COUNCIL FOR MEDICAL SCHEMES

Annual Performance Plan for 2023/24

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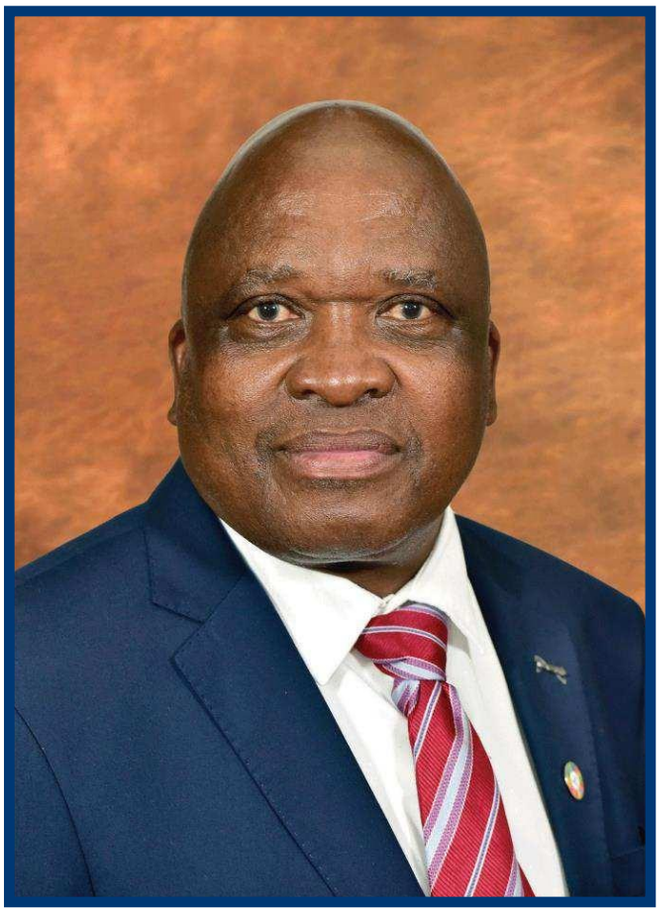
Annual Performance Plan for 2023/24

Tabling: March 2023

EXECUTIVE AUTHORITY STATEMENT



The Council for Medical Schemes has established itself as an effective and efficient regulator over the years, and this has been demonstrated by the consistent execution of its mandate, its responsiveness to the protection of the members of medical schemes, and it is promoting access to healthcare. I am also pleased by the CMS's overall performance against its set objectives and 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.

The National Department of Health has been working 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. Recently, the CMS demonstrated this in their submission to the Competition Commission who ruled against the excessive COVID-19 PCR test price.

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.

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 approach will go a long way 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 implementation of the National Health Insurance (NHI) Fund.

I am satisfied that the CMS will meet with the strategic outcomes that it set for itself in the five-year plan under review. I thank the Council, the Registrar, and his staff for the development of this Annual Performance Plan and wish them well in the further execution of what remains in their five year plan.

DR. MJ PHAAHLA, MP
MINISTER OF HEALTH

ACCOUNTING AUTHORITY STATEMENT

In its 22 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) and its Regulation. 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 continue to play its key oversight role to the CMS during the most interesting era of the health sector in South Africa.

The finalisation and implementation of the proposed MSA as amended is expected to provide the CMS with improved capacity to become a more effective and efficient industry regulator.

This Annual Performance Plan has been developed within the context of the constraints that are presented by the lagging effect of COVID-19 pandemic on the economy and its impact on the regulatory and operational effectiveness of the CMS as a regulatory authority. I am, however, assured by the CMS's excellent performance and resilience during this period under the same constraints, and believe that the organisation is on track to achieve its 5 year strategic goals .

The strategic trajectory for the CMS in the remaining period of our five-year plan, entails providing effective and efficient regulation of the medical schemes industry and playing a significant role in the implementation of Universal Health Coverage through 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
- Driving the mitigating of fraud, waste and abuse risks through industry lead initiatives
- Harmonise the medical schemes regulatory frameworks within the SADC region
- Consolidation of options and medical schemes
- Completion of the review of the Prescribed Minimum Benefits by adding a health promotion and disease prevention package in a phased-in manner
- Support the Presidential health Compact activities.

Furthermore, 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.

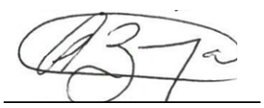
I extend my gratitude to fellow members of the Council, the Registrar, the CMS Management and staff for the continued focus on the mandate as entrenched in the MSA and the development of this Annual Performance Plan in particular. I further wish the CMS, under the leadership of the Registrar together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

Dr. Memela M Makiwane
Chairperson: Council for Medical Schemes

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 2023/24.

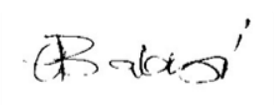


Ms. Andiswa Zinja
Chief Financial Officer

Mr. Michael Willie
Executive Manager: Policy, Research and Monitoring

Mr. Ephraim Tlhako
Chief Information Officer

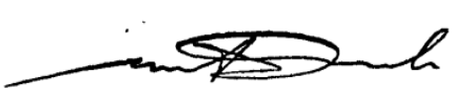
Vacant
Executive Manager: Member Protection



Mr. Zongezile Baloyi
Executive Manager: Corporate Services

Dr. Sipho Kabane
Chief Executive Officer and Registrar

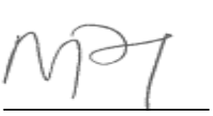
Mr. Khayalethu Mvulo
Council Secretariat



Dr. Memela M Makiwane
Chairperson: Council for Medical Schemes

Mr. Reginald Sadiki
Executive Manager: Office of the CE & Registrar

DR MJ PHAAHLA, MP
MINISTER OF HEALTH



Mr. Mfana Maswanganyi
Executive Manager: Regulation

TABLE OF CONTENTS

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 aligned with the progressive realisation and access to universal health care for all. A key objective of the NHA is to unite the various elements of the national health system with a common goal of actively promoting and improving the national health system in South Africa. Added to this is the intent to foster a spirit of cooperation and shared responsibility among public and private health professionals, providers, and other relevant stakeholders within the context of national, provincial, and district health plans. This also includes the process of providing a framework for a structured uniform health system within the Republic, considering the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services.

1.2. 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;
- perform any other functions conferred on the Council by the Minister or by the Act.

1.3. 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 National Health Act.
- 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.
- *Skills Development Levies Act 9 of 1999*
  To provide for the imposition of skills development levy and for matters connected therewith
- Public Finance Management Act, 1 of 1999 (PFMA)
  Provides for 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 persons. 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,
- The Pharmacy Amendment Act 88 of 1997
  Allows for ownership of pharmacies by non-pharmacists. This aimed to improve the distribution of pharmacy services in rural and outlying areas.
- 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.
- The Medical, Dental and Supplementary Health Services Amendment Act 89 of 1997
  Enables health professionals to experience a broader range of services than they would normally have in a university setting. It also provides for interaction between the private and public sectors.
- 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.
- Competition Act 89 of 1998
  Determine what is manufactured, how resources are going to be allocated in the production process and to whom those goods are going to be distributed or sold. Aims to structure and control the market so as to increase and protect competition. The value of competition should be that it enhances consumer welfare by making goods and services more accessible and affordable
- Medicines and Related Substances Control Act 101 of 1965 (the Medicines Act)
  To ensure the safety, efficacy, and quality of medicines
- *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 the prevalence of non-communicable diseases;
5. reduce injury, accidents and violence by 50% 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 achieving 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 the 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 population of South Africa in 2021 was estimated to be 60,14 million lives, 8,95 million of which are covered by private healthcare funding. This coverage is largely a function of the individual's socio-economic status, and this is influenced by the growth of the economy and employment rate. There is a positive correlation between employment and membership growth within the medical scheme's environment. Even for those individuals belonging to medical schemes, affordability remains a challenge as healthcare costs continue to increase at rates that are significantly higher than inflation. The decrease in the number of

individuals that enjoy cover through private funding remains a challenge to this industry.

The CMS as a regulator of the medical schemes industry, plays a key role in facilitating and promoting the health of all citizens in support of Vision 2030.

The National Department of Health, under the leadership of the Minister of Health, is tasked with the immense 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 of the National Department of Health (NDoH) for 2020 – 2025:

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

1.4. Policy Mandates

The Minister has been very consistent in the articulation of policy developments that affect the medical schemes industry. 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
- Medium-Term Strategic Framework Priorities 2020-2025

These mandates remain relevant to the medical schemes industry. 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)
- Financial Sector Regulatory Act, and
- Conduct of Financial Institutions Bill (COFI Bill)

The Medical Schemes Amendment Act

After the publishing of the Medical Schemes Amendment bill, the CMS continues to make extensive inputs during the period for comments by key stakeholders. During the 202 3/24 financial year, our expectations are that there a process will be put in place that will prioritise the legislative focus on ensuring that key shortfalls in the Medical Schemes Act will be addressed as important changes are effected in the National Health Insurance Bill. This period will then be followed by the prioritization of the processing of the Medical Schemes Amendment Bill to ensure effectiveness in regulation and harmony with the National Insurance 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, developing the regulations. The following extensive research has been conducted regarding the role of the Independent Healthcare Intermediary.

The successful implementation of the new MSA and Regulations will empower the CMS to become a more effective and efficient regulator in the transition towards the full implementation of the NHI

The National Health Insurance (NHI)

The objective of the NHI Bill is to provide universal access to quality health care for all South Africans, as enshrined in the Constitution. The Constitution recognizes healthcare as a fundamental human right. It states that "everyone has the right to have access to health care services, the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights and no one may be refused emergency medical treatment." The NHI Bill seeks to achieve this by ensuring that:

- No one is deprived of the above mentioned rights because of their socio-economic status;
- One public health fund is created with adequate resources to plan for and effectively meet the health needs of the entire population, not just for a selected few; and
- The ultimate goal is to achieve Universal Health Coverage (UHC).

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. The Portfolio Committee on Health has held public hearings, where different stakeholders have articulated their positions vis-à-vis' the National Health Insurance Bill. These hearings continued until all stakeholders have made their presentations. There was finally approved for consideration by the Portfolio Committee on Health and is now being subjected to a section-by-section debate. Once all these discussions have been completed at the level of the Portfolio Committee, the Bill will then be referred to the National Council of Provinces for further, debates before it is presented to the President for promulgation.

The CMS is expected to align its legislation with all the key changes that will be presented by the NHI Act. The CMS continues to see its role as playing both supportive to the National Department of Health and a direct role in coordinating the efforts of the medical industry in the realisation of Universal Health Coverage as envisaged through the NHI.

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

The Financial Sector Regulation Act, which was passed in 2017 and the Conduct of Financial Institutions published in December 2018 are the main legislations introduced to implement the "Twin Peaks" regulatory framework for the country. This regulatory approach seeks to entrench the establishment of a Financial Sector Conduct Authority on the one hand and a Prudential Authority on the other. The Financial Sector Conduct Authority is mandated to regulate the conduct of financial institutions, while the Prudential Authority is tasked with ensuring that all the participants in the financial sector are fit and proper. These pieces of legislation that are in principle supported by the Council for Medical Schemes have been written in a manner that is likely to create regulatory arbitrage between these two authorities and the Council for Medical Schemes at the point of implementation. The CMS is, with the support of the National Health Ministry, currently engaged in intense discussions with the National Treasury and Financial Sector Conduct Authority to address this challenge. These ongoing discussions are aimed at ensuring that there is legislative and regulatory alignment between the FSRA, COFI Bill and the Medical Schemes Act.

2. Updates to Institutional Policies and Strategies

The CMS has in place the Ethics Code: Code of Conduct, Enterprise Risk Management Framework, ICT, HR, Finance, and Stakeholder Relations Policies. These institutional policies are periodically reviewed and approved by the Accounting Authority. The CMS has adopted several new policies, including the remuneration policy and philosophy, and is in the process of implementing these. The CMS newly adopted Ethics Code: Code of Conduct policy is a comprehensive Ethics Policy whose aim is to introduce an ethical culture to prevent and address fraud and corruption. New Ethics Code of Conduct pocket booklets will continue to be issued to new staff members.

Since adopting the Organisational Diagnostic Exercise Report by the Accounting Authority, the institution

implemented a new Business Operational and Service Delivery Models after concluding a business process mapping project.

3. Updates to Relevant Court Rulings

CMS vs Health-Squared

The Council for Medical Schemes (CMS) made an application to place Health Squared Medical Scheme under provisional curatorship effective from Thursday, 8 September 2022.

The CMS brought the curatorship application to examine the actual financial position of the scheme and oversee the liquidation process. The Court agreed with CMS that a curator is a suitable remedy to address the concerns raised by CMS. The CMS has a statutory duty to uphold the rights and interests of beneficiaries.

The Curator's role and mandate are to, amongst others, restore overall effective governance of the scheme, whilst ensuring continued servicing of members and beneficiaries of the scheme. Mr. Seoloane is expected to take complete control of the scheme and attend to all complaints and queries from concerned beneficiaries seeking assistance with their membership.

Upon receiving the Court order, the CMS liaised with the appointed curator to establish communication channels between the members and all relevant stakeholders. As such, members of Health Squared are informed to direct all queries, complaints and questions to the appointed curator.

The curator remains in charge of the scheme, is also instrumental and will pave legally construed and legitimate process for the final liquidation of the scheme. The matter will be heard in February 2023 wherein the curator will table his final report supported by recommendations clearly mapping the way forward in terms of the fate of the Scheme.

CMS vs Bp Medical Society

The Registrar and Council for Medical Schemes are seeking to place BP Medical Aid Society, which is a closed medical scheme, duly registered as such in terms of section 24 of the MSA under provisional curatorship.

The CMS brought the curatorship application on the basis that the Board of Trustees of BPMA ("the BoT") are not being properly constituted in terms of section 57 (2) of the "the MSA and the in-fighting amongst the BoT and their inability to perform their functions coupled with the Bot's non-compliance with the scheme's rules ("the rules").

The curator's role and mandate is to take immediate control of, and in the place of the board of trustees, manage the business and operations of the BPMAS, together with all assets and interests relating to the business of BPMA, in line with the provisions of the MSA and BPMAS scheme rules.

The application brought by the CMS was issued in the Western Cape High Court. The application was opposed on the 18th of July 2022 by BPMAS, and the necessary affidavit were submitted.

At this stage, the safe assumption would be that the matter will be ready for hearing in the first quarter of 2023.

IPASA vs Registrar

IPASA filed a section 49 appeal wherein the Registrar dismissed IPASA's complaint that they were unfairly excluded by Medical Schemes. At the Appeals committee hearing it was found that the Schemes were not given adequate notice of responding to IPASA's allegations. Based on this point, the Appeals committee ruled that the Registrar must issue section 43 notices to all the affected Schemes.

The Registrar complied with the ruling and the section 43 notices are underway.

Mokoditoa vs Registrar

Mokoditoa lodged High Court action complaining that he was unfairly treated by the CMS and Medical Schemes regarding payment of his claims. The matter was defended by the Registrar and the said Medical Schemes.

The matter is still pending for an order.

Kinsman vs Registrar– Equality Court

Ms Kinsman complaint to the equality court that she was unfairly discriminated by the Registrar and Council. The Registrar opposed the application and ultimately the Equality Court found that the Registrar was correct and dismissed Ms Kinsmans unfair discrimination allegations.

Kinsman vs Registrar- Appeal Board

The Registrar filled an appeal to the Appeals Board against the finding that Ms Kinsman was unfairly disqualified as a trustee and the award of compensation in her favour.

The Appeals Board ruled in favour of the Registrar and set aside the Appeals Committee ruling that was in favour of Ms Kinsman.

PART B: OUR STRATEGIC FOCUS

1. Update Situation Analysis

The situational analysis in this section has utilised a combination of PESTEL, SWOT, and economic outlook to identify key challenges and priorities for the CMS in the next financial years.

1.1 External Environment Analysis

Table 1: PESTEL analysis

POLITICAL	ECONOMIC	SOCIAL	TECHNOLOGICAL	ENVIRONMENTAL	LEGAL
• East European War • Lack of Ethical Leadership at National and Scheme level • Pervasive national Corruption & Fraud culture • Unmanaged Conflict of Interest • Civil unrest and impact on medical schemes membership and access to care, in particular, medical service providers and pharmacies that were directly affected	• High Inflation leading to high interest rates • Impact of Medical Inflation on contributions • Increasing unemployment • Increasing poverty • Increasing inequity • Economy contraction • Budget deficit • Economic reconstruction and recovery plan (ERRP) after COVID-19 • Labour unrests and protests due to high cost of living	• Shifting burden of disease to non-communicable diseases • Increasing life expectancy • Gender-Based Violence • Gender Inequality • Outcomes of the Hybrid Working model • Social unrests & Protests • Lack of Pandemic and Disaster preparedness Member disinterest in the affairs of their medical scheme.	• Impact of ageing ICT infrastructure against increased demand • Increasing demand for ICT skills leading to brain drain • Cybersecurity and privacy risks • Availability of Virtual platforms for AGM's and other regulatory activities • E-learning • Webinars Conferences • E-health/ Telemedicine • Availability of Tools of trade • Big-Data • AL/Analytics Robotics • Digital transformation - transactions • Use of Block chain technology • The impact of 4IR on access to care	• Energy crisis (Load shedding) • Water crisis • Connectivity crisis • Climate change and variability • Waste and littering • Pollution • Impact of, less paper prints and more electronic communication through sign flow • The cost of green buildings against access to care and funding •	• Implementation of the FSRA and COFI Bill • NHI Parliamentary engagements • Certificate of Need Regulations • Regulations on Pensions Fund and Retirement Annuity withdrawal limits • Consumer rights and laws • Transformation and B-BBEE requirements • POPIA and Disaster Management Act • Cybersecurity Act • PPPFA Act

According to economic forecasts the high interest rates accompanied by high inflation rates, will still be with us well into the 2023/24 financial year. The ongoing Ukraine-Russia war has contributed to the high costs of goods and services including fuel and the additional fuel demands related to load shedding has exacerbated the situation. The impact of these economic factors will be felt by households as they try to re-adjust their purchasing patterns to meet the high costs created by inflation. The social environment continues to be characterised by an increasing and shifting burden of disease, largely driven by an increasing incidence of non-communicable diseases, influenced by an ageing population. The impact of the burden of disease against the backdrop of a stagnant membership growth experienced by the medical schemes industry, worsens the risk profile across most schemes.

The CMS that regulates the entities that house 16% of the population, is duty bound to address this emerging burden of non-communicable diseases, in order to improve the overall health outcomes of the entire population., It is therefore important to note that the CMS is making strong headway in developing a Primary Healthcare Package (PHC), as part of the Prescribed Minimum Benefits review. This PHC package will supplement the PMBs, to address the health needs of the most vulnerable risk groups.

The high cost of healthcare technology (as well as Health Technology Assessments) is a key cost driver of healthcare input costs, which in turn puts upward pressure on contributions. The share of healthcare technology in the cost basket of health services is likely to continue to increase as the burden of diseases increases and the treatment thereof becomes more complex. Climate change is expected to worsen the burden of disease, as it introduces new diseases.

The CMS continues to provide technical and policy support to the National Department of Health (NDoH). This includes supporting the NHI Bill, and continued work related to provider distribution in support of human resources for health planning. The Financial Sector Regulatory Act and COFI Bill pose a threat to the CMS's regulatory domain.

The utilisation of virtual platforms for meetings has increased since 2020. In the regulatory environment, the CMS saw an increase in the number of medical schemes that opted for virtual platforms. The CMS issued Circular 20 of 2021, supporting the use of the virtual platform for meetings at the beginning of the Annual General Meeting (AGM) season. The 50 medical schemes that were granted exemptions to host virtual AGMs for 2020 were duly advised to review their scheme rules and make the necessary amendments where the rules of the scheme do not cater for virtual AGMs in order to accommodate the challenges posed by the Covid-19 pandemic. Continued monitoring and evaluation of virtual platforms and value add to members will remain a priority and an area of focus.

Ageing Profile of Medical Schemes and Increasing Disease Burden

In addition to the effect and impact of COVID-19, the sector will continue to be impacted by the ageing profile of medical scheme members and the rising burden of disease. This had become more apparent in the 2021-22 era, where several schemes with an older age profile continued to have difficulties, which significantly impact their sustainability. Health Squared Medical Scheme is an example of those schemes that struggled with an increased risk profile as a result of their membership profile, amongst other challenges.

As most resources were redirected to combat the COVID-19 pandemic, other important epidemics such as Pulmonary Tuberculosis and HIV, were left unattended and this had a significant impact on burden diseases. TB and HIV interventions were negatively impacted. This is demonstrated by the decline in many support programmes aimed at reducing the burden of HIV. The graph below, which depicts a sharp decline in the number of voluntary Medical Male Circumcisions (MMCs) between 2019 and 2021, with the trend reversing in 2021 but remaining lower than in 2019. The graph also demonstrates that access to ARTs was not disrupted.

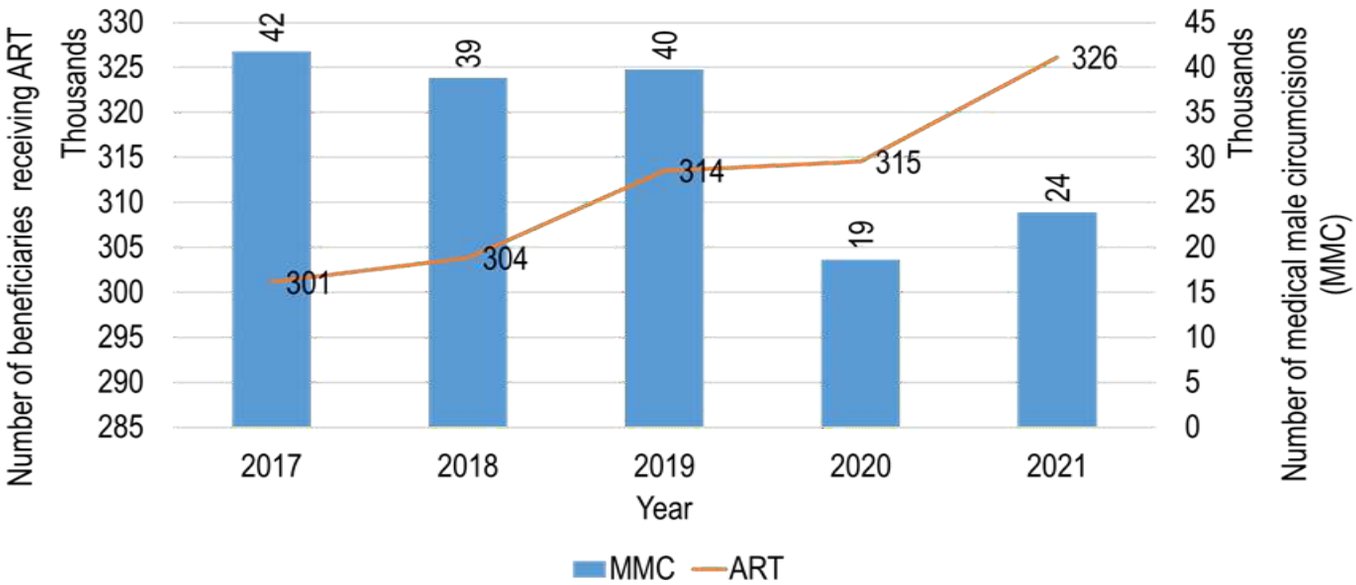


Figure 1: Impact of COVID-19 on HIV Prevention- Number of Medical Male Circumcisions & number of beneficiaries receiving ART. Source: CMS/ SANAC (2022)

The long term impact of COVID-19 on other non-communicable diseases (NCDs) is undeniable, and this will be closely monitored in the future through Disease Management Programs. The CMS will through the PMB review process align itself with the National Strategic Plan for the Prevention and Control of Non-Communicable Diseases, 2022 – 2027, which reflects the department's sustainable, human-rights-based pathway to accelerate our response toward the prevention and control of NCDs, risk factors and mental health conditions.

This Strategic Plan allows the NDoH to adopt an integrated, person-centered approach to improve NCDs' health system and introduce care cascades for hypertension and diabetes. The proposed 90-60-50 cascade for diabetes and hypertension is the first step to improving the early detection and treatment of NCDs and is articulated as follows:

- 90% of all people over 18 will know whether they have raised blood pressure and/or raised blood glucose or not.
- 60% of people with raised blood pressure or blood glucose will receive an intervention.
- 50% of people receiving interventions are controlled.

Industry Trends

The medical schemes industry the CMS regulates consists of various key stakeholders with diverse interests and agendas. As of 31 March 2022, CMS regulated 72 medical schemes, 27 administrators (Including self-administered schemes), 44 managed care organisations (including schemes providing their own managed care services to members), 2156 broker organisations, and 7530 individual brokers. The role of the CMS is to regulate these entities utilising the MSA and Regulations to ensure that all the 8.95 million scheme beneficiaries' interests are protected. This means that the CMS should ensure that all the regulated entities are always compliant with the MSA and its provisions.

The CMS regulates the medical schemes industry through beneficiary training and education, registering 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, reviewing the beneficiary entitlements in the form of Prescribed Minimum Benefits (PMBs), and providing training and support for the regulated entities.

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 covered 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**, 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 the scheme level and providing members access to the complaints resolution mechanisms at the Registrar's office and appeals processes, based on evidence-base clinical care.

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.
The regulation of private hospitals is an example of a key policy intervention required to allow for the stabilisation of healthcare costs.

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. In the past five years (2016-2020), the CMS has 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. Its internal and external environmental factors have largely determined the level of CMS's effectiveness as a regulator. These environmental factors can either positively or negatively impact 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. The CMS has also had opportunities to make presentations to this Portfolio Committee on the Section 59 Investigation and its Annual Performance Plan as well the Budget for the current financial year. CMS has submitted its Annual Report to parliament through the National Health Ministry, and this is presented to Parliament on October 13th, 2022.

Industry Trends Analysis as at end December 2021

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 significant observed industry trends that influence scheme member welfare over the years include:

On the positive side:

- The net healthcare result for all medical schemes combined reflected a surplus of R820.52 million in 2021 (2020: R19.93 billion surplus). The decline in performance resulted from higher utilisation of benefits during 2021.
- The financial market rebounded during 2021, resulting in an increased investment income compared to 2020. The net surplus of all schemes, after investment income and consolidation adjustments, was R12.18 billion in 2021.
- The industry solvency levels improved further from a solvency ratio of 44.55% in 2020 to 46.73% in 2021; the industry solvency is higher the statutory requirement of 25% throughout the period under consideration.
- Only two medical schemes failed to meet the 25% statutory solvency.
- The number of Efficiency Discounted Options (EDOs) increased from 40 in 2014 to 66 in March 2022 (although with a marginal decrease compared to the previous reporting period)
- The proportion of the beneficiaries covered by the EDOs decreased marginally from 23.5% to 23.2% during the period under review.
- There was a reduction in the number of schemes from 74 in 2020 to 72 in March 2022. This is in line with CMS policy stance to increase risk pooling for sustainability.

These positive industry trends mean that medical schemes have been mainly 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. However, the proportion of beneficiaries covered by the EDO's has remain ed relatively unchanged at around 23.2%.

On the negative side:

- In 2021, 8.95 million people enrolled on 74 schemes. The number of medical scheme beneficiaries increased by 0.55 percent from 2020 to 2021. The number of restricted scheme beneficiaries rose by 1.9%, while open scheme beneficiaries rose by 0.9%.
- The average age of medical scheme beneficiaries in 2021 was 33.71 years compared to 33.55 years reported in 2020. Female beneficiaries were generally older than male beneficiaries. The average age of female medical scheme beneficiaries was 34.7 years in 2021, and that of males was 32.3 years.
- Total healthcare expenditure on benefits paid in 2021 increased to R205.3 billion, up by 15.32% from the 2020 reported amount of R178.1 billion. Total hospital expenditure increased by 18.68% between 2020 and 2021, from 62.6 billion to 74.3 billion. The average amount paid per beneficiary for hospital services increased by 18.56% to R8 346.40. from R7 039.74. Just over 92% of total expenditure toward hospitals was paid to private hospitals. The significant increase in expenditure is largely attributed to the low base of 2020, which was a decline between 2019-2020 due to COVID-19.
- Prescribed Minimum Benefits (PMBs) expenditure (risk + savings) amounted to R92.4 billion in 2020 and increased to R108.6 billion in 2021, representing an increase of 17.5%. As a percentage of the total benefit paid, the PMB expenditure accounted for 52.9% of benefits paid in 2021, up from 51.9% of benefits paid in 2020. This further depicts the increased expenditure on disease burden.
- Poor governance and financial management of schemes resulted in a number of schemes being placed under curatorship in this period. This trend continues to persist.

A key lesson from the above analysis, is that the medical aid industry faces significant challenges to its

long-term viability, such as an aging population and affordability of its options. Significant growth has occurred in the industry, but membership growth has recovered from the decline observed in 2020 due to the COVID-19 pandemic. In 2020–21, a notable increase in benefits paid across most disciplines, mostly in double digits, was also observed. This was the result of a low starting point in 2020. The increase in PMB-related benefits as a percentage of total benefits paid is indicative of the increased disease burden. Some hospital groups and other players' continued introduction of products similar to a medical scheme's business without prior approval continues to hinder the sustainability of risk pools. The CMS is currently finalizing an LCBO framework for the minister's consideration, which will provide guidelines for products geared toward low-income earners.

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 Amendment Bill (MSAB)2018
- Health Market Inquiry report
- Review of the Financial Sector Regulation Act and the COFI Bill

The MSAB 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 (2015), 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 MSAB 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 the role of medical schemes and the CMS. It is envisaged that medical schemes will be permitted to provide only complementary cover at full implementation of the Fund.

The legislative framework for achieving greater access to health care is already in place.
The Portfolio Committee is currently reviewing clause-by-clause deliberations of the National Health Insurance Bill. The committee was busy with this process before its members went on their constituency period by the end of August 2022.

The CMS supports the view that the main Health Sector Reform is the implementation of the National Health Insurance, and all other policy interventions have to be analysed and aligned to it before implementation.

The Presidential Health Compact is a product of a Presidential Health Summit that was convened in October 2018. This is a commitment between the Public and Priva te sectors aimed at addressing the key challenges. The CMS continues to participate in the Presidential Health Compact during the year under review. Over 600 diverse stakeholders in the health sector came together during the summit to discuss their concerns about the quality of care in the public health sector, leading to its signing in 2019. Between 2019 and 2021, there was an incremental improvement of 49% in implementing the interventions included in the compact. In addition, seven indicators from four pillars completed the implementation of their interventions. These indicators accounted for an additional 13% of the 53 indicators, compared to a 2% achievement rate in 2019.

Economic Outlook

This was done to ensure that the organisation considers all the external factors that are likely to impact on it at an operational and regulatory level. The protection of beneficiary interests and ensuring that the medical schemes industry is regulated in a manner that is complementary to National Health Policy are the key reasons behind the

evaluation of the external environment.

This section provides a review of external events which have had an influence on specific areas of impact the CMS strategic outlook had focused its regulatory responsiveness on. This section also seeks to highlight ways in which the special projects envisaged by CMS at the time of formulating the five -year plan provide the depth and tactical flexibility to render the CMS strategy resilient enough to turn emerging threats into opportunities for medical schemes' beneficiaries. The specific external risks covered in this section are COVID-19 and the economic effects of the invasion of Ukraine by Russia.

Context: Protecting Guaranteed Cover & Cross-Subsidisation

The Medical Schemes Act guarantees cover (at minimum, consistent cover year after year) for medical schemes' beneficiaries through Prescribed Minimum Benefits (PMBs). The Prescribed Minimum Benefits (PMBs), which cover: i) catastrophic cover for a list of health-seeking episodes and ii) routine care for a prescribed list of non-communicable diseases/chronic conditions.

The business model of medical schemes is to ensure the sustainability of healthcare finance for relatively sicker and elderly risk profiles through cross-subsidisation from relatively healthier and younger individuals. Figure 2 shows how healthcare financing is allocated relative to beneficiary age groups. The figure shows that in 2020, 32.8% of all beneficiaries are forty-five years and older, yet these beneficiaries consume 61.4% of the total healthcare expenditure by medical schemes.

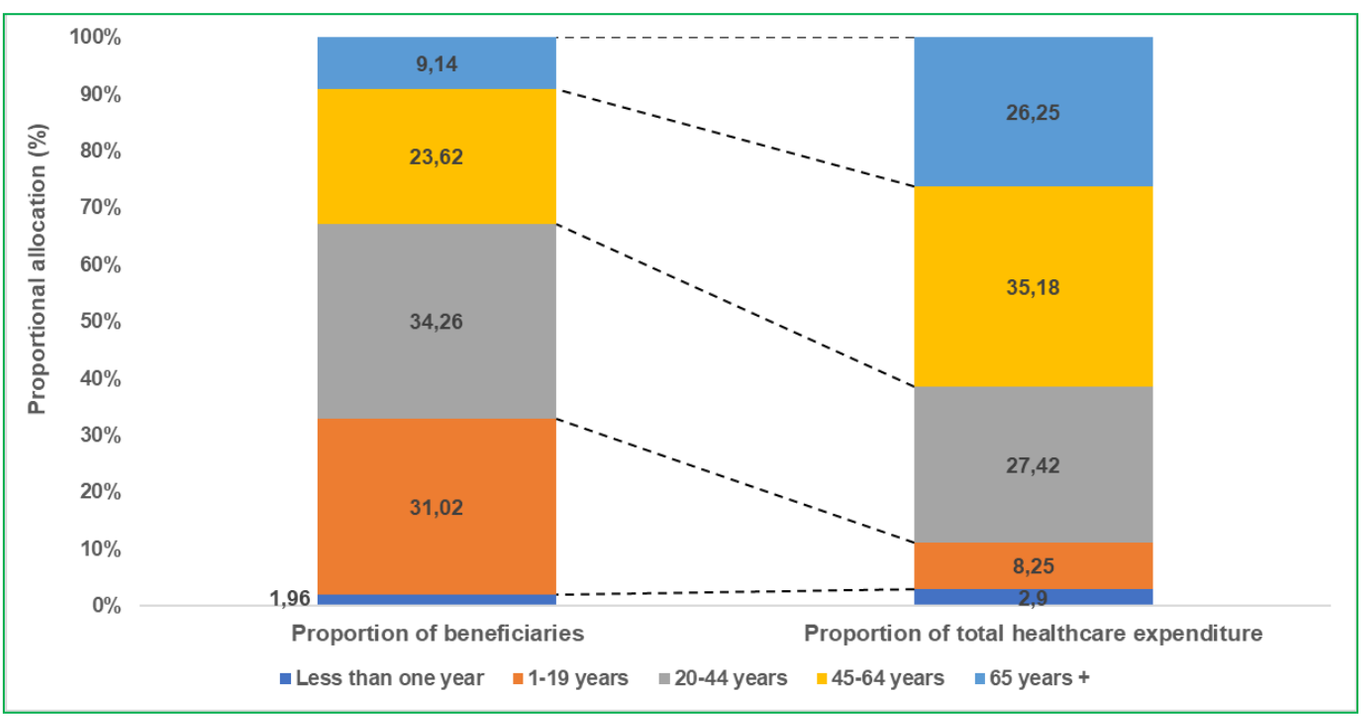


Figure 2: Proportional healthcare expenditure by age group (2020)
Source: Industry Report 2020, CMS, p. 22

The sustainability of this business model for financing the health needs of medical scheme beneficiaries, is exposed to the hazards of elements in the regulatory/institutional external environment. For example:

- The future costs of healthcare can be impacted by deferred utilisation resulting from State Disaster Regulation, which required people to defer non-life-threatening health-seeking activities – threatening the resilience cross-subsidization business model.
- Price shocks resulting from the inflationary effects, could leave households unable to afford comprehensive benefit cover due to the impact of inflation on real incomes. Thus, leaving more vulnerable risk groups with less health financing from cross-subsidisation.

Therefore, effective access to quality healthcare interventions may be impacted by external factors to the CMS's regulatory task environment. The next subsections take a closer look at the threats in the external environment, and then explain how special projects could be responsive enough to turn threats into opportunities.

Describing the external environment

Impact on CPI: Economic Recessions

International price shocks eventually find their way through to customer price index (CPI) levels. These price shocks cause price spikes across household goods baskets that make up components of CPI. One of the components is the health and health insurance basket.

The CMS release Circular 44 of 2022, which is a guideline to industry on benefit changes and contributions as affected by inflation.

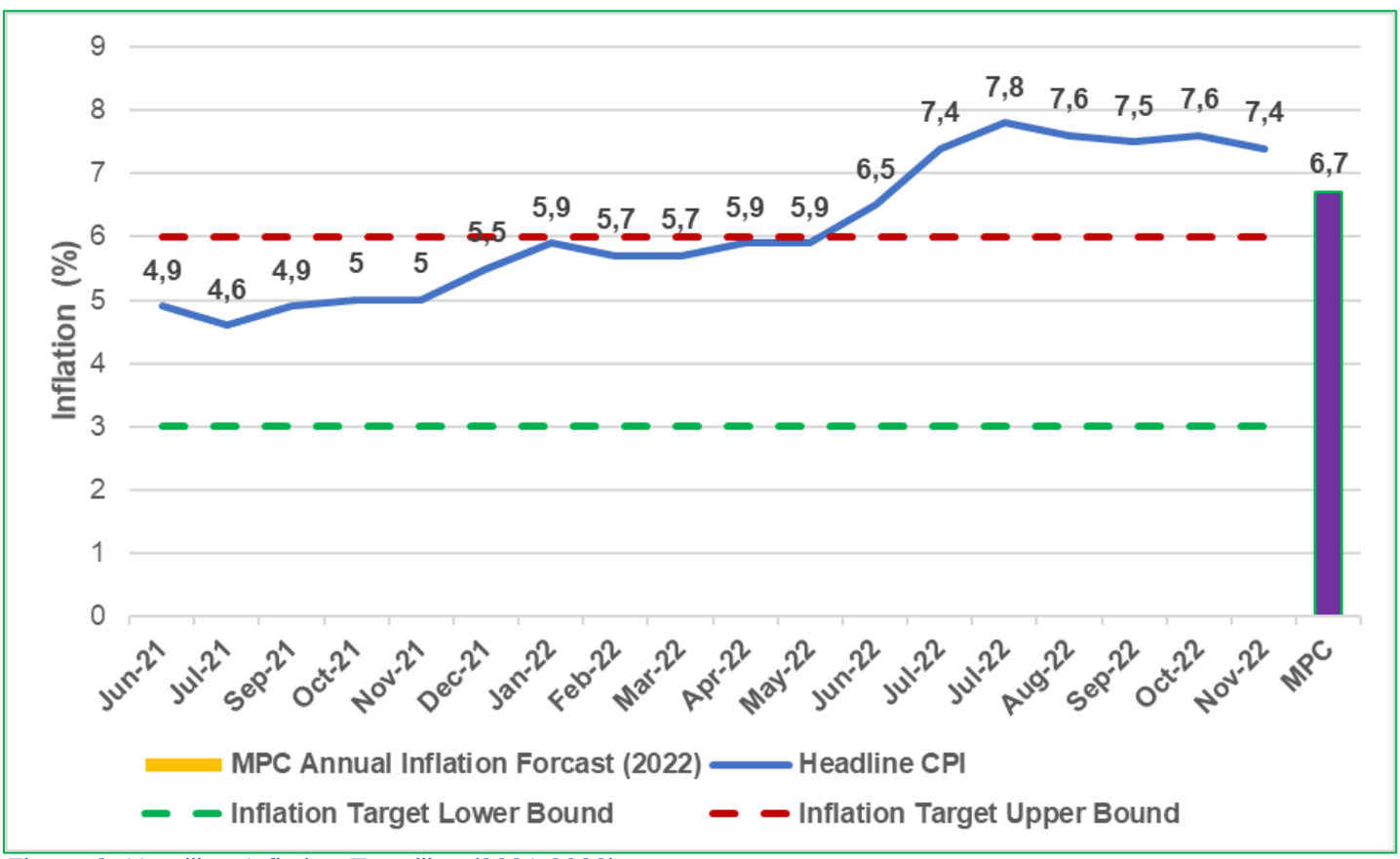


Figure 3: Headline Inflation Trendline (2021-2022)

Sources: November 2022 MPC Statement, South African Reserve Bank (SARB) & STATS SA

The year-on-year headline consumer inflation rate as measured by the consumer price index (CPI) was 5.9% in April 2022, before accelerating sharply to 6.5% in May 2022, before hitting a high of 7.4% in June 2022. Inflation reached its local maximum in August 2022 (7.8%). Overall, inflation is expected to average 6.7% in 2022 (SARB,2022)

According to the latest inflation forecast of the SARB, as outlined in the July Monetary Policy Statement (MPC), headline inflation is expected to average 5.74% in 2023, before moderating to 4.% in 2024 within the bank's target range of between 3% and 6%.

The inflationary impact of the Russia-Ukraine conflict is likely to have an inflationary impact on healthcare goods and services. If unchecked the inflationary spike will need to be priced into health insurance premiums and/or reserves to cushion beneficiaries from the hike in the general price level (or CPI). That said, the CMS special projects are likely to mitigate the full effects of price increases, and thus create an

opportunity to strengthen healthcare financing on behalf of the beneficiaries of medical schemes.

Consumer Confidence and Households' Expenditure Adjustments

The Consumer Confidence Index (CCI) is a leading economic indicator that primarily gives a forecast on the level of confidence consumers have about the economy (in the near to medium term). When consumers have a grim forecast of the economy, it usually results in them holding off on making purchases of durable goods and discretionary items and can indicate a slowdown in consumption that canresult in an economic recession. Moreover, discretionary spending comes under immense pressure during inflationary environments, as is currently the case in South Africa.

Figure 4 illustrates that consumers are negative about South Africa's future growth prospects because of a combination of high unemployment and the rising cost of living. The figure shows that:

- Consumer sentiment registered a -33 during the first COVID-19 wave
- As a result of the economic impact of the Russia-Ukraine conflict, consumer sentiment registered a low –25 in June 2022
- Although the CCI improved at the end of 2022, consumer confidence remains negative at –8

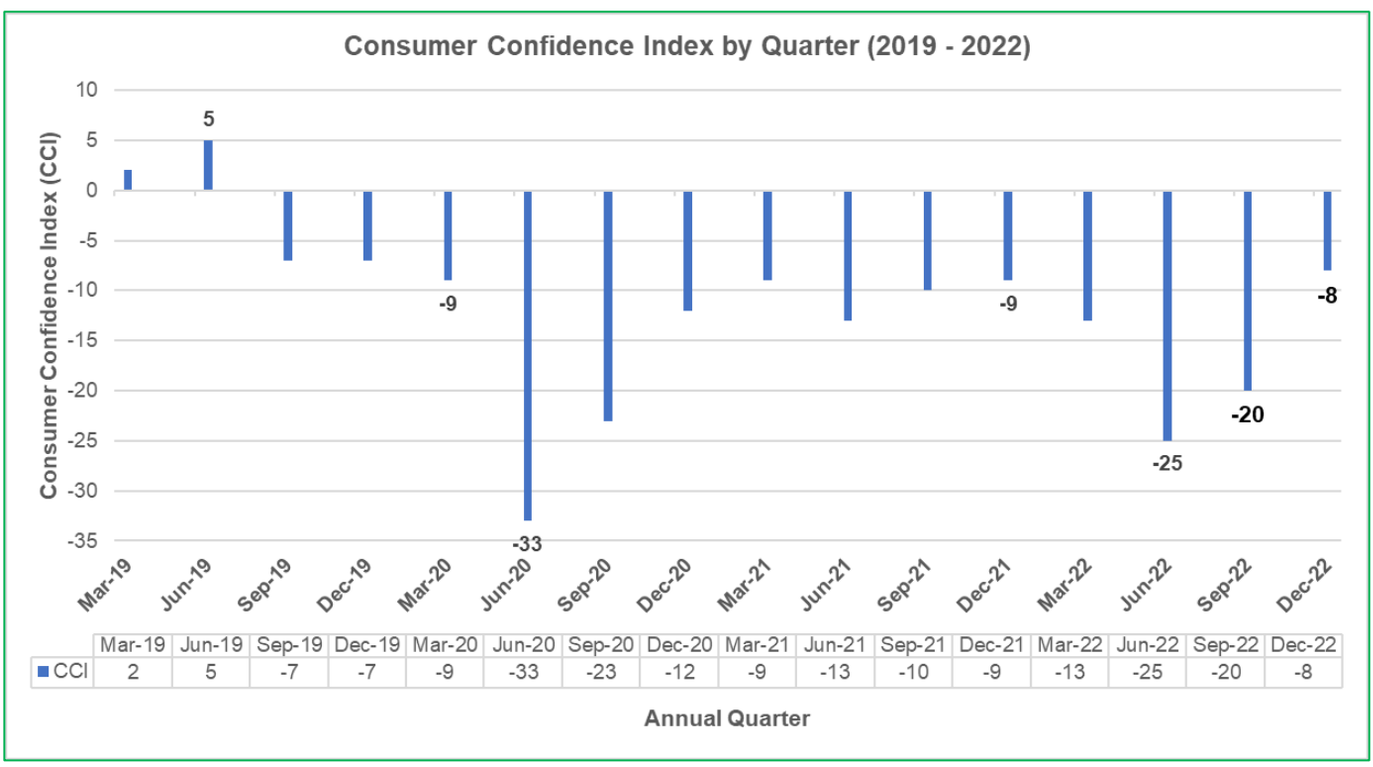


Figure 4: Consumer Confidence Index (CCI) by quarter (2019 – 2022)
Source: Bureau of Economic Research, Stellenbosch University

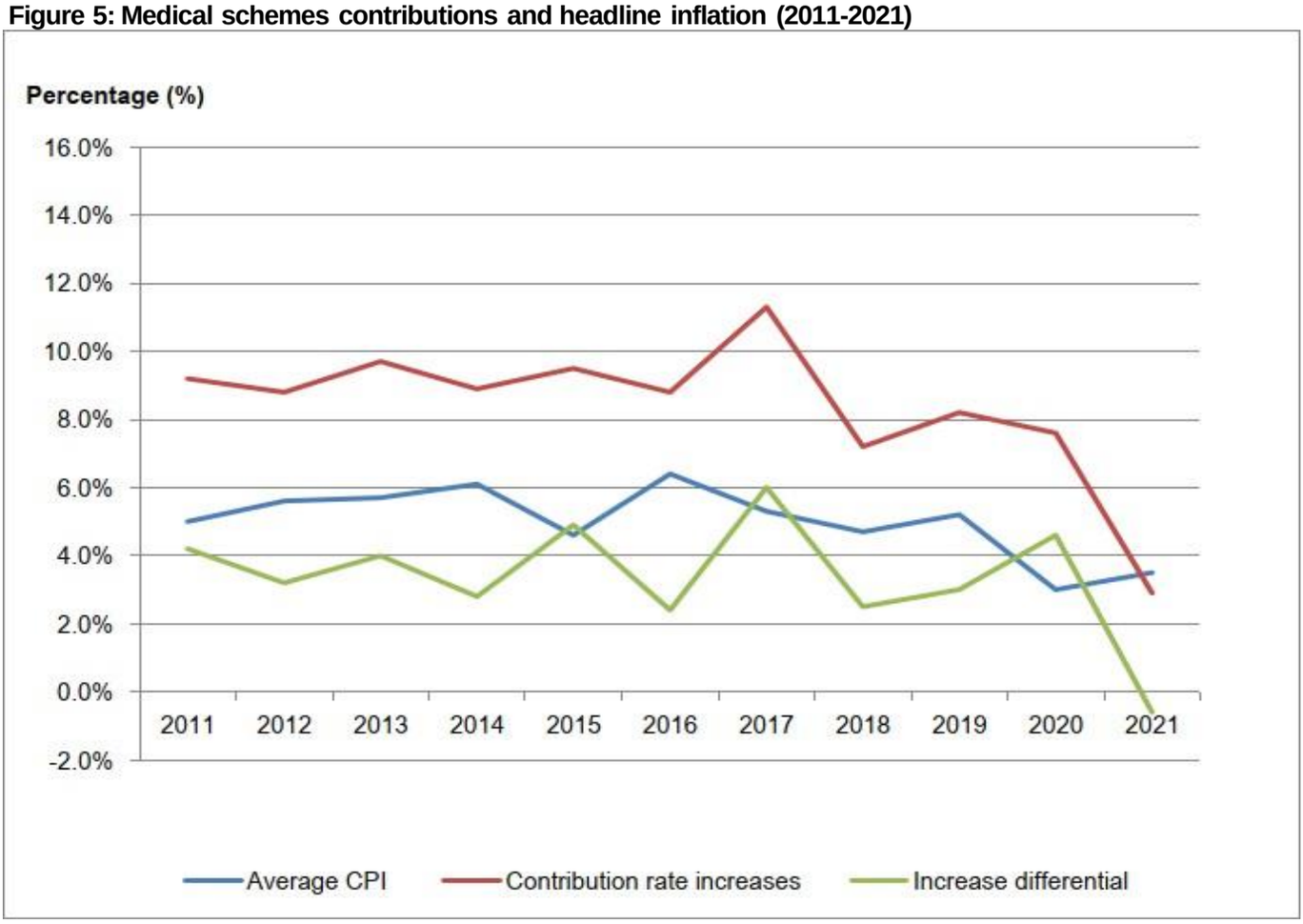
The trend in the CCI has implications for medical schemes' ability to attract new members and to retain members who need catastrophic cover on comprehensive options. This is because people will hold off on making expensive purchases due to economic uncertainty. The impact of economic uncertainty on consumer sentiment will have an impact on household expenditure shares, as they reprioritize consumption. Most importantly, this may put significant pressure on the cross-subsidization business model of schemes. It is imperative that regulatory responsiveness provides opportunities to secure guaranteed cover for relatively sicker and older beneficiaries.

Describing the CMS task environment

Medical scheme contribution increase rate relative to headline inflation

The graph below (figure 5) provides an illustration of trends of the contribution increase rate as reported in the CMS 2020/21 Annual Report, relative to CPI.

Figure 5: Medical schemes contributions and headline inflation (2011-2021)



It is evident from figure 5 above, that medical scheme contribution increases rates have consistently surpassed the CPI, except in 2021. As indicated in the CMS 2020/2021 Annual report, the 2021 benefit year was the first time in over a decade that the industry implemented contributions increase below CPI. This was mainly a collaborative effort between the CMS and the industry aimed at providing financial relief to members grappling with the adverse economic climate induced by the COVID-19 pandemic.

The economic impact of COVID-19 has had a negative impact on CPI and the health care component of the general price index. COVID-19 had an impact on supply chain networks on a global level though.

The impacts of the Russia-Ukraine war have accelerated inflation this year, particularly through its impact on fuel and food prices. However, the same pass-through is not yet evident in health & insurance prices but, is likely to be reflected in early 2023 after providers and administrators negotiate for inflation-adjusted contracts. If the effects are unchecked by responsive interventions, to accommodate for this lagged inflationary adjustment, medical schemes may price this into their reserves loading for 2023 which will likely be reflected in contribution increases for 2023. In addition, if beneficiaries are under pressure as highlighted in the previous section, they are likely to aggressively downgrade to less comprehensive options regardless of their need for catastrophic cover, which will further put pressure on the business model of medical schemes.

Regulatory Responsiveness to External Threats

Outcome statement 1 requires the management of high costs and ensuring quality through responsive interventions. Such as enabling medical scheme contracting for managed care arrangements that support reimbursement models that incentive cost-effective long-term benefits for medical scheme beneficiaries.

This can be achieved through a multilateral negotiation forum as per the Health Market Inquiry (HMI)

final recommendation. This forum ought to be spear headed by the National Department of Health (NDoH), with the participation of the Council for Medical Schemes (CMS). This type of strategic project can mitigate against the prospective need for medical schemes to price-in cushioning from:

- deferred utilization on the onset of COVID19 disaster management regulations, and
- exported expensive health technology created by price shocks caused by the invasion of Ukraine by Russia.

The statement for performance outcome 2 encourages the attainment of affordable healthcare through enabling effective risk pooling. To this end, a special project on the standardization and simplification of benefit options had been incorporated into the CMS strategic five-year plan. The standardization project will add resilience to creating sustainable cover through:

- The standardisation and simplification of benefit options will make beneficiaries more price sensitive as information on benefits will be more accessible and understandable, thus
- making quality and affordability transparent quality features and just mere confusing choice, and also medical schemes below 6,000 members become more viable prospects, especially if they provide perceivable value for those who seek guaranteed cover (continued similar coverage year in and year out) from catastrophic risk.
- This way contribution increases will have to be matched with benefit enrichment, and small medical schemes covering vulnerable risk groups will become more competitive alternatives as beneficiaries are more able to distinguish cherry-picking from quality in the price signalling by medical schemes.

1.2 Internal Environment Analysis

Table 2: SWOT analysis

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
• Unique expertise, • Hybrid working model • Experienced, skilled personnel, Sole mandate • Track record of success in legal challenges, • Unqualified audits • >80% overall performance against set objectives • Single source of information for Industry performance • Functional Governance Body • CMS Branding and Image • Revamped CMS website • Partnerships and collaboration with other regulators and industry bodies through MoU's • MoU's with institutions of higher learning i.e., Stellenbosch University, Sefako Makgatho, Wits • Join Learning Network partnering with NDoH, NT and the World Bank • Published research in	• Insufficient resources for current operations • Sustainable funding model challenges • Lack of a cohesive communication strategy • Capacity constraints in communication/ No Spokesperson • Unfilled key posts and High Staff Turnover • Ageing ICT infrastructure • Inability to comprehensively respond to energy, network and other ICT challenges • Succession Planning and Continuity, • Reactive Regulatory than proactive approach • Lack of a comprehensive Stakeholder Management Strategy o NDoH o National Treasury	• Partnership with other regulators • Support for the NDOH in the implementation of the NHI • Fast-tracking the development and implementation of new Regulations • Prioritization of the Medical Schemes Amendment Bill processing • Alternative Funding Model for the CMS	• FSRA and COFI Bill, • Attack by conglomerates • Increased Litigation • Prolonged SIU and Section 59 investigations • Cybersecurity and Act • POPIA Act • Undesirable Business Practices • Unregistered product doing business of the medical scheme • Increasing and shifting burden of disease and its impact on scheme risk profiles • Performance Incentive Moratorium, • Potential of FWA • Scheme reserves and surplus generated during the pandemic

peer reviewed Journals	○ Regulated entities and others • Lack of succession planning and retention strategy, • Delayed appeals process		

Table 2 above articulates the key internal 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 the Council and all the internal units at the CMS, and the interventions to these have been captured in our operational plans. This analysis has also been used for the identification of new and emerging risks that have the potential of impeding the CMS efforts at achieving its goals and objectives. The Mushrooming of unregistered healthcare products that are doing the business of a "medical scheme" continue to threaten medical schemes membership and undermine the regulatory environment. The CMS is currently finally finalizing an LCBO framework and guidelines which will seek to create an enabling environment for low-income earners, which will be subject to approval by the Minister of Health. This framework will also consider other processes such as the PMB Primary Health Care package (PHC) that has recently been costed and the similar primary health care package that has been developed by NDoH.

The 2020 period saw gains in the medical schemes sector, where nearly all medical schemes generated a surplus. This was because of the low utilization of services and some of the elective procedures deferred due to the COVID-19 pandemic that was prioritised over other conditions. There is an opportunity that some of these monetary gains by schemes can potentially be abused or misused or could be rechanneled back to members through benefit design and product development.

Sisonke Health Medical scheme, being a restricted medical scheme for the employees of Sibanye-Still Waters, together with Lonmin Medical scheme, also a restricted medical scheme for employees of Lonmin Plc, applied for amalgamation in 2021. The application complied with the provision of Section 63, however, Lonmin Medical Scheme (MS) failed to achieve the requisite voting results to allow for the transaction to be confirmed in terms of Section 63(6). Lonmin MS has a ratification clause in its rules, wherein such a situation, the Registrar may approve such lower votes upon good cause shown. The merger could not proceed as there was legal prohibition since Lonmin Plc was acquired by Sibanye-Still water in 2019 and had been defunct. Although the Competition Commission approved this acquisition and also based the approval of the proposed merger of the two schemes hereon. The merger cannot be completed as Lonmin Plc is defunct, and the eligibility on Lonmin Medical Scheme is dependent on one being employed by Lonmin Plc. Furthermore, the continued operation of the Lonmin Medical Scheme is not supported considering the non-existent of Lonmin Plc, and Sibanye-Still Waters currently operates two restricted medical schemes, while it is a single employer.

The CMS is actively seeking ways to determine if Lonmin MS can continue to provide service even though it does not have an employer, and whether it is legally permissible for the Registrar to ratify the lower votes achieved, in order for the amalgamation to be concluded. These matters under still under consideration by the CMS.

Notwithstanding a high turnover rate from the previous financial year, the work environment remains stable and productive to achieve. The placement of employees in the new structure resulting from the business process mapping exercise was successfully completed during the second quarter of 2022/23 financial year.

Continuous consultative and information sharing meetings between management and the recognised

labour brought significant improvements in employer/employee relations in the organisation and has therefore, reduced the number of CCMA referrals and labour costs.

The focus of the Human Resources sub-division will in 2023/24 to address identified challenges will include:

- Employee retention: Review of the employment value proposition to reduce high staff turnover rate and retain critical talent
- Learning and development: Increase training spending to optimally utilise employees' capabilities
  to ensure that the organisations have potential successors
- Performance management: Identify performance improvement areas of employees to ensure that performance standards are met.
- Benefits and rewards: Benchmark benefits and remuneration to attract and retain employees

Recruitment of suitably qualified persons remain a critical function of the human resources sub-division to ensure that CMS remain a more effective and efficient organisation. Filling of newly created posts will be prioritised based on the organisational needs and availability of the budget.

Information Technology

Information and technology are strategic enablers to the CMS business and the ICT & IM sub-programme is expected to:

- Provide information and technology enablers which support strategic business processes and projects in support of the National Health Insurance (NHI)
- Strengthen the organisation's ability to counter cyber-attacks and improve information security
- Establish a robust ICT Disaster Recovery & Business Continuity solution, which will allow for seamless failover of critical systems in case of a disaster.

The ICT & IM sub-programme will embark on a process to redesign and integrate its critical business applications to keep up with the technological landscape, ensure effective business information flow and digitalisation of business processes to ensure that the CMS is an effective and efficient organisation.

It has increasingly become vital to secure and protect CMS information assets in compliance with the POPI Act and more so in the era of hybrid/remote work which necessitates the ICT & IM sub-programme to improve information and cyber security capabilities.

With a huge demand to access CMS systems anywhere and anytime as well as highly digitalised business processes, it is critical that the ICT & IM sub-programme embark on a robust business continuity programme to ensure reliable network connectivity, high availability of systems and effective data backup solution to avoid business disruptions.

Financial Management

The slow economic growth, difficult fiscal environment together with the increased unemployment rate has impacted on the CMS' ability to raise sufficient revenue cover and its operational requirements. Even though the financial position of the CMS continues to improve year after year, there are strategic projects that are not sufficiently funded for. This, therefore, negatively impacts on CMS' achievement of optimal performance. The CMS continues to manage its operations and continues to deliver on its mandate with the use of cost containment strategies which is not sustainable in the long-term, hence the organisation is focusing on updating its funding model for long-term sustainability. The CMS continues to improve its internal controls on compliance, financial reporting, and cost management in line with the applicable statutory requirement, more specifically the Public Finance Management Act (PFMA), No 1 of 1999. The CMS has been receiving unqualified audit opinion over the past years, and it is targeting to move to a clean audit over the next Medium-Term Expenditure Framework (MTEF). The areas of improvement relate mainly to the controls over Supply Chain Management (SCM) processes that the CMS is currently working on improving.

PART C:
MEASURING OUR PERFORMANCE

1. 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 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 R211 million sourced largely through medical aid schemes members' levies.

Programmes and Sub-Programmes

1. Programme 1: (Administration)

1.1 Sub-Programme 1.1 (CEO and Registrar)

Purpose (CEO and Registrar)

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

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.

1.1.1 Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
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 the Review and Development of a Strategic Plan and Annual Performance Plan is done for Council's consideration by the 31st January each year	New indicator	New indicator	New indicator	1	1	1	1
Output Indicator 1.2	Ensure that the overall performance of the entity is 80% of the predetermined objectives	New indicator	90.83%	83.33%	80%	80%	80%	80%
Output Indicator 1.3	Ensure that an Annual Performance Information report produced is reliable, accurate and complete by the 31st July each year in line with the statutory requirements	1	1	1	1	1	1	1

1.1.2 Quarterly targets for 2023/24 (Office of the CEO)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
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 the Review and Development of a Strategic Plan and Annual Performance Plan is done for Council's Consideration by the 31st January each year	Annually	1	n/a	n/a	n/a	1
Output Indicator 1.2	Ensure that the overall performance of the entity is 80% of the predetermined objectives	Quarterly	80%	80%	80%	80%	80%

Output Indicator 1.3	Ensure that an Annual Performance Information report produced is reliable, accurate and complete by the 31st July each year in line with the statutory requirements	Annually	1	n/a	1	n/a	n/a

1.1.3 Explanation of Performance over the Medium-Term Period (CEO and Registrar)

A strategic risk assessment and risk rating workshop is planned for the financial year jointly between Council, the Audit and Risk Committee, and the CMS management. The governance structures will continue to exercise oversight over the organisation's strategic risks. The CMS submitted its Annual Performance Plan for the 2023/24 financial year on 31 January 2023. The CMS aims to continue on the same trajectory of achieving an overall performance of above 80% against predetermined objectives.

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

Expenditure (1.1)				
Office of the CEO and Registrar	**2022/2023**	**2023/2024**	**2024/2025**	**2025/2026**
Compensation of employees	**5 328 714**	**6 021 099**	**6 271 166**	**6 556 946**
Salaries and wages	5 328 714	6 021 099	6 271 166	6 556 946
Goods and services	**4 291 211**	**4 219 043**	**3 489 320**	**3 586 139**
Communication	2 085	2 176	2 273	2 374
Consultants	2 069 001	2 000 000	1 246 715	1 246 715
Legal fees	1 924 275	1 924 275	1 924 275	2 010 482
Other unclassified expenditure	10 422	10 882	11 366	11 876
Staff cost note	2 296	-	-	-
Venue and facilities	89 062	79 062	93 025	103 025
Travel and subsistence	194 070	202 648	211 666	211 666
TOTAL	**9 619 925**	**10 240 142**	**9 760 486**	**10 143 085**

The budget allocated will contribute to the achievement of the Key Performance Indicators of the Sub-Programme by ensuring that the CMS continue on the same trajectory of achieving an organisational overall performance of above 80% against predetermined objectives.

The allocated budget for the Sub-Programme is resourced to advance engagements key stakeholders. The CMS will continue to have strategic engagements with local regional and international regulators and stakeholders using the allocated goods and services budget.

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

Purpose (Office of the CFO)

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

1.2.1 Sub-Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Outcome 4: To become a more effective and efficient organisation								
Output 3: Ensure that reported financial information is useful and reliable, and in accordance with the Expenditure Management and Reporting Framework.								
Output Indicator 3.1	An unqualified opinion issued by the Auditor-General South Africa on the Annual Financial Statements by the 31st July each year	1	1	1	1	1	1	1
Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities.								
Output Indicator 4.1	Review, develop and implement a funding model that considers the long-term strategic outcomes of the CMS by the end of each year	New Indicator	New Indicator	New Indicator	1	1	1	1
Output Indicator 4.2	Produce a budget that is approved by Council by the 31st January each year	New Indicator	1	1	1	1	1	1

1.2.2 Quarterly targets for 2023/24 (Office of the CFO)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 3: Ensure that reported financial information is useful and reliable, and in accordance with the Expenditure Management and Reporting Framework.							
Output Indicator 3.1	An unqualified opinion issued by the Auditor-General South Africa on the Annual Financial Statements by the 31st July each year	Annually	1	n/a	1	n/a	n/a
Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities.							
Output Indicator 4.1	Review, develop and implement a funding model that considers the long-term strategic outcomes of the CMS by the end of each year	Annually	1	n/a	n/a	n/a	1
Output Indicator 4.2	Produce a budget that is approved by Council by the 31st January each year	Annually	1	n/a	n/a	n/a	1

1.2.3 Explanation of Performance over the Medium-Term Period (Office of the CFO)

The financial position of CMS continues to improve each year. This is mainly attributed to the cost management strategies employed by the CMS. The management of cost with no change in revenue is however not sustainable and hence the CMS is focusing on updating its funding model for long-term sustainability.

The CMS continues to improve its internal controls on compliance, financial reporting, and cost management in line with the applicable statutory requirements, more specifically the Public Finance Management Act (PFMA), No1 of 1999. For the 2023/24 financial year, a new indicator was planned for implementation that relates to the B-BBEE compliance where the CMS is aiming to achieve a compliant score. This achievement is being phased in over the MTEF period.

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

Expenditure (1.2)				
Office of the CFO	**2022/2023**	**2023/2024**	**2024/2025**	**2025/2026**
Compensation of employees	**12 951 569**	**14 730 168**	**15 354 588**	**16 050 874**
Salaries and wages	8 874 452	10 468 530	10 903 307	11 400 175
Social contributions	4 077 118	4 261 639	4 451 282	4 650 699
Goods and services	**2 685 896**	**1 403 647**	**1 452 759**	**1 515 971**
Communication	6 430	6 714	7 013	7 327
Consultants	1 402 211	300 000	300 000	313 440
Bank charges	115 070	120 156	125 503	131 126
Non life insurance	632 451	800 000	835 600	873 035
Other unclassified expenditure	307 505	87 516	91 410	95 505
Printing and publication	147 989	10 000	10 445	10 913
Staff cost note	2 296	-	-	-
Venue and facilities	39 261	39 261	41 008	42 845
Travel and subsistence	32 682	40 000	41 780	41 780
TOTAL	**15 637 465**	**16 133 815**	**16 807 348**	**17 566 845**

The budget allocated will assist the Sub-Programme to ensure that the controls that the CMS has put in place for effective and efficient management of its finances are well established and automated, as well as to ensure that the development and implementation of a funding model considers the long-term strategic outcomes of the CMS. In addition, the budget allocated will ensure that there is effective financial management on strategic priorities. The budget is mainly driven by salaries, however, all administrative functions are insourced.

1.3 Sub-Programme 1.3: (Information and Communication Technology (ICT) and Information Management (IM))

Purpose (ICT & IM)

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.

1.3.1 Sub-Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Outcome 4: To become a more effective and efficient organisation								
Output 5: An established ICT infrastructure that ensures information is available, accessible and protected.								
Output Indicator 5.1	Percentage of network uptime	99%	99%	98%	99%	95%	95%	95%
Output Indicator 5.2	Percentage of IT security incidents (breaches)	5%	0.75%	2%	5%	5%	5%	5%
Output Indicator 5.3	Number of successful IT Disaster Recovery (DR) failover tests	New indicator	2	2	2	2	2	2
Output 6: Provide software applications that serve both internal as well as external stakeholders and which improves business operations and performance.								
Output Indicator 6.1	Percentage of business-critical application systems uptime (server uptime)	99%	99%	99%	95%	95%	95%	95%

1.3.2 Quarterly targets for 2023/24 (ICT & IM)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 5: An established ICT Infrastructure that ensures information is available, accessible and protected.							
Output Indicator 5.1	Percentage of network uptime	Quarterly	95%	95%	95%	95%	95%
Output Indicator 5.2	Percentage of IT security incidents (breaches)	Quarterly	5%	5%	5%	5%	5%
Output Indicator 5.3	Number of successful IT Disaster Recovery (DR) failover tests	Quarterly	2	n/a	1	n/a	1
Output 6: Provide software applications that serve both internal as well as external stakeholders and which improves business operations and performance.							
Output Indicator 6.1	Percentage of business-critical application systems uptime (server uptime)	Quarterly	95%	95%	95%	95%	95%

1.3.3 Explanation of Performance over the Medium-Term Period (ICT and IM

The Information Communication Technology and Information Management (ICT&IM) programme will continue to provide information and technology enablers to support the CMS in achieving its business objectives. A hybrid cloud solution will be implemented to ensure high availability of systems, online data backup and business continuity. Network availability and cyber security capabilities will be improved to be able to support secured hybrid/remote work arrangements.

1.3.4 Reconciling performance targets with the budget and MTEF (ICT and IM)

Expenditure (1.3)				
Information Systems and Knowledge Management	**2022/2023**	**2023/2024**	**2024/2025**	**2025/2026**
Compensation of employees	**13 131 754**	**15 541 474**	**16 186 939**	**16 924 585**
Salaries and wages	13 131 754	15 541 474	16 186 939	16 924 585
Goods and services	**12 625 270**	**17 061 356**	**15 398 550**	**14 968 704**
Communication	3 126 900	3 165 109	3 410 406	3 563 193
Computer services	4 988 423	9 274 658	5 940 708	5 961 201
Consultants	651 809	650 000	1 650 000	1 101 536
Lease payments	483 194	504 551	527 004	550 613
Other unclassified expenditure	1 965 397	2 052 267	2 343 593	2 198 792
Printing and publication	8 396	9 755	10 189	10 645
Property payments	573 265	598 603	625 241	653 252
Staff cost note	2 296	-	-	-
Venue and facilities	22 170	22 170	23 156	24 194
Repairs and maintenance	757 769	764 242	826 473	863 499
Travel and subsistence	45 653	20 000	41 780	41 780
TOTAL	**25 757 024**	**32 602 830**	**31 585 489**	**31 893 290**

The ICT & IM sub-programme has 15 staff members accounted for in the personnel/salaries budget item. Software license subscriptions contributes to majority of the goods and services budget. The cost for communication (telephone and internet connectivity) has increased as a result of remote work while some significant budget amount is dedicated to knowledge management, security and maintenance/upgrade of current ICT infrastructure. Further, there is a significant increase in the budget for Computer Services due to planned systems upgrade. The ICT & IM sub-programme is not adequately funded as there are number of urgent ICT initiatives which need to be attended to. There is therefore a need to source and dedicate more financial resources to address urgent ICT projects so as to capacitate the sub-program to be able to support the CMS business operations. These projects include ICT infrastructure upgrade, cloud implementation, systems upgrade (replacement) and cybersecurity and information security capability improvements.

1.4 Sub-Programme 1.4: (Corporate Services)

Purpose (Corporate Services)

The purpose of the Sub-programme is to:

- provide legal advice and representation to the CMS and business units to ensure the integrity of regulatory decisions;
- provide high-quality service to internal and external customers by assessing their needs and proactively addressing those needs through developing, delivering, and continuously improving human resource programmes that promote and support the Council's vision; and
- create and promote awareness and understanding of the Medical Schemes Act (1998) and the Industry among all regulated and non-regulated entities through communication, marketing, and stakeholder engagement.

1.4.1 Sub-Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Outcome 4: To become a more effective and efficient organisation								
Output 7: Legal advisory and support services for effective regulation of the industry and operations of the office.								
Output Indicator 7.1	Percentage of written and verbal legal opinions provided to internal stakeholders attended to within 14 days	80%	85%	95%	90%	95%	95%	95%
Output 8: Defending decisions of the Council and the Registrar								
Output Indicator 8.1	Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days	100%	100%	100%	100%	100%	100%	100%
Output 9: Build competencies and retain skilled employees.								
Output Indicator 9.1	Minimise staff turnover rate to less than 15% per annum	8.33%	18.3%	9.5%	<15%	<15%	<15%	<15%
Output Indicator 9.2	Average number of days to fill a vacancy (turnaround time of 90 working days for each vacancy that exists during the year), excluding the position of CEO and Executives	18 vacancies during the period were filled within 120 days,	70.8 days	492 days	120 days	90 Days	90 Days	90 Days

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 the 31st May each year (excluding employees out of office on extended absence)	100%	100%	100%	95%	95%	95%	95%
Output Indicator 10.2	Percentage of employees' performance assessment concluded, bi-annually (excluding employees out of office on extended absence)	100%	99.10%	99.72%	95%	95%	95%	95%
Output 11: Ensure maximisation in the coordination of various planning efforts that are undertaken in relation to the CMS facilities								
Output Indicator 11.1	Develop an Office Capacity and Utilisation Report by the 30th June each year	New Indicator	New Indicator	New Indicator	1	1	1	1
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 12: To create awareness and collaboration with stakeholders while enhancing the visibility and protecting the reputation of the CMS.								
Output Indicator 12.1	Number of stakeholder awareness activities conducted	21	55	67	30	35	40	45
Output Indicator 12.2	Percentage of stakeholder awareness of the CMS resulting from a survey	50%	50%	57%	60%	65%	70%	75%
Output 13: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year.								
Output Indicator 13.1	Submission of the CMS Annual Report by the 31st August to the Executive Authority	1	1	1	1	1	1	1

1.4.2 Quarterly targets for 2023/24 (Corporate Services)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 7: Legal advisory and support services for effective regulation of the industry and operations of the office.							
Output Indicator 7.1	Percentage of written and verbal legal opinions provided to internal stakeholders attended to within 14 days	Quarterly	90%	90%	90%	90%	90%
Output 8: Defending decision of the Council and the Registrar							
Output Indicator 8.1	Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days	Quarterly	100%	100%	100%	100%	100%
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	Average number of days to fill a vacancy (turnaround time of 90 working days for each vacancy that exists during the year), excluding the position of CEO and Executives	Quarterly	90 days	90 days	90 days	90 days	90 days
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 the 31st May each year (excluding employees out of office on extended absence)	Annually	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 11: Ensure maximisation in the coordination of various planning efforts that are undertaken in relation to the CMS facilities							
Output Indicator 11.1	Develop an Office Capacity and Utilisation Report by the 30th June each year	Annually	1	1	n/a	n/a	n/a
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations							
Output 12: To create awareness and collaboration with stakeholders while enhancing the visibility and protecting the reputation of the CMS							
Output Indicator 12.1	Number of stakeholder awareness activities conducted	Quarterly	35	8	8	9	10
Output Indicator 12.2	Percentage of stakeholder awareness of the CMS resulting from a survey	Annually	65%	n/a	n/a	n/a	65%
Output 13: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year.							
Output Indicator 13.1	Submission of the CMS Annual Report by the 31st August to the Executive Authority	Annually	1	n/a	1	n/a	n/a

1.4.3 Explanation of Performance over the Medium-Term Period (Corporate Services)

Corporate Services provides legal services and support and ensures legislative compliance. It conducts legal research about private health to inform the development of policy, regulations, and standards. It also aims to continue in the same trajectory of outperforming and exceeding its set targets. It is implementing applicable legislation to enable CMS to maintain its going regulatory status. Effective regulatory strategies that will result in achieving the targets. Strengthen regulatory mandate with industry stakeholders to address concerns with the intended reforms. Develop and enhance regulations to ensure that the industry is regulated effectively capabilities for ensuring good corporate governance. Clarify the position on LCBO and the disruption to the industry by illegal products. Ensure the issuing of licenses in alignment with the Amendment Bill.

Creating capacity for regulatory standards to ensure effective and efficient accreditation, subject to compliance with the accreditation requirements as contemplated in the MS Act in accordance with the NHI. The sub-unit is further engaged with the National Treasury and the FSCA in challenges and plays a role in the alignment of the FSRA and CoFI Bill. The CMS ability to highlight and legally challenge uncompetitive practices by service providers and associations has played a vital role in shaping the behaviour of service providers.

Corporate Services will continue to review the CMS policies in order to create a more conducive working environment for staff members to deliver on the CMS strategic outcomes. Corporate Services will continue to implement Council approved policies as and when changes are made. A new performance management template that is aligned to the balanced scorecard system and SMART criteria will be monitored and be reported against. The remuneration philosophy and employee value proposition policy continue to be implemented and reported against.

During the financial year, the CMS will be in the last year of its lease agreement for its offices and will actively consider its options for approval by Council as the Accounting Authority.

The Corporate Services sub-unit will continue to strengthen collaboration with co-regulators and professional bodies efforts that result in increased stakeholder awareness, education and training activities.

1.4.4 Reconciling performance targets with the budget and MTEF (Corporate Services)

Expenditure (1.4)				
Corporate Services	**2022/2023**	**2023/2024**	**2024/2025**	**2025/2026**
Compensation of employees	**16 730 077**	**18 226 760**	**18 983 748**	**19 848 845**
Salaries and wages	16 730 077	18 226 760	18 983 748	19 848 845
Goods and services	**34 026 719**	**33 511 698**	**32 036 605**	**34 815 561**
Agency and support / outsourced services	13 470	14 065	14 691	15 349
Communication	1 530	50 000	52 225	54 565
Consultants	1 217 586	1 040 000	1 050 000	1 050 000
Lease payments	14 836 554	14 623 068	12 801 537	14 254 847
Advertising and marketing	911 775	700 000	731 150	763 906
Legal fees	5 985 481	5 500 000	5 222 500	5 589 000
Other unclassified expenditure	483 186	776 096	886 183	912 547
Printing and publication	486 588	400 000	417 800	436 517
Property payments	4 901 727	5 160 210	5 286 754	6 128 764
Staff cost note	3 092 963	3 142 477	3 337 718	3 356 051
Venue and facilities	145 283	149 383	208 256	213 028
Repairs and maintenance	273 435	281 992	294 541	307 736
Training and staff development	1 563 630	1 500 000	1 566 750	1 566 750
Travel and subsistence	113 511	174 407	166 501	166 501
TOTAL	**50 756 797**	**51 738 459**	**51 020 352**	**54 664 406**

The sub-programme managed to significantly reduce the overall legal expenditure defending the decisions of the Council and the Registrar in litigation to ensure that there is support services for effective regulation of the industry and operations of the CMS. The budget allocated will be used to ensure that the sub-programme build organisational competencies and retain skilled employees by ensuring that staff turnover rate is capped at less than 15% per annum, and that the turnaround time to fill available vacancies (excluding the position of CEO) is less than 120 days. In addition, the budget will be used to maximise performance of the CMS to improve organisational efficiency and maintain high-performance culture by improving the CMS B-BBEE targets.

The budget will also be used to create awareness and collaboration with stakeholders while enhancing the visibility and protecting the reputation of the CMS by engaging in communication activities such as Coordination of the CMS Industry Report Launch, Media liaison (including press briefings, press releases, interviews and media enquiries), editing of publications (newsletter, information booklets, circulars, etc.), communication campaigns, advertising and industry roadshows.

1.5 Sub-programme 1.5: (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 Council Secretariat also provides support to the independent Appeal's Board and ensures that all the rulings are communicated to key stakeholders. The program seeks to achieve the above objective through seamless board administration, secretariat service and support.

1.5.1 Sub-Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Outcome 4: To become a more effective and efficient organisation								
Output 14: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority								
Output Indicator 14.1	Complete meeting packs to be circulated at least 7 days before the meeting	New Indicator	New Indicator	New Indicator	New Indicator	80%	85%	90%
Output Indicator 14.2	Minutes of Council and Committee meetings to be included in the meeting pack of the subsequent meeting	New Indicator	New Indicator	New Indicator	New Indicator	80%	85%	90%
Output Indicator 14.3	Percentage of Communicated Council resolutions within 3 days of the meeting to the affected internal stakeholders	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%
Output Indicator 14.4	Number of training sessions held for Council and/or Committee/s	New Indicator	New Indicator	New Indicator	1	1	1	1
Output Indicator 14.5	Percentage of signed annual declaration of financial interest by Council Members (excluding Council Members out of office on extended absence)	New Indicator	New Indicator	New Indicator	100%	90%	90%	90%
Output 15: Support Dispute Resolution Forums in furtherance of Council and MSA objectives								
Output Indicator 15.1	Support the publication of rulings of the Appeals Committee and the Appeal Board within 14 days of receipt from the Presiding Officers.	New Indicator	100%	75%	100%	75%	75%	75%

1.5.2 Quarterly targets for 2023/24 (Council Secretariat)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 14: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority							
Output Indicator 14.1	Complete meeting packs to be circulated at least 7 days before the meeting	Quarterly	80%	80%	80%	80%	80%
Output Indicator 14.2	Minutes of Council and Committee meetings to be included in the meeting pack of the subsequent meeting	Quarterly	80%	80%	80%	80%	80%
Output Indicator 14.3	Percentage of Communicated Council resolutions within 3 days of the meeting to the affected internal stakeholders	Quarterly	100%	100%	100%	100%	100%

Output Indicator 14.4	Number of training sessions held for Council and/or Committee/s	Annually	1	n/a	n/a	n/a	1
Output Indicator 14.5	Percentage of signed annual declaration of financial interest by Council Members (excluding Council Members out of office on extended absence)	Annually	90%	n/a	n/a	n/a	90%
Output 15: Support Dispute Resolution Forums in furtherance of Council and MSA objectives							
Output Indicator 15.1	Support the publication of rulings of the Appeals Committee and the Appeal Board within 14 days of receipt from the Presiding Officers.	Quarterly	100%	100%	100%	100%	100%

1.5.3 Explanation of Performance over the Medium-Term Period (Council Secretariat)

The Council Secretariat will continue to provide critical corporate governance support services to the Council as Accounting Authority and its six governance committees, and any necessary support that may be required by the Office of the CEO. Key focus will be at ensuring the effective functioning of the committees and ensuring that they deliver on their mandate. This should assist in terms making Full Council work easier by fostering a culture where Council has full confidence in its committees to make quality recommendations to it. The dispute resolutions forums will receive special focus through the provision of a resource to ensure that matters are processed timeously.

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

Expenditure (1.5)				
Council Secretariat	**2022/2023**	**2023/2024**	**2024/2025**	**2024/2025**
Compensation of employees	**1 946 719**	**2 913 988**	**3 035 195**	**3 173 510**
Salaries and wages	1 946 719	2 913 988	3 035 195	3 173 510
Goods and services	**7 726 397**	**6 801 024**	**7 146 147**	**7 176 327**
Agency and support / outsourced services	72 627	72 627	75 859	79 258
Communication	46 245	48 201	50 240	52 491
Consultants	1 155 418	1 181 036	1 263 942	1 263 944
Board costs	5 715 216	4 800 000	5 003 040	5 003 040
Other unclassified expenditure	89 415	93 197	97 139	101 113
Venue and facilities	132 831	128 450	144 306	154 306
Training and staff development	260 575	212 695	235 602	246 157
Travel and subsistence	254 070	264 817	276 019	276 019
TOTAL	**9 673 116**	**9 715 012**	**10 181 342**	**10 349 837**

The budget allocated will be used to ensure the Council as a board executes its mandate and delivers on its objections. Training and development as well as the dispute resolution forums will receive sharp focus in order to ensure that Council and the Appeal Board are in fact resolving appeals and that members are adequately empowered to execute their duties.

1.6 Programme 2: Strategy, Performance and Risk

Purpose (Strategy, Performance and Risk)

The purpose of this Programme is:

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

1.6.1 Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Outcome 4: To become a more effective and efficient organisation								
Output 16: Ensure that strategic projects are scoped, and project plans are in place								
Output Indicator 16.1	Development and Maintain a Strategic Projects Register	New Indicator	New Indicator	New Indicator	1	1	1	1
Output Indicator 16.2	Scope and develop plans for strategic projects	New Indicator	New Indicator	New Indicator	80%	80%	80%	80%
Output 17: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.								
Output Indicator 17.1	Produce Quarterly Performance Information report that is reliable, accurate and complete, at the time of submission to the Executive Authority by the end of the month following the quarter	New Indicator	New Indicator	New Indicator	4	4	4	4

1.6.2 Quarterly targets for 2021/22 (Strategy, Performance and Risk)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 16: Ensure that strategic projects are scoped, and project plans are in place							
Output Indicator 16.1	Development and Maintain a Strategic Projects Register	Annually	1	n/a	n/a	n/a	1
Output Indicator 16.2	Scope and develop plans for strategic projects	Quarterly	80%	80%	80%	80%	80%
Output 17: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.							
Output Indicator 17.1	Produce Quarterly Performance Information report that is reliable, accurate and complete, at the time of submission to the Executive Authority by the end of the month following the quarter	Quarterly	4	1	1	1	1

1.6.3 Explanation of Performance over the Medium-Term Period (Strategy, Performance & Risk)

The programme will be engaging in strategic projects to provide information to the Council through the Office of the Registrar on organisational and health reform matters to achieve the government's objective of an equitable and sustainable healthcare financing system in support of universal access. These will include the co-ordination and the review, formulation, implementation, performance monitoring and evaluation of the Strategic, Annual Performance and Operational Plans, the co-ordination of all efforts aimed at ensuring that the CMS is compliant with all the relevant legislation

The programme, will in consultation with all relevant stakeholders, develop and maintain the CMS Enterprise Risk Management and Compliance Frameworks. Identify and evaluate the risks to the organization's people, property, finances, and image and implement measures to control and mitigate risks in consultation with the Council through the office of the Registrar. In addition, the programme will review and implement the Council's Ethics Policy in developing an ethical leadership culture within the CMS, as well as co-ordinate the CMS Audit function (Internal and External)

1.6.4 Reconciling performance targets with the budget and MTEF (Strategy, Performance & Risk)

Expenditure (2)				
Strategy, Performance and Risk	**2022/2023**	**2023/2024**	**2024/2025**	**2024/2025**
Compensation of employees	**3 004 824**	**-**	**-**	**-**
Salaries and wages	3 004 824	-	-	-
Goods and services	**2 648 578**	**2 735 379**	**2 909 328**	**3 037 236**
Consultants	1 498 578	1 564 815	1 634 449	1 707 686
Audit costs	1 000 000	1 000 000	1 044 500	1 091 294
Other unclassified expenditure	8 000	8 354	8 725	9 116
Printing and publication	-	100 000	114 895	120 042
Staff cost note	2 000	-	-	-
Venue and facilities	90 000	40 000	52 225	54 565
Travel and subsistence	50 000	22 210	54 533	54 533
TOTAL	**5 653 402**	**2 735 379**	**2 909 328**	**3 037 236**

The personnel that will carry out the work in this programme are under the office of the CEO. A decision on whether the full programme is to be moved to the Office of the CEO is still pending. The budget allocated will contribute to the achievement of the Key Performance Indicators of the Programme by ensuring that the CMS institutionalises its Enterprise Risk Management and Project Management Methodologies towards the achievement of its strategic outcomes.

The allocated budget for the Programme will be used to continue the coordination of the audit function of the CMS.

1.6 Programme 3: (Regulation)

Purpose (Regulation)

The purpose of this Programme is:

- Ensure brokers and broker organisations, administrators and managed care organisations are accredited, and administration compliance certificates are issued to self-administered medical schemes and managed care compliance certificates to medical schemes providing their own managed care services to members, in line with the accreditation requirements as set out in the Medical Schemes Act (1998), including whether applicants are fit and proper, have the necessary resources, skills, capacity and infrastructure and are financially sound.
- To serve beneficiaries of medical schemes and the public in general by reviewing and approving changes to contributions paid by members and benefits offered by schemes. The Programme analyses and approves all scheme rules to ensure consistency with the MSA. This ensures that the beneficiaries have access to affordable and appropriate quality health care. By doing this, we help the CMS ensure that the rules of medical schemes are fair to beneficiaries and are consistent with the MSA;
- Serve members of medical schemes and the public in general by taking appropriate action to enforce compliance with the Medical Schemes Act;
- To monitor and regulate the overall financial performance of medical schemes in line with the financial requirements of the MSA, through the analysis of financial information.

1.6.1 Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
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	80%	84.8%	92.6%	80%	80%	80%	80%
Output Indicator 18.2	Percentage of managed care organisation applications analysis completed within three months of receipt of complete information	100%	100%	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	100%	100%	100%	100%	100%	100%	100%
Output 19: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998).								

Output Indicator 19.1	Percentage of interim rule amendments processed within 14 working days of receipt of all information	80%	96.8%	80%	80%	80%	80%	80%
Output Indicator 19.2	Percentage of annual rule amendments processed before the 31st December of each year	90%	100%	90%	90%	90%	90%	90%
Output 20: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 20.1	Number of draft inspection reports issued annually	New Indicator	New Indicator	New Indicator	10	10	10	10
Output 21: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 21.1	Percentage of commissioned inspection finalised within 12 months from the date the appointment letter was signed	New Indicator	New Indicator	New Indicator	60%	60%	60%	60%
Output 22: Ensure enforcement action is undertaken against regulated entities.								
Output Indicator 22.1	Percentage of enforcement actions undertaken during the period	100%	100%	100%	70%	70%	70%	70%
Output 23: Strengthen and monitor governance systems of medical schemes and other regulated entities.								
Output Indicator 23.1	Percentage of governance interventions implemented during the period	100%	100%	100%	70%	70%	70%	70%
Output Indicator 23.2	Number of scheme member meetings attended (including virtual meetings)	40	26	51	44	44	44	44
Output 24: Monitor and regulate the financial soundness of medical schemes.								
Output Indicator 24.1	Percentage of business plan decisions processed in respect of Regulation 29	100%	0%	100%	100%	100%	100%	100%
Output Indicator 24.2	Percentage of Section 35(11) decisions processed in respect of schemes with rapidly reducing Solvency (but whose solvency is still above the statutory minimum required solvency)	n/a	n/a	100%	100%	100%	100%	100%
Output Indicator 24.3	Percentage of auditor approved applications analysed	100%	100%	99%	100%	80%	80%	80%
Output Indicator 24.4	Number of quarterly financial return reports published (excluding quarter four)	3	3	3	3	3	3	3
Output Indicator 24.5	Number of financial sections prepared for the Annual Report	1	1	1	1	1	1	1

1.6.2 Quarterly targets for 2023/24 (Regulation)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
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	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%
Output 19: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998).							
Output Indicator 19.1	Percentage of interim rule amendments processed within 14 working days of receipt of all information	Quarterly	80%	80%	80%	n/a	80%
Output Indicator 19.2	Percentage of annual rule amendments processed before the 31st December of each year	Annually	90%	n/a	n/a	90%	n/a
Output 20: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws							
Output Indicator 20.1	Number of draft inspection reports issued annually	Quarterly	10	n/a	3	3	4
Output 21: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act, 1998 and all other related laws							
Output Indicator 21.1	Percentage of commissioned inspection finalised within 12 months from the date the appointment letter was signed	Quarterly	60%	60%	60%	60%	60%
Output 22: Ensure enforcement action is undertaken against regulated entities.							
Output Indicator 22.1	Percentage of enforcement actions undertaken during the period	Quarterly	70%	70%	70%	70%	70%
Output 23: Strengthen and monitor governance systems of medical schemes and other regulated entities.							
Output Indicator 23.1	Percentage of governance interventions implemented during the period	Quarterly	70%	70%	70%	70%	70%
Output Indicator 23.2	Number of scheme member meetings attended (including virtual meetings)	Quarterly	44	33	11	n/a	n/a

Output 24: Monitor and regulate the financial soundness of medical schemes.							
Output Indicator 24.1	Percentage of business plans decisions processed in respect of Regulation 29	Quarterly	100%	100%	100%	100%	100%
Output Indicator 24.2	Percentage of Section 35(11) decisions processed in respect of schemes with rapidly reducing solvency (but whose solvency is still above the statutory minimum required solvency	Quarterly	100%	100%	100%	100%	100%
Output Indicator 24.3	Percentage of auditor approval applications analysed	Quarterly	80%	80%	80%	80%	80%
Output Indicator 24.4	Number of quarterly financial return reports published (excluding quarter four)	Quarterly	3	n/a	1	1	1
Output Indicator 24.5	Number of financial sections prepared for the Annual Report	Annually	1	n/a	1	n/a	n/a

1.6.3 Explanation of Performance over the Medium-Term Period (Regulation)

The Regulation programme will continue to verify the qualifications of individuals applying to be accredited as brokers. The programme will monitor compliance by accredited entities with conditions imposed and the financial soundness of risk-bearing entities on an annual basis to ensure their financial soundness.

The registration of the rules of medical schemes and, as such, contributes to the objective of the CMS to ensure that schemes are regulated efficiently based on rules that are fair and compliant with the MSA. The programme will ensure that the general operations of medical schemes relating to governance, contribution rates and benefits offered are based on registered scheme rules.

The programme will continue to foster compliance with the MSA and take proportionate actions to promote a culture of compliance with legislation. These will include the institution of inspections, enforcement actions, governance interventions and attending member meetings.

The unit will continue to monitor and regulate the financial soundness of medical schemes by reviewing business plans from medical schemes, processing auditor approval applications and producing financial reports.

1.6.4 Reconciling performance targets with the Budget and MTEF (Regulation)

Expenditure (3)				
Regulation	**2022/2023**	**2023/2024**	**2024/2025**	**2024/2025**
Compensation of employees	**36 595 620**	**40 113 766**	**41 779 762**	**43 683 684**
Salaries and wages	36 595 620	40 113 766	41 779 762	43 683 684
Goods and services	**4 312 599**	**3 314 769**	**4 380 582**	**4 457 858**
Consultants	3 376 598	2 540 000	3 540 000	3 591 792
Other unclassified expenditure	460 026	345 000	355 130	371 040
Printing and publication	15 493	10 000	10 445	10 913
Staff cost note	9 185	-	-	-
Venue and facilities	62 477	61 600	64 341	66 194
Travel and subsistence	388 821	358 169	410 666	417 919
TOTAL	**40 908 219**	**43 428 535**	**46 160 344**	**48 141 541**

The budget allocated to the Programme will be used to ensure that accredited entities and brokers are compliant with the requirements for accreditation in order to provide accredited services and monitor legal compliance throughout the period of accreditation, as well as to ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act. In addition, the budget will assist to inspect regulated entities in terms of routine monitoring of compliance with the Medical Schemes Act, and to inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act. Furthermore, the budget will also be used to monitor and regulate the overall financial performance of medical schemes in line with the financial requirements of the MSA, through the analysis of financial information. This will be done by using the goods and services costs allocated to the Programme.

1.7 Programme 4: (Policy, Research and Monitoring)

Purpose (Policy, Research and Monitoring)

The purpose of the Programme is to serve beneficiaries of medical schemes and members of the public by collecting and analysing data to monitor, evaluate and report on trends in medical schemes, measure risk in medical schemes and develop recommendations to improve regulatory policy and practice. By doing this, the programme helps the CMS to contribute to the development of policy that enhances the protection of the interests of beneficiaries and members of the public. The Unit also undertakes strategic research that would enable the CMS to advise the NDoH on policy initiatives. It also provides a mechanism for the CMS to provide support to the NDoH on key policy reforms such as the NHI.

1.7.1 Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate								
Output 25: Conduct research to inform appropriate national health policy interventions								
Output Indicator 25.1	Number of research projects and support projects published in support of the National Health Policy	12	12	12	17	17	17	17
Output 26: Monitoring trends to improve regulatory policy and practice.								
Output Indicator 26.1	Non-financial report submitted for inclusion in the annual report	1	1	1	1	1	1	1
Outcome 1: To promote the improvement of quality and the reduction of costs in the private healthcare sector								
Output 27: Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements								
Output Indicator 27.1	The number of benefit definition guidelines published	10	10	10	10	5	7	10
Output Indicator 27.2	Develop preventative and primary healthcare package to incorporate into the PMBs	A service based preventative and primary healthcare Package and costing methodology report was submitted to the Executive Authority	Revised and updated PMB befits package costed	Primary health care package in support of the review of the PMBs was developed	Review and update revised PMB benefit package	Review and update revised PMB benefit package	Phased in implementation of the revised benefit package which will consider one of the 10 services identified under PHC which will be a function affordability.	Phased in implementation of the revised benefit package which will consider additional service identified under PHC which will be a function affordability.

1.7.2 Quarterly targets for 2023/24 (Policy, Research and Monitoring)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate							
Output 25: Conduct research to inform appropriate national health policy interventions							
Output Indicator 25.1	Number of research projects and support projects published in support of the National Health Policy	Quarterly	17	1	2	6	8
Output 26: Monitoring trends to improve regulatory policy and practice.							
Output Indicator 26.1	Non-financial report submitted for inclusion in the annual report	Annually	1	n/a	1	n/a	n/a
Outcome 1: To promote the improvement of quality and the reduction of costs in the private healthcare sector							
Output 27 Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements							
Output Indicator 27.1	The number of benefit definition guidelines published	Quarterly	5	n/a	1	2	2
Output Indicator 27.2	Develop preventative and primary healthcare package to incorporate into the PMBs	Annually	Review and update revised PMB benefit package	n/a	n/a	n/a	Review and update revised PMB benefit package

1.7.3 Explanation of Performance over the Medium-Term Period (Policy, Research & Monitoring)

The programme will continue 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.

1.7.4 Reconciling performance targets with the budget and MTEF (Policy, Research & Monitoring)

Expenditure (4)				
Policy,Research and Monitoring	**2022/2023**	**2023/2024**	**2024/2025**	**2024/2025**
Compensation of employees	**9 537 149**	**11 766 365**	**12 255 043**	**12 813 510**
Salaries and wages	9 537 149	11 766 365	12 255 043	12 813 510
Goods and services	**158 564**	**1 143 500**	**1 760 896**	**1 786 226**
Consultants	88 629	1 100 000	1 694 570	1 718 801
Other unclassified expenditure	18 484	19 500	20 368	21 280
Staff cost note	2 296	-	-	-
Venue and facilities	4 225	4 000	4 178	4 365
Travel and subsistence	44 929	20 000	41 780	41 780
TOTAL	**9 695 713**	**12 909 865**	**14 015 939**	**14 599 737**

The budget allocated will contribute to the achievement of the Key Performance Indicators by conducting research projects and support strategic projects to inform appropriate national health policy interventions and making publications in support of the National Health Policy, and to Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements. This will be done through the entire budget allocated to the Programme.

1.8. Programme 5: Member Protection

Purpose (Member Protection)

The purpose of the Programme is to:

- Provide customer service and training in support of the CMS Stakeholder engagement initiatives.
- Serve the beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner which is clinically appropriate and evidence based. By doing this, we ensure that beneficiaries are treated fairly and that medical schemes and other regulated entities are compliant with the Act, Regulations and registered scheme rules.
- Provide support to the office on clinical matters so that good quality medical scheme cover is maximised and that regulated entities are properly governed through prospective and retrospective regulation, with inputs to benefits, and ensuring that the policies and protocols applied are aligned with best practice and the local South African standards, taking into consideration affordability and sustainability of schemes

1.8.1 Programme performance indicators and annual targets

Outcome Indicator	Performance Indicators	Audited/actual performance			Estimated performance	Medium-term targets		
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 28: To enhance knowledge and skills among stakeholders in order to create an in-depth understanding of governance and compliance with the Medical Schemes Act through education and training interventions.								
Output Indicator 28.1	Number of stakeholder education and training sessions	35	56	108	50	55	60	60
Output 29: To provide Customer care interventions by rendering effective and efficient services.								
Output Indicator 29.1	Percentage of customer care interventions resulting from calls and e-mailed queries handled by the customer care centre	New Indicator	New Indicator	100%	90%	90%	90%	90%
Output 30: Resolve complaints with the aim of protecting beneficiaries of medical schemes.								
Output Indicator 30.1	Percentage of complaints older than 120 calendar days adjudicated during the reporting period in accordance with complaints standard operating procedures	New Indicator	New Indicator	New Indicator	75%	80%	80%	80%
Output Indicator 30.2	Percentage of category 2 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures	New Indicator	New Indicator	New Indicator	New Indicator	80%	80%	80%
Output Indicator 30.3	Percentage of category 1 complaints adjudicated within 60 calendar days and in accordance with complaints standard operating procedures	New Indicator	New Indicator	New Indicator	New Indicator	80%	80%	80%

Output Indicator 30.4	Percentage of Rulings submitted to Corporate Services for publication on the CMS website within 30 days following the lapse of the 3 months appeal deadline	New Indicator	100%	68%	80%	80%	80%	80%
Outcome 1: To promote the improvement of quality and the reduction of costs in the private healthcare sector								
Output 31: Formulate CMS Scripts for publication								
Output Indicator 31.1	The number of CMS Scripts published.	New Indicator	New Indicator	New Indicator	New Indicator	5	5	5
Output 32: Provide clinical opinions to resolve complaints and enquiries.								
Output Indicator 32.1	Percentage of category 1 clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication Unit	90%	92.75%	100%	90%	90%	90%	90%
Output Indicator 32.2	Percentage of category 2 clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication Unit	95%	100%	100%	95%	95%	95%	95%
Output Indicator 32.3	Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication Unit	98%	100%	100%	98%	98%	98%	98%
Output Indicator 32.4	Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days	98%	100%	100%	98%	98%	98%	98%

1.8.2 Quarterly targets for 2022/23 (Member Protection)

Outcome Indicator	Performance Indicators	Reporting period	Annual target	Quarterly targets			
		2023/24	2023/24	1st	2nd	3rd	4th
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations							
Output 28: To enhance knowledge and skills among stakeholders in order to create an in-depth understanding of governance and compliance with the Medical Schemes Act through education and training interventions.							
Output Indicator 28.1	Number of stakeholder education and training sessions	Quarterly	55	13	13	16	13
Output 29: To provide Customer care interventions by rendering effective and efficient services.							
Output Indicator 29.1	Percentage of customer care interventions resulting from calls and e-mailed queries handled by the customer care centre	Quarterly	90%	90%	90%	90%	90%
Output 30: Resolve complaints with the aim of protecting beneficiaries of medical schemes.							
Output Indicator 30.1	Percentage of complaints older than 120 calendar days adjudicated during the reporting period in accordance with complaints standard operating procedures	Quarterly	80%	80%	80%	80%	80%

Output Indicator 30.2	Percentage of category 2 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures	Quarterly	80%	80%	80%	80%	80%
Output Indicator 30.3	Percentage of category 1 complaints adjudicated within 60 calendar days and in accordance with complaints standard operating procedures	Quarterly	80%	80%	80%	80%	80%
Output Indicator 30.4	Percentage of Rulings submitted to Corporate Services for publication on the CMS website within 30 days following the lapse of the 3 months appeal deadline.	Quarterly	80%	80%	80%	80%	80%
Outcome 1: To promote the improvement of quality and the reduction of costs in the private healthcare sector							
Output 31: Formulate CMS Scripts for publication							
Output Indicator 31.1	The number of CMS Scripts published.	Quarterly	5	1	1	1	2
Output 32: Provide clinical opinions to resolve complaints and enquiries.							
Output Indicator 32.1	Percentage of category 1 clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication Unit	Quarterly	90%	90%	90%	90%	90%
Output Indicator 32.2	Percentage of category 2 clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication Unit	Quarterly	95%	95%	95%	95%	95%
Output Indicator 32.3	Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication Unit	Quarterly	98%	98%	98%	98%	98%
Output Indicator 32.4	Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days	Quarterly	98%	98%	98%	98%	98%

1.8.3 Explanation of Performance over the Medium-Term Period (Member Protection)

The programme will continue to provide customer service and training in support of the CMS Stakeholder engagement initiatives. Through timely and efficient investigation and adjudication of complaints, the programme will ensure that the interests of medical scheme beneficiaries are protected and that all regulated entities comply with the Act, Regulations and registered scheme rules. By issuing well considered, legally sound rulings, the programme will contribute to effective regulation of the medical scheme industry while ensuring a well-informed membership population.

The programme will be providing support to the office on clinical matters so that good quality medical scheme cover is maximised and that regulated entities are properly governed through prospective and retrospective regulation.

1.8.4 Reconciling performance targets with the Budget and MTEF (Member Protection)

Expenditure (5)				
Member Protection	**2022/2023**	**2023/2024**	**2024/2025**	**2024/2025**
Compensation of employees	**22 128 409**	**27 183 715**	**28 312 703**	**29 602 925**
Salaries and wages	22 128 409	27 183 715	28 312 703	29 602 925
Goods and services	**3 612 483**	**1 740 000**	**1 877 044**	**1 896 075**
Communication	1 530	50 000	52 225	54 565
Consultants	1 783 728	1 400 000	1 460 000	1 460 000
Advertising and marketing	911 775	-	-	-
Other unclassified expenditure	90 923	40 500	42 302	44 197
Printing and publication	486 588	-	-	-
Staff cost note	5 740	-	-	-
Venue and facilities	181 374	104 500	119 284	134 314
Travel and subsistence	150 824	145 000	203 233	202 998
TOTAL	**25 740 892**	**28 923 715**	**30 189 747**	**31 499 000**

The budget allocated will contribute to the achievement of the Key Performance Indicators by enhancing knowledge and skills among stakeholders to create an in-depth understanding of governance and compliance with the Medical Schemes Act through education and training interventions, as well as by resolving complaints with the aim of protecting beneficiaries of medical schemes**.** In addition, the budget will be used to formulate CMS Scripts to ensure uniform interpretation of the Scripts and entitlements, as well as to provide clinical opinions to resolve complaints and enquiries. This will be done through the entire allocated budget

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

- The following table reflects the alignment between the NDP goals, MTSF Priorities, and NDOH strategic goals with the CMS strategic goals for the period 2020 to 2025:

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
Average male and female life expectancy at birth increased to 70 years	Priority 3: Education, Skills and Health – Progressive improvement in the total life expectancy of South Africans	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 and the Clinical Unit are currently engaged in the analysis of health care data to measure health quality outcomes at the 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	Priority 3: Education, Skills and Health – Universal health coverage for all South Africans achieved by 2030	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	Priority 3: Education, Skills and Health – Reduction of maternal and child mortality Africans	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* • 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	Priority 3: Education, Skills and Health - Drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill-health	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.

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
Health System reforms completed	Priority 3: Education, Skills and Health – Develop a comprehensive policy and legislative framework to mitigate the risks related to medical litigation	Goal 2: Achieve UHC by Implementing NHI	*Outcome 1: To promote the improvement of quality and the reduction of costs 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 contributions 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.
	Priority 3: Education, Skills and Health – Implement the costed infrastructure plan to improve efficiency and effectiveness of health services delivery	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 will facilitate the regulation of medicine pricing in South Africa.
	Priority 3: Education, Skills and Health - Drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill-health	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 terms 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.

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
Primary health care teams deployed to provide care to families and communities	Priority 3: Education, Skills and Health – Improve the quality of primary healthcare services through expansion of Ideal Clinic Programme	Goal 2: Achieve UHC by Implementing 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 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	Priority 3: Education, Skills and Health – Universal health coverage for all South Africans achieved by 2030	Goal 2: Achieve UHC by Implementing 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

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

Adequate Funding:

The levy rate over the past 3 years has moved from R40,41 in 2020/21 to R44,06 in 2022/23. CMS is proposing a levy rate of R47,57 for the 2023/24 financial year. The 47,57 consists of R46,57 which translates to a 5,7% in line with projected inflation for the 2023/24 financial year. Further, an additional once off R1 increase in levies to fund upgrade in ICT systems and infrastructure. The total proposed levy increase therefore translates to a 7,97% increase from the 2022/23 financial year. The once off increase of R1 will fall away in the 2024/25 financial year and any proposed levy increase will

consider a base levy amount of R46,57. CMS is of the view that the levy rate imposed is not sufficient to cover the work of the Regulator. It is also concerning that the annual rate increase is capped to CPI and not linked directly to the projects that CMS undertakes based on legislative requirements.

The proposed levy increase is not sufficient to fund all the competing priorities of the organisation hence the entity

The entity is therefore continues to reviewing, developing, and implementing an alternative funding model that will be aligned with its strategy and fully finance the strategic outcomes of the organisation

Adequate Human Resources:

The CMS currently has a total personnel headcount of 134, 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 completed Business Process Mapping exercise has identified that additional positions will be required by the CMS for optimal and efficient operations.

Organisational Restructuring:

The CMS underwent an Organisational Diagnostic Exercise to ascertain its readiness to implement its organisational strategies in an effective and efficient manner. The recommendation of this exercise necessitated a review of the Business Operational and Business Service Delivery Models that led to the programme structure changes that were approved by the Council in May 2020. The approved structure clustered functions together to create a more collaborative value chain between divisions. As a service organisation, the new structure makes provision for 28 additional capacity requirements to improve operational effectiveness and efficiency.

Integrated ICT platform:

The CMS is looking at improving its operating in a sub-optimal manner due to a lack of supportive ICT infrastructure. This has not been upgraded as often as it is required. There is also a need to integrate all the regulatory functions and business processes to provide an end -to-end integrated solution ICT platform to replace the current dysfunctional legacy and stand-alone systems 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, and the South African Revenue Services (SARS).

- 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 is 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.

2. Programme Resource Considerations for 2023/24

The CMS Strategic Plan, Annual Performance Plan and Budget For 2023/24

The Council for Medical Schemes' budget for 2023/24 that should accompany the Strategic plan (2020 -2025) and the Annual Performance Plan (2023/24), which was approved by the 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 2023/24.

In our 2023/24 budget, CMS proposed a levy of R47,57 per member per annum (pmpa), which is an increase of R3,51 per family per year compared to the levies collected in 2022/23. The 47,57 consists of R46,57 which translates to a 5,7% in line with projected inflation for the 2023/24 financial year. Further, an additional once-off R1 increase in levies to fund upgrade in ICT systems and infrastructure. The total proposed levy increase therefore translates to a 7,97% increase from the 2022/23 financial year. The once off increase of R1 will fall away in the 2024/25 financial year and any proposed levy increase will consider a base levy amount of R46,57.

Costing for goods and services is based on inflationary projections, past usage , contractual arrangements, and future requirements for delivery on the 2023/24 APP targets. In respect of the cost-of-living adjustment for employees, the CMS applied CMS specific policies as guided by the National Treasury guidelines for costing and budgeting for compensation of employees.

CMS budgeted revenue increased from R186,5 million in 2021/22 to R194,4 million in 2022/23 due to inflationary related adjustments. R211 million is planned for 2023/24 with R213 million and R223 million for 2024/25 and 2025/26, respectively. CMS revenue includes levy income, tariff related income and interest revenue.

Included in the above budgeted revenue are transfers received from Health which decreased from R6.66 million in 2020/21 to R6,27 million in 2022/23 due to the tightening of the fiscal environment. In 2023/24 and 2024/25 the transfers are expected to increase to R6,54 million and R6.63 million respectively.

Albeit the proposal of 5,7% plus a R1 once off ICT related increase, it is worth highlighting 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 Health and National Treasury on its funding moving forward.

The strategic trajectory for the CMS for the current five-year cycle entails ensuring effective and efficient regulation of the medical scheme industry and playing a significant role in the implementation of Universal Health Co verage 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 2023/24 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 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

The CMS Budget Table, presented below, covers the budget and funding proposal based on the annual levy increase. This proposal shows an increase in total budgeted expenditure from R194 Million to R211 Million, which represents an increase of 7,97%. This increase includes the R1 once off ICT related funding. The base increase is in lie with projected inflation at 5,7%.

Overview of budget and MTEF estimates Table, on the other hand, provides a programmatic break–down of the consolidated budget for the 2023/24 financial year. The detailed breakdown of the proposed budget as per economic classification is provided in the overview of budget per classification and MTEF Table.

The presented budget supports the Annual Performance Plan for the Council for Medical Schemes for the 2023/24 financial year, albeit with significant resource constraints.

Council for Medical Schemes

Funding Proposal for 2023/24

CMS Budget

Description	2022/2023	2023/2024	2024/2025	2025/26
Goods and services	72 087 715	71 930 415	70 451 230	73 240 097
Compensation of employees	121 354 836	136 497 335	142 179 145	148 654 880
Operating cash expenditure	**193 442 552**	**208 427 750**	**212 630 375**	**221 894 977**
Capital expenditure	1 042 300	2 500 000	1 088 682	1 137 455
Total cash requirement (TABLE 2)	**194 484 852**	**210 927 750**	**213 719 057**	**223 032 433**
Accreditation fees	(6 798 998)	(7 093 658)	(7 409 326)	(7 741 264)
Registration Fees	(534 644)	(423 168)	(441 999)	(461 801)
Interest Received	(2 028 234)	(3 171 000)	(3 351 747)	(3 542 797)
Government grant	(6 272 000)	(6 537 000)	(6 831 000)	(6 831 000)
Other income	(286 063)	(302 369)	(319 604)	(337 821)
Total income excluding levies	**(15 919 940)**	**(17 527 195)**	**(18 353 676)**	**(18 914 682)**
Income from levies	178 564 912	193 400 555	195 365 382	204 117 751
Total membership	4 053 041	4 065 747	4 065 747	4 065 747
Levy amount proposed	R 44,06	R 47,57	R 48,05	R 50,20
Levy amount approved	R 44,06			
Levy increase (in Rand) based on approved levy	R1,79	R3,51	R2,05	R2,15
Levy increase (in %) based on approved levy	4,23%	7,97%	4,45%	4,48%

Overview of budget and MTEF estimates:

Consolidated expenditure - Per Programme	2022/2023	2023/2024	2024/25	2025/2026
ADMINISTRATION	**111 444 327**	**120 430 258**	**119 355 018**	**124 617 463**
Office of the CEO and Registrar	9 619 925	10 240 142	9 760 486	10 143 085
Office of the CFO	15 637 465	16 133 815	16 807 348	17 566 845
Information Systems and Knowledge Management	25 757 024	32 602 830	31 585 489	31 893 290
Corporate Services	50 756 797	51 738 459	51 020 352	54 664 406
Council Secretariat	9 673 116	9 715 012	10 181 342	10 349 837
Strategy, Performance and Risk	5 653 402	2 735 379	2 909 328	3 037 236
Regulation	40 908 219	43 428 535	46 160 344	48 141 541
Policy,Research and Monitoring	9 695 713	12 909 865	14 015 939	14 599 737
Member Protection	25 740 892	28 923 715	30 189 747	31 499 000
OPERATING CASH EXPENDITURE	**193 442 553**	**208 427 751**	**212 630 375**	**221 894 977**
Capital expenditure	1 042 300	2 500 000	1 088 682	1 137 455
TOTAL CASH REQUIREMENT	**194 484 853**	**210 927 751**	**213 719 058**	**223 032 432**
ACCREDITATION FEES	-6 798 998	-7 093 658	-7 409 326	-7 741 264
REGISTRATION FEES	-534 644	-423 168	-441 999	-461 801
INTEREST RECEIVED	-2 028 234	-3 171 000	-3 351 747	-3 542 797
GOVERNMENT GRANT	-6 272 000	-6 537 000	-6 831 000	-6 831 000
OTHER INCOME	-286 063	-302 369	-319 604	-337 821
LEVIES ON MEDICAL SCHEMES	-178 564 912	-193 400 555	-195 365 382	-204 117 751
TOTAL INCOME	**-194 484 852**	**-210 927 750**	**-213 719 057**	**-223 032 433**

Overview of budget per classification and MTEF

Per Economic classification	2022/2023	2023/2024	2024/2025	2025/2026
Compensation of employees	**121 354 836**	**136 497 335**	**142 179 145**	**148 654 880**
Salaries and wages	117 277 719	132 235 697	137 727 863	144 004 181
Social contributions	4 077 118	4 261 639	4 451 282	4 650 699
Goods and services	**72 087 717**	**71 930 416**	**70 451 231**	**73 240 097**
Agency and support / outsourced services	86 097	86 692	90 550	94 607
Communication	3 184 720	3 322 200	3 574 382	3 734 514
Computer services	4 988 423	9 274 658	5 940 708	5 961 201
Consultants	13 243 557	11 775 851	13 839 676	13 453 914
Lease payments	15 319 748	15 127 619	13 328 540	14 805 460
Advertising and marketing	1 823 551	700 000	731 150	763 906
Audit costs	1 000 000	1 000 000	1 044 500	1 091 294
Bank charges	115 070	120 156	125 503	131 126
Board costs	5 715 216	4 800 000	5 003 040	5 003 040
Legal fees	7 909 756	7 424 275	7 146 775	7 599 482
Non life insurance	632 451	800 000	835 600	873 035
Other unclassified expenditure	3 433 357	3 433 312	3 856 217	3 765 466
Printing and publication	1 145 053	529 755	563 774	589 031
Property payments	5 474 992	5 758 813	5 911 995	6 782 016
Staff cost note	3 119 072	3 142 477	3 337 718	3 356 051
Venue and facilities	766 683	628 426	749 779	796 837
Repairs and maintenance	1 031 204	1 046 235	1 121 014	1 171 236
Training and staff development	1 824 205	1 712 695	1 802 352	1 812 907
Travel and subsistence	1 274 560	1 247 251	1 447 957	1 454 976
OPERATING CASH EXPENDITURE	**193 442 553**	**208 427 751**	**212 630 375**	**221 894 977**
Capital expenditure	1 042 300	2 500 000	1 088 682	1 137 455
TOTAL CASH REQUIREMENT	**194 484 853**	**210 927 751**	**213 719 058**	**223 032 432**

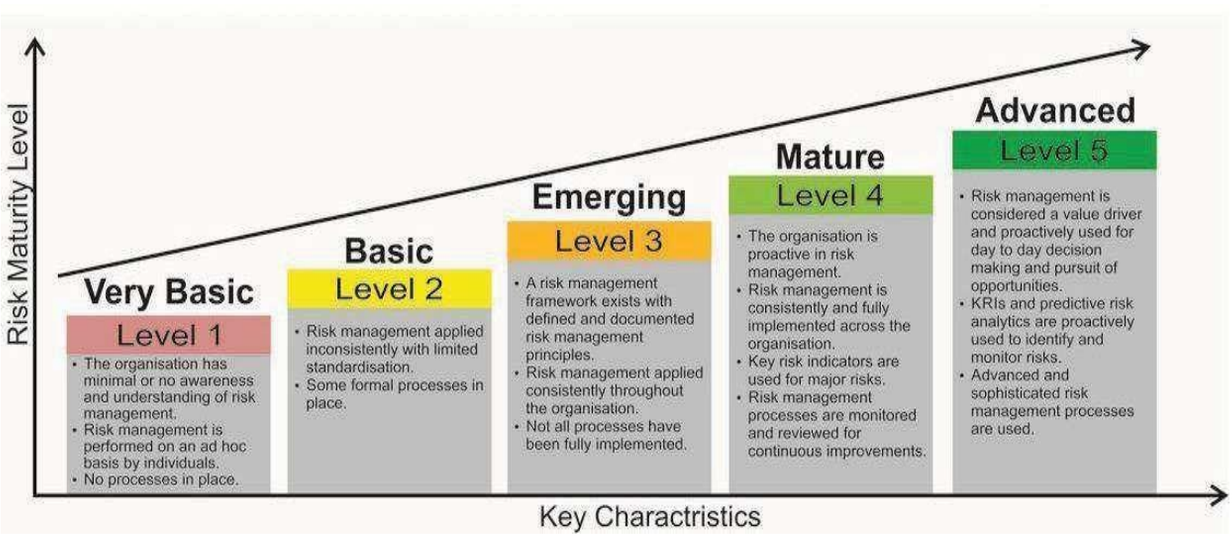
3. Updated Key Risks

Enterprise 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 are 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.

During the 2021/22 financial year, the Office of the CEO sub -programme initiated a risk maturity assessment. The assessment tool focuses on eight key focus areas comprising 75 sub-elements. These eight focus areas are as follows;

- Risk culture
- Risk identification
- Risk assessment
- Articulation of risk appetite
- Risk response
- Risk reporting
- Integration with Strategic Planning
- Assessment of ERM effectiveness

Over the next few years, the CMS would like to escalate from a level 3 to level 5 in terms of its risk maturity. Strategic risks are monitored by the governance structures.



The area of risk management is under-resourced as the CMS currently has no dedicated 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.

4. Table: Key Risks

Outcome	Key Risk	1. 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	Outdated Funding Model	1. Review of CMS funding model – alternative funding model 1.1 Using the services of an expert (for independence), review and propose an updated funding model.
Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations Outcome 4 - To become a more effective and efficient organisation	Fraud, Corruption and Unethical Behaviour within CMS	1. Present to Staff changes on the Fraud and Corruption Prevention Policy, as well as the Code of Conduct, Ethics and Whistle-blower Policy 2. Engage and support the SIU on all investigations of malpractice and maladministration 3. Appointment of an Ethics service provider to conduct a follow-up ethics assessment 4. Improved action on supervision controls 5. Random Lifestyle audits (SIU) 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. Amendment of Levies Act 2. Strengthen relationship and engagement with National Treasury and Department of Health 3. 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 4. Consider open plan office 5. Consider reinstating the Finance Committee 6. Enforcing budgetary control processes 7. Automated procurement system 8. Develop divisional skills matrix 9. Reprioritize budget items to Software & Consulting Fees 1. 10. Co-fund projects with business units

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 become 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 SOPs to ensure that MCO's have evidence based protocols 4. Monitor changes in legislation 5. Implement a cost recovery plan 6. Development and implementation of cost-effective Service Level Agreements. 7. Source legal technology system 8. Development of SOP streamline key processes 9. Prioritising the approved posts on the new structure 10. Improve stakeholder engagement activities
Outcome 4 - To become a more effective and efficient organisation	Cyber Risk	1. Continuously monitor and analyse activities on Firewall and put threat prevention measures 2. Review the Information Security Policy 3. Enable all Microsoft Enterprise Mobility & Security functionalities 4. The CMS development of the Beneficiary Register 5. Improve the firewall and email traffic filtering capabilities 6. Procure and implement a SIEM solution to detect and monitor threats

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. 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. CMS will need to develop a mechanism to analyse the impact on the governance interventions in schemes. 6. Test on whether the trustee training programmes are having a positive effect in board decision making. 7. Improve Routine and commissioned inspections – test whether the outcomes of these inspections are being implemented by schemes. 8. Increase the frequency of onsite accreditation - accredited entities 9. Standardisation of benefits and Consolidation of Schemes
Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations	FSRA + COFI Bill	1. Update the FSB MoU to be signed between CMS and FSCA.
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 - (Consumer awareness through community radio stations.) 5. Publication of relevant material to members on rulings, products etc. 6. Stakeholder mapping and milestones for 2020-2024 by end February 2022 7. Identify key priority projects to support policy direction and NHI roadmap by end of March 2023. 8. Identify target peer review journals for publishing research work. 9. Identify conferences to present research outputs. 10. Prioritise key Council projects such as the Risk Based Capital Model, Standardisation of Benefit Options and Health Quality Project 11. Offer training to all CMS leadership to articulate CMS position and policy 12. Articulation of stakeholder mapping result to internal staff 13. Development of organisation wide communication strategy 14. HR to advise the possibility of a secondary SETA 15. Other forms of SED training need to be explored 16. The position of a CPD specialist must be filled to enable the position of a CPD quality assure 17. Introduction of Consumer Education Champions in Consumer Affairs Offices will mitigate the risk.

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. Strengthen controls around supply chain management process by implementing consequence management as outlined in the latest Irregular Expenditure Framework. 4. Appoint a Compliance Officer 5. Motivating to the NDoH for urgent amendments or regulations.
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 3. A draft framework has been developed. Units need to appoint compliance champions.
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 Compliance Framework 3. Memorandum of understanding with the FSCA and the PA and Treasury 4. Memorandum of understanding with the FSCA and the PA and Treasury
Outcome 1 - To promote the improvement of quality and the reduction of costs of 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. Develop Change management plan 5. Develop Succession planning and mentoring policy 6. Prioritisation of ICT system upgrades 7. Implement an intra-unit skills transfer program and diversification of roles 8. Implement a fit for purpose backup solution 9. Host business-critical systems and backup on the Cloud 10. Increase physical storage capacity to improve reliability 11. Impose penalties for current supplier 12. Appoint a more compatible ISP partner 13. Development of Business Continuity Plans for each Business Unit

Outcome 4 - To be a more effective and efficient organisation	Reduced Productivity Risk	1. Procure Employee Productivity monitoring tool for remote work 2. Benchmark Benefits, Terms of Conditions of Service 3. Create a conducive work environment where effort is appropriately recognised and incentivised 4. Create an environment where there is certainty in key workforce areas such as remunerations, annual salary increases and pay progression 5. Filling of vacancies on time 6. Ensure the current cohort is kept motivated, engaged and hopefully retain them
Outcome 4 - To be a more effective and efficient organisation	Pandemics	1. To implement an effective business continuity plan to address all possible disruptions including pandemics, labour disputes and demonstrations by unhappy regulated entities
Outcome 4 - To be a more effective and efficient organisation	Protests	1. We continue to ensure compliance to organizational rights agreement by both CMS management and Nehawu with a view to reduce industrial action 2. 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. 3. Improve the understanding by stakeholders with regards to the regulatory environment 4. Continued media assessment by the Media Risk Assessment Committee
Outcome 1 - To promote the improvement of quality and the reduction of costs of 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	Global Warming & Climate Change	1. Maintain online meetings thereby reducing travelling emissions and catering 2. Maximise the use of electronical distribution of documents

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	Changing demographics and burden of diseases	1. Institutionalise the CMS project management methodology and reporting.
Outcome 4 - To be a more effective and efficient organisation	Identified Personnel Physical Security Risk	1. Conduct a security assessment with the SSA

4. Public Entities

Name of Public Entity	Mandate	Outcomes		Current Annual Budget (R thousand)
Council for Medical Schemes	Regulation of Medical Schemes in the protection of Beneficiary interests	Outcome 1 Outcome 2 Outcome 3 Outcome 4 Outcome 5 Outcome 6	To promote the improvement of quality and the reduction of costs in the private health care sector To encourage effective risk pooling To ensure that all regulated entities comply with the MSA and Regulations To became a more effective and efficient organisation To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry To collaborate with local, regional and international entities	R 210 928

5. Infrastructure Projects (Not Applicable)

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

6. Public Private Partnerships (Not Applicable)

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

7. Part D: Technical Indicator Descriptions (TID)

7.1. 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 the Review and Development of a Strategic Plan and Annual Performance Plan is done for Council's consideration by the 31st January each year
Short definition	Guide the review and development process of the Strategic Plan and Performance Plan
Purpose/importance	To ensure that the Council for Medical Schemes has a comprehensive and realistic Strategic and Annual Performance Plan
Source/collection of data	Consolidated inputs from EMC, Council Committees, National Department of Health (NDoH), The National Treasury, Auditor-General of South Africa (AGSA), the Internal Auditors, and Environmental analysis.
Method of calculation/Assessment	Approved SP and APP (Whichever is applicable) by the Executive Authority
Means of verification	Consider the SP and APP approval letter by Executive Authority (Whichever is applicable)
Assumptions	National Health Policy and Legislative reforms will have a direct impact on CMS structure and performance
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Not Applicable
Type of indicator	Quantitative
Calculation type	Non-Cumulative
Reporting cycle	Annually
New indicator	Yes
Desired performance	The Strategic Plan and Annual Performance Plan that is approved by the Executive Authority
Indicator responsibility	CEO
Indicator title	**Ensure that the overall performance of the entity is 80% of the predetermined objectives**
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	Number of Achieved targets for the period under review/Number of applicable targets for the period under review *100
Means of verification	Provide required report and save a copy on M-Files/OneDrive
Assumptions	National Health Policy and Legislative reforms will have a direct impact on CMS structure and performance
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Not Applicable
Type of indicator	Consolidated
Calculation type	Cumulative (Year-end)
Reporting cycle	Quarterly
New indicator	No
Desired performance	80%
Indicator responsibility	CEO

Indicator title	Ensure that an Annual Performance Information report produced is reliable, accurate and complete by 31 July each year in line with the statutory requirements.
Short definition	To ensure that CMS operates in line with their approved plans.
Purpose/importance	To ensure that the Council for Medical Schemes achieves its performance targets as set out in the annual performance plan.
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/OneDrive 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	Consider the audit opinion letter issued by Auditor-General South Africa by 31 July.
Means of verification	Provide required report and save a copy on M-Files/OneDrive
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	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annually
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

7.2. Sub-programme 1.2: (Office of the CFO)

Output 3: Ensure that reported financial information is useful and reliable, and in accordance with the Expenditure Management and Reporting Framework.

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 present fairly, in all material respects, the financial position of the Council for Medical Schemes as of 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 is also saved on M-Files/OneDrive under CMS Vault > folder Performance information audit evidence
Method of calculation/Assessment	Performance is assessed by evaluation of audit opinion obtained
Means of verifications	Auditor-General South Africa audit report
Assumptions	• Proper records of the financial affairs of the entity are maintained • Annual financial statements are prepared, approved and submitted to the Auditor-General South Africa by 31 May each year • Effective financial governance
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Not applicable
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	An unqualified audit opinion by the Auditor-General
Indicator responsibility	Chief Financial Officer

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

Indicator title	Review, develop and implement a funding model that considers the long term strategic outcomes of the CMS by end of each year
Short definition	Review, development and implementation of a funding model that is fit for the purpose
Purpose/importance	To ensure that the funding model informs the CMS budget requirements
Source/collection of data	The strategic direction of CMS as per Strategic plan, MSA and Regulations, PFMA.
Method of calculation/Assessment	Completed Phase 1 per the Funding Model Plan
Means of verifications	Consider completed phase 1 report approved by Council
Assumptions	Economic stability and non-deteriorative ability towards Medical Schemes contribution
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Not Applicable
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annually
New indicator	Yes
Desired performance	The funding model that was approved by the Executive Authority
Indicator responsibility	Chief Financial Officer
Indicator title	**Produce a budget that is approved by Council by the 31st January each year**
Short definition	This means that CMS operates in line with its approved budget that is in line with the 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 on 31 January to the 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/OneDrive under CMS Vault > folder Performance information audit evidence
Means of verifications	Provide the draft gazette to NDoH and National Treasure in line with Council budget recommendations, and respond to stakeholder responses to the gazette
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	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annually
New indicator	No
Desired performance	Approval of budget by Council on/before 31 January each year
Indicator responsibility	Chief Financial Officer

7.3. Sub-programme 1.3: (Information and Communication Technology (ICT) and Information Management (IM))

Output 5: An established ICT infrastructure that ensures information is available, accessible and protected.

Indicator title	Percentage of network 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 does not consider planned outages needed for the 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	N/A
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-end)
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 successful external penetration attempts through the CMS firewall as well as attempts internally by both staff as well as visitors to access information that 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 document management system. . 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 security incidents reports are submitted monthly to CMS by the 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 document management system
Assumptions	• Cybersecurity Threats from external hackers • Data breach from internal personnel • POPIA; and • Lack of proper monitoring tools will all affect the target
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-end)
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 the 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	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Bi-Annual
New indicator	Yes
Desired performance	Higher. At least two DR Certificates issued annually should be strived for.
Indicator responsibility	Chief Information Officer

Output 6: Provide software applications that serve both internal as well as external stakeholders and which improves business operations and performance.

Indicator title	**Percentage of business-critical application systems uptime (server uptime)**
Short definition	This indicator measures the % uptime experienced on business-critical applications and the server systems deployed in the CMS Server Farm. The higher the number of days where access to server systems was totally interrupted, the lower the % uptime (number of server incidents / 365 * 100). This indicator does not take into account the planned outages needed for the purpose of maintenance. These planned outages will be recorded separately as part of the IT Change Management process on the Manage Engine 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	Manage Engine System/Device Availability reports Data is collected by Network Manager.
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 have taken into account all the identified operational risks
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-end)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher. A 100% uptime should be strived for.
Indicator responsibility	Chief Information Officer

7.4. Sub-programme 1.4: (Corporate Services)

Output 7: Legal advisory and support services for effective regulation of the industry and operations of the office.

Indicator title	**Percentage of written and verbal legal opinions provided to internal stakeholders, attended to within 14 days.**
Short definition	Percentage of written and verbal legal opinions provided to internal and external stakeholders, attended to within 14 days.
Purpose/importance	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).
Source/collection of data	The Register of all written and verbal legal opinions is kept electronically M-Files/OneDrive. 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/OneDrive.
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/OneDrive, If a verbal opinion is made, a record thereof must be captured on email copying the legalopinions@ medicalschemes.co.za email for verification. This will also include the person with whom the legal opinion was made to.
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	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100%
Indicator responsibility	Executive Manager: Corporate Services

Output 8: 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/OneDrive. 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: 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	Qualitative
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	Executive Manager: Corporate Services

Output 9: Build competencies and retain skilled employees.

Indicator title	**Minimise staff turnover rate to less than 15% per annum.**
Short definition	The percentage rate at which an employer attracts and loses employees.
Purpose/importance	Ensure that a CMS has the right talent with the right skills at the right time. Retain scarce, critical, professional and technical skills and maintain a staff turnover rate of less than 15% by 2024.
Source/collection of data	Excel spreadsheet with number of employees.
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 terminations (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	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annually
New indicator	No
Desired performance	Retaining competent employees with the right skills at the right time.
Indicator responsibility	Executive Manager: Corporate Services
Indicator title	**Average number of days to fill a vacancy (turnaround time of 90 working days for each vacancy that exists during the year), excluding the position of CEO and Executives.**
Short definition	Time spent filling a vacancy.
Purpose/importance	Ensuring that no gap exists for longer periods of time after termination, thereby ensuring that units are able to achieve their objectives.
Source/collection of data	Council resolution for new positions. APPs and budget. Termination and appointment letter.
Method of calculation/Assessment	Existing positions: count the number of calendar days from the date of advertisement to the date a job offer is made (letter of appointment) (a vacancy should not take more than 120 working days to fill) New positions: number of days from the date of advertisement of the new position or approval of budget should not be more than 90 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 was advertised to the date a job offer is made. 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 90 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	Qualitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Maintain continuity in employment.
Indicator responsibility	Executive Manager: Corporate Services

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

Indicator title	**Percentage of employee performance agreements are signed by the 31st May each year (excluding employees out of office on extended absence)**
Short definition	Employee performance agreements are signed by each employee to ensure the achievement of the 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 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	Quantitative
Calculation type	Bi-Annual
Reporting cycle	Annually
New indicator	No
Desired performance	100%
Indicator responsibility	Executive Manager: Corporate Services
Indicator title	**Percentage of employees performance assessment concluded, bi-annually (excluding employees out of office on extended absence)**
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 employees 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 (2023/24). The target for quarter 3 will be the assessments concluded for the first half of the current year (2023/24).
Method of calculation/Assessment	The number of employees legible to participate in the appraisal cycle / Number of all performance contracts signed by employees x 100. Only employees in the employment of CMS for at least a period of 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, making it impossible for this indicator to be set at 100%.
Disaggregation of Beneficiaries	All employees in the office during the quarter are under review.
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-end)
Reporting cycle	Bi-Annually
New indicator	No
Desired performance	100%
Indicator responsibility	Executive Manager: Corporate Services

Output 11: Ensure maximisation in the coordination of various planning efforts that are undertaken in relation to the CMS facilities

Indicator title	Develop an Office Capacity and Utilisation Report by the 30th June each year
Short definition	Office space needs and usage analysis
Purpose/importance	To ensure the proper functioning of the Facilities Planning Advisory Committee
Source/collection of data	Working from home feasibility study, and any related and relevant study regarding office space utilisation
Method of calculation/Assessment	Approved needs analysis
Means of verification	Consider the needs analysis approval letter by the Registrar
Assumptions	CMS will operate from a single office
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annually
New indicator	Yes
Desired performance	Approved needs analysis by the Registrar
Indicator responsibility	Executive Manager: Corporate Services

Output 12: To create awareness and collaboration with stakeholders while 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 a 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 the 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/OneDrive
Assumptions	That budget for the listed activities is available.

Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
New indicator	Quarterly
Desired performance	No
Indicator responsibility	Executive Manager: Corporate Services
Indicator title	**Percentage of stakeholder awareness of the CMS resulting from a 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/OneDrive as a portfolio of evidence. .
Method of calculation/Assessment	the number of responses received for each question (yes/no/may be) divided by the total number of responses received x 100
Means of verification	Survey Report
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	The survey may not cover an entire or larger percentage of the population. Members may choose not to partake in the survey.
Type of indicator	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	60%
Indicator responsibility	Executive Manager: Corporate Services

Output 13: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year.

Indicator title	**Submission of the CMS Annual Report by the 31st 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 on 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
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
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	Qualitative
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	No
Desired performance	Submission of the Annual Report to the Executive Authority by 31 August annually.
Indicator responsibility	Executive Manager: Corporate Services

7.5. Sub-programme 1.5 (Council Secretariat)

Output 14: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority

Indicator title	**Complete meeting packs to be circulated at least 7 days before the meeting**
Short definition	This indicator measures the timeous delivery of information packs to the Council
Purpose/importance	To ensure that Council is furnished with information packs that will facilitate for discussions in meetings in order to enable it to make properly informed decisions
Source/collection of data	Council meetings packs and minutes
Method of calculation/Assessment	The review takes place quarterly
Means of verification	Council packs, Council calendar and minutes
Assumptions	Management will submit the information pockets from the governance committees within 9 days before the Council meeting.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	Council Secretariat
Indicator Title	**Minutes of Council and Committee meetings to be included in the meeting pack of the subsequent meeting**

Short definition	This indicator measures the timeous submission of meeting minutes to the Council
Purpose/importance	To ensure that Council minutes are submitted and approved on time
Source/collection of data	Council minutes
Method of calculation/Assessment	Number of Council minutes submitted
Means of verification	Council packs and minutes
Assumptions	Council will have meetings
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	100%
Indicator responsibility	Council Secretariat
Indicator Title	**Percentage of Communicated Council resolutions within 3 days of the meeting to the affected internal stakeholders**
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	Actual communication of rulings to relevant stakeholders is matched with the resolutions made by the Council or the relevant Committee
Means of verification	Communication and correspondence between the Secretariat and the relevant Manager
Assumptions	Council and /or Committee will hold meetings and take decisions which will then be communicated
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Qualitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100%
Indicator responsibility	Council Secretariat
Indicator Title	**Number of training sessions held for Council and/or Committee/s**
Short definition	This indicator measures the training and development of the Accounting Authority
Purpose/importance	To ensure that the Accounting Authority exercises its oversight role as mandated by the MSA
Source/collection of data	Training Attendance Register or Training Certificates
Method of calculation/Assessment	Consider Training Attendance Register or Training Certificates
Means of verification	Training Attendance Register or Training Certificates
Assumptions	Council will have internal and or external training provided, and when the need is identified
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable

Data limitations	Confidentiality
Type of indicator	Qualitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	1
Indicator responsibility	Council Secretariat
Indicator title	**Percentage of signed annual declaration of financial interest by Council Members (excluding Council Members out of office on extended absence)**
Short definition	To declare and manage conflict of interests.
Purpose/importance	To ascertain that the Council members are honest by declaring their financial and any other related interests outside of the CMS that may result in a conflict of interest
Source/collection of data	Declaration of interest forms completed by Council members
Method of calculation	The number of Council members that submitted the declaration of interest forms/Number of Council members appointed by the Minister of Health as of 30 June * 100.
/Assessment method	(Excluding Council members who are on extended leave)
Means of verification	Declaration of interest forms completed by Council members on file.
Assumptions	The assumption is that some Council members might be on extended leave during the period under review, and their forms will submit as soon as they are available
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Annually
New indicator	Yes
Desired performance	90%
Indicator Responsibility	Council Secretariat

Output 15: Support Dispute Resolution Forums in furtherance of Council and MSA objectives

Indicator Title	**Support the publication of rulings of the Appeals Committee and the Appeal Board within 14 days of receipt from the Presiding Officers.**
Short definition	This indicator measures the number of rulings published once finalised by both the Appeals Committee and the Appeal 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 received/number of rulings sent for publication within 14 days*100
Means of verification	number of rulings send for publication within 14 days
Assumptions	The right to be heard on appeal is legislated. Therefore, there will always be appeals that should be adjudicated
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No

Desired performance	75%
Indicator responsibility	Council Secretariat

7.6. Programme 2: (Strategy, Performance and Risk)

Output 16: Ensure that strategic projects are scoped, and project plans are in place.

Indicator title	Development and Maintain a Strategic Projects Register
Short definition	Development of strategic project register
Purpose/importance	To ensure that the Council for Medical Schemes properly scopes and tracks strategic projects
Source/collection of data	Requests for projects approvals
Method of calculation/Assessment	Approved Strategic Project Register
Means of Verifications	Approved requests
Assumptions	All projects will be properly scoped
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Not Applicable
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	To ensure that the Council for Medical Schemes tracks the strategic projects
Indicator responsibility	Executive Manager: Strategy, Performance and Risk
Indicator title	**Scope and develop plans for strategic projects**
Short definition	Strategic projects plan
Purpose/importance	To ensure that projects plans are informed by the CMS' outcomes
Source/collection of data	Requests for projects approvals
Method of calculation/Assessment	Number of approvals/number of requests *100
Means of verification	Approved requests
Assumptions	All projects will be properly scoped
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	To ensure that the Council for Medical Schemes plans the strategic projects
Indicator responsibility	Executive Manager: Strategy, Performance and Risk

Output 17: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.

Indicator title	Produce Quarterly Performance Information report that is reliable, accurate and complete, at the time of submission to the Executive Authority by the end of the month following the quarter
Short definition	Reporting of actual performance against stated objectives and targets, at the time of submission to the Executive Authority by the end of the month following the quarter
Purpose/importance	To record the Council for Medical Schemes performance against its targets as set out in the annual performance plan.

Source/collection of data	Draft Quarterly Performance Information Report
Method of calculation/Assessment	Approved quarterly performance information report by Council on the last day of the month following the quarter
Means of verification	Consider quarterly internal audit report
Assumptions	All targets will be met
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Not applicable
Type of indicator	Qualitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	A quarterly performance information report that is reliable, accurate and audited by the internal audit
Indicator responsibility	Executive Manager: Strategy, Performance and Risk

7.7. Programme 3: (Regulation)

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 accredited 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 for 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 are provided for not being accredited.

Source/collection of data	Applications for accreditation of brokers and brokerages are captured on the online accreditation system. All supporting documentation is filed on the CMS document management system, which is M-Files/OneDrive. 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	The 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/OneDrive.

Type of indicator	Quantitative
Calculation type	Cumulative (Year-end)
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	Executive Manager: Regulations
Indicator title	**Percentage of managed care organisation applications analysis completed within three months of receipt of complete information**
Short definition	Percentage of managed care organisation (MCO) accreditation applications and medical schemes providing own managed care services' 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 • Compliance with relevant legislation declaration • 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 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. medical schemes are issued with managed care 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, Regulation Senior Management Meeting minutes is available on M- Files. Paper trail of all documents received, interacted with and concluded on M-Files/OneDrive.
Method of calculation/Assessment	The number of complete applications evaluated within three months (in a quarter) of receipt of complete information 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 the outcome communicated / Number of Complete Applications Received x 100
Means of verification	Acknowledgement of receipt letters sent to applicants and Regulation Senior Management Meeting 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	Quantitative
Calculation type	Cumulative (Year-end)
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	Executive Manager: Regulation
Indicator title	**Percentage of administrators and self-administered schemes applications analysis completed 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 • Compliance with relevant legislation declaration • 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 provide 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 Regulation Senior Management Meeting minutes are available on M- Files. Paper trail of all documents received, interacted with and concluded on M-Files/OneDrive.
Method of calculation/Assessment	The 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 the outcome communicated / Number of Complete Applications Received x 100
Means of verification	Acknowledgement of receipt letters sent to applicants and Regulation Senior Management Meeting 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	Quantitative
Calculation type	Cumulative (Year-end)
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	Executive Manager: Regulation

Output 19: 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 timeouslythe 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 data submitted, received by the analyst, date of request of further information and the data processed and sent to the Executive Manager: Regulation 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 submissions 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) The number of amendments processed after receipt of all information in 14 working days, or less/ (Denominator) Number of amendments received 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, not applicable for Q3
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	Quantitative
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	Executive Manager: Regulation
Indicator title	**Percentage of annual rule amendments processed before the 31st 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 effective 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 affected. 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 data submitted, received by the analyst, date of request of further information and the date processed and sent to the Executive Manager: Regulation 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) The 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	Annually
New indicator	No
Desired performance	90% of submissions made to the office are processed before 31 December each year.
Indicator responsibility	Executive Manager: Regulation

Output 20: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws

Indicator title	**Number of draft inspection reports issued annually**
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 are conducted, produce an inspection report and that remedial action is implemented and followed up, if applicable or where necessary
Source/collection of data	Routine inspections in terms of Section 44(4)(b) source: • Memorandum signed by the Registrar approving the inspection (input). • Count the appointment letters to the appointed investigator (input). • Count the notice of inspection letters to the scheme (input). • A draft Inspection report issued to the scheme (output).
Method of calculation/Assessment	• Sum of draft routine inspection reports issued for the period
Means of verification	Draft Inspection reports issued

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:
Type of indicator	A scheme has delayed the submission of the relevant documentation for inspection; Resource constraints within the unit; A scheme lodges an appeal in terms of section of the 49 MS Act around the draft inspection report.
Calculation type	Quantitative
Reporting cycle	Cumulative (Year-End)
New indicator	Quarterly
Desired performance	Yes
Indicator responsibility	10

Output 21: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act (1998) and all other related laws.

Indicator title	Percentage of commissioned inspection finalised within 12 months from the date the appointment letter was signed
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. 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. • Memorandum signed by the Registrar approving the inspection (input) • Count the appointment letters to the appointed investigator (input) • A final Inspection report issued to the scheme (final stage of inspection-output).
Method of calculation/Assessment	Sum of commissioned inspections conducted (count the final inspection report received from the service provider) /Appointment letters, 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 the service provider(s)
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 commencement of an inspection by instituting legal proceedings to delay or block an inspection.
Type of indicator	Quantitative
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	Executive Manager: Regulation

Output 22: Ensure enforcement action is undertaken against regulated entities.

Indicator title	Percentage of enforcement actions undertaken during the period
Short definition	When schemes or insured entities are found to be non-compliant with the Medical Schemes Act (1998), the unit will either conduct an inspection, impose penalties, issue or issue directives to schemes entities in order to enforce compliance.
Purpose/importance	The purpose of the indicator is to ensure that medical schemes, regulated entities and insured entities are fully compliant with the Medical Schemes Act (1998) and its Regulations. The Unit will ensure to its best of its ability that all matters received result in processed interventions.
Source/collection of data	Below are measured for possible non-compliance cases that could be undertaken: • All Allegations/tip-offs/ enquiries /suspected irregularities excluding those that result in commissioned inspections or are invalid allegations. • An invalid allegation= incomplete information submitted, or those that fall outside of the unit and or the CMS mandate
Method of calculation/Assessment	Sum of enforcement actions undertaken/sum of allegation or non-compliance cases referred (count the number of letters sent to entities on non-compliance/enforcement cases) • Undertaken definition: Letter or email or correspondence sent to the scheme or regulated entity or relevant person/entity requesting information or evidence around the received allegation. • Undertaken matters exclude matters received on and after the 15th day of the performance month.
Means of verification	• Section 43 enquiry and notices, enquiries, request for information in terms of any other applicable legislation: count the correspondence (letters or emails sent to the scheme requesting information in relation to any matter connected with the business or transactions of the medical scheme. • Section 45 enquiry count the correspondence (letters or email) sent to the person requesting information to conduct the business of a medical scheme without due registration. • Penalties in terms of Section 66(3): count the correspondence (letters or email) sent to the scheme imposing the penalty). • Rulings in terms of Section 47: count the correspondence (letters or email) letter sent to the scheme enforcing compliance with the ruling. • Directives: count the correspondence (letters or email) sent to the scheme enforcing compliance with a directive.
Assumptions	• Non-Compliance with the Act at Medical schemes will occur due to misinterpretation of the Act • The Act will always be the 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 scheme has delayed the commencement of an enforcement mater by instituting legal proceedings to delay or block an enforcement action undertaken by the unit. A scheme has delayed the submission of the relevant documentation for the enforcement action. Resource constraints within the unit. A scheme lodges an appeal in terms of section of the 49 MS Act around the said enforcement action.
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	70%
Indicator responsibility	Executive Manager: Regulation

Output 23: Strengthen and monitor governance systems of medical schemes and other regulated entities.

Indicator title	Percentage of governance interventions implemented during the period.
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: • Exemption applications • Board notice 73 • Trustee vetting reports received (internal/external sources) • Internal/external information prompting curatorship i.t.o section 56
Method of calculation / Assessment	Sum of governance interventions undertaken/Sum of identified governance interventions required*100 • Undertaken definition: • Correspondence (memorandum or report or letter) approved by the Executive: Regulation for referral to the Registrar or Regulatory Decisions Committee or Council Exco or Council. • Correspondence (letter or memorandum or briefing note or email) correspondence sent to the scheme or regulated entity or relevant person/entity around governance interventions. • Undertaken matters exclude matters received within the relevant performance month.
Means of verification	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 and reports from the Curator in order to monitor the performance of the curator. • Trustee removal proceedings in terms of Section 46: count the number of section 46 notice memorandums / correspondence approved by Executive: Regulation for referral to the Registrar or Regulatory Decisions Committee or Council Exco or Council. • 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 application memorandums / correspondence approved by Executive: Regulation for referral to the Registrar or Regulatory Decisions Committee or Council Exco or Council. • Demarcation exemptions): Count the number of exemption application memorandums / correspondence approved by Executive: Regulation for referral to the Registrar or Regulatory Decisions Committee or Council Exco or Council.
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 scheme or entity has delayed the commencement of governance intervention by instituting legal proceedings to delay or block an intervention. A scheme has delayed the submission of the relevant documentation for the governance intervention. A scheme / entity lodges an appeal in terms of section of the 49 or 50 MS Act around the governance intervention.
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	70%
Indicator responsibility	Executive Manager: Regulation

Indicator title	Number of scheme member meetings attended (Including virtual meetings)
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. The meetings attended can be convened in person or virtually.
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: • Circulars • AGM/SGM or trustee election notification submission to the CMS
Method of calculation/Assessment	Sum of member meetings attended quarterly (count the number of reports produced from attendance of meetings).
Means of verification	Annual General Meetings, Special General Meetings and Elections of Trustee Meetings: • Count the scheme AGM/SGM or trustee election notification submission to the CMS for the AGMs attended. • Count the communication sent to scheme, informing them of CMS' attendance of the AGM/SGM or Trustee Election. Count the report compiled by the unit after a scheme AGM, SGM, or Trustee Election Meeting proceedings have been monitored. (AGM Report).
Assumptions	• The office will always monitor scheme meetings to ensure proceedings of the meeting are conducted according to scheme rules • The 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	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	44
Indicator responsibility	Executive Manager: Regulation

Output 24: Monitor and regulate the financial soundness of medical schemes.

Indicator title	Percentage of business plans decision processed in respect of Regulation 29
Short definition	Percentage of business plans decisions made in respect of schemes below the statutory minimum solvency level as required by Regulation 29.
Purpose/importance	To measure monitoring actions/interventions in respect of schemes below the Regulation 29 solvency.
Source/collection of data	The Unit will identify schemes with solvency levels below the minimum required Regulation 29(2) solvency level. Content Management System on M-Files/OneDrive - CMS Vault – FSU folder The Regulation 29(4) business plan is counted when a decision is made by the Senior Management Committee. The decision may entail a variety of actions. *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 is made to the Senior Management*

	Meeting.
Method of calculation/Assessment	The number of business plan decision processed / number of Regulation 29 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, memorandum with recommendation and SMM decision (minutes of meeting).
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 SMM decision. To ensure an appropriate matching of the receipt and recommendation in a single reporting period, the business plan receipt will only be counted when the SMM decision is made.
Type of indicator	Qualitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100% of submissions received per year, are processed.
Indicator responsibility	Executive Manager: Regulation
Indicator title	**Percentage of Section 35(11) decisions processed in respect of schemes with rapidly reducing solvency (but whose solvency is still above the statutory minimum required solvency)**
Short definition	Percentage of decisions made in respect of identified schemes with rapidly reducing solvency.
Purpose/importance	To measure monitoring actions in respect of schemes with rapidly reducing solvency.
Source/collection of data	The Unit will identify schemes with rapidly reducing solvency. Content Management System on M- files – CMS Vault – FSU folder. The Section 35(11) response is counted when a decision is made by the Senior Management Meeting. The decision may entail a variety of actions. *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. The Section 35(11) response is analysed, and a recommendation is made to the Senior Management Meeting.*
Method of calculation/Assessment	The number of decisions made / number of Section 35 (11) 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	Section 35(11) response and SMM decision (minutes of meeting).
Assumptions	• The assumptions are 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 Section 35(11) responses are generally received at the end of a reporting period following the audit of scheme financials. Based on circumstances, there might be interaction with the scheme over months until a satisfactory reserving policy / 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 SMM decision. To ensure an appropriate matching of the receipt and recommendation in a single reporting period, the business plan receipt will only be counted when the SMM decision is made.
Type of indicator	Qualitative

Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100% of identified schemes per year.
Indicator responsibility	Executive Manager: Regulation
Indicator title	**Percentage of auditor approved applications analysed.**
Short definition	This indicator measures the percentage of complete applications for auditor approval analysed and finalised as per Section 36 of the MSA. An application is deemed to be complete if all the required supporting documentation is submitted, and all queries had been addressed
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 the nature and size of the scheme.
Source/collection of data	Auditor approval letters: after analysis, the decision may entail a variety of actions Content Management System on M-Files/OneDrive CMS Vault – FSU folder. Schemes requiring approval submit application forms through the CMS web portal.
Method of calculation/Assessment	The number of auditor approval decision letter /number of schemes complete applications received at least two weeks before the quarter ends (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	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100% of complete applications received per year are processed.
Indicator responsibility	Executive Manager: Regulation
Indicator title	**Number of quarterly financial return reports published (excluding quarter four).**
Short definition	This indicator measures the number of consolidated medical schemes quarterly financial reports published.
Purpose/importance	This indicator measures the financial performance of medical schemes during the year
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	Quantitative
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	Executive Manager: Regulation
Indicator title	**Number of financial sections prepared for the Annual Report.**
Short definition	This indicator measures whether the financial sections were 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 audited financial performance of medical schemes
Source/collection of data	Financial sections of the annual report submitted for inclusion in the annual report.
Method of calculation/Assessment	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	Quantitative
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
Indicator responsibility	Executive Manager: Regulation

7.8. Programme 4: (Policy, Research and Monitoring)

Output 25: 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/OneDrive.
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, and 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	The sum of research projects completed as per AOP and filed on M-Files/OneDrive
Assumptions	Data sourced from administrators, schemes and other sources for conducting research projects are assumed to be 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	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Industry response rate.
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	All projects are completed as per minimum quality standards prescribed by the SOP.

Indicator Responsibility	Executive Manager: Policy, Research & Monitoring

Output 26: Monitoring trends to improve regulatory policy and practice.

Indicator title	Non-financial report submitted for inclusion in 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 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 be correct and validated prior to submission to the Office. Minimal checks and data validation are also done internally for any glaring data issues.
Disaggregation of Beneficiaries	Data is stratified by various dimensions subject to research objectives. These include but are 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	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Annually
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	Executive Manager: Policy, Research & Monitoring

Output 27: Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements

Indicator title	The number of benefit definitions guidelines published.
Short definition	The number of PBs benefits definitions guidelines published.
Purpose/importance	Benefit definitions guidelines 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 guidelines are published on the CMS website.
Method of calculation/Assessment	Count number of PMB benefit definitions guideline publications on CMS website. (Including revised and updated versions)
Means of Verifications	Published benefit definition guidelines on the CMS website
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Benefit Definitions affecting vulnerable groups such as Women, Children, the 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	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Publication of specific numbers of benefit definitions guidelines on the CMS website
Indicator responsibility	Executive Manager: Policy, Research and Monitoring
Indicator title	**Develop preventactive and primary healthcare package to incorporateinto the PMBs**
Short definition	As per Regulations, PMBs must be reviewed every two years. During 2022/2023, 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 Review and updated revised PMB benefit package.
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/OneDrive.
Method of calculation/Assessment	A preventative and primary healthcare package will be developed and will be stored on M-Files/OneDrive.
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	A dedicated database for all documents on the PMB review exists on M-Files/OneDrive.
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	No
Desired performance	Publication of a revised PMB package.
Indicator responsibility	Executive Manager: Policy, Research and Monitoring

7.9. Programme 5: (Member Protection)

Output 28: 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	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	45
Indicator responsibility	Executive Manager: Member Protection

Output 29: 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 the 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	Quantitative
Calculation type	Cumulative (Year-end)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	90%
Indicator responsibility	Executive Manager: Member Protection

Output 30: Resolve complaints with the aim of protecting beneficiaries of medical schemes.

Indicator title	Percentage of complaints older than 120 calendar days adjudicated during the reporting period in accordance with complaints standard operating procedures
Short definition	This output indicator enables active reporting of complaints that may have aged beyond 120 calendar days during the reporting period
Purpose/importance	To ensure that complaints that have aged due to dependencies in the process are still attended to with the aim of protecting beneficiaries of medical schemes
Source/collection of data	CMS Complaints Adjudication IT system database
Method of calculation/Assessment	Number of complaints older than 120 calendar days resolved / Number of complaints older 120 calendar days unresolved x 100
Means of verification	Report drawn from Complaints database
Assumptions	Complaints will be received continuously since member complaints is a legislated right. Volume and complexity cannot be assumed.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not applicable
Data limitations	None

Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	Significant reduction of complaints that are beyond 120 calendar days of age. A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	Executive Manager: Member Protection
Indicator title	**Percentage of category 2 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures**
Short definition	Category 2 complaints are clinically and/or legally complex, requiring extensive investigation, collation of evidence as well as secondary referral for inputs within CMS and externally
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	Category 2 resolved performance: Number of category 2 complaints resolved within 120 calendar days/ Number of category 2 complaints resolved x 100
Means of verification	Report drawn from Complaints database
Assumptions	Complaints will be received continuously since member complaints is a legislated right. Volume and complexity cannot be assumed.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	80% A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	Executive Manager: Member Protection
Indicator title	**Percentage of category 1 complaints adjudicated within 60 calendar days and in accordance with complaints standard operating procedures**
Short definition	Category 1 complaints are uncomplicated but require secondary referral for inputs within CMS or externally (i.e. referral for clinical opinion). Category level can only be determined after receipt of all responses and supporting documents.
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	Category 1 resolved performance: Number of category 1 complaints resolved within 60 calendar days/Number of category 1 complaints resolved) *100
Means of verification	Report drawn from Complaints database
Assumptions	Complaints will be received continuously since member complaints is a legislated right. Volume and complexity of complaints cannot be assumed.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	80%. A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	Executive Manager: Member Protection

Indicator Title	Percentage of Rulings submitted to Corporate Services for publication on the CMS website within 30 days following the lapse of the 3 months appeal deadline
Short definition	This indicator measures the number of topical rulings submitted to Corporate Services for publication. Topical rulings are rulings which relate to prevalent complaint trends identified during the period of publication, which also have an educational value for medical scheme beneficiaries
Purpose/importance	To ensure that medical scheme beneficiaries understand their rights, responsibilities and benefit entitlements. The rulings will also enable the rationale behind decisions taken and provide clarity on the correct interpretation of the Medical Schemes Act and the rules of medical schemes.
Source/collection of data	Rulings Workflow report drawn from complaints database
Method of calculation/Assessment	The number of rulings referred for publication within 30 days following the lapse of the 3 months within which an appeal must be filed / number of topical rulings identified during the reporting period*100
Means of verification	Referrals to Corporate services to Publish rulings; Publication link received from Corporate Services
Assumptions	Resolution of member complaints is legislated. Therefore, there will always be complaints that must be adjudicated and ruled upon.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Qualitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	80%
Indicator responsibility	Executive Manager: Member Protection

Output 31: Formulate CMS Scripts for publication

Indicator title	The number of CMS Scripts published.
Short definition	The number of CMS Scripts guidelines published.
Purpose/importance	CMS Scripts are published to clarify member entitlements prospectively, thereby reducing the number of complaints received by the Complaints and Adjudication Unit.
Source/collection of data	CMS Scripts guidelines are published on the CMS website.
Method of calculation/Assessment	Count number of CMS Scripts guideline publications on CMS website. (Including revised and updated versions)
Means of Verifications	No of scripts submitted to Corporate Communications Unit/
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	CMS Scripts affecting vulnerable groups such as Women, Children, the Disabled and the Elderly will be prioritised for guidelines. High financial impact conditions such as oncology are prioritised
Spatial Transformation	Not Applicable
Data limitations	Not applicable
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	Publication of specific numbers of CMS Scripts guidelines on the CMS website
Indicator responsibility	Executive manager: Member Protection

Output 32: 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	Clinical Opinions workflow 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 Clinical opinions workflow 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: The 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	A dedicated database for all clinical opinions exists on Clinical opinions workflow.
Type of indicator	Quantitative
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	Executive Manager: Member Protection
Indicator title	**Percentage of category 2 clinical opinions provided within 60 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 medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.
Source/collection of data	Clinical opinions workflow 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 timeless than 60 working days for full completion. Count of clinical opinions electronically via the Clinical opinions workflow 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: The 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 workflow Spread Sheet
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Dedicated database for all clinical opinions workflow.
Type of indicator	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Quarterly

New indicator	No
Desired performance	To attend to 95% of category 2 all clinical opinions within the timeframes of the SOP.
Indicator responsibility	Executive Manager: Member Protection
Indicator title	**Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication Unit**
Short definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication and via e-mail and telephonic enquiries with the view to ensure that member's complaints enquiries are resolved.
Purpose/importance	To protect the members of the medical schemes, facilitate access to medical scheme ben and ensure that members receive rightful cover.
Source/collection of data	M-Files/OneDrive Complaints Database and Clinical enquiries e-mail database.
Method of calculation/Assessment	Sum of clinical enquiries, electronically via email and telephonic. Enquiries are captured b clinical analyst on a spreadsheet. (Total number of clinical opinions responded to within 7 total number of clinical opinions received for the period).
Means of verification	Clinical Opinions workflow 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 follow manual count.
Type of indicator	Quantitative
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	Executive Manager: Member Protection
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 and via e-mail and telephonic enquiries with the view to ensure that member's complaints enquiries are resolved.
Purpose/importance	To protect the members of the medical schemes, facilitate access to medical scheme ben and ensure that members receive rightful cover.
Source/collection of data	M-Files/OneDrive Complaints Database and Clinical enquiries e-mail database.
Method of calculation/Assessment	Sum of clinical enquiries, electronically via email and telephonic. Enquiries are captured b clinical analyst on a spreadsheet. (Total number of clinical opinions responded to within 7 total number of clinical opinions received for the period).
Means of verification	Clinical Opinions workflow 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 follow manual count.
Type of indicator	Quantitative
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	Executive Manager: Member Protection

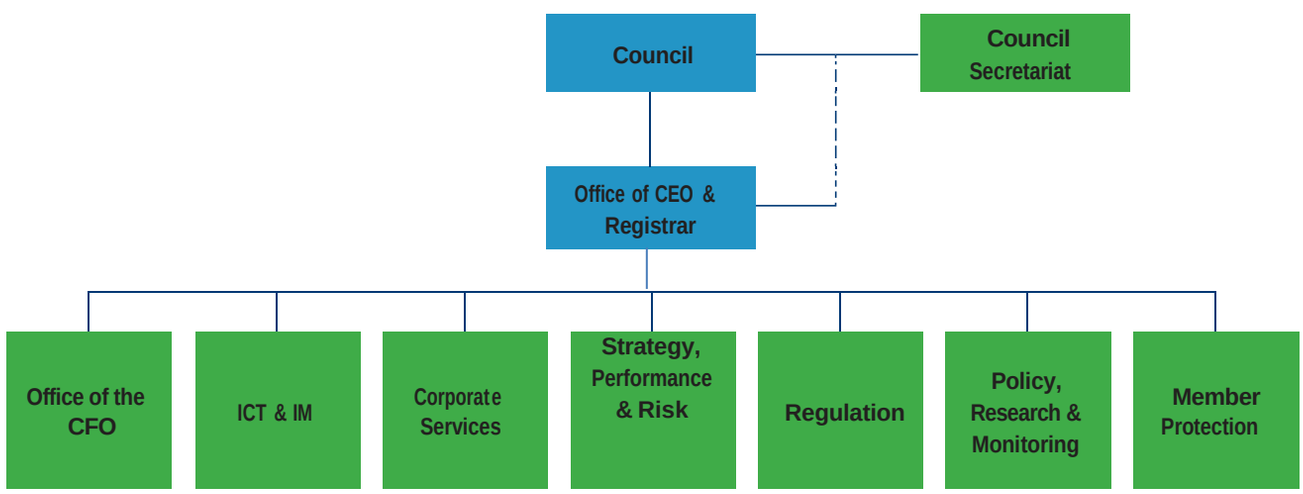
COUNCIL FOR MEDICAL SCHEMES

ANNEXURES TO THE ANNUAL PERFORMANCE PLAN

Annexure A: Amendments to the Strategic Plan

This is the third year of the implementation of the 2020-2025 Strategic Plan. The strategic plan has been revised to amend the programmes as follows:

Programme 1	Administration
Sub-Programme 1.1	CEO: Office of the CEO
Sub-Programme 1.2	CFO: Office of the CFO
Sub-Programme 1.3	ICT & IM: Information Communication Technology and Information Management
Sub-Programme 1.4	CORS: Corporate Service (This programme now includes Legal Services, HR, Part of Stakeholder Relations, and Office Management)
Sub-Programme 1.5	CS: Council Secretariat
Programme 2	SPR: Strategy, Performance and Risk (This programme now includes Strategy, Performance, Risk, Audit Function)
Programme 3	REG: Regulation (This programme now includes Accreditation, Benefits Management, Compliance and Investigations, Financial Supervision
Programme 4	R&M: Policy, Research and Monitoring
Programme 5	MP: Member Protection (This programme now includes The other part of Stakeholder Relations, Clinical Unit, Complaints Adjudication)



CMS Materiality and Significance Framework

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 R1.89 million. This is reviewed and submitted to the Executive Authority on an annual basis.

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 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	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 R1.89 (based on 1% of total CMS revenue as at 31 March 2022).	
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 R1.89m (based on 1% of total CMS revenue as at 31 March 2022) 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 R1.89m (based on 1% of total CMS revenue as at 31 March 2022).	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 R1.89m (based on 1% of total CMS revenue as at 31 March 2022).	

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 performanceagainstpredeterminedobjectivesanditsfinancialpositionasattheendofthefinancial 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.
(ii) Any criminal or disciplinary steps taken as a consequence of such losses or irregular expenditure or fruitless and wasteful expenditure.		Report annually in the annual financial statements.
(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 2022	Calculated materiality and significance value
Total Revenue (0.5 - 1%)	1%	R188 750 000	R188 750 000

The CMS materiality and significance value will be R1.89 million 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 R1 000 000.

Annexure B: Conditional Grants

Name of Grant	Purpose	Outputs	Current Annual Budget (R thousand)	Period of Grant
Unconditional Grant	Policy Development	NHI Projects	R6 537 000	2023/24

Annexure C: Consolidated Indicators (Not Applicable)

Institution	Output Indicator	Annual Target	Data Source

NOTES

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