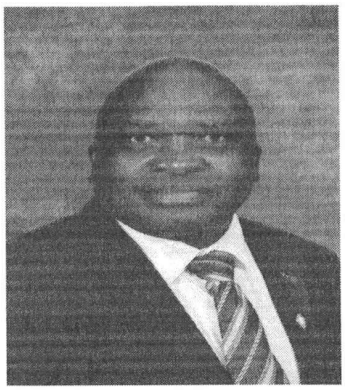
COUNCIL FOR MEDICAL SCHEMES

Annual Performance Plan for 2022/23

Date of Tabling: March 2022

Executive Authority Statement



The Council for Medical Schemes (CMS) submitted its Strategic Plan for the fiscal years 2020 to 2025 as well as its Annual Performance Plan for 2022/23, and these were well received by me. I am satisfied with the alignment between the Strategic Plan and the Annual Performance Plan. I am encouraged by the new vision of the CMS that seeks to promote affordable and accessible health cover towards Universal Health Coverage (UHC).

This signals a new determined approach by the CMS to support national policy initiatives that are driven by the National Department of Health (NDoH). This approach will go a long way in 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.

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

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

The CMS 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 promoting access to healthcare. I am also pleased by the manner in which the finances of CMS have been managed. CMS has obtained unqualified audit reports from the Office of the Auditor General of South Africa every year since its inception. Consequently, I am satisfied to endorse this annual performance plan.

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

DR. MJ PHAAHLA, MP

MINISTER OF HEALTH

Accounting Authority Statement

During its 21 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 play its key oversight role to the CMS during the most interesting era of the health sector in South Africa. This era has seen the release of the draft Medical Schemes Amendment and National Health Insurance Bills as well as the Health Market Inquiry final report.

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

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

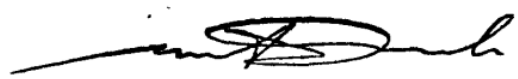
- Policy development and research
- Reduction of costs and quality improvement
- Reduction of fraud, waste and abuse
- Support establishment of a coding authority
- Harmonise the medical schemes regulatory frameworks in the SADC
- Consolidation of options and medical schemes
- Primary Health Care package as part of the Prescribed Minimum Benefits
- Presidential Health Compact

This Annual Performance Plan has been developed within the context of the constraints that are presented by the COVID-19 pandemic to the regulatory and operational effectiveness of the CMS as a regulatory authority. I am, however, assured by the CMS's excellent performance in the previous and current financial years under the same constraints.

I am convinced that this Annual Performance Plan will have a significant impact on the Strategic Plan and that there is good alignment

between these key planning efforts.

I extend my gratitude to fellow Council members, the Registrar, the CMS Management and staff for the continued focus on the mandate as entrenched in the MSA in general; 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 OF THE COUNCIL

Official Sign-Off

It is hereby certified that this Annual Performance Plan:

- Was developed by the Accounting Authority and Management of the Council for Medical Schemes under the guidance of the National Department of Health
- Takes into account all the relevant policies, legislation and other mandates for which the Council for Medical Schemes is responsible
- Accurately reflects the strategic outcome-oriented goals and objectives which the Council for Medical Schemes will endeavour to achieve over the period 2022/23.

Ms. Andiswa Zinja

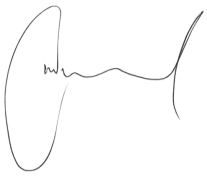
Chief Financial Officer

Mr. Ephraim Tlhako

Chief Information Officer

Vacant

Executive Manager: Corporate Services



Mr. Khayalethu Mvulo
Council Secretariat

Vacant

Executive Manager: Strategy, Performance & Risk

Vacant

Executive Manager: Regulation

Mr. Michael Willie

Executive Manager: Policy, Research and Monitoring

Vacant

Executive Manager: Member Protection

Dr. Sipho Kabane

Chief Executive Officer and Registrar

Dr. Memela M Makiwane

Chairperson: Council for Medical Schemes

DR. MJ PHAAHLA, MP

MINISTER OF HEALTH

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Part A: Our Mandate

1. Updates to the relevant legislative and policy mandates

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

The NHA provides the framework for a structured uniform health system for our country, taking into account the obligations imposed by the Constitution and other laws on the national, provincial, and local governments concerning health services. A key objective of the NHA is to unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa. Added to this is the intent to 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.

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; and
- 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.
- Public Finance Management Act, 1 of 1999 (PFMA)
  Provides for the effective, efficient and economic financial management in government departments and public entities.
- Promotion of Access to Information Act, 2 of 2000 (PAIA)
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies or person. It gives effect to the right of access to any information held by the state or any other entity or person.
- Protection of Personal Information Act 4, of 2013 (POPI)
  This Act sets the conditions for how an organisation can process or access information and also how it approaches the

aspect of privacy.

- Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000 (PEPUDA)
  Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.
- Broad-based Black Economic Empowerment Act, 53 of 2003 (BBBEEA)
  Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.
- Labour Relations Act, 66 of 1995 (LRA)
  to promote economic development, social justice, labour peace and democracy in the workplace.
- Financial Sector Regulation Act, 9 of 2017 (FSRA)
- *To establish a system of financial regulation by establishing the Prudential Authority and the Financial Sector Conduct Authority,*
- Promotion of Administrative Justice Act, 3 of 2000 (PAJA)
  To give effect to the right to administrative action that is lawful, reasonable and procedurally fair and to the right to written reasons for the administrative action as contemplated in section 33 of the Constitution of the Republic of South Africa.
- Financial Sector Regulation Act, 9 of 2017 (FSRA)
  To provide for the participation of the CMS as a regulator and to provide powers of inspection into financial service providers.
- Financial Advisory and Intermediary Services Act, 37 of 2002 (FAIS)
  To provide for the dual accreditation of brokers.
- Companies Act, 71 of 2008
  Provides for liquidation of medical schemes

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

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

1. raise the life expectancy of South Africans to at least 70 years;
2. progressively improve TB prevention and cure;
3. reduce maternal, infant and child mortality;
4. significantly reduce 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 the achievement of the desired outcomes. These nine priorities are as follows:

1. address the social determinants that affect health and diseases;
2. strengthen the health system;
3. improve health information systems;
4. prevent and reduce the disease burden and promote health;
5. financing universal healthcare coverage;
6. improve human resources in 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 2020 was estimated to be 59,62 million lives, 8,89 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[1] 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)
- Health Market Inquiry (HMI)
- Financial Sector Regulatory Act
- 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 2022/23 financial year, our expectations are that there will be intensive interactions with key stakeholders culminating in the finalisation and promulgation of the amendments to the MSA. The CMS is tasked with the implementation of all the legislated changes and, where necessary, developing the regulations.

The successful implementation of the new MSA and Regulations will empower the CMS to become a more effective and efficient

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

regulator. The final changes that will be incorporated in the MSAB will include relevant recommendations from the HMI, NHIB and other regulatory updates.

The National Health Insurance (NHI)

The NHI Bill was presented to and approved by Cabinet in July 2019 and has since been presented to Health Portfolio Committee. This Committee has now released the bill for further public comment. The Bill has been subjected to an extensive public consultation process through the Health Portfolio Committee roadshows. The Portfolio Committee on Health is currently holding hearings, where different stakeholders are articulating their positions vis-à-vis' the National Health Insurance Bill. These hearings will continue until all stakeholders have made their presentations. The Council for Medical Schemes is at the writing of this version of the Annual Performance Plan, yet to make its presentation. Once all the stakeholders have made their inputs, the Bill is scheduled for further parliamentary debates before it is presented to the President for promulgation.

This period coincides with the second phase of the implementation of the NHI. The CMS sees 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.

Phase 1 (2017-2022): included the piloting of and the development of systems and processes for the effective functioning of the health system
Phase 2 (2022-2026): this will entail the development of systems and processes to ensure effective functioning and administration of the NHI Fund. These reforms are categorised into four items: (a) Financing, (b) Health service provision, (c) Governance, and (d) Regulatory, as described below:

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

Phase 3 (2026-2030): will be the introduction of mandatory prepayment for the NHI, contracting for accredited private hospital and specialist services, finalisation and implementation of the Medical Schemes Act and finalisation and implementation of the NHI Act, in addition to the specific activities that the CMS will be carrying out in phase 2.

Health Market Inquiry (HMI)

The HMI panel released its findings and key recommendations in a report end of September 2019. The report was presented to the Competition Commissioner and the Minister of Trade and Industry, who presented the report to the Minister of Health and the Health Portfolio Committee in parliament. The Minister of Health is tasked with developing an implementation plan based on some of the recommendations in the report. The Minister of Health will develop this implementation plan, together with key stakeholders, including the CMS. It is envisaged that the implementation will have a significant impact on the MSAB. CMS expects that it will be expected to implement some of the recommendations directly, support the implementation of others, and play an active role in the interim arrangements leading to the establishment of new regulatory entities.

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, 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 ICT, HR, Finance, and Stakeholder Relations Policies. These institutional policies are periodically reviewed and approved by the Accounting Authority. The CMS has adopted a number of new policies, including the remuneration policy and philosophy, in 2019 and is in the process of implementing these. The CMS has reviewed its current Code of Conduct and has developed and adopted a comprehensive Ethics Policy whose aim is to introduce an ethics culture, prevent, address fraud and corruption. New Ethics Code of Conduct pocket booklets were issued during the 2021/22 financial year.

The Accounting Authority has adopted the Organisational Diagnostic Exercise Report and its recommendations, thereby allowing the institution to review its Business Operational Model, which includes a service delivery model and conducting a business process mapping. A greater part of 2022/23 will see the implementation of the new structure adopted by the Council and the migration of personnel from the old to this structure.

3. Updates to Relevant Court Rulings

CMS vs Key-Health

The North Gauteng High Court had on February 2021, placed Key-Health Medical Scheme under final curatorship following a successful application by the Registrar of the Council for Medical Schemes (CMS), in terms of Section 56(1) of the Medical Schemes Act, No. 131 of 1998 (the MS Act), and Section 5(1) and (2) of the Financial Institutions (Protection of Funds) Act 28 of 2001 (the FI Act).

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

The application has been duly granted, and the curator has assumed full control of the scheme.

The curator has attended to all the challenges that Key-Health and will be soon scheduling an AGM to elect new trustees.

CMS vs Compcare

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

CMS successfully resisted an application by Compcare to use the name of its administrator, Universal Health Care. The CMS argued that this would lead to confusion amongst members of Compcare, and this would not be in the best interest of the members of the scheme. The Constitutional Court agreed with the CMS and dismissed the application by Compcare.

CMS vs COTTY

CMS successfully defended an application by COTTY to render section 50 appeal irrelevant in so far as the suspension effect is concerned. CMS argued that once a 50 appeal is lodged, the order by the Appeals Committee is suspended pending the section 50 determination. The court agreed with this interpretation.

CMS vs Thebemed

The High Court granted a curatorship application on 10 September 2019 in favour of the CMS after the scheme's solvency levels were reduced to a precarious state. The CMS has worked with the curator to closely monitor the scheme to ensure that the scheme's solvency improves significantly to protect the interests of members. The curator is recruiting a PO for the scheme, and once the hand-over process is complete, the curator will apply for the upliftment of the curatorship. It is anticipated that the scheme will be handed back to the newly elected Board of Trustees following a court hearing that will occur in early 2022.

Part B: Our Strategic Focus

1. Update Situation Analysis

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

1.1 External Environment Analysis

Table 1: PESTEL analysis

POLITICAL	ECONOMIC	SOCIAL	TECHNOLOGICAL	ENVIRONMENTAL	LEGAL
• State of Disaster • Ethical Leadership • Corruption & Fraud • Conflict of Interest • COVID-19 Vaccine's hesitancy • COVID-19 infections • Civil unrest and impact on medical schemes membership and access to care, in particular, medical service providers and pharmacies that were directly affected • Elections-Learnings from Zambia • National municipality elections	• Increasing unemployment • Increasing poverty • Increasing inequity • Economy contraction • Real GDP decline to 2006 levels • Post-financial crisis growth has been wiped out • Budget deficit • Economic recovery plan after COVID-19 • Capacity for Vaccines Manufacture & producing PPEs • South African Economic Reconstruction and Recovery Plan	• Declining life expectancy • Gender-Based Violence • Working remotely • Social welfare • Education (COVID-19 infections in schools) • Protests • Service/Wages • Fighting Crime • Covid-19 Vaccine Hesitancy	• Cybersecurity and privacy • Virtual platforms • E-learning • Webinars Conferences • E-health/ Telemedicine • Tools of trade • Big-Data • AL/Analytics Robotics • Digital transformation-transactions • Block chain technology	• Lack of energy (Load shedding) • Climate change and variability • Waste and littering • Pollution • Lack of water/ droughts • Save trees, prints less electronic communication through sign flow	• NHI Parliamentary engagements • Mandatory COVD-19 Vaccines • Certificate of Need Regulations • Regulations on Pensions Fund and Retirement Annuity withdrawal limits • Consumer rights and laws • Transformation • POPIA and Disaster Management Act

Table 1 above provides a substantial but not exhaustive list of the key external environmental issues that have an influence on the CMS operations or regulatory environment. The extent to which these external factors are likely to affect the CMS cannot be predicted with great accuracy in the medium to long term. The CMS has to, however, ensure that the risks that are posed by these factors to its ability to achieve its set objectives have to be understood and plans put in place to mitigate against them. A key contextual issue in the development of Table 1 and the accompanying analysis is the persistence of the COVID-19 in the 2022/23 financial year, as was the case in the two previous years.

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

The revelations of governance failures, unethical behaviour, corruption and budget cuts and well and cost containment strategies in the public domain will negatively impact the government's ability to fund public health entities such as the CMS.

The collapse of the economy during the Covid-19 pandemic will exacerbate unemployment, poverty, and inequity, which will be experienced in the 2022/23 financial year. With unemployment levels persistently above the 30% mark due to structural factors, the pressure on household incomes and reduced employment prospects will remain. The fact that medical scheme membership is associated with employment and a growing economy means that scheme members are likely to decrease slightly in the medium to long term, rendering the sustainability of the industry questionable. This will potentially also put pressure on the CMS revenue stream.

The massive Covid-19 vaccine roll-out that is led by the Health Ministry, whose aim is to achieve herd immunity by ensuring that 70% of the targeted population is vaccinated, is making significant strides. Despite the progress in the vaccine roll-out programme, South Africa still experienced a fourth wave between November and December 2021, and is likely to extend to early 2022.

However, Covid-19 hesitancy remains a threat to achieving herd immunity and targets set by the NDoH across various population groups. Hesitancy levels are also notable in the medical scheme's environment. Interventions currently being explored also include the introduction of mandatory vaccination. The recent preparedness survey conducted by the CMS amongst medical scheme members revealed that nearly sixty percent of the respondents indicated that they would accept the Covid-19 vaccine if their employer provided it. Employer provision of the vaccine coupled with training, education and awareness campaigns, may be one of the key strategies to combat vaccine hesitancy.

The utilisation of virtual platforms for meetings has seen an exponential 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. 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 considering the Covid-19 pandemic. Continued monitoring and evaluation of virtual platforms and value add to members will remain a priority area of focus.

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

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

In terms of scenario planning, it appears as if we are moving into a scenario of a difficult economic recovery. This scenario emanates from an analysis based on the economic recovery and NHI implementation as key uncertainties in the CMS environment over the remainder of the five years Strategic Planning Circle. This scenario will be dominated by extensive legal challenges to the CMS and the Ministry as they attempt to implement the National Health Insurance. This scenario will also signal fewer resources to the CMS to address its regulatory short-falls, human resources, IT systems and other operational challenges. The aggregated impact of this scenario is slow progress towards regulatory effectiveness and efficiency as well as delayed delivery of the National Health Insurance support programmes.

The medical schemes industry the CMS regulates consists of various key stakeholders with diverse interests and agendas. As of 31 March 2021, CMS regulated 74 medical schemes, 19 administrators (Including self-administered schemes), 41 managed care organisations and 2231 broker organisations, and 7 872 individual brokers. The role of the CMS is to regulate these entities utilising the MSA and Regulations to ensure that all the 8.9 million scheme beneficiaries' interests are protected. This means that the CMS should ensure that all the regulated entities are always compliant with the MSA and its provisions.

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**[2], which removed the ability of schemes to discriminate against older and sicker members through the selective non-provision of key benefits;

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

- **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.

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 CMS is currently faced with significant financial difficulties due to resource constraints. This has led to key strategic projects not being fully implemented, thus negatively impacting the role that the Regulator has to play in the medical schemes industry.

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

Despite our best intentions with the promulgation of the MSA and its regulations in 2000, the CMS has been met with serious challenges in being an effective regulator due to challenges by industry players and certain legislative limitations. This situation has led to the CMS seeking to amend specific areas of the MSA in order to strengthen its effectiveness and efficiency as a regulator. In the past five years, the CMS has not been successful in effecting the necessary legislative changes due to the long and onerous route that this process has taken. The release of the Medical Schemes Act Amendment Bill (MSAAB) for public comment in June 2018 represents a massive shift toward the legislative empowerment of the CMS, and we whole-heartedly welcome this move.

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 was presented to Parliament after the Local Government Elections on November 10th, 2021.

Industry Trends

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

On the positive side

- Medical schemes registered a record-high net healthcare result for all medical schemes combined, reflecting a surplus of R19.93 billion in 2020 (2019: R1.03 billion surplus). This was mainly due to the lower utilisation of health services and because some of the elective procedures were deferred due to the pandemic.
- The industry solvency levels improved significantly from a solvency ratio of 35.61% in 2019 to 44.55% in 2020, still higher than the statutory requirement of 25% throughout the period under consideration
- The number of schemes that failed to meet the 25% statutory solvency remained at seven between 2014 and 2020
- The number of Efficiency Discounted Options (EDOs) increased from 40 in 2014 to 69 in March 2021
- The proportion of the beneficiaries covered by the EDOs increased from 25.3 to 28.8% in 2020
- There was a reduction in the number of schemes from 83 in 2014 to 74 in 2020. 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. It is, however, of great concern that the proportion of beneficiaries covered by the EDO's has not changed over the years and remains at 23.50%.

On the negative side

- COVID-19 has adversely affected the global sphere and claimed more than 500 lives in the medical schemes sector by August 2021.
- COVID-19 has also had a negative impact on life expectancy. Statistics South Africa reports that Life expectancy at birth for males declined from 62,4 in 2020 to 59,3 years in 2021 (3,1-year drop) and from 68,4 in 2020 to 64,6 years for females (3,8-year drop).
- The number of scheme beneficiaries declined by 1,1% between 2019 and 2020.
- The decline was more notable in the open schemes; restricted schemes depicted a slight increase over the same review period.
- The industry experienced an increasing age profile of 0,4 factor, with beneficiaries ageing from 33.0 years in 2019 to 33.4 in 2020.
- The growing levels of Out-of-Pocket (OOP) payments in the industry continue to affect members negatively. The CMS conducted study showed that OOPs incurred by members increased at an annual rate of 7.9%, from an estimated R22.3 billion in 2013 (R2 562.83 per beneficiary per annum (pbpa)) to over R35.2 billion in 2019 (R3 913.94 pbpa), in real terms. OOPs made up just over 18% of the total amount claimed from medical schemes in 2019; this increased from 15.5% in 2013. OOPs incurred for medicines dispensed increased annually by 7.8% between 2013 and 2019, from R7.4 billion to R11.6 billion, respectively.
- Poor governance and financial management of schemes resulted in a number of schemes being placed under curatorship in this period

The main conclusion that can be drawn from the above-observed trends is that the medical aid industry is faced with serious sustainability challenges. A negative beneficiary growth was experienced due to COVID-19 and other socio-economic factors, resulting in more principal members exiting at a slightly higher rate than dependants.

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

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

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

Policy Developments

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

- Promulgation of the NHI Bill
- Promulgation of the Medical Schemes 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 experience in countries that have implemented NHI varies subject to the model employees. However, there is evidence that reduced benefit offering with medical schemes only offering a complimentary benefit to that which will be offered under the NHI will likely result in the reduction of regulated entities.

The HMI was identifying market and regulatory failures in the private health industry. The HMI has made final recommendations in order to address the identified market and regulatory failures. Among other gaps identified in the HMI report is the need for a Supply-Side Health Regulator (SSHR) and establishment of a risk adjustment mechanism, encourage reinsurance contracts, changes in the medical schemes solvency approach to remove barriers of entry, strengthening of corporate governance and the establishment of a body the will undertake health technology assessment including a review of quality health outcomes.

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 Private 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

There is significant uncertainty about South Africa's economic outlook for 2022 and beyond. On the one hand, the country will benefit from a strong global economic context and less restrictive lockdown regulations alongside rising local vaccination rates.
On the other hand, the country faces many challenges carried over from 2021. These include electricity load-shedding, under-pressure municipal finances, as well as global and local supply chain challenges.

It has been observed that from a policy perspective, fiscal and monetary authorities have started rolling back the stimulus provided over the past two years hence the recent increase in interest rates by the Reserve Bank. This means that both fiscal and monetary policy will gradually become less accommodative over the next three years in offsetting the impact of COVID-19 at a household level.

According to the National Treasury most recent Economic Outlook, GDP was expected to contract in the third quarter of 2021 with an improvement towards the end of 2022 because of stronger than expected GDP outcomes in the first half of 2021.

Table 1 outlines expected macroeconomic performance for 2022, 2023 and 2024, set out medium-term projections.

Table 1: Macroeconomic performance and projections

Calendar year	2018	2019	2020	2021	2022	2023	2024
Percentage change		**Actual**		**Estimate**		**Forecast**	
Final household consumption	2.4	1.1	-6.5	5.7	2.0	1.9	1.9
Final government consumption	1.0	2.7	1.3	0.1	-1.4	-2.9	-0.1
Gross fixed-capital formation	-1.8	-2.4	-14.9	1.2	3.1	3.4	3.5
Gross domestic expenditure	1.6	1.2	-8.0	4.9	2.4	1.9	1.7
Exports	2.8	-3.4	-12.0	10.3	2.9	2.6	2.7
Imports	3.2	0.5	-17.4	9.5	5.3	4.0	2.6
Real GDP growth	**1.5**	**0.1**	**-6.4**	**5.1**	**1.8**	**1.6**	**1.7**
GDP inflation	4.0	4.5	5.3	5.4	1.3	3.2	4.4
GDP at current prices (R billion)	**5 358**	**5 605**	**5 521**	**6 112**	**6 304**	**6 607**	**7 018**
CPI inflation	4.6	4.1	3.3	4.5	4.2	4.3	4.5
Current account balance (% of GDP)	-3.0	-2.6	2.0	3.8	0.4	-1.5	-1.7

Source: National Treasury, Reserve Bank and Statistics South Africa

Table 1 above also illustrates an inflation projection of 4.2 per cent for 2022 and is expected to remain well contained within the target range by the South African Reserve Bank approaching 4.5 per cent in 2024. Risks to the inflation outlook are primarily assessed to the upside, mainly stemming from non-core inflation.

The resurgent COVID-19 infections leading to the fourth wave is likely going to continue to slow economic recovery with a negative impact on employment. By June 2021, the total number of jobs (14.9 million) remained 1.5 million below pre-pandemic levels. Whilst the official unemployment rate rose to 34.4%, the highest recorded since the publication of the Quarterly Labour Force Survey began in 2008. During the second quarter of 2021, the number of private-sector jobs reached a post-2005 low (National Treasury Economic Outlook 2021). Public-sector employment gains appear to be driving a partial recovery in jobs, consisting largely of temporary work and training opportunities created through public employment programmes.

The potential for recovery in 2022 remains, and the GDP growth is projected at 4.5% for the advanced economies compared to 1.8 % for South Africa, increasing to 1.7% in 2024. South Africa is currently attempting to increase the number of people receiving vaccines whilst also assessing the viability of making vaccines against Covid-19 mandatory, at least for certain sectors of the population, as some other countries have done.

1.2 Internal Environment Analysis

Table 2: SWOT analysis

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Unique expertise Experienced, skilled personnel Sole mandate Track record Success in legal challenges Unqualified audits Integrated annual report Single source of information for Industry performance. New Council appointed in 2021 which creates stability and certainly CMS Branding and Image • CMS website Partnerships and collaboration with other regulators and industry bodies through MoU • Competition Commissioner • Health Quality Assessment • Stellenbosch University • Join Learning Network partnering with NDoH, NT and the World Bank	Reputational risk Filing of Snr vacancies Reputational risk Litigations Confidential Information leaks Data & Information Security Succession Planning and Continuity Budget Approval Process Reactive Regulatory than proactive approach Stakeholder Management • NDoH • National Treasury Staff turnover Labour costs Impact of COVID-19 on business continuity staff turnover Succession planning	MSAB/NHI/HMI CMS and NDoH Forum Personnel Secondment and Sharing of information COVID-19 working group Coding standards and regulation CMS Branding and Image CMS website Alternative Funding Model for the CMS Alternative Reimbursement Models (ARMS) Mid-year budget review • Identify Key Performance Areas Organisational Design/CMS Fit for Purpose • New structure Implementation & migration Change Management Working remotely / Office space"	COFI Bill Institutional Knowledge and high Training and development Collusion with regulated entities Legal pushbacks Internal resistance to change – culture Leadership and mandate change Performance Incentive Moratorium Independent Community Pharmacists (ICPA) • Impact on Networks & DSPs • Co-payments Mushrooming of Healthcare vouchers or similar products Potential of FWA scheme reserves and surplus generated during the pandemic

Table 2 above articulates the key strengths and weaknesses that the CMS has as a regulatory entity, as well as the external threats and opportunities that lurk in its external environment. It is important to note that these strengths and weaknesses have been extensively workshopped with all the internal units at the CMS, and the interventions to these have been captured in our operational plans. The Mushrooming of Healthcare vouchers or similar products 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 NDOH. 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 as a result of 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 which are potential to abuse or misuse by schemes could be rechanneled back to members through benefit design and product development.

The Business Process Mapping exercise is meant to address a significant amount of the challenges that emanate from the internal environment. Coupled with the audit review for 2020/21, the performance targets that are related to the Compliance & Investigations, as well as Complaints Adjudication functions, had to be revised and realigned to the CMS mandate. This resulted in significant changes. The targets for the new indicators are baseline targets, which will assist the CMS in achieving its predetermined outcomes in an effective and efficient manner.

The CMS has enjoyed a fairly stable organisational environment, despite the fact that there has been an increased staff turnover during the past year due to the non-renewal of contracts and employees moving to "greener pastures." The Council, with the support of the Office of the CEO, undertook an Organisational Diagnostic exercise to address key organisational challenges at the CMS. The key findings and recommendations revealed that there is a need to review the organisation's operational and service models as well as to conduct a level 1 to 3 business process mapping. This was communicated to staff members since there is a potential to restructure the organization. The process of migrating current employees into a new proposed structure is one of the key activities in the 2021/22 financial year. This process is planned to be finalised in the second quarter of the 2022/23 financial year.

Employer/employee relations continues to be a challenge in the organisation, and there is recognition that ongoing information sharing sessions can improve the manner in which disputes and grievances are managed. As a way of reducing conflict related legal costs both at Labour court and High court, HR developed and presented conflict management intervention for all staff at CMS. The Labour relations unit shall also represent CMS in all CCMA matters going forward, and this shall reduce legal costs tremendously. As a way of comparison, legal costs in this current financial year are lesser than the 2020/2021 financial year.

To improve productivity and increase motivation in the workplace, the Human Resources sub-division will continue to focus on the following key strategic projects:

- Talent Management: The qualification framework to be aligned to position requirements, to ensure that the right employees with the right qualifications are appointed and retained.
- Learning and development: Centralise learning and development to prioritise training based on the needs of the organisation. The learning and development framework will provide opportunities for optimal utilisation of employees and maximise their developmental capacity
- Performance Management: Through performance reviews and appraisals, identify areas of improvement to ensure that employees meet required performance standards
- Diversity and Inclusion: Re-launch the values to improve inclusivity
- Remuneration: Continue to benchmark remuneration and benefits to strategically position the organisation with the market.
- Succession Planning: Introduce leadership development programmes to ensure that employees are ready to take over leadership roles when opportunities arise.

The human resources sub-division plays a critical role in the placement of employees in the new organisational structure to ensure that the CMS remains a more effective and efficient organisation. The filling of new positions will be implemented in a phased-in approach. Priority will be given to leadership and critical posts when vacancies are filled. This will also consider the promotion of the Broad-Based Black Economic Empowerment to ensure the attainment of the management control element of the B-BBEE Scorecard.

INFORMATION TECHNOLOGY

The ICT & KM sub-programme will continue to play a significant role in providing technology enablers that support strategic business processes and strategic projects identified by the business. The sub-programme will embark on a process to overhaul a number of its IT systems in order to have a more integrated IT platform and automate as many business processes as possible to ensure that it keep up with the rapid technological changes. This will enable the organisation to become more efficient in its operations.

The sub-programme will further strengthen the organisation's ability to counter cyber-security threats posed by both the internal as well as external environment. It has increasingly become vital that the organisation's information assets are secured and protected against attacks, especially more so as there has been an increase in remote work where most employees are working from home. Therefore, several additional security measures aimed at strengthening mobile device security as well as network and applications' security vulnerabilities will be implemented.

The sub-programme will also continue with its efforts to ensure the establishment of a robust ICT Business Continuity and Disaster Recovery solution, which will allow for real-time replication of data, availability and seamless failover of our critical systems and applications in case of a disaster.

FINANCIAL MANAGEMENT

CMS has shown significant improvement in its financial management and governance, as can be evidenced by the unqualified audit opinion received from the Office of the Auditor General of South Africa. The improvement is further extended to supply chain management, where a significant reduction is seen on matters reported on the management report year on year. This is attributed to the enforcement of controls that strengthen compliance, a supply chain management unit that is fully capacitated with competent individuals and policies and procedures are aligned with the relevant National Treasury prescripts. The supply chain function will continue to be the focus as the organisation strives to move to a clean audit outcome.

Another focus over the MTEF is the financial sustainability of the CMS. The organisation has been incurring a deficit over the previous three (3) years with no reserves. The entity will therefore be reviewing, developing, and implementing an alternative funding model that will be aligned with its strategy and fully finance the strategic outcomes of the organisation.

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 R194 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

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
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	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1
Output Indicator 1.2	Ensure that the overall performance of the entity is 80% of the targets set for the year	New indicator	New indicator	90.83%	80%	80%	80%	80%
Output Indicator 1.3	Ensure that an Annual Performance Information report produced is reliable, accurate and complete by 31 July each year in line with the statutory requirements	1	1	1	1	1	1	1
Outcome 6:	**To collaborate with local, regional, and international entities**							
Output 2: Develop strategic relationships with other regulators and stakeholders								
Output Indicator 2.1	Number of signed Memoranda of Understanding with local, regional and international regulators and stakeholders	New indicator	New indicator	4	4	4	4	4

1.1.2 Quarterly targets for 2022/23 (Office of the CEO)

Performance indicators		Reporting period	Annual target	Quarterly targets			
		2022/23	2022/23	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	Quarterly	1	n/a	n/a	1	n/a
Output Indicator 1.2	Ensure that the overall performance of the entity is 80% of the targets set for the year	Quarterly	80%	80%	80%	80%	80%
Output Indicator 1.3	Ensure that an Annual Performance Information report produced is reliable, accurate and complete by 31 July each year in line with the statutory requirements	Annually	1	n/a	1	n/a	n/a
Outcome 6:	**To collaborate with local, regional and international entities**						
Output 2:	**Develop strategic relationships with other regulators and stakeholders**						
Output Indicator 2.1	Number of signed memoranda of understanding with local, regional and international regulators and stakeholders	Quarterly	4	1	1	1	1

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 2021/22 financial year on 31 January 2021. The CMS aims to continue on the same trajectory of achieving an overall performance of above 80% against predetermined objectives. The high increase in Salaries and wages is due to the position of Executive Manager: CEO office which was budgeted for under Strategy office in 2021/22 financial year. In 2022/23 this position is placed properly in CEO's office. The Strategy office position is vacant and will be filled in 2022/23 financial year.

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

Expenditure (1.1)	Budget			
Office of the CEO and Registrar	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**3 424 223**	**5 328 714**	**5 565 842**	**6 178 084**
Salaries and wages	3 424 223	5 328 714	5 565 842	6 178 084
Goods and services	**4 299 385**	**4 308 566**	**4 318 633**	**3 264 240**
Communication	1 999	2 084	2 176	2 274
Consultants	2 069 001	2 069 001	2 069 001	1 000 000
Legal fees	1 924 275	1 924 275	1 924 275	1 924 275
Other unclassified expenditure	9 999	10 422	10 885	11 374
Staff cost note	2 203	2 296	2 398	2 506
Venue and facilities	89 062	89 062	89 062	93 061
Training and staff development	16 652	17 356	18 128	18 942
Travel and subsistence	186 194	194 070	202 706	211 808
TOTAL	**7 723 608**	**9 637 280**	**9 884 475**	**9 442 325**

1.2. Sub-Programme 1.2: (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

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 4: To be 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 31 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	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1
Output Indicator 4.2	Produce a budget that is approved by Council by 31 January each year	New Indicator	New Indicator	1	1	1	1	1

1.2.2 Quarterly targets for 2022/23 (Office of the CFO)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2022/23	2022/23	1st	2nd	3rd	4th
Outcome 4: To be 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 31 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	Annually	1	n/a	n/a	n/a	1
Output Indicator 4.2	Produce a budget that is approved by Council by 31 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 CMS will continue to manage its finances as prescribed by the Public Finance Management Act (PFMA) and maintain a strong system of internal controls for effective and efficient management of its finances. It constantly seeks ways to improve its systems to better align with the requirements of the PFMA and best practices. This is evidenced by the unqualified audit opinion on its annual financial statements for 2020/21 from the Auditor-General.

The CMS is considering alternative funding model that will strengthen its financial position in the medium to long-term for its financial sustainability.

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

Expenditure (1.2)	Budget			
Office of the CFO	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**13 100 153**	**12 951 569**	**13 713 423**	**15 221 900**
Salaries and wages	8 859 052	8 874 452	9 269 365	10 288 995
Social contributions	4 241 101	4 077 118	4 444 058	4 932 905
Goods and services	**1 817 809**	**2 876 028**	**1 939 866**	**2 008 906**
Communication	6 169	6 430	6 716	7 018
Consultants	402 211	1 402 211	402 211	402 211
Bank charges	110 400	115 070	120 191	125 588
Non life insurance	606 784	632 451	660 595	690 256
Other unclassified expenditure	295 026	307 505	321 189	335 611
Printing and publication	141 983	147 989	154 574	161 515
Staff cost note	2 203	2 296	2 398	2 506
Venue and facilities	39 261	39 261	39 261	41 024
Training and staff development	182 416	190 132	198 593	207 510
Travel and subsistence	31 356	32 682	34 136	35 669
TOTAL	**14 917 962**	**15 827 597**	**15 653 289**	**17 230 806**

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

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 4: To be 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	99.41%	99%	99%	99%	99%	99%	99%
Output Indicator 5.2	Percentage of IT security incidents (breaches)	0%	5%	0.75%	5%	5%	5%	5%
Output Indicator 5.3	Number of successful IT Disaster Recovery (DR) failover tests	New indicator	New indicator	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 uptime business-critical application systems (server uptime)	100%	99%	99%	99%	95%	95%	95%
Output 7: Effectively provide information management services and organise and manage organisational knowledge with a view to enhancing knowledge sharing.								
Output Indicator 7.1	Percentage of PAIA requests for information received and finalised within 30 days	98.5%	95%	95%	95%	95%	95%	95%

1.3.2 Quarterly targets for 2022/23 (ICT & IM)

Outcome Indicator	Performance indicators	Reporting period	Annual target	Quarterly targets			
		2022/23	2022/23	1st	2nd	3rd	4th
Outcome 4: To be 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	99%	99%	99%	99%	99%
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 uptime business-critical application systems (server uptime)	Quarterly	95%	95%	95%	95%	95%
Output 7: Effectively provide information management services and organise and manage organisational knowledge with a view to enhancing knowledge sharing.							
Output Indicator 7.1	Percentage of PAIA requests for information received and finalised within 30 days	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 continue to be dedicated to achieving its annual targets and commitment to supporting the CMS in achieving its business outcomes. The unit will conduct two disaster recovery failover tests, an ICT vulnerability test in order to maintain less than 5% of major cyber security incidents/attacks, and maintain a high response rate to PAIA information requests for the medium-term period.

The 2020/21 financial year was not business as usual as the CMS, like most organisations, had to rapidly adapt to new ways of running its business operations due to the COVID-19 pandemic. With the rapid spread of the disease and the national COVID-19 lockdown regulations implemented, the ICT&IM unit will continue to ensure that all employees can work remotely from the safety of their homes. This is made possible by providing technology enablers, including mobile devices, maximising the use of digital technologies such as Microsoft Teams for employee collaboration, Sign-Flow for workflow and internal memorandum approvals, and M-Files for electronic document management.

In order to ensure that the CMS continues to be an effective and efficient regulator of the medical schemes industry, the ICT&IM programme will prioritise the digitisation and automation of as many business processes as possible, integrate siloed applications, and upgrade legacy systems in order to develop a more integrated regulatory system that is responsive to the needs of the industry. Digitised business processes and integrated applications will enable the delivery of business insights for effective monitoring and evaluation of CMS performance as a regulator. The implementation of a hot disaster recovery site (to enable business continuity) still remains one of the key priorities for the new financial year, and there is a strategic consideration to implement a hybrid cloud solution as it is more cost-effective.

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

Expenditure (1.3)	Budget			
Information Systems and Knowledge Management	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**12 898 426**	**13 131 754**	**14 313 612**	**15 888 109**
Salaries and wages	12 898 426	13 131 754	14 313 612	15 888 109
Goods and services	**12 303 446**	**12 795 372**	**13 334 774**	**13 904 239**
Communication	3 000 000	3 126 900	3 266 047	3 412 693
Computer services	4 785 976	4 988 423	5 210 408	5 444 355
Consultants	651 809	651 809	651 809	651 809
Lease payments	463 584	483 194	504 696	527 357
Other unclassified expenditure	1 885 634	1 965 397	2 052 857	2 145 030
Printing and publication	8 055	8 396	8 769	9 163
Property payments	550 000	573 265	598 775	625 660
Staff cost note	2 203	2 296	2 398	2 506
Venue and facilities	22 170	22 170	22 170	23 165
Repairs and maintenance	727 016	757 769	791 490	827 028
Training and staff development	163 199	170 102	177 672	185 649
Travel and subsistence	43 800	45 653	47 684	49 825
TOTAL	**25 201 872**	**25 927 126**	**27 648 386**	**29 792 349**

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;
- 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

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 4: To become a more effective and efficient organisation								
Output 8: Legal advisory and support services for effective regulation of the industry and operations of the office.								
Output Indicator 8.1	Percentage of written and verbal legal opinions provided to internal and external stakeholders attended to within 14 days	279	80%	85%	85%	90%	95%	95%
Output 9: Defending decisions of the Council and the Registrar								
Output Indicator 9.1	Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days	100% 17	100%	100%	100%	100%	100%	100%
Output 10: Build competencies and retain skilled employees.								
Output Indicator 10.1	Minimise staff turnover rate to less than 15% per annum	4.48%	8.33%	18.3%	<15%	<15%	<15%	<15%
Output Indicator 10.2	Turnaround time to fill a vacancy (turnaround time of 120 working days for each vacancy that exists during the year), excluding the position of CEO	There were 14 vacancies during the period, 12 were filled within 120 days, one took longer than the 120 days to fill and the recruitment process was	18 vacancies during the period were filled within 120 days,	70.8 days	120 days	120 days	120 days	120 days

		underway for 3						
Output Indicator 10.3	Improve the CMS B-BBEE targets [according to the Broad-Based Black Economic Empowerment Act (BBBEEA targets)], annually	New Indicator	New Indicator	New Indicator	New Indicator	40 - 54	55 - 69	70 - 79
Output Indicator 10.4	Develop and maintain a talent management Policy Framework by implementing a career path and succession plan	New Indicator	New Indicator	New Indicator	1	1	1	1
Output 11: Maximise performance to improve organisational efficiency and maintain high-performance culture.								
Output Indicator 11.1	Percentage of employee' performance agreements are signed by 31st May each year (excluding employees out of office on extended absence)	100%	100%	100%	95%	95%	95%	95%
Output Indicator 11.2	Percentage of employees' performance assessment concluded, bi-annually (excluding employees out of office on extended absence)	93.97%	100%	99.10%	95%	95%	95%	95%
Output Indicator 11.3	Number of Training and Development Sessions to Improve Employee Relations	New Indicator	New Indicator	New Indicator	4	4	4	4
Output Indicator 11.4	Percentage of signed annual declarations of financial interest by CMS employees (excluding employees out of office on extended absence)	New Indicator	New Indicator	New Indicator	New Indicator	100%	100%	100%
Output 12: Ensure maximisation in the coordination of various planning efforts that are undertaken in relation to the CMS facilities								
Output 12.1	Develop an Office Capacity and	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1

	Utilisation Report by 30 June each year							
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 13: To create awareness and collaboration with stakeholders while enhancing the visibility and protecting the reputation of the CMS.								
Output Indicator 13.1	Number of stakeholder awareness activities conducted	85	21	55	25	30	35	40
Output Indicator 13.2	Percentage of stakeholder awareness of the CMS resulting from a survey	64	50%	50%	55%	60%	65%	70%
Output 14: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year.								
Output Indicator 14.1	Submission of the CMS Annual Report by 31 August to the Executive Authority	1	1	1	1	1	1	1

1.4.2 Quarterly targets for 2022/23 (Corporate Services)

Performance Indicators		Reporting period 2022/23	Annual target 2022/23	Quarterly targets			
				1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 8: Legal advisory and support services for effective regulation of the industry and operations of the office.							
Output Indicator 8.1	Percentage of written and verbal legal opinions provided to internal and external stakeholders attended to within 14 days	Quarterly	85%	85%	85%	85%	85%
Output 9: Defending decisions of the Council and the Registrar							
Output Indicator 9.1	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 10: Build competencies and retain skilled employees.							
Output Indicator 10.1	Minimise staff turnover rate to less than 15% per annum.	Annually	<15%	n/a	n/a	n/a	<15%
Output Indicator 10.2	Turnaround time to fill a vacancy (turnaround time of 120 working days for each vacancy that exists during the year), excluding the position of CEO	Quarterly	120 days	120 days	120 days	120 days	120 days
Output Indicator 10.3	Improve CMS B-BBEE targets [according to the Broad-Based Black Economic Empowerment Act (BBBEEA targets)], annually	Annually	40 - 54	n/a	n/a	n/a	40 - 54
Output Indicator 10.4	Develop and maintain a talent management policy framework by implementing a career path and succession plan	Annually	1	n/a	n/a	n/a	1

Output 11: Maximise performance to improve organisational efficiency and maintain high performance culture.							
Output Indicator 11.1	Percentage of employee' performance agreements are signed by 31 May each (excluding employees out of office on extended absence)	Annual	95%	95%	n/a	n/a	n/a
Output Indicator 11.2	Percentage of employees' performance assessment concluded, bi-annually (excluding employees out of office on extended absence)	Bi-annually	95%	95%	n/a	95%	n/a
Output Indicator 11.3	Number of Training and Development Sessions to Improve Employee Relations	Quarterly	4	1	1	1	1
Output Indicator 11.4	Percentage of signed annual declarations of financial interest by CMS employees (excluding employees out of office on extended absence)	Annual	100%	100%	n/a	n/a	n/a
Output 12: Ensure maximisation of the coordination of various planning efforts that are undertaken in relation to the CMS facilities							
Output 12.1	Develop an Office Capacity and Utilisation Report by 30 June 2022	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 13: To create awareness and collaboration with stakeholders while enhancing the visibility and protecting the reputation of the CMS.							
Output Indicator 13.1	Number of stakeholder awareness activities conducted	Quarterly	30	7	7	8	8
Output Indicator 13.2	Percentage of stakeholder awareness of the CMS resulting from a survey	Annually	60%	n/a	n/a	n/a	60%
Output 14: CMS must ensure that an Annual Report is submitted to the Executive Authority five months after the end of a financial year.							
Output Indicator 14.1	Submission of the CMS Annual Report by 31 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 aims to continue in the same trajectory of outperforming and exceeding its set targets. The sub-unit will continue to track relevant laws and judgements to ensure that current legislative developments and jurisprudence is taken into account when key decisions are made. The sub-unit has made an important contribution to the LCBO processes; it is also playing a significant role in the amendment of the Medical Schemes Act in accordance with the NHI and HMI. 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)	Budget			
Corporate Services	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**14 039 022**	**16 730 077**	**18 235 784**	**20 241 721**
Salaries and wages	14 039 022	16 730 077	18 235 784	20 241 721
Goods and services	**37 211 245**	**32 721 991**	**31 901 451**	**26 371 501**
Agency and support / outsourced services	12 923	13 470	14 069	14 701
Communication	1 468	1 530	1 598	1 670
Consultants	2 217 586	1 217 586	1 217 586	1 217 586
Lease payments	13 668 381	14 836 554	15 496 781	11 792 586
Advertising and marketing	911 775	911 775	911 775	952 714
Legal fees	11 129 477	5 985 481	4 080 838	1 897 919
Other unclassified expenditure	367 635	483 186	500 238	518 209
Printing and publication	466 841	486 588	508 241	531 061
Property payments	4 702 798	4 901 727	5 119 854	5 212 718
Staff cost note	2 967 440	3 092 963	3 230 600	3 375 654
Venue and facilities	145 283	145 283	145 283	151 806
Repairs and maintenance	262 338	273 435	285 603	298 427
Training and staff development	248 394	258 901	270 422	282 564
Travel and subsistence	108 904	113 511	118 562	123 886
TOTAL	**51 250 267**	**49 452 068**	**50 137 235**	**46 613 221**

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

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 4: To become a more effective and efficient organisation								
Output 15: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority								
Output Indicator 15.1	Develop an Annual Council Work Plan for Council and its Committees by 31 March	New Indicator	New Indicator	New Indicator	1	1	1	1
Output Indicator 15.2	Develop and Review Council and Committees Governance Charters	New Indicator	New Indicator	New Indicator	1	6	6	6
Output Indicator 15.3	Communicate 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 15.4	Arrange Council meetings quarterly	New Indicator	New Indicator	New Indicator	New Indicator	4	4	4
Output Indicator 15.5	Arrange Council Committees meetings	New Indicator	New Indicator	New Indicator	New Indicator	4	4	4
Output Indicator 15.6	Facilitate training and development of Council	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1
Output Indicator 15.7	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	New Indicator	100%	100%	100%
Output 16: Support Dispute Resolution Forums in furtherance of Council and MSA objectives								
Output Indicator 16.1	Arrange the Appeals Committee hearings	New Indicator	New Indicator	New Indicator	New Indicator	12	12	12
Output Indicator 16.2	Arrange the Appeal Board hearings	New Indicator	New Indicator	New Indicator	New Indicator	4	4	4
Output Indicator 16.3	Support the publication of rulings of the Appeals Committee and the Appeal Board within 14 days of	New Indicator	New Indicator	100%	100%	100%	100%	100%

	receipt from the Presiding Officers.							

1.5.2 Quarterly targets for 2022/23 (Council Secretariat)

Performance Indicators		Reporting period 2022/23	Annual target 2022/23	Quarterly targets			
				1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 15: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority							
Output Indicator 15.1	Develop an Annual Council Work Plan for Council and its Committees by 31 March	Quarterly	1	n/a	n/a	n/a	1
Output Indicator 15.2	Develop and Review Council and Committees Governance Charters	Quarterly	6	n/a	n/a	n/a	6
Output Indicator 15.3	Communicate Council resolutions within 3 days of the meeting to the affected internal stakeholders	Quarterly	100%	100%	100%	100%	100%
Output Indicator 15.4	Arrange Council meetings quarterly.	Quarterly	4	1	1	1	1
Output Indicator 15.5	Arrange Council Committees meetings	Quarterly	4	1	1	1	1
Output Indicator 15.6	Facilitate training and development of Council	Annual	1	n/a	n/a	n/a	1
Output Indicator 15.7	Percentage of signed annual declaration of financial interest by Council Members (excluding Council Members out of office on extended absence)	Annual	100%	100%	n/a	n/a	n/a
Output 16: Support Dispute Resolution Forums in furtherance of Council and MSA objectives							
Output Indicator 16.1	Arrange the Appeals Committee hearings	Quarterly	12	3	3	3	3
Output Indicator 16.2	Arrange the Appeal Board hearings	Quarterly	4	1	1	1	1
Output Indicator 16.3	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 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.

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

Expenditure (1.5)	Budget			
Council Secretariat	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**1 829 128**	**1 946 719**	**2 121 924**	**2 355 335**
Salaries and wages	1 829 128	1 946 719	2 121 924	2 355 335
Goods and services	**5 482 292**	**7 726 397**	**8 062 725**	**8 419 488**
Agency and support / outsourced services	172 627	72 627	72 627	75 888
Communication	44 368	46 245	48 201	50 240
Consultants	1 108 527	1 155 418	1 204 292	1 255 233
Board costs	3 574 994	5 715 216	5 969 543	6 237 576
Other unclassified expenditure	56 518	89 415	93 197	97 139
Venue and facilities	89 064	132 831	138 450	144 307
Training and staff development	250 000	260 575	271 597	283 086
Travel and subsistence	186 194	254 070	264 817	276 019
TOTAL	**7 311 420**	**9 673 116**	**10 184 649**	**10 774 823**

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 CMS 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

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 4: To become a more effective and efficient organisation								
Output 17: Ensure that strategic projects are scoped, and project plans are in place								
Output Indicator 17.1	Development and Maintain a Strategic Projects Register	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1
Output Indicator 17.2	Scope and develop plans for strategic projects	New Indicator	New Indicator	New Indicator	New Indicator	80%	80%	80%
Output 18: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.								
Output Indicator 18.1	Review and Develop a Strategic Plan and Annual Performance Plan for the consideration of the CEO & Registrar as well as Council	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1
Output Indicator 18.2	Produce an Annual Performance Information report that is reliable, accurate and complete by 31 July each year in line with the statutory requirements	1	1	1	1	1	1	1
Output Indicator 18.3	Produce Quarterly Performance Information report that is reliable, accurate and complete	New Indicator	New Indicator	New Indicator	New Indicator	4	4	4
Output 19: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS.								

Output Indicator 19.1	Number of strategic risk register reports submitted to the Council for monitoring	4	4	4	4	4	4	4
Output 20: An effective, efficient and transparent system of coordinating the CMS Audit function is maintained								
Output Indicator 20.1	Ensure the development of an Internal Audit three year rolling plan and reports, for the Audit and Risk Committee's adoption and monitoring	New Indicator	New Indicator	New Indicator	New Indicator	4	4	4
Output indicator 20.2	Coordinate the External Audit Function and submit an Audit Strategy and Reports to Council for adoption	New Indicator	New Indicator	New Indicator	New Indicator	1	1	1

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

Performance indicators		Reporting period	Annual target	Quarterly targets			
		2022/23	2022/23	1st	2nd	3rd	4th
Outcome 4: To become a more effective and efficient organisation							
Output 17: Ensure that strategic projects are scoped, and project plans are in place							
Output Indicator 17.1	Development and Maintain a Strategic Projects Register	Annually	1	n/a	n/a	n/a	1
Output Indicator 17.2	Scope and develop plans for strategic projects	Quarterly	80%	80%	80%	80%	80%
Output 18: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.							
Output Indicator 18.1	Review and Develop a Strategic Plan and Annual Performance Plan for the consideration of the CEO & Registrar as well as Council	Annually	1	n/a	n/a	1	n/a
Output Indicator 18.2	Produce an Annual Performance Information report that is reliable, accurate and complete by 31 July each year in line with the statutory requirements	Annually	1	n/a	1	n/a	n/a
Output Indicator 18.3	Produce Quarterly Performance Information report that is reliable, accurate and complete	Quarterly	4	1	1	1	1
Output 19: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS.							
Output Indicator 19.1	Number of strategic risk register reports submitted to the Council for monitoring	Quarterly	4	1	1	1	1
Output 20: An effective, efficient and transparent system of coordinating the CMS Audit function is maintained							
Output Indicator 20.1	Ensure the development of an Internal Audit three year rolling plan and reports, for the Audit and Risk Committee's adoption and monitoring	Quarterly	1	1	1	1	1
Output indicator 20.2	Coordinate the External Audit Function and submit an Audit Strategy and Reports to Council for adoption	Annually	1	n/a	1	n/a	n/a

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)	Budget			
STRATEGY PERFORMANCE AND RISK	2021/22	2022/2023	2023/2024	2024/2025
Compensation of employees	**2 860 623**	**3 004 824**	**3 275 258**	**3 635 537**
Salaries and wages	2 860 623	3 004 824	3 275 258	3 635 537
Goods and services	**2 612 038**	**2 666 578**	**2 736 736**	**2 859 615**
Consultants	1 437 761	1 498 578	1 565 265	1 635 545
Audit costs	1 174 278	1 000 000	1 000 000	1 044 900
Other unclassified expenditure	-	8 000	8 356	8 731
Staff cost note	-	2 000	2 089	2 183
Venue and facilities	-	90 000	90 000	94 041
Training and staff development	-	18 000	18 801	19 645
Travel and subsistence	-	50 000	52 225	54 570
TOTAL	**5 472 661**	**5 671 402**	**6 011 994**	**6 495 152**

1.7 Programme 3 (Regulation)

Purpose (Regulation)

The purpose of the Programme is to:

- Ensure brokers and broker organisations, administrators and managed care organisations are accredited in line with the accreditation requirements as set out in the Medical Schemes Act (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;
- Serve beneficiaries of medical schemes, the Registrar's Office and Trustees by analysing and reporting on the financial performance of medical schemes and ensuring adherence to the financial requirements of the MSA. By doing this, the unit helps the CMS to monitor and promote the financial performance of schemes in order to achieve an industry that is financially sound.

1.7.1 Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations.								
Output 21: 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 21.1	Percentage of broker and broker organisation applications accredited within 30 working days per quarter on receipt of complete information	5030	80%	84.8%	80%	80%	80%	80%
Output Indicator 21.2	Percentage of managed care organisation applications analysis completed, and outcomes communicated to applicants, within three months of receipt of complete information	22	100%	100%	100%	100%	100%	100%
Output Indicator 21.3	Percentage of administrators and self-administered schemes' applications analysis completed, and outcomes	14	100%	100%	100%	100%	100%	100%

	communicated to applicants, within three months of receipt of complete information							
Output 22: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998).								
Output Indicator 22.1	Percentage of interim rule amendments processed within 14 working days of receipt of all information	96.2%	80%	96.8%	80%	80%	80%	80%
Output Indicator 22.2	Percentage of annual rule amendments processed before 31 December of each year	100%	90%	100%	90%	90%	90%	90%

Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 23: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 23.1	Number of draft inspection reports issued annually	New Indicator	New Indicator	New Indicator	New Indicator	10	10	10
Output 24: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act, 1998 and all other related laws								
Output Indicator 24.1	Percentage of commissioned inspection finalised within 12 months from the date the appointment letter was signed	New indicator	New indicator	New indicator	New indicator	60%	60%	60%
Output 25: Ensure enforcement action is undertaken against regulated entities.								
Output Indicator 25.1	Percentage of enforcement actions undertaken during the period	92%	100%	100%	100%	70%	70%	70%
Output 26: Strengthen and monitor governance systems of medical schemes and other regulated entities.								
Output Indicator 26.1	Percentage of governance interventions implemented during the period	100% 116	100%	100%	100%	70%	70%	70%
Output Indicator 26.2	Number of scheme member meetings attended (including virtual meetings)	38	40	26	42	44	46	46

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 3: To ensure that all regulated entities comply with National Policy the MSA and Regulations								
Output 27: Monitor and promote the financial soundness of medical schemes.								
Output Indicator 27.1	Percentage of business plans processed in respect of Regulation 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar)	88%	100%	0%	100%	100%	100%	100%
Output Indicator 27.2	Percentage of business plans processed in respect of schemes with rapidly reducing solvency (but above statutory minimum)	100%	n/a	0%	100%	100%	100%	100%
Output Indicator 27.3	Percentage of auditor applications analysed	100%	100%	100%	100%	100%	100%	100%
Output Indicator 27.4	Number of quarterly financial return reports published (excluding quarter four)	3	3	3	3	3	3	3
Output Indicator 27.5	Number of financial sections prepared for the Annual Report	1	1	1	1	1	1	1

1.7.2 Quarterly targets for 2022/23 (Regulation)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2022/23	2022/23	1st	2nd	3rd	4th
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations.							
Output 21: 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 21.1	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 21.2	Percentage of managed care organisation applications analysis completed, and outcomes communicated to applicants, within three months of receipt of complete information	Quarterly	100%	100%	100%	100%	100%
Output Indicator 21.3	Percentage of administrators and self-administered schemes' applications analysis completed, and outcomes communicated to applicants, within three months of receipt of complete information	Quarterly	100%	100%	100%	100%	100%
Outcome 22: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998).							
Output Indicator 22.1	Percentage of interim rule amendments processed within 14 working days of receipt of all information	Quarterly	80%	80%	80%	80%	80%
Output Indicator 22.2	Percentage of annual rule amendments processed before 31 December of each year	Quarterly	90%	n/a	n/a	90%	n/a

Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations							
Output 23: Inspect regulated entities for routine monitoring of compliance with the Medical Schemes Act, 1998 and all other related laws							
Output Indicator 23.1	Number of draft inspection reports issued annually	Quarterly	10	n/a	3	3	4
Output 24: Inspect regulated entities for alleged irregularity or non-compliance with the Medical Schemes Act (1998) and all other related laws.							
Output Indicator 24.1	Percentage of commissioned inspections finalised within 12 months from the date the appointment letter was signed	Quarterly	60%	60%	60%	60%	60%
Output 25: Ensure enforcement action is undertaken against regulated entities.							
Output Indicator 25.1	Percentage of enforcement actions undertaken during the period	Quarterly	70%	70%	70%	70%	70%
Output 26: Strengthen and monitor governance systems of medical schemes and other regulated entities.							
Output Indicator 26.1	Percentage of governance interventions implemented during the period	Quarterly	70%	70%	70%	70%	70%
Output Indicator 26.2	Number of scheme member meetings attended, (including virtual meetings)	Quarterly	44	34	10	n/a	n/a
Output 27: Monitor and promote the financial soundness of medical schemes.							
Output Indicator 27.1	Percentage of business plans processed in respect of Regulation 29 (which requires all schemes below statutory solvency to submit nature and causes of failure to the Registrar)	Quarterly	100%	100%	100%	100%	100%
Output Indicator 27.2	Percentage of business plans processed in respect of schemes with rapidly reducing solvency (but above statutory minimum)	Quarterly	100%	100%	100%	100%	100%
Output Indicator 27.3	Percentage of auditor applications analysed	Quarterly	100%	100%	100%	100%	100%
Output Indicator 27.4	Number of quarterly financial return reports published (excluding quarter four)	Quarterly	3	n/a	1	1	1
Output Indicator 27.5	Number of financial sections prepared for the Annual Report	Annual	1	n/a	1	n/a	n/a

1.7.3 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. These will include the institution of inspections, enforcement actions, governance interventions and attending member meetings.

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

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

Expenditure (3)	Budget			
REGULATION	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**35 089 943**	**36 595 620**	**39 889 226**	**44 277 041**
Salaries and wages	35 089 943	36 595 620	39 889 226	44 277 041
Goods and services	**4 576 071**	**4 766 996**	**5 968 918**	**6 034 000**
Consultants	3 239 564	3 376 598	4 519 428	4 519 428
Other unclassified expenditure	441 356	460 026	480 497	502 071
Printing and publication	14 863	15 492	16 181	16 907
Staff cost note	8 812	9 185	9 593	10 024
Venue and facilities	62 477	62 477	62 477	65 282
Training and staff development	435 957	454 398	474 619	495 929
Travel and subsistence	373 041	388 821	406 124	424 359
TOTAL	**39 666 014**	**41 362 616**	**45 858 144**	**50 311 041**

1.8 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 and HMI.

1.8.1 Programme performance indicators and annual targets

Performance Indicators		Audited/Actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry.								
Output 28: Conduct research to inform appropriate national health policy interventions								
Output Indicator 28.1	Number of research projects and support projects published in support of the National Health Policy	14	12	12	12	17	17	17
Output 29: Monitoring trends to improve regulatory policy and practice.								
Output Indicator 29.1	Non-financial report submitted for inclusion in the annual report	1	1	1	1	1	1	1

1.8.2 Quarterly targets for 2022/23 (Policy, Research and Monitoring)

Performance Indicators		Reporting period	Annual target	Quarterly targets			
		2022/23	2022/23	1st	2nd	3rd	4th
Outcome 5: To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry.							
Output 28: Conduct research to inform appropriate national health policy interventions.							
Output Indicator 28.1	Number of research projects and support projects published in support of the National Health Policy,	Quarterly	17	1	2	6	8
Output 29: Monitoring trends to improve regulatory policy and practice.							
Output Indicator 29.1	Non-financial report submitted for inclusion in the Annual Report	Annual	1	n/a	1	n/a	n/a

1.8.3 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.

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

Expenditure (4)	Budget			
POLICY, RESEARCH AND MONITORING	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**9 314 249**	**9 537 149**	**10 395 492**	**11 538 997**
Salaries and wages	9 314 249	9 537 149	10 395 492	11 538 997
Goods and services	**307 915**	**317 012**	**326 987**	**337 690**
Consultants	88 629	88 629	88 629	88 629
Other unclassified expenditure	17 734	18 484	19 307	20 174
Staff cost note	2 203	2 296	2 398	2 506
Venue and facilities	4 225	4 225	4 225	4 415
Training and staff development	152 018	158 449	165 500	172 931
Travel and subsistence	43 105	44 929	46 928	49 035
TOTAL	**9 622 164**	**9 854 161**	**10 722 480**	**11 876 686**

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1.9 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. By doing this, we ensure that beneficiaries are treated fairly by their medical schemes.
- 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.

1.9.1 Programme performance indicators and annual targets

Performance Indicators		Audited/actual performance			Estimated performance	Medium-term targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 30: 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 30.1	Number of stakeholder education and training sessions	New indicator	35	56	40	50	55	60
Output 31: To provide Customer care interventions by rendering effective and efficient services.								
Output Indicator 31.1	Percentage of customer care interventions resulting from calls and e-mailed queries handled by the customer care centre	New Indicator	New Indicator	New Indicator	90%	90%	90%	90%
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations								
Output 32: Resolve complaints with the aim of protecting beneficiaries of medical schemes.								
Output Indicator 32.1	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	New Indicator	75%	80%	80%
Output Indicator 32.2	Percentage of category 4 complaints adjudicated	55%	65%	76%	70%	75%	80%	80%

	within 120 calendar days and in accordance with complaints standard operating procedures							
Output Indicator 32.3	Percentage of category 1 complaints adjudicated within 30 working days and in accordance with complaints standard operating procedures	New Indicator	New Indicator	76%	70%	75%	80%	80%
Output Indicator 32.4	Percentage of category 2 complaints adjudicated within 60 working days and in accordance with complaints standard operating procedures,	New Indicator	New Indicator	76%	70%	75%	80%	80%
Output Indicator 32.5	Percentage of category 3 complaints adjudicated within 90 working days and in accordance with complaints standard operating procedures	New Indicator	New Indicator	76%	70%	75%	80%	80%
Output Indicator 32.6	Percentage of Rulings submitted to Corporate Services for publication on the CMS website within 30 calendar	New Indicator	New Indicator	100%	100%	80%	80%	80%

	days following the lapse of 3 months within which an appeal must be filed.							
Output 33: Appeal Committee hearings attended based on requests from Council								
Output Indicator 33.1	Percentage of Appeal Committee hearings attended based on requests from the Council	100%	100%	100%	100%	100%	100%	100%
Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector								
Output 34: Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements								
Output Indicator 34.1	The number of benefit definitions published.	10	10	10	10	10	10	10
Output Indicator 34.2	A service-based preventative and primary healthcare package and costing methodology report was submitted to the Executive Authority	Develop primary healthcare package for incorporation into the PMBs		Revised and updated PMB befits package costed	Review and update revised PMB benefit package	Review and update revised PMB benefit package	Review and update revised PMB benefit package	Review and update revised PMB benefit package
Output 35: Provide clinical opinions to resolve complaints and enquiries.								
Output Indicator 35.1	Percentage of category 1 clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication Unit	54%	90%	92.75%	90%	90%	90%	90%
Output Indicator 35.2	Percentage of category 2 clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication Unit	99%	95%	100%	95%	95%	95%	95%

Output Indicator 35.3	Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication Unit	98%	98%	100%	98%	98%	98%	98%
Output Indicator 35.4	Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days	98%	98%	100%	98%	98%	98%	98%

1.9.2 Quarterly targets for 2022/23 (Member Protection)

Performance Indicators		**Reporting period 2022/23**	**Annual target 2022/23**	**Quarterly targets**			
				1st	**2nd**	**3rd**	**4th**
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations							
Output 30: 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 30.1	Number of stakeholder education and training sessions	Quarterly	50	12	12	14	12
Output 31: To provide Customer care interventions by rendering effective and efficient services.							
Output Indicator 31.1	Percentage of customer care interventions resulting from calls and e-mailed queries handled by the customer care centre	Quarterly	90%	90%	90%	90%	90%
Outcome 3: To ensure that all regulated entities comply with National Policy, the MSA and Regulations							
Output 32: Resolve complaints with the aim of protecting beneficiaries of medical schemes.							
Output Indicator 32.1	Percentage of complaints older than 120 calendar days adjudicated during the reporting period in accordance with complaints standard	Quarterly	75%	75%	75%	75%	75%

	operating procedures						
Output Indicator 32.2	Percentage of category 4 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures	Quarterly	75%	75%	75%	75%	75%
Output Indicator 32.3	Percentage of category 1 complaints adjudicated within 30 working days and in accordance with complaints standard operating procedures	Quarterly	75%	75%	75%	75%	75%
Output Indicator 32.4	Percentage of category 2 complaints adjudicated within 60 working days and in accordance with complaints standard operating procedures,	Quarterly	75%	75%	75%	75%	75%
Output Indicator 32.5	Percentage of category 3 complaints adjudicated within 90 working days and in accordance with complaints standard operating procedures	Quarterly	75%	75%	75%	75%	75%
Output Indicator 32.6	Percentage of Rulings submitted to	Quarterly	80%	80%	80%	80%	80%

	Corporate Services for publication on the CMS website within 30 days following the lapse of 3 months within which an appeal must be filed.						
Output 33: Appeal Committee hearings attended based on written request received from Council							
Output Indicator 33.1	Percentage of Appeal Committee hearings attended based on written request received from the Council	Quarterly	100%	100%	100%	100%	100%
Outcome 1: To promote the improvement of quality and the reduction of costs in the private health care sector							
Output 34: Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements							
Output Indicator 34.1	The number of benefit definitions published	Quarterly	10	2	2	3	3
Output Indicator 34.2	Develop preventative and primary healthcare package to incorporate into the PMBs	Annual	Develop primary healthcare package for incorporation into the PMBs	n/a	n/a	n/a	Review and update revised PMB benefit package
Output 35: Provide clinical opinions to resolve complaints and enquiries.							
Output Indicator 35.1	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 35.2	Percentage of category 2 clinical opinions provided within 60 working days of receipt	Quarterly	95%	95%	95%	95%	95%

	of a request from Complaints Adjudication Unit						
Output Indicator 35.3	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 35.4	Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days	Quarterly	98%	98%	98%	98%	98%

1.9.3 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, and serve the beneficiaries of medical schemes and the public by investigating and resolving complaints in an efficient and effective manner. by doing this, the programme ensures that beneficiaries are treated fairly by their medical schemes.
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.

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

Expenditure (5)	**Budget**			
MEMBER PROTECTION	**2021/22**	**2022/2023**	**2023/2024**	**2024/2025**
Compensation of employees	**20 517 216**	**22 128 409**	**24 119 966**	**26 773 162**
Salaries and wages	20 517 216	22 128 409	24 119 966	26 773 162
Goods and services	**3 866 897**	**3 908 775**	**3 954 695**	**4 052 171**
Communication	1 468	1 530	1 598	1 670
Consultants	1 783 728	1 783 728	1 783 728	1 783 728
Advertising and marketing	911 775	911 775	911 775	952 714
Other unclassified expenditure	87 233	90 923	94 969	99 233
Printing and publication	466 841	486 588	508 241	531 061
Staff cost note	5 507	5 740	5 996	6 265
Venue and facilities	181 374	181 374	181 374	189 518
Training and staff development	284 268	296 292	309 477	323 373
Travel and subsistence	144 703	150 824	157 536	164 609
TOTAL	**24 384 114**	**26 037 184**	**28 074 661**	**30 825 333**

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

a. 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***

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
			Vaccinations have been included in the revised PMB list as part of the development of a more primary healthcare-focused package. The vaccination list is specific and includes vaccination like HPV, Human papilloma virus (7 to 12-year-old), hepatitis A B C D, etc.
Prevalence of non-communicable diseases reduced	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.
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.

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
	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.
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

NDP Goals 2030	MTSF Priorities	NDoH strategic goals 2020 - 2025	CMS Strategic Outcomes 2020 to 2025
			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

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

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

The key elements of these outcome indicators include the following:

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

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

Adequate Funding:

The CMS is currently faced with significant financial difficulties due to resource constraints. This has led to key strategic projects not being fully implemented, thus negatively impacting the role that the Regulator has to play in the medical schemes industry. These constraints are mainly attributed to the increase in the regulatory work of CMS that is not matched by the same increase in funding. The rise in unemployment, and the decline in membership levels is concerning for CMS as the entity is funded mainly through levies. Over the last period of 3 years, the tariff-related revenue stream has declined. That with there being no contingency reserves places the role of the Regulator at significant risk.

The levy rate over the past 3 years has moved from R38,67 in 2019/20 to R42,27 in 2021/22. CMS is proposing a levy rate of R44,06 for the 2022/23 financial year. 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 entity is therefore 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 132, including temporary and contract personnel which is below the required numbers based on workloads. The CMS is understaffed and relies on interns and temporary personnel to carry out some of its core regulatory functions. Additional resources will enable this organisation to have reasonable staffing levels to effectively carry out its mandate. The recently completed Business Process Mapping exercise has indicated that an additional 16 posts will be required by the CMS for optimal and efficient operations.

Organisational Restructuring:

The CMS 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 dated 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, South African Revenue Services (SARS),

d. We have already indicated that as a regulatory body, our contribution to the achievement of the desired impact is both direct and indirect. The direct contribution is made through our research, policy and monitoring of the medical schemes industry. The advice to the Health Ministry is based on this rigorous research. The greater contribution to the impact 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.

3. Programme Resource Considerations for 2022/23

The CMS Strategic Plan, Annual Performance Plan and Budget For 2022/23

The Council for Medical Schemes' budget for 2022/23 that should accompany the Strategic plan (2020-2025) and the Annual Performance Plan (2022/23), 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 2022/23.

In our 2022/23 budget, we proposed a levy of ***R44,06*** per member per annum (pmpa), which is an increase of **R1,79** per family per year compared to the levies collected in 2021/22. In percentage terms, the proposal amounts to a 4,23% increase which is within CPI. By comparison, the increases in the preceding three years were 7.03%, 4,5% and 4.6%, respectively. An inflationary increase of 4,23% was applied for goods and services and capital expenditure as per Treasury guidelines. In respect of the cost-of-living adjustment for employees, the CMS applied the guidelines as per Treasury guidelines for costing and budgeting for compensation of employees.

Non-tax revenue received increased in 2018/19 from R162 million to R180 million in 2021/22 due to related inflationary adjustments. R187 million is planned for 2022/23 with R196 million and R205 million for 2023/24 and 2024/25, respectively. Non-tax revenue includes Levy Income as administrative fees and Tariff related income as other non-tax revenue.

There has been a significant decline in other non-tax revenue from R5.33 million in 2018/19 to R2.32 million in 2021/22 with a continued projected decline in 2022/23 to R2.31 million followed by a marginal inflationary increase over the rest of the MTEF. The decline can be linked to the push back CMS receives from schemes when it comes to the collection of recoveries and COVID-19 impact during the 2020/21 financial year moving forward. The Levy Income has been increasing in line with inflation over the years.

Transfers from Health received increased in 2018/19 from R5.67 million to R6.66 million in 2020/21 due to inflationary adjustments. There is a decline in 2021/22 to R6.18 million to the tightening of the fiscal environment. Moving along the MTEF period, there is a marginal total budget increase from R6.27 million and R6.83 million in 2022/23 and 2024/25, respectively.

Albeit the proposal of 4.23%, it is worth bringing to your attention that the proposed increase is not sufficient to fully fund CMS's mandate as a Regulator. CMS will therefore be engaging further with the Department of 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 Coverage using the National Health Insurance vehicle in South Africa. In order to execute this mandate, the CMS will, in addition to its core mandate, contribute to the following key areas:

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

The specific challenges that the CMS will need to prioritise for the 2022/23 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

Table 1, presented below, covers the budget and funding proposal based on the annual levy increase. This proposal shows an increase in total budgeted expenditure from R186 Million to R194 Million, which represents an increase of 4,1%.

Table 2, on the other hand, provides a programmatic break–down of the consolidated budget for the 2022/23 financial year. The detailed breakdown of the proposed budget as per economic classification is provided in Table 3. The budget presented above supports the Annual Performance Plan for the Council for Medical Schemes for the 2022/23 financial year, albeit with significant resource constraints.

Council for Medical Schemes

Funding Proposal for 2022/23

Table 1: CMS Budget

Description	Line Ref		2021/2022	2022/2023	2023/2024	2024/2025
Goods and services	A1		72 477 099	72 087 715	72 544 785	67 251 851
Compensation of employees	A2		113 072 984	121 354 836	131 630 528	146 109 886
Operating cash expenditure	**A**		**185 550 083**	**193 442 552**	**204 175 312**	**213 361 737**
Capital expenditure	B		1 000 000	1 042 300	1 088 682	1 971 915
Total cash requirement (TABLE 2)	**C**	**A + B**	**186 550 083**	**194 484 852**	**205 263 995**	**215 333 651**
Inspection fees (recovery)	D2		(102 302)	-	-	-
Accreditation fees	E		(6 779 733)	(6 798 998)	(7 101 553)	(7 420 413)
Registration Fees	F		(512 947)	(534 644)	(558 436)	(583 510)
Interest Received	G		(1 945 922)	(2 028 234)	(2 118 491)	(2 213 611)
Government grant	H1		(6 181 000)	(6 272 000)	(6 537 000)	(6 831 000)
Other income	I		(274 454)	(286 063)	(298 793)	(312 209)
Total income excluding levies	**J**	**D + E + F + G + H+ I**	**(15 796 358)**	**(15 919 940)**	**(16 614 273)**	**(17 360 743)**
Income from levies	K	C - J	170 753 725	178 564 912	188 649 722	197 972 909
Total membership	L		4 039 705	4 053 041	4 099 542	4 117 143
Levy amount proposed	M	K / L	R 42,27	R 44,06	R 46,02	R 48,09
Levy amount approved			R 42,27			
Levy increase (in Rand) based on approved levy			R 1,86	R1,79	R1,96	R2,07
Levy increase (in %) based on approved levy			4,60%	4,23%	4,45%	4,49%

Table 2: Overview of budget and MTEF estimates

Consolidated expenditure - Per Programme	Budget			
	2021/22	2022/2023	2023/2024	2024/2025
ADMINISTRATION	**106 405 130**	**110 517 187**	**113 508 033**	**113 853 523**
Office of the CEO and Registrar	7 723 608	9 637 280	9 884 475	9 442 325
Office of the CFO	14 917 962	15 827 597	15 653 289	17 230 806
Information Systems and Knowledge Management	25 201 872	25 927 126	27 648 386	29 792 349
Corporate Services	51 250 267	51 471 574	52 250 772	48 821 302
Council Secretariat	7 311 420	7 653 610	8 071 112	8 566 742
STRATEGY PERFORMANCE AND RISK	5 472 661	5 671 402	6 011 994	6 495 152
REGULATION	39 666 014	41 362 616	45 858 144	50 311 041
POLICY, RESEARCH AND MONITORING	9 622 164	9 854 161	10 722 480	11 876 686
MEMBER PROTECTION	24 384 114	26 037 184	28 074 661	30 825 333
OPERATING CASH EXPENDITURE	**185 550 083**	**193 442 552**	**204 175 312**	**213 361 737**
Capital expenditure	1 000 000	1 042 300	1 088 682	1 971 915
TOTAL CASH REQUIREMENT	**186 550 083**	**194 484 852**	**205 263 995**	**215 333 651**
ACCREDITATION FEES	-6 779 733	-6 798 998	-7 101 553	-7 420 413
REGISTRATION FEES	-512 947	-534 644	-558 436	-583 510
INTEREST RECEIVED	-1 945 922	-2 028 234	-2 118 491	-2 213 611
GOVERNMENT GRANT	-6 181 000	-6 272 000	-6 537 000	-6 831 000
OTHER INCOME	-376 756	-286 063	-298 793	-312 209
LEVIES ON MEDICAL SCHEMES	-170 753 725	-178 564 912	-188 649 722	-197 972 909
TOTAL INCOME	**-186 550 083**	**-194 484 852**	**-205 263 995**	**-215 333 651**
(SURPLUS) / DEFICIT	-	-	-	-

Consolidated expenditure - Per Programme	Budget			
	2021/22	2022/2023	2023/2024	2024/2025
ADMINISTRATION	**106 405 130**	**110 517 187**	**113 508 033**	**113 853 523**
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TOTAL INCOME	**-186 550 083**	**-194 484 852**	**-205 263 995**	**-215 333 651**
(SURPLUS) / DEFICIT	-	-	-	-

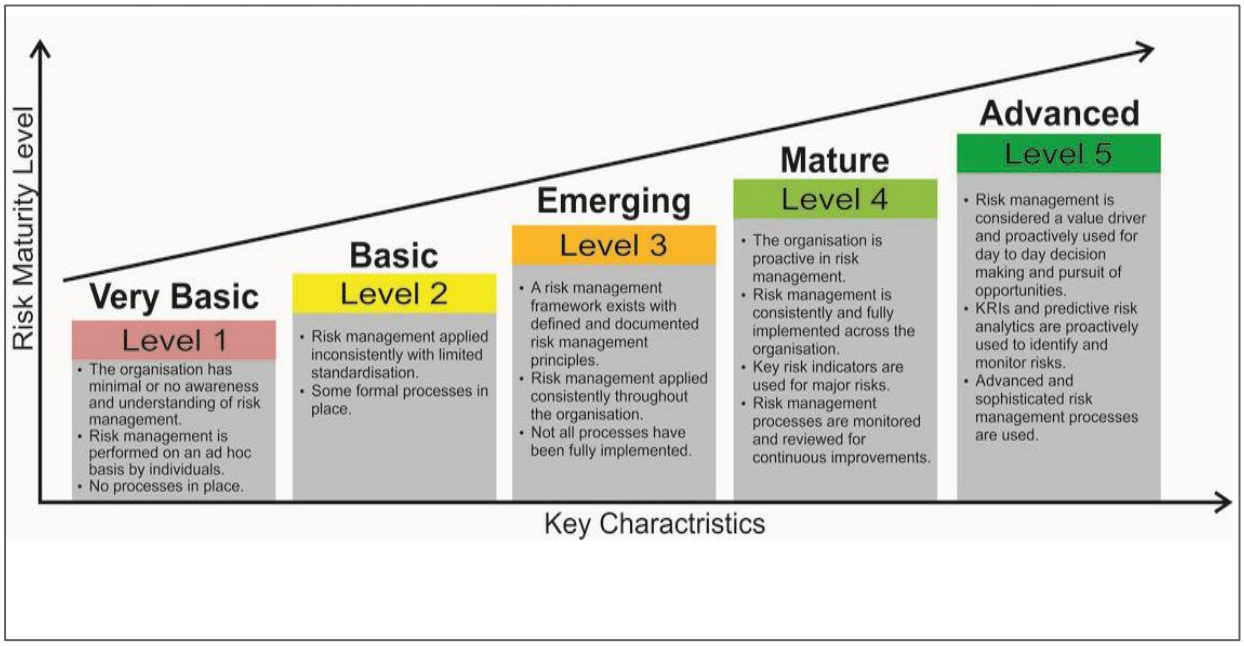
4. Updated Key Risks

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.

5. Table: Key Risks

Outcome	Key Risk	Risk Mitigation
Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation	Fraud, Corruption and Unethical Behaviour within CMS	1. Workshop Staff on 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 **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 with 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 the end of February 2022 7. Identify key priority projects to support policy direction and NHI roadmap by the 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
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. Should CMS be looking at going out to each scheme board and doing specific training annually?

		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 **Outcome 4** - To be a more effective and efficient organisation	Outdated Funding Model	1. Review of CMS funding model – alternative funding model
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 a 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. To explore staff working remotely – need strengthen performance contracts and deliverables - Linked to Business Operation Model and Process Mapping 5. Consider open plan office 6. Consider reinstating the Finance Committee 7. Enforcing budgetary control processes 8. Automated procurement system 9. Develop divisional skills matrix
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 the supply chain management process by implementing consequence management as outlined in the latest Irregular Expenditure Framework. 4. Implement the Post Audit Findings Management Plan, 5. Appoint a Compliance Officer
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. 4. Council documents to be saved on M-files. 5. This will be verified through the audit findings follow up review by internal auditors. 6. Electronic distribution of Council packs (Board Portal)
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	Litigation	1. Increased legal budget 2. Review of Rules Registration SOP to ensure consistency with the MSA 3. Review Managed Care Accreditation SOPs to ensure that MCO's have evidence-based protocols

Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation **Outcome 5** - To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry **Outcome 6** - To collaborate with local, regional and international entities		4. Monitor changes in legislation 5. Implement a cost recovery plan
Outcome 3 - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation **Outcome 6** - To collaborate with local, regional and international entities	Non-Compliance with regulatory framework (Twin Peaks) Demarcation / concurrent jurisdiction	1. Improve interaction with the FSCA, Prudential Authority and National Treasury. 2. Develop the harmonisation of Regulatory Framework 3. Memorandum of understanding with the FSCA and the PA and Treasury
Outcome 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 an 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 a Change management plan 5. Finalise the Business Operational Model project 6. Develop Succession planning and mentoring policy
Outcome 4 - To be 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
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
Outcome 4 - To be a more effective and efficient organisation	Covid-19 Pandemic	1. To implement an effective business continuity plan to address all possible disruptions including pandemics, labour disputes and demonstrations by unhappy regulated entities

		2. Develop work from home policy
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 reducing 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. Improved understanding of the regulatory environment by regulated parties

6. 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** - To promote the improvement of quality and the reduction of costs in the private health care sector **Outcome 2** - To encourage effective risk pooling **Outcome 3** - To ensure that all regulated entities comply with the MSA and Regulations **Outcome 4** - To be a more effective and efficient organisation **Outcome 5** - To conduct policy driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry **Outcome 6** - To collaborate with local, regional and international entities	R 194 164

7. Infrastructure Projects (Not Applicable)

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

8. Public Private Partnerships (Not Applicable)

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

9. Part D: Technical Indicator Descriptions (TID)

9.1 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**
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	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	The Strategic Plan and Annual Performance Plan that was approved by the Executive Authority
Indicator responsibility	CEO
Indicator title	**Ensure that the overall performance of the entity is 80% of the targets set for the year**
Short definition	Overall Organisation Performance
Purpose/importance	To ensure that Council achieves its performance targets as set out in the annual performance plans for the year.
Source/collection of data	Combined Assurance framework with included Internal Audit
Method of calculation/Assessment	Quarterly Management and Internal Audit Reports Number of achieved targets per quarter/number of applicable targets per quarter
Means of verification	Provide required report and save a copy on M-Files

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 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
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	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	No
Desired performance	An annual performance information report that is reliable, accurate and complete with no material findings by the Auditor-General.
Indicator responsibility	CEO

Output 2: Develop strategic relationships with other regulators and stakeholders

Indicator title	**Number of signed memoranda of understanding with local, regional and international regulators and stakeholders**
Short definition	Signed memoranda of understanding by the Office of the Registrar
Purpose/importance	Establishing formalised agreements, attending regular meetings, and scheduling visits to local, regional and international regulatory authorities will ensure that the CMS is recognised by key regulators as an effective and efficient sector regulator.
Source/collection of data	Signed memoranda of understanding
Method of calculation/Assessment	Verification of filed MoU's with Legal, and filling of meeting registers within the Office of the Register
Means of verification	Provide required MoU and save a copy on M-Files
Data limitations	Meetings register and minutes for meetings hosted by the stakeholder will depend on the sharing of this
Assumptions	Stakeholder interests are not homogenous
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Type of indicator	Quantitative
Calculation type	Cumulative (Year-end)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100% of MoU's signed and or maintained, and 100% of meetings scheduled and held
Indicator responsibility	CEO

9.2 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 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	Annual
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**
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	Approved funding model
Means of verifications	Consider the funding model approval 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	Annual
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 31 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 under CMS Vault > folder Performance information audit evidence Provide the draft gazette to NDoH and National Treasure in line with Council budget recommendations, and respond to stakeholder responses to the gazette
Means of verifications	Draft annual budget and draft gazette w.r.t the budget
Assumptions	• Final submission date as prescribed – 31 January each year • Approval is received from both the Minister of Health and the Minister of Finance The budget may change depending on the assessment by the Executive Authority and National Treasury
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	The budget submitted only gets approved once concurrence is received from the Minister of Health and Finance. The budget may change depending on the assessment by Executive Authority and National Treasury.
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual

New indicator	No
Desired performance	Approval of budget by Council on/before 31 January each year
Indicator responsibility	Chief Financial Officer

9.3 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 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 M-Files. Days: 1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days, the formula is (number of hours of the incident/24) Incidents: The number of security incidents calculated in days. These do not include planned attempts. Formula: (Security incidents/days) multiplied by 100. Annual: ((Security incidents/365) * 100. Q1: (Security incidents) / 91) * 100. Q2: (Security incidents) / 92) * 100. Q3: (Security incidents) / 92) * 100. Q4: (Security incidents) / 91) * 100.
Purpose/importance	Security incidents may seriously affect and compromise the ability of the CMS to act as custodian of beneficiary and scheme data which it is required to collect as part of its regulatory mandate. It may also cause the CMS to be in default in terms of current legislation aimed at protecting the privacy of information such as the Promotion of Personal Information Act (POPI Act, Act 4 of 2013) as well as the Electronic Communication and Transactions Act (ECT Act, Act 36 of 2005).
Source/collection of data	Firewall reports and Email security 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 M-Files
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 uptime business-critical application systems (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 Advent Net Helpdesk System. This indicator also assumes a 24/7 network availability. 1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days, the formula is (number of hours of the incident/24) Incidents: The number of incidents calculated in days. Formula: (Days minus Incidents)/days) multiplied by 100. Annual: (365 – Incidents)/365) * 100. Q1: (91 – Incidents) / 91) * 100. Q2: (92 – Incidents) / 92) * 100. Q3: (91 – Incidents) / 92) * 100. Q4: (91 – Incidents) / 91) * 100.
Purpose/importance	A lowering of the total number of days during which interruptions occurred will result in a higher % uptime which may indicate that the application systems were developed using sound software development methodologies and that the software development environment produces stable applications which are able to support business processes and operations.
Source/collection of data	Advent Net Helpdesk System Software with built-in change management processes. Data is collected by Manager: Software Development.
Method of calculation/Assessment	1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days, the formula is (number of hours of the incident/24)

	Incidents: The number of incidents calculated in days. Formula: (Days minus Incidents)/days) multiplied by 100. Annual: (365 – Incidents)/365) * 100. Q1: (91 – Incidents) / 91) * 100. Q2: (92 – Incidents) / 92) * 100. Q3: (92 – Incidents) / 92) * 100. Q4: (91 – Incidents) / 91) * 100.
Means of verification	Number of incidents/downtimes experienced on critical Applications (server report)
Assumptions	The assumptions have taken into account all the identified operational risks
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	Higher. A 100% uptime should be strived for.
Indicator responsibility	Chief Information Officer

Output 7: Effectively provide information management services and organise and manage organisational knowledge with a view to enhancing knowledge sharing.

Indicator title	**Percentage of PAIA requests for information received and finalised within 30 days.**
Short definition	This indicator measures the percentage of PAIA requests for information received by the Deputy Information Officer for a specific period and dealt with successfully or resolved within a period of 30 days after receipt.
Purpose/importance	The CMS, as a public entity, receives Promotion of Access to Information Act (PAIA) request from public members and other stakeholders. The PAIA act stipulates that an entity should respond to the request for information within 30 days. A steady increase in the resolution rate within 30 days from 80% in 2021/22 to 95% in 2022/23 will be indicative of an improved customer experience and response time.
Source/collection of data	A register of all PAIA requests for information is maintained by the Deputy Information Officer on M-Files. Data is collected by Knowledge Manager in his capacity as the Deputy Information Officer.
Method of calculation/Assessment	PAIA requests for information received by the Knowledge Manager in his capacity as Deputy Information Officer for a specific period and dealt with successfully or resolved within a period of 30 days after receipt. Formula: (PAIA requests for information resolved <30 days/PAIA requests for information received within the reporting period) multiplied by 100.

	Annual and quarterly: (PAIA requests for information requests resolved <30 days/PAIA requests for information requests received within the reporting period) * 100.
Method of verification	Number of PAIA information requests finalised within 30 days of receiving the request
Assumptions	The assumptions have taken into account all the identified operational risks
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	The Unit will not carry over requests not resolved at the end of the quarter to the next quarter; these will be counted as received in the quarter under consideration. These only apply to those requests that are still within the 30-day period of being resolved.
Type of indicator	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	Lower the count for PAIA requests for information whilst steadily increasing the resolution rate within 30 days of receipt.
Indicator responsibility	Chief Information Officer

9.4 Sub-programme 1.4: (Corporate Services)

Output 8: 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 and external stakeholders, attended to within 14 days.**
Short definition	Render prompt internal reliable written and verbal legal opinions and representations to Council and other business units as opposed to soliciting external legal opinions. The Unit provides legal opinions to internal stakeholders (that is, the Council and business units of the CMS) and to external stakeholders (anyone who writes to the office and enquires about the medical schemes industry and the laws that govern same in this instance, we express an opinion on the law relating to the MSA).
Purpose/importance	The actions of the Council and the Registrar are protected and take place within the context of sound legal advice.
Source/collection of data	A register of all written and verbal legal opinions is kept electronically on M-Files. Dedicated email address used for requests for legal opinions. All source documents are stored on M-Files. Legal opinions provided are also stored on M-Files.
Method of calculation/Assessment	Count the number of legal opinions processed versus the legal opinion requests on the register and attended to within 14 days*100. The register is maintained electronically.
Means of verification	Legal opinions inbox on M-Files, 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 you.
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 9: Defending decisions of the Council and the Registrar.

Indicator title	**Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days.**

Short definition	Take responsibility for litigation against the Registrar and the Council to enforce the Medical Schemes Act (1998).
Purpose/importance	Decisions of Council and Registrar are protected and enforced in accordance with the Act. The Unit or appointed external attorneys and counsel appear for court and tribunal hearings.
Source/collection of data	A database of all matters received and handled is maintained electronically on M-Files. Email evidence of the actual brief will be kept for all matters. Notice of intention to defend will be issued or other relevant pleadings as may be relevant. Only matters where CMS is required to respond will be counted.
Method of calculation/Assessment	Percentage calculated by dividing the: 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 10: 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 2023.
Source/collection of data	Excel spreadsheet. List of key staff members as per succession planning framework.
Method of calculation/Assessment	Divide the number of terminations by employees by the total number of employees at the end of the reporting period, expressed as a percentage (e.g. 2/20 x 100= 15%).

Means of verification	List of resignations (1 April to 31 March)
Assumptions	The assumption is that HR will retain the 15% staff turnover rate based on previous years' experience.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	No
Desired performance	Retaining competent employees with the right skills at the right time.
Indicator responsibility	Executive Manager: Corporate Services
Indicator title	**Turnaround time to fill a vacancy (turnaround time of 120 working days for each vacancy that exists during the year), excluding the position of CEO.**
Short definition	Time spent filling a vacancy.
Purpose/importance	Ensuring that no gap exists for longer periods of time after resignation, thereby ensuring that units are able to achieve their objectives.
Source/collection of data	Council resolution for new positions. APPs and budget. Resignation and appointment letter.
Method of calculation/Assessment	Existing positions: count the number of calendar days from the resignation of the vacancy to the date the appointment is made (letter of appointment) (a vacancy should not take more than 120 working days to fill) New positions: number of days from the date of approval of the new position or approval of budget should not be more than 120 working days. Vacancies that arise in the previous financial year will be carried over into the new financial year; this will be the actual number of days taken to fill the vacancy, irrespective of the financial year, from the date it arises to the date it is filled. The position of Registrar/CEO is outside the control of CMS as the appointment of this position is carried out by the Executive Authority
Means of verification	Date of Advertisement and Date of Appointment Letter
Assumptions	The assumption is that HR will retain the 120 working days turnaround target to fill the vacancy based on previous trends except in exceptional circumstances of the Executive Management decision.
Disaggregation of Beneficiaries	Target as per the CMS EE Plan for the year.
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Qualitative
Calculation type	Cumulative (Year-End)

Reporting cycle	Quarterly
New indicator	No
Desired performance	Maintain continuity in employment.
Indicator responsibility	Executive Manager: Corporate Services
Indicator title	**Improve CMS B-BBEE targets [according to the Broad-Based Black Economic Empowerment Act (BBBEEA targets)], annually**
Short definition	To ensure that CMS achieves its targets according to Section 9(5): Codes of Good Practice.
Purpose/importance	To achieve equity in the workplace by promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination and implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups in order to ensure equitable representation in all occupational categories and levels in the workforce.
Source/collection of data	CMS approved Employment Equity Plan.
Method of calculation/Assessment	Vacancies are filled in accordance with under-representation within an occupational level. Where under-representation has been identified in the analysis, the numerical goals to achieve the equitable representation of suitably qualified people from designated groups across each level will be set. Numerical goals and targets will be set on each level in relation to the economically active population (EAP) statistics of the Gauteng province. As per the employment equity plan for CMS.
Means of verification	Verification Certificate by a SANAS accredited service provider
Assumptions	The assumption is that HR will continue to achieve the EE targets as per the CMS EE Plan.
Disaggregation of Beneficiaries	Target as per the CMS EE Plan for the year.
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	Yes
Desired performance	A B-BBEE score of between 40 to 54
Indicator Responsibility	Executive Manager: Corporate Services
Indicator title	**Develop and maintain a talent management policy framework by implementing a career path and succession plan**
Short definition	To develop talent management policy frameworks and implementation capacity
Purpose/importance	To enhance the talent management value chain through structured talent management a framework to attract and retain the talented and skilled workforce

Source/collection of data	CMS approved talent management policy framework
Method of calculation /Assessment method	The number of approved talent management policies/frameworks includes but is not limited to: Learning and development strategy, Talent Management policy, Talent Sourcing, Performance Management Policy, Remuneration Philosophy, Employee Benefits, Reward and Recognition Policy.
Means of verification	Number of approved policies and number of developed and engaged for higher positions
Assumptions	The assumption is that HR will have an available budget to effectively develop and implement the talent management value chain
Disaggregation of Beneficiaries	To be integrated into the identified policies
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	No
Desired performance	CMS approved talent management policy framework
Indicator Responsibility	Executive Manager: Corporate Services

Output 11: Maximise performance to improve organisational efficiency and maintain high performance culture.

Indicator title	**Percentage of employee performance agreements are signed by 31 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	Annual
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 (2022/23). The target for quarter 3 will be the assessments concluded for the first half of the current year (2022/23).
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
Indicator title	**Number of Training and Development Sessions to Improve Employee Relations**
Short definition	Training on conflict resolution and collective bargaining frameworks as well as ensuring capacity building and compliance with relevant labour legislation and code of good practices
Purpose/importance	A climate of trust, cooperation and stability is created
Source/collection of data	Training and awareness on employer/employee relations
Method of calculation /Assessment	Number of employee relations management interventions
Means of verification	Quarterly Reports/HR Newsletters/Internal Communiques and or Survey
Assumptions	The assumption is that HR facilitates workshops, awareness sessions annually, facilitate counselling, mediation and interventions to address relationship issues and provide support to units on disciplinary matters. Organisational Rights Agreement, wage negotiations and policies and labour legislation will be observed
Disaggregation of Beneficiaries	All employees in the office during the quarter under review.
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	4
Indicator responsibility	Executive Manager: Corporate Services
Indicator title	**Percentage of signed annual declarations of financial interest by CMS employees (excluding employees out of office on extended absence)**
Short definition	To declare and manage conflict of interests.
Purpose/importance	To ascertain that the CMS employees 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 CMS employees
Method of calculation /Assessment method	The number of employees that submitted the declaration of interest forms/Number of employees employed by the CMS as of 30 June * 100. (Excluding employees who are on extended leave)
Means of verification	Declaration of interest forms completed by CMS employees on file.

Assumptions	The assumption is that some employees might be on extended leave during the period under review, and their forms will be submitted as soon as they are back in the office
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	100%
Indicator Responsibility	Executive Manager: Corporate Services

Output 12: 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 30 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	To be reviewed at the end of the current lease agreement
Data limitations	None
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	Approved needs analysis by the Registrar
Indicator responsibility	Executive Manager: Corporate Services

Output 13: 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
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	30
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 as a portfolio of evidence.
Method of calculation/Assessment	, the number of responses received for each question (yes/no/maybe) 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	Annual
New indicator	No
Desired performance	60%
Indicator responsibility	Executive Manager: Corporate Services

Output 14: 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 31 August to the Executive Authority**
Short definition	The CMS Annual Report is produced in line with statutory requirements to report on the performance of the CMS against targets set out in the Strategic Plan document and APP, as well as the resources allocated to the organisation. The report is presented to the Executive Authority, who tables it in

	Parliament; thereafter, it is presented to the Portfolio Committee on Health. The Annual Report is subsequently presented to industry role-players as well as the media and published on the CMS website for access by members of the public.
Purpose/importance	The Annual Report serves as a key tool for the CMS to account for the performance of the organisation against set targets, including the organisation's financial position and human resources information, for the year under review, in line with statutory requirements for public entities. The report also provides valuable information to stakeholders on key industry developments and trends.
Source/collection of data	The information contained in the CMS Annual Report is sourced internally from the respective business units based 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 2018.
Means of verification	Proof of submission to the Executive Authority
Assumptions	That all contributing documents, such as the Auditor-General's Report, will be complete and approved by 31 August 2019.
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Unavailability of the required information and/or sources of information and/or human resources; non-compliance/non-adherence to production schedule and deadlines.
Type of indicator	Qualitative
Calculation type	Non-cumulative
Reporting cycle	Annual
New indicator	No
Desired performance	Submission of the Annual Report to the Executive Authority by 31 August annually.
Indicator responsibility	Executive Manager: Corporate Services

9.5 Sub-programme 1.5 (Council Secretariat)

Output 15: Corporate governance, Secretariat & Board administration Support and Legal Services for effective governance by the Accounting Authority

Indicator Title	**Develop an Annual Council Work Plan for Council and its Committees by 31 March.**
Short definition	This indicator measures the development of an annual year plan for Council consideration
Purpose/importance	To ensure that Council meetings are planned for and scheduled in advance in order to allow Council as the Accounting Authority to exercise its Oversight Role
Source/collection of data	Annual Year-Plan and Council Minutes
Method of calculation/Assessment	Annual Year-Plan
Means of verification	Annual Year-Plan and Council Minutes

Assumptions	Council will have meetings in Q4 of each year to consider Year-Plan for the following Financial Year
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	No
Desired performance	100%
Indicator responsibility	**Council Secretariat**
Indicator Title	**Develop and Review Council and Committees Governance Charters.**
Short definition	This indicator measures the development and or review of the Council Charter(s), including the sub-committees
Purpose/importance	To ensure that governance principles are consistent with best practice
Source/collection of data	Charters and Council/Sub-Committee Minutes
Method of calculation/Assessment	Number of Charter's and Council/Sub-Committee Minutes
Means of verification	Charters and Council/Sub-Committee Minutes
Assumptions	Council will have meetings in Q4 of each year to consider Year-Plan for the following Financial Year
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	No
Desired performance	6
Indicator responsibility	Council Secretariat
Indicator Title	**Communicate Council resolutions within 3 days of the meeting to 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	Annual Year-Plan
Means of verification	Annual Year-Plan and Council Minutes; Resolution register; Communiques of Council Resolutions to relevant executive managers; Matters arising action lists; Feedback reports at each Council meeting for past and outstanding resolutions and matters arising
Assumptions	Council and its committees will hold their meetings as planned
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	**Arrange Council meetings**
Short definition	This indicator measures the sittings of the Accounting Authority in exercising oversight
Purpose/importance	To ensure that the Accounting Authority exercises its oversight role as mandated by the MSA
Source/collection of data	Meeting minutes
Method of calculation/Assessment	Consider meeting minutes
Means of verification	Consider meeting minutes
Assumptions	Council will continue to have meetings as and when required
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	4

Indicator responsibility	Council Secretariat
Indicator Title	**Arrange Council Committees meetings**
Short definition	This indicator measures the sittings of the Accounting Authority in exercising oversight
Purpose/importance	To ensure that the Accounting Authority exercises its oversight role as mandated by the MSA
Source/collection of data	Meeting minutes
Method of calculation/Assessment	Consider meeting minutes
Means of verification	Consider meeting minutes
Assumptions	Council will continue to have meetings as and when required
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	4
Indicator responsibility	Council Secretariat
Indicator Title	**Facilitate training and development of Council**
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	4
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 /Assessment method	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. (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	Annual
New indicator	Yes
Desired performance	100%
Indicator Responsibility	Council Secretariat

Output 16: Support Dispute Resolution Forums in furtherance of Council and MSA objectives

Indicator Title	**Arrange the Appeals Committee hearings**
Short definition	This indicator measures the number of Appeals Committee hearings scheduled
Purpose/importance	This indicator measures the scheduling of appeals once the appeal is ready for adjudication by the Appeals Committee
Source/collection of data	Appeals Register - consisting of complete appeal filings; set down notices; hearing roll and hearing recording/transcripts (set out a schedule of all documents for an appeal to be ready for enrolment – include it into the complaints SoPs for handover to appeals committee)
Method of calculation/Assessment	Consider the number of Appeals Committee hearings
Means of verification	Appeals Register

Assumptions	The right to be heard on appeal is legislated; if a party aggrieved by the Registrar's ruling or a decision by the Registrar with the concurrence of Council wishes to appeal that decision, the appeal should be adjudicated expeditiously, as justice delayed is justice denied.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	12
Indicator responsibility	Council Secretariat
Indicator Title	**Arrange the Appeal Board hearings**
Short definition	This indicator measures the number of the Appeal Board hearings scheduled
Purpose/importance	This indicator measures the scheduling of appeals once the appeal is ready for adjudication by the Appeal Board
Source/collection of data	Appeals Register - consisting of complete appeal filings; set down notices; hearing roll and hearing recording/transcripts (set out a schedule of all documents for an appeal to be ready for enrolment – include it into the complaints SOP for handover to appeals board)
Method of calculation/Assessment	Consider the number of Appeal Board hearings
Means of verification	Appeals Register
Assumptions	The right to be heard on appeal is legislated; if a party aggrieved by the Registrar's ruling or a decision by the Registrar with the concurrence of Council wishes to appeal that decision, the appeal should be adjudicated expeditiously, as justice delayed is justice denied.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	Confidentiality
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	4
Indicator responsibility	Council Secretariat
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	100%
Indicator responsibility	Council Secretariat

9.6 Programme 2: (Strategy, Performance and Risk)

Output 17: 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 18: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.

Indicator title	**Review and Develop a Strategic Plan and Annual Performance Plan for the consideration of the CEO & Registrar as well as Council**
Short definition	Review and develop Strategic Plan and Annual Performance Plan
Purpose/importance	To facilitate the Council for Medical Schemes Strategic and Annual Performance Plan process
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 Council (1st draft, 31st of October, Final submission 31st January)
Means of verification	Consider the SP and APP (Whichever is applicable) submitted on the due date to Executive Authority (1st draft, 31st of October, Final submission 31st January),
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	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	The Strategic Plan and Annual Performance Plan (Whichever Applicable) that was approved by the Council
Indicator responsibility	Executive Manager: Strategy, Performance and Risk
Indicator title	**Produce an Annual Performance Information report that is reliable, accurate and complete by 31 July each year**
Short definition	Reporting of actual performance against stated objectives and targets.
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 Annual Performance Information Report
Method of calculation/Assessment	Approved annual performance information report by Council on 31st July each year
Means of verification	Consider the issued opinion letter by the Auditor-General South Africa on 31 July of each year
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	Non-Cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	An annual performance information report that is reliable, accurate and complete with no material findings by the Auditor-General South Africa.

Indicator responsibility	Executive Manager: Strategy, Performance and Risk
Indicator title	**Produce Quarterly Performance Information report that is reliable, accurate and complete**
Short definition	Reporting of actual performance against stated objectives and targets.
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

Output 19: An effective, efficient and transparent system of risk management is maintained in order to mitigate the risks exposure of the CMS

Indicator title	**Number of strategic risk register reports submitted to the Council for monitoring**
Short definition	To ensure that the risks of the Council are mitigated to an acceptable risk tolerance level.
Purpose/importance	Risk management will ultimately help CMS to achieve: Greater organisational clarity of purpose by clearly identifying policy needs and actions required to meet Outcome Indicators. More cohesiveness of effort through organisational consistency and clear role definition, better decisions and thorough consideration of issues. Faster reactions through concentration on key performance trends. Accountability by recording decisions in context and allocating responsibility for action.
Source/collection of data	Quarterly strategic risk register reports submitted to Council for monitoring. Council minutes are kept.
Method of calculation/Assessment	Council minutes reflect the discussions on the strategic risk report submitted and discussed at Council.

Means of verification	Provide required register and save a copy on M-Files
Assumptions	The number of submissions is determined by the Executive Authority in concurrence with the Department of Planning, Monitoring and Evaluation
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not Applicable
Data limitations	Not applicable
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	To ensure that risks are at an acceptable risk tolerance level or are mitigated.
Indicator Responsibility	Executive Manager: Strategy, Performance and Risk

Output 20: An effective, efficient and transparent system of coordinating the CMS Audit function is maintained

Indicator title	**Ensure the development of an Internal Audit three year rolling plan and reports, for the Audit and Risk Committee's adoption and monitoring**
Short definition	Monitor Internal Audit Outcomes
Purpose/importance	Develop Internal Audit Reports and submit them to Council for monitoring
Source/collection of data	Three year Internal Audit rolling plan and Internal Audit Reports presented to Audit and Risk Committee of Council
Method of calculation/Assessment	Three year Internal Audit rolling plan and One Internal Audit Reports presented to Audit and Risk Committee of Council per Quarter
Means of verification	Three year Internal Audit rolling plan and One Internal Audit Report presented to Audit and Risk Committee of Council per quarter
Assumptions	The audit function will be executed timeously within budget
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Qualitative
Calculation type	Cumulative
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	A quarterly internal audit report that is reliable, accurate and complete by the internal auditors
Indicator Responsibility	Executive Manager: Strategy, Performance and Risk

Indicator title	**Coordinate the External Audit Function and submit an Audit Strategy and Reports to Council for adoption**
Short definition	Monitor External Audit Outcomes
Purpose/importance	Respond to External Audit Reports and submit to Council for monitoring
Source/collection of data	External Audit Strategy and External Audit Reports presented to Audit and Risk Committee of Council
Method of calculation/Assessment	External Audit Strategy and One External Audit Report presented to Audit and Risk Committee of Council per annum
Means of verification	External Audit Strategy and One External Audit Report presented to Audit and Risk Committee of Council per annum
Assumptions	The audit function will be executed timeously and within budget
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	None
Type of indicator	Qualitative
Calculation type	Non-Cumulative
Reporting cycle	Annual
New indicator	Yes
Desired performance	An annual external audit report that is reliable, accurate and complete by the external auditors
Indicator Responsibility	Executive Manager: Strategy, Performance and Risk

9.7 Programme 3: (Regulation)

Output 21: 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. 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.
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 and outcomes communicated to applicants, within three months of receipt of complete information**
Short definition	Percentage of managed care organisation (MCO) accreditation applications and self-administered schemes compliance certificate applications analysis completed within three months of receipt of complete information. New and renewal applications are included. Relevant information includes: • Completed accreditation/compliance certificate application form. • Declaration of conflict of interest • Group structure (MCOs) • Organogram • Copies of managed care agreements with medical schemes in place. (MCOs) • Copies of sub-contracting agreements (where applicable). • Latest audited annual financial statements and most recent management accounts. (MCOs) • Positive confirmation of tax compliance status. (MCOs) • Copies of managed care protocols and formularies. • Proof of payment of the prescribed application fee. (MCOs) Additional information may be requested during the analysis of the applications. Applicants must meet the three key requirements for accreditation: • The applicant must be fit and proper. • The applicant must have the necessary systems, resources, skills and capacity to provide managed care services. • The applicant must be financially sound. Once the evaluations have been completed, applicants are either accredited for a period of two years, or unsuccessful applicants are informed of the reasons for non-accreditation. Self-administered schemes are issued with compliance certificates (valid for three years) if all the requirements are met in respect of the managed care services provided to members.
Purpose/importance	Managed care organisations must be accredited in order to provide managed care services to medical schemes as defined in the Medical Schemes Act (1998).
Source/collection of data	Acknowledgement letter of receipt of an application, Steering Committee minutes is available on M-Files. Paper trail of all documents received, interacted with and concluded on M-Files.

Method of calculation/Assessment	The number of complete applications evaluated within 30 days (in a quarter) of receipt and outcomes communicated divided by the total number of complete applications received expressed as a percentage during the quarter. Number of Complete Applications evaluated and the outcome communicated / Number of Complete Applications Received x 100
Means of verification	Acknowledgement of receipt letters sent to applicants and Steering Committee minutes.
Assumptions	• Entities applying for accreditation are actively in business
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	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 and outcomes communicated to applicants, within three months of receipt of complete information**
Short definition	Indicates the percentage of Administrator accreditation and self-administered scheme compliance certificate applications evaluated within 3 months of receipt of all relevant information. New and renewal applications are included. Relevant information includes: • Completed accreditation/compliance certificate application form. • Declaration of conflict of interest • Group structure. (Administrators) • Organogram • Copies of administration agreements with medical schemes in place. (Administrators) • Copies of sub-contracting agreements (where applicable); • Latest audited Annual Financial Statements and most recent management accounts. (Administrators) • Positive confirmation of tax compliance status. (Administrators). • Proof of payment of the prescribed application fee (Administrators). Additional information may be requested during the analysis of the applications.

	Applications must meet the three key requirements for accreditation: • The applicant must be fit and proper. • The applicant must have the necessary systems, resources, skills and capacity to provide the services. • The applicant must be financially sound. Once the evaluations have been completed, applicants are either accredited for a period of two years, or unsuccessful applicants are informed of the reasons for non-accreditation. Self-administered schemes are issued with compliance certificates (valid for three years) if all the requirements are met in respect of the administration services provided to members.
Purpose/importance	Administrators must be accredited in terms of the Medical Schemes Act (1998) in order to 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 Steering Committee minutes are available on M-Files. Paper trail of all documents received, interacted with and concluded on M-Files.
Method of calculation/Assessment	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 Steering Committee minutes.
Assumptions	• Entities applying for accreditation are actively in business
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	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

Outcome 22: To ensure that rules of the schemes are simplified, standardised, fair and compliant with the Medical Schemes Act (1998).

Indicator title	**Percentage of interim rule amendments processed within 14 working days of receipt of all information.**

Short definition	A rule amendment represents a change to the rules that govern the relationship between a medical scheme and its members. Interim rule amendments are received throughout the year, and in order to ensure that rules are effective and up-to-date, they need to be processed with 14 days of the receipt of all information.
Purpose/importance	The purpose is to ensure that rules submitted by the schemes are efficiently and effectively analysed and approved with the stipulated time frames. This ensures that all schemes operate according to the approved rules which are aimed at protecting members and beneficiaries. The indicator measures the effectiveness of the processing of rule amendments received within the targets identified to ensure that schemes receive feedback regarding the submitted amendments timeously. The indicator measures the effectiveness of the processing of rule amendments received within the targets identified.
Source/collection of data	Hardcopies of interim rule amendments submitted are captured on a register and Excel spreadsheet. The capturing of the data submitted, received by the analyst, date of request of further information and the data processed and sent to the GM is captured for each rule submission. The spreadsheet will use the information captured to calculate the performance of the Unit.
Method of calculation/Assessment	The spreadsheet captures all the 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 days or less / (Denominator) Number of amendments processed in the period (excluding those with outstanding information) * 100. The calculation takes into account all rule amendment requests received from 1 March to End of February of each year
Means of verification	Rule amendment applications and Approval letters
Assumptions	The assumptions are that all identified operational risks have been taken into account
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	The indicator is only a measure of the percentage of submissions completed within 14 days. It is based on the number of submissions made by schemes during each quarter.
Type of indicator	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 31 December of each year.**
Short definition	A rule amendment represents a change to the rules that govern the relationship between a medical scheme and its members. Annual rule amendments that are processed under this indicator are required by schemes as they need updating to contributions and benefits each year in order to keep the schemes relevant and sustainable.
Purpose/importance	The unit ensures that annual rule amendments submitted during September/October that are effecting on 1 January the following year are processed after receipt of all info before 31 December of that year

	to enable schemes to operate the benefit year with approved rules. This ensures that the schemes have rules that are approved and are compliant with the Medical Schemes Act (1998) and are not unfair to members of medical schemes when they are 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 GM is captured for each rule submission. The spreadsheet will use the information captured to calculate the performance of the Unit.
Method of calculation/Assessment	The spreadsheet captures all the annual rule submissions received effective 1 January and also the date that they were processed to calculate the target of submissions processed by 31 December. The performance target of the unit is calculated in the following way: (Numerator) 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	Quarterly
New indicator	No
Desired performance	90% of submissions made to the office are processed before 31 December each year.
Indicator responsibility	Executive Manager: Regulation

Outcome 23: 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 final 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: A scheme has delayed the submission of the relevant documentation for inspection; Resource constraints within the unit;
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	Yes
Desired performance	10
Indicator responsibility	Executive Manager: Regulation

Output 24: 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 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 25: 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 rulings, request insurance entities to apply for demarcation exemption or issue directives to schemes in order to enforce compliance.
Purpose/importance	The purpose of the indicator is to ensure that medical schemes, insured entities and regulated entities are fully compliant with the Medical Schemes Act (1998) and its Regulations. The Unit will ensure that all matters received result in processed interventions.
Source/collection of data	Below are 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)
Means of verification	• Section 43 enquiry, and notices, enquiries, request for information in terms of any other applicable legislation: count the letters 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 letters 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 letter sent to the scheme imposing the penalty). • Rulings in terms of Section 47: count the letter sent to the scheme enforcing compliance with the ruling. • Directives: count the letter 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 matter is received in a quarter but attended to in a different quarter due to a delay in obtaining information on the matter from the scheme or internal parties.
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	100%
Indicator responsibility	Executive Manager: Regulation

Output 26: 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 notifications • 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*100
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 in order to monitor the performance of the curator. • Trustee removal proceedings in terms of Section 46: count the number of section 46 notice letters issued • Board Notice 73 of 2004: Count, the number of Board, notices issued to the scheme /industry. • Exemptions in terms of Section 8(h): Count the number of exemption letters sent to the scheme communicating the result of an application. • Demarcation exemptions: count the exemption letter issued to insured entities communicating the result of an application.
Assumptions	• Non-Compliance with the Act at Medical schemes will occur due to misinterpretation or non-adherence to the Act;
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Limitations may arise where: A matter is received in a quarter but attended to in a different quarter due to a delay in obtaining information on the matter from the scheme or internal parties.
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Quarterly
New indicator	No
Desired performance	60%
Indicator responsibility	Executive Manager: Regulation

Indicator title	**Number of scheme member meetings attended during the period (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: <u>Annual General Meetings, Special General Meetings and Elections of Trustee Meetings:</u> • 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	<u>Annual General Meetings, Special General Meetings and Elections of Trustee Meetings:</u> • 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 27: Monitor and promote the financial soundness of medical schemes.

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

Short definition	Percentage of recommendations in respect of identified schemes with rapidly reducing solvency.
Purpose/importance	To measure monitoring actions in respect of schemes with rapidly reducing solvency This indicator measures the performance of medical schemes during the year as part of the Early Warning System.
Source/collection of data	The Unit will identify schemes with rapidly reducing solvency Content Management System on M-files - CMS Vault – FSU folder. The recommendation may entail a variety of actions, such as requiring schemes to submit a reserving plan and /or management accounts on a business plan detailing how reserves will be managed.
Method of calculation/Assessment	The number of business plans processed / number of business plans received*100. Where there are no Schemes fitting the category of rapidly declining solvency, the assumption is that the target is not applicable
Means of verification	Business plans and Approval letters
Assumptions	• The assumptions 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 business plans are generally received at the end of a reporting period following the audit of scheme financials. Typically, there will be interaction with the scheme over months until a satisfactory business plan detailing an appropriate turnaround strategy is submitted and analysed. As such, cases will always be carried over into the next period. There will, therefore, always be a lag between identification, receipt and a final recommendation.
Type of indicator	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 applications analysed.**
Short definition	This indicator measures the percentage of applications for auditor approval analysed and finalised as per Section 36 of the MSA.
Purpose/importance	Section 36 of the MSA requires the Registrar to approve the appointment of auditors by medical schemes. This is to ensure that scheme auditors are appropriately skilled and experienced for the nature and size of the scheme.
Source/collection of data	Auditor approval letters: after analysis, an auditor application can either be approved or rejected. The Unit counts all applications analysed. Content Management System on M-files - CMS Vault – FSU folder. Schemes requiring approval submit application forms through the CMS web portal.
Method of calculation/Assessment	Work out the percentage taking the number of schemes applications analysed (this includes both approved and rejected applications) /number of schemes applications received at least two weeks before 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 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 as part of the Early Warning System.
Source/collection of data	Publication of quarterly reports on CMS website. One quarterly report per quarter, except for the last quarter of the year.
Method of calculation/Assessment	Sum of quarterly reports that are published on the CMS website.
Means of verification	Quarterly Reports published
Assumptions	Three quarterly reports will be prepared.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	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 the number of financial sections prepared in respect of the Annual Report. The Annual Financial Statements of schemes are analysed, and a consolidated report is prepared as part of the industry report in the CMS Annual Report.

Purpose/importance	This indicator measures the financial performance of medical schemes based on financial performance during the year.
Source/collection of data	Financial sections of the annual report submitted for inclusion in the annual report. Publication of the Annual Report on the CMS website.
Method of calculation/Assessment	The sum of the financial section of the annual report submitted to the Stakeholder Relations Unit.
Means of verification	Annual Report
Assumptions	One financial section of the annual report will be submitted for inclusion in the annual report.
Disaggregation of Beneficiaries	Not applicable
Spatial Transformation	Not applicable
Data limitations	None
Type of indicator	Quantitative
Calculation type	Cumulative (Year-End)
Reporting cycle	Annual
New indicator	No
Desired performance	One set of input in respect of the financial sections of the Annual Report in 2021/22.
Indicator responsibility	Executive Manager: Regulation

9.8 Programme 4: (Policy, Research and Monitoring)

Output 28: Conduct research to inform appropriate national health policy interventions

Indicator title	**Number of research projects and support projects published in support of the national health policy**
Short definition	Undertake strategic research to inform national health policy interventions like the National Health Insurance and Health Market Inquiry.
Purpose/importance	Section 7 (b) of the Medical Schemes Act (1998) states that CMS needs to control and coordinate the business of the medical schemes in a manner that is complementary to the national health policy. Whist Section 7 (e) and (g) states that CMS must advise the minister on any matter concerning medical schemes, including collecting and disseminating information about private health care.
Source/collection of data	CMS website, under publications and M-files.
Method of calculation/Assessment	Sum of research projects completed. Research projects are undertaken for internal and external consumption. For internal projects, the project is counted when sent to the unit it was intended for, 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

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 29: 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	Annual
New indicator	No
Desired performance	Report on the analysis of non-financial data is completed in time to be published in the Annual Report.
Indicator responsibility	Executive Manager: Policy, Research & Monitoring

9.9 Programme 5: (Member Protection)

Output 30: 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 31: 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 32: 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 working 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 working days of age. A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	Executive Manager: Member Protection
Indicator title	**Percentage of category 4 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures**
Short definition	Category 4 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 4 resolved performance: Number of category 4 complaints resolved within 120 calendar days/ Number of category 4 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	No
Desired performance	A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	Executive Manager: Member Protection

Indicator title	**Percentage of category 1 complaints adjudicated within 30 working days and in accordance with complaints standard operating procedures**
Short definition	Category 1 complaints are uncomplicated and can be resolved on receipt of all responses and supporting documentation without requiring secondary referrals. 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 30 calendar days/ Number of category 1 complaints resolved) *100
Means of verification	Report drawn from the 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	No
Desired performance	A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	Executive Manager: Member Protection
Indicator title	**Percentage of category 2 complaints adjudicated within 60 working days and in accordance with complaints standard operating procedures**
Short definition	Category 2 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 2 resolved performance: Number of category 2 complaints resolved within 60 calendar days/Number of category 2 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	No
Desired performance	A higher percentage of resolved complaints indicates higher performance.
Indicator responsibility	Executive Manager: Member Protection
Indicator title	**Percentage of category 3 complaints adjudicated within 90 working days and in accordance with complaints standard operations procedures**
Short definition	Category 3 complaints are moderately complex and require collation of evidence and secondary referral for inputs within CMS or 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 database
Method of calculation/Assessment	Category 3 resolved performance: Number of category 3 complaints resolved within 90 calendar days/ Number of category 3 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. Volumes 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	No
Desired performance	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 3 months within which an appeal must be filed**
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 33: Appeal Committee hearings attended based on written requests received from Council

Indicator title	**Percentage of Appeal Committee hearings attended based on written requests received from Council**
Short definition	As per the provisions of section 48 (1) of the Medical Schemes Act (1998), Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council. The Appeal Committee may, in terms of Section 48(6), issue a written request for any person who may be able to give material information concerning the subject of an appeal, to appear before it.
Purpose/importance	To ensure that the panel (Appeals Committee) hearing appeals understand the reasons for the rulings issued on complaints, the unit appears before the panel on the date of hearings and provide clarity on the interpretation of the Medical Schemes Act and the rules of medical schemes.
Source/collection of data	CMS Complaints Adjudication IT system database
Method of calculation/Assessment	Total number appeals attended/Total number written requests received*100
Means of verification	Attendance Register
Assumptions	Dependent on written requests received
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	100%
Indicator responsibility	Executive Manager: Member Protection

Output 34: Formulate Prescribed Minimum Benefits (PMBs) definitions to ensure uniform interpretation of the benefits and entitlements

Indicator title	**The number of benefit definitions 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: Member Protection
Indicator title	**Develop preventative and primary healthcare package to incorporate into 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.
Method of calculation/Assessment	A preventative and primary healthcare package will be developed and will be stored on M-Files.
Means of verification	New PMB Package inclusive of Primary Healthcare Package
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	A dedicated database for all documents on the PMB review exists on M-Files.
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: Member Protection

Output 35: 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 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	Category 3 will be allocated to a clinical opinion of a very complex nature requiring extensive inputs, additional documentation and research. These will require expert/specialist consultation before a conclusion can be reached. 100% of clinical opinions of this nature will be aimed for completion within 90 days of receipt from the Complaints Adjudication Unit. Count of clinical opinions electronically via the Complaints Database. The calculations of the proposed indicators will be according to the formula below: Completion of 98% of clinical opinions referred to within 90 working days calculated by: The number of completed clinical opinions between 60-90 working days /Total number of clinical opinions referred in ≤ 90 working days* 100.
Means of verification	Clinical Opinions workflow Spread Sheet
Assumptions	Availability of Resources
Disaggregation of Beneficiaries	Not Applicable
Spatial Transformation	Not Applicable
Data limitations	Dedicated Clinical opinions workflow database limitation
Type of indicator	Quantitative
Calculation type	Non-cumulative
Reporting cycle	Quarterly
New indicator	No
Desired performance	To attend to 98% of all category 3 clinical opinions 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 Unit and via e-mail and telephonic enquiries with the view to ensure that member's complaints and enquiries are resolved.
Purpose/importance	To protect the members of the medical schemes, facilitate access to medical scheme benefits and ensure that members receive rightful cover.

Source/collection of data	M-Files Complaints Database and Clinical enquiries e-mail database.
Method of calculation/Assessment	Sum of clinical enquiries, electronically via email and telephonic. Enquiries are captured by each clinical analyst on a spreadsheet. (Total number of clinical opinions responded to within 7 days / total number of clinical opinions received for the period).
Means of verification	Clinical Opinions 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 following a 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

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

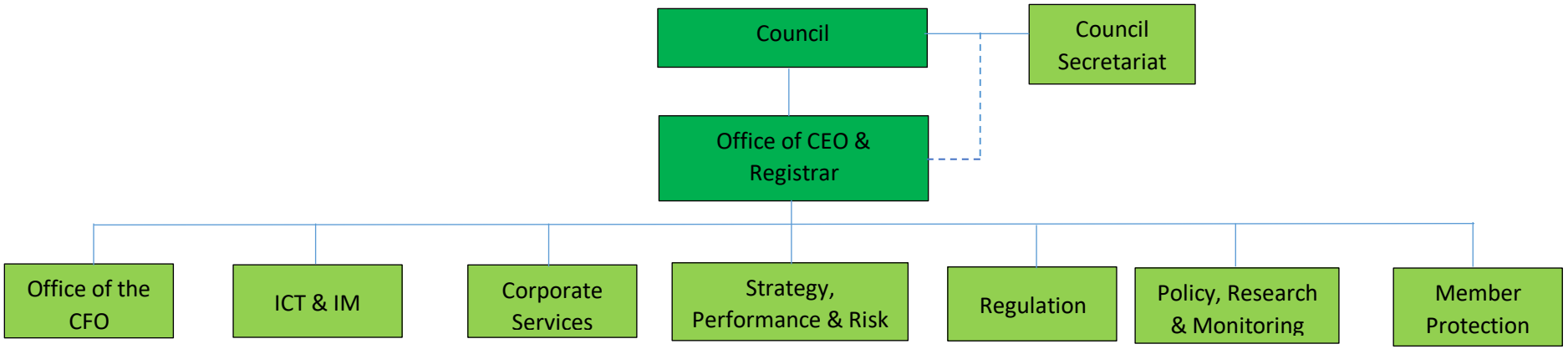
- **Sub-Programme 1.1 - CEO:** Office of the CEO
- **Sub-Programme 1.2 - CFO:** Office of the CFO
- **Sub-Programme 1.3 – ICT & IM:** Information Communication Technology and Information Management
- **Sub-Programme 1.4 - CORS:** Corporate Service (*This programme now includes Legal Services, HR, Part 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)*



The following outputs are revised or added to complement the structural changes to the programmes:

- Output 1: Ensure that reported performance information is in accordance with the Framework for Strategic and Annual Performance Plans.
- Output 3: Ensure that reported financial information is useful and reliable, and in accordance with the Expenditure Management and Reporting Framework.
- Output 4: Ensure effective financial management and alignment of budget allocation with strategic priorities.
- Output 12: Ensure maximisation in the coordination of various planning efforts that are undertaken in relation to the CMS facilities.
- Output 17: Ensure that strategic projects are scoped, and project plans are in place.
- Output 18: Compile performance information in accordance with the Framework for Strategic and Annual Performance Plans.
- Output 20: An effective, efficient and transparent system of coordinating the CMS Audit function is maintained.
- Output 28: Conduct research to inform appropriate national health policy interventions.
- Output 33: Appeal Committee hearings attended based on written requests received from Council.

The Annual Performance Plan is currently aligned with the Strategic Plan and has been revised to include a new sub-programme for the Council Secretariat. The entity has developed an Acceptable Levels of Materiality and Significance Framework in line with Treasury Regulation 28.3. The materiality/significant framework per current policy is R1.75 million. This is reviewed and submitted to the Executive Authority on an annual basis.

CMS Materiality and Significance Framework

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

Section 50: Fiduciary duties of accounting authorities

1) The Accounting Authority for a public entity must:

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

Section 51: General responsibilities of accounting authorities

1) An Accounting Authority for a public entity:

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

Section 54: Information to be submitted by accounting authorities

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

PFMA section	*Quantitative (Amount)*	*Qualitative (Nature)*
a) Establishment of a company.	*Any proposed establishment of a legal entity.*	*Full particulars to be disclosed simultaneously to the Minister of Health and Minister of Finance (National Treasury) for approval.*
b) Participation in a significant partnership, trust, unincorporated joint venture or similar arrangement.	*Qualifying transactions exceeds R1.75m (based on 1% of total CMS revenue as at 31 March 2020).*	
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 R1.75m (based on 1% of total CMS revenue as at 31 March 2020) 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 R1.75m (based on 1% of total CMS revenue as at 31 March 2020).*	*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 R1.75m (based on 1% of total CMS revenue as at 31 March 2020).*	

Section 55: Annual report and financial statements

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

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

   b) include particulars of:

PFMA section	*Quantitative (Amount)*	*Qualitative (Nature)*
(i) Any material losses through criminal conduct and any irregular expenditure and	*All instances.*	*Report quarterly to the Minister of Health.*

fruitless and wasteful expenditure that occurred during the financial year.		*Report annually in the annual financial statements.*
(ii) Any criminal or disciplinary steps taken as a consequence of such losses or irregular expenditure or fruitless and wasteful expenditure.		
(iii) Any losses recovered or written off.		
(iv) Any financial assistance received from the state and commitments made by the state on its behalf.		
(v) Any other matters that may be prescribed.	*All instances, as prescribed.*	

Section 56: Assignment of powers and duties by accounting authorities

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

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

Element	**Percentage (%) rand to be applied against R value**	**Audited value at 31 March 2020**	**Calculated materiality and significance value**
Total Revenue (0.5 - 1%)	1%	R 174 573 000	R 174 573 000

The CMS materiality and significance value will be R1.75 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 272 000	2022/23

Annexure C: Consolidated Indicators (Not Applicable)

Institution	Output Indicator	Annual Target	Data Source