STRATEGIC PLAN 2013/14

FOR THE FISCAL YEARS 2011/12 – 2014/15

Final

8 November 2012

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Foreword

During its 12 years of existence, the Council for Medical Schemes has built a proud culture of protecting beneficiaries of medical schemes by enforcing the provisions of the Medical Schemes Act (131 of 1998). The pillars of the Act are the requirements for open enrolment, community rating and prescribed minimum benefits. Linked with the governance requirements stipulated in the Act, these provisions protect beneficiaries against discrimination based on health status and other arbitrary grounds.

In spite of spending comparatively large sums on health care, the life expectancy of South Africans are much lower than that of other countries at similar levels of development, which spend similar amounts on health care. The health system is also marred by inequitable access to care and health care resources.

Government's Programme of Action 2009 highlights ten priority areas for government up to 2014, and includes the goal of improving the health of all South Africans. (See paragraph 2.3.1 on page 9 of the strategic plan). To support this goal, the Department of Health has developed a ten point plan (paragraph 2.3.2, page 10), which identifies the development of a National Health Insurance System (NHI) as a priority. Another priority is indicated as the overhauling of the public health system. In his budget speech of February 2011, the Minister of Finance has indicated that considerable amounts have been allocated towards the improvement of the public health system in preparation for NHI in the 2011/12 budget, and that government will engage with potential funding models for NHI in the next period. Council enthusiastically supports these initiatives, and this strategic plan indicates that considerable effort and resources are allocated towards this goal.

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 health care prices, and leaves many medical scheme beneficiaries unprotected. The office supports the Department in the development of an alternative mechanism for the determination of private health care prices.

Due to governance failures, 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 attract high legal costs and increase the cost of regulation, the cost of regulating the medical schemes industry amounts to a mere 0.01% of contributions paid to medical schemes.

In the planning period, Council will strengthen its prospective regulatory functions, while maintaining its concurrent and retrospective regulatory activities.

I thank the Registrar and his staff for the development of this strategic plan, and wish them well in the execution of these plans. The plans are endorsed by Council, who is committed to ensuring that the required resources are made available for the execution of this plan.

Mr Trevor Bailey

Acting Chairperson: Council for Medical Schemes

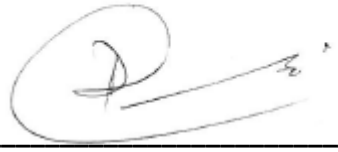
Certification

It is hereby certified that this Strategic Plan:

Was developed by the management of the Council for Medical Schemes under the guidance of Council

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 2013/14.

Daniel Lehutjo **Signature:** 

Chief Financial Officer

Boshoff Steenekamp **Signature:** 

Strategic Projects Specialist

Monwabisi Gantsho **Signature:** 

Registrar and Chief Executive Officer

Approved by:

T Bailey **Signature:** 

Acting Chairperson: Council for Medical Schemes

Part A: Strategic overview

1. CMS vision, mission and values

1.1. Vision

We strive to be a fair custodian of equitable access to medical schemes in order to support the improvement of universal access to healthcare.

1.2. 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; and
- advising the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives.

1.3. 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.

2. Legislative and other mandates

2.1. Constitutional mandates

Section 27 of the Constitution places the obligation of the state to make reasonable legislation to progressively realise access to healthcare. The Medical Schemes Act (131 of 1998) represents such legislation, which creates the framework for non-discriminatory access to medical schemes. More details on access to medical schemes are presented in paragraph 3.3 (page 17).

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.

2.2. Legislated mandates

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

a) protect the interests of the beneficiaries at all times;
b) control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy;
c) 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;
d) investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act;
e) collect and disseminate information about private health care;
f) 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;
g) advise the Minister on any matter concerning medical schemes; and
h) perform any other functions conferred on the Council by the Minister or by the Act.

2.3. 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.

2.3.1. Governments programme of Action – 10 priority areas up to 2014

1) speed up **economic growth** and transform the economy to create decent work and sustainable livelihoods;
2) introduce a massive programme to build **economic and social infrastructure;**

3) develop and implement a comprehensive **rural development** strategy linked to land and agrarian reform and food security;
4) strengthen the **skills and human resource base;**
5) improve the **health profile** of all South Africans;
6) intensify the fight against **crime** and corruption;
7) build cohesive, caring and sustainable **communities;**
8) pursue **African advancement** and enhanced international cooperation;
9) ensure **sustainable resource management** and use; and
10) build a **developmental state**, improve public services, and strengthen democratic institutions.

2.3.2. The Department of Health's ten point plan

1) Provision of strategic leadership and creation of a social compact for better health outcomes.
2) Implementation of a National Health Insurance Plan (NHI).
3) Improving quality of services.
4) Overhauling the health care system and improve its management.
5) Improved Human Resources Planning, Development and Management.
6) Revitalisation of infrastructure.
7) Accelerate implementation of the HIV & AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increase focus on tuberculoses (TB) and other communicable diseases.
8) Mass mobilisation for better health of the population.
9) Review of the drug policy.
10) Strengthen research and development.

2.3.2.1. Key elements in the implementation of a NHI

a) Finalise policy proposal on the NHI.
b) Finalise draft of legislation to support the creation of the NHI.
c) Set up National Quality Management and Accreditation Body.
d) Perform an audit of Health Information and Communications Technology (ICT) at all levels of the National Health System public sector only.
e) Draft the National ICT Strategy for Health.

The Department of Health (DoH) has published a draft policy paper in the Government Gazette of 12 August 2011, and Council has engaged with this draft policy and has submitted comments to the Department of Health[1].

[1] CMS comments on the NHI green paper, available at: http://www.medicalschemes.com/files/National%20Health%20Insurance/CMSCommentsOnDraftNHIPolicy_20120119.pdf

2.4. **Relevant court rulings**

The Guardrisk court case, which has ruled that some gap-cover health insurance products are not in contravention of the Act, places 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.

Close collaboration with National Treasury has resulted in the development of a draft set of regulations under the Insurance laws, which are due for publication soon. The objective if these regulations are to address the demarcation between medical schemes and health insurance products.

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 DoH 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.

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.

3. Situational analysis

3.1. Context

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**[2], 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

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

- **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.

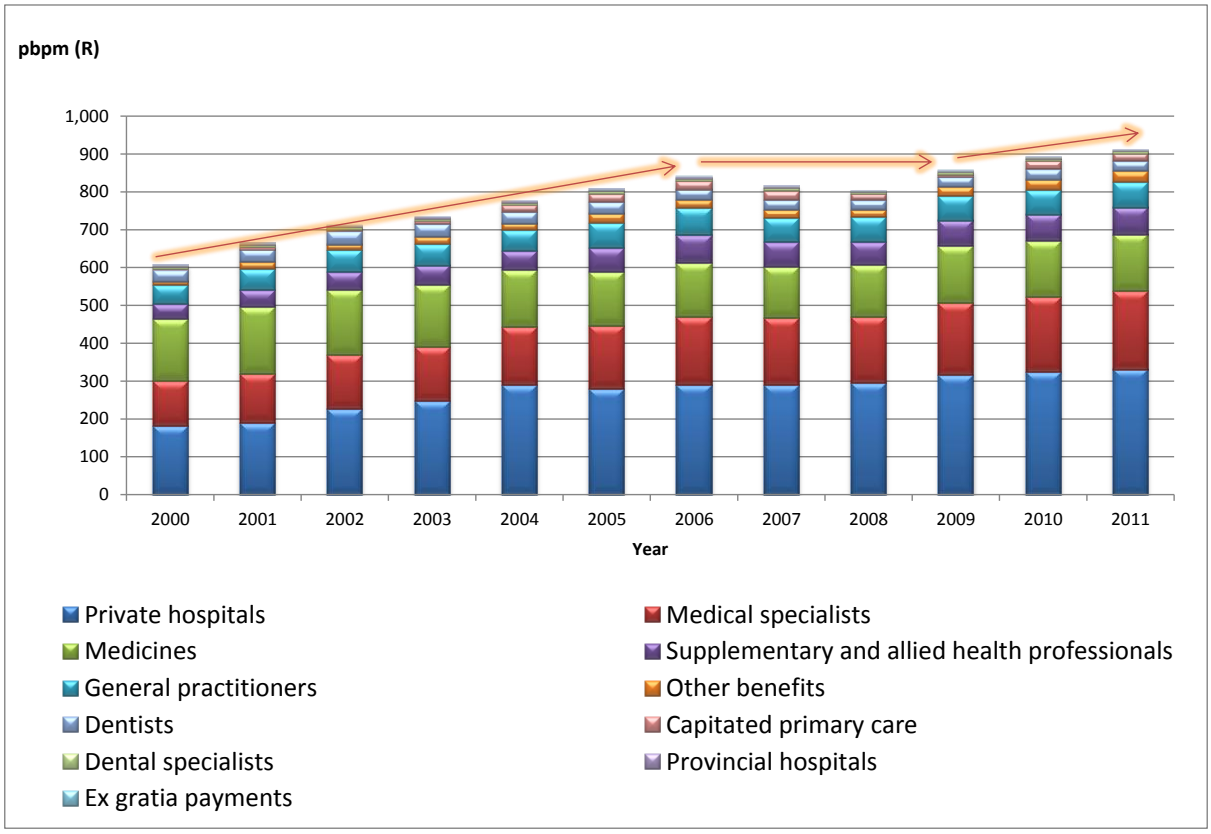
The introduction of the above measures ensures that all health insurers operate on a level playing field, which maximises the advantages and minimise the disadvantages of a competing and highly commercialised multi-fund health system. However, many facets of the funding and provision of private health 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.

3.2. **Developments over the past ten years**

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 1, page 14);
- 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 2, page 15);
- Introduction of new solvency requirements which reduced the risk of rapid unforeseen insolvencies in schemes;
- After 2001 introduced 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;
- From 2001 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
- Introduction of a complaints system from 2000 and a call centre from 2003, which established a more organised interface with the public.

Figure 1: Trends in benefits paid per beneficiary per month from 2000 to 2011 (2011 prices)

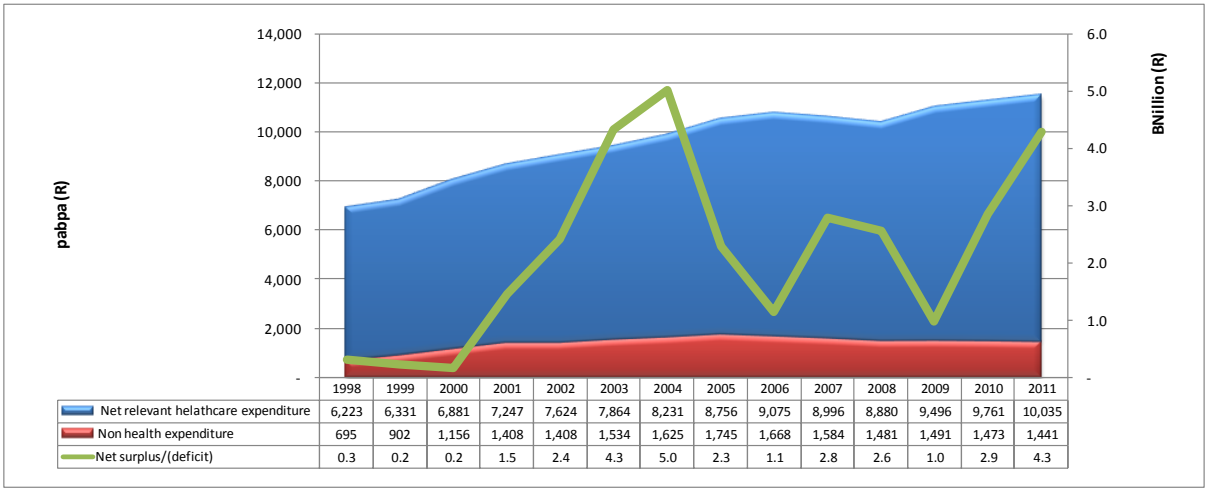


Source: Council for Medical Schemes, Annual Reports.

The trend in health benefits paid showed a large increase between 2000 and 2006, appeared to be stabile between 2006 and 2009, but again showed steep increases from 2009.

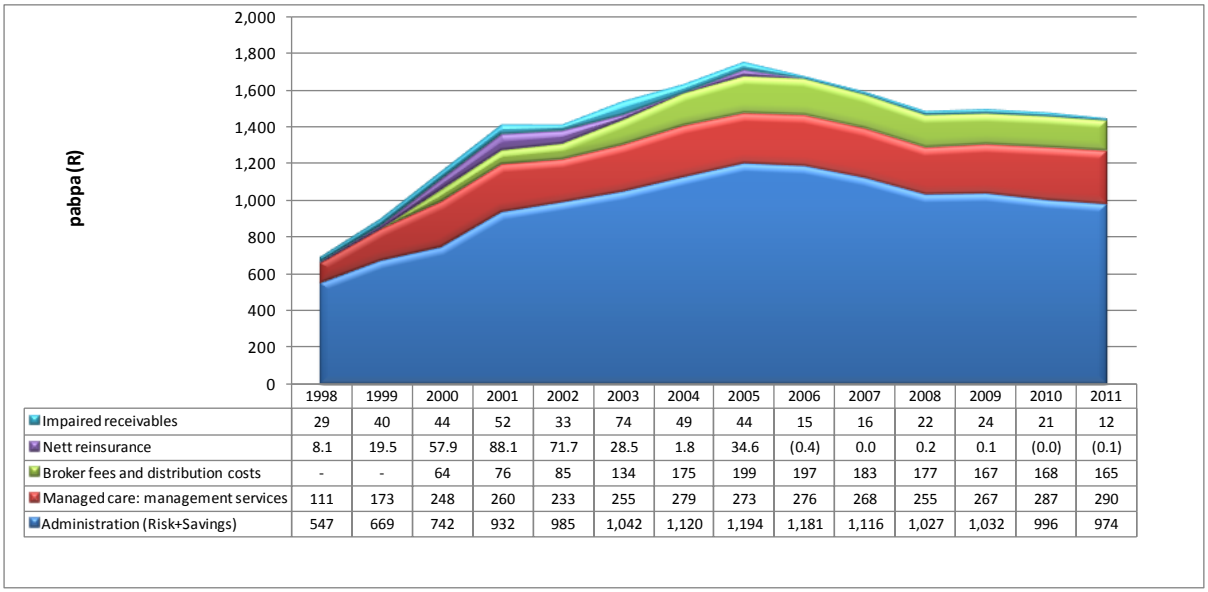
The high level of increases in specialist and hospital costs are not sustainable in the long run, and the CMS will continue to support the Ministry of Health to develop a firm and transparent price determination process and systems.

Figure 2: Net relevant health and non-health expenditure trends per beneficiary per annum from 1998 to 2011 (2011 prices) and net results



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Net relevant helathcare expenditure	6,223	6,331	6,881	7,247	7,624	7,864	8,231	8,756	9,075	8,996	8,880	9,496	9,761	10,035
Non health expenditure	695	902	1,156	1,408	1,408	1,534	1,625	1,745	1,668	1,584	1,481	1,491	1,473	1,441
Net surplus/(deficit)	0.3	0.2	0.2	1.5	2.4	4.3	5.0	2.3	1.1	2.8	2.6	1.0	2.9	4.3

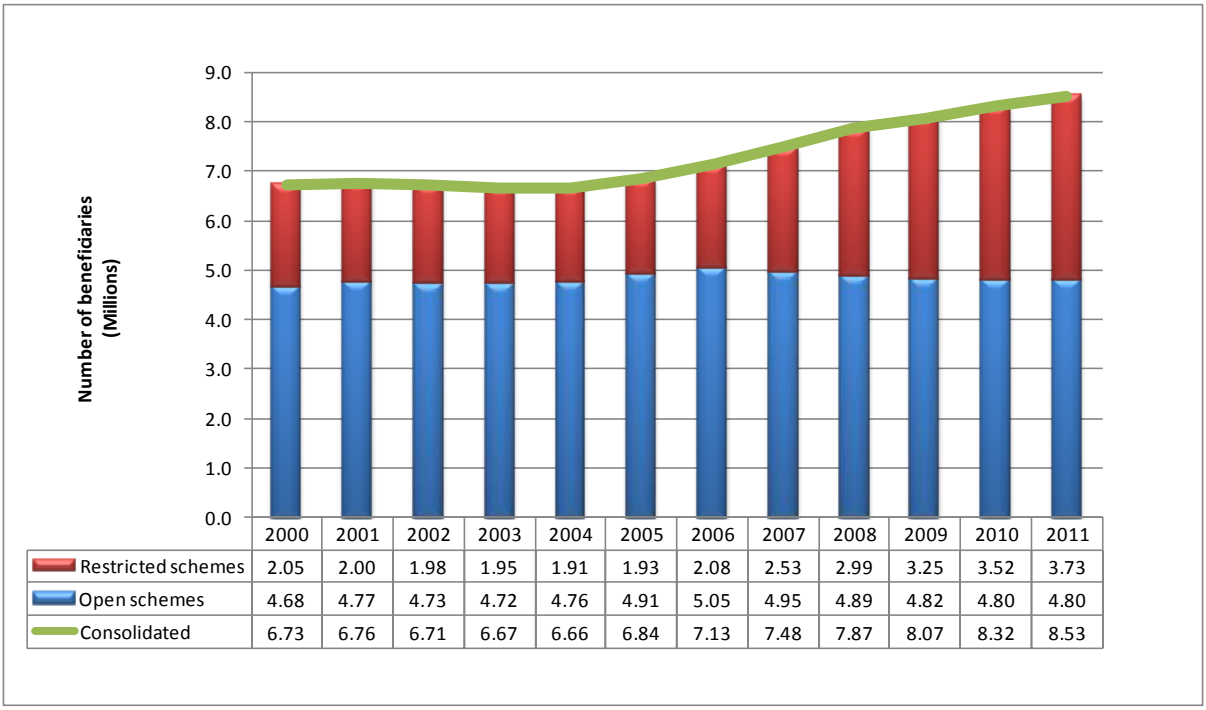
Figure 3: Non-health expenditure trends per beneficiary per annum from 1998 to 2011 (2011 prices)



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Impaired receivables	29	40	44	52	33	74	49	44	15	16	22	24	21	12
Nett reinsurance	8.1	19.5	57.9	88.1	71.7	28.5	1.8	34.6	(0.4)	0.0	0.2	0.1	(0.0)	(0.1)
Broker fees and distribution costs	-	-	64	76	85	134	175	199	197	183	177	167	168	165
Managed care: management services	111	173	248	260	233	255	279	273	276	268	255	267	287	290
Administration (Risk+Savings)	547	669	742	932	985	1,042	1,120	1,194	1,181	1,116	1,027	1,032	996	974

Source: Council for Medical Schemes, Annual Reports.

Figure 4: Number of medical Scheme Beneficiaries (2000 – 2011)

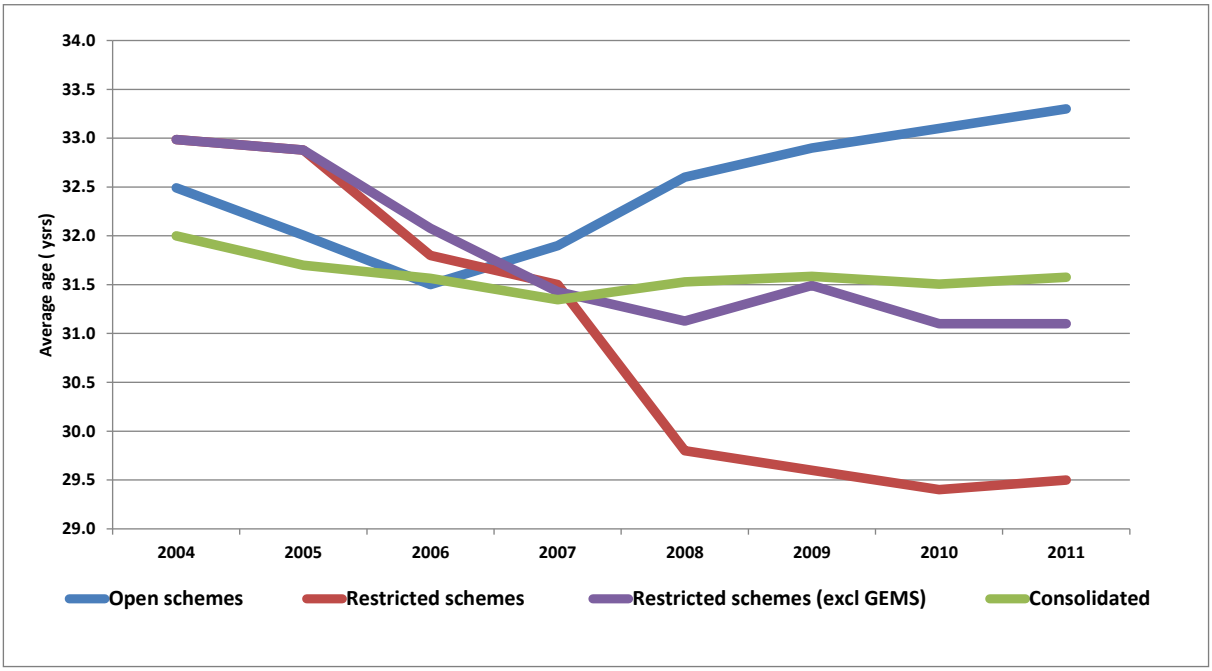


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Restricted schemes	2.05	2.00	1.98	1.95	1.91	1.93	2.08	2.53	2.99	3.25	3.52	3.73
Open schemes	4.68	4.77	4.73	4.72	4.76	4.91	5.05	4.95	4.89	4.82	4.80	4.80
Consolidated	6.73	6.76	6.71	6.67	6.66	6.84	7.13	7.48	7.87	8.07	8.32	8.53

Source: Council for Medical Schemes, Annual Reports.

Despite the positive trends in costs, both claims costs and non-health costs, 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 below 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.

Figure 5: Trends in the Average Age of Beneficiaries (2000 – 2011)



3.3. **Access to health care – Risk pooling**

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.

3.3.1. 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.

The implementation of a fully community rated system requires:

- *A system of risk adjustment which adjusts for the difference in risk profiles of benefit options and schemes;*
- *An expanded and more clearly defined set of mandatory minimum benefits (MMB);*
- *Clear separation within schemes between mandatory minimum benefits and supplementary benefits; and*
- *A more clearly defined set of contribution tables which: prevents de-facto risk rating through the manipulation of contribution tables; distinguish between mandatory and supplementary benefits; and separate out broker fees.*

3.3.2. Benefit coverage

Some medical schemes manipulate beneficiary entitlements through shifting claims that should be insured into the self-insured (medical savings account and equivalent benefits as well as out-of-pocket payments) portion of benefits. Members usually do not understand their schemes fully and have difficulty engaging with their scheme's rules. The present regulatory framework does not provide enough protection due to structural difficulties involved in expanding MMBs (due to the absence of an industry wide community rating mechanism), which is necessary to simplify the way in which entitlements are reflected in scheme rules.

The implementation of a revised framework to protect access to medical scheme benefit entitlements should encompass the following measures:

- *MMBs must be defined as benefit packages, rather than merely disease treatment pairs (DTPs) which can be simply expressed in the rules;*
- *Overall benefit designs need to be standardised and simplified, with a clear framework to govern benefit exclusions (to prevent beneficiaries from finding out too late what they're not covered for);*

- *All rules relating to benefits should be filed electronically, with electronic validations used to verify compliance with the Act and with the requirements for transparency;*
- *Marketing material must provide clear information on entitlements, and be subject to oversight by the CMS (already happening, but there are limitations due to the lack of standardisation);*
- *The rules regarding the use of Designated Service Providers (DSPs) and protocols, particularly where they involve the public sector must be tightened up to prevent schemes using these as a means to indirectly deny benefits;*
- *A price regulation framework must be introduced to fix the levels at which MMBs are funded, as well as to regulate the extent of balance billing and the improper application of co-payments.*

3.3.3. Open enrolment

Open enrolment is a cornerstone of the medical schemes system ensuring free movement between schemes and options without penalty. The implementation of the Government Employee's Medical Scheme (GEMS), which is able to restrict access to members, has impacted negatively on this framework. This has caused some schemes to refuse (bad risk) members that should have been taken up by GEMS.

Again the example of Transmed and GEMS can be used. Besides the Regulation 8 challenge which was set aside by the Supreme Court of appeal, other assaults on risk pooling, and community rating, 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.

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.*

3.3.4. Full community rating

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 at least three years implementing a system of full community rating, with material implications for the evolution of the medical schemes system. The impact of GEMS, which is causing systemic distortions in scheme risk profiles, has resulted in a number of harmful scheme failures, which left members with unpaid hospital bills. This trend is expected to continue for the next few years.

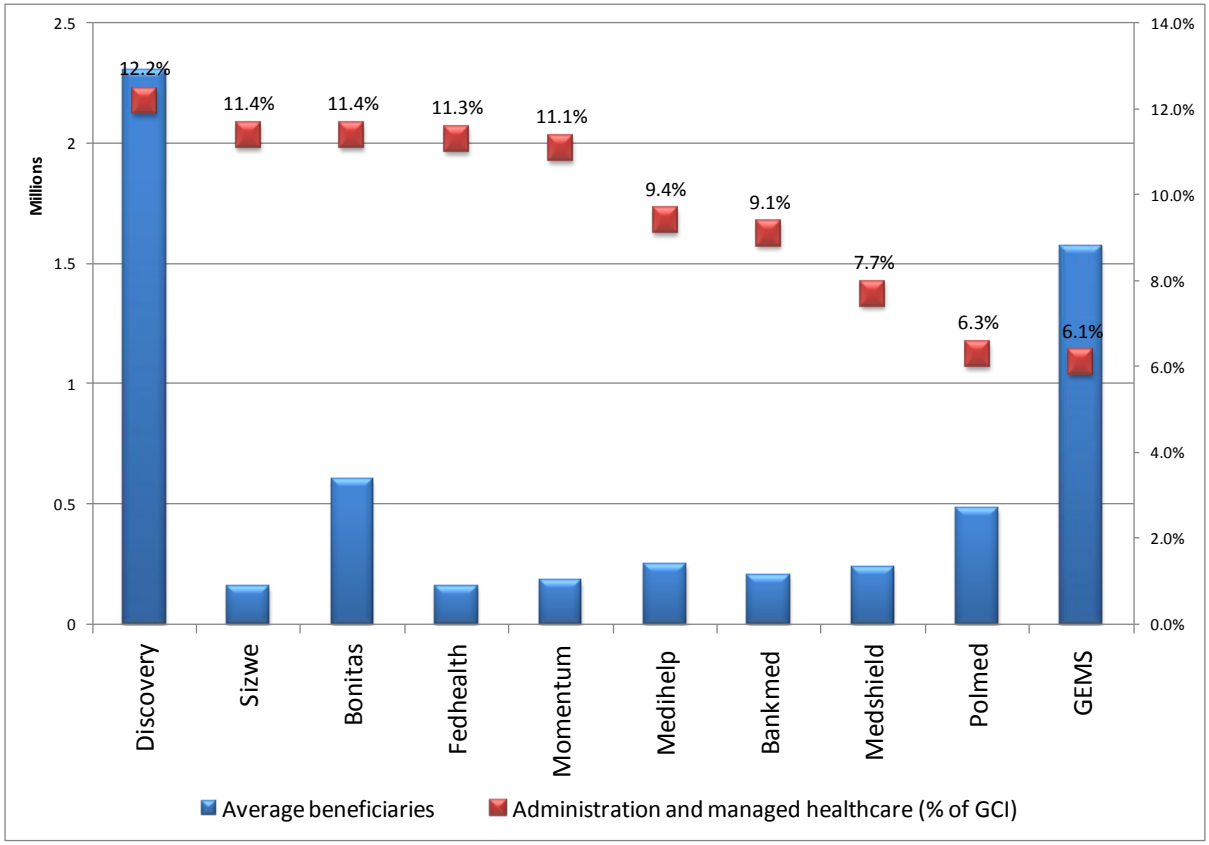
Further preparations for a system of full community rating, which includes the development of a central beneficiary registry, will continue. Final implementation should occur in conjunction with changes to the benefit framework.

3.3.5. Affordability – costs

Real cost increases, primarily due to hospital and specialist cost increases, during the latter part of the 1990s and early 2000s effectively restricted beneficiary growth. Although pharmaceutical cost increases were to a degree contained from 2004, the failure to implement a comprehensive reform left many gaps for prices and costs to come through hospital fee increases and professional fees. There is therefore a need to provide a permanent and stable price determination framework for the private sector sufficient to remove historical distortions.

Non-healthcare costs are also a problem, with administration charges and broker fees set without any coherent relationship to value-add. Administration costs do not vary predictably with scale, in the market, suggesting that these fees are not set competitively. When the highest cost schemes are compared with GEMS (Figure 6) it is clear that administration costs are excessive. For instance, Discovery Health Medical Scheme's (DHMS) administration cost per beneficiary per month is nearly three times that of GEMS, despite DHMS having almost twice the scale of GEMS. The average for open schemes is also more than double the cost of GEMS. These high costs are consequently unrelated to scale, and may have more to do the governance of these schemes.

Figure 6: Administration and managed care costs of 10 largest schemes (2011)



A factor contributing to weak scheme performance may involve the existence of conflicted brokers who have incentives to offer poor advice given their sources of income. The Act presently permits a scheme to provide broker commissions rather than the beneficiaries or employers served. It also fails to discount medical scheme contributions where no use is made of a broker. As such, ordinary consumer pressure on schemes to perform properly is diminished due to conflicted advice while brokers receive remuneration without having to provide value adding services. The former adds cost to the scheme while the latter adds cost to the broker service.

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;*
- *The implementation of full community rating to incentivise price competition between schemes on claims costs;*
- *Request that the Department of Health expedite the implementation of the full pharmaceutical reform framework, which would include:*
  - *International benchmarking of prices charged in the domestic private market;*
  - *Parallel importation of medicines;*
  - *Proper regulation of logistics fees paid by pharmaceutical manufacturers;*
  - *The proper regulation of dispensing by general practitioners and specialists;*
- *The implementation of governance reforms for schemes (discussed below);*
- *The introduction of broker reforms which would include:*
  - *A prohibition on schemes, administrators, managed care companies from paying brokers;*
  - *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.*

3.3.6. 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 MMB framework (needed for risk pooling purposes) which could end up excluding low-income groups. In addressing this consequence, two mechanisms were considered. The first being the Low-income Medical Schemes (LIMS) framework which would have exempted lower income groups from the full MMB – the disadvantage is that it would create a third tier in access health care. The second was to see the introduction of a limited contribution subsidy to compensate low-income groups for not claiming their implicit subsidy for state services or being able to claim the tax subsidy. This should be financed from a restructuring of the existing tax subsidy on a zero-sum basis. Both these options are subject to the future developments of the NHI.

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 exemption framework for MMBs must be considered for persons in lower income bands; 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.*

3.3.7. 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, access may be restricted through incentives provided by schemes. In some instances schemes may not permit applications arriving except through a broker, which is a way of providing revenue to brokers. 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. It also requires that administrators have the capacity to deal directly with member applications. This should come about with more stringent requirements placed on administrator accreditation standards and ensuring compliance with the legislation, which requires this.

3.4. Policy harmonisation

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.

3.4.1. Collaboration with the Department towards the development and implementation of the NHI

A discussion document on the implementation of NHI was published by the DoH in August 2011. Depending on the final format that the NHI will take, there are multiple areas where the CMS will support the development of NHI in an attempt to broaden, deepen and heighten access to health care. In its comments on the NHI green paper of 19 January 2012[3], the CMS has made the following recommendations:

Recommendation 1:	Harness available public and private sector resources through the creation of a collaborative atmosphere through a social compact (see Recommendation 2 and Recommendation 9).
Recommendation 2:	Prioritise the continued increase on public health expenditure, strengthen the public service delivery, develop the capacity to purchase from the private sector, and start increasing revenue collection.
Recommendation 3:	Consider corruption containment when designing governance structures.
Recommendation 4:	The national NHI fund should have a governance structure that clearly separates policy-making from oversight and operations; the board must have statutorily defined technical competencies and have the power to appoint and remove the executive (in concurrence with the Minister).

[3] CMS comments on the NHI green paper, available at: http://www.medicalschemes.com/files/National%20Health%20Insurance/CMSCommentsOnDraftNHIPolicy_20120119.pdf

Recommendation 5: The national NHI board must have advisory sub-committees, which should include a clinical governance sub-committee.

Recommendation 6: Independent governance structures, accountable to communities, should be developed for sub-national NHI structures.

Recommendation 7: District health authorities should be established which must be accountable to local communities and provincial governments.

Recommendation 8: The role of public hospital boards should be strengthened so that these boards are independent and accountable to local communities, and have the powers to appoint and remove the executive.

Recommendation 9: Demonstrate the role of the private sector to stakeholders by actively purchasing services from the private sector.

Recommendation 10: Remove the market power imbalance in the determination of healthcare prices through the re-establishment of central bargaining in a statutory pricing regulator.

Recommendation 11: Remove vertical relationships between hospital groups and their supply chain, including relationships with pathology groups, radiology groups, pharmacies and pharmaceutical suppliers, medical device provision, and consumables and surgicals used in-hospital.

Recommendation 12: Remove conflicts of interest with related services that occur through ownership links, shares, inducements of any form, between specialists, emergency transport providers and general practitioners.

Recommendation 13: Reduce market concentration and private bed proliferation in the major metropolitan areas through improvements in the hospital licensing system; licensing should require a minimum level of diversity in hospital ownership, require that a minimum level of hospital licenses are held by non-profit hospital groups, that licenses are preferentially granted to hospitals that directly employ their specialists and general practitioners, and strict population-based criteria for the establishment and licensing of new private hospitals should be applied.

Recommendation 14: Create conditions under which private hospitals can employ specialists and general practitioners to allow for the establishment of staff-model Health Maintenance Organisations (HMOs).

Recommendation 15: Reconsider the functions of the proposed statutory pricing regulator to oversee a health price negotiation chamber, ensure compliance, enforcement, and the capacity to declare undesirable business practices, to issue private hospital licences, to do a technical review of health prices, to provide independent technical support to the NHI purchasing function, and be the custodian of clinical coding systems.

Recommendation 16: The development of supplementary, complementary or substitutive insurance products must be carefully monitored and interventions, which should include risk adjustment mechanisms, must be instituted to protect risk pools and prevent discrimination against older and sicker members of the population.

Recommendation 17: Amendments to the Medical Schemes Act to strengthen regulation of medical schemes in support of the implementation of NHI.

Recommendation 18: Demarcation regulations must be adjusted over time as NHI matures to prevent the dumping of sicker and older members of the society on the NHI risk pool, preventing younger and healthier members of the public to belong to risk-rated low-risk health insurance risk pools, causing harm to other risk pools.

Recommendation 19: The Department should reconsider the introduction of a system of risk adjustment; such a system would protect older and sicker members of society during the implementation of NHI and the transition process, and would continue to ensure that risk pools are properly balanced after full

implementation; technical capacity is required for risk-adjusted capitation payments.

Recommendation 20: Better control over private health care resource data must be gained through an amendment to the Medical Schemes Act whereby the CMS will establish a register of privately practising health professionals.

Recommendation 21: Establish an accreditation task team with CMS officials to collaborate with the OHSC in the accreditation of facilities.

Recommendation 22: Considering the quadruple burden of disease in the country, the 15% of total government spending (Abuja target) might be too low.

Recommendation 23: The means test at public hospitals should at least be adjusted to keep up with inflation since 2006. In view of the NHI development, consideration must be given to gradually remove the means test.

Recommendation 24: The Medical Schemes Act must be amended to improve governance in medical schemes and to improve broker regulation. This will lead to further reductions in non-health costs.

Recommendation 25: The introduction of a pricing authority must be expedited to contain costs in the private sector. Such steps will speed up the ability for the NHI to purchase services from the private sector.

Recommendation 26: Migration of medical scheme members to the NHI should be done in a co-ordinated manner to prevent the overloading of the currently pressurised public sector.

Recommendation 27: Consider adapting the South African Identity document for use in NHI. Smart card and biometric identification technology should be applied. Provision should be made for legal residents who do not qualify for a South African ID document.

Recommendation 28: The NHI policy document should clearly define which services refugees and asylum seekers will have access to and how undocumented migrants will access health care services. In different countries coverage ranges from full access, partial access or no access.

Recommendation 29: Provision should be made for short-term visitors and students with no health insurances in their home countries to obtain private health insurance in South Africa.

Recommendation 30: Health care personnel should get proper training about migrants' rights to access health care services.

Recommendation 31: Measures should be put in place to deliver services that are linguistically comprehensible to migrants.

Recommendation 32: The establishment of strong localised governance structures are required prior to the introduction of decentralised purchasing or the establishment of integrated primary care business units.

Recommendation 33: A clearly defined comprehensive primary care package (incorporating vertical programmes) must be purchased from integrated primary care providers in the medium to long term.

Recommendation 34: The purchasing function for primary care must be assigned to the lowest feasible level in the medium to long term. This may be a yet-to-be developed organisation, but could be existing structures. The current capacity at the district level is inadequate, and capacity should therefore be developed at the provincial level. Where metropolis exist, capacity to do active purchasing of primary care could be developed at this level.

Recommendation 35: Central to the purchasing function is the existence of a suitably mandated authority that is a capable to contract with primary care providers for the

provisioning of a well-defined package of primary care services. During the piloting phase, work must commence to establish such authorities.

Recommendation 36: In the short term, before the introduction of capitation based integrated primary care, it is important to pilot test the approach - preferably in more than one province, in rural and metropolitan areas simultaneously. Until exemption is obtained from the Health Professions Council of South Africa (HPCSA) in respect of group practices, and until state tender drugs are available, the model can be tested with state employees in a state facility. Clear monitoring and evaluation criteria must be developed upfront. Purchasing and contracting capacity should be developed during the pilot test; extensive reliance must be placed on the World Bank "How-to" manual in this respect.

Recommendation 37: During the pilot phase, remuneration must be on a salaried basis, and work must start on the introduction of salaries with incentives. These incentives could consider FFS and / or performance (which could include outcome, preventative activity, and community-based work).

Recommendation 38: Remuneration for privately practising doctors doing session work should ideally be at the same hourly rate as similarly qualified and experienced full time employees. General Practitioners should be appointed on a sessional basis where specific tasks could be performed to augment clinical services. Specialists should be available on a sessional basis to provide further training and advice on the management of complex patients.

Recommendation 39: Extensive consideration must be given to the administrative and management skills required for the functioning of primary care centres as business units. Course contents and training material for the future training of general and financial managers must be developed during the piloting phase.

Recommendation 40: During the pilot phase, the centres would have to start on a line level budget. Work must start to develop the most appropriate capitation models, and shadow budgets must be maintained. Such shadow budgets must be initially based on raw capitation, with risk adjustments being done as more information about the served population is collected.

Recommendation 41: Consideration must be given to "freedom of choice" in the development of enrolment databases.

Recommendation 42: Sessional appointments will continue to alleviate staff shortages at state hospitals. In the short term, remuneration must be adjusted to equal the hourly rates of full time public sector employees.

Recommendation 43: In the short to medium term, RWOPS must be abandoned and sessional appointments must continue to alleviate staff shortages. Structural and systemic solutions addressing the underlying problems (financial and non-financial) can only be in place in the long term.

Recommendation 44: Great care must be taken in the utilisation of diagnostic and inpatient services in the private sector and should be used in the short term only to address immediate shortcomings in the public sector.

Recommendation 45: Where specific surgical procedures are purchased privately, this must be done on a per case payment basis.

Recommendation 46: An IT system supportive of the active purchasing function is critical to ensure the implementation of NHI.

3.4.2. Means test for public hospital services

As already discussed above, there is presently no coordination within government and the CMS regarding the future developments for the means test for public hospital services. This matter was

raised by the Taylor Committee of Inquiry in 2002, but has not been dealt with since, and requires attention in this strategic framework period.

3.4.3. Public hospital services

Although the Act materially impacts on public hospitals (MMBs, DSPs, reimbursement requirements), there is no mechanism by which the CMS can coherently interact with public hospitals to achieve synergistic effects.

The CMS needs to approach government with a view to establishing a routine link between the CMS and the public health system to ensure that strategies are developed jointly rather than in silos.

3.4.4. Public chronic care services

Some medical schemes offer scheme chronic benefits at a sub-optimal level by making the public sector the DSP. Despite this there are many opportunities to design interventions for medical schemes, which aid in developing a coherent chronic benefit delivery platform in the public sector. The poor coordination within government on these opportunities is a lost opportunity for the development of the public sector delivery platform.

There is consequently a need to coordinate the development of policy regarding chronic benefits, including the distribution of medicines, to develop more balanced service delivery options in South Africa.

3.4.5. Liaison with other regulators

The CMS routinely engages with other regulators on key health policy issues, including the Health Professions Council of South Africa (HPCSA), the Competition Commission and the Financial Services Board (FSB). Good cooperation with these regulators occurs on a case by case basis.

3.5. Medical scheme governance

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.

3.5.1. Boards and Principal Officers

There are instances where boards may have conflicts of interests, and may have board members that would fail a due diligence assessment. Amendments to the Act are required to close many of these gaps by inter alia, 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.

The above reforms are in the process of being included in a Medical Schemes Amendment Bill, which will be refined with the Department before being submitted to the Minister.

3.5.2. Oversight arrangements

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.*

3.6. Scheme responsiveness

Normal market forces place only a limited requirement on schemes to respond to the needs of beneficiaries where accountability for their actions or failures to act is not firmly entrenched in the law. Although a degree of accountability is established through schemes having to compete for members (open schemes), this is not sufficient to protect all beneficiaries. Information problems in this segment of the market prevent normal market mechanisms from ensuring accountability.

3.6.1. 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 20 working days;*
- *That a specific dispensation be required for urgent medical conditions, including CMS processes, whereby complaints must be resolved quicker;*
- *That all schemes are required to report on all disputes, including the nature of each dispute and how the matter was resolved; and*
- *That schemes must afford members the opportunity to appeal decisions made in respect of those complaints.*

3.6.2. Intermediation

As already discussed above, the incentives of brokers need to be changed through changes to legislation.

3.6.3. Accessibility of rules

Although much has been done to ensure that members have access to the rules, they remain difficult 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.

3.6.4. Democratisation of schemes

The corporate governance arrangements, which require strengthening, may mitigate against the appointment of responsible board members in some instances. Brokers and other entities with conflicts of interests may manipulate elections using proxy forms. Many of these problems could be managed through amendments to the Medical Schemes Act.

The complete corporate governance and broker reform framework discussed above must be implemented.

3.7. Council responsiveness

As an organ of state the CMS is ultimately accountable to the people of South Africa. However, a considerable distance exists between the people and the CMS. Bridging this gap requires that the regulator be held properly accountable for responding to the needs it was established for. However, this may not be sufficient to ensure it is responsive unless there is some feedback on how it deals with the public.

3.7.1. 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 complaints and appeals;*
- *more CMS panels to hear 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.*

3.7.2. Complaints against Council performance

To ensure that the CMS is responsive it is imperative that it collects information on how it is performing in relation to its duties wherever it deals with the public. This should not however become a vehicle for special interests to discredit the regulator.

It is consequently proposed that:

- *Provision be made for complaints against the CMS – and that these be reported on to CMS and in the Annual Report;*
- *That a CMS sub-committee be established to review any complaints received together with the Registrar.*

3.7.3. 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. The CMS has greatly expanded the amount of information it is collecting, and researches a great deal of it. However, questions about whether enough research is being done, and whether more information needs to be placed in the public domain to aid academic research.

3.7.4. Information collected but not used

The CMS collects a great deal of information on schemes, much of which is made public. Internal research is however fairly limited, and tied to very specific projects and processes.

Consideration therefore needs to be given to:

- *Making more data available in the public domain in an easy to use format; and*
- *Supporting academic research.*

Since 2012, the Annexures to the Annual report will be published in Excel format which is more accessible to researchers that the previous PDF format.

3.7.5. Health outcomes and quality of care

Although it is a function of the CMS, to date no work has been done to collect information on health outcomes. The CMS has however been instrumental in implementing the ICD10 reporting framework, which is a precursor to collecting this kind of information.

Key strategic units will be expanded to focus on this function in the future with a view to making information on health outcomes in the private sector publicly available.

3.8. Strategic advice and support

Consistent with the strategic goal of harmonising strategic health policy, the CMS is well placed to provide insight into the functioning of the private health systems and to advice on how to reform it.

3.8.1. 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 health costs and risk adjustment.

3.8.2. 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;
- Participation in various Ministerial committees; and
- Regular interaction with the Ministry in respect of the development of NHI.

3.8.3. 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.
- **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); and
- ~ Routine inspections.

- **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;
  - ~ Council appeal committee; and
  - ~ Appeal board.

3.8.4. Prospective regulation

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 prior review by the CMS of office bearers before they are appointed; and
- There is no standardised test required for the appointment of actuaries and auditors of schemes.

3.8.5. Concurrent regulation

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 composite indicators of scheme risk, to ensure a coordinated response within CMS, has not yet been implemented. A major project was implemented to review and develop such an approach, and is now complete. 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.

3.8.6. Retrospective regulation

The retrospective regulatory framework is presently hampered by capacity constraints in the area of compliance and the inability of the CMS to control prosecutions. Consideration needs to be given to expanding the senior investigative staff of compliance.

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. There however a clear need for consideration to be given to expanding the number of possible hearings in a given year by both the committee and the board.

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.

Consideration also needs to be given to a regime to support lodging appeals and/or to ensure that support in a form of representation can be provided to members where required, to prevent them being outgunned by medical schemes and related parties.

3.9. Developing the CMS strategic plan

3.9.1. February 2011 version

The first version of this strategic plan started with workshops during October 2010 facilitated by officials from the National Treasury Technical Assistance Unit (TAU)[4]

The first, albeit rudimentary, drafts of the Strategic Plan (SP) and Annual Performance Plan (APP) were submitted to Council and considered during the strategic planning session in November 2010. The plans were further refined at further workshops with Council on the impact of the NHI on the CMS strategy and amendments to the Medical Schemes Act during January 2011.

Further drafts of the first SP and APP were considered during the operational planning session in February 2011, and the plans were approved by Council on 24 February 2011.

[4] The Technical Assistance Unit is a support facility in the National Treasury that provides technical assistance through a wide range of process management and advisory support, along the programme management cycle, to all the national and provincial government departments and local government

3.9.2. November 2011 version

During the implementation of the first version of the Strategic Plan, it became apparent that the first plan contained numerous technical errors which had to be corrected by way of re-submitting the entire plan. The first draft of this version was prepared by the office during August 2011, and submitted to Council for consideration during the Strategic Planning session on 26 and 27 August 2011. Subsequent to more discussion between Council and the Registrar's office, this draft was submitted to Council on 21 October 2011 after the Council subcommittee on Finance has considered the draft budget, which will be considered by Council at its meeting on 27 October 2011.

3.9.3. November 2012 Version

Even though the CMS has received a clean performance audit for the 2011/12 year, which was based on the February 2011 version, the management letter from the Auditor General has indicated that there were numerous technical changes required to the plan which affects many of the previously used indicators and targets. To address these, a revised version of the plan was developed, and considered by Council during its strategic planning session of 23 and 24 August 2012.

After these changes the office held an operational planning session in September, and further small changes were made to the plan before its final approval in October 2012.

Key decisions taken by Council includes a request that the office must finalise a Medical Schemes Amendment Bill (MSAB) to address the matters raised in the Situational Analysis in this strategic plan, and that a Council delegation must meet with the Minister to discuss the advice given to the Minister in respect Goal 4. These matters included a request for guidance on the demarcation regulations, further collaboration on NHI, price determination, risk adjustment, the PMB regulations, statutory fees and amendments to the Medical Schemes Act.

4. Strategic Risk Register

Strategic Goal	Risk Description	Root Causes	Controls	Action Plan
Access to good quality medical scheme cover is maximised.	Barriers to accessing medical schemes.	1. Beneficiaries are discriminated against based on their health status or any factor correlated with it (such as age). 2. Cost increase. 3. Affordability (Provider rates v/s scheme rates).	1. Routine inspections and accreditation process.2. Strengthening the complaints adjudication process, and the enforcement of these rulings. Benefit definition process. 3. Cost increases approval of contribution increases. Support of the regulation of private health prices. Tariff determination process. Alternative re-imbursement Involvement with the Competition Commission. 4. Providing advise on policy issues. Involvement of the Registrar and the Council with the Ministry of Health.	1. Continue supporting the MoH on a price determination process. 2. Work on the MSAB to improve the processes around the resolution of complaints. 3. Strengthen open enrolment, community rating, and PMB provisions in the MSAB. 4. Support Treasury on demarcation regulations.
CMS provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the NHI development process.	The privileged position of the CMS, with access to private health data and experience in regulating elements of the private health care industry might not find expression in strategic health policy	1. Perception that the CMS has a vested interest in the maintenance of the status quo. 2. Lack of policy harmonisation.	1. Adherence to the Medical Schemes Act, PFMA, Treasury Regulations, etc. 2. Support of the Executive Authority. 3. Ensuring good relations with the DoH & Ministry. 4. Research and inputs from other departments.	1. Continued interaction with the MoH and the DoH.

Strategic Goal	Risk Description	Root Causes	Controls	Action Plan
Medical schemes are properly governed, are responsive to the environment, and beneficiaries are informed and protected.	Barriers to accessing medical benefits	1. Lack of adequate information on available benefits. 2. Medical schemes deliberately exclude benefits. 3. Lack of transparency in pricing from the service providers. 4. Language and terminology give rise to challenges in interpretation. 5. Demarcation - health insurance products.	1. Appeals process. 2. Defined rules for the schemes to comply with. 3. Enforcing penalties for non-compliance. 4. Routine inspections and accreditation. 5. Legislation amendments. 6. PMB definitions process. 7. Communication guidelines. 8. Code of conduct.	1. Finalise communication guidelines. 2. Benefit definition process. 3. Review of Code of conduct. 4. Analyse marketing material, for consistency and adherence to communication guidelines. 5. Participate in drafting of the demarcation regulations.
Medical schemes are properly governed, are responsive to the environment, and beneficiaries are informed and protected.	Ineffective board / governance structures. (Unfit and improper board)	1. Lack of expertise. 2. Absence of a strong corporate governance framework. 3. Member apathy.	1. Monitoring AGMs and elections, anonymous tip-off line. 2. Governance guideline. 3. Enforcement of statutory powers: including appointment of compliance officers, routine inspections, removal of trustees, and appointment of curators. 4. Trustee training. 5. Litigation.	1. Completion of MSAB to improve corporate governance. 5. Implementation of the traffic light approach to trustee training.
Medical schemes are properly governed, are responsive to the environment, and beneficiaries are informed and protected.	Corporate governance failures resulting in financial collapse of medical schemes. (Inadequate processes for overseeing governance)	1. Conflict of interest due to weak regulatory and legislative framework. 2. Delays in the implementation of the Medical Schemes Amendment Bill. 3. Delays in CMS processes in responding to indicators. 4. Ineffective law enforcement. 5. Corruption.	1. Accreditation & Registration. 2. Education, training, media liaison. 2. Monitoring: Financials, inspections, complaints, customer care centre, media. 3. Enforcement: Complaints adjudication process, litigation, curatorships, liquidations.	1. Completion of MSAB to improve corporate governance. 2. Complete trustee remuneration project. 3. Composite risk index. 4. Real time monitoring. 5. Implementation of the traffic light approach to trustee training.

Strategic Goal	Risk Description	Root Causes	Controls	Action Plan
CMS is responsive to the needs of the environment by being an effective and efficient organisation.	Inefficient management of the appeal processes	1. Delays in dealing with complaints and appeals. 2. Inadequate case management systems and processes.	1. Existence of the secretary to the appeals committee / board, and the legal unit. 2. Obtain opinions and counsel on strategic matters. 3. Adherence to PAJA.	1. Review of the legislative and regulatory framework. Completion of MSAB to improve corporate governance. 2. Introduction of case management IT system.
CMS is responsive to the needs of the environment by being an effective and efficient organisation.	Inappropriate funding model	Inability to adapt to changes in the environment.	1. Reviewing the current levies model. 2. Alternative funding models. 3. Reviewing the current fees and penalties.	Committee in place to research alternative funding models.
CMS is responsive to the needs of the environment by being an effective and efficient organisation.	Ineffective management decisions due to inadequate information.	1. Inadequate MIS. 2. Outdated IT systems. 3. Misalignment between the IT strategy and the organisation's strategy.	1. Continuous updating the IT and reporting systems. 2. Regular feedback at EXCO on reporting requirements. 3. Application of sound IT policies and procedures, based on the COBIT Framework. 4. Regular IT steering committee meetings to ensure IT Governance.	1. Development of a comprehensive Management Information System (MIS) Dashboard using SQL Reporting Services.
CMS provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the NHI development process.	Inadequate support to the Ministry and Department of Health in developing and implementing NHI	1. Ineffective participation in NHI development and implementation process. 2. Inadequate funding from DoH to support CMS projects.	1. Participation of CMS officials in Ministerial Advisory Committee on NHI. 2. Annual budget support from DoH. 3. Input to policy papers on NHI.	1. Formalise participation on MAC. 2. Motivate for increased budget support. 3. Provide input to White Paper once released.

Strategic Goal	Risk Description	Root Causes	Controls	Action Plan
CMS provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the NHI development process.	Under regulating	1. Capacity constraints. 2. Inability to control prosecutions. 3. Weak penalty framework.	1. Guidelines, Act and processes used by CMS. 2. Composite risk index and close monitoring.	1. Finalising the MSAB. 2.Entering into MOU with other regulators.

Part B: Programme Strategic Objectives

5. Programme 1 (Office of the CEO)

5.1. Sub-Programme 1.1 (CEO and Registrar)

5.1.1. 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.

5.1.2. Strategic objectives (CEO and Registrar)

The CEO and Registrar oversee the activities of the office of the Council for Medical schemes, and have the following unique strategic objectives:

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

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

Goal 3 *CMS is responsive to the needs of the environment by being an effective and efficient organisation*

Goal 4 *CMS provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the NHI development process*

Strategic Objective 1.1.4.1	**Develop international strategic relationships with other regulators**
Objective statement	Develop strategic relationships with regulators from other countries by visiting and / or hosting regulators from other countries at least once per year by 2014/15
Indicator	Number of meetings with regulators from other countries
Baseline	One meeting with a regulator from another country was held during 2010/11
Strategic Objective 1.1.3.1	**Secretarial support service**
Objective statement	To provide secretarial services to 66 events of the Council for Medical Schemes and the Appeal Board by 2014/15
Indicator	Number of Council meetings supported per year Number of EXCO meetings supported per year Number of Appeal subcommittee meetings supported per year Number of Appeal Board hearings supported per year Number of Strategic Management meetings supported per year Number of Regulatory Decision Committee meetings supported per year Number of Remuneration Committee meetings supported per year Number of HR subcommittee meetings supported per year
Baseline	25 events were supported in 2010/11

5.1.3. Resource considerations (CEO and Registrar)

1.1 CEO and Registrar	Audited outcomes			Adjusted appropriatio	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of employees	**3**	**3**	**3**	**4**	**4**	**5**	**5**
Total	**3,402,418**	**2,455,509**	**5,497,204**	**8,522,658**	**8,552,173**	**9,677,913**	**10,258,588**
Compensation of employees	2,222,494	1,061,087	2,862,010	4,328,126	4,323,574	4,921,493	5,216,783
Goods and services	1,179,924	1,394,422	2,635,194	4,194,532	4,228,599	4,756,420	5,041,805
Council Committees	456,207	887,228	1,260,691	1,716,998	1,775,473	1,917,516	2,032,567
Council Members Fees	141,497	175,752	450,852	1,868,944	930,986	1,500,000	1,590,000
Staff Training	162,848	5,803	32,058	69,728	240,000	78,000	82,680
Other	419,372	325,639	891,593	538,862	1,282,140	1,260,904	1,336,558

5.2. Sub-Programme 1.2 (Strategy office)

5.2.1. Purpose (Strategy Office)

The purpose of the Strategy Office 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, to support the Council in its strategic and operational planning and to provide support to the Office on clinical matters.

5.2.2. Strategic objectives (Strategy Office)

Goal 1: Access to good quality medical scheme cover is maximized

Strategic Objective 1.2.1.1	**Support the Prescribed Minimum Benefit (PMB) Review conducted by the Department of Health (DOH)**
Objective statement	Technical support provided to the PMB review process on a rolling basis, recommendation on amendments to the PMB regulations at least once every two years
Indicator	At least one submission to the Department of Health on amendments to Prescribed Minimum Benefits regulations every two years
Baseline	Two amendments proposed to PMB regulations in 2009/10, one anticipated in 2011/12

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

Strategic Objective 1.2.2.1	**The Prescribed Minimum Benefit code of conduct is updated**
Objective statement	Produce one Prescribed Minimum Benefit code of conduct report per year
Indicator	Number of Prescribed Minimum Benefit compliance reports released per year per year
Baseline	n/a in 2009/10 (New function), 1 Code of Conduct document produced in 2010/11
Strategic Objective 1.2.2.2	**Number of final benefit definitions published**
Objective statement	Coordinate clinical advisory committees' consultation with stakeholders to clarify PMB benefits definitions and publish 10 benefit definitions for PMB conditions per year by 2013/14
Indicator	The minimum number of final benefit definitions published per year
Baseline	n/a in 2010/11 (New function)
Strategic Objective 1.2.2.3	**Provide clinical opinions**
Objective statement	Coordinate the clinical review committee which oversees the provisioning of clinical opinions to other units within CMS
Indicator	Number of clinical matters reviewed by the Clinical Review Committee per year
Baseline	n/a opinions in 2010/11 (New function)

Goal 3: *CMS is responsive to the needs of the environment by being an effective and efficient organisation*

Strategic Objective 1.2.3.1	**Strategic plan and annual performance plan**
Objective statement	Coordinate the annual strategic planning session with the CMS, the annual operational planning sessions, prepare the annual strategic plan and annual performance plan for submission to the Council, do monthly performance measurements and update the risk register quarterly. By 2013 a coherent planning and motoring system will be in place.
Indicator	Annual submission of the draft and final Strategic and Annual Performance plans to Executive Authority
Baseline	1 Strategic plan and annual performance plan

Goal 4: *Council provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the NHI development process*

Strategic Objective 1.2.4.1	**Support universal access through recommendations made to the National Health Insurance MAC committee**
Objective statement	Provide support in accordance with National Health Insurance MAC terms of reference
Indicator	Number of written reports submitted to National Health Insurance Ministerial Advisory Committee per year
Baseline	1 in 2010/11
Strategic Objective 1.2.4.2	**Policy recommendations made to the Department of Health**
Objective statement	Make policy recommendations to the Department of Health
Indicator	Number of policy recommendations made to the Department of Health per year
Baseline	1 in 2010/11
Strategic Objective 1.2.4.3	**The Medical Schemes Act is reviewed to protect the legislated framework**
Objective statement	Review the Medical schemes Act and produce recommendations. By 2014/15 one recommendation will be made.
Indicator	At least one recommendation made to amend the Medical schemes Act per year
Baseline	0 amendments proposed in 2010/11

5.2.3. Resource considerations (Strategy office)

1.2 Strategy office	**Audited outcomes**			**Adjusted appropriation**	**Medium-term expenditure estimates**		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of Employees	**8**	**8**	**6**	**6**	**6**	**6**	**6**
Total	**7,387,034**	**7,322,815**	**4,351,513**	**2,193,164**	**4,196,888**	**4,859,887**	**5,125,468**
Compensation of employees	4,962,572	5,832,418	3,979,660	1,624,878	3,990,228	4,628,687	4,906,408
Goods and services	2,424,461	1,490,397	371,853	568,286	206,660	231,200	219,060
Rent	1,144,091	994,785	-	-	-	-	-
Software License Subscription	-	19,920	-	-	-	-	-
Staff Training	55,230	102,831	60,484	71,219	75,300	100,000	106,000
Other	1,225,140	372,861	311,369	497,067	131,360	131,200	139,072

5.3. Sub-Programme 1.3 (Complaints Adjudication Unit)

5.3.1. Purpose (Complaints Adjudication Unit)

We 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.

5.3.2. Strategic Objectives (Complaints Adjudication Unit)

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

Strategic Objective 1.3.2.1	**Complaints resolution**
Objective statement	Investigation and resolution of complaints in an efficient and effective manner.
Indicator	Estimated number of complaints received per year Percentage of complaints resolved per year Minimum percentage of complaints resolved within 30 working days Minimum percentage of complaints resolved within 60 working days Minimum percentage of complaints resolved within 90 working days Minimum percentage of complaints resolved within 120 working days Minimum percentage of complaints resolved within 120+ working days
Baseline	4888 out of 6138 complaints were resolved within 120 working days in 2011-12.

5.3.3. Resource considerations (Complaints Adjudication Unit)

1.3 Complaints Adjudication	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of Employees	**7**	**7**	**7**	**8**	**8**	**9**	**9**
Total	**2,589,737**	**2,834,261**	**4,990,574**	**3,697,785**	**4,122,245**	**4,291,421**	**4,548,906**
Compensation of employees	2,543,697	2,750,659	4,610,434	3,599,534	3,937,745	4,161,921	4,411,636
Goods and services	46,040	83,602	380,140	98,251	184,500	129,500	137,270
Staff Training	35,309	67,070	49,498	64,248	134,000	71,500	75,790
Other	10,731	16,532	330,642	34,003	50,500	58,000	61,480

The trends in the volume of complaints have been assessed and the current capacity in the Unit is insufficient and will be assessed in the ensuing financial years.

The constant increase in volume of complaints in the last financial year and the unintended consequence of delays in resolving the said complaints has resulted in a need to get an additional Legal Officer. The Unit experienced backlogs due to accumulation of complaints and the effect of the delay in resolving complaints is that there could be loss of credibility on the ability of CMS to carry out its mandate.

The stats below which can also be confirmed from the published Annual Report shows that the Unit is over-stretched as it cannot cope with the demands placed on it by beneficiaries of medical

schemes. There is serious capacity constraints which need to be addressed so as to try and meet the demands placed upon the Unit.

2007-08	2008-09	2009-10	2010-11	2011-12
2891 (total number of complaints)	**3138** (increase of 247 new complaints from the previous year)	**4488** (increase of 1350 complaints which translates to an increase of 43%)	**5617** (increase of 1129 complaints, this translates to a 25.1 % increase)	**6138** (increase of 521 complaints in the last financial year)

An additional staff member in 2012/13 may alleviate the pressure and there could be improved performance levels.

6. Programme 2 (Corporate services)

6.1. Sub-Programme 2.1 (Internal Finance Unit)

6.1.1. Purpose (Internal Finance Unit)

The Internal Finance Unit serves all business units in CMS, the senior management team and Council by maintaining an efficient, effective and transparent system of financial 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.

6.1.2. Strategic Objectives (Internal Finance Unit)

Goal 3: CMS is responsive the needs of the environment by being an effective and efficient organisation

Strategic Objective 2.1.3.1	**Annual financial statements**
Objective statement	An effective, efficient and transparent system of financial management is maintained.
Indicators	Number of GRAP compliant annual financial statements submitted by 31 May each year;
Baseline	One GRAP compliant annual financial statements submitted Achieved unqualified audit reports for 2010/11
Strategic Objective 2.1.3.2	**Budget management**
Objective statement	Monitoring of spending pattern against the approved operational plan and provide explanation to variances on a monthly basis
Indicators	Number of budget reports and management accounts produced per year to ensure budgeted resources allocated to the strategic objectives that are utilised for the intended purpose
Baseline	Monthly (12) budget reports
Strategic Objective 2.1.3.3	**Revenue management**
Objective statement	Levies are collected in April and August each year to meet the organizations budget requirements
Indicators	Percentage of levy income collected per year
Baseline	100% of levy income collected in 2010/2011
Strategic Objective 2.1.3.4	**Supply Chain Management**
Objective statement	An appropriate procurement and provisioning system which is fair, equitable, transparent, competitive and cost-effective
Indicators	Number of demand management plans submitted to National Treasury by 30 April Percentage of creditors paid within 30 days of approval A supplier database is in place and updated annually
Baseline	One demand management plan submitted to National Treasury 99% of creditors are paid within 30 days.

Strategic Objective 2.1.3.5	**Cash management**
Objective statement	Sufficient funds are available to meet operational requirements for the financial year
Indicators	Number of cash flow projections produced to meet operational requirements per year
Baseline	12 Cash flow projections were produced during 2010/11
Strategic Objective 2.1.3.6	**Asset management**
Objective statement	Safeguarding of assets within the organisation by maintaining an accurate asset register
Indicators	Number of asset register updates per year Percentage of assets insured during the year
Baseline	12 Asset register updated during 2010/11 100% of assets insured during 2011/12
Strategic Objective 2.1.3.7	**Payroll management**
Objective statement	Salaries are paid to legitimate employees of Council in accordance with the HR policies
Indicators	Number of payrolls produced in a financial year
Baseline	13 payroll runs were produced during 2010/11
Strategic Objective 2.1.3.8	**Internal controls**
Objective statement	An effective control environment is maintained in the Council
Indicators	Number of audit and risk committee meetings held in a year Number of finance committee meetings held in a year An approved internal audit plan is in place annually
Baseline	5 Audit and risk committee meetings were held during 2010/11 3 Finance committee meetings were held during 2010/11 1 internal audit approved audit plan in place 2010/11
Strategic Objective 2.1.3.9	**Risk management**
Objective statement	An effective, efficient and transparent system of risk management is maintained.
Indicators	Number of risk register updates per year
Baseline	4 Risk register updates during 2010/2011
Strategic Objective 2.1.3.10	**Planning and Budgeting**
Objective statement	An effective performance and budgeting management environment is maintained in the Council
Indicators	Annual performance report submitted to executive authority by 31 May Number of performance information reports submitted to executive authority per year
Baseline	One strategic and annual plan per year submitted to Executive Authority during 2011/12 Four performance information reports submitted to Executive Authority during 2011/12
Strategic Objective 2.1.3.11	**Office Management**
Objective Statement	A productive and conducive working environment is maintained
Indicator	Percentage employees having an allocated office space which is properly resourced and well maintained per year
Baseline	100% of employees having allocated office space which was properly resourced and well maintained

6.1.3. Resource considerations (Internal Finance Unit)

2.1 Internal Finance	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of Employees	**7**	**7**	**7**	**7**	**9**	**10**	**10**
Total	**8,269,833**	**9,738,091**	**13,553,018**	**15,196,127**	**18,024,932**	**19,824,020**	**21,013,461**
Compensation of employees	3,348,973	3,684,831	4,128,589	4,536,199	6,318,230	6,745,635	7,150,373
Goods and services	4,920,860	6,053,260	9,424,429	10,659,928	11,706,702	13,078,385	13,863,088
Employee Benefits	815,991	927,084	1,081,758	1,234,920	1,327,968	1,587,133	1,682,361
External Audit Fees	445,117	723,397	484,475	752,117	629,542	679,905	720,700
Insurance	128,182	124,845	133,414	134,995	150,032	159,034	168,576
Internal Audit Fees	229,787	386,656	883,530	616,653	788,212	850,000	901,000
Operational projects	-	-	-	-	-	32,000	33,920
Rent	2,042,336	2,155,021	4,301,386	4,487,608	5,234,447	5,955,063	6,312,367
Repairs & Maintenance	77,085	467,825	393,614	1,145,952	1,041,346	608,916	645,451
Staff Training	108,856	174,747	275,294	190,143	250,000	215,000	227,900
Water & Electricity	361,210	550,209	692,748	948,529	991,875	1,158,000	1,227,480
Other	712,297	543,476	1,178,211	1,149,010	1,293,280	1,833,334	1,943,334
							-
Payments for capital assets	**812,217**	**2,409,253**	**2,039,375**	**1,742,401**	**2,039,373**	**1,697,004**	**1,798,824**
Amortization	169,811	1,162,352	847,936	536,075	847,936	490,680	520,121
Depreciation	642,406	1,246,901	1,191,439	1,206,326	1,191,437	1,206,324	1,278,703
Total	**9,082,050**	**12,147,344**	**15,592,393**	**16,938,528**	**20,064,305**	**21,521,024**	**22,812,285**

The trends in the volume of transactions have been assessed and believe that the current capacity is sufficient to contend with the current volume. There is a need to strengthen the Unit in order to deal with the demands of Supply Chain Management. Council has approved the appointment of a Supply Chain Management Officer for the financial year 2013/14.

6.2. Sub-Programme 2.2 (Information and Communication Technology (ICT) and Knowledge Management (KM))

6.2.1. Purpose (ICT & KM)

We serve the CMS business units by providing technology enablers and making information available to stakeholders

6.2.2. Strategic Objectives (ICT & KM)

Goal 3: CMS is responsive to the needs of the environment by being an effective and efficient organisation

Strategic Objective 2.2.3.1	**Training and Support**
Objective statement	Provide assistance to personnel in the field that use all of the computer hardware, software and IT services. The Unit will reduce the number of desktop support calls to 300 cases per year and train 70 staff members per year by 2014/15
Indicators	Number of desktop support incidents/cases concluded for the year. Number Of CMS staff trained on the use of the various ICT systems in use at CMS per year.
Baseline	1000 desktop support incidents in 2010/11 40 members of staff trained in 2010/11
Strategic Objective 2.2.3.2	**Operations**
Objective statement	Diligently maintain the computer network, systems, software and hardware of the organisation to ensure the availability of information, disk space, response time, bandwidth, communication, and information security. The Unit will achieve a network and server uptime of 99% whilst reducing security incidents to 1% per annum by 2014/15.
Indicator	Percentage network Uptime per year. Percentage server Uptime per year Maximum percentage of security Incidents per year
Baseline	98% Network Uptime in 2010/11 96% Server Uptime in 2010/11 No baseline Security Incidents in 2010/11 – New Indicator
Strategic Objective 2.2.3.3	**Software Development**
Objective statement	Focus development responsibilities on creating, editing, and maintaining the custom software applications in use at CMS. The unit will reduce the number of custom application “bugs” to 200 per year, and will increase the uptime percentage to custom applications, while network access exists, to 99% by 2014/15.
Indicators	Maximum number of custom software application “bugs”/incidents reported per year. % uptime, of custom developed application systems during working days, where full network access exists.
Baseline	400 custom application incidents in 2012/13 98,8% uptime in 2012/13

Strategic Objective 2.2.3.4	Knowledge and Records Management
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 98% of all requests for information and will capture 3000 records per annum electronically by 2014/15
Indicators	Percentage of requests for information responded to and successfully dealt with per year. No. of records electronically captured (scanned) per year.
Baseline	250 requests for information received in 2010/11. 1000 records electronically captured in 2010/11.

6.2.3. Resource considerations (ICT & KM)

2.2 ICT and KM	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Number of employees	8	9	14	14	11	11	11
Total	4,895,949	6,239,490	9,482,724	8,072,293	9,973,834	10,870,129	11,522,336
Compensation of employees	2,869,064	3,387,256	5,954,238	5,471,479	6,531,782	6,884,083	7,297,128
Goods and services	2,026,885	2,852,234	3,528,486	2,600,814	3,442,052	3,986,046	4,225,209
Software License Subscription	118,593	318,701	383,467	305,902	484,900	898,400	952,304
Staff Training	141,033	169,950	212,612	122,128	190,000	190,000	201,400
Other	1,767,259	2,363,583	2,932,407	2,172,784	2,767,152	2,897,646	3,071,505

Business requirements

Strategic Objective 2.2.3.1	Training and Support

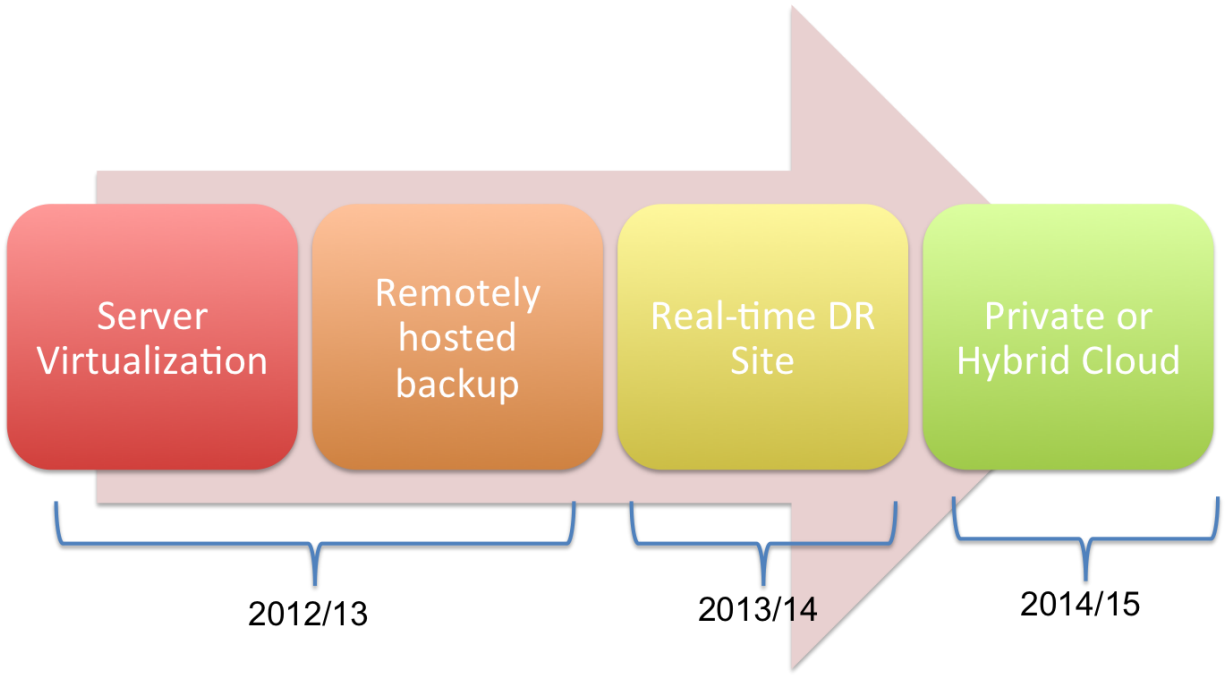
End-user office productivity

CMS has made big strides in improving office productivity through the introduction of Microsoft Office SharePoint Server (MOSS) and Office 2007. It has however become clear that MOSS is not a proper Electronic Document Management solution and therefore it will be replaced with the M-Files document management solution. This solution provides better scalability, ease of use and search functionality. Our Microsoft Office package is still on version 2007 and we will also need to replace this package with the latest package available to further improve productivity and reduce costs. We will continue our drive to reduce the number of server platforms through virtualisation and we will seek hosted solutions where we believe it is more cost efficient than self-hosted solutions. Our recent adoption of the Mimecast Mail Archiving hosted solution has proven that these solutions provide scalability, redundancy and reduced cost of ownership.

Strategic Objective 2.2.3.2	Operations

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

CMS Roadmap



Server and Desktop Virtualization

We will continue with the virtualisation of our server environment to reduce the number of physical servers for improved manageability. We intend reducing the number of physical servers from the current 30 plus to no more than 5. This will in turn allow us to perform remote online backups as well as introduce a remote disaster recovery site which will allow for realtime failovers (a hot site).

Network connectivity

We will require more bandwidth over the next three years to accommodate our linkage to remote backup and DR sites as well as other hosted solutions. We will therefore need to invest more material and money in increasing our current bandwidth as well as our backup line capability. We also need to revamp our current network by upgrading it to a full 1 Gig wired network and by introducing a 384MBPS Wireless Network.

Telephony

The gradual decrease in inter-connect fees have nullified the cost savings benefit of least cost routers. We will therefore benefit by routing our voice calls over a Broadlink solution. This will not only result in a decrease in the actual call rates, but will also enable us to cancel our existing ISDN, Diginet and older analogue lines with Telkom.

Disaster Recovery

Our 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.

Network Security

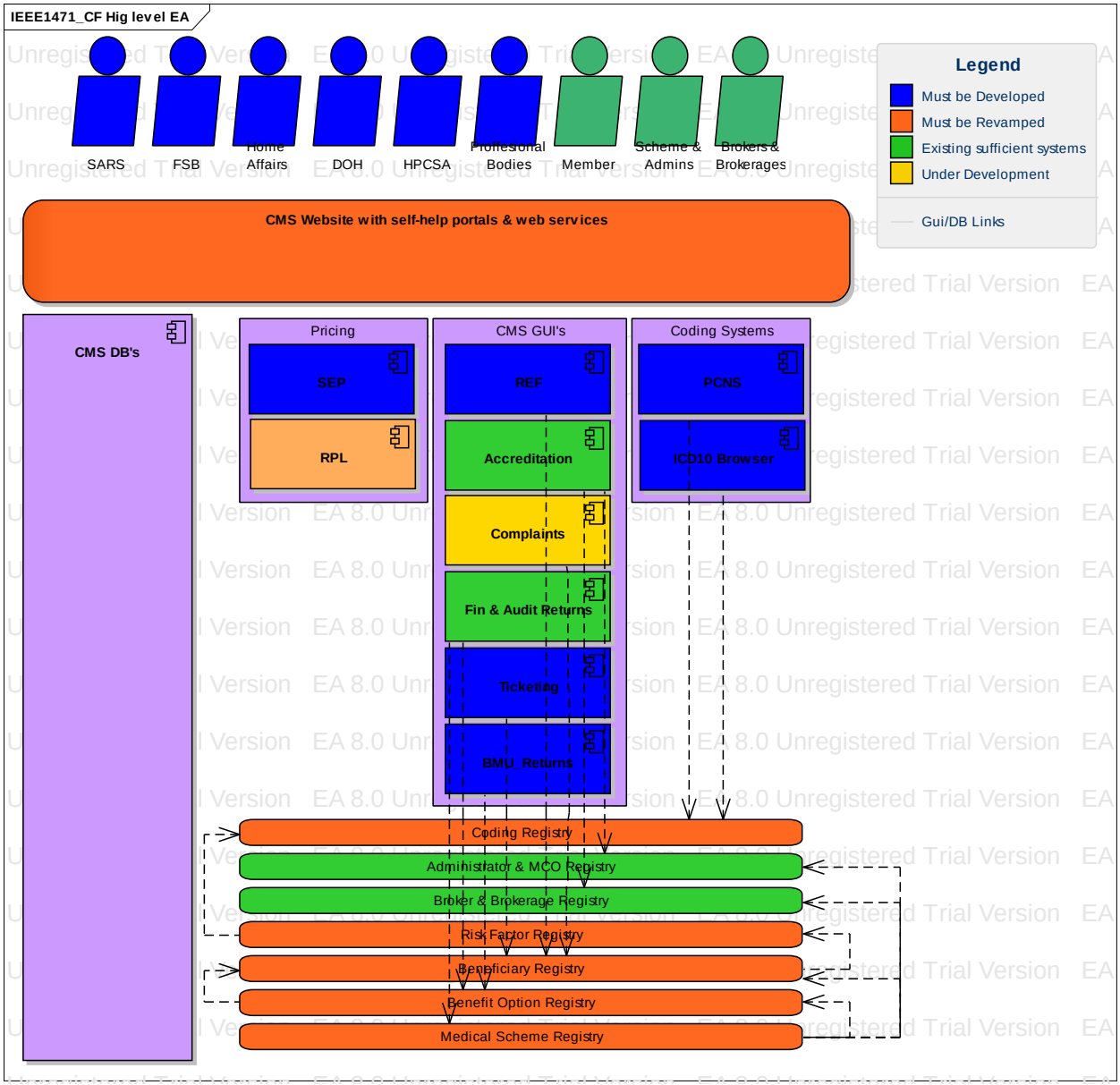
We will continue to expand on our blade technology implemented at firewall level by acquiring additional blades which will assist with data loss prevention and intrusion prevention. We will also expand the management of devices which link to our network.

Strategic Objective 2.2.3.3	Software Development

Several new demands have already or may be placed on the software development sub-unit. These demands include but are not limited to:

- The development of a benefit option and scheme registration system.
- The development of a beneficiary registry.
- The Development of a Real-time Monitoring System and its associated web services.

The following diagram provides an overview of the proposed high level Enterprise Architecture Framework which will seek to address these needs:



We will be using Microsoft Dynamics XRM to develop a new medical scheme registry, benefit option registry and beneficiary registry, over the next three years. Dynamics XRM also include out of the box CRM and customer ticketing which will be utilised by the entire CMS in the form of a Case Management System..

We will also utilize the built in Reporting Services functionality of Microsoft SQL 2008 R2 to produce meaningful management dashboards which will aid in risk based decision making. To achieve the meaning full reports we want to establish a Data Warehouse during the next 3 years. This will enable management to see different views of their data for better decision making.

Most of the functionality described above will be exposed using our website with its associated portals.

Strategic Objective 2.2.3.4	Knowledge and Records Management

1. Part of our main objective is to unlock information within CMS, creating and maintaining an environment where information and knowledge becomes paramount. The developmental stages of E-library should be viewed as a positive step in unlocking new information and the sharing of it within the organisation. The E-library should be a means for people to access new knowledge, anytime, and anywhere.

2. The scanning of CMS records is continuing, so far a lot of records found within the office has been scanned using a bureau scanning service. A process of unlocking information from our scanned documents by batch OCR processing continues. A more robust EDMS solution in the form of M-file has been acquired, which will be deployed throughout CMS.

The next three years will place the following requirements on us:

- To make E-library an effective information tool, that provides up to date information to CMS
- Establish a fully functional Registry Office
- Using bureau scanning services to continue to scan all documents of significance stored in our own filing room and at Metrofile.

In order to effectively achieve our objectives, we will need to provide intensive training on how to utilise the E-library to CMS staff, to roll out a registry office and appoint an additional registry clerk. We will also need to invest in additional scanners and scanning as well as indexing software. Apart from scanning, the registry office will monitor and track the movement of physical files. We shall also speed up the approval of our disposal authority with the National Archives in order to minimise unnecessary paper in the organisation.

6.2.4. 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
Knowledge & Records Management		
Registry Clerk	Vacant & not on post establishment.	To be created and advertised.

6.3. Sub-Programme 2.3 (Human Resources Management)

6.3.1. Purpose of the Human Resources Management Unit

Human Resources is committed to providing 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 Council for Medical Schemes by supporting its administration and staff through Human Resources Management advice and assistance, enabling them to make decisions that maximize its most important asset: its people and to continue the development of CMS as an employer of choice.

6.3.2. Strategic Objectives (Human Resources Management Unit)

Goal 3: CMS is responsive to the needs of the environment by being an effective and efficient organisation

Strategic Objective 2.3.3.1	**Talent Management, Staff retention and succession planning**
Objective statement	Measures are implemented to retain employees to achieve a staff turnover rate is less than 8% by 2015
Indicator	Maximum staff turnover rate per year Number of High Potential individuals engaged and developed for strategic positions
Baseline	Staff turnover rate was 4.8% in 2010/11 18 individuals engaged and developed for strategic positions
Strategic Objective 2.3.3.2	**Performance is maximised**
Objective statement	The performance management framework is maintained to ensure that performance is maximised, with 100% (100) of employees undergoing a bi-annual performance review and 65%of employees participating in training in accordance with a personal development plan by 2014/15.
Indicator	Percentage of performance reviews conducted during the year Percentage of employees undergoing training in accordance with a personal development plan annually
Baseline	78 of employees underwent bi-annual performance reviews in 2010/11 48 employees underwent training in accordance with a personal development plan in 2010/11.

Strategic Objective 2.3.3.3	A productive work environment
Objective statement	Measures are taken to maintain a productive work environment. Health days, employee diversity information sessions, a values and work ethics workshops. By 2014/15, 1 health day per year will be held, **100** employees will attend a cultural diversity session, and 1workshop on values and work ethics will be held per year.
Indicator	Number of health days held per year Percentage of employees attending cultural awareness session per year Number of workshops on values and work ethics per year
Baseline	One health day was held in 2010/11 number of cultural awareness sessions held in 2010/11 Number of workshops held on values and work ethics in 2010/11
Strategic Objective 2.3.3.4	**Human Resource Management systems and processes**
Objective statement	Human Resource Management systems and processes are refined and improved. This ensures that all relevant policies and procedures are regularly updated. These include policies and procedures for recruitment and selection, 1 customer service survey will be undertaken, with the aim of surveying 86 employees by 2014/15
Indicator	Percentage of employees surveyed in respect of HR customer service per year
Baseline	86 employees participated in the HR customer service survey in 2010/11

6.3.3. Resource considerations (Human Resources Management Unit)

2.3 Human Resource Management	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of employees	**4**	**4**	**5**	**5**	**5**	**6**	**6**
Total	**3,598,400**	**4,330,964**	**5,041,420**	**4,962,440**	**5,894,678**	**6,383,741**	**6,766,765**
Compensation of employees	1,670,738	1,884,378	2,311,443	2,856,245	3,061,827	3,362,368	3,564,110
Goods and services	1,927,662	2,446,586	2,729,977	2,106,195	2,832,851	3,021,373	3,202,655
Employee Wellness	168,623	201,901	329,062	352,003	421,159	446,429	473,215
HR Organisational Strategy	470,598	458,295	389,720	344,455	711,960	950,476	1,007,505
Operational planning	350,883	446,412	403,136	245,187	212,000	224,720	238,203
Staff Training	63,500	95,865	120,628	141,572	162,000	125,000	132,500
Other	874,057	1,244,113	1,487,431	1,022,978	1,325,732	1,274,748	1,351,233

Staff turnover rates:

The turnover rate for the period 2010/2011 is 0 %

7. Programme 3 (Accreditation Unit)

7.1. Purpose (Accreditation Unit)

We ensure brokers, administrators and managed care organisations are assessed and accredited to the extent to which they meet the accreditation requirements as set out in the Medical Schemes Act, including whether applicants are fit and proper, have the necessary resources, skill, capacity and infrastructure and are financially sound.

7.2. Strategic Objectives (Accreditation Unit)

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

Strategic Objective 3.2.1.	**Broker accreditation applications processed**
Objective statement	Process 4 620 broker accreditation applications within 30 days of receipt of all relevant information per year by 2014/15.
Indicator	Total number of broker accreditation applications processed during the year within 30 days of receipt of all relevant information Number of new individual broker accreditation applications **processed** during the year within 30 days of receipt of all relevant information Number of **new individual broker** accreditation applications **accredited** during the year within 30 days of receipt of all relevant information Number of **new broker organisation** accreditation applications **processed** during the year within 30 days of receipt of all relevant information Number of **new broker organisation** accreditation applications **accredited** during the year within 30 days of receipt of all relevant information Number of individual **broker renewal accreditation** applications **processed** during the year Within 30 days of receipt of all relevant information Number of individual **broker renewal accreditation** applications **accredited** during the year within 30 days of receipt of all relevant information Number of **broker organisation renewal** accreditation applications **processed** during the year within 30 days of receipt of all relevant information Number of **broker organisation renewal** accreditation applications **accredited** during the year within 30 days of receipt of all relevant information
Baseline	Total of 5 906 broker applications processed in 2010/11 964 new individual broker application processed in 2010/11 591 new individual brokers accredited in 2010/11 137 new broker organisation applications processed in 2010/11 90 new broker organisation applications accredited in 2010/11 3631 individual broker renewal applications processed in 2010/11 2760 individual broker renewal applications accredited in 2010/11 1174 broker organisation renewal applications processed in 2010/11 875 broker organisation renewal applications accredited in 2010/11
Strategic Objective 3.2.2	**Managed Care Organisations (MCOs) accreditation applications processed**
Objective statement	Process 28 MCO accreditation applications per year by 2014/15.

Indicator	Number of managed care organisation applications processed during the year within 2 months of receipt of all relevant information and upon conclusion of on-site evaluations as determined Number of managed care organisation applications accredited during the year within 3 months of receipt of all relevant information and upon conclusion of on-site evaluations as determined
Baseline	26 applications processed in 2010/11 25 MCOs accredited in 2010/11
Strategic Objective 3.2.3	**Administrator accreditation applications processed**
Objective statement	Process 12 administrator accreditation applications per year by 2014/15.
Indicator	Number of applications by administrators and self administered schemes processed during the year within 2 months of receipt of all relevant information and upon conclusion of onsite evaluations as determined Number of applications by administrators and self administered schemes accredited during the year within 3 months of receipt of all relevant information and upon conclusion of on -site evaluations as determined
Baseline	15 applications processed in 2010/11 14 applications accredited in 2010/11

7.3. **Resource considerations (Accreditation Unit)**

3 Accreditation	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of employees	**7**	**7**	**7**	**9**	**9**	**9**	**9**
Total	**3,099,755**	**3,713,560**	**4,659,077**	**5,353,400**	**6,077,272**	**6,486,824**	**6,876,034**
Compensation of employees	2,864,872	3,429,582	4,440,883	4,910,715	5,501,453	5,741,324	6,085,804
Goods and services	234,883	283,978	218,194	442,685	575,819	745,500	790,230
Accreditation Cost	123,694	154,508	129,440	319,962	425,815	434,000	460,040
Staff Training	72,223	62,588	39,721	55,372	75,000	227,000	240,620
Other	38,966	66,882	49,033	67,351	75,004	84,500	89,570

The Unit currently accommodates 9 members of staff in terms of the approved structure. 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. On site evaluations are carried out in respect of administrators and MCOs to assess their compliance with pre-determined standards to measure infrastructure, skills, capacity and performance.

Key personnel have been increased during 2010/11 to enable the Unit to conduct evaluation of MCOs and to introduce evaluation of the clinical aspects of managed care delivery by applicants. It is envisaged that an additional Clinical Analyst post in addition to one post filled will address the key resource needs of the Unit.

Accreditation Analysts who currently evaluate administrators will in due course also extend their skills towards evaluation of MCOs together with the Clinical Analyst to ensure a detailed evaluation of all aspects of performance by applicants. However, not all managed care applications will be able to be assessed by means of on-site evaluations prior to accreditation or renewal of accreditation with the current staff compliment due to the detailed investigation and time taken to complete the evaluation and findings based on the assessment of compliance with all standards. A staggered approach is therefore required.

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.

The introduction of on-site evaluation of managed care organisations ensures that a factual assessment is carried out in similar way as it is done with administrators to ensure compliance with fit and proper requirements and all relevant standards for accreditation. It also assists the office with broader understanding of managed care practices and initiatives with a view of formulating policy over time.

In addition, we ensure that both manage care organisations who accept risk from client schemes and administrators submit their annual audited financial statements to the office. These audited statements are analysed, monitored and appropriate action is taken where necessary to ensure compliance with financial soundness requirements.

8. Programme 4 (Research and Monitoring)

8.1. Purpose (Research and Monitoring Unit)

We 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

8.2. Strategic Objectives (Research and Monitoring Unit)

Goal 1: Access to good quality medical scheme cover is maximized

Strategic Objective 4.1.1	**The scheme risk measurement system is maintained**
Objective statement	The scheme risk measurement system is maintained through the publication of articles on risk adjustment systems, the analysis of scheme risk factor submissions and research on the scheme risk measurement system. By 2014 /15, 1 article on scheme risk measurement, 85 scheme-specific risk measurement reports and an annual scheme risk-measurement report will be produced.
Indicator	Minimum number of articles on scheme risk adjustment systems published per year Percentage of scheme specific risk measurement reports published per year Number of scheme risk measurement research reports published per year
Baseline	One article published per year in 2010/11 Five reports published in 2010/11 None research reports published in 2010/11 (new indicator) 1 set of inputs produced in 2010/11

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

Strategic Objective 4.2.1	**Monitor ICD 10 implementation**
Objective statement	The Unit monitors ICD 10 compliance by providers through reports submitted by medical schemes and participates in the activities of the Ministerial Task Team on ICD 10 implementation coordinated by the Department of Health. By 2014/15, the unit will have published 4 reports per year and participated in Task Team activities as planned by the Department of Health.
Indicator	Number of Ministerial Task Team meetings attended per year. Number of ICD 10 compliance reports produced per year
Baseline	Four quarterly ICD 10 compliance reports were produced during 2010/11 and four quarterly National Task Team meetings were attended.
Strategic Objective 4.2.2	**Practice Code Numbering System (PCNS)**
Objective statement	The CMS must approve an entity to operate a practice code numbering system and an approved organisation will be in place at all times and submit 4 quarterly reports by 2014/15.
Indicator	Ensure that an approved entity is contracted with to manage the PCNS at all times Receipt of quarterly reports of statistics on providers registered on the PNCS per year Annual review of performance of approved entity
Baseline	An approved entity was in place in 2010/11 Four quarterly reports were received from the approved entity in 2010/11 and a review is done annually

Goal 4: *Council provides influential strategic advice and support for the development and implementation of strategic health policy, including support to the NHI development process*

Strategic Objective 4.4.1	**Research**
Objective statement	Research is conducted on aspects of the health system that have an impact on medical schemes and 4 projects will be completed per year by 2014/15.
Indicator	Number of research projects finalized per year
Baseline	4 research projects finalized in 2010/11.
Strategic Objective 4.4.2	**Specialised technical support**
Objective statement	Other CMS business units are supported with specialised technical input on research and statistics and 4 specialised technical support projects will be completed per annum by 2014/15.
Indicator	Number of support projects finalized per year
Baseline	4 support projects finalized in 2010/11.
Strategic Objective 4.4.3	**Annual report**
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. By 2014/15, these activities will be conducted once per year.
Indicator	Number of inputs given into the Registrar's Review, Review of Operations sections completed analyses of data done on an annual basis.
Baseline	Done annually

8.3. **Resource considerations (Research and Monitoring Unit)**

4 Research and Monitoring	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of employees	**7**	**7**	**7**	**8**	**8**	**8**	**8**
Total	**2,943,355**	**2,377,327**	**3,199,404**	**4,674,833**	**5,718,297**	**6,577,755**	**6,972,420**
Compensation of employees	2,643,136	2,119,561	2,996,823	4,427,102	5,429,407	5,810,458	6,159,085
Goods and services	300,219	257,766	202,581	247,731	288,890	767,297	813,335
Operational projects	-	-	-	-	-	400,000	424,000
Staff Training	44,184	198,949	133,200	155,036	116,000	183,500	194,510
Other	256,035	58,817	69,381	92,695	172,890	183,797	194,825

Key Expertise	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Health Economics	1	2	2	2	2	2	2
Statistics	1	1	1	3	3	3	3
Nursing/Clinical	1	1	1	1	0	0	0
Public Health/ Health Systems	1	1	1	1	3	3	3
Administrative support	1	1	1	1	1	1	1

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 health care 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. Existing capacity will be adequate to achieve this over the next 5 year period. 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. In 2012/13, an expert on developing health quality and outcomes indicators will be engaged and this is expected to have an impact on research costs. An increase in the amount allocated for research costs is expected to increase largely attributed to work anticipated on Health Outcomes and Quality Measurement

9. Programme 5: Stakeholder Relations

9.1. Purpose of the Stakeholder Relations Unit

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.

9.2. Strategic Objectives (Stakeholder Relations Unit: Communications, Education and Training, Customer care centre)

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

Strategic Objective 5.2.1	**Trustee Training**
Objective statement	Total of 100 trustees trained per year leading to improved governance of all schemes and understanding of the Medical Schemes Act by 2014/15
Indicator	Number of trustees trained per year
Baseline	70 trustees trained in 2010/11
Strategic Objective 5.2.2	**Consumer Education and Awareness**
Objective statement	Develop and implement education and awareness programmes per year by 2014/15
Indicator	Number consumer education and awareness sessions conducted by CMS per year
Baseline	24 427 of beneficiaries received consumer education from CMS in 2010/11
Strategic Objective 5.2.3	**Coordinate external training undertaken by other CMS units**
Objective statement	Coordinate and support external training undertaken by other CMS units by 2014/15
Indicator	Number of training session coordinated per year
Baseline	2 sessions coordinated in 2010/11
Strategic objective 5.2.4	**Communication with stakeholders**
Objective statement	Effective and proactive communication to the medical schemes industry, beneficiaries, the media, Council members and staff as well as other stakeholders on the key developments in the regulatory and policy environment, and the stance and attitude of the Council for Medical Schemes (CMS or Council) to these developments; 36 communiqués will be published per year by 2014/15
Indicator	Number of *CMS News* published per year Number of CMScript published per year Number of *Masihambisane* published per year Number of Press conferences held per year Number of Press releases published per year Percentage of Media enquiries handled per year
Baseline	In 2010/11, 36 communiqués were published
Strategic objective 5.2.5	**Publication of and engagement with stakeholders on Council's Annual Report**
Objective statement	Ensuring the publication of Council's Annual Report, and organising its launch and road shows
Indicator	Publication of Council's Annual Report Launch of Council's Annual Report (press conference) Number of road shows of Council's Annual Report per year

Baseline	Council's Annual Report published and launched, and road shows in 2010/11
Strategic objective 5.2.6	**Support for other Units**
Objective statement	Support for other Units in the achievement of their strategic objectives from a communications perspective; 52 Circulars will be drafted and edited in 2014/15
Indicator	Estimated number of Circulars to be drafted and edited per year
Baseline	In 2010/11, 20 Circulars were drafted and edited
Strategic Objective 5.2.7	**Customer Care Service**
Objective statement	Provide effective customer services by rendering relevant telephonic and written guidance and advice to our stakeholders. The unit will increase the number of calls handled to 46000 per year, and less than 2760 calls will be abandoned per year by 2014/15
Indicators	Estimated number of calls handled per year Number of calls abandoned per year Average Talk Time per year
Baseline	41 838 calls handled in 2011/12 3334 calls abandoned in 2011/12 2m27s Average Talk Time in 2011/12
Strategic objective 5.2. 8	**Engagement with stakeholders**
Objective statement	Effective and proactive with stakeholder in the medical schemes industry, beneficiaries, the media, Council members and staff as well as other stakeholders on the key developments in the regulatory and policy environment, and the stance and attitude of the Council for Medical Schemes (CMS or Council) to these developments; 4 engagement sessions will be held by 2014/15
Indicator	Number of forums and engagement sessions per annum
Baseline	Not applicable
Strategic objective 5.2. 8	**Advertisements placed in the media**
Objective statement	Advertisements placed with relevant media channels to ensure improved awareness of the Council; 2 runs of advertisements will be done by 2014/15
Indicator	Number of advertisements in newspapers, magazines and radio
Baseline	Not applicable

9.3. Resource considerations (Stakeholder Relations Unit – Communications, Education and Training, Customer care centre)

5 Stakeholder Relations	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of employees	**5**	**5**	**5**	**5**	**8**	**12**	**12**
Total	**2,099,138**	**458,997**	**1,678,907**	**5,738,031**	**7,364,372**	**8,548,377**	**9,061,280**
Compensation of employees	807,840	-	3,133	3,786,797	5,198,521	5,734,893	6,078,987
Goods and services	1,291,298	458,997	1,675,774	1,951,234	2,165,851	2,813,484	2,982,293
Annual Report	-	80,028	571,076	423,585	655,000	694,000	735,640
Consumer Education	851,877	-	1,104,698	1,211,790	896,680	1,026,000	1,087,560
Operational projects	-	-	-	-	-	400,000	424,000
Staff Training	11,058	-	-	81,209	202,170	200,000	212,000
Other	428,362	378,969	-	234,650	412,001	493,484	523,093

Education and Training

Strategic Objective 5.2.1	Trustee Training
Strategic Objective 5.2.2	Consumer Education and Awareness
Strategic Objective 5.2.3	Coordinate external training undertaken by other CMS units

The biggest expenditure items for the unit are external education and training initiatives and staff salaries. This can be expected to increase over the next three years to cater for the specialised skills required in the Unit in order to carry out our functions. With the Unit's more intense focus on trustee training and in light of the Education & Training Strategy that requires the unit to focus on more scheme specific trustee training, it will also leads to the need for additional staff with training and education qualifications.

More often members of the public and other stakeholders and consumer groups cry out that not many consumers 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 units list of stakeholders that required training and again result in both a need for additional financial and human resources in order to perform the units functions. This will result in an increase of the expenditure in relation to consumer awareness and education. The Unit is also required to seek the service of external training service providers for training and that will result in more cost increases. The publication and the conversation of the trustee training manual will require additional funding due to cost escalations.

The Unit coordinates the external training requirements of various internal units and the number of such session may vary in frequency and number depending on the Unit's operations in a particular financial year.

The Unit will require an additional resource in the form of senior Education and Training Specialist in order to fully implement the trustee training function of the Unit.

Communication

Strategic objective 5.2.4	Communication with stakeholders
Strategic objective 5.2.5	Publication of and engagement with stakeholders on Council's Annual Report
Strategic objective 5.2.6	Support for other Units

The limited and already severely strained human resources capacity in the Communications Unit has remained stagnant since May 2008. The Communications Unit, and specifically the Communications Manager, is facing serious challenges in meeting the Unit's strategic objectives while being put under persistent pressure to take on ever-more work. The capacity requirements of the Unit should be given urgent and serious attention and consideration if the strategic objectives are to be met. The Unit has been motivating for additional capacity since the 2008/09 financial year.

Customer Care Service Centre (CCSC)

Strategic Objective 5.2.7	Customer Care Service Centre (CCSC)

- The number of customer related calls has been increasing steadily over the past three years, with calls exceeding 300 a day. 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 thus take longer to finalise calls than would a simpler call centre and thus the volume is currently too high for the three available consultants. Where we had previously anticipated a growth of calls to 42000 in 2012/13, by the end of June 2012, the CCSC had already received 47 000 calls. The increase in call volume means that we will need to beef up the Customer Care 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 CCSC 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 as well as hellopter.com enquiries.

- CMS will also need to invest in a replacement Customer Care management system as the current system has become outdated and is still analogue and therefore does not integrate with our existing digital system.

Should the CCSC further expand, new premises will have to be sought for housing it, as the current premises can only accommodate 4 agents.

Stakeholder Relations

Strategic objective 5.2.8	Engagement with Stakeholders
	Advertising

Improved engagements with stakeholders are required and for this purpose a combination of forums and indabas will be held to discuss pertinent and relevant issues with stakeholders. To improve awareness of the Council, advertising in various media is required, as this will lead to more exposure of the Council in the media.

9.4. Human Resource requirements (Stakeholder Relations Unit – Communications, Education and Training, Customer care centre)

Education and Training

Objective & Position	Current	Proposed
Senior Education and Training Specialist	Vacant & not on post establishment.	To be created and advertised.
Education Officer	Vacant & not on post establishment	To be created and advertised

Communication

The number of staff members in the Communications Unit has remained stagnant at two full-time employees since May 2008 and should be revisited urgently given the amount and type of work that is being done by this strategic Unit – and to allow the Unit to continue meeting its mandate. Furthermore, additional demands are being placed on the Unit.

Customer Care Service Centre (CCSC)

Objective &Position	Current	Proposed
Customer Care Consultant	Vacant & not on post establishment.	To be created and advertised.

10. Programme 6 (Compliance)

10.1. Purpose (Compliance Unit)

We serve members of medical schemes and the public in general by analysing, reviewing and investigating information on possible transgressions of the Medical Schemes Act and taking appropriate actions to enforce compliance with the Act.

By doing this we help the Council for Medical Schemes foster compliance with the Medical Schemes Act and take proportionate actions to promote a culture of compliance with legislation.

10.2. Strategic Objectives (Compliance Unit)

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

Strategic Objective 5.2.1	**Enforcement of rulings and directives**
Objective statement	Maximise number of directives issued and rulings enforced by 2014
Indicator	Estimated number of rulings and directives enforced to ensure compliance per year
Baseline	57 enforced and directives issued in the year 2010/11
Strategic Objective 5.2.2	**Inspection of regulated entities**
Objective statement	Inspect or Investigate regulated entities
Indicator	Number of inspections or investigations instituted per year
Baseline	5 inspected or investigated in 2010/11
Strategic Objective 5.2.3	**Prepare Exemption applications for adjudication by Council**
Objective statement	Adjudicate on all applications for exemptions received
Indicator	Estimated number of exemptions applications for adjudication by the Council per year
Baseline	12 exemptions lodged are adjudicated upon
Strategic Objective 5.2.4	**Strengthen and monitor Governance systems**
Objective statement	Implement framework for good governance
Indicator	Number of Annual General Meeting/Special General Meetings & Trustee elections attended and monitored per year Number of officers of regulated entities vetted per year Number of section 46 proceedings instituted per year Number of Curatorship's/Liquidations & Compliance officers overseen and monitored per year
Baseline	No baseline as the strategic objective is new

10.3. Resource considerations (Compliance Unit)

6 Compliance	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Number of employees	4	4	5	6	6	7	7
Total	3,822,056	4,390,837	3,217,986	5,033,679	5,411,663	6,281,485	6,658,374
Compensation of employees	2,543,697	3,151,992	2,757,991	4,059,243	4,430,937	5,304,285	5,622,542
Goods and services	1,278,359	1,238,845	459,995	974,436	980,726	977,200	1,035,832
Investigation Costs	794,125	378,431	348,024	837,056	795,000	500,000	530,000
Operational projects	-	-	-	-	-	200,000	212,000
Staff Training	59,181	92,145	53,818	71,884	109,505	120,000	127,200
Other	425,053	768,269	58,153	65,496	76,221	157,200	166,632

During the period 2007/08 till 2008/09 the unit constituted of two staff members. The number was increased to three for the period 2009/10. During these periods the unit mainly focused on basic monitoring of compliance with the Act by regulated entities.

With the number of complaints received and irregularities uncovered, it became necessary to increase capacity of the unit. Due to financial/budget constraints the number was increased to 5 during the 2009/10 financial year. The gaps and constraints that were identified were in respect of our inability to conduct more inspections and at the same time attend to general non-compliance matters. During 2010/11 financial year the staff compliment was increased to 5 (1 temporary Personal Assistant and 1 Senior Investigator).

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.

In view of these challenges, the Unit has gradually introduced the concept of compliance officers. This is not legislated and is mainly done by agreement with regulated entities. The concept has worked so far as the regulated entities carry the costs. Some of the Compliance Officer's work is done by the Unit itself. This also stretches the limited resources in the Unit.

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 be employed for the 2011/12 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 by the unit of its mandate.

A further strategic objective has been added for the reporting period 2013/14 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.

Outsourced Inspections

Period	Cost	
2008/09	R 1,2 million	
2009/10	R 2 million	
2010/11	R 1 million	Estimates
2011/12	R 1,3 million	
2012/13		
2013/14		

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.

10.4. Human Resource requirements (Compliance Unit)

Position	Current	Proposed
Senior investigator	3	4

11. Programme 7 (Benefits Management Unit)

11.1. Purpose of the Benefits Management Unit

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

11.2. Strategic Objectives (Benefits Management Unit)

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

Strategic Objective 7.2.1	**Scheme rule amendments**
Objective statement	Process 275 of medical scheme rule amendments per year by 2014/15
Indicator	Estimated number of rule amendments processed per year
Baseline	314 rule amendments processed in 2010/11. The target for 2013/14 has been reduced in line with the performance in 2011/12 of 275 rule amendments processed.
Strategic Objective 7.2.2	**Monitor scheme marketing material**
Objective statement	Evaluate 45 schemes' marketing materials and application forms and ensure that these are in accordance with scheme rules per year by 2014/15
Indicator	Estimated number of schemes' marketing material reviewed per year
Baseline	40 schemes' marketing material analysed per year in 2010/11
Strategic Objective 7.2.3	**Registration of new schemes**
Objective statement	Process 1 application per year for the registration of a new scheme by 2014/15
Indicator	Number of applications for new schemes considered per year
Baseline	1 applications processed in 2010/11
Strategic Objective 7.2.4	**Manage scheme amalgamations**
Objective statement	Manage3 applications for amalgamations per year in accordance with prevailing legislation by 2014/15
Indicator	Number of amalgamations managed per year
Baseline	8 Amalgamation managed in 2010/11

11.3. Resource considerations (Benefits Management Unit)

7 Benefits Management	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Number of Employees	**7**	**7**	**7**	**7**	**8**	**8**	**8**
Total	**3,057,607**	**4,793,677**	**5,217,647**	**3,905,864**	**4,861,426**	**4,913,030**	**5,207,812**
Compensation of employees	2,960,103	4,041,229	4,799,523	3,753,762	4,545,016	4,677,242	4,957,877
Goods and services	97,504	752,448	418,124	152,102	316,410	235,788	249,935
Operational projects	-	-	-	-	-	20,000	21,200
Staff Training	78,040	73,585	97,186	112,497	250,000	160,000	169,600
Other	19,464	678,863	320,938	39,605	66,410	55,788	59,135

In the strategic session with Council in November 2010 emphasis was placed on the requirement that CMS monitors the marketing materials of schemes and also the requirement that schemes communicate with members in a language that is in layman terms and compliant to the CP Act that would take force in 2011.

The Unit has determined that in order to implement the strategy determined by Council there is a capacity requirement in order for the stringent monitoring of marketing materials to take place for medical schemes. This strategy as well as requirements for the effective running of the Unit has been supplied and the additional skilled resource consideration was approved for the 2012/13 financial year.

Resourcing and expenditure trends

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 Head, 3 senior analysts, 2 analysts and an administrator. The Unit is responsible for the following strategic objectives for which the following resources are applied.

Strategic objective	Staff
7.2.1: Scheme rule amendments	All registered schemes divided amongst 3 senior analysts and 2 analysts
7.2.2: Monitor scheme marketing material	Schemes marketing materials and application forms analysed per year based on quarterly targets set above.
7.2.3: Registration of new schemes	Allocated to analysts based on experience and complexity
7.2.4: Management of scheme amalgamations	Allocated to analyst based on distribution of schemes as per strategic objective 7.2.1

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

11.4. Human Resource Requirement (Benefit Management Unit)

The Unit has identified the need for further resources in order to ensure that the unit focuses on a key area that affects members. This is the monitoring of marketing and communication by schemes to its members.

The numbers of key staff (as indicated above) are the 3 senior analysts and 3 analysts responsible for the registration of scheme rules, new schemes, marketing material and amalgamations. A key requirement identified by the Unit during the 2011/12 reporting period is the emphasis on monitoring of communication of schemes to its members and the impact of the consumer protection legislation.

We have identified this as a key area that requires skilled input in order to ensure that beneficiaries receive correct and relevant communication from schemes. The motivation for the acquiring of this skill has been made and approved for the expansion of the Unit with skill in technical marketing and the monitoring and evaluation of communication with guidelines being set for the industry for 2012/13.

12. Programme 8 (Legal Services Unit)

12.1. Purpose (Legal Services Unit)

We provide legal advice and representation to the CMS and business units to ensure the integrity of regulatory decisions.

12.2. Strategic Objectives (Legal Services Unit)

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

Strategic Objective 8.2.1	**Legal advisory service**
Objective statement	To provide written and verbal legal opinions, and representations to the CMS and the Office of the Registrar to protect the integrity of regulatory decisions. The unit will provide 55 written & verbal legal opinions by 2014/15.
Indicator	Estimated number of written and verbal legal opinions provided to the CMS or business units per year
Baseline	40 written and verbal legal opinions were provided to the CMS or business units in 2010/11
Strategic Objective 8.2.2	**Legal support service**
Objective statement	To provide a legal support services to the Office of the Registrar and the Council 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 work toward to reducing the targeted 20 cases by 2014/15
Indicator	Estimated number of court cases where court papers are filed per year
Baseline	In 25 cases papers were filed in court and other tribunals in 2010/11

12.3. Resource considerations (Legal Services Unit)

8 Legal Services	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Number of employees	**3**	**3**	**3**	**3**	**4**	**4**	**4**
Total	**5,400,635**	**6,357,813**	**12,261,175**	**12,823,025**	**7,879,726**	**3,038,909**	**3,221,244**
Compensation of employees	1,634,383	1,428,712	1,836,283	2,128,882	3,001,944	6,753,002	7,158,182
Goods and services	3,766,252	4,929,101	10,424,892	10,694,143	4,877,782	6,753,002	7,158,182
Appeal Board	508,663	84,407	422,586	228,695	477,000	541,002	573,462
Legal Fees	3,146,499	4,802,735	9,892,398	10,388,582	4,200,000	6,000,000	6,360,000
Staff Training	68,044	8,962	19,992	12,563	89,000	95,000	100,700
Other	43,047	32,997	89,916	64,303	111,782	117,000	124,020

There has been an upward trend in unplanned litigation against 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.

13. Programme 9 (Financial Supervision Unit)

13.1. Purpose of the Financial Supervision Unit

We 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.

13.2. Strategic Objectives (Financial Supervision Unit)

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

Strategic Objective 9.2.1	**Improve statutory returns as tools for monitoring and publish reports on findings**
Objective statement	Development of specifications for the Statutory Annual and Quarterly Return Online Systems. The unit will develop specifications annually for the Annual and Quarterly Return Online Systems by 2014/15. The unit will also publish 3 Quarterly Reports and 1 financial section of the Annual Report by 2014/15.
Indicators	Number of IT Specifications produced in respect of Statutory Quarterly Return per year Number of IT Specifications produced in respect of Statutory Annual Return per year Number of Quarterly Reports published per year Number of financial sections prepared for the Annual Report per year
Baseline	1 set of IT Specifications provided in respect of Quarterly Return in 2010/2011 1 set of IT Specifications provided in respect of the Annual Return in 2010/2011 3 Quarterly Reports published 1 set of input in respect of the financial sections of the Annual Return in 2010/2011
Strategic Objective 9.2.2	**Improve reporting by medical schemes (Data Quality)**
Objective statement	Training sessions for administrators, schemes and auditors annually by 2014/15, as well as input to reporting guidelines. The unit will also publish standard financial guidelines annually, and provide input to the Accounting and Auditing Guides issued by South African Institute of Chartered Accountants (SAICA) and Independent Regulatory Board of Auditors (IRBA) respectively.
Indicators	Number of training sessions held in respect of reporting of financial information Rejection of 100% of statutory returns received that do not meet quality specifications as identified. Rejection of 100% of Annual Financial Statements received that do not meet quality specifications as identified. Number of guidelines published per year Number of inputs prepared for SAICA guide per year Number of inputs prepared for IRBA guide per year

Baseline	There was 1 rejection of return in 2010/2011 (Protea Medical Aid Society) 2 Training sessions held in 2010/2011 1 set of inputs provided into Accounting Guide issued by SAICA in 2010/2011 1 set of inputs provided into Auditing Guide issued by IRBA in 2010/2011 1 set of guidelines published in 2010/2011
Strategic Objective 9.2.3	**Provide specialized financial advice**
Objective statement	Provide units and other stakeholders with financial inputs as per request on contribution and benefits, exemptions, new schemes and non-compliance and inspections and any other matter as requested. The unit will process all requests for specialized financial advice by 2014/15.
Indicators	100% of requests for specialized advice processed per year
Baseline	There were 97 requests for specialised advise in 2010/11, which were finalised.
Strategic Objective 9.2.4	**Provide financial oversight of medical schemes/ Close monitoring**
Objective statement	Recommendations provided on action plans i.r.o regulation 29 (schemes below solvency) by 2014/15 such that beneficiaries of medical schemes are protected.
Indicators	Recommendations in respect of Regulation 29 (schemes below solvency) for 100% of business plan submissions received per year Recommendations on action plans for schemes with rapidly reducing schemes solvency but above statutory minimum for 100% of schemes identified per year
Baseline	6 recommendations in respect of Regulation 29 (Spectramed, Umvuso, Commed, Resolution Health, Transmed & Pharos) 5 recommendations in respect of scheme with rapidly reducing solvency but above statutory minimum (Xstrata, Goldfields, Compcare, Tiger Brands & Foschini)
Strategic Objective 9.2.5	**Governance and Independence**
Objective statement	100% of schemes submitting auditor approval questionnaires on time by 2014/15. The unit will analyse and make recommendations for 100% of submitted applications for auditor approvals as well as reinsurance applications.
Indicators	Number of online auditor approval questionnaire published per year Audit approval letters drafted such that 100% of applications by schemes are responded to annually Responses to 100% of schemes that submitted reinsurance applications
Baseline	1 online auditor approval questionnaire in 2010/2011 1 scheme submitted an application for reinsurance

13.3. Resource considerations (Financial Supervision Unit)

9 Financial Supervision	Audited outcomes			Adjusted appropriation	Medium-term expenditure estimates		
Rand	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Number of employees	**8**	**10**	**10**	**10**	**10**	**11**	**11**
Total	**5,062,144**	**6,413,836**	**7,028,287**	**7,131,365**	**8,285,899**	**9,927,492**	**10,523,141**
Compensation of employees	4,852,556	6,166,904	6,691,106	6,926,938	7,787,702	9,244,190	9,798,841
Goods and services	209,588	246,932	337,181	204,427	498,197	683,302	724,300
Operational projects	-	-	-	-	-	100,000	106,000
Staff Training	93,228	153,761	234,046	144,281	293,895	327,300	346,938
Other	116,359	93,171	103,135	60,146	204,302	256,002	271,362

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 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 will 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.