreements are signed by no later than 31 May of each year
Short definition	Employee performance agreements signed by each employee to ensure achievement of CMS's objectives for the year.
Purpose/importance	Alignment of individual performance agreements to organisation's strategic objectives in improving organisational efficiency
Source/collection of data	Performance agreement and performance appraisal document agreed and signed between staff and line managers
Method of calculation	Count the number of performance contracts signed by 31 May of each year / by total number of employees
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	Same as target
Indicator responsibility	HR Manager/HR Officer

Indicator title	Percentage of employee performance assessments concluded, bi annually
Short definition	Employees are assessed for their key performance indicators bi-annually. Interviews are conducted between the supervisors and subordinates to agree on the performance scores these are signed by both and filed with the HR unit.
Purpose/importance	Alignment of individual performance agreements to organisation's strategic objectives in improving organisational efficiency.
Source/collection of data	Performance agreement and performance review document agreed between employee and line managers. The bi-annual assessments are conducted and finalised by 30 September and 31 March of each year
Method of calculation	number of employees legible to participate in the appraisal cycle / Number of all performance contract signed by employees Only employees in the employment of CMS for at least a period on 9 months are eligible to participate in the performance assessment and rewards. Employees employed for less than 9 months (by the second assessment period) are considered too new to be assessed. Employees that resign during the first performance assessment cycle will not be included. Those employees who resign during the second assessment cycle and have been here for the full period of 12 months will be considered and performance bonus pro-rated accordingly.
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Bi Annually
New indicator	No
Desired performance	100%
Indicator responsibility	HR Manager/HR Officer

1.5. Programme 1.5 (Legal Services Unit)

1.5.1. Strategic Objective 1.5.3.1 - Legal advisory service for effective regulation of the industry and management of the office

Indicator title	Percentage of written and verbal legal opinions generated internally to internal and external stakeholders; per year
Short definition	Render prompt reliable written and verbal legal opinions and representations to Council and other business units
Purpose/importance	The actions of Council and the Registrar are protected and take place within the context of sound legal advice
Source/collection of data	A register of all opinion provided is kept
Method of calculation	number of legal opinions generated internally / total number of legal opinion generated (this number includes legal opinions drafted externally) x 100
Data limitations	Matters of a legal nature are unpredictable and therefore can only be estimated
Type of indicator	Measures activities
Calculation type	Percentage
Reporting cycle	Quarterly
New indicator	Continues without change from the previous year
Desired performance	Higher
Indicator responsibility	General Manager: Legal Services

1.5.2. Strategic Objective 1.5.3.2 - Support CMS mandate by defending decisions of Council and the Registrar

Indicator title	Percentage of court and tribunal appearances in legal matters received and handled by the unit per year
Short definition	Take responsibility for litigation against the Registrar and the Council to enforce the Medical Schemes Act.
Purpose/importance	Decisions of Council and Registrar are protected and enforced in accordance with the Act
Source/collection of data	A register of all matters is kept.
Method of calculation	Percentage calculation by dividing the number of matters handled by the number of matters received *100. A simple count will be performed at the beginning and at the end of each reporting period.
Data limitations	Matters of a legal nature are unpredictable and therefore can only be estimated, therefore matters handled are being counted and not matters resolved as some matters may await an outcome for a long period of time or may be inconclusive. It is also very difficult to determine how many matters will be received in any given period of time as this will depend on enforcement action and initiatives by other units in the office, such as the compliance unit.
Type of indicator	Measures activities
Calculation type	Simple addition and percentage calculation.
Reporting cycle	Quarterly
New indicator	Counts will continue without change from the previous year, but a percentage calculation will be performed based on a count of matters received as well as a count of matters handled for a specific period.
Desired performance	100% of all matters received should be in a state of being handled for any given period.
Indicator responsibility	General Manager: Legal Services

2. Programme 2 (Strategy office)

2.1. Strategic Objective 2.1.1 Formulate Prescribed Minimum Benefits definitions to ensure members are adequately protected

Indicator title	The number of PMB definitions and CMS scripts articles published per year
Short definition	Number of Prescribed minimum benefit reports and number of CMS script articles produced
Purpose/importance	Benefit definitions and CMS scripts are provided in order to clarify member entitlements prospectively thereby reducing the number of complaints received by the Complaints and Adjudication unit.
Source/collection of data	CMS website
Method of calculation	Count publications

Q1	Q2	Q3	Q4
3 CMScripts published	3 CMScripts 2 PMB Definition published	2 CMScripts	2CMScripts 2 PMB Definition published

Data limitations	None
Type of indicator	Output
Calculation type	Numbers
Reporting cycle	Quarterly
New indicator	No
Desired performance	4 benefit definitions and 10 CMScripts published
Indicator Responsibility	Senior Manager Clinical Unit

2.2. Strategic Objective 2.2.1 Provide clinical opinions to resolve complaints and enquiries

Indicator title	Percentage of clinical complaints reviewed within 30 days of receipt from Complaints Adjudication
Short definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit and via e-mail and telephonic enquiries with the view to ensure that member's complaints and enquiries are resolved
Purpose/importance	To protect the members of the medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.
Source/collection of data	M-Files Complaints Database and Clinical database
Method of calculation	Count of clinical opinions, Electronically via the complaints database, register maintained by the unit for BMU, email and telephone Enquiries and Demarcation (manual count) (total number of clinical opinions completed / total number of clinical opinion received for the period)

Q1	Q2	Q3	Q4
90% Complaints within 30 days	90% Complaints within 30 days	90% Complaints within 30 days	90% Complaints within 30 days

Data limitations	Dedicated database for all clinical opinions does not exist. The current statistics are extracted from the M-Files Document Centre. Communicated to IT and during Operation Planning session unit will be developing a spreadsheet to maintain evidence of all e-mail and telephonic enquiries
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Monthly, Quarterly and Yearly
New indicator	No
Desired performance	To attend to 100% of all clinical opinions within the timeframes of the SOP
Indicator responsibility	Senior Manager: Clinical Unit

Indicator title	Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days
Short definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit and via e-mail and telephonic enquiries with the view to ensure that member's complaints and enquiries are resolved
Purpose/importance	To protect the members of the medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.
Source/collection of data	M-Files Complaints Database and Clinical database
Method of calculation	Count of clinical opinions, Electronically via the complaints database, register maintained by the unit for BMU, email and telephone Enquiries and Demarcation (manual count) (total number of clinical opinions completed / total number of clinical opinion received for the period)

Q1	Q2	Q3	Q4
90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days	90% of email and telephone Enquiries within 7 days

Data limitations	Dedicated database for all clinical opinions does not exist. The current statistics are extracted from the M-Files Document Centre. Communicated to IT and during Operation Planning session unit will be developing a spreadsheet to maintain evidence of all e-mail and telephonic enquiries
Type of indicator	Output
Calculation type	Percentage
Reporting cycle	Monthly, Quarterly and Yearly
New indicator	No
Desired performance	To attend to 100% of all clinical opinions within the timeframes of the SOP
Indicator responsibility	Senior Manager: Clinical Unit

3. Programme 3 (Accreditation Unit)

3.1. Strategic Objective 3.2.1. – Accredit brokers based on their compliance with the requirements for accreditation in order to provide broker services

Indicator title	Number of brokers and broker organisations that comply with the accreditation requirements are accredited within 21 working days of receipt of complete applications
Short definition	Broker and broker organisation applications that meet the accreditation requirements are accredited
Purpose/importance	Indicates the total number of new and renewal broker and broker organisation applications received and accredited within 21 working days from date of receipt of complete information. Additional information is requested in respect of incomplete applications and unsuccessful applicants are informed of the reasons for not being accredited.
Source/collection of data	Applications are recorded and accredited on the database and accreditation updated on the website
Method of calculation	Count number of complete applications received that meet the accreditation requirements accredited within 21 working days
Data limitations	None
Type of indicator	Output
Calculation type	Number
Reporting cycle	Quarterly
New indicator	Revised
Desired performance	To process 100% of all broker and broker organisation applications that meet the accreditation requirements within 21 working days of receipt of complete application. An increase or decrease in the number of applications accredited is merely an indication of the number of actual applications received and does not necessarily indicate a better or worse performance in terms of the stated objective.
Indicator responsibility	Accreditation Manager: Brokers and General Manager: Accreditation

3.2. Strategic Objective 3.2.2. - Accredit Managed Care Organisations (MCOs) based on their compliance with the accreditation requirements in order to provide managed care services as defined

Indicator title	Number of managed care organisation applications accredited within 3 months of receipt of all relevant information
Short definition	Indicates the number of Managed Care Organisation applications accredited within 3 months of receipt of all relevant information, subject to approval by the Council's Executive Committee. New and renewal applications are included. Applications must meet the three key requirements for accreditation: • The applicant must be fit and proper; • The applicant must have the necessary systems, resources, skills and capacity to provide the managed care services; and • The applicant must be financially sound.
Purpose/importance	Indicates the workload in terms of new and renewal managed care organisation accreditation applications accredited within the set timeframes during the period; Once processed, applicants are either accredited, additional information is requested in respect of incomplete applications, or unsuccessful applicants are informed of the reasons for non-accreditation.
Source/collection of data	• Written accreditation applications in the prescribed format; • Acknowledgement of receipt of application sent to applicant; • Managed Care Accreditation Steering Committee minutes; • Council Executive Committee minutes; and • Accreditation certificate. • Accreditation status updated on the website
Method of calculation	Applications are recorded on the database and accredited. On-site evaluations are conducted to measure compliance with standards
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	quarterly
New indicator	Revised
Desired performance	To process 100% of all complete applications received that meet the accreditation requirements within 3 months of receipt. An increase or decrease in the number of managed care organisation accreditation applications accredited is merely an indication of the workload and does not necessarily indicate a better or worse performance in terms of the stated objective.
Indicator responsibility	Accreditation Manager: Administrators & MCOs and General Manager of Unit

3.3. Strategic Objective 3.2.3. – Accredit Administrators and issue Compliance Certificates to Self-Administered schemes based on their compliance with the accreditation requirements in order to provide administration services

Indicator title	Number of applications by administrators and self-administered schemes accredited within 3 months of receipt of all relevant information
Short definition	Administrator applications accredited, and self-administered schemes approved for issuance of the compliance certificate, within 3 months of receipt of all relevant information, subject to approval by the Council's Executive Committee. New and renewal applications are included. Applications must meet the three key requirements for accreditation: • The applicant must be fit and proper; • The applicant must have the necessary systems, resources, skills and capacity to provide the services; and
	• The applicant must be financially sound.
Purpose/importance	Indicates the workload in terms of new and renewal administrator accreditation applications accredited, and new and renewal compliance certificate applications approved, within the set timeframes during the period. Once processed, applicants are either accredited, additional information is requested in respect of incomplete applications, or unsuccessful applicants are informed of the reasons for non-accreditation.
Source/collection of data	• Written accreditation and compliance certificate applications in the prescribed format; • Acknowledgement of receipt of application sent to applicant; • Administrator Accreditation Steering Committee minutes; • Council Executive Committee minutes; and • Accreditation or Compliance certificate. • Accreditation status updated on the website
Method of calculation	Applications are recorded on the database and processed. On-site evaluations are conducted to measure compliance with standards
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	quarterly
New indicator	Revised
Desired performance	To process 100% of all complete applications received that meet the requirements for accreditation within 3 months of receipt. An increase or decrease in the number of administrator and self-administered scheme new and renewal accreditation or compliance certificate applications accredited/approved is merely an indication of the workload and does not necessarily indicate a better or worse performance in terms of the stated objective.
Indicator responsibility	Accreditation Manager: Administrators & MCOs and General Manager of Unit

4.Programme 4 (Research and Monitoring Unit)

4.1. Strategic Objective 4.2.1: To ensure that a Practice Code Numbering system is administered by an approved entity in order to facilitate claims payment and resource planning

Indicator title	Number of quarterly reports received from the PCNS service provider reflecting active practice code numbers, per year
Short definition	Assessing performance of the entity appointed to administer the Practice Code Numbering System (PCNS)
Purpose/importance	To ensure that treating provider is correctly identified in the billing statement as per Regulation 5 (e)
Source/collection of data	The provider registry maintained by the approved entity on behalf of CMS
Method of calculation	Quarterly reports incorporating number and categories of providers registered on the PCNS submitted by the approved entity within 30 days of the end of a quarter.
Data limitations	The data is limited to those providers who register for purposes of submitting claims to medical schemes
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	All quarterly reports to be submitted on time
Indicator responsibility	General Manager: Research & Monitoring

4.2. Strategic Objective 4.4.1 Conduct research to inform appropriate policy interventions

Indicator title	Number of research projects and support projects finalised, per year
Short definition	The total number of research projects and technical support projects completed in a financial year
Purpose/importance	To ensure continuous improvement of policy and regulatory interventions by the CMS in influencing performance of the medical schemes industry
Source/collection of data	Research and support reports approved at the EMC and Council. Most of the data is collected through the Annual Statutory Returns system or ad-hoc requests for data from the industry.
Method of calculation	Number of research and support projects produced
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Annual
New indicator	No
Desired performance	All the approved projects completed on time with clear recommendations
Indicator responsibility	General Manager: Research & Monitoring

4.3. Strategic Objective 4.4.2 Monitoring trends to improve regulatory policy and practice

Indicator title	Non-financial report submitted for inclusion into the annual report
Short definition	The analysis of clinical, demographic, utilisation and benefits paid data received through the Statutory Return by medical schemes
Purpose/importance	Monitor trends in the environment and also to provide influential strategic advice and support for the development and implementation of strategic health policy
Source/collection of data	Annual Statutory Return system
Method of calculation	Statistical analyses and report of the data in the above-stipulated categories
Data limitations	Data received from medical schemes is sometimes inaccurate or under reported
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Annual
New indicator	No
Desired performance	Report on the analysis of non-financial and demographic data is completed in time to be published in the annual report
Indicator responsibility	General Manager: Research & Monitoring

5. Programme 5 (Stakeholder Relations Unit)

5.1. Strategic Objective 5.2.1 - Create awareness and provide training in order to enhance the visibility and reputation of CMS

Indicator title	Percentage of member awareness of CMS resulted from survey
Short definition	To measure the awareness of members about the work of CMS
Purpose/importance	The purpose of the survey is to determine how many medical scheme members are aware of the CMS and its roleThe results of the survey will determine what improvements can be implemented for further awareness.
Source/collection of data	A survey will be carried out by SHR in collaboration with medical schemes and a service provider in marketing trends
Method of calculation	Survey results, scientifically calculated
Data limitations	Survey may not cover entire a larger percentage of the population. Members may choose not to partake in the survey
Type of indicator	Impact
Calculation type	Cumulative
Reporting cycle	Annually
New indicator	New
Desired performance	To have all members aware of CMS
Indicator responsibility	General Manager: Stakeholder Relations

Indicator title	Number of stakeholder training and awareness sessions, per year
Short definition	To effectively create awareness and train stakeholders to understand their relevant roles and responsibilities in the medical scheme environment.
Purpose/importance	The indicator measures how effectively consumer awareness was created and stakeholders were trained to keep abreast with the legislative requirements needed to understand their roles and responsibilities.
Source/collection of data	1. Consumer awareness survey completed. 2. Evaluation form completed by attendees after each training session. 3. Number of consumer education sessions; Number of trustee training sessions; Number of Indabas and number of forums 2 = 2 consumer education sessions in first quarter 4 = 4 consumer education sessions in second quarter 6 = 2 trustee training sessions, 4 consumer education sessions 6 = 4 consumer education sessions and 2 accredited trustee training sessions
Method of calculation	Survey results scientifically calculated; scientifically calculate percentage of good/excellent responses received from evaluation forms
Data limitations	Invalid responses in survey and evaluation forms
Type of indicator	Output
Calculation type	Cumulative and non-cumulative
Reporting cycle	Quarterly
New indicator	Revised existing indicator
Desired performance	Higher
Indicator responsibility	SHR managers (communication, contact centre and communication)

5.2. Strategic Objective 5.2.2 - Communication and engagement to inform and empower stakeholders

Indicator title	Publication of CMS' Annual Report by 31 August
Short definition	The production and publication of the CMS Annual Report, newsletters, advertisements and stakeholder engagement to inform and empower stakeholders.
Purpose/importance	Reporting on CMS' financial year and industry trends through the Annual Report, newsletters, advertisements and media engagement better inform and empower stakeholders to fulfil their roles and thereby enhance the reputation of CMS.
Source/collection of data	Annual Report published on CMS website,
Method of calculation	One CMS Annual Report per financial year; simple numerical counting of newsletters and advertisements; Indabas and forums; media monitoring tool
Data limitations	Unavailability of required information and/or sources of information and/or human resources; non-compliance/non-adherence to production schedule and deadlines
Type of indicator	Output
Calculation type	Cumulative and non-cumulative
Reporting cycle	Annual; quarterly
New indicator	Same since revision in 2008
Desired performance	Timeously informed and empowered stakeholders to enhance reputation of CMS
Indicator responsibility	Communications Manager, Contact Centre Manager and General Manager of SHR

Indicator title	Percentage of positive or neutral feedback received on CMS reputation through a media monitoring tool
Short definition	The media monitoring tool allows SHR to monitor, react and be pro-active in enhancing a positive image of CMS
Purpose/importance	To take corrective action in order to enhance service delivery and improve CMS' reputation amongst the general public and media.
Source/collection of data	Media monitoring reports
Method of calculation	Statistics
Data limitations	Unavailability of reports
Type of indicator	Output; outcome; impact
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	Not applicable
Desired performance	Engagement with all schemes, administrators, regulators and other industry stakeholders Increased awareness of the functions of CMS and enhanced reputation of CMS
Indicator responsibility	General Manager: Stakeholder Relations and relevant sub-units

6. Programme 6 (Compliance and Investigation Unit)

6.1. Strategic Objective 6.2.1 Regulated entities comply with Legislation

Indicator title	Percentage of non-compliance cases against regulated entities undertaken, per year
Short definition	When schemes are found to be non-compliant the unit will either conduct an inspection, impose penalties, issue rulings or directives to enforce compliance.
Purpose/importance	The purpose of the indicator is to ensure that medical schemes and regulated entities are fully compliant with the Medical Schemes Act and its Regulations. The unit will ensure that interventions are initiated in 100% of cases.
Source/collection of data	Evidence of all interventions are filed by the unit as well as captured onto the case management system. Commissioned inspection (count letter of appointment sent to the scheme confirming an inspection) impose penalties (On sending a letter to the scheme imposing the penalty issue rulings (this will be counted on the letter sent to the scheme) directives (this will be counted on the letter sent to the scheme)
Method of calculation	Number of cases attended to / number of cases received for the quarter * 100
Data limitations	Some cases may not be captured on the system Some cases may not be captured in the report.
Type of indicator	Output
Calculation type	Percentage calculation
Reporting cycle	Quarterly
New indicator	Indicator has been revised to indicate percentage rather than number
Desired performance	higher
Indicator responsibility	Compliance Officer / Senior Investigator

6.2. Strategic Objective 6.2.2 Strengthen and Monitor governance systems

Indicator title	Number of governance interventions implemented, per year
Short definition	This indicator is intended to show how many forms of governance intervention were instituted
Purpose/importance	This indicator is important to improve governance in medical schemes.
Source/collection of data	EMC report and the Operational plan of the unit
Method of calculation	The indicator is calculated by : Counting the number of annual general and scheme general meetings and elections of trustees meetings monitored and a report prepared which details proceedings of the meetings. (reports issued) Counting the number of reports issued after the vetting of officer of the regulated entities. (reports issued) Counting the number of meetings scheduled in order to monitor the performance of the curator. Counting the number of section 46 notices issued. (letters issued) Counting the number of routine inspection instituted per year. (reports issued) Counting the number of exemption letters sent to scheme communicating the result of the application. Counting the number of Board notices issued to the scheme /industry.
Data limitations	Limitations may arise where: Schemes fail to notify the office of the date of the Annual General meeting or elections Schemes fail to notify the office who their newly elected officers are Non-attendance of monthly report meetings with the office by the Curator /Compliance officer. Lack of co-operation by the inspected regulated entities
Type of indicator	Activities
Calculation type	Cumulative
Reporting cycle	Quarterly
New indicator	No changes to indicator
Desired performance	Lower – indicates fewer interventions needed as schemes are being compliant
Indicator responsibility	Senior investigator/Compliance officer

7. Programme 7 (Benefits management unit)

7.1. Strategic Objective 7.2.1 - Analyse scheme rule amendments

Indicator title	Percentage of interim rule amendments processed within 14 days of receipt of all information per year
Short definition	Is to ensure that rules submitted by the schemes are efficiently and effectively analysed and approved with the stipulated time frames.
Purpose/importance	To ensure that all schemes operate according to the approved rules which are aimed at protecting members and beneficiaries.
Source/collection of data	Submissions of hardcopies of interim rule amendments is captured on a register and excel spreadsheet. The capturing of the date submitted, received by the analyst, date of request of further information and the date of process and sent to the GM is captured for each rule submission.
Method of calculation	The spreadsheet captures all the submission received per quarter and calculates the number of submissions processed within 14 days. This is used to calculate the percentage completed as required.
Data limitations	The indicator is only a measure of the percentage of submissions completed within 14 days. It is based on the number of submissions made by Schemes during each quarter.
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Quarterly
New indicator	It is a revised indicator and the method of calculation has been enhanced.
Desired performance	All submissions made to the office are processed within 14 days.
Indicator responsibility	General Manager: Benefit Management

Indicator title	Percentage of annual rule amendments processed before 31 December of each year
Short definition	The unit ensures that annual rule amendments submitted during September/October are processed before 31 December of that year to enable schemes to operate the benefit year with approved rules.
Purpose/importance	To ensure that the rules that are approved are compliant with the Medical Schemes Act and are not unfair to members of medical schemes.
Source/collection of data	Submission of hardcopies of annual rule amendments are captured on a register and excel spreadsheet. The capturing of the date submitted, received by the analyst, date of request of further information and the date of process and sent to the GM is captured for each rule submission.
Method of calculation	The spreadsheet captures all the annual rule submissions received effective 1 January and calculates the number of submissions processed by 31 December. This is used to calculate the percentage completed as required.
Data limitations	The indicator is only a measure of the percentage of submissions completed by 31 December. It is based on the number of submissions made by Schemes effective 1 January each year.
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	Annual
New indicator	Revised indicator that now calculates the processing of annual rule amendments before 31 December each year.
Desired performance	All submissions made to the office are processed before 31 December 2015.
Indicator responsibility	General Manager: Benefit Management

8. Programme 8 (Financial Supervision Unit)

8.1. Strategic Objective 8.2.1 Monitor and promote the financial soundness of medical schemes

Indicator title	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan received
Short definition	Percentage of recommendations in respect of schemes below solvency where business plans submitted
Purpose/importance	Is to measure monitoring actions in respect of schemes below solvency
Source/collection of data	Content Management system on M-files - CMS Vault – FSU folder
Method of calculation	Count/tally of cases once recommendation has been made
Data limitations	None
Type of indicator	Output
Calculation type	Numbers
Reporting cycle	Quarterly
New indicator	Existing
Desired performance	100% of submissions received per year
Indicator responsibility	General Manager: Financial Supervision

Indicator title	Recommendations on action plans for schemes with rapidly reducing solvency (but above statutory minimum) for 100% of schemes identified
Short definition	Percentage of recommendations in respect of identified schemes with rapidly reducing solvency
Purpose/importance	Is to measure monitoring actions in respect of schemes with rapidly reducing solvency
Source/collection of data	Content Management system on M-files - CMS Vault – FSU folder
Method of calculation	Count/tally of cases once recommendation has been made
Data limitations	None
Type of indicator	Output
Calculation type	Numbers
Reporting cycle	Monthly, quarterly and annually
New indicator	Yes
Desired performance	100% of identified schemes per year
Indicator responsibility	General Manager: Financial Supervision

Indicator title	Number of Quarterly financial return reports published (excluding quarter 4)
Short definition	This indicator measures the number of quarterly reports published per year,
Purpose/importance	This indicator measures the performance of medical schemes during the year, as part of the Early Warning system.
Source/collection of data	CMS Website. Publication Quarterly reports
Method of calculation	Count/tally of cases once quarterly reports are published on CMS website
Data limitations	None
Type of indicator	Output
Calculation type	Numbers
Reporting cycle	Quarterly
New indicator	Existing
Desired performance	1 Quarterly Report per quarter, except the last quarter of the year
Indicator responsibility	FSU Analyst (Project leader: Quarterly Returns project)

Indicator title	Number of financial sections prepared for the Annual Report
Short definition	This indicator measures the number of financial sections prepared in respect of the Annual Report
Purpose/importance	This indicator measures the performance of medical schemes
Source/collection of data	CMS Website. Publication Annual Report.
Method of calculation	Count/tally of cases once annual report been published on CMS website
Data limitations	None
Type of indicator	Output
Calculation type	Numbers
Reporting cycle	Annually
New indicator	Existing
Desired performance	1 set of input in respect of the financial sections of the Annual Report in 2015/16
Indicator responsibility	General Manager: Financial Supervision

9. Programme 9 (Complaints Adjudication Unit)

9.1. Strategic Objective 9.2.1 - Resolve complaints with the aim of protecting beneficiaries of medical schemes

Indicator title	Percentage of complaints adjudicated within 120 working days and in accordance with complaints procedure, per year
Short definition	As per the provisions of section 47 (2) of the Medical Schemes Act 131/1998, complaints must be resolved as soon as possible after receipt of comments from parties complained against or referred to Council for resolution if they cannot be resolved by the Registrar's Office.
Purpose/importance	To ensure speedy resolution of complaints with the aim of protecting beneficiaries of medical schemes
Source/collection of data	CMS Complaints Adjudication IT system
Method of calculation	Electronically via the complaints database
Data limitations	Requires improvement and this has been communicated to the IT developers
Type of indicator	Output
Calculation type	Cumulative
Reporting cycle	quarterly
New indicator	The indicator has been revised
Desired performance	A higher percentage of resolved complaints indicates higher performance
Indicator responsibility	Senior Manager and Legal Adjudication Officers

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