COUNCIL FOR MEDICAL SCHEMES

Annual Performance Plan for 2021/22

Date of Tabling: March 2021

Executive Authority Statement

The Council for Medical Schemes (CMS) submitted its strategic plan for the fiscal years 2020 to 2025 as well as its Annual Performance Plan for 2021/22, and these were well received by me. I am satisfied with the alignment between the Strategic Plan and the Annual Performance Plan. I am encouraged by the new vision of the CMS that seeks to promote affordable and accessible health cover towards Universal Health Coverage (UHC).

This signals a new determined approach by the CMS to support national policy initiatives that are driven by the National Department of Health (NDoH). This approach will go a long way in the next four years in ensuring both the private and public health sectors move in the same direction, towards the achievement of national and international goals as articulated in the National Development Plan 2030, the Presidential Health Compact, and the Sustainable Development Goals, respectively. This vision is in line with the second phase to implement the National Health Insurance (NHI) Fund.

The National Department of Health will work closely with the CMS to ensure that the process to review the Prescribed Minimum Benefits (PMB) is accelerated to ensure that a single common primary healthcare package is made available to the South African population irrespective of whether this is accessed from the public or private health sector.

I am supportive of the quest by the CMS to play an active role in the reduction of costs and the improvement of the quality of health care in the private sector. This alone will ensure that these services are affordable and accessible, resulting in better health outcomes for the country as a whole.

The CMS has established itself as an effective and efficient regulator over the years, and this is demonstrated by the execution of its mandate and its responsiveness to the protection of the members of medical schemes and promoting access to healthcare. I am also pleased by the manner in which the finances of CMS have been managed. CMS has obtained unqualified audit reports from the office of the Auditor General of South Africa every year since its inception. Consequently, I am satisfied to endorse this strategic plan.

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

DR. ZWELINI MKHIZE, MP

MINISTER OF HEALTH

Accounting Authority Statement

During its 20 years of existence, the Council for Medical Schemes (the CMS) has built a proud culture of protecting beneficiaries of medical schemes by enforcing the provisions of the Medical Schemes Act 131 of 1998 (MSA). The main pillars of the MSA are the requirements for open enrolment, community rating, and prescribed minimum benefits. Linked with the governance requirements stipulated in the MSA, these provisions protect beneficiaries against discrimination based on health status and other arbitrary grounds.

The Council, under my leadership, is ready to play its key oversight role to the CMS during the most interesting era of the health sector in South Africa. This era has seen the release of the draft Medical Schemes Amendment and National Health Insurance Bills as well as the Health Market Inquiry final report. The process of finalising and implementing these three policy initiatives will provide a basis for all the key initiatives that this organisation will be busy within the next five years.

The finalisation and implementation of the proposed MSA are expected to provide the CMS with the capacity that it currently lacks to become a more effective and efficient industry regulator. The proposed National Health Insurance Act will establish a fund that will be the foundation of the National Health Insurance when it is fully implemented. The proposed Medical Schemes Act intends to provide stability and certainty in the medical schemes industry in the transition towards Universal Health Coverage.

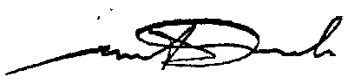
The strategic trajectory for the CMS for the next five years entails ensuring effective and efficient regulation of the medical schemes industry and playing a significant role in the implementation of Universal Health Coverage using the National Health Insurance as the chosen vehicle in South Africa. The CMS will as part of its greater mandate, make significant contributions in the following key areas, as the industry regulator:

- Policy development and research
- Reduction of costs and quality improvement
- Reduction of fraud, waste and abuse
- Support establishment of a coding authority
- Harmonise the medical schemes regulatory frameworks in the SADC
- Consolidation of options and medical schemes
- Beneficiary Registry

- Primary Health Care package

I am convinced that this Annual Performance Plan will have a significant impact on the Strategic Plan and that there is good alignment between these key planning efforts.

I extend my gratitude to fellow Council members, the Registrar, the CMS Management and staff, for the continued focus on the mandate as entrenched in the MSA; in particular, the development of this strategic plan. I further wish the CMS under the leadership of the Registrar together with the CMS management well in the execution of this plan.



DR. MEMELA M MAKIWANE

CHAIRPERSON OF THE COUNCIL

Official Sign-Off

It is hereby certified that this Annual Performance Plan:

- Was developed by the Accounting Authority and Management of the Council for Medical Schemes under the guidance of the National Department of Health
- 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 2020 to 2025

Ms. Andiswa Zinja

Chief Financial Officer

Mr. Ephraim Tlhako

General Manager: Information Technology & Knowledge Management

Ms. Agnes Sethogoa

Acting General Manager: Human Resources

Mr. John Letsoalo

Acting General Manager: Legal Services

Mr. Khayalethu Mvulo
Company Secretariat

Vacant

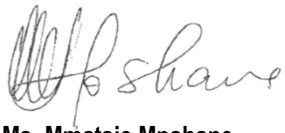
Strategy Office

Ms. Florence Maphanga

Acting General Manager: Accreditation

Mr. Michael Willie

General Manager: Research and Monitoring



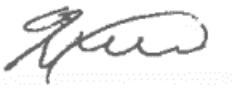
Ms. Mmatsie Mpshane

Acting General Manager: Stakeholder Relations

Mr. Thamsanqa Diniso

Acting General Manager: Compliance and Investigations

Mr. Mashilo Leboho
Acting General Manager: Benefit Management



Ms. Elizabeth Figueiredo

Acting General Manager: Financial Supervision

Ms. Thembekile Phaswane

General Manager: Complaints Adjudication

Mr. Reginald A Sadiki

Executive Manager: Office of the CEO & Registrar

Dr. Sipho Kabane

Chief Executive Officer and Registrar

Dr. Memela M Makiwane

Chairperson: Council for Medical Schemes

DR. ZWELINI MKHIZE, MP

MINISTER OF HEALTH

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Part A: Our Mandate

1. Updates to the relevant legislative and policy mandates

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

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

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

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

1.3. The Medical Schemes Act, 131 of 1998 (MSA)

The MSA established the Council for Medical Schemes. Section 7 of the MSA confers the following functions on Council:

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

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

Amongst others these are:

- Constitution of the Republic of South Africa, Act 108 of 1996
  To provide the legal foundation for the existence of the republic sets out the rights and duties of its citizens, and defines the structure of the government.
- Medical Schemes Act; 131 of 1998 (MSA)
  To regulate to affairs of medical schemes and protect the interest of beneficiaries.
- Council for Medical Schemes Levy Act, 58 of 2000
  Provides a legal framework for the Council to collect levies from medical schemes.
- Occupational Health and Safety Act, 85 of 1993 (OHSA)
  Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.
- Employment Equity Act, 55 of 1998 (EEA)
  Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.
- Skills Development Act, 97 of 1998 (SDA)

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

- Public Finance Management Act, 1 of 1999 (PFMA)
  Provides for the effective, efficient and economic financial management in government departments and public entities.
- Promotion of Access to Information Act, 2 of 2000 (PAIA)
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies or person. It gives effect to the right of access to any information held by the state or any other entity or person.
- Protection of Personal Information Act 4, of 2013 (POPI)
  This Act sets the conditions for how an organisation can process or access information and also how it approaches the aspect of privacy.
- Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000 (PEPUDA)
  Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.
- Broad-based Black Economic Empowerment Act, 53 of 2003 (BBBEEA)
  Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.
- Labour Relations Act, 66 of 1995 (LRA)
  to promote economic development, social justice, labour peace and democracy in the workplace.
- Financial Sector Regulation Act, 9 of 2017 (FSRA)
- *To establish a system of financial regulation by establishing the Prudential Authority and the Financial Sector Conduct Authority,*
- Promotion of Administrative Justice Act, 3 of 2000 (PAJA)
  To give effect to the right to administrative action that is lawful, reasonable and procedurally fair and to the right to written reasons for the administrative action as contemplated in section 33 of the Constitution of the Republic of South Africa.
- Financial Sector Regulation Act, 9 of 2017 (FSRA)
  To provide for the participation of the CMS as a regulator and to provide powers of inspection into financial service providers.
- Financial Advisory and Intermediary Services Act, 37 of 2002 (FAIS)
  To provide for the dual accreditation of brokers.
- Companies Act, 71 of 2008
  Provides for liquidation of medical schemes

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

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

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

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

1. address the social determinants that affect health and diseases;
2. strengthen the health system;
3. improve health information systems;
4. prevent and reduce the disease burden and promote health;
5. financing universal healthcare coverage;
6. improve human resources in health sector;

7. review management positions and appointments and strengthen accountability mechanisms;
8. improve quality by using evidence; and
9. meaningful public-private partnerships

The current population of South Africa is estimated at approximately 58 million lives, 8,9 million of which are covered by private healthcare. This is largely a function of the socio-economic status of the majority of the South African population, with unemployment at the forefront. There is a correlation between employment and membership growth within the medical schemes environment. Even for those belonging to medical schemes, affordability remains a challenge as healthcare costs continue to increase at rates that are significantly higher than inflation. A lot, therefore, remains to be done in increasing access to medical schemes' cover. The CMS as a regulator plays a key role in facilitating and promoting the health of all citizens in support of Vision 2030. The CMS will need to, inter alia, develop an inclusive private healthcare framework that will cater for vulnerable groups of the population, in line with the broader objectives of Universal Health Coverage.

The current Minister of Health, Dr Zwelini Mkhize, is tasked with the vast responsibility of carrying out government policy objectives in respect of the healthcare system of South Africa, as contained in the NDP Vision 2030.

Below are the five-year goals[1] of the NDOH for 2020 – 2025:

- Goal 1: Increase Life Expectancy improve Health and Prevent Disease
- Goal 2: Achieve UHC by Implement NHI
- Goal 3: Quality Improvement in the Provision of care
- Goal 4: Build Health Infrastructure for effective service delivery

1.5. Policy Mandates

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

- National Development Plan: 2030
- Sustainable Development Goals 2030
- Strategic Plan of the National Department of Health 2020-2025

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

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

The main developments that have a direct bearing on the medical schemes industry have been the:

- Medical Schemes Amendment Bill (MSAB)
- National Health Insurance Bill (NHIB)
- Health Market Inquiry (HMI)
- Presidential Health Compact Summit 2019
- Financial Sector Regulatory Act
- Conduct of Financial Institutions Bill (COFI Bill)

The Medical Schemes Amendment Act

The CMS has made extensive inputs during the period for comments by key stakeholders. Our expectations is that during the 2021/22 financial year there will be intensive interactions with key stakeholders culminating in the finalisation and promulgation of the amendments to the MSA. The CMS is tasked with the implementation of all the legislated changes and where necessary develop the

[1] National Department of Health, Strategic Plan, 2020/21 to 2024/25; published 2020

regulations. The successful implementation of the new MSA and Regulations will empower the CMS to become a more effective and efficient regulator. The final changes that will be incorporated in the MSAB will include recommendations from the HMI, NHIB and other regulatory updates.

The National Health Insurance (NHI)

The NHI Bill was presented to and approved by Cabinet in July 2019, and has since been presented to Health Portfolio Committee. This Committee has now released the bill for further public comment. The Bill has been subjected to an extensive public consultation process through the Health Portfolio Committee roadshows and is scheduled for further parliamentary debates before it is presented to the President for promulgation.

This period coincides with the beginning of the second phase of the implementation of the NHI. The CMS sees its role as playing both a supportive and a direct role in the delivery of all the activities according to the Act that should occur in the private sector.

Phase 1 (2012-2017): included the piloting of and the development of systems and processes for the effective functioning of the health system

Phase 2 (2017-2022): which is the second phase will entail the development of systems and processes to ensure effective functioning and administration of the NHI Fund. These reforms are categorised into four items: (a) Financing, (b) Health service provision, (c) Governance, and (d) Regulatory, as described below:

Financing	**Provision**
Public Sector - Restructuring Equitable share - Hospitals (i) Establish cost-based budget for hospitals, - (ii) introduce case-mix based budget - PHC (i) Establish Clinic Budget, (ii) Introduce capitation contracting **Private Sector** - High price for health services - Price regulation for the all services included in the NHI comprehensive benefit framework - Removal of Differential pricing of services based on diagnosis - Co-Payments and Balanced billing	**Public Sector** - School Health, Maternal and woman's health - Mental Illness, Elderly, Disability and Rehabilitation - Expansion of Service Benefits, and Implementation PHC services through 1st 1000 clinics **Private Sector** - Introduction of Single Service Benefits Framework - Reduce the number of options per scheme - Reform of PMBs and alignment to NHI services benefits, including common protocols/care pathways
Governance **Public Sector** - Established Central Hospital as Semi-autonomous structure - Strengthen Governance and delegations of Hospitals - Strengthen Governance and delegation of Districts **Private Sector** - Governance and non-health care - Reserves and solvency **Interim Institutional Structure** - Establishment of NHI Transitional Structures - Establishment of Health System Reform Structures - Interim NHI Fund	**Regulatory** **Public Sector** - Legislation to create NHI Fund – the NHI Bill introduction - Legislation Amendments: (i) National Health Act; (ii) The Health Professions Act and (iii) General Health Legislation Amendment **Private Sector** - Medical Schemes Act and regulations Reform - Consolidation: (i) Consolidate GEMS and other state medical schemes into single structure; (ii) Reduce the number of Medical Schemes and (iii) Reduce the number of options in Medical Schemes - Licensing of health establishments

Phase 3 (2021-2025): will be the introduction of mandatory prepayment for the NHI, contracting for accredited private hospital and specialist services, finalisation and implementation of the Medical Schemes Act and finalisation and implementation of the NHI Act, in addition to the specific activities that the CMS will be carrying out in phase 2.

Health Market Inquiry (HMI)

The HMI panel released its findings and key recommendations in a report end of September 2019. The report was presented to the Competition Commissioner and the Minister of Trade and Industry who will present this to the Minister of Health. The Minister of Health

is tasked with developing an implementation plan based on the report. This implementation plan will be developed by the Health Minister, together with key health sector stakeholders, including the CMS. It is envisaged that the implementation will have a significant impact on the MSAB. CMS expects that it will be expected to implement some of the recommendations directly, support the implementation of others, and to play an active role in the interim arrangements leading to the establishment of new regulatory entities.

Presidential Health Compact Summit 2019

In October 2018, the President hosted a health summit of all key health sector stakeholders to find solutions to the current public and private health sector challenges. This summit resulted in the development of the Presidential Health Compact, which binds both the public and private sectors to address the identified challenges in the partnership. This compact is supported by a detailed implementation plan that consists of nine pillars or areas of commitment. It is envisaged that this compact will have a significant influence on the health reforms for the next five years.

Financial Sector Regulatory Act (FSRA) and Conduct of Financial Institutions (COFI) Bill

The CMS is working together with the National Treasury, Financial Sector Conduct Authority, and the Prudential Authority to ensure that there is harmonisation in the regulatory framework. This should also ensure that there are role clarification and collaboration in the sectors that they co-regulate.

2. Updates to Institutional Policies and Strategies

The CMS has ICT, HR, Finance, and Stakeholder Relations Policies. The policies are periodically reviewed and approved by the Accounting Authority. The CMS has adopted a new remuneration policy and philosophy in 2019 and is in the process of implementing these. The CMS has reviewed its current Code of Conduct and has developed and adopted a comprehensive Ethics Policy in the light of the recent whistle-blower allegations received during the 2019 financial year. New Ethics Code of Conduct pocketbooks will be issued in 2021/22.

The Accounting Authority has adopted the Organisational Diagnostic Exercise Report and its recommendations, thereby allowing the institution to review its Business Operational Model, which includes a service delivery model and conducting a business process mapping. A greater part of 2021/22 will see the implementation of the new structure adopted by the Council and the migration of personnel from the old to this structure.

3. Updates to Relevant Court Rulings

CMS vs Foodmed

The Western Cape High Court has on 16 July 2019, placed the Food Worker's Medical Benefit Fund (Foodmed) under provisional curatorship following a successful application by the Registrar of the Council for Medical Schemes (CMS), in terms of Section 56(1) of the Medical Schemes Act, No. 131 of 1998 (the MS Act), and Section 5(1) and (2) of the Financial Institutions (Protection of Funds) Act 28 of 2001 (the FI Act).

The curatorship application was necessitated by the expiration of the scheme Board of Trustees (BoT) and the curatorship our application is to ensure that proper governance at the scheme is upheld.

The application has been duly granted and the curator, Adv. Deon Van Wyk has assumed control of the scheme. Allegations of misconduct on the part of the PO was also received in relation to the Annual General Meeting and the curator was tasked to institute the necessary disciplinary action.

The curator has attended to all the challenges that Foodmed was faced with and the scheme has been handed back to a legitimately elected Board of Trustees.

CMS vs Thebemed

The High Court granted a curatorship application on 10 September 2019 in favour of the CMS after the scheme's solvency levels reduced to a precarious state. The CMS has worked with the curator to closely monitor the scheme to ensure that the scheme's solvency improves significantly to protect the interests of members.

CMS vs SAMWUMED

The scheme was placed under curatorship on 20 October 2018 due to material irregularities at the scheme. The appointed curator has addressed all the challenges that SAMWUMED was faced with and the scheme has now been handed over to a legitimately appointed Board of Trustees.

Compcare vs Registrar and CMS

This matter concerns an application to have the scheme's name changed to that if its administrator, i.e. Universal Healthcare. The Registrar rejected the rule amendment and the Appeals Committee confirmed the decision when the scheme took the matter on appeal. The Appeal Board overturned the decision and directed the Registrar to implement the name change. Due to the impact of such a name change on the arm's length relationship that there is supposed to be between a scheme and administrators, as well as the impact on members who will likely be confused by the change. The Registrar took the matter on review to the High Court on 17 August 2020, which ruled in its favour. An appeal has been lodged on this matter and it is due to serve in the Constitutional Court soon.

SOUTH AFRICAN MEDICAL ASSOCIATION vs CMS

South African Medical Association v CMS (Modifiers) This longstanding matter relates to a complaint lodged with the Competition Tribunal by the CMS against the South African Medical Association (SAMA) and the South African Paediatric Association (SAPA) on the one hand and SAMA and the Society of Cardiothoracic Surgeons of South Africa (SOCTS) on the other hand. In the complaint referrals, the CMS alleges that these parties are involved in indirect price-fixing by way of the publication of certain codes in the doctor's billing guide (DBG) issued by SAMA, which are not provided for in the National Health Reference Price List (NHRPL).

The effect of these publications means that paediatricians and neonatologists are allowed to charge a 50% surcharge by charging a new code, Modifier 0019(b) on certain intensive care items; and cardiothoracic surgeons are allowed to use a formula in terms of which they can charge a separate fee under code 1348 for each saphenous vein graft performed under a single anaesthetic, subject to the application of Modifier 0005. As a result of this conduct, members and consumers, in general, are required to pay more for these health services while medical schemes are not obliged to fund these codes.

There have been several interlocutory disputes ranging from the right of the CMS to lodge the complaint in its capacity as a regulatory body, to an application to strike out our case due to allegations by SAMA that it is too vague. These interlocutory applications have now been adjudicated by the Competition Tribunal. The parties then appealed to the Competition Appeal Court to adjudicate on the failed interlocutory application, the Competition Appeal Court again ruled in favour of the CMS. Since the interlocutory applications have failed in both forums, the pleadings have been consolidated by the CMS and the merits of the matter can now be dealt with afresh by the Competition Tribunal.

CMS vs KEYHEALTH

The section 43 inquiry indicated material irregularities at the scheme. Registrar and council resolved to place the scheme under curatorship. A court order to place Keyhealth under curatorship was issued on 31 August 2020.

CMS vs BONITAS

The Scheme appointed a Principal Officer (PO) but did not follow proper human resource processes and their own recruitment policy. The CMS issued directives to the scheme to restart the process of the appointment due to the founded process. Bonitas issued an urgent interdict application against the decision of the Registrar of the Council for Medical Scheme (CMS) dated 5 February 2020. On the 18th March 2020 the High Court held that CMS is interdicted and restrained from taking any action i.r.o of the directives. The costs of the application are reserved until the case is finalised by the High Court.

Part B: Our Strategic Focus

4. Situation Analysis

The situational analysis below has utilised a combination of a SWOT, PESTEL, and scenario planning to identify key challenges and priorities for the CMS in the next five years. The comprehensive presentations to this effect are reflected at a high level only, due to the complex nature and the volume of information generated.

4.1 External Environment Analysis

Table 1: PESTEL analysis

POLITICAL	ECONOMIC	SOCIAL	TECHNOLOGICAL	ENVIRONMENTAL	LEGAL
• State of Disaster • Ethical Leadership • Conflict of Interest • Budget review • State incapacity • COVID- 19 Funds • Public Accountability • *Zondo Commission*	• Economy contraction • Real GDP decline to 2006 levels • Post-financial crisis growth has been wiped out • Budget deficit • Junk Status • Increasing unemployment • Increasing poverty • Increasing inequity	• Working remotely • Social welfare • Education (Quality) • Protests • Service/Wages • Ageing population • Burden of disease • Gender Based Violence • Fighting Crime • Cultural barriers, lifestyle attitudes • Climate change	• Virtual platforms • E-learning • Conferences • E-health • Cellphones • Laptops • Data • AL/Analytics Robotics • Digital transactions • Block chain technology • Cyber-security	• Lack of energy (Load shedding) • Climate change and variability • Waste and littering • Pollution • Lack of water/ droughts • Save trees, prints less electronic communication Sign flow	• Advertising standards • Clicks Case Study • Racial inequality and low inter-group trust • Equal opportunities • Consumer rights and laws • Product labelling and product safety • Sanitizer Dispensers • Food safety • Transformation

Table 1 above provides a substantial but not exhaustive list of the key external environmental issues that are likely to have an influence on its operations or regulatory environment. A key contextual issue in the development of Table 1 and the accompanying analysis is the persistence and existence of the COVID-19 pandemic for a greater part of the 2021/22 financial year.

The regulations that accompany the efforts to combat the COVID-19 pandemic will continue to have an impact on humans, services and goods movement, employment, poverty, and inequities. These in turs will have a considerable impact on scheme membership, regulation, and sustainability of the medical scheme industry in the short, medium, to long term.

The revelations of governance failures, unethical behaviour, and corruption that is in the public domain will impact negatively on the ability of the government to fund public health entities such as the CMS as well as public perceptions about its ability to deliver on the National Health Insurance.

The collapse of the economy that has been exacerbated by the COVID-19 pandemic is likely to ensure that employment, poverty, and inequities will worsen in the next five years. The fact that medical scheme membership is associated with employment and a growing economy means that scheme members are likely to decrease in the medium to long term, rendering the sustainability of the industry questionable.

The redirection of resources to address the immediate impact of COVID-19 means that less attention will be paid to other serious public health priorities such as TB, HIV and non-communicable diseases. We are likely to see an increased incidence and prevalence of these ignored diseases, including gender-based violence in the years to come. This increasing burden of disease is also likely to affect the funding of schemes and affordability negatively.

The epidemiologists and other experts have been at pains in indicating that the effects of climate change, energy, and water shortages will result in more similar pandemics in the future.

In terms of scenario-planning, it appears as if we are moving into a scenario of a difficult economic recovery coupled with significant challenges to the implementation of the National Health Insurance. This scenario emanates from an analysis based on the economic recovery and NHI implementation as key uncertainties in the CMS environment over the next 5 years.

The medical schemes industry the CMS regulates consists of various key stakeholders with diverse interests and agendas. As of 31 March 2020, CMS regulated 76 medical schemes, 19 administrators (Including self-administered schemes), 41 managed care organisations and 2231 broker organisations, and 7 872 individual brokers. The role of the CMS is to regulate these entities utilising the

MSA and Regulations to ensure that all the 8.9 million scheme beneficiaries' interests are protected. This means that the CMS should ensure that all the regulated entities are at all times compliant with the MSA and its provisions.

CMS regulates the medical schemes industry through beneficiary training and education, registering of medical schemes and options, accrediting administrators, brokers, and managed care organisations, resolving complaints, conducting inspections, and defending legal challenges. Other important regulatory functions include collecting key industry data, the review of the beneficiary entitlements in the form of Prescribed Minimum Benefits (PMBs), and the provision of training and support for the regulated entities.

The private health industry organically responds to the demand for healthcare but does not address healthcare needs. For this reason, public policy intervention is necessary to 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 changes of regulatory instruments. It was, however, not until 1998 that a framework was implemented to modernise and update the system with a view to maximising fair access to medical schemes cover along the lines of developments in Europe and South America. The central aim of these reforms, provided for in the MSA, was to enhance the risk pooling potential of medical schemes and other important regulatory and oversight mechanisms by introducing:

- **A preferred health insurance vehicle,** which required that any 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);
- **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;
- **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 original intentions in the introduction of the above measures were to ensure that all health funders operate on a level playing field, which maximises the advantages and minimise the disadvantages of a competing and highly commercialised multi-fund health industry. However, many facets of the funding and provision of private health services are still not adequately regulated, resulting in systemic shortfalls in coverage, the quality of coverage, cost containment, and impact on the public health system.

Certain of these inadequacies pertain to the public health service as well, which contributes to private sector costs, coverage, and unfair access to the health system for low-income groups. Understanding where these gaps are located and how health policy should respond remains a major challenge for the CMS and Government, and that all role players respond appropriately to these deficiencies. The regulation of private hospitals is an example of a key policy intervention required to allow for the stabilisation of healthcare costs.

Despite our best intentions with the promulgation of the MSA and its regulations in 2000, the CMS has been met with serious challenges in being an effective regulator due to challenges by industry players and certain legislative limitations. This situation has led to the CMS seeking to amend specific areas of the MSA in order to strengthen its effectiveness and efficiency as a regulator. In the past five years,

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

the CMS has not been successful in effecting the necessary legislative changes due to the long and onerous route that this process has taken. The release of the Medical Schemes Act Amendment Bill (MSAAB) for public comment in June 2018 represents a massive shift toward the legislative empowerment of the CMS, and we whole-heartedly welcome this move.

The CMS has, in the past five years (2014-2019) carried its mandate of regulating medical schemes, administrators, brokers and managed care organisations with great determination and success within the context of limited resources that have been placed at its disposal. The level of CMS's effectiveness as a regulator has largely been determined by its internal and external environmental factors. These environmental factors can either have a positive or negative impact on the organisation's effectiveness and efficiency as a regulator.

Portfolio Committee on Health Engagements

This strategic review takes into consideration the engagements the CMS had the sixth administration Portfolio Committee on Health. The Committee has been appraised on the CMS mandate and strategic outlook, including the CMS functions. The Committee expressed its gratitude and support for the work CMS has done thus far.

Industry Trends

The following section analyses the key industry trend from the CMS perspective, which is mainly driven by the protection of the interests of scheme beneficiaries. The important observed industry trends that influence scheme member welfare in the past five years include:

On the positive side

- The schemes have maintained an average solvency ratio of 35.61% compared to the statutory requirement of 25% throughout the period under consideration
- The number of schemes that failed to meet the 25% statutory solvency remained at seven between 2014 and 2019
- The number of Efficiency Discounted Options (EDOs) increased from 40 in 2014 to 69 in March 2019
- The proportion of the beneficiaries covered by the EDOs increased from 25.3 to 28.8% throughout this period

These positive industry trends essentially mean that medical schemes have largely been successful in compliance with the 25% solvency requirements during this period. The scheme beneficiaries are expected to have benefited from an increase in the number of EDO options through lower annual contribution increases during this period. It is, however, of great concern that the proportion of beneficiaries covered by the EDO's has not changed during the past five years and remains at 23.50%.

On the negative side

- The number of scheme beneficiaries only grew by 0.8% between 2014 and 2019
- There was a reduction in the number of schemes from 83 in 2014 to 76 in 2019
- Poor governance and financial management of schemes resulted in a number of schemes being placed under curatorship in this period
- The number of accredited administrators decreased from 28 in 2014 to 19 in 2019
- The number of accredited brokers decreased from 10 780 in 2014 to 10 103 in 2019
- The number of accredited managed care organisations increased from 39 in 2014 to 41 in 2019

The main conclusion that can be drawn from the above observed trends is that the medical aid industry is faced with serious sustainability challenges. These challenges are characterised by low beneficiary growth, reduction in the number of registered, regulated entities, increasing beneficiary dissatisfaction, and an increase in the number of non-EDO scheme options. Apart from the trends indicated above, other significant developments have characterised the industry in the period under consideration that is noteworthy.

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

There has also been an increase in the complaints related to diagnostic and procedure code disputes between schemes and service providers. The CMS will establish a mechanism to address these disputes with the support of other regulators. The disputes between schemes and service providers in the management of alleged fraudulent transactions are of great concern to the CMS. The CMS

believes that it can play an active role in developing and implementing interventions to address these disputes. These will, however, require support by the industry and fellow regulators.

Policy Developments

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

- Promulgation of the NHI Bill
- Promulgation of the Medical Schemes Act Amendment Bill
- Health Market Inquiry report
- Review of the Financial Sector Regulation Act and the COFI Bill
- Presidential Health Compact

The MSAA and the NHI Bills were released on the 28th of June 2018 for public comment until the middle of September 2018. The release of these bills was preceded by the release of the NHI White Paper (2016), NHI Policy Document (2017), and the Gazette on the NHI Implementation structures (2017). These documents were aimed at providing a detailed policy direction for the Universal Health Coverage for South Africa in the form of the National Health Insurance.

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

The HMI was identifying market and regulatory failures in the private health industry. The HMI has made final recommendations in order to address the identified market and regulatory failures. It is patently clear that a significant number of these recommendations will require for CMS to perform specific functions, while the establishment of the proposed Supply-Side Health Regulator (SSHR) is being contemplated

The Presidential Health Compact is a product of a Presidential Health Summit that was convened in October 2018. This is a committed Public-Private partnership that is aimed at addressing the key challenges that have been identified in both the public and private sectors.

Economic Outlook

The outlook of the economy in the past five years has adversely affected the growth in the number of medical schemes' membership. Sluggish economic growth, the country's junk status, increased unemployment, and poverty rates have ensured that the number of people that get to take up medical scheme membership is limited. The growth of schemes' membership has also been limited by the members leaving schemes and the dependents that were being removed by principal members. The COVID-19 pandemic has added its voice to these sustainability issues.

The prices of goods and services were largely stable in the past five years, and the annual contribution increases were largely in line with the annual Consumer Price Index (CPI), except for a spike that was experienced in late 2016, and early 2017. This spike was attributed to increased claims by members as a result of a sudden increase in the number of private hospital beds in specific areas of the country. The licensing of private hospitals in the next five years is likely to have this kind of influence on member annual contribution increases.

There was a sudden decrease in the demand for health services for a greater part of the COVID-19 pandemic due to the restrictions on travel and generalised anxiety and fear by the population of the pandemic itself. This in effect means that there is a pent-up demand that may result in increased demand for these services as the restrictions are lifted. This could lead to reduced solvency in medical schemes and dramatic price increases that will pose a challenge to the sustainability of medical schemes.

The consolidation of schemes is supported by the CMS, as it ensures risk pooling and encourages social solidarity and affordability of scheme costs to members. The standardisation of scheme options is also supported by the CMS as it will assist members to make

rational choices in the purchase of options in schemes. The number of scheme options is currently 271 in number, and this high number adds to the complexities of making rational choices as a scheme member.

The CMS is supportive of the National Health Policy as outlined above. These is further illustrated in section 6 of this document, whereby the NDP Goals - 2030, MTSF Priorities (Presidential Health Compact), NDoH Goals - 2020 to 2025, and the CMS Outcomes – 2020 to 2025 are aligned.

The CMS is concerned about the increasing market concentration of the administrators and managed care organisations that has occurred in the past five years. Our concerns are centered around the market failures that will result in market dominance and other anti-competitive behaviour by these entities, which may be at odds with the beneficiary interests and welfare. The full implementation plan based on the final recommendations of the HMI report will address these concerns.

4.2 Internal Environment Analysis

Table 2: SWOT analysis

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Unique expertise • Experienced, skilled personnel • Sole mandate • Track record • Success in legal challenges • Clean audits • Integrated annual report • Single source of information for Industry performance	• Reputational risk • Litigations • Confidential Information leaks • Data & Information Security • Succession Planning and Continuity • Budget Approval Process - Tedious Budget Process - Reactive • Stakeholder Management - NDoH - National Treasury	• MSAB/NHI/HMI • CMS and NDoH Forum • Personnel Secondment and Sharing • Coding standards and regulation • Optimise on COVID- 19 • Mid-year budget review • Identify Key Performance Areas • CMS Branding and Image • CMS website • Organisational Design • CMS Fit for Purpose • Working remotely / Office space	• COFI Bill • Institutional Knowledge • Succession plan • Training and development • Change Management • Business Process Mapping • Collusion with regulated entities • Legal pushbacks • Internal resistance – culture • Leadership and mandate change • New Council by 2021 • Performance Incentive - Moratorium

Table 2 above articulates the key strengths and weaknesses that the CMS has as a regulatory entity, as well as the external threats and opportunities that lurk in its external environment. It is important to note that these strengths and weaknesses have been extensively workshopped with all the internal units at the CMS, and the interventions to these have been captured in our operational plans. The Business Process Mapping exercise is meant to address a significant amount of the challenges that emanate from the internal environment.

The CMS has enjoyed a fairly stable organisational environment, despite the fact that there has been an increased staff turn-over during the past year, as a result of non-renewal of contracts and employees moving to “greener pastures.” The Council, with the support of the Office of the CEO, undertook an Organizational Diagnostic exercise to address key organisational challenges at the CMS. The key findings and recommendations revealed that there is a need to review the organisation’s operational and service models as well as to conduct a level 1 to 3 business process mapping. This was communicated to staff members since there is a potential to restructure the organization. The process of migrating current employees into a new proposed structure will be one of the key activities in the 2021/22 financial year.

The CMS was faced with a string of allegations against its senior officials indicating that there was corrupt and unethical conduct in the manner that they carried out their functions at the CMS. Seven officials were suspended with full pay, pending the outcome of the comprehensive investigations. One official resigned when faced with charges, and the other six officials are still under investigation. The absence of senior officials at the CMS has created a leadership gap and may affect the operations in the medium to long term. The investigations have been completed, and the appropriate disciplinary measures implemented.

There has been a number of disciplinary matters in the organisation, and most of them were finalised at the CCMA level. We recognise and value our people as our most important asset in achieving the vision of CMS, which is to promote fair and equitable access to health care in order to maximise the health of South Africans. The Human Resources sub-programme strategy for the next five years is to

improve on the culture, leadership, talent management, performance, reward and recognition and personal development, so as to ensure that CMS is able to achieve its strategic goals and our people receive a positive experience at work.

In order to increase motivation, improve productivity and staff retention, the Human Resources sub-programme will embark on the following key strategic projects:

- Talent Management
- Learning and development
- Performance Management
- Diversity and Inclusion
- Remuneration and
- Succession Planning

The CMS currently has a total personnel headcount of 132, including temporary and contract personnel which is below the required numbers based on workloads. The CMS is understaffed and relies on interns and temporary personnel to carry out some of its core regulatory functions. Additional resources will enable this organisation to have reasonable staffing levels to effectively carry out its mandate. The recently completed Business Process Mapping exercise has indicated that an additional 16 posts will be required by the CMS for optimal and efficient operations. The CMS is promoting the national agenda on Broad-Based Black Economic Empowerment and is working towards achieving its targets in as far as the employment of people with disabilities is concerned. The CMS is promoting the national agenda on Broad-Based Black Economic Empowerment (BBBEE) and is working towards achieving its targets in as far as the employment of people with disabilities is concerned. The CMS has engaged with BBBEE Commissioner and subsequently had a workshop to address the CMS role regarding economic transformation in as far the private healthcare sector is concerned, as well as the CMS BBBEE Compliance. The CMS is embarking on appointing a service provider to conduct a BBBEE Compliance verification for the organisation.

INFORMATION TECHNOLOGY

Over the next five years, the ICT & KM sub-programme will continue to play a significant role in providing technology enablers that support strategic processes and projects identified by the business. The sub-programme will embark on a process to overhaul the entire IT systems in order to keep up with the rapid technological changes in the environment. This will enable the organisation to become more efficient in its operations.

It has become clear that the CMS cannot continue to fulfil its regulatory mandate effectively without a properly functioning medical scheme member database. This membership database, also called the Central Beneficiary Registry (CBR), will enable the CMS to deliver focussed services to medical scheme members and will further improve our ability to conduct meaningful research in aid of National Health priorities such as the establishment of the NHI Fund. To this end, all efforts will be directed to operationalise the NBR over the next two years. Other system development efforts will also focus on the renewal of existing key systems such as the Financial Statutory Returns, Complaints System, the Council Website as well as the Accreditation System.

The sub-programme will further strengthen the organisation's ability to counter cyber-security threats posed by both the internal as well as external environment. This will be achieved by introducing several additional security measures aimed at strengthening the external as well as internal vulnerability surface. The sub-programme will also continue with its efforts to ensure a robust ICT Disaster Recovery solution is established in the form of a HOT Site, which will allow for real-time replication of data and seamless failover of our critical servers in case of a disaster.

FINANCIAL MANAGEMENT

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

Management must ensure that financial management and internal controls of the CMS is strengthened and that policies are reviewed and applied consistently. An area that requires further attention is that of consequence management in cases where there has been non-compliance with policies and Regulations. The CMS has in place relevant governance structures to oversee the financial environment of the entity. The Audit and Risk Committee operates under an approved charter and oversees the work of the internal auditors.

Part C: Measuring Our Performance

5. Institutional Programme Performance Information

The information that is currently used to measure institutional performance at the CMS is largely input and process indicators. This is to a large extent determined by the mandate that we carry as a regulator, as opposed to a service delivery entity. Our mandate as earlier on stated is derived from Section 7, of the MSA, which states the functions of the CMS as to:

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

The measurement of outputs, outcomes and impact indicators at the CMS, is an approach that is at this stage in its infancy. The capacity, skills and competency of accelerating this process is minimal, given the fact that we have a headcount figure for personnel of less than 140, and an annual budget of R201.7m sourced largely through medical aid schemes members' levies.

Programmes and Sub-Programmes

5.1. Programme 1 (Administration)

Sub-Programme 1.1 (CEO and Registrar

Purpose (CEO and Registrar)

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

The CEO and Registrar is responsible for leading the development and execution of the Council for medical schemes strategy. The CEO and Registrar is ultimately responsible for all day-to-day management decisions and for implementing the CMS's strategic and annual plans therefore there are three new specific objectives or indicators developed for this sub-programme.

5.1.1 Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 4: To become a more effective and efficient organisation								
Output 1: Ensure that reported performance information is in accordance with the Framework for Strategic and Annual Performance plans.								
Output Indicator 1.1	Ensure that overall performance of the entity is maintained at above 80%	New indicator	New indicator	New indicator	80%	80%	80%	80%
Output Indicator 1.2	Produce Annual Performance Information report that is reliable, accurate and complete by 31 July each year	1	1	1	1	1	1	1
Output 2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS.								
Output Indicator 2.1	Number of strategic risk register reports submitted to the Council for monitoring	4	4	4	4	4	4	4
Outcome 6: To collaborate with local, regional and international entities								
Output 3: Collaboration with local, regional and international entities								
Output Indicator 3.1	Number of signed Memoranda of Understanding	New indicator	New indicator	New indicator	4	4	4	4

5.1.2 Quarterly targets for 2021/22 (Office of the CEO)

Performance indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 1: Ensure that reported performance information is in accordance with the Framework for Strategic and Annual Performance plans.							
Output Indicator 1.1	Ensure that overall performance of the entity is maintained at above 80%	Quarterly	80%	80%	80%	80%	80%
Output Indicator 1.2	Produce an Annual Performance Information report that is reliable, accurate and complete by 31 July each year	Annually	1	n/a	1	n/a	n/a
Output 2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS.							
Output Indicator 2.1	Number of strategic risk register reports submitted to the Council for monitoring	Quarterly	4	1	1	1	1
Output 3: Develop strategic relationships with other regulators and stakeholders							
Output Indicator 3.1	Number of memoranda of understanding with local, regional and international regulators and stakeholders	Quarterly	4	1	1	1	1

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

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

5.2.1 Sub-Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 4: To be a more effective and efficient organisation								
Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities.								
Output Indicator 4.1	An unqualified opinion issued by the Auditor-General South Africa on the Annual Financial Statements by 31 July each year	1	1	1	1	1	1	1
Output 5: Ensure that reported performance information is useful and reliable and in accordance with the Performance Management and Reporting Framework.								
Output Indicator 5.1	Produce a budget that is approved by Council by 31 January each year	New indicator	New indicator	New indicator	1	1	1	1

5.2.2 Quarterly targets for 2021/22 (Office of the CFO)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities.							
Output Indicator 4.1	An unqualified opinion issued by the Auditor-General South Africa on the Annual Financial Statements by 31 July each year	Annually	1	n/a	1	n/a	n/a
Output 5: Ensure that reported performance information is useful and reliable and in accordance with the Performance Management and Reporting Framework.							
Output Indicator 5.1	Produce a budget that is approved by Council by 31 January each year	Annually	1	n/a	1	n/a	n/a

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

Purpose (ICT & KM)

The purpose of the sub-programme is to provide secure, reliable, innovative and process driven information and communication technology and knowledge management solutions, thereby improving productivity and business value.

5.3.1 Sub-Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 4: To be a more effective and efficient organisation								
Output 6: An established ICT Infrastructure that ensures information is available, accessible and protected.								
Output Indicator 6.1	Percentage of network and server uptime,	99.7%	99.45%	99.41%	99%	99%	99%	99%
Output Indicator 6.2	Percentage of IT security incidents (breaches),	1.1%	0.27%	0%	5%	5%	5%	5%
Output Indicator 6.3	Number of successful IT Disaster Recovery (DR) failover tests	New indicator	New indicator	New indicator	2	2	2	2
Output 7: Provide software applications that serve both internal as well as external stakeholders that improve business operations and performance.								
Output Indicator 7.1	Percentage of uptime, of all installed application systems where network access exists	99.7%	99.47%	100%	99%	99%	99%	99%
Output 8: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing.								
Output Indicator 8.1	Percentage of physical requests for information received and finalised within 30 days	98%	97.5%	98.5%	95%	95%	95%	95%

5.3.2 Quarterly targets for 2021/22 (ICT & KM)

Outcome Indicator	Performance indicators	Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 6: An established ICT Infrastructure that ensures information is available, accessible and protected.							
Output Indicator 6.1	Percentage of network and server uptime	Quarterly	99%	99%	99%	99%	99%
Output Indicator 6.2	Percentage of IT security incidents (breaches)	Quarterly	5%	5%	5%	5%	5%
Output Indicator 6.3	Number of successful Disaster Recovery (DR) failover tests	Quarterly	2	n/a	1	n/a	1
Output 7: Provide software applications that serve both internal as well as external stakeholders and which improves business operations and performance.							
Output Indicator 7.1	Percentage of uptime, of all installed application systems where network access exists	Quarterly	99%	99%	99%	99%	99%
Output 8: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing.							
Output Indicator 8.1	Percentage of requests for information received and finalised within 30 days	Quarterly	95%	95%	95%	95%	95%

5.4 Sub-Programme 1.4 (Human Resources Management)

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

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

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

By doing this, the Sub-programme helps the CMS by supporting its administration and staff through human resource management advice and assistance, enabling them to make decisions that optimise its most important asset: its people and to continue the development of the CMS as an employer of choice.

5.4.1 Sub-Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/2022	2022/23	2023/24
Outcome 4: To become a more effective and efficient organisation								
Output 9: Build competencies and retain skilled employees.								
Output Indicator 9.1	Minimise staff turnover rate to less than 15%	7.1%	4.48%	8.33%	<15%	<15%	<15%	<15%
Output Indicator 9.2	Turnaround time to fill a vacancy (turnaround time of 120 working days for each vacancy that exists during the year), excluding position of CEO	There were 5 out of 14 positions that tool longer than the 90 days to fill	There were 16 vacancies during the period, 12 were filled within 120 days, one took longer than the 120 days to fill and the recruitment process was underway for 3	There were 14 vacancies during the period, 9 were filled within 120 days, 3 took longer than 120 days and the recruitment process was underway for 2.	120 days	120 days	120 days	120 days
Output Indicator 9.3	Achievement of employment equity targets [according to the Broad-Based Black Economic Empowerment (BBBEEA)]	79.82%	97.12%	100%	85%	85%	85%	85%
Output Indicator 9.4	Develop talent management Policy Framework	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1

Output 10: Maximise performance to improve organisational efficiency and maintain high performance culture.								
Output Indicator 10.1	Percentage of employee' performance agreements are signed by no later than 31 May of each year (excluding employees out of office on extended absence)	100%	100%	93.28%	100%	95%	95%	95%
Output Indicator 10.2	Percentage of employees' performance assessment concluded, bi-annually (excluding employees out of office on extended absence)	100%	100%	100%	100%	95%	95%	95%
Output Indicator 10.3	Number of Training and Development Sessions to Improve Employee Relations	New Indicator	New Indicator	New Indicator	New Indicator	4	4	4

5.4.2 Quarterly targets for 2021/22 (Human Resource Management)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 9: Build competencies and retain skilled employees.							
Output Indicator 9.1	Minimise staff turnover rate to less than 15% per annum.	Annually	<15%	n/a	n/a	n/a	<15%
Output Indicator 9.2	Turnaround time to fill a vacancy (Turnaround time of 120 working days to fill a vacancy that exists during the year), excluding position of CEO	Quarterly	120 days	120 days	120 days	120 days	120 days
Output Indicator 9.3	Achievement of employment equity targets (according to the BBBEEA targets), annually	Annually	85%	n/a	n/a	n/a	85%
Output Indicator 9.4	Develop talent management policy framework	Annually	1	n/a	n/a	n/a	1

Output 10: Maximise performance to improve organisational efficiency and maintain high performance culture.							
Output Indicator 10.1	Percentage of employee' performance agreements are signed by no later than 31 May of each year (excluding employees out of office on extended absence)	Annual	95%	95%	n/a	n/a	n/a
Output Indicator 10.2	Percentage of employees' performance assessment concluded, bi annually (excluding employees out of office on extended absence)	Bi-annually	95%	95%	n/a	95%	n/a
Output Indicator 10.3	Number of Training and Development Sessions to Improve Employee Relations	Quarterly	4	1	1	1	1

5.5 Sub-Programme 1.5 (Legal Services)

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

5.5.1 Sub-Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 4: To become a more effective and efficient organisation								
Output 11: Legal advisory and support services for effective regulation of the industry and operations of the office.								
Output Indicator 11.1	Percentage of written and verbal legal opinions provided to internal and external stakeholders, attended to within 14 days	100% 175	267	80%	80%	85%	90%	95%
Output 12: Defending decisions of the Council and the Registrar								
Output Indicator 12.1	Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days	100% 25	100% 17	100%	100%	100%	100%	100%

5.5.2 Quarterly targets for 2021/22 (Legal Services)

Performance Indicators		Reporting period 2021/22	Annual target 2021/22	Quarterly targets			
				1st	2nd	3rd	4th
Output 11: Legal advisory and support services for effective regulation of the industry and operations of the office.							
Output Indicator 11.1	Percentage of written and verbal legal opinions provided to internal and external stakeholders, attended to within 14 days	Quarterly	85%	85%	85%	85%	85%
Output 12: Defending decisions of the Council and the Registrar							
Output Indicator 12.1	Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days	Quarterly	100%	100%	100%	100%	100%

5.6 Sub-programme 1.6 (Council Secretariat)

Purpose (Council Secretariat)

The purpose of this programme is to provide corporate governance services to the Council as Accounting Authority and its committees. The program seeks to achieve the above objective through seamless board administration, secretariat service and support.

5.6.1 Sub-Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 4: To become a more effective and efficient organisation								
Output 13: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority								
Output Indicator 13.1	Develop an Annual Council Work Plan for Council and its Committees by 31 March	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1
Output Indicator 13.2	Develop and Review Council and Committees Governance Charters	New Indicator	New Indicator	New Indicator	New Indicator	6	6	6
Output Indicator 13.3	Support execution of Statutory Council & Sub-committee decisions, resolutions and matters arising	New Indicator	New Indicator	New Indicator	New Indicator	100%	100%	100%
Output Indicator 13.4	Notify the Executive Authority six month before the term of office of Council members is due to expire. Report resignations and vacancies to the Executive Authority within 2 working days	New Indicator	New Indicator	New Indicator	New Indicator	100%	100%	100%
Output 14: Support Dispute Resolution Forums in furtherance of Council and MSA objectives								
Output Indicator 14.1	Percentage of Appeal Committee and Appeals Board Scheduled within 14 days upon receipt of all supporting documents (as per schedule)	New Target	New Target	New Target	100%	100%	100%	100%
Output Indicator 14.2	Percentage of Appeals Committee and Appeals Board Rulings published on the CMS website within 14 days of issuing the ruling	New Target	New Target	New Target	100%	100%	100%	100%

5.6.2 Quarterly targets for 2021/22 (Council Secretariat)

Performance Indicators		Reporting period 2021/22	Annual target 2021/22	Quarterly targets			
				1st	2nd	3rd	4th
Output 13: Corporate governance, Secretariat & Board administration Support and Legal Compliance Services for effective governance by the Accounting Authority							
Output Indicator 13.1	Develop an Annual Council Work Plan for Council and its Committees by 31 March	Quarterly	1	N/A	N/A	N/A	1
Output Indicator 13.2	Develop and Review Council and Committees Governance Charters	Quarterly	6	N/A	N/A	N/A	6
Output Indicator 13.3	Support execution of Statutory Council & Sub-committee decisions, resolutions and matters arising	Quarterly	100%	100%	100%	100%	100%
Output Indicator 13.4	Notify the Executive Authority six month before the term of office of Council members is due to expire. Report resignations and vacancies to the Executive Authority within 2 working days	Quarterly	100%	100%	100%	100%	100%
Output 14: Support Dispute Resolution Forums in furtherance of Council and MSA objectives							
Output Indicator 14.1	Percentage of Appeal Committee and Appeals Board Scheduled within 14 days upon receipt of all supporting documents (as per schedule)	Quarterly	100%	100%	100%	100%	100%
Output Indicator 14.2	Percentage of Appeals Committee and Appeals Board Rulings published on the CMS website within 14 days of issuing the ruling	Quarterly	100%	100%	100%	100%	100%

5.7 Programme 2 (Strategy Office)

Purpose (Strategy Office)

The purpose of this programme is to engage in strategic projects as well as to provide information to the Ministry on health reform matters in order to achieve government's objective of an equitable and sustainable healthcare in support of universal access. It strives to provide support to the office of the Registrar on clinical matters so that good quality medical scheme cover would be maximised in order that regulated entities are properly governed, through prospective and retrospective regulations. The unit also undertakes strategic research that would enable the CMS to advise the NDOH on policy initiatives. It provides the mechanism for the CMS to provide support to the NDOH on key policy reforms such as the NHI and HMI. The unit outputs of the unit enhances the protection of members and beneficiaries of medical schemes. It enhances the provision of medical cover that is evidence based and sustainable.

5.7.1 Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector								
Output 15:Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements								
Output Indicator 15.1	The number of benefit definitions published	10 CMScripts and 7 PMB definitions	10	10	10	10	10	10
Output Indicator 15.2	Develop preventative and primary health care package to incorporate into the PMBs	New indicator	Draft costed PMB benefit package completed but not submitted to the Council	A service based preventative and primary healthcare package and costing methodology report was submitted to the Executive Authority	Develop primary healthcare package for incorporation into the PMBs	Review and update revised PMB benefit package	Implementation and monitoring of the revised PMB benefit package	Implementation and monitoring of the revised PMB benefit package
Output 16: Provide clinical opinions with a view to resolve complaints and enquiries.								
Output Indicator 16.1	Percentage of category 1* clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication Unit	40%	98%	90%	90%	90%	90%	90%

Output Indicator 16.2	Percentage of category 2* clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication Unit	New indicator	100%	95%	95%	95%	95%	95%
Output Indicator 16.3	Percentage of category 3* clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication Unit	New indicator	100%	98%	98%	98%	98%	98%
Output Indicator 16.4	Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days	99%	99%	98%	98%	98%	98%	98%
Output 17: Conduct research to inform appropriate national health policy interventions								
Output Indicator 17.1	Number of research projects and support projects published in support of the National Health Policy	5	5	5	5	5	5	5

5.7.2 Quarterly targets for 2021/22 (Strategy Office)

Performance Indicators		Reporting period 2021/22	Annual target 2021/22	Quarterly targets			
				1st	2nd	3rd	4th
Output 15:Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements							
Output Indicator 15.1	The number of benefit definitions published	Quarterly	10	2	2	3	3
Output Indicator 15.2	Develop preventative and primary healthcare package to incorporate into the PMBs	Annual	Develop primary healthcare package for incorporation into the PMBs	n/a	n/a	n/a	Develop primary healthcare package for incorporation into the PMBs
Output 16: Provide clinical opinions to resolve complaints and enquiries.							
Output Indicator 16.1	Percentage of category 1* clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication Unit	Quarterly	90%	90%	90%	90%	90%
Output Indicator 16.2	Percentage of category 2* clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication	Quarterly	95%	95%	95%	95%	95%
Output Indicator 16.3	Percentage of category 3*clinical opinions provided	Quarterly	98%	98%	98%	98%	98%

	within 90 working days of receipt of a request from Complaints Adjudication Unit						
Output Indicator 16.4	Percentage of clinical enquiries received via e-mail or telephone reviewed within 7 days	Quarterly	98%	98%	98%	98%	98%
Output 17: Conduct research to inform appropriate national health policy interventions.							
Output Indicator 17.1	Number of research projects and support projects published in support of the National Health Policy,	Quarterly	5	1	1	2	1

5.8 Programme 3 (Accreditation Unit)

Purpose (Accreditation Unit)

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

5.8.1 Outcome Indicators (Accreditation Unit)

Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations.								
Output 18: Accredit regulated entities based on their compliance with the requirements for accreditation in order to provide accredited services and monitor legal compliance throughout the period of accreditation.								
Output Indicator 18.1	Percentage of broker and broker organisation applications accredited within 30 working days per quarter on receipt of complete information	4854	5500	80%	80%	80%	80%	80%
Output Indicator 18.2	Percentage of managed care organisation applications analysis completed and outcome communicated to applicants, within three months of receipt of complete information	21	15	100%	100%	100%	100%	100%
Output Indicator 18.3	Percentage of administrators and self-administered schemes' applications analysis completed and outcome communicated to applicants, within three months of receipt of complete information	14	6	100%	100%	100%	100%	100%

5.8.2 Quarterly targets for 2021/22 (Accreditation Unit)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 18: Accredit regulated entities based on their compliance with the requirements for accreditation in order to provide accredited services and monitor legal compliance throughout the period of accreditation.							
Output Indicator 18.1	Percentage of broker and broker organisation applications accredited within 30 working days per quarter on receipt of complete information	Quarterly	80%	80%	80%	80%	80%
Output Indicator 18.2	Percentage of managed care organisation applications analysis completed within three months of receipt of complete information	Quarterly	100%	100%	100%	100%	100%
Output Indicator 18.3	Percentage of administrators and self-administered schemes' applications analysis completed within three months of receipt of complete information	Quarterly	100%	100%	100%	100%	100%

5.9 Programme 4 (Research and Monitoring)

Purpose (Research and Monitoring)

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

5.9.1 Programme performance indicators and annual targets

Performance Indicators		Audited/Actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry.								
Output 19: Conduct research to inform appropriate policy interventions.								
Output Indicator 19.1	Number of research projects finalised	10	9	12	12	12	12	12
Output 20: Monitoring trends to improve regulatory policy and practice.								
Output Indicator 20.1	Non-financial report submitted for inclusion in the annual report	1	1	1	1	1	1	1

5.9.2 Quarterly targets for 2021/22 (Research and Monitoring)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 19: Conduct research to inform appropriate policy interventions.							
Output Indicator 19.1	Number of research projects finalised,	Quarterly	12	n/a	1	4	7
Output 20: Monitoring trends to improve regulatory policy and practice.							
Output Indicator 20.1	Non-financial report submitted for inclusion in the Annual Report	Annual	1	n/a	1	n/a	n/a

5.10 Programme 5: Stakeholder Relations

Purpose (Stakeholder Relations)

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

5.10.1 Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 21: To create awareness and collaboration with stakeholders, while enhancing the visibility and protecting the reputation of the CMS.								
Output Indicator 21.1	Number of stakeholder awareness activities conducted	8	7	21	21	25	30	35
Output Indicator 21.2	Percentage of stakeholder awareness of CMS resulting from survey	40.3%	n/a	50%	50%	55%	60%	65%
Output 22: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year.								
Output Indicator 22.1	Submission of Annual Report by 31 August to the Executive Authority	1	1	1	1	1	1	1
Output 23: To enhance knowledge and skills among stakeholders, in order to create an in-depth understanding of governance and compliance with the Medical Schemes Act, through education and training interventions.								
Output Indicator 23.1	Number of stakeholder education and training sessions	New indicator	New indicator	New indicator	35	40	45	50
Output 24: To provide Customer care interventions by rendering effective and efficient services.								
Output Indicator 24.1	Percentage of customer care interventions resulting from calls and e-mailed queries handled by customer care centre	New Indicator	New Indicator	New Indicator	New Indicator	90%	90%	90%

5.10.2 Quarterly targets for 2021/22 (Stakeholder Relations)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 21: To create awareness and collaboration through with stakeholders, while enhancing the visibility and protecting the reputation of the CMS.							
Output Indicator 21.1	Number of stakeholder awareness activities conducted	Quarterly	25	5	5	6	9
Output Indicator 21.2	Percentage of stakeholder awareness of the CMS resulting from survey	Annual	50%	n/a	n/a	n/a	50%

Output 22: The CMS must ensure that an Annual Report are submitted to the Executive Authority five months after the end of a financial year.							
Output Indicator 22.1	Submission of Annual report by 31 August to the Executive Authority	Annual	1	n/a	1	n/a	n/a
Output 23: To enhance knowledge and skills among stakeholders, in order to create an in-depth understanding of governance and compliance with the Medical Schemes Act, through education and training interventions.							
Output Indicator 23.1	Number of stakeholder education and training sessions	Quarterly	40	10	10	10	10
Output 24: To provide Customer care interventions by rendering effective and efficient services.							
Output Indicator 24.1	Percentage of customer care interventions resulting from calls and e-mailed queries handled by customer care centre	Quarterly	90%	90%	90%	90%	90%

5.11 Programme 6 (Compliance and Investigation)

Purpose (Compliance and Investigation)

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

5.11.1 Programme performance indicators and annual targets

Performance Indicators		Audited actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 25: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 25.1	Number of routine inspections conducted	13	14	13	13	15	17	19
Output 26: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 26.1	Percentage of commissioned inspections conducted	New indicator	New indicator	80%	80%	80%	85%	90%
Output 27: Ensure enforcement action is undertaken against regulated entities.								
Output Indicator 27.1	Percentage of enforcement actions undertaken to ensure compliance with the Medical Schemes Act (1998)	100% 39	100% 72	100% 37	100%	100%	100%	100%
Output 28: Strengthen and monitor governance systems medical schemes and other regulated entities.								
Output Indicator 28.1	Percentage of governance interventions implemented	100% 105	100% 108	100%	100%	100%	100%	100%
Output Indicator 28.2	Number of scheme member meetings attended (including virtual meetings)	41	33	40	40	42	44	46

5.11.2 Quarterly targets for 2021/22 (Compliance and Investigation)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 25: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws							
Output Indicator 25.1	Number of routine inspections conducted	Quarterly	15	n/a	6	5	4
Output 26: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act (1998) and all other related laws.							
Output Indicator 26.1	Percentage of commissioned inspections conducted	Quarterly	80%	80%	80%	80%	80%
Output 27: Ensure enforcement action is undertaken against regulated entities.							
Output Indicator 27.1	Percentage of enforcement actions undertaken to ensure compliance with the Medical Schemes Act (1998)	Quarterly	100%	100%	100%	100%	100%
Output 28: Strengthen and monitor governance systems of medical schemes and other regulated entities.							
Output Indicator 28.1	Percentage of governance interventions implemented	Quarterly	100%	100%	100%	100%	100%
Output Indicator 28.2	Number of scheme member meetings attended, (including virtual meetings)	Quarterly	42	34	8	n/a	n/a

5.12 Programme 7 (Benefits Management)

Purpose (Benefits Management)

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

5.12.1 Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 29: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act.								
Output Indicator 29.1	Percentage interim rule amendments processed within 14 working days of receipt of all information	87% 101	96.3% 108	80%	80%	80%	80%	80%
Output Indicator 29.2	Percentage of annual rule amendments processed before 31 December of each year	98.9% 90	100% 91	90%	90%	90%	90%	90%

5.12.2 Quarterly targets for 2021/22 (Benefits Management)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Outcome 29: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998).							
Output Indicator 29.1	Percentage interim rule amendments processed within 14 working days of receipt of all information	Quarterly	80%	80%	80%	60%	100%
Output Indicator 29.2	Percentage of annual rule amendments processed before 31 December of each year	Quarterly	90%	n/a	n/a	90%	n/a

5.13 Programme 8 (Financial Supervision)

Purpose (Financial Supervision)

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

5.13.1 Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 3: To ensure that all regulated entities comply with National Policy the MSA and Regulations								
Output 30: Monitor and promote the financial soundness of medical schemes.								
Output Indicator 30.1	Percentage of business plans processed in respect of Regulation 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar)	100%	88%	100%	100%	100%	100%	100%
Output Indicator 30.2	Percentage of business plans processed in respect of schemes with rapidly reducing solvency (but above statutory minimum)	-	100%	n/a	100%	100%	100%	100%
Output Indicator 30.3	Percentage of auditor applications analysed	New indicator	100%	100%	100%	100%	100%	100%
Output Indicator 30.4	Number of quarterly financial return reports published (excluding quarter four)	3	3	3	3	3	3	3
Output Indicator 30.5	Number of financial sections prepared for the Annual Report	1	1	1	1	1	1	1

5.13.2 Quarterly targets for 2021/22 (Financial Supervision)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Output 30: Monitor and promote the financial soundness of medical schemes.							
Output Indicator 30.1	Percentage of business plans processed in respect of Regulation 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar)	Quarterly	100%	100%	100%	100%	100%
Output Indicator 30.2	Percentage of business plans processed in respect of schemes with rapidly reducing solvency (but above statutory minimum)	Quarterly	100%	100%	100%	100%	100%
Output Indicator 30.3	Percentage of auditor applications analysed	Quarterly	100%	100%	100%	100%	100%
Output Indicator 30.4	Number of quarterly financial return reports published (excluding quarter four)	Quarterly	3	n/a	1	1	1

Output Indicator 30.5	Number of financial sections prepared for the Annual Report	Annual	1	n/a	1	n/a	n/a

5.14 Programme 9 (Complaints Adjudication)

Purpose (Complaints Adjudication)

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

5.14.1 Programme performance indicators and annual targets

Performance Indicator		Audited/actual performance			Estimated performance	Medium-term targets		
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 31: Resolve complaints with the aim of protecting beneficiaries of medical schemes.								
Output Indicator 31.1	Percentage of category 4 complaints adjudicated within 120 working days and in accordance with complaints standard operating procedures	84%	68%	55%	65%	70%	75%	80%
Output Indicator 31.2	Percentage of category 1 complaints adjudicated within 30 working days and in accordance with complaints standard operating procedures	New Target	New Target	New Target	70%	70%	75%	80%
Output Indicator 31.3	Percentage of category 2 complaints adjudicated within 60 working days and in accordance with complaints standard operating procedures,	New Target	New Target	New Target	70%	70%	75%	80%
Output Indicator 31.4	Percentage of category 3 complaints adjudicated within 90 working days and in accordance with complaints standard operating procedures	New Target	New Target	New Target	70%	70%	75%	80%
Output Indicator 31.5	Percentage of Rulings published on the CMS website within 14 days of issuing the ruling	New Target	New Target	New Target	70%	100%	100%	100%
Output 32: Appeal Committee hearings attended based on Council Secretariat schedules								
Output Indicator 32.1	Percentage of Appeal Committee hearings attended based on Council Secretariat schedules	100%	100%	100%	100%	100%	100%	100%

5.14.2 Quarterly targets for 2021/22 (Complaints Adjudication)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2021/22	2021/22	1st	2nd	3rd	4th
Outcome 31: Resolve complaints with the aim of protecting beneficiaries of medical schemes.							
Output Indicator 31.1	Percentage of category 4 complaints adjudicated within 120 working days and in accordance with complaints procedure,	Quarterly	70%	70%	70%	70%	70%
Output Indicator 31.2	Percentage of category 1 complaints adjudicated within 30 working days and in accordance with complaints procedure,	Quarterly	70%	70%	70%	70%	70%
Output Indicator 31.3	Percentage of category 2 complaints adjudicated within 60 working days and in accordance with complaints procedure,	Quarterly	70%	70%	70%	70%	70%
Output Indicator 31.4	Percentage of category 3 complaints adjudicated within 90 working days and in accordance with complaints procedure,	Quarterly	70%	70%	70%	70%	70%
Output Indicator 31.5	Percentage of Rulings published on the CMS website within 14 days of issuing the ruling	New Target	New Target	100%	100%	100%	100%
Output 32: Percentage of Appeal Committee hearings attended based on Council Secretariat schedules							
Output Indicator 32.1	Percentage of Appeal Committee hearings attended based on Council Secretariat schedules	Quarterly	100%	100%	100%	100%	100%

6. Explanation of planned performance over the medium-term period

a. The following table reflects the alignment between the NDP goals, MTSF Priorities, the Presidential Health Compact and NDOH strategic goals with the CMS strategic goals for the period 2020 to 2025:

NDP Goals 2030	MTSF Priorities (Presidential Health Compact)	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
Average male and female life expectancy at birth increased to 70 years	HIV&AIDS and TB prevented and successfully managed Maternal, infant and child mortality reduced PILLAR 4: Engage the private sector in improving the access, coverage and quality of health services	Goal 1: Increase Life Expectancy improved Health and Prevent Disease	***Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry*** • The CMS Research and Monitoring, as well as the Clinical Unit, are currently engaged in the analysis of health care data with the aim to measure health quality outcomes at benefit option level. • One of the pillars of the medical schemes Act is the PMB package and enforcement of Regulation 8 which makes payment of PMBs in full a requirement for all registered medical schemes. • Currently, the CMS is in the process of revising the PMB package with an emphasis to include more primary health care benefits. • In addition, the PMB definition, which is a key part of the PMB review, will ensure that there is an improved understanding by scheme members of their benefits and entitlements • The inclusion of the Primary Healthcare (including TB) in the PMB's as part of the review process will lead to an overall improvement of the National Health Outcomes
Tuberculosis (TB) prevention and cure progressively improved	PILLAR 5: Improve the quality, safety and quantity of health services provided with a focus on primary health care	Goal 3: Quality Improvement in the Provision of Care	***Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry*** ***Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector*** Treatment of TB is part of the PMB package and is treated in line with public sector protocol. The inclusion of the Primary Healthcare (including TB) in the PMB's as part of the review process will lead to an overall improvement of the National Health Outcomes CMS is engaged in advanced talks to form a partnership with HQA to develop a common template for reporting on quality outcomes in the private sector.
Maternal, infant and child mortality reduced	PILLAR 8: Engage and empower the community to ensure adequate and appropriate community-based care.	Goal 1: Increase Life Expectancy improved Health and Prevent Disease	***Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector***

NDP Goals 2030	MTSF Priorities (Presidential Health Compact)	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
			Vaccinations have been included in the revised PMB list as part of the development of a more primary healthcare-focused package. The vaccination list is specific and includes vaccination like HPV Human papilloma virus (7 to 12-year-old) hepatitis A B C D, etc.
Prevalence of non-communicable diseases reduced	PILLAR 5: Improve the quality, safety and quantity of health services provided with a focus on primary health care. PILLAR 8: Engage and empower the community to ensure adequate and appropriate community-based care.	Goal 3: Quality Improvement in the Provision of Care	***Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry*** The CMS through its Research and Monitoring Programme monitors the prevalence of non-communicable diseases within the medical schemes environment by analysing Scheme Risk measurement data as well as data submitted by means of the utilisation returns. This information is shared with relevant stakeholders in an effort to inform trends and advise on how best to reduce prevalence.
Health System reforms completed	Health care costs reduced PILLAR 6: Improve the efficiency of public sector financial management systems and processes. PILLAR 7: Strengthen the governance and leadership to improve oversight, accountability and health system performance at all levels. PILLAR 9: Develop an information system that will guide the health system policies, strategies and investments.	Goal 2: Achieve UHC by Implement NHI	***Outcome 1: To promote the improvement quality and the reduction of costs of in the private health care sector*** The CMS is currently engaged in a project to review and replace the current solvency framework with a risk-based solvency framework. If implemented this framework may result in a reduction of scheme contribution by members. The CMS is actively participating in the pricing enquiry currently being conducted by the Competition Commission. Once the report is finalised it is envisaged that recommendations by the Competition Commission will eventually lead to a reduction in health care costs.
	Efficient health management information system for improved decision making	Goal 4: Build Health Infrastructure for effective service delivery	***CMS provides strategic advice to influence and support the development and implementation of National health policy*** The CMS is currently developing a registry of all funded patients in South Africa. Once completed this system will be linked to the patient health register and will facilitate the overall improvement of the health management information system. The CMS is developing a system for the management of a single exit price for medicines on behalf of the National Department of Health (NDoH). Once completed this system

NDP Goals 2030	MTSF Priorities (Presidential Health Compact)	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
			will facilitate the regulation of medicine pricing in South Africa.
	Improved quality of health care	Goal 3: Quality Improvement in the Provision of Care	***Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector*** The CMS fulfils an accreditation function in term of managed care organisations, administrators, brokers and broker organisations. The ongoing accreditation of these entities is dependent on inspection of their ability to render the required services at a specified health care level. In as far as an accreditation of managed care entities is concerned, evaluation of health outcomes, resources employed and the price paid for such services is being undertaken to determine the clinical effectiveness and value proposition of these entities. CMS has furthermore also commenced work on chronic conditions (CDLs) and Utilisation management of services as it relates to hospitals and medicines with the aim of eliminating waste from the system. This initiative will be further developed over the next five years. The NDoH guidelines serve as a minimum benchmark for quality health outcomes. Once entry-level criteria, process indicators and outcomes have been concluded, the same will be incorporated in the CMS accreditation standards and applied to managed care entities for purposes of ongoing accreditation. Finally, the CMS, through its compliance inspectorate also ensures compliance with different aspects of the Medical Schemes Act some of them which relate to improving the overall quality of health care delivery.
Primary health care teams deployed to provide care to families and communities	Re-engineering of Primary health care PILLAR 8: Engage and empower the community to ensure adequate and appropriate community-based care.	Goal 2: Achieve UHC by Implement NHI	***CMS provides strategic advice to influence and support the development and implementation of National health policy*** Currently, the CMS is in the process of revising the PMB package with an emphasis to include more primary health care benefits. The role that CMS will play towards the achievement of this NDP mandate is the collection, analysis and provision of private health quality data. This is covered by Strategic Goal 5: To conduct policy-driven research, monitoring and evaluation of the medical schemes industry In addition, the PMB definition, which is a key part of the PMB review, will

NDP Goals 2030	MTSF Priorities (Presidential Health Compact)	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
			ensure that there is an improved understanding by scheme members of their benefits and entitlements The inclusion of the Primary Healthcare (including TB) in the PMB's as part of the review process will lead to the overall improvement of the National Health Outcomes
Universal Health coverage achieved	Universal health coverage achieved through implementation of National Health Insurance	Goal 2: Achieve UHC by Implement NHI	***Outcome 2: To encourage effective Risk Pooling*** Resulting from the publication of the NHI Bill, CMS will be exploring the support of risk pool consolidation. This involves a number of initiatives that are underway at the CMS that include, but are not limited to the following: • Standardisation of Options • Consolidation of Schemes <6000 members • Consolidation of Government funded schemes • Central Beneficiary Registry

b. The CMS has chosen the outcomes indicators based on its mandate that is located in Section 7 of the Medical Schemes Act, which has been cited several times above. This mandate also forms the basis of its articulated Mission for the next five years. The CMS has set itself a strategic trajectory for the next five years that is aimed at achieving the following:

- Improving operational effectiveness and efficiency
- Playing a significant role in the implementation of the Universal Health Coverage (National Health Insurance)

The key elements of these outcome indicators include the following:

- Protection of scheme member interests
- Ensuring that the entities that are regulated by the CMS are compliant with the MSA and its regulations
- Ensuring operational effectiveness and efficiency
- Providing the Minister of Health with sound advice on Health Policy issues that are related to the medical schemes industry
- Reduction of costs and improvement of quality in the private health sector
- Increased stakeholder engagements

c. The key enablers for the successful achievement of the five-year outcome targets are:

Adequate Funding:

The CMS is currently faced with significant financial difficulties due to resource constraints. The proposed increased levy tabled for the 2020/21 financial year of R42,54 per principal member per annum (ppmpa) has not yet been approved. CMS is therefore operating with a levy of R38,67 as approved in the 2019/20 financial year that does not consider the inflationary adjustment and current financial pressures of the Regulator in achieving its mandate.

The CMS has revised downwards and resubmitted its 2020/21 levy increases to be in line with inflation, R40,41 ppmpa. This revised submission is not sufficient to fully fund CMS's mandate as a Regulator. Based on the resubmitted 2020/21 budget, CMS's total budget is planned at R186,5m in 2021/22 financial year. This assumes an approved levy of R42,27 ppmpa.

The other revenue that the CMS collects, outside of levies, has declined by more than 40% over the past 3 years. This can be attributed to our enabling Legislative documents that are outdated and have not been reviewed to enable CMS to be adequately resourced to carry out its Vision fully and effectively and be an agile and transformative Regulator.

Considering the above, the CMS will be engaging further with the Department of Health and National Treasury on its funding strategy moving forward.

Adequate Human Resources:

The CMS currently has a total personnel headcount of 132 including temporary and contract personnel which is below the required numbers based on workloads. The CMS is understaffed and relies on interns and temporary personnel to carry out some of its core regulatory functions. Additional resources will enable this organisation to have reasonable staffing levels to effectively carry out its mandate. The recently completed Business Process Mapping exercise has indicated that an additional 16 posts will be required by the CMS for optimal and efficient operations.

Organisational Restructuring:

The CMS has grown organically over time and now has macro and micro structures that are not fit for purpose. The current structure encourages silo-functioning and has led to low productivity and conflict. There is an urgent need for restructuring to improve operational effectiveness and efficiency. This was highlighted by the Organisational Diagnostic report. The completion of the implementation of the organisation diagnostic report which was adopted by Council in May 2020 has resulted in the following outputs –

- New Service delivery model
- New business operational model (macro and micro structures)
- Business process mapping

The full implementation of the new structure will require additional resources to fill in the 16 additional posts.

Integrated ICT platform:

The CMS operating in a sub-optimal manner due to lack of supportive ICT infrastructure. This has not been updated as often as it is required. There is also a need to integrate all the regulatory functions to provide an end to end solution to the currently dysfunctional stand-alone processes.

Stakeholder Collaboration:

Given the resource constraints and the fact that the success of the CMS is dependent on the support by key stakeholders, we have no alternative except to establish a partnership with the different key stakeholders. These stakeholders include all the entities that we regulate (medical schemes, administrators, managed care organisations and brokers); fellow regulators (Health Professions Council of South Africa, Office of Health Standards Compliance, Financial Sector Conduct Authority and Prudential Authority); National Department of Health and Industry Associations (Board Health Funders, Health Funders Association, Financial Intermediary Association, National Healthcare Professional Association, Considerable amount of effort will go into engaging with other stakeholders including but not limited to the Competition commission, South African Revenue Services (SARS),

d. We have already indicated that as a regulatory body, our contribution to the achievement of the desired impact is both direct and indirect. The direct contribution is made through our research, policy and monitoring of the medical schemes industry. The advice to the Health Ministry is based on this rigorous research. The greater contribution to the impact as achieved indirectly through that manner in which we control the industry in a manner that is complementary to National Policy. These indirect contributions are also part of the greater challenge that we have in providing outputs, outcomes and impact indicators to measure organisational performance.

7. Programme Resource Considerations for 2021/22

The CMS Strategic Plan, Annual Performance Plan And Budget For 2021/22

The Council for Medical Schemes' budget for 2021/22 that should accompany the Strategic plan (2020-2025) and the Annual Performance Plan (2021/22), which was approved by Council and submitted to Treasury and the National Department of Health is included here for completeness. We have also included the annual levy increase proposed for 2021/22.

In our 2021/22 budget, we proposed a levy of ***R42,27*** per member per annum (pmpa), which is an increase of **R1,86** per family per year compared to the levies collected in 2020/21. In percentage terms, the proposal amounts to a 4,6% increase which is within CPI. By comparison, the increases in the preceding three years were 6.30%, 7.03% and 4,5% respectively. An inflationary increase of 4,5% was applied for goods and services and capital expenditure as per Treasury guidelines. In respect of the cost-of-living adjustment for employees, the CMS applied the guidelines as per Treasury guidelines for costing and budgeting for compensation of employees.

Albeit the proposal of 4.6%, it is worth bringing to your attention that the proposed increase is not sufficient to fully fund CMS's mandate as a Regulator. CMS will therefore be engaging further with the Department of Heath and National Treasury on its funding moving forward.

The strategic trajectory for the CMS for the next five years entails ensuring effective and efficient regulation of the medical scheme industry and playing a significant role in the implementation of Universal Health Coverage using the National Health Insurance vehicle in South Africa. In order to execute this mandate, the CMS will in addition to its core mandate, contribute to the following key areas:

- Policy development and research
- Reduction of costs and quality improvement
- Reduction of fraud, waste and abuse
- Support establishment of a coding authority
- Harmonise the medical schemes regulatory frameworks in the SADC
- Consolidation of options and medical schemes
- Beneficiary Registry
- Primary Health Care package
- Development of the LCBO framework.

The specific challenges that the CMS will need to prioritise for the 2021/22 financial year based on our current risks include the following:

- The implementation of the recommendations of the Section 59 investigations
- The implementation of the recommendations of the SIU investigation
- The development and implementation of the business process mapping, service and operational business models for the CMS based on the recommendations of the Council sponsored Organisational Diagnostic exercise
- The finalisation of the proposals for the Medical Schemes Amendment Bill that incorporate the recommendations from the National Health Insurance and the Health Market Inquiry
- The implementation of the development of the Guidance Framework for the Low-Cost Benefit Options

Budget

Table 1, presented below covers the budget and funding proposal based on the annual levy increase. This proposal shows an increase in total budgeted expenditure from R179,0 Million to R186,5 Million, which represents an increase of 4,2%.

Table 2, on the other hand, provides a programmatic break–down of the consolidated budget for 2021/22 financial year. The detailed break-down of the proposed budget as per economic classification is provided in Table 3. The budget presented above supports the Annual Performance Plan for the Council for Medical Schemes for the 2021/22 financial year albeit significant resource constraints.

Council for Medical Schemes

Funding proposal for 2021/2022

Table 1: CMS Budget

Description	Line Ref		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Goods and services	A1		52 365 841	54 453 240	64 084 222	63 473 528	72 477 099	75 811 045	79 298 353
Compensation of employees	A2		98 174 779	106 702 173	120 594 550	114 649 748	113 072 984	118 274 341	123 714 961
Operating cash expenditure	**A**		**150 540 621**	**161 155 412**	**184 678 773**	**178 123 276**	**185 550 083**	**194 085 387**	**203 013 315**
Capital expenditure	B		3 536 023	3 781 117	3 627 192	900 000	1 000 000	1 046 000	1 094 116
Total cash requirement (TABLE 2)	**C**	**A + B**	**154 076 644**	**164 936 529**	**188 305 965**	**179 023 276**	**186 550 083**	**195 131 387**	**204 107 431**
Surplus funds (NHI related projects & HMI)	D1		-	-	(1 916 667)		-	-	-
Inspection fees (recovery)	D2		-	-	(9 321 895)	(102 302)	(102 302)	(107 008)	(111 931)
Accreditation fees	E		(9 315 016)	(7 504 000)	(9 536 067)	(6 779 733)	(6 779 733)	(7 091 601)	(7 417 815)
Registration Fees	F		(366 383)	(45 385)	(422 959)	(512 947)	(512 947)	(536 542)	(561 223)
Interest Received	G		(2 835 878)	(4 483 382)	(4 995 730)	(1 945 922)	(1 945 922)	(2 035 434)	(2 129 064)
Government grant	H1		(5 496 000)	(5 815 000)	(5 987 000)	(6 530 000)	(6 181 000)	(6 465 326)	(6 762 731)
Other income	I		(1 787 315)	(2 842 899)	(789 606)	(274 454)	(274 454)	(287 079)	(300 284)
Total income excluding levies	**J**	**D + E + F + G + H+ I**	**(19 800 592)**	**(20 690 666)**	**(32 969 924)**	**(16 145 358)**	**(15 796 358)**	**(16 522 990)**	**(17 283 048)**
Income from levies	K	C - J	134 276 052	144 245 863	155 336 041	162 877 918	170 753 725	178 608 396	186 824 383
Total membership	L		3 950 927	3 992 102	4 016 708	4 030 619	4 039 705	4 039 705	4 039 705
Levy amount proposed	M	K / L	R 33,99	R 36,13	R 38,67	R 40,41	R 42,27	R 44,21	R 46,25
Levy amount approved			R 33,99	R 36,13	R 38,67				
Levy increase (in Rand) based on approved levy			R 1,98	R 2,14	R 2,54	R 1,74	R 1,86	R1,94	R2,03
Levy increase (in %) based on approved levy			6,19%	6,30%	7,03%	4,49%	4,60%	4,60%	4,60%

Table 2: Overview of budget and MTEF estimates

Consolidated expenditure - Per Programme	Actual outcome (Audited)			Budget			
	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
ADMINISTRATION							
Office of the CEO and Registrar	12 321 197	12 251 365	18 741 172	16 231 419	7 723 611	8 078 897	8 450 526
Office of the CFO	30 818 317	34 301 623	36 843 475	34 122 020	38 428 571	40 196 285	42 045 314
Information Systems and Knowledge Management	17 352 812	20 211 984	21 495 599	24 940 721	25 201 872	26 361 158	27 573 772
Human Resources	7 483 783	10 560 950	11 728 896	8 869 322	10 254 249	10 725 945	11 219 338
Legal Services	12 405 477	10 707 032	22 709 105	21 974 528	15 212 224	15 911 986	16 643 937
Council Secretariat					7 311 418	7 647 743	7 999 540
STRATEGY OFFICE	11 463 279	13 700 822	13 332 791	9 867 676	10 573 646	11 060 034	11 568 796
ACCREDITATION	9 262 317	9 052 136	9 480 639	8 451 442	7 910 129	8 273 995	8 654 599
RESEARCH AND MONITORING	6 412 344	6 382 171	8 468 129	6 492 729	9 622 164	10 064 784	10 527 764
STAKEHOLDER RELATIONS	13 130 156	14 044 655	13 607 674	9 171 162	12 465 495	13 038 908	13 638 698
COMPLIANCE AND INVESTIGATION	19 457 514	16 764 333	15 370 825	11 058 421	14 094 647	14 743 001	15 421 179
BENEFIT MANAGEMENT	6 521 609	6 518 576	7 125 393	6 029 699	5 927 435	6 200 097	6 485 302
FINANCIAL SUPERVISION	11 883 278	12 951 637	13 262 016	11 778 311	11 733 802	12 273 557	12 838 140
COMPLAINTS AND ADJUDICATION	6 499 587	6 851 823	7 677 204	9 135 826	9 090 819	9 508 997	9 946 411
OPERATING CASH EXPENDITURE	**165 011 670**	**174 299 107**	**199 842 916**	**178 123 276**	**185 550 083**	**194 085 387**	**203 013 315**
Capital expenditure	3 536 023	3 781 117	3 812 179	900 000	1 000 000	1 046 000	1 094 116
TOTAL CASH REQUIREMENT	**168 547 693**	**178 080 224**	**203 655 095**	**179 023 276**	**186 550 083**	**195 131 387**	**204 107 431**
SURPLUS FUNDS (NHI related projects & HMI)	-	-	-	-	-	-	-
INSPECTION FEES RECOVERIES	-	-	(2 071 328)	(102 302)	(102 302)	(107 008)	(111 931)
ACCREDITATION FEES	(9 315 016)	(7 504 000)	(8 170 400)	(6 779 733)	(6 779 733)	(7 091 601)	(7 417 815)
REGISTRATION FEES	(366 383)	(45 385)	(469 435)	(512 947)	(512 947)	(536 542)	(561 223)
INTEREST RECEIVED	(2 835 878)	(4 483 382)	(3 281 212)	(1 945 922)	(1 945 922)	(2 035 434)	(2 129 064)
GOVERNMENT GRANT	(5 496 000)	(5 815 000)	(6 481 351)	(6 530 000)	(6 181 000)	(6 465 326)	(6 762 731)
OTHER INCOME	(1 787 315)	(2 842 899)	(880 958)	(274 454)	(274 454)	(287 079)	(300 284)
LEVIES ON MEDICAL SCHEMES	(134 276 052)	(144 245 863)	(156 215 392)	(162 877 918)	(170 753 725)	(178 608 396)	(186 824 383)
TOTAL INCOME	**(154 076 644)**	**(164 936 529)**	**(177 570 077)**	**(179 023 276)**	**(186 550 083)**	**(195 131 387)**	**(204 107 431)**
(SURPLUS) / DEFICIT	14 471 049	13 143 694	26 085 018	0	0	0	0

Per Economic classification		Actual outcome (Audited)			Budget			
		2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Compensation of employees		**98 150 056**	**105 982 725**	**116 570 088**	**114 649 748**	**113 072 984**	**118 274 341**	**123 714 961**
Salaries and wages		95 585 153	102 966 757	113 278 352	110 871 791	108 831 883	113 838 150	119 074 704
Social contributions		2 564 903	3 015 968	3 291 736	3 777 958	4 241 101	4 436 192	4 640 257
Goods and services		**66 861 614**	**68 316 382**	**83 272 828**	**63 473 528**	**72 477 099**	**75 811 046**	**79 298 354**
Agency and support / outsourced services		159 528	226 495	562 819	3 542	185 550	194 086	203 014
Communication		500 801	537 130	754 230	2 445 138	3 055 473	3 196 024	3 343 041
Computer services		3 377 486	4 152 727	4 582 954	5 290 581	4 785 976	5 006 131	5 236 413
Consultants		14 884 652	14 064 819	14 942 422	7 156 785	12 998 816	13 596 761	14 222 212
Lease payments		12 037 550	12 109 445	12 402 618	12 126 952	14 131 966	14 782 036	15 462 010
Advertising and marketing		3 433 995	1 606 191	1 385 355	265 185	1 823 551	1 907 434	1 995 176
Audit costs		696 717	739 763	1 122 636	1 388 705	1 174 278	1 228 294	1 284 796
Bank charges		117 171	112 285	85 223	54 649	110 400	115 479	120 791
Board costs		1 453 590	3 657 828	3 456 720	3 435 389	3 574 994	3 739 444	3 911 458
Legal fees		14 972 313	7 801 881	20 751 583	18 376 263	13 053 752	13 654 225	14 282 319
Non life insurance		481 064	522 697	448 585	627 267	606 784	634 696	663 893
Other unclassified expenditure		2 502 674	3 311 662	4 210 603	2 330 936	3 251 595	3 401 169	3 557 623
Printing and publication		1 019 743	1 014 116	1 154 782	915 456	1 098 582	1 149 117	1 201 976
Property payments		4 215 934	4 399 936	5 074 025	4 936 219	5 252 798	5 494 427	5 747 171
Staff cost note		1 953 925	4 224 189	4 833 127	2 694 449	2 990 570	3 128 137	3 272 031
Venue and facilities		1 052 532	3 174 776	1 659 308	31 257	542 457	567 410	593 511
Repairs and maintenance		881 675	751 428	542 988	409 180	989 355	1 034 865	1 082 469
Training and staff development		994 650	2 164 980	1 389 940	914 057	1 732 904	1 812 617	1 895 998
Travel and subsistence		2 125 611	3 744 034	3 912 911	71 519	1 117 298	1 168 694	1 222 454
OPERATING CASH EXPENDITURE		**165 011 670**	**174 299 107**	**199 842 916**	**178 123 276**	**185 550 083**	**194 085 387**	**203 013 315**
Capital expenditure		3 536 023	3 781 117	3 812 179	900 000	1 000 000	1 046 000	1 094 116
TOTAL CASH REQUIREMENT		**168 547 693**	**178 080 224**	**203 655 095**	**179 023 276**	**186 550 083**	**195 131 387**	**204 107 431**

Table: Budget Allocation for programme and sub-programmes as per the ENE

7.1 Reconciling performance targets with the budget and MTEF (CEO and Registrar)

Expenditure (1.1)	Actual outcome (Audited)			Budget			
Office of the CEO and Registrar	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**1 932 210**	**2 346 891**	**5 351 069**	**7 329 695**	**3 424 223**	**3 581 738**	**3 746 498**
Salaries and wages	1 932 210	2 346 891	5 351 069	7 329 695	3 424 223	3 581 738	3 746 498
Goods and services	**10 388 987**	**9 904 475**	**13 390 102**	**8 901 723**	**4 299 387**	**4 497 159**	**4 704 028**
Agency and support / outsourced services	148 417	222 930	520 180	-	-	-	-
Communication	64 345	66 422	44 328	7 625	2 000	2 092	2 188
Consultants	420 948	1 480 217	4 624 216	3 913 845	2 069 000	2 164 174	2 263 726
Board costs	1 453 590	3 657 828	3 456 720	3 435 389	0	0	0
Legal fees	6 617 642	1 780 050	2 793 638	1 521 618	1 924 275	2 012 792	2 105 380
Other unclassified expenditure	17 470	49 984	54 895	4 593	10 000	10 460	10 941
Staff cost note	-	-	-	-	2 203	2 304	2 410
Venue and facilities	377 102	746 749	519 958	2 329	89 063	93 160	97 445
Training and staff development	82 622	405 453	147 773	16 324	16 652	17 418	18 219
Travel and subsistence	1 206 852	1 494 842	1 228 395	-	186 194	194 759	203 718
TOTAL	**12 321 197**	**12 251 365**	**18 741 172**	**16 231 419**	**7 723 611**	**8 078 897**	**8 450 526**

7.2 Reconciling performance targets with the budget and MTEF (Office of the CFO)

Expenditure (1.2)	Actual outcome (Audited)			Budget			
Office of the CFO	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**12 129 901**	**13 878 895**	**15 317 434**	**14 589 689**	**15 310 303**	**16 014 577**	**16 751 247**
Salaries and wages	9 564 998	10 862 927	12 025 698	10 811 732	11 069 202	11 578 385	12 110 991
Social contributions	2 564 903	3 015 968	3 291 736	3 777 958	4 241 101	4 436 192	4 640 257
Goods and services	**18 688 416**	**20 422 727**	**21 526 041**	**19 532 330**	**23 118 268**	**24 181 708**	**25 294 067**
Communication	2 700	13 674	5 898	1 312	6 169	6 453	6 750
Consultants	981 882	2 271 331	1 918 175	663 275	1 839 972	1 924 610	2 013 143
Lease payments	11 641 355	11 708 668	12 001 886	11 725 948	13 668 381	14 297 127	14 954 795
Audit costs	696 717	739 763	1 122 636	1 388 705	1 174 278	1 228 294	1 284 796
Bank charges	117 171	112 285	85 223	54 649	110 400	115 479	120 791
Non life insurance	481 064	522 697	448 585	627 267	606 784	634 696	663 893
Other unclassified expenditure	389 019	443 173	993 839	259 834	399 111	417 470	436 674
Printing and publication	126 639	23 558	215 268	157 952	141 983	148 514	155 346
Property payments	3 854 121	3 990 641	4 361 499	4 425 205	4 702 798	4 919 127	5 145 407
Staff cost note	-	-	-	-	2 203	2 304	2 410
Venue and facilities	65 341	104 269	29 303	6 443	39 261	41 067	42 956
Repairs and maintenance	204 089	162 990	221 876	73 664	213 156	222 961	233 217
Training and staff development	95 042	282 916	94 052	145 944	182 416	190 807	199 584
Travel and subsistence	33 276	46 762	27 802	2 133	31 356	32 798	34 307
TOTAL	**30 818 317**	**34 301 623**	**36 843 475**	**34 122 020**	**38 428 571**	**40 196 285**	**42 045 314**

7.3 Reconciling performance targets with the budget and MTEF (ICT and KM)

Expenditure (1.3)	Actual outcome (Audited)			Budget			
Information Systems and Knowledge Management	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Compensation of employees	**9 865 845**	**11 425 562**	**11 846 231**	**13 690 927**	**12 898 426**	**13 491 754**	**14 112 375**
Salaries and wages	9 865 845	11 425 562	11 846 231	13 690 927	12 898 426	13 491 754	14 112 375
Goods and services	**7 486 967**	**8 786 422**	**9 649 368**	**11 249 794**	**12 303 446**	**12 869 404**	**13 461 397**
Communication	423 656	453 976	704 005	2 436 201	3 000 000	3 138 000	3 282 348
Computer services	3 377 486	4 152 727	4 582 954	5 290 581	4 785 976	5 006 131	5 236 413
Consultants	88 838	184 080	260 153	633 333	651 809	681 792	713 154
Lease payments	396 195	400 777	400 733	401 004	463 584	484 909	507 215
Other unclassified expenditure	1 503 086	2 170 839	2 316 711	1 535 544	1 885 634	1 972 374	2 063 103
Printing and publication	7 486	7 241	-	-	8 055	8 425	8 813
Property payments	361 813	409 295	712 527	511 014	550 000	575 300	601 764
Staff cost note	467 854	229 040	-	-	2 203	2 304	2 410
Venue and facilities	13 473	10 978	14 657	-	22 170	23 190	24 256
Repairs and maintenance	633 096	539 255	291 532	318 805	727 016	760 459	795 440
Training and staff development	177 082	138 994	291 205	122 012	163 199	170 706	178 559
Travel and subsistence	36 902	89 221	74 892	1 300	43 800	45 815	47 922
TOTAL	**17 352 812**	**20 211 984**	**21 495 599**	**24 940 721**	**25 201 872**	**26 361 158**	**27 573 772**

7.4 Reconciling performance targets with the budget and MTEF (Human Resource Management)

Expenditure (1.4)	Actual outcome (Audited)			Budget			
Human Resources	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**4 922 508**	**5 113 586**	**5 654 319**	**5 660 750**	**4 828 776**	**5 050 900**	**5 283 242**
Salaries and wages	4 922 508	5 113 586	5 654 319	5 660 750	4 828 776	5 050 900	5 283 242
Goods and services	**2 561 275**	**5 447 364**	**6 074 577**	**3 208 572**	**5 425 473**	**5 675 044**	**5 936 096**
Agency and support / outsourced services	11 110	3 565	42 639	3 542	12 923	13 518	14 139
Consultants	567 675	798 105	804 828	241 323	1 898 785	1 986 129	2 077 491
Other unclassified expenditure	264 912	240 821	167 526	186 486	284 338	297 418	311 099
Staff cost note	1 478 072	3 995 149	4 833 126	2 694 449	2 964 136	3 100 486	3 243 108
Venue and facilities	118 355	101 948	114 187	22 485	93 261	97 551	102 038
Repairs and maintenance	44 490	49 183	29 580	16 711	49 183	51 445	53 811
Training and staff development	52 825	225 046	42 389	22 578	98 999	103 553	108 317
Travel and subsistence	23 836	33 547	40 302	20 998	23 847	24 944	26 092
TOTAL	**7 483 783**	**10 560 950**	**11 728 896**	**8 869 322**	**10 254 249**	**10 725 945**	**11 219 338**

7.5 Reconciling performance targets with the budget and MTEF (Legal Services)

Expenditure (1.5)	Actual outcome (Audited)			Budget			
Legal Services	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**3 938 956**	**4 488 772**	**4 583 506**	**5 074 595**	**3 945 712**	**4 127 214**	**4 317 066**
Salaries and wages	3 938 956	4 488 772	4 583 506	5 074 595	3 945 712	4 127 214	4 317 066
Goods and services	**8 466 521**	**6 218 260**	**18 125 599**	**16 899 934**	**11 266 512**	**11 784 772**	**12 326 871**
Legal fees	8 354 671	6 021 830	17 957 945	15 345 151	10 129 477	11 641 433	12 176 939
Legal Fees (Sec 59)				1 509 494	1 000 000		
Other unclassified expenditure	7 488	3 280	4 214	1 484	10 132	10 598	11 086
Staff cost note	-	-	-	-	2 203	2 304	2 410
Venue and facilities	2 150	2 390	4 040	-	2 697	2 822	2 951
Training and staff development	68 846	107 865	83 072	28 032	85 795	89 742	93 870
Travel and subsistence	33 366	82 895	76 328	15 773	36 207	37 873	39 615
TOTAL	**12 405 477**	**10 707 032**	**22 709 105**	**21 974 528**	**15 212 224**	**15 911 986**	**16 643 937**

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7.6 Reconciling performance targets with the budget and MTEF (Council Secretariat)

Expenditure (1.6)	Actual outcome (Audited)			Budget			
Council Secretariat	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees					**1 829 128**	**1 913 268**	**2 001 278**
Salaries and wages					1 829 128	1 913 268	2 001 278
Goods and services					**5 482 290**	**5 734 476**	**5 998 261**
Agency and support / outsourced services					172 627	180 568	188 874
Communication					44 367	46 408	48 543
Consultants					1 108 528	1 159 520	1 212 858
Board costs					3 574 994	3 739 444	3 911 458
Other unclassified expenditure					56 517	59 116	61 836
Venue and facilities					89 063	93 160	97 445
Training and staff development					250 000	261 500	273 529
Travel and subsistence					186 194	194 759	203 718
TOTAL					**7 311 418**	**7 647 743**	**7 999 540**

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

Expenditure (2)	Actual outcome (Audited)			Budget			
STRATEGY OFFICE	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**10 017 108**	**10 654 383**	**10 056 473**	**8 987 755**	**8 851 024**	**9 258 171**	**9 684 047**
Salaries and wages	10 017 108	10 654 383	10 056 473	8 987 755	8 851 024	9 258 171	9 684 047
Goods and services	**1 446 171**	**3 046 439**	**3 276 318**	**879 921**	**1 722 622**	**1 801 863**	**1 884 749**
Consultants	1 069 837	2 106 780	2 546 055	773 939	1 464 927	1 532 314	1 602 800
Other unclassified expenditure	22 709	25 495	13 052	3 333	24 797	25 937	27 130
Venue and facilities	81 466	268 313	255 771	-	41 134	43 026	45 006
Training and staff development	100 485	149 675	120 711	99 442	137 396	143 716	150 327
Travel and subsistence	171 674	496 176	340 729	3 206	52 166	54 565	57 076
TOTAL	**11 463 279**	**13 700 822**	**13 332 791**	**9 867 676**	**10 573 646**	**11 060 034**	**11 568 796**

7.8 Reconciling performance targets with the budget and MTEF (Accreditation Unit)

Expenditure (3)	Actual outcome (Audited)			Budget			
ACCREDITATION	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Compensation of employees	**9 031 526**	**8 444 922**	**8 412 361**	**8 082 096**	**7 325 000**	**7 661 950**	**8 014 400**
Salaries and wages	9 031 526	8 444 922	8 412 361	8 082 096	7 325 000	7 661 950	8 014 400
Goods and services	**230 792**	**607 214**	**1 068 278**	**369 346**	**585 130**	**612 046**	**640 200**
Consultants	-	102 120	-	-	-	-	-
Other unclassified expenditure	127 263	144 592	360 603	272 864	313 231	327 639	342 711
Venue and facilities	24 944	6 934	3 657	-	22 982	24 039	25 144
Training and staff development	27 450	107 767	88 555	96 482	92 629	96 889	101 346
Travel and subsistence	51 135	245 802	615 463	-	154 086	161 174	168 588
TOTAL	**9 262 317**	**9 052 136**	**9 480 639**	**8 451 442**	**7 910 129**	**8 273 995**	**8 654 599**

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

Expenditure (4)	Actual outcome (Audited)			Budget			
RESEARCH AND MONITORING	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Compensation of employees	**6 260 649**	**5 929 005**	**8 208 869**	**6 460 288**	**9 314 249**	**9 742 704**	**10 190 869**
Salaries and wages	6 260 649	5 929 005	8 208 869	6 460 288	9 314 249	9 742 704	10 190 869
Goods and services	**151 695**	**453 165**	**259 259**	**32 442**	**307 915**	**322 079**	**336 895**
Consultants	-	206 833	-	-	88 629	92 706	96 971
Other unclassified expenditure	14 654	16 476	15 112	-	17 734	18 550	19 403
Staff cost note	-	-	-	-	2 203	2 304	2 410
Venue and facilities	2 524	13 765	4 085	-	4 225	4 419	4 623
Training and staff development	86 979	160 018	144 296	32 442	152 018	159 011	166 326
Travel and subsistence	47 537	56 073	95 766	-	43 105	45 088	47 162
TOTAL	**6 412 344**	**6 382 171**	**8 468 129**	**6 492 729**	**9 622 164**	**10 064 784**	**10 527 764**

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7.10 Reconciling performance targets with the budget and MTEF (Stakeholder Relations)

Expenditure (5)	Actual outcome (Audited)			Budget			
STAKEHOLDER RELATIONS	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**8 016 766**	**8 403 843**	**9 523 921**	**7 833 714**	**8 622 896**	**9 019 549**	**9 434 449**
Salaries and wages	8 016 766	8 403 843	9 523 921	7 833 714	8 622 896	9 019 549	9 434 449
Goods and services	**5 113 390**	**5 640 812**	**4 083 753**	**1 337 448**	**3 842 599**	**4 019 359**	**4 204 249**
Communication	10 100	3 058	-	-	2 936	3 072	3 213
Consultants	-	91 635	9 830	270 346	637 601	666 931	697 609
Advertising and marketing	3 433 995	1 606 191	1 385 355	265 185	1 823 551	1 907 434	1 995 176
Other unclassified expenditure	60 450	130 875	146 094	22 574	119 079	124 556	130 286
Printing and publication	877 960	978 627	934 974	757 505	933 681	976 631	1 021 556
Staff cost note	8 000	-	-	-	2 203	2 304	2 410
Venue and facilities	339 813	1 874 826	701 814	-	98 650	103 188	107 934
Training and staff development	74 921	113 769	80 710	20 533	127 198	133 050	139 170
Travel and subsistence	308 152	841 831	824 977	1 305	97 700	102 194	106 895
TOTAL	**13 130 156**	**14 044 655**	**13 607 674**	**9 171 162**	**12 465 495**	**13 038 908**	**13 638 698**

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7.11 Reconciling performance targets with the budget and MTEF (Compliance and Investigation)

Expenditure (6)	Actual outcome (Audited)			Budget			
COMPLIANCE AND INVESTIGATION	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**7 477 155**	**9 475 778**	**9 976 487**	**10 214 620**	**10 528 089**	**11 012 381**	**11 518 951**
Salaries and wages	7 477 155	9 475 778	9 976 487	10 214 620	10 528 089	11 012 381	11 518 951
Goods and services	**11 980 359**	**7 288 555**	**5 394 338**	**843 801**	**3 566 558**	**3 730 620**	**3 902 228**
Consultants	11 755 472	6 823 718	4 779 160	660 724	3 200 000	3 347 200	3 501 171
Other unclassified expenditure	32 751	25 263	33 116	4 121	46 636	48 781	51 025
Printing and publication	3 000	-	-	-	6 094	6 375	6 668
Staff cost note	-	-	-	-	2 203	2 304	2 410
Venue and facilities	2 866	3 037	1 806	-	1 356	1 418	1 483
Training and staff development	59 673	159 340	80 165	152 151	160 330	167 705	175 420
Travel and subsistence	126 597	277 197	500 091	26 805	149 940	156 837	164 051
TOTAL	**19 457 514**	**16 764 333**	**15 370 825**	**11 058 421**	**14 094 647**	**14 743 001**	**15 421 179**

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7.12 Reconciling performance targets with the budget and MTEF (Benefits Management)

Expenditure (7)	Actual outcome (Audited)			Budget			
BENEFIT MANAGEMENT	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**6 421 172**	**6 371 707**	**6 968 052**	**5 974 824**	**5 810 766**	**6 078 062**	**6 357 653**
Salaries and wages	6 421 172	6 371 707	6 968 052	5 974 824	5 810 766	6 078 062	6 357 653
Goods and services	**100 437**	**146 869**	**157 341**	**54 874**	**116 669**	**122 035**	**127 649**
Other unclassified expenditure	26 550	20 198	27 642	554	30 244	31 636	33 091
Printing and publication	4 659	4 690	4 540	-	8 769	9 172	9 594
Staff cost note	-	-	-	-	2 203	2 304	2 410
Venue and facilities	2 000	1 986	4 000	-	1 107	1 158	1 211
Training and staff development	56 366	99 362	71 968	54 320	49 557	51 837	54 221
Travel and subsistence	10 862	20 633	49 191	-	24 789	25 929	27 122
TOTAL	**6 521 609**	**6 518 576**	**7 125 393**	**6 029 699**	**5 927 435**	**6 200 097**	**6 485 302**

7.13 Reconciling performance targets with the budget and MTEF (Financial Supervision)

Expenditure (8)	Actual outcome (Audited)			Budget			
FINANCIAL SUPERVISION	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Compensation of employees	**11 749 455**	**12 685 677**	**13 108 411**	**11 656 467**	**11 426 088**	**11 951 688**	**12 501 466**
Salaries and wages	11 749 455	12 685 677	13 108 411	11 656 467	11 426 088	11 951 688	12 501 466
Goods and services	**133 823**	**265 961**	**153 604**	**121 844**	**307 714**	**321 869**	**336 675**
Consultants	-	-	4	-	39 565	41 385	43 288
Other unclassified expenditure	34 330	38 418	75 253	39 547	51 245	53 602	56 068
Venue and facilities	20 929	37 581	4 029	-	37 033	38 736	40 518
Training and staff development	63 652	168 049	65 486	82 297	133 441	139 580	146 000
Travel and subsistence	14 912	21 913	8 833	-	44 227	46 262	48 390
TOTAL	**11 883 278**	**12 951 637**	**13 262 016**	**11 778 311**	**11 733 802**	**12 273 557**	**12 838 140**

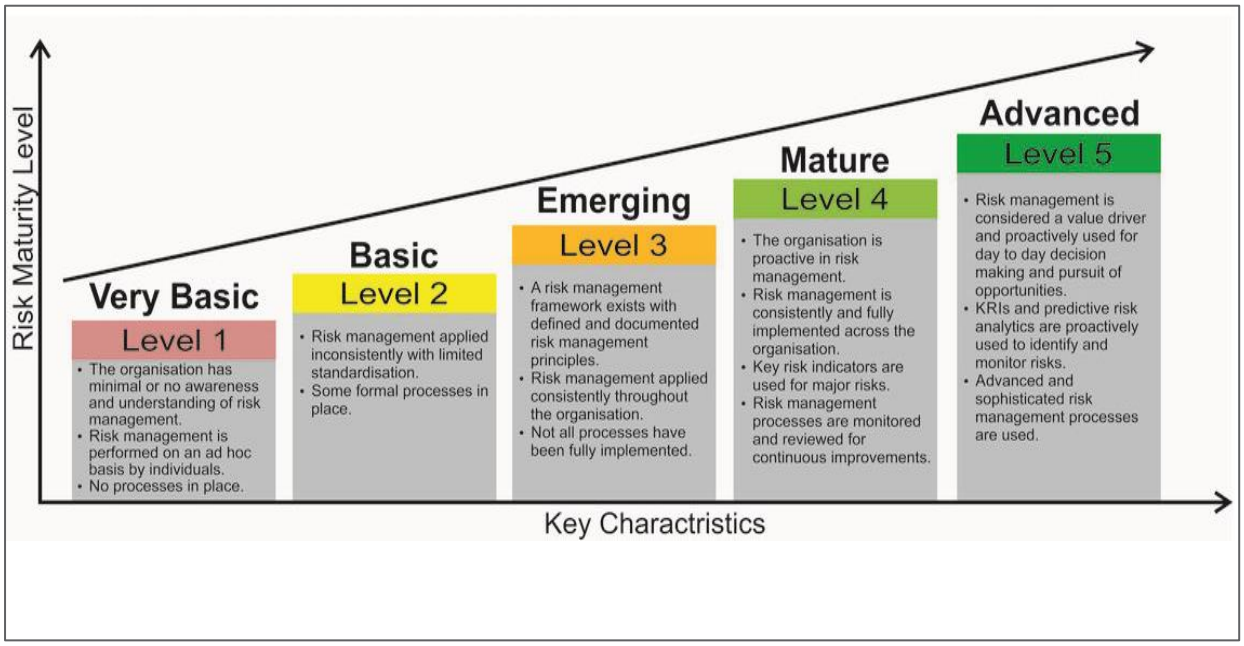
7.14 Reconciling performance targets with the budget and MTEF (Complaints Adjudication)

Expenditure (9)	Actual outcome (Audited)			Budget			
COMPLAINTS AND ADJUDICATION	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Compensation of employees	**6 386 805**	**6 763 705**	**7 562 955**	**9 094 327**	**8 958 303**	**9 370 385**	**9 801 423**
Salaries and wages	6 386 805	6 763 705	7 562 955	9 094 327	8 958 303	9 370 385	9 801 423
Goods and services	**112 782**	**88 118**	**114 249**	**41 499**	**132 516**	**138 612**	**144 988**
Other unclassified expenditure	1 992	2 248	2 545	-	2 897	3 030	3 169
Staff cost note	-	-	1	-	2 203	2 304	2 410
Venue and facilities	1 570	2 001	2 000	-	456	477	499
Training and staff development	48 708	46 726	79 559	41 499	83 273	87 104	91 110
Travel and subsistence	60 512	37 143	30 144	-	43 687	45 697	47 799
TOTAL	**6 499 587**	**6 851 823**	**7 677 204**	**9 135 826**	**9 090 819**	**9 508 997**	**9 946 411**

8. Updated Key Risks

Risk Management has gained traction in public entities in the recent past. Over the years the CMS has developed and implemented an enterprise risk management framework and policy. Although the risks is discussed at operational and strategic levels in the organisation there still is a need for a drive from management to embed more fully a risk culture in the business through challenging discussions and communication.

The Office of the CEO sub-programme over the next few years would like to take the CMS from a level 3 to level 5 in terms of its risk maturity. Strategic risks are monitored by different governance structures.



The area of risk management is under resourced as the CMS currently has only one resource dealing with the risk of the entire organisation. The organisation has grown over the years and resources must be put in place to match the proportionate organic growth of the organisation.

Table: Key Risks

Outcome	Key Risk	Risk Mitigation
Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation	Fraud, Corruption and Unethical Behaviour within CMS	1. Engage and support the SIU on all investigations of malpractice and maladministration 2. Appointment of an Ethics service provider to conduct an ethics assessment, develop policy and framework, establish an ethics strategy and develop an ethics code of conduct booklet is appointed is done 3. Ethics Assessment done, and the report is tabled before the HRSE committee 4. Improved action on supervision controls 5. Random Lifestyle audits 6. Ethics should be a standing item on the EMC agenda 7. Improve Consequence Management
Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation	Inadequate Resources	1. Review of CMS funding model – alternative funding model 2. Amendment of Levies Act – Legal opinion on definition of member 3. Strengthen relationship and engagement with National Treasury and Department of Health 4. To explore purchasing of building– lease ending 2023 – look at collaboration with DOH – look at getting a bigger building that can house CMS and NHI – to have discussions with DOH 5. To explore staff working remotely – need strengthen performance contracts and deliverables - Linked to Business Operation Model and Process Mapping 6. Open plan office 7. Consider reinstating the Finance Committee 8. Enforcing budgetary control processes 9. Automated procurement system

Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation **Outcome 5** - To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry	Poor Stakeholder Engagements	1. Scheme Marketing material: SHR together with BMU to ensure that marketing material sent to members from schemes include the details of CMS 2. Strengthen compliance with S57 4(d) / Consumer protection Act - obliges schemes to make members aware of their rights - to get schemes to publish information on their marketing material on details of CMS 3. Member awareness surveys 4. Establish direct contact to members using the Beneficiary registry 5. Publication of relevant material to members on rulings, products etc. 6. Prepare an annual plan of all research planned for the year. 7. Budget to be linked with the strategy 8. Monitor changes in legislation 9. Stakeholder mapping and milestones for 2020-2024 by end February 2020 10. Identify key priority projects to support policy direction and NHI roadmap by end of March 2020. 11. Develop divisional skills matrix 12. Identify target peer review journals for publishing research work. 13. Identify conferences to present research outputs. 14. Closely aligned research outputs to the Council priorities and Strategy on key priority projects such as Consolidation project. 15. Prioritise key Council projects such as the Risk Based Capital Model, Standardisation of Benefit Options and Health Quality Project 16. Automating of annual statutory returns process in order to optimise on current resources 17. Intensify CMS brand in all media platforms 18. Intensify stakeholder engagement 19. Roll out intensify customer engagement 20. Provide access to general channels of information 21. Create a M-files library of CMS policy and statement; 22. The CMS website must be used effectively; 23. Offer training to all CMS leadership to articulate CMS position and policy; 24. SHR to coordinate all CMS public pronunciations; 25. Ensure consistent messaging in CMS policy and statement; 26. Articulation of stakeholder mapping result to internal staff; 27. Creation of media risk management committee to advise media through press releases, with responses from the entities which we regulate; 28. Articulate position and role of the CMS through media responses

Outcome 2 - To encourage effective risk pooling **Outcome 3** - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation	Failure to Regulate	1. 1.Improved PMB Review Process 2. Strengthening of the Medical Schemes Act 3. CMS to set up technical task team together with DOH to open communication on the progress on the bill 4. Council to present the amendments to the Minister of Health highlighting the importance of having the bill passed. 5. Test the impact of governance intervention by the Compliance and investigation unit 6. CMS will need to develop a mechanism to analyse the impact on the governance interventions in schemes. 7. Test on whether the trustee training programmes are having a positive effect in board decision making. Should CMS be looking at going out to each scheme board and doing specific training annually? 8. Improve Routine and commissioned inspections – test whether the outcomes of these inspections are being implemented by schemes. 9. Improve Non-Compliance register 10. Formulate a non-compliance register of all non-compliance matters relating to all schemes and entities 11. Non-compliance matrix linked to regulatory enforcement 12. Increase the frequency of onsite accreditation - accredited entities 13. Increased compliance monitoring - accredited entities

Outcome 4 - To be a more effective and efficient organisation	Non-compliance with Legislation and guidelines	1. Develop a compliance framework for CMS 2. Training to staff on contract management 3. Training and awareness workshops on conflict management 4. Strengthen controls around supply chain management process by implementing consequence management as outlined in the latest Irregular Expenditure Framework. 5. Further resource the supply chain management function 6. Centralisation of procurement 7. Implement the Audit Findings Management Plan, 8. Develop a SCM User Manual, and engage IA to assist with internal investigations and consequential management 9. Use of the Contract Management system 10. Appoint a Compliance Officer and Internal investigator
Outcome 4 - To be a more effective and efficient organisation	Poor corporate governance practices within CMS	1. Align governance practices of CMS to best practice. 2. The compliance framework needs to be finalised and approved to ensure effective compliance controls and processes – 31 March 2020 3. A draft framework has been developed. Units need to appoint compliance champions. 4. It is recommended that the use of M-files be enforced on users. 5. Council documents to be saved on M-files. 6. This will be verified through the audit findings follow up review by internal auditors. 7. Electronic distribution of Council packs

Outcome 1 - To promote the improvement of quality and the reduction of costs in the private health care sector **Outcome 2** - To encourage effective risk pooling **Outcome 3** - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation **Outcome 5** - To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry **Outcome 6** - To collaborate with local, regional and international entities	Litigation	1. increased legal budget 2. Review of Rules Registration SOP to ensure consistence with the MSA 3. Review Managed Care Accreditation SOP's to ensure that MCO's have evidence based protocols
Outcome 1 - To promote the improvement of quality and the reduction of costs in the private health care sector **Outcome 3** - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation	Business Continuity	1. IT Disaster recovery testing: Testing must be run with appointed service provider for audit purposes at least once per annum. 2. Establish a remote hot site for disaster recovery for CMS 3. Develop Secondment Policy 4. Business mapping could lead to clustering of units 5. Change management 6. Business process mapping 7. Develop frameworks for career path and succession planning

Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations Outcome 4 - To be a more effective and efficient organisation Outcome 6 - To collaborate with local, regional and international entities	Non-Compliance with regulatory framework (Twin Peaks) Demarcation / concurrent jurisdiction	1. Improve interaction with the FSCA, Prudential Authority and National Treasury. 2. Develop the harmonisation of Regulatory Framework 3. Memorandum of understanding with the FSCA and the PA and Treasury
Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations Outcome 4 - To be a more effective and efficient organisation	Outdated Funding Model	1. - 3. Review of CMS funding model – alternative funding model
Outcome 4 - To be a more effective and efficient organisation	Cyber Risk	1. Continuously monitor and analyse activities on Firewal and put threat prevention measures 2. Review the Information Security Policy 3. Enable all Microsoft Enterprise Mobility & Security functionalities
Outcome 4 - To be a more effective and efficient organisation	Reduced Productivity Risk	1. Revive the (SHE) Committee as well as the SHE Policy 2 Training for the SHE Committee Members 3. Install hand sanitizers and sanitize the entire office space 4. Screen staff members 5. Procure maks and gloves for all staff members 6. Develop a screening protocol to be used at all entrances 7. Procure Employee Productivity monitoring tool for remote work

Outcome 4 - To be a more effective and efficient organisation	Pandemics	1. Revive the (SHE) Committee as well as the SHE Policy
Outcome 4 - To be a more effective and efficient organisation	Protests	1. HR to continuously consult and inform members of staff on matters that affect them in an open and transparent manner to improve employer/employee relations.

9. Public Entities

Name of Public Entity	Mandate	Outcomes	Current Annual Budget (R thousand)
Council for Medical Schemes	Regulation of Medical Schemes in protection of Beneficiary interests	**Outcome 1** - To promote the improvement of quality and the reduction of costs in the private health care sector **Outcome 2** - To encourage effective risk pooling **Outcome 3** - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation **Outcome 5** - To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry **Outcome 6** - To collaborate with local, regional and international entities	R 186 600

10. Infrastructure Projects (Not Applicable)

No.	Project name	Programme	Project description	Outputs	Project start date	Project completion date	Total Estimated cost	Current year Expenditure
	N/A							

11. Public Private Partnerships (Not Applicable)

PPP	Purpose	Outputs	Current Value of Agreement	End Date of Agreement
N/A				

Part D: Technical Indicator Descriptions (TID)

12.1 Sub-programme 1.1 (Office of the CEO)

Output 1: Ensure that reported performance information is in accordance with the Framework for Strategic and Annual Performance plans.

Indicator title	**Ensure that overall performance of the entity is maintained at above 80%**
Short definition	Overall Organisation Performance
Purpose/importance	To ensure that Council achieves its performance targets as set out in the annual performance plans for the year.
Source/collection of data	Combined Assurance framework with included Internal Audit
Method of calculation/Assessment	Quarterly Management and Internal Audit Reports Number of achieved targets per quarter/number of applicable targets per quarter
Means of verification	Provide required report and save copy on M-Files
Assumptions	National Health Policy and Legislative reforms will have a direct impact on CMS structure and performance
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not Applicable
Data limitations	Not Applicable
Type of indicator	Outputs
Calculation type	Annually
Reporting cycle	Quarterly
New indicator	No
Desired performance	80%
Indicator responsibility	CEO
Indicator title	**Produce an Annual Performance Information report that is reliable, accurate and complete by 31 July each year.**
Short definition	Reporting of actual performance against stated objectives and targets. To ensure that CMS operates in line with their approved plans.
Purpose/importance	To ensure that Council achieves its performance targets as set out in the annual performance plans for the year.
Source/collection of data	An audit opinion letter issued by the Auditor-General South Africa on 31 July of each year. This is saved on M-Files under CMS Vault folder Performance information audit evidence. The opinion on the audit of reported information will be included in the management report.
Method of calculation/Assessment	Count the audit opinion letter issued by Auditor-General South Africa by 31 July.
Means of verification	Provide required report and save copy on M-Files
Assumptions	The number of submissions and sign-offs of the report will be affected by National Elections
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Not applicable
Type of indicator	Outputs
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	No
Desired performance	An annual performance information report that is reliable, accurate and complete with no material findings by the Auditor-General.
Indicator responsibility	CEO

Output 2: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS.

Indicator title	**Number of strategic risk register reports submitted to the Council for monitoring, .**
Short definition	To ensure that the risks of the Council are mitigated to an acceptable risk tolerance level.
Purpose/importance	Risk management will ultimately help CMS to achieve: Greater organisational clarity of purpose by clearly identifying policy needs and actions required to meet Outcome Indicators. More cohesiveness of effort through organisational consistency and clear role definition, better decisions through thorough consideration of issues. Faster reactions through concentration on key performance trends. Accountability by recording decisions in context and allocating responsibility for action.
Source/collection of data	Quarterly strategic risk register reports submitted to Council for monitoring. Council minutes are kept.
Method of calculation/Assessment	Council minutes reflect the discussions on the strategic risk report submitted and discussed at Council.
Means of verification	Provide required register and save copy on M-Files
Assumptions	Number of submissions is determined by the Executive Authority in concurrence with the Department of Planning, Monitoring and Evaluation
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	Not applicable
Type of indicator	Outputs
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	To ensure that risks are at an acceptable risk tolerance level or are mitigated.
Indicator responsibility	CEO

Output 3: Collaboration with local, regional and international entities.

Indicator title	**Collaboration with local, regional and international entities**
Short definition	Stakeholder Engagements by the Office of the Registrar
Purpose/importance	The establishment of formalised agreements, attendance of regular meetings and scheduled visits to local, regional and international regulatory authorities will ensure that the CMS is recognised by key regulators as an effective and efficient sector regulator.
Source/collection of data	Meetings register
Method of calculation/Assessment	Verification of filed MoU's with Legal, and filling of meeting registers within the Office of the Register
Means of verification	Provide required MoU and save copy on M-Files
Data limitations	Meetings register and minutes for meetings hosted by the stakeholder will depend on the sharing of this
Assumptions	Stakeholder interest are not homogenous
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Type of indicator	Output
Calculation type	Quarterly
Reporting cycle	Quarterly
New indicator	
Desired performance	80% of MoU's signed and or maintained, and 80% of meetings scheduled and held
Indicator responsibility	CEO

12.2 Sub-programme 1.2 (Office of the CFO)

Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities.

Indicator title	**An unqualified opinion issued by the Auditor-General South Africa on the Annual Financial Statements by 31 July each year.**
Short definition	This means that our financial statements presents fairly, in all material respects, the financial position of the Council for Medical Schemes as at 31 March
Purpose/importance	This is to ensure that a transparent financial management system is maintained.
Source/collection of data	An audit opinion is issued by the Auditor-General South Africa on 31 July of each financial year based on annual financial statements submitted for audit purposes. The audit opinion is published with the financial statements in our annual report and are also saved on M-Files under CMS Vault > folder Performance information audit evidence
Method of calculation/Assessment	Performance is assess by evaluation of audit opinion obtained
Means of verifications	Auditor-General South Africa annual report
Assumptions	• Proper records of the financial affairs of the entity is maintained • Annual financial statements are prepared, approved and submitted to the Auditor-General South Africa by 31 May each year
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Not applicable
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	No
Desired performance	An unqualified audit opinion by the Auditor-General
Indicator responsibility	Chief Financial Officer

Output 5: Ensure that reported performance information is useful and reliable and in accordance with the performance management and reporting framework.

Indicator title	**Produce a budget that is approved by Council by 31 January each year**
Short definition	This means that CMS operates in line with its approved budget that is in line with strategy
Purpose/importance	To ensure that Council achieves its objectives as set out in the strategic and annual performance plans for the year.
Source/collection of data	A Submission made 31 January to Executive Authority and National Treasury of the CMS budget and plans.
Method of calculation/Assessment	Consider submission letter to Executive Authority and National Treasury on 31 January each year as saved on M-Files under CMS Vault > folder Performance information audit evidence Provide the draft gazette to NDoH and National Treasure inline with Council budget recommendations, and respond to stakeholder responses to the gazette
Means of verification	Draft annual budget and draft gazette w.r.t the budget
Assumptions	• Final submission date as prescribed – 31 January each year • Approval is received from both the Minister of Health and the Minister of Finance • The budget may change depending on the assessment by the Executive Authority and National Treasury
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	The budget submitted only gets approved once concurrence is received from the Minister of Health and Finance. The budget may change depending on the assessment by Executive Authority and National Treasury.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	No
Desired performance	Approval of budget by Council on/before 31 January each year
Indicator responsibility	Chief Financial Officer

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

Output 6: An established ICT infrastructure that ensures information is available, accessible and protected.

Indicator title	**Percentage of network and server uptime**
Short definition	This indicator measures the percentage of network uptime reported over a period. The more network incidents reported during the year, less the percentage uptime (Network Incidents/365 * 100). These network incidents include switch and router failures, failure in ISP connectivity and general line outages. This indicator also measures the % uptime experienced on all the server systems deployed in the CMS Server Farm. The higher the number of days where access to server systems was totally interrupted, the lower the % uptime (number of server incidents / 365 * 100). This indicator does not consider planned outages needed for purpose of maintenance. These planned outages will be recorded separately as part of the IT Change Management process on the Manage Engine Service Desk application. Days: Days of the year. Incidents: The number of incidents calculated in **days**. These exclude planned maintenance incidents. Formula: (**Days** minus Incidents)/days) multiplied by 100. Annual: ((365 – Incidents)/365) * 100. Q1: (91 – Incidents) / 91) * 100. Q2: (92 – Incidents) / 92) * 100. Q3: (91 – Incidents) / 91) * 100. Q4: (91 – Incidents) / 91) * 100.
Purpose/importance	A reduced network uptime may be indicative of serious network/IT infrastructure related issues which need to be addressed to prevent connectivity issues and possible data loss. A reduced network uptime may seriously impact and compromise the ability of the CMS to run software application systems to support business operations.
Source/collection of data	Manage Engine Service Desk System Software and its build-in change management process. Internet Service Provider network availability report. Data is collected by the Network Manager
Method of calculation/Assessment	Days: Days of the year. 1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days the formula is (number of hours of the incident/24) Incidents: The number of incidents calculated in days. These exclude planned maintenance incidents. Formula: (Days minus Incidents)/days) multiplied by 100. Annual: ((365 – Incidents)/365) * 100. Q1: (91 – Incidents) / 91) * 100. Q2: (92 – Incidents) / 92) * 100. Q3: (91 – Incidents) / 92) * 100. Q4: (91 – Incidents) / 91) * 100.
Means of verification	Number of incidents/downtimes experienced on the network
Assumptions	The assumption has taken into account all the identified operational risks
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Impact
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher. A 100 % uptime should be strived for.
Indicator responsibility	Chief Information Officer
Indicator title	**Percentage of IT security incidents (Breaches),** .
Short definition	This indicator measures the percentage of IT security events reported over a period. The more security incidents reported during the year, the more the percentage of incidents (Security Incidents/365 * 100). These security incidents include external penetration attempts through the CMS firewall as well as attempts internally to by both staff as well as visitors to access information which they are not entitled to access. This indicator does not consider planned penetration attempts as part of annual security audits performed. These planned penetration attempts will be recorded separately as part of the IT Change Management process on M-Files. Days: 1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days the formula is (number of hours of the incident/24) Incidents: The number of security incidents calculated in days. These do not include planned attempts. Formula: (Security incidents/days) multiplied by 100. Annual: ((Security incidents/365) * 100. Q1: (Security incidents) / 91) * 100.

	Q2: (Security incidents) / 92) * 100. Q3: (Security incidents) / 92) * 100. Q4: (Security incidents) / 91) * 100.
Purpose/importance	Security incidents may seriously affect and compromise the ability of the CMS to act as custodian of beneficiary and scheme data which it is required to collect as part of its regulatory mandate. It may also cause the CMS to be in default in terms of current legislation aimed at protecting the privacy of information such as the Promotion of Personal Information Act (POPI Act, Act 4 of 2013) as well as the Electronic Communication and Transactions Act (ECT Act, Act 36 of 2005).
Source/collection of data	Firewall reports submitted monthly to CMS by the Security Service Provider. Data is collected by the Network Manager.
Method of calculation/Assessment	Days: 1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days the formula is (number of hours of the incident/24) Incidents: The number of security incidents calculated in days. These do not include planned attempts. Formula: (Security incidents/days) multiplied by 100. Annual: ((Security incidents/365) * 100. Q1: (Security incidents) / 91) * 100. Q2: (Security incidents) / 92) * 100. Q3: (Security incidents) / 92) * 100. Q4: (Security incidents) / 91) * 100..
Means of verification	Number of security incidents experienced report filed on M-Files
Assumptions	• Cybersecurity Threats from external hackers • Data breech from internal personnel • POPIA; and • Lack of proper monitoring tools will all affect the target
Disaggregation of Beneficiaries	Refers to TID for Programme 1.4: Human Resources
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Impact
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	Lower. A zero percent (0 %) incident rate should be strived for.
Indicator responsibility	Chief Information Officer
Indicator title	**Number of successful IT Disaster Recovery (DR) failover tests**
Short definition	This indicator measures the ability of the CMS to recover ICT systems in case of a disastrous event by counting the number of disaster recovery certificates issued by an independent external service provider, which verify successful recovery of specified systems at the remote DR site. A DR Recovery Certificate issued by an external provider signifies the ability of the CMS to recover its data at the remote site in case of a DR event. Initially one certificate and thereafter two certificates per annum will be required to signify that this indicator has been met.
Purpose/importance	The inability of the CMS to recover IT systems following a disastrous event may seriously cripple the business and may even lead to the closure of the business. By verifying the CMS ICT Unit's ability to recover key IT systems at a remote site, assurance is provided that the CMS will be able to recover its data in case of a disaster.
Source/collection of data	Externally issued Disaster Recovery Certificate.
Method of calculation/Assessment	Counting of externally issued DR Certificate(s).
Means of verification	Disaster Recovery Certificate confirming successful testing
Assumptions	• Backup tapes corrupted; and • Lack of resources will affect the target
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Impact
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	Yes
Desired performance	Higher. At least two DR Certificates issued annually should be strived for.

Indicator responsibility	Chief Information Officer

Output 7: Provide software applications that serve both internal as well as external stakeholders and which improves business operations and performance.

Indicator title	**Percentage of uptime, of all installed application systems where network access exists,**
Short definition	This indicator measures the % uptime of all installed applications deployed in CMS. This indicator does not take into account the planned outages needed for purpose of maintenance. These planned outages will be recorded separately as part of the IT Change Management process on the Advent Net Helpdesk System. This indicator also assumes a 24/7 network availability. 1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days the formula is (number of hours of the incident/24) Incidents: The number of incidents calculated in days. Formula: (Days minus Incidents)/days) multiplied by 100. Annual: (365 – Incidents)/365) * 100. Q1: (91 – Incidents) / 91) * 100. Q2: (92 – Incidents) / 92) * 100. Q3: (91 – Incidents) / 92) * 100. Q4: (91 – Incidents) / 91) * 100.
Purpose/importance	A lowering of the total number of days during which interruptions occurred, will result in a higher % uptime which may indicate that the application systems were developed using sound software development methodologies and that the software development environment produces stable applications which are able to support business processes and operations.
Source/collection of data	Advent Net Helpdesk System Software with built-in change management processes. Data is collected by Manager: Software Development.
Method of calculation/Assessment	1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days the formula is (number of hours of the incident/24) Incidents: The number of incidents calculated in days. Formula: (Days minus Incidents)/days) multiplied by 100. Annual: (365 – Incidents)/365) * 100. Q1: (91 – Incidents) / 91) * 100. Q2: (92 – Incidents) / 92) * 100. Q3: (92 – Incidents) / 92) * 100. Q4: (91 – Incidents) / 91) * 100.
Means of verification	Number of incidents/downtimes experienced on critical Applications (server report)
Assumptions	The assumptions has taken into account all the identified operational risks
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Impact
Calculation type	Non-Cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher. A 100% uptime should be strived for.
Indicator responsibility	Chief Information Officer

Output 8: Effectively provide information management services and organise and manage organisational knowledge with a view to enhance knowledge sharing.

Indicator title	**Percentage of requests for information received and finalised within 30 days.**
Short definition	This indicator measures the percentage of requests for information received by the knowledge management officer for a specific period and dealt with successfully or resolved within a period of 30 days after receipt. These requests include requests received for PAIA material, books, articles, legislative research, case law research, interlibrary loan requests and off-site storage requests. **This indicator does not measure self-help actions performed by stakeholders through the various e-portals on our website and elsewhere**. The aim is to lower the number of physical requests and to steadily increase the resolution rate of such requests within 30 days.
Purpose/importance	A decrease in requests for information is indicative of a well utilised and fully resourced electronic-based knowledge management function (through the various e-portals) as well as repository and a need for the information contained therein. Increased access to explicit information stored on CMS systems will lead to better

	informed decision making. A steady increase in the resolution rate within 30 days from 80% in 2017/18 to 95% in 2019/20 will be indicative of an improved customer experience and response time.
Source/collection of data	A register of physical access requests is maintained by the knowledge management officer on M-Files. Data is collected by Knowledge Manager.
Method of calculation/Assessment	Requests will include both physical and online submissions made by stakeholders. Requests for information received by the knowledge management officer for a specific period and dealt with successfully or resolved within a period of 30 days after receipt, these include both physical and online submissions This excludes self-help actions performed on the electronic portals. Formula: (physical and online submissions requests resolved <30 days/physical and online submissions requests received within the reporting period) multiplied by 100. Annual and quarterly: (physical requests resolved <30 days/physical requests received within the reporting period) * 100.
Method of verification	Number of information requests finalised within 30 days of receiving request (source request)
Assumptions	The assumptions have taken into account all the identified operational risks
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not Applicable
Data limitations	The Unit will not carry over requests not resolved at the end of the quarter to the next quarter; these will be counted as received in the quarter under consideration. These only apply to those requests that are still within the 30 day period of being resolved.
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	Lower the count for physical access requests to information whilst steadily increasing the resolution rate within 30 days of receipt.
Indicator responsibility	Chief Information Officer

12.4 Sub-programme 1.4 (Human Resources)

Output 9: Build competencies and retain skilled employees.

Indicator title	**Minimise staff turnover rate to less than 15%.**
Short definition	The percentage rate at which an employer attracts and loses employees.
Purpose/importance	Ensure that a CMS has the right talent with the right skills at the right time. Retain scarce, critical, professional and technical skills and maintaining a staff turnover rate of less than 15% by 2022.
Source/collection of data	Excel spreadsheet. List of key staff members as per succession planning framework.
Method of calculation/Assessment	Divide the number of terminations by employees by the total number of employees at the end of the reporting period, expressed as a percentage (e.g. 2/20 x 100= 15%).
Means of verification	List of resignations (1 April to 31 March)
Assumptions	The assumption is that HR will retain the 15% staff turnover rate based on previous years' experience.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	Retaining competent employees with the right skills at the right time.
Indicator responsibility	General Manager: Human Resources
Indicator title	**Turnaround time to fill a vacancy (turnaround time of 120 working days for each vacancy that exists during the year), excluding position of CEO.**
Short definition	Time spent in filling a vacancy.
Purpose/importance	Ensuring that no gap exists for longer periods of time after resignation thereby ensuring that units are able to achieve their objectives.
Source/collection of data	Council resolution for new positions. APPs and budget. Resignation and appointment letter.
Method of calculation/Assessment	Existing positions: count the number of calendar days from the resignation of the vacancy to the date the appointment is made (letter of appointment) (a vacancy should not take more than 120 working days to fill) New positions: number of days from date of approval of new position or approval of budget should not be more than 120 working days. Vacancies that arise in the previous financial year will be carried over into the new financial year; this will be the actual number of days taken to fill the vacancy, irrespective of the financial year, from the date it arises to the date it is filled. The position of Registrar/CEO is outside the control of CMS as the appointment of this position is carried out by the Executive Authority
Means of verification	Date of Advertisement and Date of Appointment Letter
Assumptions	The assumption is that HR will retain the 120 working days turnaround target to fill the vacancy based on previous trends except in exceptional circumstances of the Executive Management decision.
Disaggregation of Beneficiaries	Target as per the CMS EE Plan for the year.
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Maintain continuity in employment.
Indicator responsibility	General Manager: Human Resources

Indicator title	**Achievement of employment equity targets (according to the BBBEEA targets) .**
Short definition	To ensure that CMS achieves its targets according to Section 9(5): Codes of Good Practice.
Purpose/importance	To achieve equity in the workplace by promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination and implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups, in order to ensure equitable representation in all occupational categories and levels in the workforce.
Source/collection of data	CMS approved Employment Equity Plan.
Method of calculation/Assessment	Vacancies are filled in accordance with under representation within an occupational level. Where under-representation has been identified in the analysis, the numerical goals to achieve the equitable representation of suitably qualified people from designated groups across each level will be set. Numerical goals and targets will be set on each level in relation to the economically active population (EAP) statistics of the Gauteng province. As per the employment equity plan for CMS.
Means of verification	Verification Certificate by a SANAS accredited service provider
Assumptions	**The assumption is that HR will continue to achieve the EE targets as per the CMS EE Plan.**
Disaggregation of Beneficiaries	Target as per the CMS EE Plan for the year.
Spatial Transformation	**Not Applicable**
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Annually
New indicator	Revised
Desired performance	Higher
Indicator Responsibility	General Manager: Human Resources

Output 10: Maximise performance to improve organisational efficiency and maintain high performance culture.

Indicator title	**Percentage of employees' performance agreements are signed by no later than 31 May of each year.**
Short definition	Employee performance agreements signed by each employee to ensure achievement of CMS's objectives for the year.
Purpose/importance	Alignment of individual performance agreements to the organisation's Outcome Indicators in improving organisational efficiency
Source/collection of data	Performance agreement and performance appraisal document agreed and signed between staff and line managers.
Method of calculation/Assessment	Count the number of performance contracts signed by 31 May of each year and divide by the total number of employees.
Means of verification	Signed performance agreements
Assumptions	**The assumption is that HR will achieve the 95% target of signed performance agreements by all employees in office during the period of the signing of the performance contracts.** **There are technical limitations such as grievances and absenteeism, that make it not possible for this indicator to be set at 100%.**
Disaggregation of Beneficiaries	All employees in the office during the quarter under review.
Spatial Transformation	**Not Applicable**
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	100%
Indicator responsibility	General Manager: Human Resources
Indicator title	**Percentage of employees' performance assessments concluded, bi-annually.**

Short definition	Employees are assessed for their key performance indicators bi-annually. Interviews are conducted between the supervisors and subordinates to agree on the performance scores these are signed by both and filed with the HR Unit.
Purpose/importance	Alignment of individual performance agreements to organisation's Outcome Indicators in improving organisational efficiency.
Source/collection of data	Performance agreements and performance review documents agreed between employee and line managers. The bi-annual assessments are conducted and finalised by October and April of each year. The target for quarter 1 will be the assessments concluded for the previous financial year (2020/21). The target for quarter 3 will be the assessments concluded for the first half of the current year (2021/22).
Method of calculation/Assessment	Number of employees legible to participate in the appraisal cycle / Number of all performance contract signed by employees x100. Only employees in the employment of CMS for at least a period on 9 months are eligible to participate in the performance assessment and rewards. Employees employed for less than 9 months (by the second assessment period) are considered too new to be assessed. Employees that resign during the first performance assessment cycle will not be included. Those employees who resign during the second assessment cycle and have been here for the full period of 12 months will be considered and performance bonus pro-rated accordingly.
Means of verification	Signed performance assessment reports
Assumptions	**The assumption is that HR will achieve the 95% target of signed performance agreements by all employees in office during the period of the signing of the performance contracts.** **There are technical limitations such as grievances and absenteeism, that make it not possible for this indicator to be set at 100%.**
Disaggregation of Beneficiaries	All employees in the office during the quarter under review.
Spatial Transformation	Not Applicable
Data limitations	**None**
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Bi-Annually
New indicator	No
Desired performance	100%
Indicator responsibility	General Manager: Human Resources
Indicator title	**Develop talent management policy framework**
Short definition	To develop talent management policy frameworks and implementation capacity
Purpose/importance	To enhance the talent management value chain through structured talent management a framework to attract and retain talented and skilled workforce
Source/collection of data	CMS approved talent management policy framework
Method of calculation /Assessment method	Number of approved talent management policies/frameworks which includes but not limited to: Learning and development strategy, Talent Management policy, Talent Sourcing, Performance Management Policy, Remuneration Philosophy, Employee Benefits, Reward and Recognition Policy.
Means of verification	Number of approved policies and number of developed and engaged for higher positions
Assumptions	The assumption is that HR will have available budget to effectively develop and implement the talent management value chain
Disaggregation of Beneficiaries	To be integrated in the identified policies
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Collaborative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annually
New indicator	New
Desired performance	Higher
Indicator Responsibility	OD Manager
Indicator title	**Number of Training and Development Sessions to Improve Employee Relations**
Short definition	Training on conflict resolution and collective bargaining frameworks as well as ensuring capacity building and compliance with relevant labour legislation and code of good practices
Purpose/importance	Climate of trust, cooperation and stability is created

Source/collection of data	Training and awareness on employer/employee relations
Method of calculation /Assessment	Number of employee relations management interventions
Means of verification	Quarterly Reports/HR News Letters/Internal Communiques and or Survey
Assumptions	The assumption is that HR facilitate workshops, awareness sessions annually, facilitate counselling, mediation and interventions to address relationship issues and provide support to units on disciplinary matters. Organisational Rights Agreement, wage negotiations and policies and labour legislation will be observed
Disaggregation of Beneficiaries	All employees in the office during the quarter under review.
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	Yes
Desired performance	4
Indicator responsibility	Labour Relations Officer

12.5 Sub programme 1.5 (Legal Services)

Output 11: Legal advisory service for effective regulation of the industry and operations of the office.

Indicator title	**Percentage of written and verbal legal opinions provided to internal and external stakeholders, attended to within 14 days.**
Short definition	Render prompt internal reliable written and verbal legal opinions and representations to Council and other business units as opposed to soliciting external legal opinions. The Unit provides legal opinions to internal stakeholders (that is the Council and business units of the CMS) and to external stakeholders (anyone who writes to the office and enquires about the medical schemes industry and the laws that govern same in this instance we express an opinion on the law relating to the MSA).
Purpose/importance	The actions of Council and the Registrar are protected and take place within the context of sound legal advice.
Source/collection of data	A register of all written and verbal legal opinions is kept electronically on M-Files. Dedicated email address used for requests for legal opinions. All source documents are stored on M-Files. Legal opinions provided are also stored on M-Files.
Method of calculation/Assessment	Count the number of legal opinions processed versus the legal opinion requests on the register and attended to within 14 days*100. The register is maintained electronically.
Means of verification	Legal opinions inbox on M-Files
Assumptions	Functional legal system
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Matters of a legal nature are unpredictable and therefore can only be estimated. Verbal opinions are noted after the fact. Verbal opinions are recorded after the fact.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher
Indicator responsibility	General Manager: Legal Service Unit

Output 12: Defending decisions of the Council and the Registrar

Indicator title	**Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days.**
Short definition	Take responsibility for litigation against the Registrar and the Council to enforce the Medical Schemes Act (1998).
Purpose/importance	Decisions of Council and Registrar are protected and enforced in accordance with the Act. The Unit or appointed external attorneys and counsel appear for court and tribunal hearings.
Source/collection of data	A database of all matters received and handled is maintained electronically on M-Files. Email evidence of the actual brief will be kept for all matters. Notice of intention to defend will be issued or other relevant pleadings as may be relevant. Only matters where CMS is required to respond will be counted.
Method of calculation/Assessment	Percentage calculated by dividing the: Number of actions initiated for court and tribunal appearances within 14 days/total of number legal matters received *100. Annual calculation – aggregation over the period
Means of verification	On-going legal cases report
Assumptions	• Functional legal system • Existence of a Litigious environment
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Matters of a legal nature are unpredictable and therefore can only be estimated, therefore matters handled are being counted and not matters resolved as some matters may await an outcome for a long period of time or may be inconclusive. It is also very difficult to determine how many matters will be received in any given period of time as this will depend on enforcement action and initiatives by other units in the office, such as the Compliance Unit.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100% of all matters received should be in a state of being handled for any given period.
Indicator responsibility	General Manager: Legal Service Unit

Output 13: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority

Indicator Title	**Develop an Annual Council Work Plan for Council and its Committees by 31 March.**
Short definition	This indicator measures the development of an annual year plan for Council consideration
Purpose/importance	To ensure that Council meetings are planned for and scheduled in advance in order to allow Council as the Accounting Authority to exercise its Oversight Role
Source/collection of data	Annual Year-Plan and Council Minutes
Method of calculation/Assessment	Annual Year-Plan
Means of verification	Annual Year-Plan and Council Minutes
Assumptions	Council will have meetings in Q4 of each year to consider Year-Plan for the following Financial Year
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	Council Secretariat
Indicator Title	**Develop and Review Council and Committees Governance Charters.**
Short definition	This indicator measures the development and or review of the Council Charter(s) including the sub-committees
Purpose/importance	To ensure that governance principles are consistent with best practice
Source/collection of data	Charter's and Council/Sub-Committee Minutes
Method of calculation/Assessment	Number of Charter's and Council/Sub-Committee Minutes
Means of verification	Charter's and Council/Sub-Committee Minutes
Assumptions	Council will have meetings in Q4 of each year to consider Year-Plan for the following Financial Year
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	5
Indicator responsibility	Council Secretariat
Indicator Title	**Support execution of Statutory Council & Sub-committee decisions, resolutions and matters arising**
Short definition	This indicator measures the support given to the execution of the decisions and resolutions, and matters arising from Council and Sub-Committee meetings
Purpose/importance	To ensure that Council meetings records are maintained and achieved in line with current and best practice
Source/collection of data	Council & Sub-Committee standing agenda and minutes derived from Council & Sub-Committee charters; Minutes; Resolution register; Communiques of Council Resolutions to relevant executive managers; Matters arising action lists; Feedback reports at each Council meeting for past and outstanding resolutions and matters arising;
Method of calculation/Assessment	Annual Year-Plan
Means of verification	Annual Year-Plan and Council Minutes; Resolution register; Communiques of Council Resolutions to relevant executive managers; Matters arising action lists; Feedback reports at each Council meeting for past and outstanding resolutions and matters arising
Assumptions	Council and its committees will hold its meetings as planned

Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	Council Secretariat
Indicator Title	**Notify the Executive Authority six month before the term of office of Council members is due to expire. Report resignations and vacancies to the Executive Authority within 2 working days**
Short definition	This indicator measures the response time to inform the executive authority on term of office of the Council members
Purpose/importance	To ensure that the Executive Authority is timeously informed on the term of office of Council members
Source/collection of data	Notice of resignation and notice(s) send to the Executive Authority
Method of calculation/Assessment	Resignations(s), notices to the EA, and appointment letters
Means of verification	Resignations(s), notices to the EA, and appointment letters
Assumptions	All notices will be done in writing
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	Council Secretariat

Output 14: Schedule and Register Appeals Committee and Appeals Board hearings as and when received

Indicator Title	**Percentage of Appeal Committee and Appeals Board Scheduled within 14 days upon receipt of all supporting documents (as per schedule)**
Short definition	Percentage of Appeal Committee and Appeals Board Scheduled within 14 days upon receipt of all supporting documents (as per schedule)
Purpose/importance	This indicator measures the scheduling of appeals once the appeal is ripe for adjudication by the Appeals Committee of the Appeals Board
Source/collection of data	Appeals Register - consisting of complete appeal filings; set down notices; hearing roll and hearing recording/transcripts (set out a schedule of all documents for an appeal to be ripe for enrolment – include it into the complaints SoPs for handover to appeals committee)
Method of calculation/Assessment	The number of appeals ripe for hearing should equal the number of appeals scheduled for a hearing *100 within 14 days of the complete appeal filing (as per the list of what constitutes a “complete appeal filing”)
Means of verification	Appeals Register
Assumptions	The right to be heard on appeal is legislated; if a party aggrieved by the Registrar’s ruling or a decision by the Registrar with concurrence of Council , wishes to appeal that decision the appeal should be adjudicated expeditiously, as justice delayed is justice denied.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly

New indicator	Yes
Desired performance	100%
Indicator responsibility	Council Secretariat
Indicator Title	**Percentage of Appeals Committee and Appeals Board Rulings published on the CMS website within14 days of issuing the ruling**
Short definition	This indicator measures the number of rulings published by the Secretariat once finalised by both the Appeals Committee and the Appeals Board
Purpose/importance	To ensure that the public understands the reasons for the rulings issued on appeals, and provide clarity on the interpretation of the Medical Schemes Act and the rules of medical schemes.
Source/collection of data	Appeals Ruling as received from the presiding officer
Method of calculation/Assessment	Number of Rulings Published/Number of Rulings Issued*100
Means of verification	Published ruling on the CMS website per quarter
Assumptions	The right to be heard on appeal is legislated therefore there will always be appeals which should be adjudicated
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	Council Secretariat

12.6 Programme 2 (Strategy office)

Output 15: Formulate PMBs definitions to ensure uniform interpretation of the benefits and entitlements.

Indicator title	**The number of benefit definitions published.**
Short definition	The number of PBMs definitions published.
Purpose/importance	Benefit definitions are published to clarify member entitlements prospectively thereby reducing the number of complaints received by the Complaints and Adjudication Unit.
Source/collection of data	Benefit definitions are published on the CMS website.
Method of calculation/Assessment	Count number of PMB benefit definitions publications on CMS website.
Means of Verifications	Published Circular or the CMS Scripts
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Benefit Definitions affecting vulnerable groups such as Women, Children, Disabled and the Elderly will be prioritised for definition High financial impact conditions such as oncology are prioritised
Spatial Transformation	Not Applicable
Data limitations	Not applicable
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Publication of specific numbers of benefit definitions.
Indicator responsibility	Senior Strategist
Indicator title	**Develop preventative and primary health care package to incorporate into the PMBs.**
Short definition	As per Regulations PMBs must be reviewed every two years. During 2019/2020 a service based PMB package will be submitted to the Executive Authority. The PMB review will be carried out in 3 phases: Phase 1 is the development of the Preventative Healthcare package.

	Phase 2 "Develop a primary healthcare package". Phase 3 Implementation, monitoring and evaluation of the future PMBs.
Purpose/importance	To ensure that members and beneficiaries of medical schemes are protected.
Source/collection of data	A preventative and primary healthcare package will be available on M-Files.
Method of calculation/Assessment	A preventative and primary healthcare package will be developed and will be stored on M-Files.
Means of verification	New PMB Package inclusive of Primary Healthcare Package
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Dedicated database for all documents on the PMB review exists on M-Files.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Annually
New indicator	No
Desired performance	Publication of a revised PMB package.
Indicator responsibility	Senior Strategist

Output 16: Provide clinical opinions to resolve complaints and enquiries.

Indicator title	**Percentage of category 1* clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication Unit.**
Short definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit with the view to ensure that members' complaints are resolved.
Purpose/importance	To protect the members of the medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.
Source/collection of data	M-Files Complaints Database and Clinical Opinions Database.
Method of calculation/Assessment	The clinical opinions are to be weighted based on their complexity and allocated a category. Category 1 clinical opinion will be an uncomplicated clinical opinion that will be expected to be analysed and 90% of these are expected to be completed within 30 working days of referral/receipt from the Complaints Adjudication Unit. Count of clinical opinions - electronically via the C Database. The calculations of the indicators will be according to the formula below: Completion 90% of clinical opinions referred within 30 working days calculated by: Number of completed opinions in ≤ 30 working days /Total number of clinical opinions referred in ≤ 30 working days X 100.
Means of verification	Clinical Opinions Spread Sheet
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	Dedicated database for all clinical opinions exists on M-Files.
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To attend to 90% of all clinical opinions within the timeframes of the Standard Operating Procedure (SOP).
Indicator responsibility	Senior Strategist
Indicator title	**Percentage of category 2* clinical opinions provided within 60 working days of receipt from Complaints Adjudication Unit, .**

Short definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit with the view to ensure that members' complaints are resolved.
Purpose/importance	To protect the members of medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.
Source/collection of data	M-Files Complaints Database.
Method of calculation/Assessment	The clinical opinions are to be weighted based on their complexity and allocated a category. This categorisation will be carried out by the most experienced Clinical Analysts in the Unit. A category 2 clinical opinion will be a more complex clinical opinion compared to a category 1 requiring more in-depth analysis and time less than 60 working days for full completion. Count of clinical opinions, electronically via the Clinical opinions Database. The calculations of the proposed indicators will be according to the formula below: Completion of 95% of clinical opinions referred within 60 working days calculated by: Number of completed clinical opinions between 30-60 working days /total number of clinical opinions referred in ≤ 60 working days *100.
Means of verification	Clinical Opinions Spread Sheet
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Dedicated database for all clinical opinions exists on M-Files.
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To attend to 95% of all clinical opinions within the timeframes of the SOP.
Indicator responsibility	Senior Strategist
Indicator title	**Percentage of category 3* clinical opinions provided within 90 working days of receipt from Complaints Adjudication Unit.**
Short definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit with the view to ensure that members' complaints are resolved.
Purpose/importance	To protect the members of medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.
Source/collection of data	M-Files Clinical opinions Database
Method of calculation/Assessment	Category 3 will be allocated to a clinical opinion of a very complex nature requiring extensive inputs, additional documentation and research. These will require experts/specialist consultation before a conclusion can be reached. 100% of clinical opinions of this nature will be aimed for completion within 90 days of receipt from the Complaints Adjudication Unit. Count of clinical opinions, electronically via the Complaints Database. The calculations of the proposed indicators will be according to the formula below: Completion of 98% of clinical opinions referred to within 90 working days calculated by: Number of completed clinical opinions between 60-90 working days /Total number of clinical opinions referred in ≤ 90 working days* 100.
Means of verification	Clinical Opinions Spread Sheet
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Dedicated database for all clinical opinions exists on M-files

Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To attend to 98% of all clinical opinions within the timeframes of the SOP.
Indicator responsibility	Senior Strategist
Indicator title	**Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days.**
Short definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit and via e-mail and telephonic enquiries with the view to ensure that member's complaints and enquiries are resolved.
Purpose/importance	To protect the members of the medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.
Source/collection of data	M-Files Complaints Database and Clinical enquiries e-mail database.
Method of calculation/Assessment	Sum of clinical enquiries, electronically via email and telephonic. Enquiries are captured by each clinical analyst on a spreadsheet. (Total number of clinical opinions responded to within 7 days / total number of clinical opinions received for the period).
Means of verification	Clinical Opinions Spread Sheet
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Accuracy of captured number of emailed and telephonic enquiries by clinical analyst following a manual count.
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To attend to 98% of all clinical enquiries within the timeframes of the SOP.
Indicator responsibility	Senior Strategist

Output 17: Conduct research to inform appropriate national health policy interventions

Indicator title	**Number of research projects and support projects published in support of the national health policy, .**
Short definition	Undertake strategic research to inform national health policy interventions like the National Health Insurance and Health Market Inquiry.
Purpose/importance	Section 7 (b) of the Medical Schemes Act (1998) states that CMS needs to control and coordinate the business of the medical schemes in a manner that is complementary to the national health policy. Whist Section 7 (e) and (g) states that CMS must advise the minister on any matter concerning medical schemes including collecting and disseminating information about private health care.
Source/collection of data	CMS website, under publications and M-files.
Method of calculation/Assessment	Sum of research projects completed. Research projects are undertaken for internal and external consumption. For internal projects, the project is counted when sent to the unit it was intended for, this is sent via email. Email evidence will be kept. For external research projects carried out these will be published within one of the following mechanisms: submission to the Department of Health, CMS website, conference paper submissions, submissions to a local or international journal for publication, publication through a circular and/or as part of a circular and CMS News publication.
Means of verification	Clinical Opinions Spread Sheet
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable

Data limitations	Industry response rate.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Publication of all research reports.
Indicator Responsibility	Senior Strategist

12.7 Programme 3 (Accreditation)

Output 18: Accredit regulated entities based on their compliance with the requirements for accreditation in order to provide accredited services and monitor legal compliance throughout the period of accreditation.

Indicator title	**Percentage of broker and broker organisation applications finalised within 30 working days per quarter on receipt of complete information**
Short definition	Indicates the percentage of broker and broker organisation applications (meeting the accreditation requirements) accredited with 30 working days of receipt of complete information. Complete information means: • Completed accreditation application form. • Copies of broker or brokerage agreements with medical schemes in place. • Copies of sub-contracting agreements (where applicable). • Copy of most recent audited Annual Financial Statements in respect of broker organisations. • Tax clearance certificate. • Documentary proof of relevant experience. • Copy of Identity Document (ID). • Letter of supervision. • Copy of academic qualification. • Proof of license by FSCA. • Proof of payment of the prescribed fee. • Any additional information required and requested. Applications must meet the following four key requirements for accreditation: • Fit and proper requirement. • The qualification requirement including qualification verifications. • The appropriate experience. • Financially sound legal entities. • License verification with FSCA Once processed, applicants are either accredited for a period of two years whilst unsuccessful applicants are notified of the findings and are provided with reasons of not being accredited. Incomplete applications remain pending for a period of six months. Thereafter, such applications expire and application fees are forfeited.
Purpose/importance	Brokers and brokerages must be accredited in order to provide broker services to members and potential members of the medical schemes as defined in the Medical Schemes Act (1998). Unsuccessful applicants are notified and reasons provided for not being accredited.
Source/collection of data	Applications for accreditation of brokers and brokerages are captured on the on-line accreditation system. All supporting documentation is filed on the CMS document management systems which is M-Files. The accreditation certificates are available on the accreditation system for audit purposes. A list of all accredited and non-accredited brokers and brokerages is drawn from the system.
Method of calculation/Assessment	Number of applications processed within 30 days in a quarter , (Excluding applications still within 30 days), divided by complete applications received within 30 days Ensure applications rolled over due to incompleteness are finalised within 30 days of receipt of complete information.
Means of verification	Report drawn from the broker accreditation system.
Assumptions	• Brokers applying for accreditation are still actively in business • Numbers may vary according to likely acquisitions and retirements
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	The system figures could change depending on whether brokers and broker organisations are refused accreditation or applications are withdrawn or disqualified due to incorrect and incomplete information received during a period; and also due to incorrect filing of applications on M-files.
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To process 80% of all broker and broker organisation applications that meet the accreditation requirements within 30 working days of receipt of complete information.
Indicator responsibility	General Manager: Accreditation

Indicator title	**Percentage of managed care organisation applications analysis completed, and outcome communicated to applicants, within three months of receipt of complete information**
Short definition	Percentage of managed care organisation (MCO) accreditation applications and self-administered schemes compliance certificate applications analysis completed within three months of receipt of complete information. New and renewal applications are included. Relevant information includes: • Completed accreditation / compliance certificate application form. • Declaration of conflict of interest • Group structure.(MCOs) • Organogram • Copies of managed care agreements with medical schemes in place. (MCOs) • Copies of sub-contracting agreements (where applicable). • Latest audited annual financial statements and most recent management accounts. (MCOs) • Positive confirmation of tax compliance status. (MCOs) • Copies of managed care protocols and formularies. • Proof of payment of the prescribed application fee. (MCOs) Additional information may be requested during the analysis of the applications. Applicants must meet the three key requirements for accreditation: • The applicant must be fit and proper. • The applicant must have the necessary systems, resources, skills and capacity to provide the managed care services. • The applicant must be financially sound. Once the evaluations have been completed, applicants are either accredited for a period of two years, or unsuccessful applicants are informed of the reasons for non-accreditation. Self-administered schemes are issued with compliance certificates (valid for three years) if all the requirements are met in respect of the managed care services provided to members.
Purpose/importance	Managed care organisations must be accredited in order to provide managed care services to medical schemes as defined in the Medical Schemes Act (1998).
Source/collection of data	Acknowledgement letter of receipt of an application, Steering Committee minutes are available on M-Files. Paper trail of all documents received, interacted with and concluded on M-Files.
Method of calculation/Assessment	Number of complete applications evaluated within 30 days (in a quarter) of receipt and outcomes communicated divided by the total number of complete applications received expressed as a percentage during the quarter. Number of Complete Applications evaluated and outcome communicated / Number of Complete Applications Received x 100
Means of verification	Acknowledgement of receipt letters sent to applicants and Steering Committee minutes.
Assumptions	• Entities applying for accreditation are actively in business
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To analyse 100% of all applications received that meet the accreditation requirements within 3 months of receipt of all relevant information.
Indicator responsibility	General Manager: Accreditation
Indicator title	**Percentage of administrators and self-administered schemes' applications analysis completed and outcome communicated to applicants within three months of receipt of complete information**
Short definition	Indicates the percentage of Administrator accreditation and self-administered scheme compliance certificate applications evaluated within 3 months of receipt of all relevant information. New and renewal applications are included. Relevant information includes: • Completed accreditation / compliance certificate application form. • Declaration of conflict of interest • Group structure. (Administrators) • Organogram • Copies of administration agreements with medical schemes in place. (Administrators) • Copies of sub-contracting agreements (where applicable);

	• Latest audited Annual Financial Statements and most recent management accounts. (Administrators) • Positive confirmation of tax compliance status. (Administrators). • Proof of payment of the prescribed application fee (Administrators). Additional information may be requested during the analysis of the applications. Applications must meet the three key requirements for accreditation: • The applicant must be fit and proper. • The applicant must have the necessary systems, resources, skills and capacity to provide the services. • The applicant must be financially sound. Once the evaluations have been completed, applicants are either accredited for a period of two years, or unsuccessful applicants are informed of the reasons for non-accreditation. Self-administered schemes are issued with compliance certificates (valid for three years) if all the requirements are met in respect of the administration services provided to members.
Purpose/importance	Administrators must be accredited in terms of the Medical Schemes Act (1998) in order to provided third party administration services to medical schemes. Self-administered schemes must maintain the same standard of administration.
Source/collection of data	Acknowledgement letter of receipt of application and Steering Committee minutes are available on M-Files. Paper trail of all documents received, interacted with and concluded on M-Files.
Method of calculation/Assessment	Number of complete applications evaluated within 3 months of receipt and outcome communicated divided by the total number of complete applications received expressed as a percentage during the quarter. Number of Complete Applications evaluated and outcome communicated / Number of Complete Applications Received x 100
Means of verification	Acknowledgement of receipt letters sent to applicants and Steering Committee minutes.
Assumptions	• Entities applying for accreditation are actively in business
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To analyse 100% of all applications received that meet the requirements for accreditation within 3 months of receipt of all relevant information.
Indicator responsibility	General Manager: Accreditation

12.8 Programme 4 (Research and Monitoring)

Output 19: Conduct research to inform appropriate policy interventions.

Indicator title	**Number of research projects finalised**
Short definition	The total number of research projects completed in a financial year.
Purpose/importance	To ensure continuous improvement of policy and regulatory interventions by the CMS in influencing the performance of the medical schemes industry.
Source/collection of data	Portfolio of evidence will be stored on the central repository as per Annual Operational Plan (AOP)
Method of calculation/Assessment	Sum of research projects completed as per AOP. The approval evidence will be contained in the Portfolio of evidence which will be stored on the central repository as per SOP.
Means of verification	Sum of research project completed as per AOP and filed on M-Files
Assumptions	Data sourced from administrators, schemes and other sources for conducting research projects is assumed to correct and validated. Minimal checks and data validation are also done internally for any glaring data issues. Findings are also triangulated to check validity and reliability.
Disaggregation of Beneficiaries	Data is stratified buy various dimensions subject to research objectives. These include but not limited to: • Demographics • Attributes of a dimension of analysis
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	All projects completed as per minimum quality standards prescribed by the SOP.
Indicator responsibility	General Manager: Research & Monitoring

Output 20: Monitoring trends to improve regulatory policy and practice.

Indicator title	**Non-financial report submitted for inclusion into the Annual Report.**
Short definition	The analysis of clinical, demographic, utilisation and benefits paid data received through the Statutory Return by medical schemes.
Purpose/importance	Monitor trends in the environment and to provide influential strategic advice and support for the development and implementation of strategic health policy.
Source/collection of data	Non-financial report included in the published Annual Report.
Method of calculation/Assessment	The Annual Report contains the non-financial report submitted by the Unit. The non-financial report section in the CMS Annual Report must be counted.
Means of verification	Annual Report inclusive of the non-financial report
Assumptions	Data received from schemes and administrators for populating the analysis of clinical, demographic, utilisation and benefits paid sections of the annual report is assumed to correct and validated at prior submission to the Office. Minimal checks and data validation are also done internally for any glaring data issues.
Disaggregation of Beneficiaries	Data is stratified buy various dimensions subject to research objectives. These include but not limited to: • Demographics • Utilisation statistics • Quality health outcomes • Benefits paid • Expenditure on PMBs • Provider distribution
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Annual
New indicator	No
Desired performance	Report on the analysis of non-financial data is completed in time to be published in the Annual Report.
Indicator responsibility	General Manager: Research & Monitoring

12.9 Programme 5 (Stakeholder Relations)

Output 21: To create awareness and collaboration through engagement with respective stakeholders, whilst enhancing the visibility and protecting the reputation of the CMS.

Indicator title	**Number of stakeholder awareness activities conducted, .**
Short definition	To raise the level of awareness among members and other stakeholders regarding the CMS services, legislation and policy developments through the following activities: Media engagement: • Advertising (newspapers). • Advertorials (content that is written up by CMS and paid for). • Content production (TV and radio). Stakeholder engagement: • Exhibitions. • CMS hosted summit and conference. • Principal Officer Forums. • Publications (CMS News and CMScripts).
Purpose/importance	The indicator measures the number of stakeholder awareness activities conducted in the reporting period.
Source/collection of data	Media engagement: Newspaper adverts will be kept. Advertorials (the content of advertorial will be kept). Content production (media monitoring reports will be used to show media coverage on the CMS). Stakeholder engagement: Exhibitions (letter from the host for exhibitions). CMS-hosted summit and conference (attendance register or list of delegate report), Principal Officer forums (attendance registers and agendas). Publications (CMS News and CMScripts copies of the publication will be kept).
Method of calculation/Assessment	Sum of stakeholder activities undertaken for the period.
Means of verification	Monthly reports provided by the unit and filed on M-Files
Assumptions	That budget for the listed activities is available.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher
Indicator responsibility	General Manager: Stakeholder Relations
Indicator title	**Percentage of stakeholder awareness of CMS resulting from survey, .**
Short definition	A survey to measure the level of awareness, positive perception or attitude among stakeholders (members and beneficiaries of medical schemes, and entities regulated by the CMS), conducted on an annual basis. This information will be used to identify areas where the CMS need to improve on communication or education & training activities for stakeholders.
Purpose/importance	The purpose of the survey is to determine how many medical scheme members are aware of the CMS and its role. The results of the survey will determine what improvements can be implemented for further awareness.
Source/collection of data	Data for the survey will be collected via a questionnaire designed to source information from respondents regarding their level of awareness about the services offered by the CMS, perception about the services offered by the CMS, or attitude and/or practice regarding services offered by the CMS. The questionnaire will be accessed via a dedicated platform for the study. A link for the questionnaire will be distributed through medical schemes and other regulated entities. Survey results will be available on M-Files as a portfolio of evidence.
Method of calculation/Assessment	Calculation of the results will be based on the level of awareness, positive perception, or positive attitude, against the total survey responses received The calculation will be based on the methodology that will be agreed with the service provider.

Means of verification	
Assumptions	That the sample of respondents is a cross-section of the total member population.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Survey may not cover an entire or larger percentage of the population. Members may choose not to partake in the survey.
Type of indicator	Impact
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	To have all members aware of CMS's role.
Indicator responsibility	General Manager: Stakeholder Relations

Output 22: CMS must ensure that an annual report is submitted to the Executive Authority 5 months after the end of a financial year.

Indicator title	**Submission of CMS Annual Report by 31 August to the Executive Authority.**
Short definition	The CMS Annual Report is produced in line with statutory requirements to report on the performance of the CMS against targets set out in the Strategic Plan document and APP, as well as the resources allocated to the organisation. The report is presented to the Executive Authority, who tables it in Parliament; thereafter it is presented to the Portfolio Committee on Health. The Annual Report is subsequently presented to industry role players as well as the media, and published on the CMS website for access by members of the public.
Purpose/importance	The Annual Report serves as a key tool for the CMS to account for the performance of the organisation against set targets, including the organisation's financial position and human resources information, for the year under review, in line with statutory requirements for public entities. The report also provides valuable information to stakeholders on key industry developments and trends.
Source/collection of data	The information contained in the CMS Annual Report is sourced internally from the respective business units based performance against targets set out in the APP. The information in the industry section of the annual report is sourced by the respective business units from the medical schemes, analysed and repackaged for inclusion in the report.
Method of calculation/Assessment	The delivery note signed and dated by an official from the NDoH upon receipt of the Annual Report, serves as evidence showing that the annual report has been duly submitted to the Executive Authority by 31 August 2018.
Means of verification	Proof of submission to the Executive Authority
Assumptions	That all contributing documents, such as the Auditor-General's Report will be complete and approved by 31 August 2019.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Unavailability of the required information and/or sources of information and/or human resources; non-compliance/non-adherence to production schedule and deadlines.
Type of indicator	Output
Calculation type	Non-cumulative
Reporting cycle	Annual
New indicator	Revised
Desired performance	Submission of the Annual Report to the Executive Authority by 31 August annually.
Indicator responsibility	General Manager: Stakeholder Relations

Output 23: To enhance knowledge and skills among stakeholders, in order to create an in-depth understanding of governance and compliance with the Medical Schemes Act through education and training interventions.

Indicator title	**Number of stakeholder education and training sessions, .**
Short definition	To effectively educate and train stakeholders to understand their relevant roles and responsibilities in the medical scheme environment.
Purpose/importance	The indicator measures how effectively education and training interventions were conducted to stakeholders in empowering them to keep abreast of legislative requirements needed to understand their roles and responsibilities.
Source/collection of data	For consumer education sessions, trustee training sessions and broker training sessions, registers are kept. Sessions held over a two-day period will be counted as one session. Consumer education sessions – attendance registers or acknowledgement communique are kept. Where attendance registers are not feasible a communique from the stakeholder confirming attendance will be kept.
Method of calculation/Assessment	A simple count of the number of sessions held through source documents filed
Means of verification	Attendance Registers including virtual meeting registers
Assumptions	That budget for the listed activities is available.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher
Indicator responsibility	General Manager: Stakeholder Relations

Output 24: To provide Customer care interventions by rendering effective and efficient services

Indicator title	**Percentage of customer care interventions resulting from calls and e-mailed queries handled by customer care centre**
Short definition	To effectively handle telephone enquiries and queries from beneficiaries of medical schemes,
Purpose/importance	To advise beneficiaries of medical schemes of their rights and obligations as per Medical Schemes Act 131 of 1998
Source/collection of data	System generated call statistics and mimecast for emails
Method of calculation/Assessment	To calculate the percentage of calls handled vs total calls received
Means of verification	System generated reports
Assumptions	
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Output
Calculation type	Non-Cumulative
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Higher
Indicator responsibility	General Manager: Stakeholder Relations

12.10 Programme 6 (Compliance and Investigation)

Output 25: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act and related laws

Indicator title	**Number of routine inspections conducted.**
Short definition	Routine inspections are conducted for the purpose of monitoring whether a scheme is compliant with the Medical Schemes Act (1998) and related laws including scheme rules as well as governance guidelines.
Purpose/importance	The purpose of the indicator is to ensure that medical schemes, insured entities and other regulated entities are fully compliant with the Medical Schemes Act (1998) and other applicable legislation. The Unit will ensure that all inspections conducted, produce an inspection report and that remedial action is implemented and followed up, if applicable or where necessary.
Source/collection of data	Routine inspection in terms of Section 44(4)(b) source: • Memorandum signed by the registrar approving the inspection (the initial stage of inspection). • Count the appointment letters to the appointed investigator (the initial stage of the inspection). • Count the notice of inspection letters to the scheme (the initial stage of inspection). • A final Inspection report issued to the scheme (final stage of inspection).
Method of calculation/Assessment	Sum of routine inspections conducted The calculation takes into account all inspections conducted from 1 March to End of February of each year
Means of verification	Inspection reports received from service provider(s) as filed on M-Files
Assumptions	The assumptions are that all identified operational risks have been taken into account
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Limitations may arise where: A scheme has delayed the finalisation of an inspection by instituting legal proceedings to delay or block an inspection. A scheme does not respond to the preliminary inspection report thereby delaying the process of issuing a final inspection report.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher
Indicator responsibility	General Manager: Compliance and Investigation

Output 26: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act and related laws

Indicator title	**Percentage of commissioned inspection conducted, .**
Short definition	Commissioned inspections are conducted when there are alleged irregularities identified or non -compliance with the legislation by a medical scheme, insured entity or a regulated entity.
Purpose/importance	The purpose of the indicator is to ensure that medical schemes, insured entities and regulated entities are fully compliant with the Medical Schemes Act (1998) and its Regulations. The Unit will ensure that all allegations received or identified are investigated thoroughly to ensure that schemes are held accountable for any contraventions with the prescribed legislation.
Source/collection of data	The Unit cannot predict the number of commissioned inspections in terms of Section 44(4)(a) that will be required to be carried out in any given year. Commissioned inspections are based on information received or uncovered through various sources which could include tip-offs, referrals or irregularities suspected. The Unit uses the appointment letters of the investigators as evidence for this indicator. The appointment letters are signed by the Registrar. Commissioned inspections can exceed a reporting period and it is difficult to anticipate the duration of such an inspection. Count appointment letters to the appointed investigator (the initial stage of the inspection).
Method of calculation/Assessment	Sum of commissioned inspections conducted (count the final inspection report received from the service provider) /Number of tip-offs, referrals and or irregularities suspected /received*100 The calculation takes into account all inspections conducted from 1 March to End of February of each year

Means of verification	Inspection reports received from service provider(s) as filed on M-Files
Assumptions	The assumptions is that all identified operational risks have been taken into account
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Limitations may arise where: A scheme has delayed the commencement of an inspection by instituting legal proceedings to delay or block an inspection.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Lower - a commissioned inspection can only be ordered upon receipt of allegations. The number of inspections that may need to be ordered is therefore impossible to predict.
Indicator responsibility	General Manager: Compliance and Investigation

Output 27: Ensure enforcement action is undertaken against regulated entities

Indicator title	**Percentage of enforcement actions undertaken to ensure compliance with the Medical Schemes Act (1998),**
Short definition	When schemes or insured entities are found to be non-compliant the with the Medical Schemes Act (1998), the unit will either conduct an inspection, impose penalties, issue rulings, request insurance entities to apply for demarcation exemption or issue directives to schemes in order to enforce compliance.
Purpose/importance	The purpose of the indicator is to ensure that medical schemes, insured entities and regulated entities are fully compliant with the Medical Schemes Act (1998) and its Regulations. The Unit will ensure that all matters received result in processed interventions.
Source/collection of data	Below are measures for possible non-compliance cases that could be undertaken: • Section 43 enquiry: count the letters sent to the scheme requesting information in relation to any matter connected with the business or transactions of the medical scheme. • Penalties in terms of Section 66(3): count the letter sent to the scheme imposing the penalty). • Rulings in terms of Section 47: count the letter sent to the scheme enforcing the compliance with the ruling. • Directives: count the letter sent to the scheme enforcing compliance with a directive. • Demarcation exemptions: count the exemption letter issued to insured entities communicating the result of an application.
Method of calculation/Assessment	Sum of enforcement actions undertaken (count the number of letters sent to entities on non-compliance/enforcement cases).
Means of verification	
Assumptions	• Non-Compliance with the Act at Medical schemes will occur due to misinterpretation to the Act • The Act will always be framework in which the Regulator provides regulatory supervision to medical schemes.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Limitations may arise where: A matter is received in a quarter but attended to in a different quarter due to a delay in obtaining information on the matter from the scheme or internal parties.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher
Indicator responsibility	General Manager: Compliance and Investigation

Output 28: Strengthen and monitor governance systems of medical schemes and other regulated entities

Indicator title	**Percentage of governance interventions implemented, .**
Short definition	This indicator is intended to show how many forms of governance intervention were instituted against medical schemes and other regulated entities.
Purpose/importance	This indicator is important to improve governance in medical schemes and other regulated entities.

Source/collection of data	Below are measures for possible interventions that could be undertaken: • Vetting of scheme officers: count the number of reports issued after the vetting of an officer of the regulated entities. • Curatorship monitoring: count the number of meetings scheduled in order to monitor the performance of the curator. • Trustee removal proceedings in terms of Section 46: count the number of section 46 notice letters issued • Board Notice 73 of 2004: Count the number of Board notices issued to the scheme /industry. • Exemptions in terms of Section 8(h): Count the number of exemption letters sent to scheme communicating the result of an application.
Method of calculation/Assessment	Sum of governance interventions undertaken/Sum of governance transgressions identified*100
Means of verification	Directive, Circulars or Court Rulings
Assumptions	• Non-Compliance with the Act at Medical schemes will occur due to misinterpretation or non-adherence to the Act;
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Limitations may arise where: A matter is received in a quarter but attended to in a different quarter due to a delay in obtaining information on the matter from the scheme or internal parties.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher
Indicator responsibility	General Manager: Compliance and Investigation

Indicator title	**Number of scheme member meetings attended, .**
Short definition	Monitor and observe scheme member meetings and trustee elections to ensure compliance with the Medical Schemes Act (1998) and scheme rules so that member participation is enhanced. This indicator is intended to show the process which the unit undertakes to monitor the scheme meeting (AGM, SGM and trustee elections) from the submission of scheme notification to the CMS to the participation of the Unit at scheme meeting as observers of the proceedings.
Purpose/importance	This indicator is important to improve governance in medical schemes.
Source/collection of data	Below are measures for possible interventions that could be undertaken: Annual General Meetings, Special General Meetings and Elections of Trustee Meetings: • Count the scheme AGM/SGM or trustee election notification submission to the CMS. • Count the communication sent to scheme informing them of CMS' attendance of the AGM/SGM or Trustee Election. • Count the report issued by the unit after a scheme AGM, SGM or Trustee Election Meeting proceedings have been monitored. (AGM Report).
Method of calculation/Assessment	Sum of member meetings attended quarterly (count the number of reports produced from attendance of meetings).
Means of verification	AGM Reports
Assumptions	• The office will always monitor scheme meetings to ensure proceedings of the meeting are conducted according to scheme rules • Scheme will always hold a scheme meeting annually according to the MS Act.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Limitations may arise where: Schemes fail to notify the office of the date and venue of the Annual General Meeting or elections. Schemes fail to notify the office who their newly-elected officers are. Lack of co-operation by the Scheme in terms of timeous submission of meeting packs.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher
Indicator responsibility	General Manager: Compliance and Investigation

12.11 Programme 7 (Benefits Management)

Output 29: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998)

Indicator title	**Percentage of interim rule amendments processed within 14 working days of receipt of all information .**
Short definition	A rule amendment represents a change to the rules that govern the relationship between a medical scheme and its members. Interim rule amendments are received throughout the year and in order to ensure that rules are effective and up-to-date they need to be processed with 14 days of the receipt of all information.
Purpose/importance	The purpose is to ensure that rules submitted by the schemes are efficiently and effectively analysed and approved with the stipulated time frames. This ensures that all schemes operate according to the approved rules which are aimed at protecting members and beneficiaries. The indicator measures the effectiveness of the processing of rule amendments received within the targets identified to ensure that schemes receive feedback regarding the submitted amendments timeously. The indicator measures the effectiveness of the processing of rule amendments received within the targets identified.
Source/collection of data	Hardcopies of interim rule amendments submitted are captured on a register and Excel spreadsheet. The capturing of the date submitted, received by the analyst, date of request of further information and the date processed and sent to the GM is captured for each rule submission. The spreadsheet will use the information captured to calculate the performance of the Unit.
Method of calculation/Assessment	The spreadsheet captures all the submission received per quarter and calculates the number of working days that it has taken for the processing of the amendments. The performance target of the unit is calculated in the following way: (Numerator) Number of amendments processed after receipt of all inform in 14 days or less / (Denominator) Number of amendments processed in the period (excluding those with outstanding information) * 100. The calculation takes into account all rule amendment requests received from 1 March to End of February of each year
Means of verification	Rule amendment applications and Approval letters
Assumptions	The assumptions are that all identified operational risks have been taken into account
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	The indicator is only a measure of the percentage of submissions completed within 14 days. It is based on the number of submissions made by schemes during each quarter.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	80% of submissions made to the office are processed within 14 working days.
Indicator responsibility	General Manager: Benefit Management
Indicator title	**Percentage of annual rule amendments processed before 31 December of each year.**
Short definition	A rule amendment represents a change to the rules that govern the relationship between a medical scheme and its members. Annual rule amendments that are processed under this indicator are required by schemes as they need updating to contributions and benefits each year in order to keep the schemes relevant and sustainable.
Purpose/importance	The unit ensures that annual rule amendments submitted during September/October that are effecting on 1 January the following year are processed after receipt of all info before 31 December of that year to enable schemes to operate the benefit year with approved rules. This ensures that the schemes have rules that are approved and are compliant with the Medical Schemes Act (1998) and are not unfair to members of medical schemes when they are effected. The indicator measures the effectiveness of the processing of rule amendments received by the targeted deadline identified as these have a direct impact on the operations of schemes changes for a new contribution/benefit cycle.
Source/collection of data	Hardcopies of annual rule amendments submitted are captured on a register and Excel spreadsheet. The capturing of the date submitted, received by the analyst, date of request of further information and the date of processed and sent to the GM is captured for each rule submission. The spreadsheet will use the information captured to calculate the performance of the Unit.

Method of calculation/Assessment	The spreadsheet captures all the annual rule submissions received effective 1 January and also the date that they were processed to calculate the target of submissions processed by 31 December. The performance target of the unit is calculated in the following way: (Numerator) Number of amendments processed by 31 December /(Denominator) Number of amendments received (excluding those with outstanding information) * 100.
Means of verification	Rule amendment applications and Approval letters
Assumptions	The assumptions are that all identified operational risks have been taken into account
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	The indicator is only a measure of the percentage of submissions completed by 31 December. It is based on the number of submissions made by Schemes effective 1 January each year.
Type of indicator	Output
Calculation type	Non-Cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	90% submissions made to the office are processed before 31 December each year.
Indicator responsibility	General Manager: Benefit Management

12.12 Programme 8 (Financial Supervision)

Output 30: Monitor and promote the financial soundness of medical schemes.

Indicator title	**Percentage of business plans processed in respect of Regulation 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar) .**
Short definition	The indicator measures the number of business plans processed in respect of schemes below statutory minimum solvency level where business plans are submitted as required by Regulation 29.
Purpose/importance	To measure monitoring actions/interventions in respect of schemes below solvency. This indicator measures the performance of medical schemes (against submitted business plan/course of action during the year, as part of the Early Warning System.
Source/collection of data	The business plan is counted when a business plan is either approved/rejected by the Executive Management Committee. Content Management System on M-files - CMS Vault – FSU folder Medical schemes submit quarterly returns as part of the CMS Early Warning System; from which analysis is undertaken to determine the cases requiring regulatory intervention. Further, the Act requires medical schemes to notify the Registrar of the nature and courses of failure (business plan) should they not be in compliance with Regulation 29. The business plan is analysed and a recommendation made for approval/rejection.
Method of calculation/Assessment	Number of business plans processed / number of business plans received*100. Where there are no Schemes fitting the category of below 25% solvency, the assumption is that the target is not applicable
Means of verification	Business plans and Approval letters
Assumptions	• It is assumed that there will be schemes below the solvency requirement of 25%. • However where there are no Schemes fitting the category of below 25% solvency, the assumption is that the target is not applicable
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	The business plans are generally received at the end of a reporting period following the audit of scheme financials. Typically, there will be interaction with the scheme over months until a satisfactory business plan detailing an appropriate turnaround strategy is submitted and analysed. As such, cases will always be carried over into the next period. There will therefore always be a lag between identification, receipt and a final recommendation.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100% of submissions received per year.
Indicator responsibility	General Manager: Financial Supervision
Indicator title	**Percentage of business plans processed in respect of schemes with rapidly reducing solvency (but above statutory minimum)**
Short definition	Percentage of recommendations in respect of identified schemes with rapidly reducing solvency.
Purpose/importance	To measure monitoring actions in respect of schemes with rapidly reducing solvency This indicator measures the performance of medical schemes during the year, as part of the Early Warning System.
Source/collection of data	The Unit will identify schemes with rapidly reducing solvency Content Management System on M-files - CMS Vault – FSU folder. The recommendation may entail a variety of actions such as requiring schemes to submit a reserving plan, and /or management accounts on a business plan detailing how reserves will be managed.
Method of calculation/Assessment	Number of business plans processed / number of business plans received*100. Where there are no Schemes fitting the category of rapidly declining solvency, the assumption is that the target is not applicable
Means of verification	Business plans and Approval letters
Assumptions	• The assumptions is that all identified operational risks have been taken into account • However where there are no Schemes fitting the category of rapidly declining solvency, the assumption is that the target is not applicable
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable

Data limitations	The business plans are generally received at the end of a reporting period following the audit of scheme financials. Typically, there will be interaction with the scheme over months until a satisfactory business plan detailing an appropriate turnaround strategy is submitted and analysed. As such, cases will always be carried over into the next period. There will therefore always be a lag between identification, receipt and a final recommendation.
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100% of identified schemes per year.
Indicator responsibility	General Manager: Financial Supervision
Indicator title	**Percentage of auditor applications analysed.**
Short definition	This indicator measures the percentage of applications for auditor approval analysed and finalised as per Section 36 of the MSA.
Purpose/importance	Section 36 of the MSA requires the Registrar to approve the appointment of auditors by medical schemes. This is to ensure that scheme auditors are appropriately skilled and experienced for nature and size of the scheme.
Source/collection of data	Auditor approval letters; after analysis, an auditor application can either be approved or rejected. The Unit counts all applications analysed. Content Management System on M-files - CMS Vault – FSU folder. Schemes requiring approval submit application forms through the CMS web portal.
Method of calculation/Assessment	Work out the percentage taking the number of schemes applications analysed (this includes both approved and rejected applications) /number of schemes applications received at least two weeks before quarter end (or office closure in respect of Quarter 3) *100.
Means of verification	Auditors approval letters
Assumptions	Auditor approvals are to be completed for all medical schemes on an annual basis
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100% of applications received per year.
Indicator responsibility	General Manager: Financial Supervision

Indicator title	**Number of quarterly financial return reports published (excluding quarter four).**
Short definition	This indicator measures the number of consolidated medical schemes financial quarterly reports published.
Purpose/importance	This indicator measures the financial performance of medical schemes during the year, as part of the Early Warning System.
Source/collection of data	Publication of quarterly reports on CMS website. One quarterly report per quarter, except for the last quarter of the year.
Method of calculation/Assessment	Sum of quarterly reports that are published on the CMS website.
Means of verification	Quarterly Reports published
Assumptions	Three quarterly reports will be prepared.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	One quarterly report per quarter, except for the last quarter of the year.
Indicator responsibility	General Manager: Financial Supervision

Indicator title	**Number of financial sections prepared for the Annual Report.**
Short definition	This indicator measures the number of financial sections prepared in respect of the Annual Report. The Annual Financial Statements of schemes are analysed and a consolidated report is prepared as part of the industry report in the CMS Annual Report.
Purpose/importance	This indicator measures the financial performance of medical schemes based on financial performance during the year.
Source/collection of data	Financial sections of the annual report submitted for inclusion in the annual report. Publication of the Annual Report on the CMS website.
Method of calculation/Assessment	Sum of the financial section of the annual report submitted to the Stakeholder Relations Unit.
Means of verification	Annual Report
Assumptions	One financial section of the annual report will be submitted for inclusion in the annual report.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Annually
New indicator	No
Desired performance	One set of input in respect of the financial sections of the Annual Report in 2020/21.
Indicator responsibility	General Manager: Financial Supervision

12.13 Programme 9 (Complaints Adjudication)

Output 31: Resolve complaints with the aim of protecting beneficiaries of medical schemes.

Indicator title	**Percentage of category 4 complaints adjudicated within 120 working days and in accordance with complaints standard operating procedures, .**
Short definition	As per the provisions of section 47 (2) of the Medical Schemes Act (1998), complaints must be resolved as soon as possible after receipt of comments from parties complained against or referred to the Council for resolution if they cannot be resolved by the Registrar's Office. The Unit, therefore, determined its own turnaround time (120 working days) as none is provided for in the legislation.
Purpose/importance	To ensure speedy resolution of complaints with the aim of protecting beneficiaries of medical schemes
Source/collection of data	CMS Complaints Adjudication IT system database
Method of calculation/Assessment	When a decision on a complaint is made, the complaint is closed on the system and that particular the complaint is considered resolved. Total number of complaints resolved within 120 working days / total number of complaints received during the period) * 100. In statistical terms, the method of calculation is "the number of resolved complaints over the number of received complaints". Complaints are received daily and logged onto the complaints database We take into account the open complaints at the beginning of the period plus those received during the period and determine the number of resolved complaints within a period of 120 working days The Unit starts counting the 120 working days from the day a response is received from the regulated entity, therefore the targets are determined based on complaints resolved from the date of receipt of responses from medical schemes. In statistical terms, the method of calculation is "the number of resolved complaints over the number of received complaints"*100.
Means of verification	Complaints Report
Assumptions	Complaints will be received continuously since member complaints is a legislated right
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	General Manager: Complaints Adjudication
Indicator title	**Percentage of category 1 complaints adjudicated within 30 working days and in accordance with complaints standard operating procedures, .**
Short definition	As per the provisions of section 47 (2) of the Medical Schemes Act (1998), complaints must be resolved as soon as possible after receipt of comments from parties complained against or referred to the Council for resolution if they cannot be resolved by the Registrar's Office. The Unit, therefore, determined its own turnaround time (120 working days) as none is provided for in the legislation
Purpose/importance	To ensure speedy resolution of complaints with the aim of protecting beneficiaries of medical schemes
Source/collection of data	CMS Complaints Adjudication IT database
Method of calculation/Assessment	When a decision on a complaint is made, the complaint is closed on the system and that particular complaint is considered resolved. Total number of complaints resolved within 30 working days / total number of complaints received during the period) * 100. In statistical terms, the method of calculation is "the number of resolved complaints over the number of received complaints". We take into account the open complaints at the beginning of the period plus those received during the period and determine the number of resolved complaints within a period of 120 working days

	The Unit starts counting the 120 working days from the day a response is received from the regulated entities, therefore the targets are determined based on complaints resolved from the date of receipt of responses from medical schemes.
Means of verification	Complaints Report
Assumptions	Complaints will be received continuously since member complaints is a legislated right
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	General Manager: Complaints Adjudication
Indicator title	**Percentage of category 2 complaints adjudicated within 60 working days and in accordance with complaints standard operating procedures, .**
Short definition	As per the provisions of section 47 (2) of the Medical Schemes Act (1998), complaints must be resolved as soon as possible after receipt of comments from parties complained against or referred to the Council for resolution if they cannot be resolved by the Registrar's Office. The Unit, therefore, determined its own turnaround time (120 working days) as none is provided for in the legislation
Purpose/importance	To ensure speedy resolution of complaints with the aim of protecting beneficiaries of medical schemes
Source/collection of data	CMS Complaints Adjudication IT database
Method of calculation/Assessment	When a decision on a compliant is made, the complaint is closed on the system and that particular complaint is considered resolved. Total number of complaints resolved within 60 working days / total number of complaints received during the period) * 100. In statistical terms, the method of calculation is "the number of resolved complaints over the number of received complaints". We take into account the open complaints at the beginning of the period plus those received during the period and determine the number of resolved complaints within a period of 120 working days The Unit starts counting the 120 working days from the day a response is received from the regulated entities, therefore the targets are determined based on complaints resolved from the date of receipt of responses from medical schemes.
Means of verification	Complaints Report
Assumptions	Complaints will be received continuously since member complaints is a legislated right
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	General Manager: Complaints Adjudication
Indicator title	**Percentage of category 3 complaints adjudicated within 90 working days and in accordance with complaints standard operations procedures, .**
Short definition	As per the provisions of section 47 (2) of the Medical Schemes Act (1998), complaints must be resolved as soon as possible after receipt of comments from parties complained against or referred to the Council for resolution if they cannot be resolved by the Registrar's Office. The Unit, therefore, determined its own turnaround time (120 working days) as none is provided for in the legislation
Purpose/importance	To ensure speedy resolution of complaints with the aim of protecting beneficiaries of medical schemes
Source/collection of data	CMS Complaints Adjudication IT database

Method of calculation/Assessment	When a decision on a complaint is made, the complaint is closed on the system and that particular complaint is considered resolved. Total number of complaints resolved within 90 working days / total number of complaints received during the period) * 100. In statistical terms, the method of calculation is "the number of resolved complaints over the number of received complaints". We take into account the open complaints at the beginning of the period plus those received during the period and determine the number of resolved complaints within a period of 120 working days The Unit starts counting the 120 working days from the day a response is received from the regulated entities, therefore the targets are determined based on complaints resolved from the date of receipt of responses from medical schemes.
Means of verification	Complaints Report
Assumptions	Complaints will be received continuously since member complaints is a legislated right
Disaggregation of Beneficiaries	Refer to TID for Programme 1.4: Human Resources
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	General Manager: Complaints and Adjudication
Indicator Title	**Percentage Rulings published on the CMS website within 14 days of issuing the ruling**
Short definition	This indicator measures the number of rulings published by the Complaints unit once finalised by the Complaints unit
Purpose/importance	To ensure that the public understands the reasons for the rulings issued on complaints and provide clarity on the interpretation of the Medical Schemes Act and the rules of medical schemes.
Source/collection of data	Appeals Ruling as received from the adjudicating officer
Method of calculation/Assessment	Number of Rulings Published/Number of Rulings Issued*100
Means of verification	Published rulings
Assumptions	The right to be heard on appeal is legislated therefore there will always be appeals which should be adjudicated
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	General Manager: Complaints Adjudication

Output 32: Appeal Committee hearings attended based on Council Secretariat schedules

Indicator title	Percentage of Appeal Committee hearings attended based on Council Secretariat schedules
Short definition	As per the provisions of section 48 (1) of the Medical Schemes Act (1998), Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council.
Purpose/importance	To ensure that the panel hearing appeals (Appeal committee) understand the reasons for the rulings issued on complaints, the unit appears before the panel on the date of hearings and provide clarity on the interpretation of the Medical Schemes Act and the rules of medical schemes.
Source/collection of data	CMS Complaints Adjudication IT system database
Method of calculation/Assessment	When a notice of an appeal is received by the unit, it is recorded as such in the system. Total number appeals attended/Total number of appeals received*100
Means of verification	Attendance Register
Assumptions	The right to be heard on appeal is legislated therefore there will always be appeals which should be adjudicated
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Output
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	General Manager: Complaints Adjudication

Annexures to the Annual Performance Plan

Annexure A: Amendments to the Strategic Plan

This is the second year of the implementation of the 2020-2025 Strategic Plan. The strategic plan has been revised to include the following outputs:

- Output 13: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority;
- Output 14: Support Dispute Resolution Forums in furtherance of Council and MSA objectives
- Output 15: Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements

The Annual Performance Plan is currently aligned with the Strategic Plan and has been revised to include a new sub-programme for the Council Secretariat. The entity has developed an Acceptable Levels of Materiality and Significance Framework in line with Treasury Regulation 28.3. The materiality/significant framework per current policy is R1.64m. This is reviewed and submitted to the Executive Authority on an annual basis.

CMS Materiality and Significance Framework

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

Section 50: Fiduciary duties of accounting authorities

1) The Accounting Authority for a public entity must:

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

Section 51: General responsibilities of accounting authorities

1) An Accounting Authority for a public entity:

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

Section 54: Information to be submitted by accounting authorities

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

PFMA section	***Quantitative (Amount)***	***Qualitative (Nature)***
a) Establishment of a company.	*Any proposed establishment of a legal entity.*	*Full particulars to be disclosed simultaneously to the Minister of Health and Minister of Finance (National Treasury) for approval.*
b) Participation in a significant partnership, trust, unincorporated joint venture or similar arrangement.	*Qualifying transactions exceeds R1.64m (based on 1% of total CMS revenue as at 31 March 2019).*	
c) Acquisition or disposal of a significant shareholding in a company.	*Greater than 20% of shareholding.*	
d) Acquisition or disposal of a significant asset.	*Qualifying transactions exceeds R1.64m (based on 1% of total CMS revenue as at 31 March 2019) including financial leases.*	*Any asset that would increase or decrease the overall operational functions of the CMS.*
e) Commencement or cessation of a significant business activity.	*Any activity not covered by the mandate/core business of the CMS and qualifying transactions exceeds R1.64m (based on 1% of total CMS revenue as at 31 March 2019).*	*Full particulars to be disclosed simultaneously to the Minister of Health and Minister of Finance (National Treasury) for approval.*
f) A significant change in the nature or extent of its interest in a significant partnership, trust, unincorporated joint venture or similar arrangement.	*Qualifying transactions exceeds R1.64m (based on 1% of total CMS revenue as at 31 March 2019).*	

Section 55: Annual report and financial statements

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

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

   b) include particulars of:

PFMA section	***Quantitative (Amount)***	***Qualitative (Nature)***
(i) Any material losses through criminal conduct and any irregular expenditure and fruitless and wasteful expenditure that occurred during the financial year.	*All instances.*	*Report quarterly to the Minister of Health.* *Report annually in the annual financial statements.*
(ii) Any criminal or disciplinary steps taken as a consequence of such losses or irregular expenditure or fruitless and wasteful expenditure.		
(iii) Any losses recovered or written off.		
(iv) Any financial assistance received from the state and commitments made by the state on its behalf.		

(v) Any other matters that may be prescribed.	*All instances, as prescribed.*	

Section 56: Assignment of powers and duties by accounting authorities

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

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

Element	**Percentage (%) rand to be applied against R value**	**Audited value at 31 March 2019**	**Calculated materiality and significance value**
Total Revenue (0.5 - 1%)	1%	R163 566 000	R1 635 660

The CMS materiality and significance value will be R1.64m based on the highest percentage of the total revenue element and the significant fluctuations in the month-to-month total revenue value.

Treasury circulars and guidelines related to supply chain management

The national Department of Health and National Treasury are to be notified of procurement transactions exceeding R500 000.

Annexure B: Conditional Grants

Name of Grant	Purpose	Outputs	Current Annual Budget (R thousand)	Period of Grant
Unconditional Grant	Policy Development	NHI Projects	R6 538 000	2020/21

Annexure C: Consolidated Indicators (Not Applicable)

Institution	Output Indicator	Annual Target	Data Source