

COUNCIL FOR MEDICAL SCHEMES (CMS)

STRATEGIC PLAN

2025 — 2030



Date of Tabling: March 2025

COUNCIL FOR MEDICAL SCHEMES (CMS) GENERAL INFORMATION

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EXECUTIVE AUTHORITY STATEMENT



The Council for Medical Schemes (CMS) submitted its strategic plan covering the fiscal years 2025 to 2030, which I have reviewed. I am encouraged by the CMS's visionary approach aimed at promoting affordable and accessible health coverage as a pathway toward achieving Universal Health Coverage (UHC). This strategic plan represents a significant commitment by the CMS to align with national policy initiatives spearheaded by the National Department of Health (NDoH).

The implementation of this plan is expected to substantially advance our efforts over the next five years, ensuring that both the private and public health sectors move cohesively in the same direction. This alignment is crucial for the attainment of various national and international health objectives as articulated in key frameworks, such as the National Development Plan 2030, the Presidential Health Compact, and the Sustainable Development Goals (SDGs).

Notably, this proactive vision seamlessly integrates with the second phase of the National Health Insurance (NHI) Fund's implementation. Scheduled to commence in 2026 and extend for a subsequent three years until 2028, this phase will be characterized by a more intensive focus on the contracting of healthcare services and the rollout of innovative health programs designed to enhance service delivery.

I am fully supportive of the CMS's commitment to actively engage in reducing healthcare costs while simultaneously improving the quality of services within the private sector. This dual focus is essential in ensuring that healthcare services remain both affordable and accessible to all South Africans, ultimately leading to improved health outcomes across the nation.

The CMS has consistently established itself as an effective and efficient regulator over the years. This reputation is marked by its diligence in executing its mandates and its impressive responsiveness to the needs of medical scheme members, thereby enhancing access to essential healthcare services. Moreover, I take great satisfaction in the robust financial management exhibited by the CMS; it has maintained unqualified audit reports from the Auditor General of South Africa annually since its inception, reflecting its commitment to accountability and transparency.

Consequently, I endorse this strategic plan. I commend the Council, the Registrar, and their dedicated staff for their hard work in developing this comprehensive plan, and I wish them every success in its implementation. Their efforts are vital for steering our healthcare system toward a more efficient and equitable future.

A handwritten signature in black ink, appearing to read 'A. Motsoaledi', with a long, sweeping horizontal stroke extending to the right.

DR. AARON MOTSOALEDI, MP
MINISTER OF HEALTH

ACCOUNTING AUTHORITY STATEMENT



INTRODUCTION

During its 25 years of existence, the Council for Medical Schemes (the CMS) has built a proud culture of protecting beneficiaries of medical schemes by enforcing the provisions of the Medical Schemes Act 131 of 1998 (MSA). The main pillars of the MSA are the requirements for open enrolment, community rating and prescribed minimum benefits. Linked with the governance requirements stipulated in the MSA, these provisions protect beneficiaries against discrimination based on health status and other arbitrary grounds.

The Council, under my leadership, is ready to play its key oversight role to the CMS during the most interesting era for the entire health sector in South Africa. This era has seen the signing of the National Health Insurance Bill into law. As South Africa transitions towards universal healthcare, CMS will play a critical role in aligning its regulatory functions with the NHI framework. The focus will be on ensuring a seamless integration between medical schemes and the broader NHI objectives while maintaining sustainability in the medical schemes industry.

THE STRATEGIC FOCUS OVER THE MEDIUM TO LONG-TERM PERIOD

NHI

Consistent with the NHI Act 20 of 2023, the CMS is committed to being a formidable player in this quest to achieve universal health coverage. As the first phase from 2023 to 2026 progresses, the CMS will shepherd the medical schemes industry and support the establishment of frameworks that clarify the extent of complementary cover to services not reimbursable by the NHI Fund. Similarly, the CMS looks forward to participating in the interim advisory committees and providing expertise

PMB REVIEW (PHC PACKAGE)

Prescribed Minimum Benefits (PMBs) ensure that medical scheme members have access to essential healthcare services, regardless of their scheme or benefit options. Although regulations mandate a review every two years, this process has not been consistently followed. The review period has been extended to ensure that the updated PMBs align with current regulations, health policies, and the principles of cost-effectiveness and affordability for members. To address these complexities, the CMS has defined and costed a primary healthcare (PHC) package designed to meet these challenges. Given the difficulties encountered in adhering to the two-year review requirement, the CMS intends to request the Minister to consider amending this regulation to reflect a more practical timeline.

The PMB Review will focus on developing and implementing a Primary Health Care (PHC) package for inclusion in the Prescribed Minimum Benefits (PMBs). This review will be an ongoing process that will continue to evolve as we align health benefits with the National Department of Health's (NDoH) National Health Insurance (NHI) benefits. Consequently, no specific timeline can be provided for the completion of the PMB Review. Current PMBs will be regularly updated based on health technology assessments (HTA) and evidence-based principles to ensure appropriate entitlements for beneficiaries. Guidelines for defining PMBs will be issued to the industry to protect these entitlements.

FRAUD, WASTE AND ABUSE

In continuing with the Fraud, Waste, and Abuse (FWA) agenda, the CMS will work to fortify the standards set out in the Codes of Good Practice and Tribunal guides by developing Standard Operating Procedures for dealing with problematic claims, coding, tools for monitoring and evaluation, detailed work on tribunal operations, and relevant legislation. This work and ongoing collaborations with the industry will culminate in another FWA Summit in the next financial year.

FINANCIAL SECTOR OVERSIGHT AND DUTIES

The Minister of Finance has made several determinations to improve regulatory efficiency in the exercise of functions, powers, and duties outlined in sections 291 and 292 of the Financial Sector Regulation Act (2017). As such, until 31 March 2027, the functions of the Prudential Authority (PA) and Financial Sector Conduct Authority (FSCA) related to medical schemes, along with associated powers and duties, will be carried out by the CMS instead of the PA or FSCA, but with due concurrence of these organisations

CONSUMER PROTECTION AND EMPOWERMENT

Consumer protection and awareness will remain key focus areas for the CMS in ensuring the protection of medical scheme members in the future. To break barriers presented by complicated medical jargon, limited access to information, and the cost of accessing services, the CMS will extend its member education sessions to incorporate roadshows, in addition to a new website specifically designed to enhance user experience.

ACKNOWLEDGEMENTS/ APPRECIATION

I extend my appreciation to the Honourable Minister of Health, Dr Aaron Motsoaledi, Deputy Minister. Dr Joe Phaahla and the team at the Department of Health for their exceptional leadership, advice, and support. To my colleagues in Council, old and new, thank you for your commitment to ensuring fair regulatory oversight and equitable healthcare provision. As we navigate the impending transformations in the health sector, may we continue to hold true to the CMS' vision. I would like to express my sincere gratitude to the staff at the CMS for their unwavering dedication to ensuring the efficient operation of our organization, the equitable regulation of entities, and the robust protection of medical scheme members. Additionally, I extend my best wishes to the Registrar and the team at the CMS in their pursuit of successfully implementing this plan.

Thandi Mabeba



Signed by Thandi Mabeba,
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DR. THANDI MABEBA
CHAIRPERSON OF COUNCIL

OFFICIAL SIGNOFF

It is hereby certified that this Strategic Plan:

- Was developed by the management of the Council for Medical Schemes (CMS) under the guidance of the Council.
- Takes into account all the relevant policies, legislation and other mandates for which the CMS is responsible.
- Accurately reflects the impact and outcomes which CMS will endeavour to achieve over the period 2025-2030



Dr Denisha Jairam-Owthar
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Executive Manager: Corporate Service



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**Dr. Thandi Mabeba
Chairperson of Council**

Approved by:



**Dr. Aaron Motsoaledi, MP
Minister of Health**

LIST OF ABBREVIATIONS AND ACRONYMS

AGM	Annual General Meeting
AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
APP	Annual Performance Plan
ARC	Audit and Risk Committee
B-BBEE	Broad-Based Black Economic Empowerment
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CIO	Chief Information Officer
CMS	Council For Medical Schemes
COFI	Conduct of Financial Institution Bill
CON	Certificate of Need
COVID-19	Coronavirus Disease
CPF	Consumer Protection Forum
CPI	Consumer Price Index
DPME	Department of Planning, Monitoring and Evaluation
DSPs	Designated Service Providers
EE	Employment Equity
EMC	Executive Management Committee
Exco	Executive Committee
FFS	Fee-For-Service
FSCA	Financial Sector Conduct Authority
FSRA	Financial Services Regulatory Authority
FWA	Fraud, Waste, And Abuse
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HMI	Health Market Inquiry
HPCSA	Health Professions Council of South Africa
HR	Human Resources
ICT&IM	Information And Communication Technology & Information Management
IFRS	International Financial Reporting Standards
IRMSA	The Institute of Risk Management South Africa
KM	Knowledge Management
LCBO	Low-Cost Benefit Options
MoU	Memoranda of Understanding
MSA / The Act	Medical Schemes Act, No 131 of 1998
MSAAB	Medical Schemes Act Amendment Bill
MTDP	Medium-Term Development Plan
MTEF	Medium-Term Expenditure Framework
MTSF	Medium-Term Strategic Framework
NDoH	National Department of Health
NDP	National Development Plan
NEHAWU	National Education, Health and Allied Workers' Union
NHA	National Health Accounts
NHI	National Health Insurance

NHIA	National Health Insurance Act
NHRPL	National Health Reference Price List
NOCLAR	Non-Compliance With Laws and Regulations
NSP	National Strategic Plan
PA	Prudential Authority
PAJA	Promotion of Administrative Justice Act
PCNS	Practice Code Numbering System
PESTEL	Political, Economic, Social, Technological, Environmental, And Legal
PFMA	Public Finance Management Act
PHC	Primary Healthcare
PMB	Prescribed Minimum Benefits
PMSA	Personal Medical Savings Accounts
PPPFA	Preferential Procurement Policy Framework
PPR	Preferential Procurement Regulations
QSEs	Qualifying Small Enterprises
SAAS	South African Auditing Standard
SANAC	South African National Aids Council
SAPO	African Post Office
SCA	Supreme Court of Appeal
SCM	Supply Chain Management
SDGs	Sustainable Development Goals
SMART	Specific, Measurable, Achievable, Relevant, Time-Bound
SP	Strategic Plan
SWOT	Strengths Weakness, Opportunities, And Threats
TAT	Turnaround Time
TB	Tuberculosis
TID	Technical Indicator Descriptions
UHC	Universal Health Coverage
VBHC	Value-Based Healthcare
WEF	World Economic Forum
WHO	World Health Organisation
WYPD	Women, Youth, and Persons with Disabilities

PART A: Our Mandate

1. Constitutional Mandate

The right to health is a fundamental part of our human rights and of our understanding of a life in dignity. The right to the enjoyment of the highest attainable standard of physical and mental health, to give it its full name, is not new.

Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The preamble further states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”¹.

The right to access to healthcare services is a basic human right guaranteed by the Constitution of the Republic of South Africa Act 108 of 1996 (the Constitution). Section 9 of the Constitution affirms the right to equality, including access to healthcare services². Section 27 of the Constitution specifically sets out the following in relation to healthcare:

- (1) Everyone has the right to have access to –
 - (a) healthcare services, including reproductive healthcare ...

The role of the Council for Medical Schemes (CMS or Council) in relation to the abovementioned section of the Constitution is to ensure that medical schemes operate in a way that supports the constitutional right of access to healthcare services. The Medical Schemes Act 131 of 1998 (MSA) serves to protect the interests of members of medical schemes and provides measures to coordinate the activities of medical schemes.

CMS regulates and enforces compliance with the MSA. This includes ensuring that entities providing private healthcare insurance services adhere to pre-determined standards of good governance in line with the provisions of the MSA. The MSA also sets out provisions for the operation of medical schemes.

Further to the above, the Constitution and the NHA [National Health Act 61 of 2003 (as amended)] envisage a single health system for South Africa. While the State provides access to free basic health care services to the public based on a pre-qualification means test, independent private healthcare insurance providers form part of the State’s envisioned single health system.

The National Health Insurance Act 20 of 2023 (NHI) pursues the afore-mentioned single health system with the objective of providing universal access to quality healthcare for all South Africans as enshrined in the Constitution. The NHI seeks to achieve the above by ensuring that no one is deprived of their right to access to quality healthcare due to their socio-economic status.

¹ World Health Organization (WHO): The Right to Health, Fact Sheet No. 31. Available at <https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf>

² South African Human Rights Commission (SAHRC): ACCESS TO HEALTHCARE. Available at <https://www.sahrc.org.za/home/21/files/FINAL%20Access%20to%20Health%20Care%20Educational%20Booklet.pdf>

2. Legislative and Policy Mandates

2.1 Legislative Mandate

Table 1 below shows a selection of the poignant legislation applicable to CMS, starting with the MSA that specifically sets out the mandate.

Table 1: Legislative Mandate

Legislation	Description	CMS's Role
The Medical Schemes Act 131 of 1998 (MSA)	The MSA <i>inter alia</i>: • Consolidates the laws relating to registered medical schemes • Establishes CMS as a juristic person • Provides for the appointment of the Registrar of medical schemes • Makes provision for the registration and control of certain activities of medical schemes • Protects the interests of members of medical schemes • Provides for measures for the co-ordination of medical schemes • Provides for incidental matters.	CMS enforces the provisions of the MSA and performs <i>inter alia</i> functions in Section 7 of the MSA. These functions are the following: • Protect the interests of beneficiaries at all times • Control and co-ordinate the functioning of medical schemes in a manner that is complementary with 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 • Collect and disseminate information about private health care • Make rules for the purpose of the performance of CMS functions and the exercise of its powers • Advise the Minister on any matter concerning medical schemes • Perform any other functions conferred on the Council by the Minister of Health (Minister) or by the MSA.
National Health Act 61 of 2003 (NHA)	The NHA establishes the framework for a structured, uniform health system for South Africa, considering the Constitutional obligations and other laws applicable to national, provincial, and local governments concerning health services. A primary objective of the NHA is to unite the various components of the national health system to actively promote and enhance South Africa's national health system.	The CMS supports the NHA by regulating private healthcare insurance providers.
National Health Insurance Act 20 of 2023 (NHIA)	The objective of NHIA is to provide universal access to quality healthcare for all South Africans as enshrined in the Constitution. The NHIA seeks to achieve the above by ensuring that no one is deprived of their right	CMS guide and regulates medical schemes in the transition to the NHI while fostering stakeholder collaboration.

Legislation	Description	CMS's Role
	to access quality healthcare due to their socio-economic status. NHIA entails the establishment of a single public health fund with adequate resources to effectively meet the health needs of the population. The goal is to achieve Universal Health Coverage (UHC) for the Republic of South Africa, ensuring equitable access to healthcare services.	

3. Related legislation impacting and influencing the functions of CMS

Table 2 below represents selected legislation impacting and influencing the functions of CMS.

Table 2: Legislation impacting and influencing the functions of CMS

Legislation	Description
Council for Medical Schemes Levy Act 58 of 2000 (CMSLA)	The CMSLA establishes a legal framework for CMS to collect levies from medical schemes.
Public Finance Management Act 1 of 1999 (PFMA)	The PFMA ensures effective, efficient, and economical financial management in public entities such as CMS.
Financial Sector Regulation Act, 9 of 2017 (FSRA)	The FSRA establishes a system of financial regulation via a Prudential Authority and the Financial Sector Conduct Authority.

4. Policy Mandates

CMS operates under various policy mandates that guide its strategic direction and operational priorities. Illustrated below (Table 3) are the most relevant policy mandates applicable to CMS.

Table 3: Policy Mandate

Policy	Description	CMS Role
United Nations Sustainable Development Goals (SDGs)	The aim of SDG 3 is to "ensure healthy lives and promote well-being for all at all ages." Good health is essential for individuals to reach their full potential, as both physical health and mental well-being significantly affect the quality of life. These aspects not only impact personal health but also influence the well-being of citizens. In South Africa, the health and well-being of the population are crucial for economic performance and social development. Achieving SDG 3 is directly related to improving health services, as accessible and quality healthcare is fundamental to fostering overall health and well-being.	South Africa subscribes to the United Nations SDGs. CMS, a public entity, supports this imperative.
National Development Plan Vision 2030 (NDP)	The NDP seeks to eradicate poverty and decrease inequality by 2030. It asserts that South Africa can achieve these objectives by harnessing the energies of its people,	CMS, as a public entity, discharges its legislated mandate in a manner that is consistent with national policy including the NDP Vision 2030.

Policy	Description	CMS Role
	developing an inclusive economy, strengthening capabilities, improving the capacity of the State, and fostering leadership and partnerships across society. The NDP outlines a strategic vision for South Africa's development, including nine (9) key priorities related to health: 1. Raise the life expectancy of South Africans to at least 70 years by 2030 2. Progressively improve TB prevention and cure 3. Reduce maternal, infant and child mortality 4. Significantly reduce prevalence of non-communicable diseases 5. Reduce injury, accidents and violence by 50 percent from 2010 levels 6. Complete health system reforms 7. Primary healthcare teams provide care to families and communities 8. Universal health coverage, and 9. Fill posts with skilled, suitably qualified, committed and competent individuals. Additionally, the NDP Vision 2030 outlines nine priority areas that emphasise the essential interventions needed to create a more effective health system: 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. Finance universal healthcare coverage 6. Improve human resources in health sector 7. Review management positions and appointments and strengthen accountability mechanisms, and 8. Improve quality by using evidence 9. Meaningful public-private partnerships.	
The Charter For South Africa's Public and Private Health Sectors, 2006 (Health Charter)	The Health Charter was initiated in support of the NHA and provides for the public and private health sectors to constructively engage in discussions to create an improved healthcare delivery system for South Africa. Such a system targets coherent, efficient, cost-effective, quality-driven and optimised use of all sector resources to benefit all citizens.	The CMS supports the NHA by regulating private healthcare insurance providers. To this end, it therefore contributes to the progress of the Health Charter.
National Health Insurance (NHI)	The NHI is South Africa's strategy to achieve universal health coverage. The NHI is a centralised, national insurance fund from which the government will source healthcare services from healthcare providers in both public and private sectors.	CMS regulates the activities of medical schemes and other affected key stakeholders in the NHI.

Policy	Description	CMS Role
	NHI pursues the Constitutional right of equal access to quality and affordable healthcare.	
Second Presidential Health Compact 2024-2029 (Presidential Health Compact)	The Second Presidential Health Summit, 2023 with the theme “<i>Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation</i>” reinforced the nine-pillar plan finalised at the Presidential Health Compact. These pillars are: 1. Augment Human Resources for Health Operational Plan 2. Better management of supply chain equipment and machinery can ensure improved access to essential medicines, vaccines, and medical products 3. Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities 4. Engage the private sector in improving health services’ access, coverage and quality 5. Improve health services’ quality, safety, and quantity, focusing on primary health care 6. Improve the efficiency of public sector financial management systems and processes 7. Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels 8. Engage and empower the community to ensure adequate and appropriate community-based care, and 9. Develop an information system to guide the health system’s policies, strategies, and investments. The main thrust of the Presidential Health Compact is to ensure the health system can successfully execute the obligations of the NHI framework. Key common themes emphasise the need for expanded health workforce development and deployment, addressing inequities, health systems strengthening and quality improvement, eliminating corruption, maladministration and incompetence, and strengthening governance at national, provincial, district, ward, and facility levels.	CMS regulates the activities of medical schemes, key stakeholders in the NHI and the Presidential Health Compact.
Recommendations of the Health Market Inquiry, 2019 (HMI Recommendations)	The Competition Commission’s HMI investigated the dynamics in the private healthcare market, identifying barriers to competition, and examining the factors that influence private healthcare costs. In September 2024 in a briefing to the Portfolio Committee on Health, the Department of Health (NDoH) highlighted several critical issues from the HMI affecting the private healthcare sector, including the high expenditure and inefficiencies that plague the system. These include	The regulatory functions of CMS are integral to supporting the HMI Recommendations insofar as these affect medical schemes.

Policy	Description	CMS Role
	excessive resource utilisation that fails to yield improved health outcomes.	

5. Institutional policies

The institutional policies of CMS exist at two primary levels. One level is policies relating to regulation of the industry, and the other is policies that assist the day-to-day functioning and governance of the institution.

The Council for Medical Schemes has established a range of institutional policies, including those pertaining to Information and Communication Technology (ICT), Human Resources (HR), Finance, and Stakeholder Relations. The policies are periodically reviewed to ensure they remain relevant and effective. Each review is meticulously conducted and culminates in approval from the Accounting Authority, ensuring that governance structures are maintained at the highest standard.

Policies that support the day-to-day functioning and governance of CMS include the following:

5.1. Council Charter, Council Committees Terms of Reference, Council Remuneration Policy & Delegation of Authority

The Council Secretariat Sub-Program is responsible for managing the Council's corporate governance affairs. As such, the Sub-Program works very closely with the CE/Registrar to ensure that Council business is executed effectively and efficiently.

The Council is entrusted with governing the entity in terms of the MSA. In respect of governance duties and responsibilities, the MSA is supplemented by the Companies Act of 2008, which codifies the common law duties of directors, the Public Finance Management Act of 1999, the Protocol on Corporate Governance in the Public Sector, and the King IV Report on Corporate Governance.

In line with good corporate governance practices, the Council has a Charter that governs its conduct and spells out its duties, responsibilities and expectations. Further to the Council Charter, all Committees of Council have charters in place that detail the operative terms of reference as well as the duties of each Committee. These charters are under the Council Secretariat's custodianship, which oversees their implementation, revision, updating and alignment.

The Sub-Program further administers the Council Remuneration Policy. The policy sets out the terms and conditions of remuneration for Council members and the independent members of the Audit and risk Committee. It is reviewed regularly to ensure alignment with the National Treasury prescripts.

5.2. Human Resources (HR)

Human resource (HR) policies give guidelines on a range of employment issues, outline employee expectations, organisational obligations, disciplinary procedures, behaviour standards, and help to effectively implement an organisation HR strategy.

5.3. Communications, Marketing and Stakeholder Relations Policies

The CMS HR Policies enable the organisation and employees including collaboration with Member Protection to communicate the mandate of the organisation in an effective manner and aid to bring awareness on areas or issues affecting the medical schemes and beneficiaries. In this regard, a significant milestone in the 2024/25 performance cycle has the acceleration that resulted in conducting 66 consumer awareness activities in collaboration with the Member Protection programme.

5.4. Finance, Travel and Procurement Policies

The Finance and Procurement Policies govern the financial affairs of CMS, ensures that internal controls are in place for proper segregation of duties and risk management, and that procurement is done in a fair, transparent, equitable and economical manner in line with the requirements of the PFMA.

5.5. Policy on the appointment of independent technical experts

This policy governs the process of appointing and remunerating independent technical experts who assist the Policy, Research and Monitoring Division and the Clinical Services Sub-programme by undertaking various tasks and projects, providing advice, and participating in the Committees of the respective units. This new policy was approved by the Council at the end of July 2024.

Circulars and Guidelines that support the regulatory functions of CMS include the following:

5.6. Technology Policies

The technology policies guide the CMS organisation to maintain and deliver all ICT related items to ensure this is done in a well governed manner per the ICT Governance Framework within the approved ICT Digital Strategy of the CMS. In this way best practice ICT related standards are adhered to and in compliance with ICT related legislation.

6. Circulars

- Circular 13 of 2001: Non-distributable reserves in solvency calculation
- Circular 5 of 2003: Subcontracting of broker services by an accredited broker to another organisation or individual.
- Circular 33 of 2005: Pre-funded post-retirement funds – notice for removal of pre-funding reserves or funds
- Circular 11 of 2006: Issues in audited financial statements:
 - Reporting of non-compliance matters
 - Fair value of assets for Annexure B
- Circular 32 of 2006: Implementation of Prescribed Minimum Benefits
- Circular 41 of 2006: 2006 audited financial statements:
 - Reporting of non-compliance
 - Prescription of unclaimed savings balances
- Circular 49 of 2007: Financial reporting by managed care organisations
- Circular 5 of 2007: Accreditation of Business, Family or other Trusts as Brokers.
- Circular 4 of 2008: Inclusion of benefit options results in the annual financial statements

- Circular 52 of 2010: Granting of loans by medical schemes to members must stop
- Circular 38 of 2011: Personal Medical Savings Accounts
- Circular 44 of 2011: Revised Managed Care Standards
- Circular 23 of 2012: Explanatory Note 2 of Annexure B
- Circular 41 of 2012: Disclosure requirement in respect of PMSA monies where a trust relationship had been created in the scheme's rules)
- Circular 5 of 2012: Clarification of Circular 38 of 2011 regarding personal medical savings accounts
- Circular 10 of 2013: Funding of PMBs from personal medical savings accounts when members are discharged from hospital
- Circular 6 of 2013: Annual financial information provided to members
- Circular 27 of 2014: Call to Medical Schemes to provide information and/or contact details
- Circular 48 of 2014: Classification and disclosure of administration costs included in the contracted third-party administration fees.
- Circular 51 of 2014: Managed healthcare agreements – unwarranted performance or profit-sharing incentives
- Circular 56 of 2015: Accounting for accredited managed care services
- Circular 65 of 2015: Auditor's Report – Key Audit Matters
- Circular 56 of 2017: Personal medical savings accounts
- Circular 57 of 2017: Non-compliance with Laws and Regulations (NOCLAR)
- Circular 2 of 2018: Personal Medical Savings Accounts and Scheme Rules
- Circular 27 of 2018: Audit tenure
- Circular 45 of 2018: International Travel Benefit
- Circular 77 of 2019: Classification of and reporting on administration services – accredited vs other administration services
- Circular 1 of 2020: Revised managed care accreditation standards – Version 5
- Circular 60 of 2020: Reportable Irregularities – CMS contact details
- Circular 31 of 2021: Section 61 declaration for DSPs
- Circular 49 of 2021 Qualification requirements for healthcare brokers applicants.
- Circular 26 of 2022: Brokers earning commission on own policies
- Circular 3 of 2022: Updated managed care agreement preparation guideline
- Circular 31 of 2022: Final limited administrator accreditation framework
- Circular 32 of 2022: Requirements for administration of medical schemes
- Circular 33 of 2022: Updated administrator accreditation standards – Version 7
- Circular 54 of 2022: Final updated accredited managed health care services document
- Circular 8 of 2022: Updated managed care protocol guideline

7. Guidelines

7.1. Model Rules

The model rules are designed to serve as a comprehensive guide for all stakeholders involved in the medical scheme, ensuring compliance with the relevant Act, its accompanying regulations, common law provisions, and established corporate governance practices. Additionally, these rules address various internal policy decisions, providing clear and practical guidance on the complexities that can arise in the relationships between the scheme and its members.

The primary objective of the model rules is to establish a consistent and coherent set of principles that clearly outline the legal relationship between the medical scheme and its members. By doing so, they aim to enhance transparency, accountability, and trust within the scheme-member relationship, ultimately contributing to better governance and member satisfaction.

Recognizing that the landscape of healthcare and regulation is constantly evolving, this document is intended to be dynamic. As such, it will undergo annual reviews and updates to reflect the latest developments in legislation, best practices, and feedback from stakeholders, ensuring it remains relevant and effective in guiding the medical scheme's operations.

7.2. Guidance on contribution increases and benefits changes

The guidance note, published in the form of a circular annually, provides a comprehensive overview of the requirements that medical schemes must adhere to when determining the annual increases in contributions and any changes to benefits for the upcoming benefit year. One of the primary responsibilities of the Council for Medical Schemes (CMS), as mandated by Section 7 of the Medical Schemes Act (131 of 1998), is to safeguard the interests of beneficiaries continually. This includes ensuring that beneficiaries receive the necessary support and protection in their healthcare coverage.

To fulfil this mandate, the CMS takes on the crucial role of coordinating the activities and functioning of medical schemes across the sector. A vital aspect of this role is to review and approve the annual increases in contribution rates set by these schemes. The CMS aims to ensure that these increases remain affordable for members, addressing the need for equitable access to quality healthcare services.

Moreover, by maintaining a focus on affordability, the CMS seeks to enhance the long-term financial sustainability of the medical schemes industry as a whole. This approach not only benefits current scheme members but also contributes to the overall stability and viability of healthcare provision in the country, ensuring that all individuals have access to necessary health services without undue financial burden.

7.3. Business plans

The Office of the Registrar issued the following guidelines:

- Guideline for the preparation of a business plan pursuant to an application for the registration of a new medical scheme as per Section 22 of the Medical Schemes Act;
- Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option(s) as per Section 33 of the Medical Schemes Act;
- Guideline for the preparation of a business plan pursuant to an application for an amalgamation of medical schemes as per Section 63 of the Medical Schemes Act;
- Guideline for the preparation of a business plan where a medical scheme is not meeting the statutory solvency requirements as per Regulation 29 of the Medical Schemes Act;
- Guideline to the trustees for the submission of reinsurance contracts with registered insurers to the Registrar of Medical Schemes in terms of Section 20(3) of the Medical Schemes Act;
- Guideline for the preparation of Standard Management Accounts.

7.4. Appointment of Auditors for Medical Schemes

Section 36(2) of the Medical Schemes Act, No. 131 of 1998 (the Act) states that “the appointment of an auditor shall not take effect unless it has been approved by the Registrar, subject to such conditions as he or she may deem fit”.

Standards for Authorisation of Auditors for Medical Schemes

The purpose of these standards is to set out the authorisation requirements of the Registrar of Medical Schemes (Registrar) pertaining to the eligibility criteria for audit firms, individual auditors and International Financial Reporting Standards (IFRS) advisors. In addition, it contains procedures to be followed in order to be authorised by the Registrar and be entered onto the Council for Medical Schemes (CMS) list of authorised auditors and IFRS advisors.

Audit Quality Indicators

The Office of the Registrar has commenced with stakeholder engagement to replace the Standards of Authorisation with Audit Quality Indicators (AQIs).

AQIs refers to a portfolio of qualitative and quantitative measures provided by an audit firm to an audit committee of their client, or future client, for use in transparency reports and for regulatory purposes. These measures could be used to enhance dialogue about, and an understanding of, auditors and their audits as well as ways to evaluate their audit quality. In that way, users can be better informed about key matters that may contribute to the quality of an audit (both at audit firm level and audit engagement level). This could be to the benefit of audit committees in discharging their oversight responsibilities regarding the external audit process, including the appointment or reappointment of the external auditor.

7.5. Annexure B classification

The Office of the Registrar issue on an annual basis Guidelines on the categorisation of listed assets in terms of Regulation 30 of the MSA, read in conjunction with Annexure B to the Regulations. The purpose of these Guidelines is to guide the categorisation of assets according to Annexure B to the Regulations, and not to highlight any non-compliance matters.

8. Institutional priorities and strategies governing the five-year planning period

CMS draws its mandate and strategic direction from legislation *inter alia* the MSA, NHA, NHIA, and from national policy including the NDP, NHI, Health Charter and Presidential Health Compact.

At the forefront of the CMS institutional strategies is the Strategic Plan 2025 – 2030, which incorporates Strategic Outcomes drawn from the strategic direction set in the instruments below.

8.1. National Development Plan, Vision 2030 (NDP)

The NDP aims to eradicate poverty and reduce inequality in South Africa by harnessing the potential of the population, fostering an inclusive economy, and strengthening the capabilities of the state. It sets out a strategic vision that includes nine key health priorities:

1. Raise the life expectancy of South Africans to at least 70 years
2. Progressively improve TB prevention and cure
3. Reduce maternal, infant and child mortality
4. Significantly reduce prevalence of non-communicable diseases

5. Reduce injury, accidents and violence by 50 percent from 2010 levels
6. Complete Health system reforms
7. Primary healthcare teams provide care to families and communities
8. Universal health coverage, and
9. Fill posts with skilled, committed and competent individuals.

During the five (5)-year period CMS will continue to align its regulatory functions with the above key health priorities in the NDP.

Furthermore, considering that the NDP emphasises the importance of partnerships across various sectors, CMS will actively engage with stakeholders to foster collaboration that aligns with the NDP.

8.2. Strategic Priorities of the 7th Administration and the Medium-Term Development Plan (MTDP)

The MTSF has been replaced by the Medium-Term Development Plan (MTDP) which is focussed on the following three strategic priorities for the next five years:

- Drive inclusive growth and job creation
- Reduce poverty and tackle the high cost of living, and
- Build a capable, ethical and developmental state.

8.3. Strategic Priority 1: Drive inclusive growth and job creation

Inclusive growth and job creation is the Apex Priority for the Seventh Administration. All spheres of government, clusters and sectors must prioritise interventions aimed at stimulating more rapid and inclusive growth. The MTDP 2024–2029 focuses on the following nine outcomes to achieve this Strategic Priority:

- Increased employment and work opportunities;
- Accelerated growth of industrial and labour-intensive sectors;
- Structural reforms to drive growth and competitiveness;
- Increased infrastructure investment and job creation;
- Energy security and a just energy transition;
- Increased investment, trade and tourism;
- A dynamic science, technology and innovation ecosystem for growth;
- A supportive and sustainable economic policy environment; and
- Economic transformation for a just society.

8.4. Strategic Priority 2: Reduce poverty and tackle the high cost of living

The MTDP 2024–2029 focuses on the following seven outcomes to achieve the goals and objectives of Strategic Priority 2 in reducing poverty and tackle the high cost of living:

- Reduced poverty and improved livelihoods;
- Optimised social protection and coverage;
- Improved access to affordable and quality healthcare;
- Improved education outcomes and skills;

- Spatial transformation for a more just society;
- Skills for the economy; and
- Social cohesion and nation-building.

An integral element of social protection is that citizens must be assured of universal access to an acceptable level of healthcare. The National Health Insurance (NHI) is a critical but complex initiative designed to achieve this goal and its implementation will be a high priority for the Seventh Administration. An early step will be to establish the mechanisms to engage all critical public and private stakeholders in the phased design, implementation and oversight of the new system. There is potential for stakeholder partnerships to reduce the relative cost of private medical care and support the development of improved human capacity and systems in the public health sector. However, success in this respect will require strong and inclusive leadership.

South Africa remains committed to strengthening the national and Global Leaders Network and partnerships to accelerate progress on women's, children's and adolescent's health and wellbeing in line with the sustainable development goals of maternal mortality, neonatal mortality and adolescent mortality.

8.5. Strategic Priority 3: Build a capable, ethical and developmental state

The following six outcomes were identified to achieve the goals and objectives of Strategic Priority 3: Build a building a capable, ethical and developmental state:

- Improved service delivery by local government;
- Improved governance and performance of public entities;
- A capable and professional public service;
- Digital transformation across the state;
- Safer communities and increased business confidence; and
- Effective border management and development in Africa and globally.

Achieving the first two Strategic Priorities will require a capable state that can deliver on its objectives. Effective policy making requires a clear vision and priorities, institutions of decision-making that are robust and adaptable to ensure policy coherence and make choices when trade-offs occur, and the capacity to implement these in a consistent and effective manner.

The Strategic Outcomes of CMS for the period 2025 to 2030 support the strategic priorities of the 7th Administration of Government. These Strategic Outcomes target and support both policy and regulatory reforms.

8.6. National Health Insurance (NHI)

To wide acclaim, including being welcomed by the World Health Organisation, the NHI came into effect with the proclamation of the NHIA. The objective of NHIA is to provide universal access to quality healthcare for all South Africans, as enshrined in the Constitution.

The NHIA seeks to achieve the above by ensuring that no one is deprived of their right to access quality healthcare due to their socio-economic status.

NHIA entails the establishment of a single public health fund with adequate resources to effectively meet the health needs of the population.

The goal is to achieve Universal Health Coverage (UHC) for the Republic of South Africa, ensuring equitable access to healthcare services.

CMS regulates the activities of medical schemes, key stakeholders in private healthcare services who are substantially affected by the NHI. CMS has incorporated, into the Strategic Plan for 2025 to 2030, provisions of the NHI which is supported by the UHC ambitions set out in the Health Charter, Presidential Health Compact and Recommendations of the HMI insofar as these affect the regulation of medical schemes.

9. Relevant court rulings

9.1 Swaneipoel N.O. (Executor in the Estate Late Mignon Adelia Steyn) v Profmed Medical Scheme Constitutional Court

Case number	Case CCT336/22[2024] ZACC 23
Date of court ruling	2024/10/09
Applicant	Swaneipoel N.O. (Executor in the Estate Late Mignon Adelia Steyn)
Respondent	Profmed Medical Scheme
Summary	Ms Steyn through the executor applied to the Constitutional Court as she was a member of Profmed until her membership was terminated by Profmed pursuant to her alleged failure to disclose material information on the prescribed membership application form when she applied for membership of the scheme.
Affected sections of the MSA	Section 47, 53, 29A(2)(a)
Judgement	On the merits, the Court found that the proceedings before the Appeal Board were procedurally unfair. Profmed had initially raised, then abandoned, the issue of Ms Steyn's alleged non-disclosure of her hip arthroscopy but had later reintroduced it during oral argument without admissible and properly adduced evidence. Ms Steyn had thus been denied the opportunity to present evidence in response. This had violated the right to a fair hearing under PAJA. The Court also found that Profmed had failed to prove that Ms Steyn's non-disclosures were material to the insurance contract. Specifically, the hip arthroscopy was a diagnostic procedure, not a material condition which had required disclosure. The prejudice that Ms Steyn suffered was manifest – not only had Ms Steyn faced an unpleaded case, but she had been denied her express request to be granted an opportunity to adduce evidence to meet the new unpleaded averments regarding her alleged non-disclosure of hip problems. Similarly, gastritis had been misclassified as a serious condition when it was not. Profmed had no evidence that these issues had posed a significant risk or had justified a claim of non-disclosure. Profmed bore the onus of proving not only the materiality of non-disclosure, but also that it had been induced to conclude the agreement. In this instance, Profmed's rules that referred to material non-disclosure as a ground for the cancellation of membership did not outline the standard to be applied in determining whether the information was material. However, Profmed's application form did define material information as relating to disclosure of medical conditions. This Court agreed with the applicant that a mere diagnostic medical procedure which had not resulted in a material diagnosis of a condition could not be classified as a material non-disclosure, and subsequently, a prudent and reasonable person would not have regarded it as such. A reasonable person in Ms Steyn's position could not have considered that gastritis should have been disclosed and this Court thus found that its non-disclosure was immaterial.

9.2 Solidarity vs Minister of Health Certificate of Need

Case number	Solidarity Trade Union and Others v Minister of Health and Others (61844/2021) [2024] ZAGPPHC 677; [2024] 4 All SA 264 (GP); 2024 (11) BCLR 1451 (GP); 2024 (6) SA 639 (GP) (24 July 2024)
Date of court ruling	2024/07/24
Applicant	Solidarity
Respondent	Minister of Health
Summary	Solidarity applied to the High Court to set aside the Certificate of Need for doctors and private hospitals.
Affected sections of the MSA	Section 7 & 8
Judgement	The High Court ruled in favour of that the Certificate of Need (CON) scheme for doctors and private hospitals is unconstitutional and struck out sections of the National Health Act, indicating that these sections were "unconstitutional".

9.3 CMS vs MEDIPOS

Case number	004741/2023
Date of court ruling	2023/02/15
Applicant	CMS
Respondent	Medipos
Summary	CMS applied for the appointment of a Curator for the MediPos medical scheme. Since April 2020, the scheme has had difficulty collecting contributions from the South African Post Office (SAPO).
Affected sections of the MSA	Section 56, 32, 33, 29 & Section 5(1) of the Protection of Fund Act.
Judgement	The Court ordered appointment of a Curator for Medipos, "The MediPos situation had become untenable even in the event were CMS granted them an exemption. For instance, the scheme's solvency level had declined from 90.5% pre-Covid in 2019 to 67.7% in 2020 and 36.1% in 2021. Further to this, the scheme suffered rapid decline in their reserves due to the losses incurred in both periods, thus having a negative effect on the solvency level of the scheme" added the Registrar. The Court held that Section 35(1) (2) and (3) of the Medical Schemes Act requires all medical schemes registered with the CMS to be under sound financial condition. Regulation 29 (2) of the Medical Schemes Act also instructs a scheme to maintain accumulated funds which may not be less than 25%. The Court held that with SAPO having been declared technically insolvent and indicating its intention to cut working hours and/or retrench staff, the future for Medipos looks bleak necessitating for the Registrar to act swiftly.

9.4 CMS vs BP MEDICAL SCHEME

Case number	11048/22
Date of court ruling	2023/11/27
Applicant	CMS

Respondent	BP Medical Scheme
Summary	It was brought to the attention of CMS that rule 18 was inserted into the scheme's rules following a 2002 agreement. The CMS approved this rule on the understanding that the trade union trustee was elected from among members of the respondent, which would mean that four of the seven trustees, as contemplated in the rule, would be elected from the members, which would follow the provisions of Section 57(2) of the MSA.
Affected sections of the MSA	Section 57(2)
Judgement	The Judge ordered an investigation into the scheme's affairs. The Court also ordered that the scheme hold an AGM inline with the Court Order to regularise the board of the scheme.

9.5 CMS vs OPTIVEST

Case number	CCT Constitutional Court 155/2024
Date of court ruling	2024/12/11
Applicant	CMS
Respondent	Optivest
Summary	Optivest contended that Section 58(1)(c) did not create concurrent jurisdiction between the CMS and the FSCA (Financial Sector Conduct Authority). According to it, the CMS had fundamentally misconstrued its powers under the MSA and the FSRA (Financial Services Regulatory Authority).
Affected sections of the MSA	Section 58(1)(c) of the FSRA & Section 44(1)&(2)
Judgement	The Constitutional Court upheld the judgement by the SCA. The Constitutional Court reaffirmed the CMS' mandate that even with entities that are not fully regulated or where there is co-regulation with other regulators under FSRA and Conduct of Financial Institutions Bill (COFI), the CMS still retains the mandate to investigate such entities, and it is critical that CMS remains the apex regulator in the medical scheme's environment.

Part B: Our Strategic Focus

Figure 1 below sets out illustratively the CMS Organisational Higher Purpose, Vision, Mission, and Values, and the interconnectedness of these foundational elements of the Strategic Plan.



Figure 1: CMS Organisational Higher Purpose, Vision, Mission, and Values

10. Organisational Higher Purpose

To align with international best practice guidance for the *Governance of Organisations - Guidance* (ISO 37000:2021) which places “Purpose” as the foundational principle for the governance of all types of organisations, the Council has adopted the following Organisational Higher Purpose:

*Regulating the good governance of medical schemes
to sustainably protect the interests of members, beneficiaries and other related stakeholders.*

11. Vision

Complementing the above Organisational Higher Purpose, the Vision of CMS is

*An efficient, effective, high quality, agile and trusted South African regulator
generating sustainable stakeholder value.*

12. Mission

Further supporting the Vision, the Mission is

Achieving our purpose of protecting the interests of members and beneficiaries by:

- Controlling and co-ordinating the functioning and governance of all entities conducting the business of medical schemes in a manner that is complementary to national health policy
- Investigating complaints and settling disputes in relation to the affairs of medical schemes
- Collecting, disseminating information, and collaborating with stakeholders about private health care
- Making recommendations and advising the Minister on the criteria for the measurement of quality and outcomes of health services provided by medical schemes, and related matters.

13. Values

CMS values are shown in *Table 4* below.

Table 4: CMS Values

Regulatory Philosophy (External)	Shared Values (Internal)
• <i>Transparent</i> • <i>Fair</i> • <i>Equitable</i> • <i>Consultative</i> • <i>Cost Effective</i> • <i>Firm</i> • <i>Pro-active</i> • <i>Independence</i>	• <i>Accountability</i> • <i>Ubuntu</i> • <i>Professionalism</i> • <i>Integrity</i> • <i>Honesty</i> • <i>Respect</i> • <i>Responsive</i>

14. Situational Analysis

Building on the detailed insights gathered from the strategic planning process, and aligned with the core regulatory mandate of CMS, the situational analysis below shows the internal and external environmental factors impacting the CMS.

15. External environment analysis

Industry Trends Analysis as at end of December 2023

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

On the positive side:

- Number of beneficiaries covered in the industry surpassed 9 million in 2022, and this figure continued to grow in 2023 reaching 9.13 million.

- Active number of schemes in the industry was 71 as at 2023, almost halved from the 144 schemes in 2000. This was mainly driven by consolidations between schemes and is in line with CMS stance to increase risk pooling in the industry.
- Government Funded/Associated medical schemes, representing 34.7% of beneficiaries in the industry, had a 4.68% growth in membership
- The number of Efficiency Discount Options (EDOs) increased significantly to 71 in 2023, from just 50 in 2017.
 - Proportion of beneficiaries on EDOs increased from 20% in 2017 to 37% in 2023
- Number of beneficiaries enrolling on Disease Management Programmes (DMPs) continue to show an upward trajectory. Registered beneficiaries as at 2023:
 - Hypertension and other cardiovascular conditions DMP had 3.6 million
 - Diabetes Type 2 DMP had 1.1 million
 - HIV DMP had 800 000

On the negative side:

- Medical scheme penetration in the country has declined, with only 14.7% of the South African population covered by medical schemes, compared to 16% in 2000
- The industry continues to age, with an average age being 34 years in 2023, compared to 33.8 years in 2022.
 - Female beneficiaries consistently show a higher average age and as at 2023, this was 35.2 years compared to 32.6 years male beneficiaries.
- Healthcare expenditure on benefits paid increased by 9.44% in 2023 to R 239 billion from R218.4 billion in 2022.
 - From the total 2023 expenditure, 90% of expenditure is paid from pooled medical scheme funds, with 10% being paid from members personal medical savings accounts – these splits remained the same as in 2022
 - Benefits paid to specialists amounted to R66.1 billion in 2023, showing a 5.74% increase from the 2022 figure of R62.5 billion
 - Total expenditure on hospitals increased by 9.75% in 2023 to R85 billion from R77.5 billion in 2022.
 - Private hospitals account for just over 92% of all hospital expenditure, and this proportion largely remained the same between 2022 and 2023
- Healthcare expenditure on Prescribed Minimum Benefits increased by 9.58% to R124.4 billion in 2023.
 - Expenditure per beneficiary per month increased by 8.38% to R1 145 in 2023, from an industry average of 1 056 in 2022.

- Admissions to mental health facilities increased by 13.5% between 2022 and 2023
 - The average age of a beneficiary admitted was 38 years in 2023, with females having higher admission rates compared to their male counterparts

These key trends in the industry highlight that there are pockets of excellence stemming from improved risk pooling, evident in the reduction of active medical schemes and the increased demand for benefit options (EDOs) that offer an affordable alternative to traditional options. The upward trend in the number of beneficiaries registered on Disease Management Programs demonstrates positive strides towards the delivery of quality healthcare. However, the South African medical scheme industry still faces significant challenges. These include poor penetration within the country and an overall ageing beneficiary profile. Healthcare costs continue to outpace general inflation rates, with a higher proportion of expenditure allocated to Prescribed Minimum Benefits (PMBs), indicating an increased disease burden.

Financial overview

During 2022 medical schemes utilised their built-up reserves in funding their operations. For every R100 received in contributions, R2.92 of reserves were utilised to fund the R93.96 paid in claims, and the R8.96 non-healthcare expenditure.

A snapshot of the industry

Medical scheme membership increased slightly (by 94 206 beneficiaries) during 2022, to end the year with 9.04 million beneficiaries. In 2022, a total of R210.76 billion was collected in risk contributions from members (2021: R204.69 billion) and expenditure on relevant healthcare services was reported at R198.04 billion (2021: R186.15 billion). As reported in the 2020/2021 Annual Report the 2021 year was the first time in over a decade that the industry implemented contribution increases below consumer inflation. This was the result of a collaborative effort between the Council for Medical Schemes (CMS) and the industry aimed at providing financial relief to members during the economic downturn. Schemes were able to implement these interventions due to additional reserves built-up during 2020. Schemes continued to implement below inflation increases during 2022: the increase in risk contributions pabpm was 2.56%, rising from R1 911.95 in 2021 to R1 960.92 in 2022 (compared to CPI of 6.9%). Medical schemes experienced further increases in claims compared to 2021. This was mainly due to the release of pent-up demand resulting in increased utilisation. Risk claims pabpm increased by 5.97% to R1 842.54 from R1 738.73. The claims ratio therefore increased from 2021's 90.94% to 2022's 93.96%; this resulted in a net healthcare deficit of R6.16 billion (2021: surplus R820.52 million).

Figure 2 compares the seasonality of claims during 2020, 2021 and 2022.

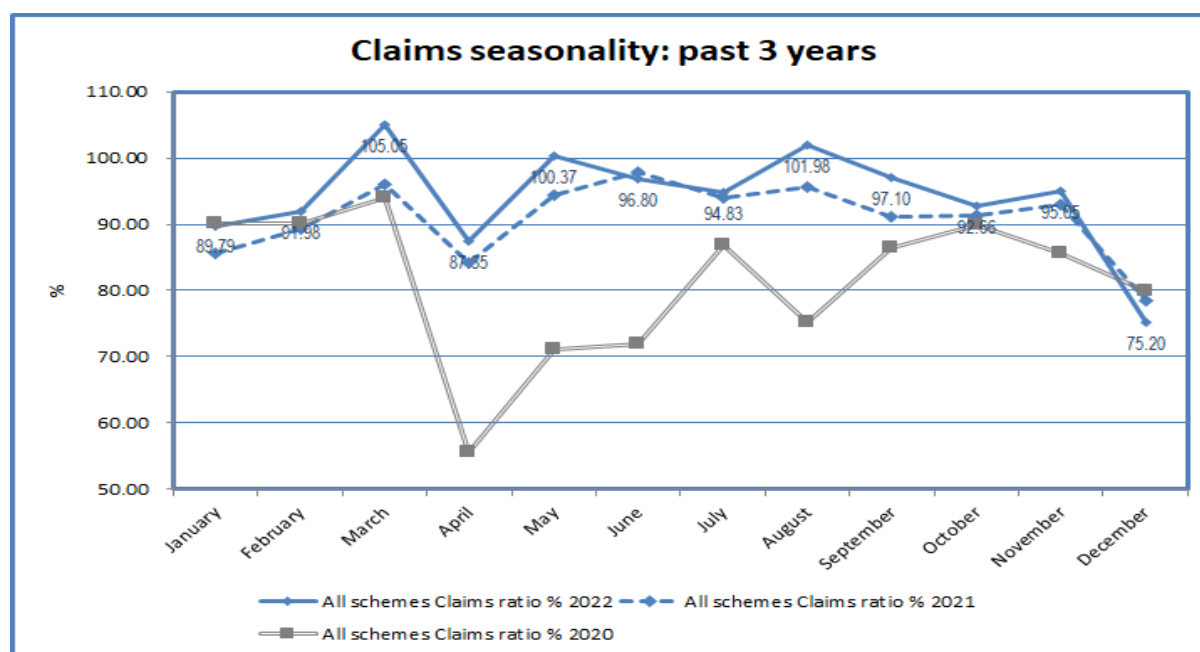


Figure 2: Claims seasonality: past 3 years

Figure 3 illustrates the reliance placed by medical schemes on investment income to maintain and grow their reserves.

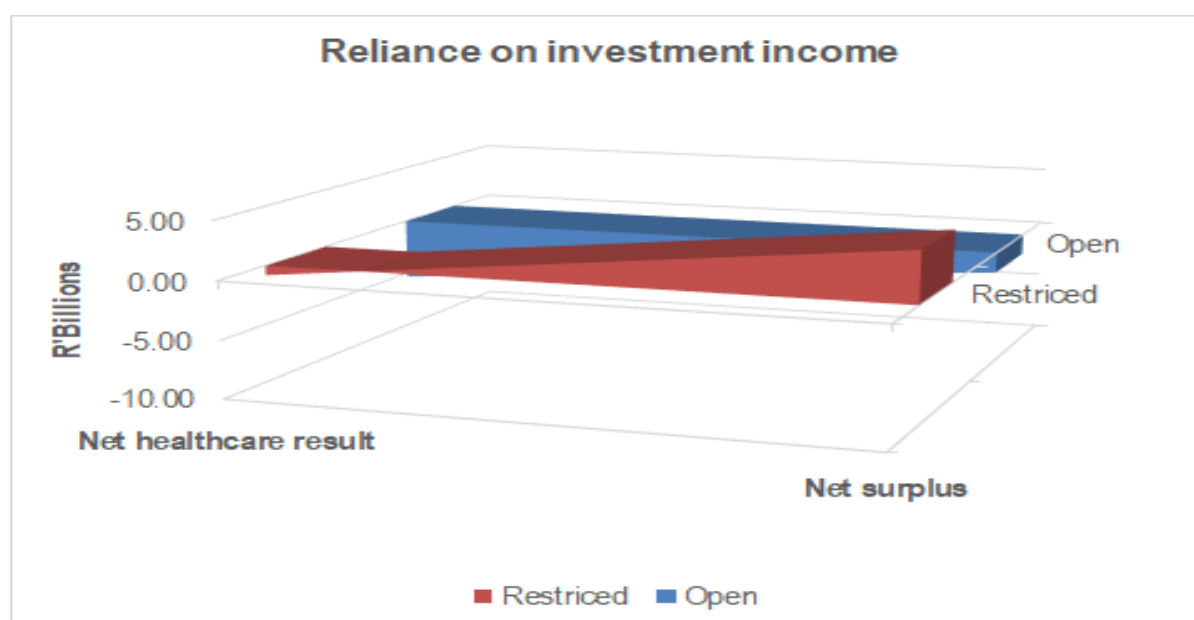


Figure 3: Reliance on investment income

Inflation rates increased rapidly during 2022. This resulted in a sharp and severe drop in most asset classes. As medical schemes generally have a high cash asset allocation, the decrease in investment income was to some extent limited.

Medical schemes incurred a net healthcare deficit of R6.16 billion in 2022 (2021: R820.52 million), Investment income positively contributed towards attaining a net surplus of R2.57 billion in 2022 (2021: R12.19 billion).

The increased investment yields had a positive effect on the overall reserving of medical schemes—the Regulation 29 reserves (Figure 4) increased by 3.84% and the solvency by 0.92% to 2022's R109.76 billion and 47.21%, respectively.

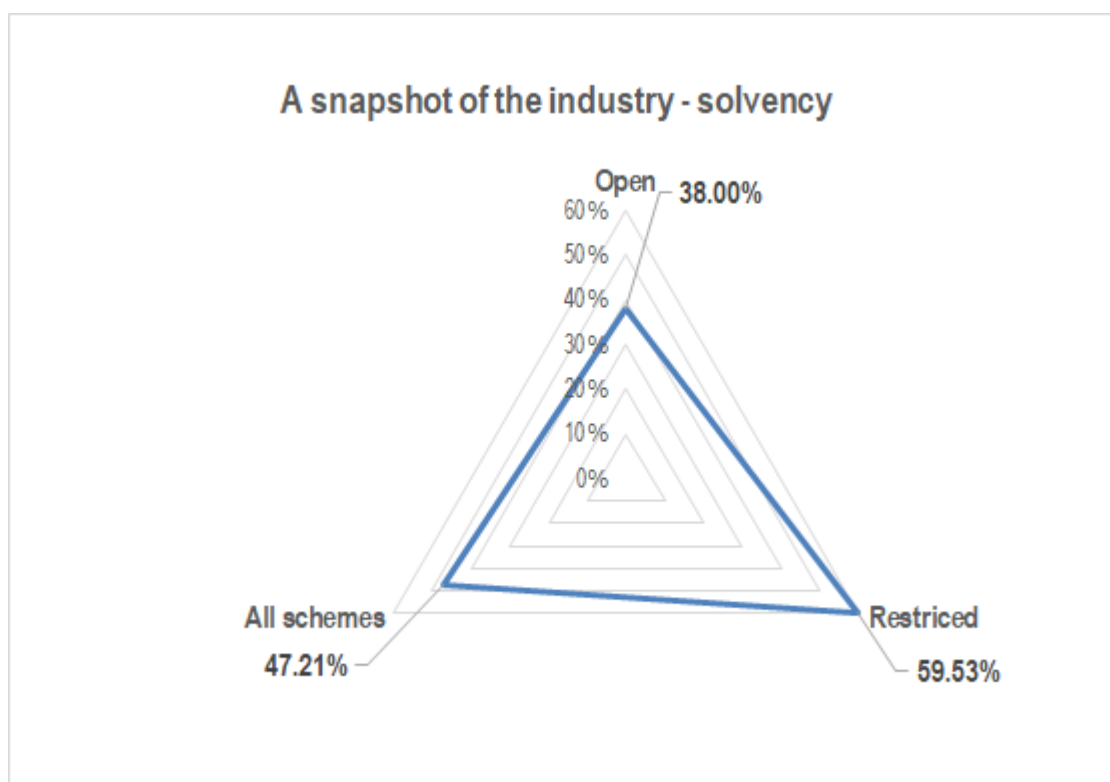


Figure 4: A snapshot of the industry - solvency

Solvency

Figure 4 shows that the medical scheme industry is financially sound; the industry solvency of 47.21% exceeds the minimum required solvency level of 25.00%. The open scheme industry's solvency level has been stable over the past decade; and decreased slightly to reach a solvency level of 38.00% at the end of 2022. The decrease was mostly driven by Discovery Health Medical Scheme's net deficit of R1.49 billion. The restricted scheme solvency level is mostly affected by the performance of Government Employee Medical Scheme (GEMS). As such the overall restricted scheme market reported an improved solvency of 59.53% in 2022, from 56.10% in 2021.

Schemes under close monitoring

Medical schemes that fall short of the statutory minimum solvency level of 25% are required to notify the CMS of the underlying causes of failure, and corrective action to be undertaken. Such schemes are then closely monitored by the CMS. Open medical schemes experienced a decrease in its solvency, from 39.71% at the end of December 2021 to 38.00% at the end of December 2022. Health Squared Medical Scheme was placed under provisional curatorship on 8 September 2022 and subsequently liquidated on 17 February 2023. The solvency ratio for all restricted schemes increased by 6.11%, from 56.10% as at 31 December 2021 to 59.53% as at 31 December 2022. 22 793 beneficiaries were in a scheme

(Transmed Medical Fund) not meeting the prescribed minimum solvency requirement (December 2021: 0.63% or 25 905 beneficiaries). Other reasons for schemes being closely monitored could include governance-related concerns or the fact that the scheme has high non-healthcare expenditure levels. Figure 5 depicts solvency trends for the last three years, for schemes below 25%, as at 31 December of the relevant year.

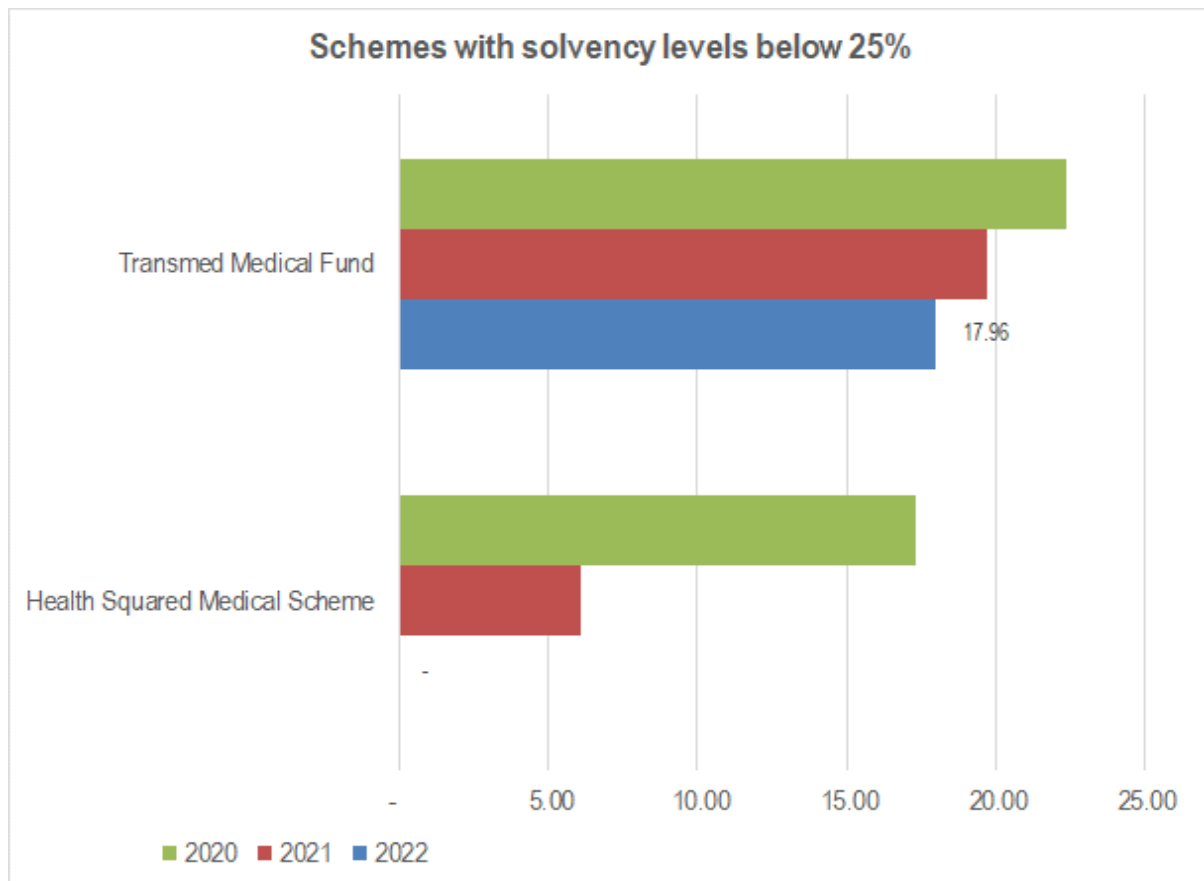


Figure 5: Schemes with solvency levels below 25%

- Spectramed fell below the minimum statutory solvency level of 25% in 2018. The scheme amalgamated with Resolution Health Medical Scheme, effective 01 January 2019; the amalgamated entity was known as **Health Squared Medical Scheme**. The scheme reported a solvency level of 6.04% in 2021, a significant decrease from 17.32% in 2020. The scheme's claims experience increased significantly from 89.92% in 2020 to 102.89% in 2021. The scheme's average age of 47.09 years (pensioner ratio of 25.93%) at the end of 2021 exceeds the open scheme industry average of 35.51 years (pensioner ratio of 10.98%). The scheme was placed under provisional curatorship on 8 September 2022 and subsequently liquidated on 17 February 2023.
- **Transmed Medical Fund** (Transmed) reported a solvency ratio of 17.96%, a decrease from 19.72% in the previous year. A business plan was submitted by the scheme and approved by the CMS. The employer group provides specific funding for the scheme's Guardian option, which had a pensioner ratio of 94.36% and a claims ratio of 102.30% at the end of 2022. The remainder of the options broke even or incurred net healthcare surpluses in 2022. Transmed remained under close monitoring in the year under review and attended regular monitoring meetings with the CMS to discuss progress against turnaround plans.

Shift to Value-Based Healthcare (VBHC)

Internationally, there is a notable shift to VBHC which focuses on enhancing the quality and outcomes of healthcare rather than simply increasing the volume of services. For medical schemes, this involves transitioning to payment models that compensate healthcare providers for delivering higher-quality care that is directed at improving patient outcomes (Outcome-based care).

The transition to VBHC faces several significant challenges. The Fee-for-Service (FFS) model encourages high service volumes. This can lead to over-treatment and increased healthcare costs while diverting attention from patient outcomes.

Additionally, bundled payments, which are designed to control costs, require accurate risk adjustment to prevent under-treatment, particularly in complex medical cases. Furthermore, capitation presents financial risks if healthcare costs exceed fixed payments, potentially incentivising providers to limit care to manage expenses.

The successful implementation of VBHC necessitates robust data systems for effective performance measurement. Providers must adapt to new care models, which can be resource-intensive and time-consuming. Addressing these complexities is essential for promoting health equity and ensuring that all populations have access to quality healthcare.

Outcome-based Care: *New Currency*

Outcome-based care, often regarded as the "new currency" in the medical schemes industry, emphasises the quality and effectiveness of healthcare services rather than the quantity of services provided. Regulators establish the frameworks within which outcome-based care operates. CMS will continue to develop guidelines that define what constitutes quality care and how outcomes are measured. This is directed *inter alia* to ensure that medical schemes and healthcare providers align their practices with national health goals, particularly those that are outcomes-based.

Digital Transformation

The rapid growth of telemedicine, artificial intelligence (AI), and digital health tools is reshaping the healthcare landscape. As medical schemes invest in digital infrastructure to enhance member engagement and improve operational efficiencies, CMS faces significant challenges and opportunities to regulate these aspects

Effective regulation in the digital health space requires collaboration among various stakeholders, including healthcare providers, technology developers, and medical schemes. CMS plans to engage with these groups (and other material stakeholders) to understand the challenges and opportunities posed by digital transformation and to develop regulations that support efficiencies in the healthcare ecosystem.

Marketing CMS

CMS media analysis over the years had projected the lack of the CMS visibility in the public mainstream. Beneficiaries of the schemes also had little or limited knowledge of their benefits and or medical aid coverage.

Multiple stakeholder engagements, media platforms, research surveys identified CMS lack of visibility being at the fore of its marketing woes. Also, this was proved by most medical scheme beneficiaries not understanding their benefit options. Previous efforts to conduct educational and consumer awareness were helpful; however, media analysis still indicated a need for greater visibility.

Towards the finalisation period the 2020-2025 CMS Strategic Plan, CMS had reported on improved visibility albeit lacking in financial resources. The strategic communication approach involved purposefully setting up media engagements and producing opinion pieces, augmenting social media platforms with credible content, webinars and introduction of podcasts.

The result of this outcome significantly increased or attracted more stakeholder collaborations. CMS entered into partnerships and signed at least 11 MOU's. Our efforts to engage Principal Officers and Board of Trustees on key policy issues via hosting annual forums, there's been palpable efforts by schemes to educate members on PMBs. Furthermore, CMS was instrumental in convening flagship programmes such as the Section 59 Investigation, Fraud, Waste and Abuse and the Lost Cost Benefit Options.

Under the strategic period, CMS marketing efforts to increase visibility shall include; digital marketing and online advertising, roadshows, CMS publications mainly member focused, increased media presence, aggressive participation in industry and stakeholder forums and events.

National Health Insurance (NHI)

While NHI has been discussed under legislative and policy matters, it is opportune to highlight that NHI encompasses several key components aimed at transforming healthcare in South Africa. Those impacting CMS include:

- Universal Health Coverage: NHI aims to deliver comprehensive healthcare services to all South Africans, encompassing both preventive and curative care
- Single-Payer System: Funded by taxpayers and additional contributions, the NHI will centralise healthcare purchasing, removing direct payments from patients
- Public and Private Integration: Private providers will contract with the NHI under a regulated pricing framework, merging them with the public system
- Standardised Benefits: A consistent package of healthcare services will be accessible to all citizens, ensuring equitable access
- Governance and Oversight: The NHI Fund will oversee service purchasing, manage funds, and ensure accountability and transparency within the system, and
- Reduced Role of Medical Schemes: Medical schemes will only cover services not included in the NHI, diminishing their current role in healthcare funding.

NHI will have a serious impact on the regulatory role of CMS. It proposes a shift from prioritising direct regulation of medical schemes to the addition and emphasis on a more supportive and complementary oversight and regulation approach. Envisaged challenges include navigating reduced regulatory authority, aligning operations and regulatory activities with NHI regulations, and maintaining member and beneficiary and other material stakeholder confidence and trust.

During the five-year period, CMS will apply *inter alia* the following approaches in relation to NHI:

- Adaptation Strategies: Redefine and align CMS's role in supporting NHI goals while safeguarding the interests of members
- Regulatory Adjustments: Update regulations to delineate CMS and NHI responsibilities

- Stakeholder Engagement: Strengthen communication and collaboration with members and beneficiaries, medical schemes, other healthcare providers, government stakeholders, and the NHI
- Capacity Building: Enhance CMS capacity to manage new regulatory oversight functions, including monitoring complementary coverage in relation to the NHI
- Risk Capacity and Risk Management: CMS plans to redefine its Risk Capacity and enhance its Risk Management Plans to consider strategic risks relating to the NHI, including financial sustainability, systems, technology and ICT, human capital, changing regulatory compliance obligations, and the protracted nature of litigation and legal challenges.

Economic Outlook

Key economic projections indicate modest Gross Domestic Product (GDP) growth for South Africa, with a projected increase of 1% in 2024 and 1.4% in 2025. This growth is primarily driven by an easing of supply constraints, including reduced power outages and improved logistics in critical sectors such as rail and ports.

Above said, the rise in government debt remains a significant concern, particularly regarding the financing of large-scale transformative policy and legislative changes like the NHI.

Added, the ageing population and the escalating impacts of climate change, present a growing need for government to address the pressures these factors are placing on public finances.

Figure 6 below contrasts the lowering inflation trend from 2018 to 2025 with increasing public debt between 2011 to 2023

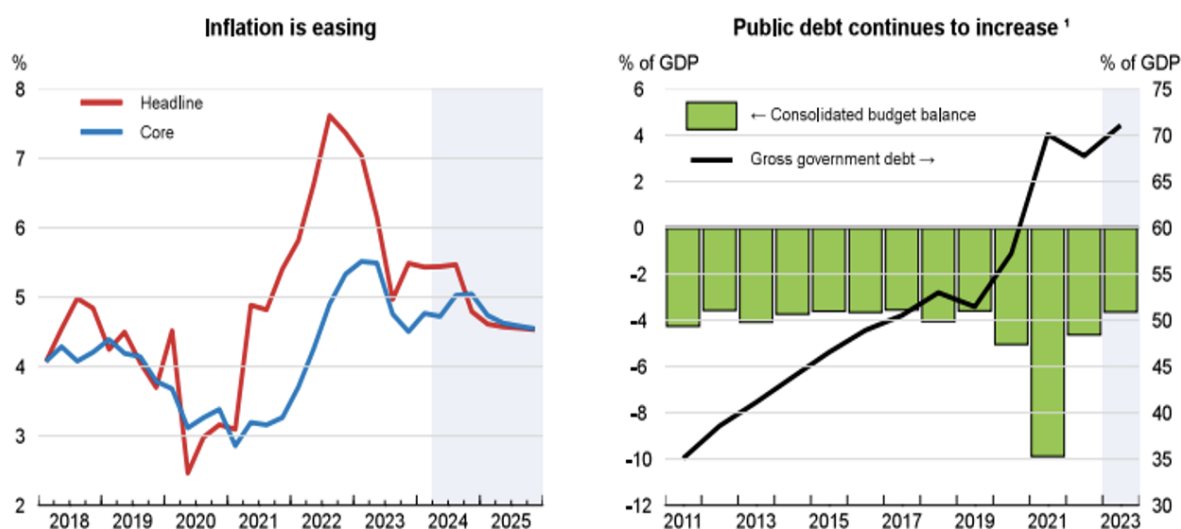


Figure 6: Graphic depiction contrasting the lowering inflation trend from 2018 to 2025 with increasing public debt between 2011 to 2023

Economic outlook: Short term projections

South Africa's economic growth is projected to average 1.6% over the next three years, which is below that of other emerging markets. This subdued growth contributes to a decline in per capita GDP, negatively affecting living standards.

In terms of inflation and the cost of living, inflation is expected to be moderate, with a projection of 4.9% in 2024 and a three-year average of 5% which is bolstered by a stronger Rand and decreasing fuel and food prices. Households are facing additional financial strain due to above-inflation increases in electricity and water costs, along with rising service prices. These include ever-rising healthcare services.

Local economic outlook and its impact on medical schemes

The current economic environment is characterised by several key trends that significantly influence medical schemes:

- **Economic Growth and Employment:** The current climate shows slow economic growth, insecure employment, and high unemployment. This has a significant impact on consumers, for example, in the form of reduced disposable income. This limits private healthcare affordability, and it contributes to membership losses for medical schemes
- **Inflation and Cost of Living:** Inflation is putting pressure on household budgets. As a result, premium increases become harder to justify, requiring schemes to find cost-saving measures
- **Regulatory Reforms:** Ongoing regulatory changes, including alignment with NHI goals, compels schemes to adapt their benefit structures and governance practices to comply with new regulations
- **Funding and Affordability Challenges:** Employers are facing pressure to cut healthcare costs due to economic constraints. This could lead to a potential reduction in employer contributions to medical schemes and a shift toward more affordable healthcare plans.

The current macroeconomic environment features high interest rates driven by ongoing inflation, a volatile rand, rising energy prices, and slow economic growth. Consequently, many households are likely to experience budget constraints in the near future, placing consumers in a precarious financial position.

Further to the above, CMS has identified key industry-specific factors that it will consider when evaluating the appropriateness of changes to benefits, increases in contribution rates, and overall assumptions regarding cost increases. These factors include:

- Economic projections about inflation
- The relationship between increases in medical scheme contributions (one contributor to healthcare insurance inflation) and consumer inflation
- Headline inflation compared to medical and health insurance inflation
- Predictions and assumptions related to healthcare utilisation.

Other strategic implications and considerations for medical schemes

As medical schemes navigate the evolving economic landscape, several strategic implications and considerations emerge. The following points for medical schemes outline key areas that CMS will integrate with its strategic focus:

- Navigating economic challenges by means of a focus on cost management, innovative benefit design, and affordability

- Embracing technology, including upgrading IT systems and technology platforms, investing in digital solutions and AI to enhance regulation
- Regulatory alignment and governance, by means of proactive adjustments to regulatory changes while enhancing internal and industry governance and compliance
- Additionally, member-centric strategies to create products and services that meet evolving member needs and expectations
- Lastly, implementing diverse reimbursement models will be vital in adapting to the changing healthcare landscape including NHI.

15.1. Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

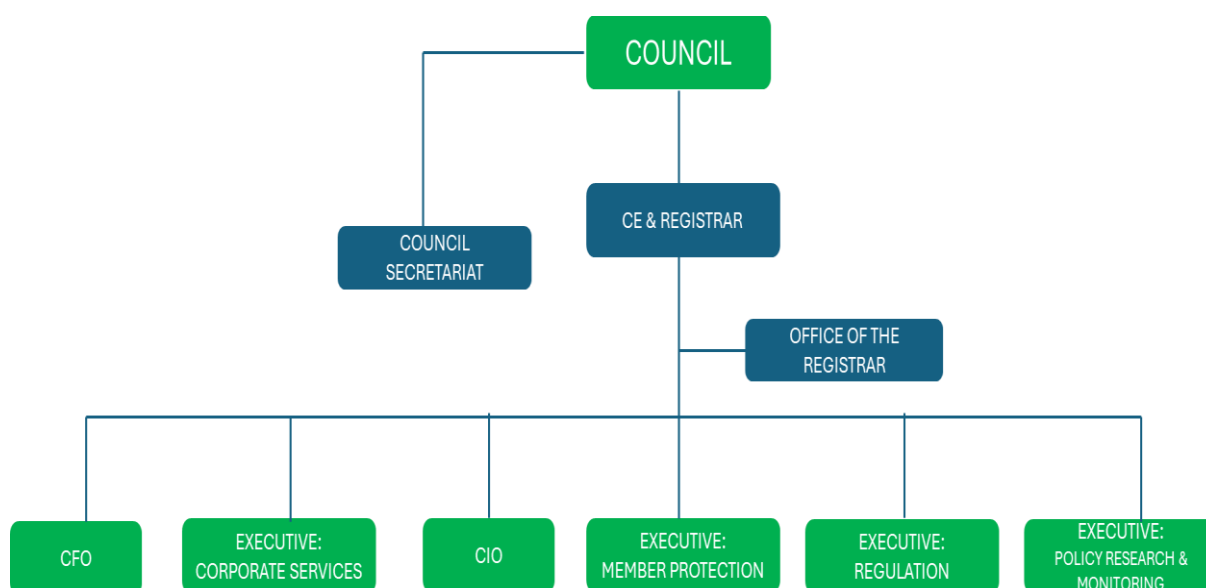
Table 5 below shows data from a SWOT analysis

Table 5: SWOT Analysis

Strengths (Internal)	Weaknesses (Internal)
• Unqualified audit opinion and achievement of objectives • Staff appointment turnaround times • Reasonable staff turnover • Safe work environment • Functioning of the Council • Integration of cleaners into staff establishment • Agile and adaptable • Highly qualified staff and expertise • Good relationship between management and the Council.	• Operational silos • Management vs. Union relations • Remuneration policy and philosophy • ICT operational challenges • Human resources capacity constraints • Outdated legislation • Restraint of trade • Key person dependencies. • Poor organisational culture • Funding model
Opportunities (External)	Threats (External)
• Digital transformation and technology upgrades • New regulations for chronic disease management • Exploring unregulated spaces and alternative income streams • Public-Private Partnerships and geographical expansion • Leveraging the NHI Act and dispensation to position CMS as a regulator of choice • Enhancing engagement with stakeholders and boosting credibility. • Supportive civil society • Independent justice system	• Political uncertainty • Quasi-competition and the paradox of having no direct competitors • High unemployment rates • Outdated legislation and declining fiscal support • Industry pushback and a lack of buy-in from stakeholders • Aging industry and challenges with low-cost membership options • Litigation increase • Ungovernable schemes • Clarity of legislative mandate (i.e. FSRA) • Absence of visibility • Cyber attacks •

15.2. Internal Environmental Analysis

Organisational Structure



Human Resources (HR)

The CMS has successfully undergone a transformation by restructuring its organizational framework to better align resources with strategic goals. This involved prioritizing the filling of new positions in a phased approach based on the approved budget. However, the budget has not been sufficient to fully fund the newly created positions in the new organisational structure. Six percent of the total positions in the approved organisational structure remain unfunded, and the CMS intends to fund these positions over the new MTEF.

The CMS remuneration philosophy, terms and conditions of service and employee benefits policies, and employment contract provides for the performance incentive and retirement benefits. However, due to budgetary constraints, the CMS is unable to fully afford employee benefits as provided for in its policies.

It should be noted that towards the end of the 2024/2025 financial year, the growth of the CMS cost of employees has reached the margins of 71% of the total CMS budget. It would then be prudent for CMS in its review of the remuneration policies to struck a balance between sustainability and the retention of talent.

Key priorities for CMS include prioritising Employment Equity, Learning and Development, Health and Safety, Employee Wellness, and Talent Management, with the aim of ensuring compliance with employment legislation and promoting work-life balance.

Looking ahead, CMS aims to enhance employee benefits and implement strategies for process improvement, effective conflict resolution, team building, and improved communication to position itself as an employer of choice and address the challenges over the last 5 years.

Stakeholder Relations

Based on the threats identified, it was crucial for CMS to develop partnerships with key stakeholders to inter alia; a) build cooperations with other regulators and civil society impacted by CMS mandate and vice versa, b) produce research knowledge for the benefit of the medical scheme and health sector, c) CMS communication aligned to national government priorities.

Information and Communications Technology (ICT)

ICT at CMS is currently on the Digital Transformation journey. This journey entails revamping and updating the aged technologies at CMS to allow for a more efficient and effective Regulator embracing the '4IR' digital technologies. These technological initiatives are tracked continuously for progress via the various governance structures at the CMS.

Figure 7 below is extracted from the ICT Digital Strategy. It outlines the essential components and their relationships with CMS's Strategic Outcomes for the period 2025 - 2030. These projects are best projections, subject to budget availability and changing business needs, and will be reviewed on an ongoing basis due to any changing dynamics that might surface.

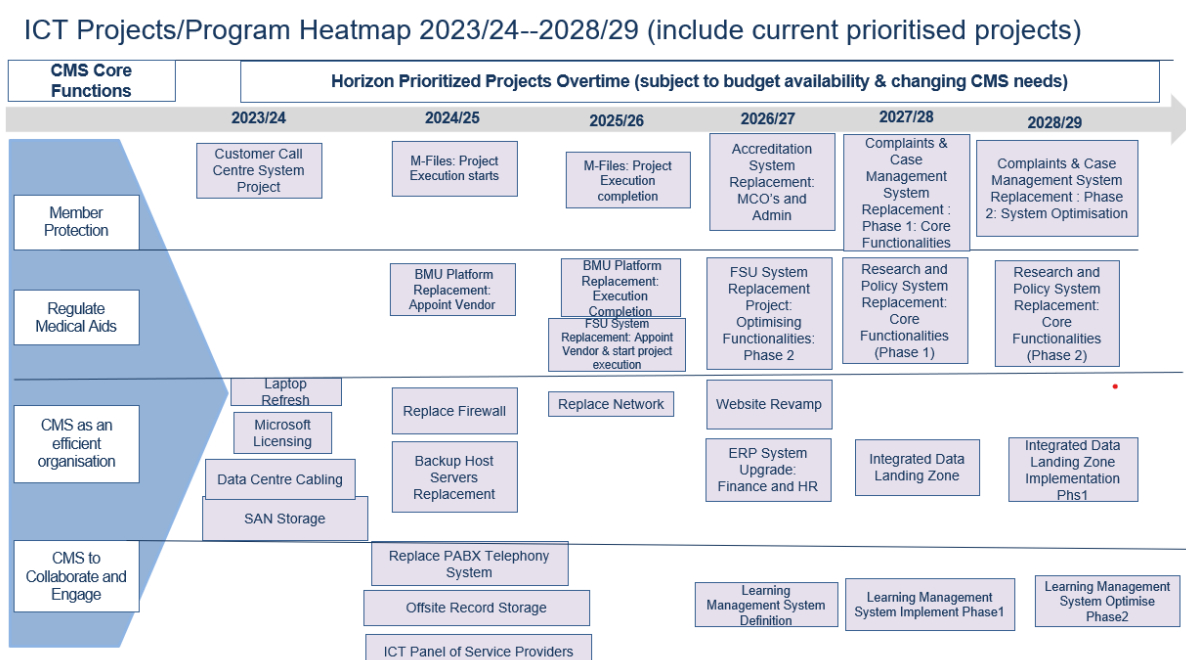


Figure 7: Digital Transformation Projects per budget availability

Financial Resources

In the last five years, CMS has encountered significant financial challenges and other resource constraints. The delayed approval of the proposed levy increase, coupled with the capping of the proposed increase to the Consumer Price Index (CPI), has had a detrimental effect on the organisation's cash flow and its ability to meet all its responsibilities as a statutory regulator.

The CMS has employed operational strategies to bolster its financial sustainability. However, it is evident that a more strategic approach is essential to ensure the organisation's long-term financial stability. As a result, the CMS will shift its focus from solely managing its budget to evaluating and enhancing its funding model with a long-term approach.

Additionally, the CMS audit outcome has displayed improvement over the past five years, reflecting enhanced performance, compliance, and financial management. The objective for the upcoming strategic period is to strive for a clean audit outcome, thus signifying a credible and well-governed regulator.

Resolution of complaints

One of the CMS's core functions is the investigation of complaints and settlement of disputes in relation to the affairs of medical schemes. During the last five years, the CMS has sought to ensure protection of the interests of medical scheme beneficiaries through resolution of complaints lodged against regulated entities. In this period, more than 12 000 complaints were successfully resolved.

Table 5 below depicts complaints resolution data over the past 5 years, specifically highlighting the number of complaints received and the number of complaints resolved:

Table 5: Complaints Resolution Statistics

Financial Year	Brought forward	Complaints registered	Total complaints	Total complaints resolved	Carried forward
2019/20	1 902	2 829	4 731	3 006	1 725
2020/21	1 725	1 729	3 454	2 490	974
2021/22	974	2 265	3 239	2 379	514
2022/23	514	2 966	3 480	3 017	463
2023/24	463	2 087	2 550	2 178	372
Total complaints		11 876		13 070	

Significant developments over the last five years

To improve the experience of complainants, the Complaints Adjudication sub-division implemented a backlog reduction strategy during the 2021/22 financial year, and this resulted in successful elimination of the historical backlog at the end of the financial year. Further, a backlog monitoring output indicator was also introduced to ensure constant monitoring of ageing complaints and avoid re-accumulation of the backlog.

Another significant development was the revision of the resolution turnaround time from 120 working days to 120 calendar days. This resulted in a 56-day reduction of the turnaround time, which benefitted complainants.

The Complaints Adjudication sub-division also implemented a new categorisation of complaints and early resolution strategy, which resulted in prioritisation of clinically urgent complaints and other non-complex complaints. Due to these interventions, a significantly higher percentage of complaints are being resolved within 0-60 days.

Complaint trends over the last five years

Over the last five years, complaint trends have remained the same in relation to short payment of claims related to Prescribed Minimum Benefits (PMB). What seems to be on the rise is the disputes over interpretation of PMB level of care and funding liability of medical schemes for high-cost, new treatment interventions. The CMS is also seeing an increase in complaints about the funding limitations on treatment of rare diseases, some of which are not on the PMB list, as well as complaints on the interpretation of Regulations 15H and 15I (c).

Number of disputes related to funding of non-PMB, rule-based benefit exclusions and membership terminations have remained relatively unchanged over the past five years.

Challenges over the last five years

There were significant challenges that impacted resolution of complaints over the past five years, key among which is the regulatory uncertainty arising from the outdated Medical Schemes Act. In addition, delays in implementing legislative and regulatory amendments have resulted in excessive delays in finalising complaints.

Over the last five years, there were four key regulatory challenges that impacted the medical schemes industry and in turn, timeous resolution of complaints.

Interpretation of section 59(3) of the Medical Schemes Act

Disputes over the correct interpretation and lawful application of section 59(3) of the MSA continue to plague the CMS as the final report of the Section 59 Investigation Panel remains outstanding since 2020. The absence of clear, regulatory guidance in this regard remains a challenge to date.

Conflicting interpretations of Regulation 28(7)

The CMS has dealt with numerous complaints wherein the interpretation of Regulation 28(7) came under scrutiny. These were complicated by several conflicting appeal rulings as well as the involvement of other parties whose conduct fall outside the CMS regulatory mandate. The combined difficulty posed by these factors, made timeous resolution of related complaints problematic.

Lack of clarity on the meaning and interpretation of day-to-day benefits

Following the High Court judgment in the case of *Keyhealth Medical Scheme v Reed*, the correct meaning and interpretation of the term “*day-to-day benefits*” became an issue of contention between medical schemes and beneficiaries. Due to the Court’s departure from the commonly accepted meaning and interpretation, the new and ambiguous meaning that was attached by the court to this term created a new wave of disputes, which require the CMS to pronounce itself on correct meaning, interpretation, and application of day-to-day benefits.

ICT system challenges

In addition to the regulatory challenges, the CMS faced serious ICT related challenges which impacted the resolution of disputes. Repeated ICT system crashes resulted in significant loss of historical complaints data, which in turn, led to loss of institutional memory and case precedents that are critical to making consistently sound, legal decisions.

High-level plans for the next five years:

One of the noted drawbacks in the management of complaints is the lack of data on the effectiveness of CMS interventions in addressing complaints to benefit not only the complainant, but the membership collective. To this end, Complaints Adjudication sub-division aims to introduce an integrated, collaborative approach to complaints management by collecting data on implementation of the Registrar and Appeal rulings as well as complaints resolution at scheme-level. This will assist in measuring the effectiveness of CMS rulings and medical scheme complaints resolution mechanisms.

Broad-Based Black Economic Empowerment (B-BBEE) initiatives

The Government has an obligation to harness national resources towards the resolution of the historical injustice of racial, gender and class exclusion in all spheres of life. In the realm of economic life, this implies the need to transform the patterns of asset ownership in a manner that reinforces the national objective of building a South African society that truly belongs to all who live in it.

The Government has developed various policy instruments, such as the Preferential Procurement Regulations of 2017 (PPR) issued in terms of the Preferential Procurement Policy Framework Act 5 of 2000 (PPPFA). The PPPFA objective is to transform the structure of the South African economy in a manner that advances previously disadvantaged persons or categories of persons, high levels of decent employment and demographic transformation of industrial assets.

CMS is committed to mainstreaming enterprise growth, empowerment and equity in the economy for designated groups through the National Treasury requirements and the CMS Supply Chain Management (SCM) Policy.

In this way, CMS will continue to leverage its procurement spend to advance historically disadvantaged persons by giving preference to designated groups (aligned to the PPPFA), exempt micro enterprises (EMEs), and qualifying small enterprises (QSEs).

Other B-BBEE initiatives

The CMS has implemented the B-BBEE Code of Good Practice by applying the preference points system of 80/20 for transactions of goods and services between R2 001 and R50 000 000 and the preference points system of 90/10 for transactions above R50 million when it is applicable.

More specific measures taken by the CMS include the following:

- Requesting and ensuring that each bidders submits a sworn affidavit and B-BBEE credentials when responding to the invitation for bids
- Using the quote evaluation system to allocate points for specific goals in line with Preferential Procurement Regulations 2022.

Status of CMS's Interventions relating to women, youth and people with disabilities

The CMS plans to continue its contribution to the three strategic priorities of the 7th Administration. This covers inter alia, on the matter of inclusive economic growth, the empowerment of designated groups, namely - women, youth, and people with disabilities.

The CMS supports government's call to develop the skills by providing internship programme as well as training for qualified graduates. This initiative has enabled CMS to host eighteen months Work Integrated Learning that allowed learners to complete the workplace learning requirements towards their qualification.

The CMS actively contributes to the empowerment of these designated groups through its talent acquisition, management and retention. Over the past five years, the staff composition at the CMS has been comprised of, on average, 55% women, 21% youth, and 3% people with disabilities. Moving forward, the CMS is committed to ensuring that its staff composition reflects the demographic representation of these designated groups within South African society.

The following *Table 6* presents the distribution of staff by age and gender. This information shows one lens on the level of diversity within the CMS workforce.

Table 6: Distribution of staff by age and gender

Age Distribution	2020 – 2021		2021 – 2022		2022 – 2023		2023 – 2024		2024 – 2025	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
20-24	0	0	0	0	1	0	1	1	0	1
25-29	5	6	6	6	5	6	5	3	5	5
30-34	4	7	3	10	5	11	5	10	7	10
35-39	16	15	10	12	12	8	9	10	5	10
40-44	5	12	13	10	10	11	14	12	16	11
45-49	13	6	11	9	12	11	12	11	12	9
50-54	10	4	11	3	10	5	10	6	10	7
55-59	7	0	8	1	11	1	9	3	13	4
60-64	2	1	2	1	2	1	3	1	2	0
Total	62	51	64	52	68	54	68	57	70	57

Interventions and tasks to overcome internal environmental challenges

In *Table 7* below are interventions and tasks that will be undertaken by CMS to overcome internal environmental challenges over the five-year period.

Table 7: Interventions and tasks to overcome internal environmental challenges

Intervention	Task
Enhanced stakeholder engagement	Strengthen collaboration, communication, and marketing efforts targeted at, and in collaboration with stakeholders, including the NDoH and National Treasury
Financial resource management	Optimise the allocation of financial resources to ensure effective operational support

• Eliminating silos	• Promote interdepartmental collaboration to break down silos and enhance teamwork initiatives
• Organisational culture and change management	• Implement change management initiatives to foster a positive organisational culture and encourage adaptability
• Improved communication	• Establish regular communication channels between staff and management to facilitate transparency and feedback
• Effective management team	• Ensure the management team is cohesive and capable
• Good governance and ethical leadership	• Uphold principles of good governance, complimented by ethical leadership from Council and accountability across all levels
• Management accountability	• Establish clear accountability mechanisms for management to the Council, ensuring mutual accountability
• Compliance and risk management	• Strengthen compliance frameworks and risk management practices to safeguard organisational integrity
• Support for leadership stability	• Ensure stability in leadership roles
• Cohesion amongst employees, management and Council	• Foster a culture of collaboration and cohesion among management, Council members, and employees

Part C: Measuring Our Performance

16. Institutional Performance Information

The following section presents CMS institutional performance information. This data is critical to the effectiveness of CMS as a regulator. It facilitates the monitoring and evaluation of progress with the delivery of the Strategic Outcomes for the 5-year period, and it supports the identification of areas for progressive improvement in regulatory oversight and institutional governance.

The seventh administration has identified three priority areas for the electoral cycle 2025-2030. The National Development Plan Vision 2030 (NDP) remains the defining blueprint for South Africa's growth and development and the seventh administration's programme. As a result, the NDP 2030's long-term vision serves as the foundation for the three priority areas of the seventh administration. The three priorities' total impact is intended to foster inclusive growth and job creation; alleviate poverty and the high cost of living; and create a capable, ethical, and developmental state.

The awaited Medium-Term Development Plan will set out a well-defined vision and strategic plan that outlines clear goals and includes specific, measurable objectives and a roadmap for achieving them.

The outcomes outlined below are therefore aimed at achieving the developmental outcomes outlined in the NDP 2030, the priorities of the seventh administration and the priorities of the NDoH.

The key role of the CMS as outlined in Section 7 of the MSA is 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.

17. Theory of Change

The Department of Planning, Monitoring and Evaluation (DPME) Framework for the drafting of Strategic Plans and Annual Performance Plans (DPME Framework) calls for the illumination of a Theory of Change as part of the strategic planning and implementation process.

The Elements of the Theory of Change for CMS is represented in *Figure 8* below.

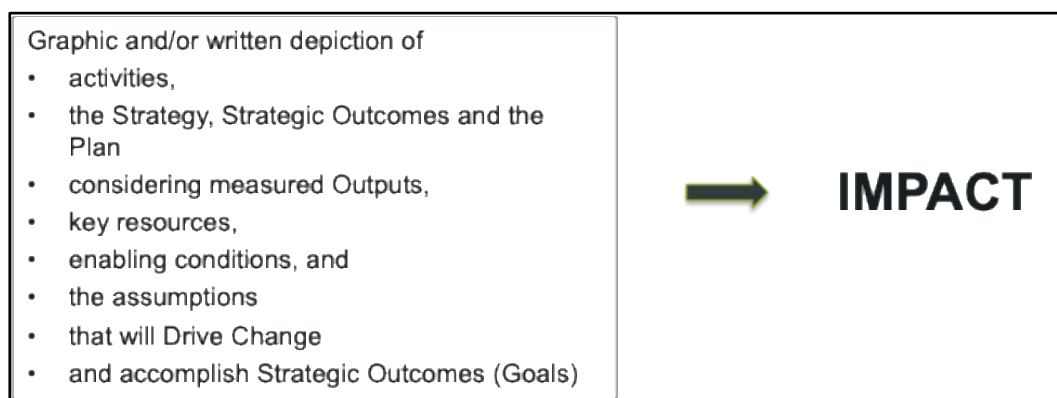


Figure 8: Elements of Theory of Change

Figure 9 is a graphic depiction of the Theory of Change.

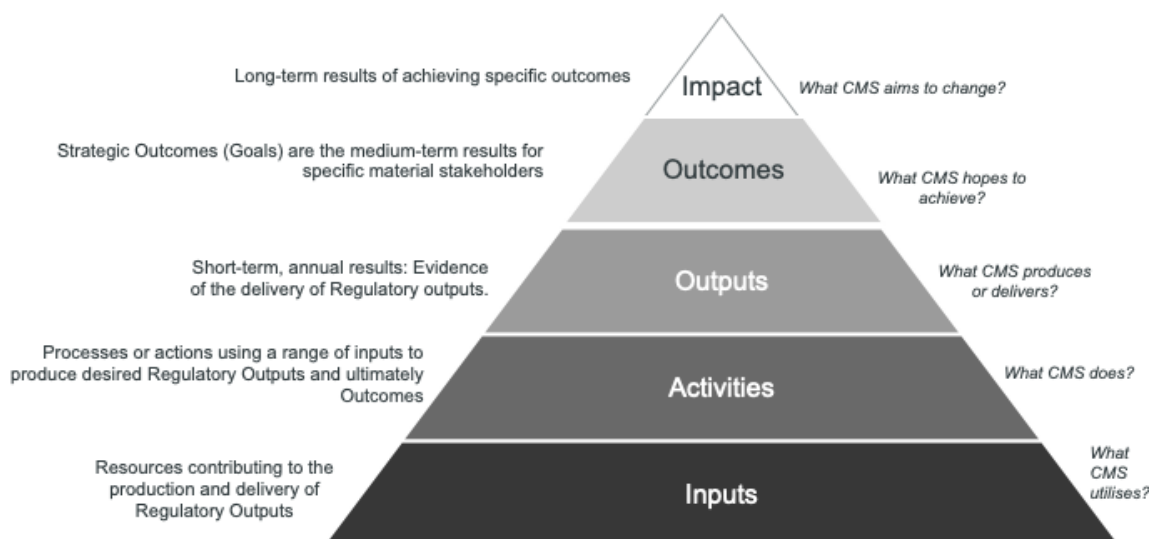


Figure 9: Graphic depiction of the Theory of Change

Table 8 below presents a comprehensive overview of the Theory of Change for the CMS, outlining critical elements such as impact, outcomes, outcome indicators, outputs, output indicators, activities, inputs, assumptions, and interventions:

Table 8: CMS Theory of Change

Impact:	Regulating the private healthcare industry to ensure improved access to affordable, cost-effective and quality healthcare	Assumptions:	Interventions:
Outcomes:	Outcome Indicators 1. Compliance with MSA and applicable legislation; Regulatory Interventions 2. Proportion of population covered by medical schemes 3. Number of benefit options 3. Diversity mix (e.g. age, gender, rich/poor; healthy/sick) 4. Visibility and awareness 5. Consistently improved audit outcomes towards a Clean Audit 5. Fraud, corruption and consequence management cases 6. Knowledge and thought leadership generation and dissemination	- Adequate manpower, skilled staff - Established and streamlined processes - Adequate technology and IT systems - Adequate infrastructure - Adequate resources to support CMS operations	- Attract, develop and retain highly skilled workforce - Upgraded and revamped technology and agile adoption - Urgency in decision-making - Funding model aligned to mandate - Addressing legislative gaps, including an amended MSA - Stakeholder engagement (collaboration, communication and marketing) - Compliance and risk management - Policy advocacy and lobbying - Support from National Department of Health and National Treasury - Accountability - Ethical and effective leadership - Stability in leadership - Cohesion between management and Council and employees - Financial resources/Funding model - Staffing - Technology Investment - Eliminating silos - Political will (Relationship with executive authority) - Modernised IT system - Effective management team - Good governance, ethical and effective leadership from Council
Outputs:	Output Indicators 1. Accreditation of brokers, broker organisations, managed care organisations, administrators and self-administered schemes 1. Rule amendments 1. Inspection of regulated entities & enforcement actions 1. Monitoring the governance systems of medical schemes and other regulated entities 1. Monitoring and promotion of the financial soundness of medical schemes 1. Financial sections prepared for the annual report 1. Stakeholder education and training sessions		

	• 1. Customer care interventions (phone and email queries) • 1. Resolution of complaints • 1. Publication of rulings • 2. Customer care interventions (phone and email queries) • 2. Resolution of complaints • 2. Publication of rulings • 2. Clinical opinions to resolve complaints and enquiries. • 3 & 6. Research to inform appropriate national health policy interventions • 3 & 6. Monitoring trends to improve regulatory policy and practice • 3 & 6. Benefit definition guidelines published • 3 & 6. The primary health cost and affordability framework • 4. Memorandum of Understanding (MoU) with local and regional entities • 5. Achievement of objectives • 5. Unqualified Audits • 5. Reasonable staff appointment turnaround times • 5. Reasonable staff turnover • 5. Network uptime, IT security incidents, IT • 5. Disaster Recovery failover tests • 5. Timeous legal opinions provided to internal and external stakeholders • 5. Stakeholder awareness activities		
Activities:	Operational Plan		
Inputs:	ICT, manpower, technical expertise and other resources		

17.1. Measuring Impact

At the pinnacle of the hierarchy (in *Figure 5*) of the Theory of Change and at the end of its ultimate application (in *Figure 4*) is Impact. This is further illuminated in the Impact Statement below that has been set by Council. The Impact Statement shows the ambitious long-term stakeholder value generation results (namely, *improved access to affordable, cost-effective and quality healthcare*) of achieving the Strategic Outcomes over the 5-year period.

Impact Statement

*Regulating the private healthcare industry
to ensure improved access to affordable, cost-effective and quality healthcare.*

17.2. Measuring Outcomes

Figure 10 below summarises the six (6) Strategic Outcomes.



Figure 10: Strategic Outcomes

18. Strategic Goals of the National Department of Health (NDoH)

The NDoH aims to improve health status through the prevention of illness, disease and the promotion of healthy lifestyles, and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.

Table 9 below shows the alignment between the NDP goals, MTDP Priorities, and NDOH strategic goals with the CMS strategic goals for the period 2025 - 2030:

Table 9: MTDP Priorities, and NDOH strategic goals Strategic Outcomes, Outcome Statements

MTDP Priorities	NDoH Strategic Goals 2025/26 – 2029/30	CMS Strategic Outcomes 2025 to 2030
Pursue achievement of universal health coverage through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care.	Improved access to affordable and quality healthcare National Health Insurance awareness improved	Outcome 1: Regulating entities in compliance with National Policy, the Medical Schemes Act and other legislation - The CMS will register and accredit all entities involved in the medical scheme business, review and approve scheme rules, manage complaints, conduct compliance inspections, and monitor the financial soundness of these entities to ensure effective regulation in accordance with the Medical Schemes Act, National Policy, and other relevant legislation. - This is all aimed at providing scheme members with the protection they need and improved access to affordable and quality healthcare.
		Outcome 2: To promote access to quality, cost-effective, and affordable private healthcare financing and related private healthcare - The CMS reports the utilisation of health services and monitors the prevalence of chronic conditions in the medical schemes' population. Other monitoring processes include the continued collection of the Scheme Risk Measurement (SRM) data to measure and report on the risk profiles of medical schemes and benefit options. This allows schemes to understand better the IMPACT of age and chronic disease on the beneficiaries covered by medical schemes. - 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. - 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.

MTDP Priorities	NDoH Strategic Goals 2025/26 – 2029/30	CMS Strategic Outcomes 2025 to 2030
Pursue achievement of universal health coverage through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care.	Governance of Public Entities strengthened	Outcome 3: To encourage risk pooling and innovation for the effective functioning of the private healthcare financing sector - The CMS supports improved access to affordable healthcare through the development of a standardized Base Benefit Package, refinement of PMBs, and collaboration on price regulation under the NHI, aiming to increase healthcare affordability, ensure equity in benefit design, and improve mental health access, with outcomes including reduced out-of-pocket expenses and improved financial protection for members. - The CMS will ensure effective risk pooling by standardizing scheme options, consolidating medical schemes with less than 6000 members, consolidating government-funded schemes, and developing and implementing a comprehensive Primary Health Care benefit package. This work will be done through a consultative approach, taking into account the risks to scheme members, employers, trade unions, and other key stakeholders. - The CMS will support the interim block exemption regulations by the Minister of Trade, Industry, and Competition that seek to establish a structured, multilateral tariff determination process in the private healthcare sector. The CMS will support of the proposed establishment of a framework for collective determination of prices and tariffs; the appointment of Tariffs Governing Body (TGB) and Multilateral Negotiating Forum (MLNF).
	Financial Management strengthened in the health sector	Outcome 4: Stakeholder engagement at local, regional and international level - The establishment of formalised agreements, attendance of regular meetings and scheduled visits to local, regional and international regulatory authorities will ensure that the CMS is recognised by key regulators as an effective and efficient sector regulator. Outcome 5: Good governance and ethical leadership - Through the review, updating, development and implementation of policies, strategies and standard operating procedures for the Office of the CEO, Office of the CFO, Information Communication and Technology (ICT), Human Resources (HR), Finance, and Legal support sub-programmes, the effectiveness and efficiency of the organisation will be improved. CMS will promote ethical and effective leadership through training, policies and incentivisation.

MTDP Priorities	NDoH Strategic Goals 2025/26 – 2029/30	CMS Strategic Outcomes 2025 to 2030
Strengthen the primary health care (PHC) system by ensuring that home and community- based services, as well as clinics and community health centres are well resourced and appropriately staffed to provide the promotive, preventive, curative, rehabilitative and palliative care services required for South Africa's burden of disease Improve the quality of health care at all levels of the health establishments, inclusive of private and public facilities	Improved maternal and newborn health	Outcome 6: Conducting policy-driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry. • Refocusing our research efforts and aligning them with policy developments in the public and private health sectors will ensure this outcome. There will be a need to reprioritise the outputs of the Policy, Research and Monitoring, as well as the Strategy office programmes to gain synergies on the one hand and avoid duplications, on the other hand. These research efforts should through partnership with other research institutions support both internal and external stakeholders in understanding the strategic trajectory of the CMS. • The CMS is in the process of revising the PMB package with an emphasis to include more primary health care benefits, including the expansion of mental health benefits within medical schemes and standardization of coverage for psychiatric care and counselling. • The role that CMS will play towards the achievement of this NDP mandate is the collection, analysis and provision of private health quality data. • In addition, the PMB definition, which is a key part of the PMB review, will ensure that there is an improved understanding by scheme members of their benefits and entitlements • The inclusion of the Primary Healthcare (including TB) in the PMB's as part of the review process will lead to the overall improvement of the National Health Outcomes
	Mental Health Care Integrated into Primary health care	
	HIV and AIDS related deaths reduced	
	TB Mortality reduced	
	Reduced burden of disease	

19. Strategic Outcomes, Outcome Statements, Indicators, Baseline and 5-year target

The table below shows the Strategic Outcomes, corresponding Outcome Statements, Outcome Indicators, a Baseline, and five-year targets.

Table 10: Strategic Outcomes, Outcome Statements, Outcome Indicators, Baseline and 5-year target

OUTCOME	OUTCOME STATEMENT	OUTCOME INDICATOR	BASELINE	FIVE-YEAR TARGET
Outcome 1: Regulating entities in compliance with National Policy, the Medical Schemes Act and other legislation	The processes of registering and accrediting all entities involved in the medical scheme business, reviewing and approving scheme rules, managing complaints, conducting compliance inspections, and monitoring the financial soundness of these entities will be streamlined to ensure effective regulation in accordance with the Medical Schemes Act, National Policy, and other relevant legislation. This is all aimed at providing scheme members with the protection they need.	Compliance with MSA and applicable legislation; Regulatory Interventions	88.39% (4761/5386) of broker and broker organisation applications accredited within 30 working days per quarter on receipt of complete information.	85%
			100% of managed care organisation and schemes providing own managed care services' applications (15/15) analysis completed within three months of receipt of complete information.	100%
			100% of administrators and self-administered schemes' applications (9/9) analysis completed within three months of receipt of complete information.	100%
			70.4% (38/54) of interim rule amendments processed within 30 working days of receipt of all information	80%
			100% (69/69) of annual rule amendments processed before the 31 st December of each year	95%
			Contributions and Benefits Changes Guidance Note publishes as a Circular annually	5
			One (1) set of Model Rules last published in 2016	5
			100% (10/10) of routine inspection draft reports issued.	80%
			0% (0/1) of warranted commissioned inspections initiated during the year.	80%
			93% (50/54) of enforcement actions initiated during the year.	80%
			97% (37/38) of governance actions initiated during the year.	80%
			90.9% (40/44) of scheme member meetings attended (including virtual meetings) as identified through the	85%

OUTCOME	OUTCOME STATEMENT	OUTCOME INDICATOR	BASELINE	FIVE-YEAR TARGET
			risk-based approach framework.	
			100% of business plan decisions processed in respect of Regulation 29	100%
			One (1) financial section prepared for the Annual Industry Report each financial year.	5
			76 stakeholder education and training sessions.	300
			100% of customer care interventions resulting from calls, e-mailed queries and walk-in consultations handled by the customer care centre.	85%
			85.1% (114/134) of complaints older than 120 calendar days adjudicated during the reporting period in accordance with complaints standard operating procedures (SOP)	75%
			83.9% (622/741) of category 2 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures (SOP).	75%
			96% (949/989) of category 1 complaints adjudicated within 60 calendar days and in accordance with the complaint standard operating procedures (SOP).	75%
Outcome 2: To promote access to quality, cost-effective, and affordable private healthcare financing and related private healthcare	In terms of Section 7 (e) of the Medical Schemes Act, one of the key functions of the Council is to collect and disseminate information about private health care. To optimise the resolution of complaints with the aim of achieving at least 80% resolution rate within 120 working days by the year 2029/30	Resolve complaints with the aim of protecting beneficiaries of medical schemes	10 CMS Scripts published	50
			99.53% of category 1 clinical opinions provided within 30 working days of receipt of a request from the Complaints Adjudication Unit	90%
			100% of category 2 clinical opinions provided within 60 working days of receipt of a request from the Complaints Adjudication Unit	90%
			100% of category 3 clinical opinions provided within 90 working days of receipt of a request from the Complaints Adjudication Unit.	95%

OUTCOME	OUTCOME STATEMENT	OUTCOME INDICATOR	BASELINE	FIVE-YEAR TARGET
			100% of clinical inquiries received via e-mail or telephone and responded to within 7 days.	95%
Outcome 3: To encourage risk pooling and innovation for the effective functioning of the private healthcare financing sector	By standardizing scheme options, consolidating medical schemes with less than 6000 members, consolidating government-funded schemes, and developing and implementing a comprehensive Primary Health Care benefit package, the CMS will ensure effective risk pooling. This work will be done through a consultative approach, taking into account the risks to scheme members, employers, trade unions, and other key stakeholders.	A new base benefits package for PMBs Enable consolidation in the medical schemes industry Number of draft benefit definition guidelines	New Indicator	5 Standardisation of options implementation reports.
			New indicator	5 PMB Review Reports on PMB review activities and progress.
			New Indicator	5 Consolidation of Schemes <6000 members reports completed.
			10 draft benefit definition guidelines developed per financial year.	50 Draft benefit definition guidelines
Outcome 4: Stakeholder engagement at local, regional and international level	The establishment of formalised agreements, attendance of regular meetings and scheduled visits to local, regional and international regulatory authorities will ensure that the CMS is recognised by key regulators as an effective and efficient sector regulator.	Visibility and awareness	Establishing rapport with regulated entities on an ongoing basis	Maintaining existing Memoranda of Understanding: 80% of meetings scheduled and held
Outcome 5: Good governance and ethical leadership	Through the review, updating, development and implementation of policies, strategies and standard operating procedures for the Office of the CEO, Office of the CFO, Information Communication and Technology (ICT), Human Resources (HR), Finance, and Legal support sub-programmes, the effectiveness and efficiency of the organisation will be improved. CMS will promote ethical and effective leadership through training, policies and incentivisation.	Consistently improved audit outcomes towards a Clean Audit Fraud, corruption and consequence management cases	Unqualified audit outcomes since inception	Unqualified audit outcome, with a gradual improvement in audit outcomes and the achievement of a clean audit by 2026/2027
			1 Council-approved funding model	5
			5 Council-approved annual budgets	5
			99% network uptime	95%
			Zero (0) IT security incidents (breaches) on our Firewalls	<5%
			2 successful IT Disaster Recovery tests.	Ten (10)

OUTCOME	OUTCOME STATEMENT	OUTCOME INDICATOR	BASELINE	FIVE-YEAR TARGET
			2 successful Backups Testing	Ten (10)
			60% ICT Engagements to enable Digital Transformation and mature the Digital Culture of CMS	60% of total respondents are satisfied overall
			60% completion of prioritised projects as per budget availability to: Modernise the ICT applications portfolio by delivering on the prioritised projects per the ICT Digital Strategy	60%
			4 ICT Policies reviewed and implemented	20
			100% of written and verbal legal opinions provided to internal and external stakeholders were attended to within 14 days	100%
			100% of court and tribunal appearances in legal matters received and action initiated by the sub-programme within 14 days as determined by specific dispute resolution structure's directives	100%
			Staff turnover rate kept at less than 15% per annum	<15%
			Vacant funded post (excluding the position of CEO and Executives) filled within 86 working days.	90% of vacant funded post (excluding the position of CEO and Executives) filled within 90 working days.
			100% of employees' performance agreements are signed by the 31 st of May each year	95%
			97% of employees' performance assessments concluded bi-annually.	95%
			51 stakeholder awareness activities were conducted.	250
			One (1) CMS Annual Report must be submitted to the Executive Authority by 31 st August.	5
			20% of Council and Committee meeting packs to be circulated at least 7 days before the meeting (Excluding Special Meetings)	80%

OUTCOME	OUTCOME STATEMENT	OUTCOME INDICATOR	BASELINE	FIVE-YEAR TARGET
			90% of Minutes of Council and Committee meetings to be included in the meeting pack of the subsequent meeting	80%.
			100% of Communicated Council resolutions within 3 days of the meeting to the affected internal stakeholders	100%
			1 training session held for Council and/or Committee/s	10
			86% of signed annual declaration of financial interest by Council Members (excluding Council Members out of office on extended absence)	90%
			75% of rulings of the Appeals Committee and the Appeal Board published within 14 days of receipt from the Presiding Officers	100%
			Percentage of MoUs signed and or maintained	80%
			Ensure the Review and Development of a Strategic Plan and Annual Performance Plan is done for Council's consideration by the 31st January each year	5
			Ensure the overall performance of the entity is 80% and above of the predetermined objectives	80%
			Ensure that an Annual Performance Information report produced is reliable, accurate and complete by the 31st July each year in line with the statutory requirements	5
Outcome 6: Conducting policy-driven research,	The refocussing of our research efforts and aligning them with the		A total of 17 research projects were completed in 2023/24	60

OUTCOME	OUTCOME STATEMENT	OUTCOME INDICATOR	BASELINE	FIVE-YEAR TARGET
monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry	policy developments in the public and private health sectors will ensure that this Outcome is achieved. There will be a need to reprioritise the outputs of the Research and Monitoring, as well as the Strategy office programmes to gain synergies on the one hand and avoid duplications, on the other hand. These research efforts should through partnership with other research institutions support both internal and external stakeholders in understanding the strategic trajectory of the CMS.	Knowledge and thought leadership generation and dissemination	One non-financial report was submitted for inclusion in the Industry Report in 2023/24	5

20. Key Risks and Mitigation

The 2024 Institute of Risk Management South Africa (IRMSA) Risk Report, released in July 2024, provides an overview of the key risks facing South Africa. These strategic risks are depicted in *Figure 11* below:



Figure 11: Key Risks facing South Africa from the IRMSA Risk Report 2024

On the international level, the Global Risks Report 2024 shows the top global risks (in *Figure 8* below) from the World Economic Forum (WEF) which monitors critical global risks facing economies and societies. This is intended to support readiness and resilience to the next global shock and proves helpful to CMS in its strategic planning.

With increasing complexity, uncertainty, and fragmentation, global risk foresight is more important than ever. The Global Risks Report is the leading benchmark for global risks, playing a crucial role in strategic decision-making for almost two decades.

Illustrated (*Figure 8*) below is an extract from the Global Risks Report 2024.

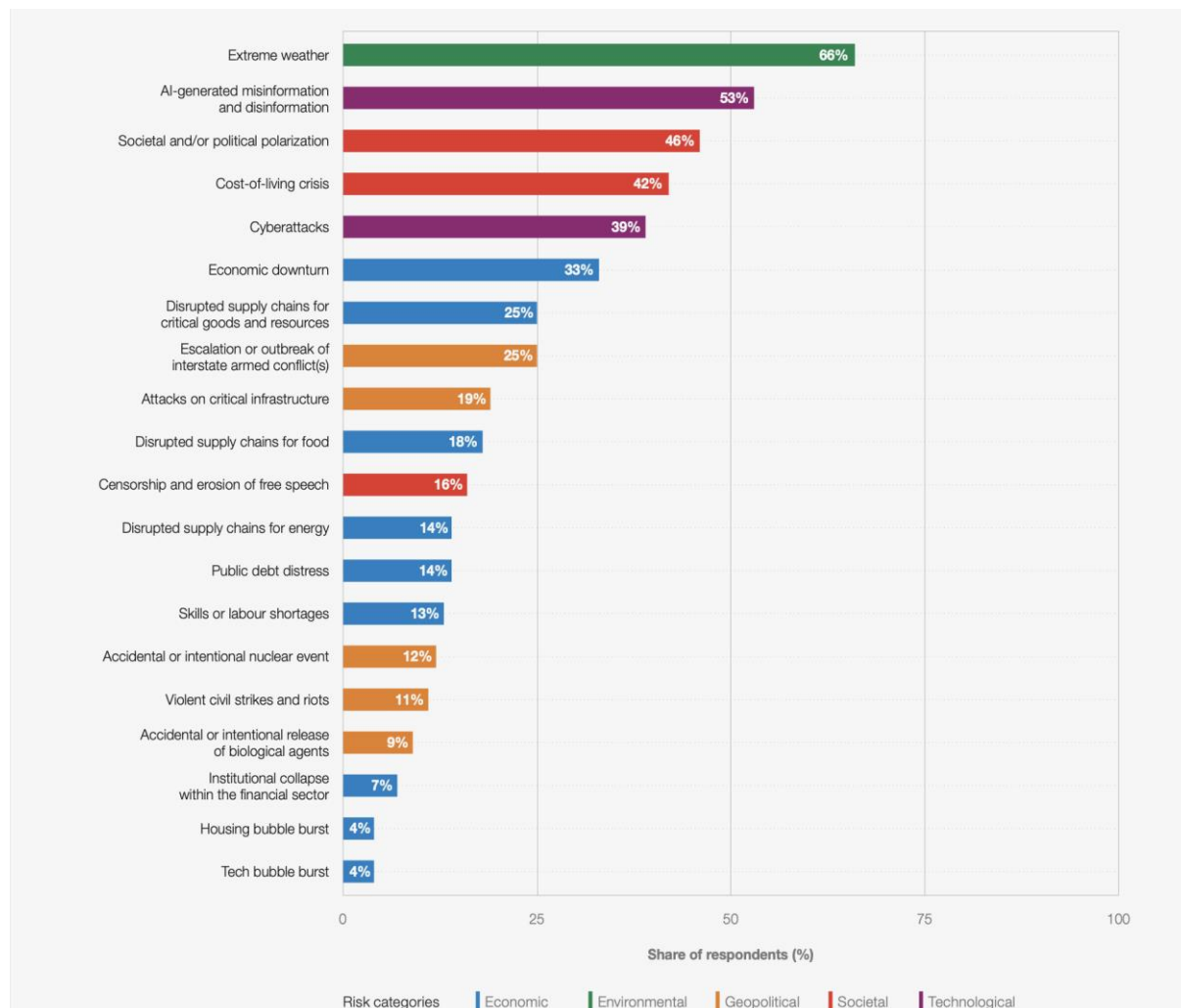


Figure 12: Extract from the Global Risks Report 2024

Benchmarked against the Global Risks Report 2024, the IRMSA Risk Report 2024 and the Situational Analysis in this Strategic Plan, CMS encounters a variety of macro-environmental strategic risks that may impact on the achievement of its Strategic Outcomes (Goals) as it navigates the complexities of regulating the medical schemes industry to protect the interests of members.

These strategic risks consider elements of a typical PESTEL in strategic planning, namely: (P)olitical, (E)conomic and (S)ocial factors, added to (T)echnological advancements, and (E)nvironmental and (L)egal/Regulatory challenges.

CMS faces the following strategic risks (identified at the Council Strategic Planning workshop – 17 January 2025:

The CMS will ensure that the risks associated with these factors affecting its ability to achieve its strategic objectives are understood, and that dynamic risk mitigation plans are in place to mitigate them.

Table 10 below outlines the Strategic Outcomes, key (strategic) risks and corresponding risk mitigation measures.

Table 10: Strategic Outcomes, Key Risks and corresponding Risk Mitigation measure

Strategic Outcome	Risk Name	Risk Response (Mitigation and Control)
1: Regulating entities in compliance with National Policy, the Medical Schemes Act and other legislation	• NHI	• Potential for CMS to play a developmental, advisory role that draws from its own lessons learned • Development of a CMS internal NHI task team • Securing clearer definition of the role of CMS from key stakeholders • Enhanced lobbying for CMS to play an integral, more critical role in the implementation of NHI • Enhanced stakeholder engagement
	• FSRA (Financial Services Regulatory Authority Act) and the Conduct of Financial Institutions (COFI) Bill	• Amplification, including clearer articulation, of the CMS position and the strategic risks to NDoH and National Treasury • Active updates to the Minister of Health • Lobbying and advocacy
2: To promote access to quality, cost-effective, and affordable private healthcare financing and related healthcare	• Business continuity and sustainability	• Standardisation and simplification of benefit options • Investment in technology
	• Amendments to legislation and regulations, in particular the Medical Schemes Act (MSA)	• Closer monitoring of the increase in Scheme tariffs • Continued lobbying for simplified legislation • Enhanced public awareness programmes • Increased lobbying in supply-side negotiation forums
3: To encourage risk pooling and innovation for the effective functioning of the private healthcare financing sector	• Fragmentation of the medical schemes industry risk pool	• Standardised benefit options • Consistency of medical scheme rules with MSA • Cross subsidisation and solidarity • Enablement of innovative benefit design • Lobbying for expediting regulatory reforms • Supporting implementation of HMI recommendations
4: Stakeholder engagement at local, regional and international level	• Negative perceptions • Litigation	• Innovative stakeholder classification and engagement • Central repository stakeholder database • Roadshows • Improved content for stakeholder engagement • Online portal • Resourcing • Finalisation of communication strategy
5: Good governance and ethical leadership	• Reduction in the fiscus • Levies Act	• Effective finance and procurement policies. • Proper budgeting. • Effective and efficient cashflow management. • EMC oversight on financial matters. • Alternative revenue streams • Increased lobbying and advocacy • Integration and efficient application of resources
	• Aged IT systems • IT Governance	• Advocacy for increase in funding and capacity • Upskilling current resources • Enhanced innovation and utilisation of current resources
	• Litigation	• Enhanced Alternative Dispute Resolution (ADR) • Internal capacitation • Enhanced integration of internal resources to limit the risk of litigation • Pro-active stakeholder engagement
6: Conducting policy-driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to Health Ministry	• Uninformed decision-making	• Enhanced communication, awareness and visibility • Improved internal coordination • Enhanced quality assurance • Position CMS as an innovation hub

21. Public Entities

Not applicable.

22. Part D: Technical indicator descriptions

Programme 1: Administration

Sub-Programme 1.1 (CEO and Registrar)

Indicator Title	1.1 Percentage of MoUs signed and or maintained
Definition	The establishment of formalised agreements, attendance of regular meetings and scheduled visits to local, regional and international regulatory authorities will ensure that the CMS is recognised by key regulators as an effective and efficient sector regulator.
Source of data	Meetings register
Method of calculation or assessment	Verification of filed MoU's with Legal, and filling of meeting registers within the Office of the Registrar
Assumptions	Availability of resources
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	80% of MoU's signed and or maintained, and 80% of meetings scheduled and held
Indicator Owner	Registrar & CE
Indicator Updater	Office of the CE

Indicator Title	2.1.Ensure that the Review and Development of a Strategic Plan and Annual Performance Plan is done for Council's consideration by the 31st January each year
Definition	Guide the review and development process of the Strategic Plan and Performance Plan
Source 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 or assessment	Approved SP and APP (Whichever is applicable) by the Executive Authority
Assumptions	National Health Policy and Legislative reforms will have a direct impact on CMS structure and performance
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	The Strategic Plan and Annual Performance Plan that is approved by the Executive Authority
Indicator Owner	Registrar & CE
Indicator Updater	Office of the CE

Indicator Title	2.2. Ensure that the overall performance of the entity is 80% and above of the predetermined objectives
Definition	Overall Organisation Performance
Source of data	Combined Assurance framework with included Internal Audit
Method of calculation or assessment	Number of Achieved targets for the period under review/Number of applicable targets for the period under review *100
Assumptions	National Health Policy and Legislative reforms will have a direct impact on CMS structure and performance
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	≥80%
Indicator Owner	Registrar & CE
Indicator Updater	Office of the CE

Indicator Title	2.3 Ensure that an Annual Performance Information report produced is reliable, accurate and complete by 31 July each year in line with the statutory requirements.
Definition	To ensure that CMS operates in line with their approved plans.
Source of data	An audit opinion letter issued by the Auditor-General South Africa on 31 July of each year. This is saved on M-Files/OneDrive under CMS Vault folder Performance information audit evidence. The opinion on the audit of reported information will be included in the management report.
Method of calculation or assessment	Consider the audit opinion letter issued by Auditor-General South Africa by 31 July.
Assumptions	The number of submissions and sign-offs of the report will be affected by National Elections
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	An annual performance information report that is reliable, accurate and complete with no material findings by the Auditor-General.
Indicator Owner	Registrar & CE
Indicator Updater	Office of the CE

Sub-programme: 1.2 Chief Financial Officer

Indicator Title	3.1 Audit Outcome
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
Source 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 the CMS Annual Report
Method of calculation or assessment	Performance is assessed by evaluation of audit opinion obtained
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 (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	Unqualified audit opinion, with gradual improvement of the audit outcome and attainment of a clean audit opinion by 2026/27
Indicator Owner	Chief Financial Officer
Indicator Updater	Chief Financial Officer

Indicator Title	4.1 Review, develop and implement a funding model that considers the long-term strategic outcomes of the CMS by end of each year
Definition	Review, development and implementation of a funding model that is fit for the purpose
Source of data	The strategic direction of CMS as per Strategic plan, MSA and Regulations, PFMA
Method of calculation or assessment	Performance is assessed by evaluation of the Council-approved CMS funding model
Assumptions	Economic stability and non-deteriorative ability towards Medical Schemes contribution
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	5 (1 per annum)
Indicator Owner	Chief Financial Officer
Indicator Updater	Chief Financial Officer

Indicator Title	4.2 Produce a budget for approval by Council by the 31st of January each year
Definition	This means that CMS operates in line with its approved budget that is in line with the strategy
Source of data	To ensure that Council achieves its objectives as set out in the strategic and annual performance plans for the year.
Method of calculation or assessment	Consider Council resolution for approval of the budget by 31 January each year.
Assumptions	Final submission date as prescribed – 31 January each year Approval is received and timing of such from both the Minister of Health and the Minister of Finance on levy increase may affect the budget. The budget may change depending on the assessment by the Executive Authority and National Treasury
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	5 (1 Annually)
Indicator Owner	Chief Financial Officer
Indicator Updater	Chief Financial Officer

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

Indicator Title	5.1 Percentage of network uptime.
Definition	This indicator measures the percentage of network uptime reported over a period. The more network incidents reported during the year, the 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: $((365 - \text{Incidents})/365) * 100.$ $\text{Q1: } (91 - \text{Incidents}) / 91) * 100.$ $\text{Q2: } (92 - \text{Incidents}) / 92) * 100.$ $\text{Q3: } (91 - \text{Incidents}) / 91) * 100.$ $\text{Q4: } (91 - \text{Incidents}) / 91) * 100.$
Source 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 or 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: $((365 - \text{Incidents})/365) * 100.$ $\text{Q1: } (91 - \text{Incidents}) / 91) * 100.$ $\text{Q2: } (92 - \text{Incidents}) / 92) * 100.$ $\text{Q3: } (92 - \text{Incidents}) / 92) * 100.$ $\text{Q4: } (91 - \text{Incidents}) / 91) * 100.$
Assumptions	The assumption has taken into account all the identified operational risks
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	95% network uptime per annum
Indicator Owner	Chief Information Officer
Indicator Updater	Chief Information Officer

Indicator Title	5.2 Percentage of IT security incidents (Breaches) On our Firewalls.
Definition	This indicator measures the percentage of IT security events reported over a period. The more security incidents reported during the year, the more the percentage of incidents (Security Incidents/365 * 100). These security incidents include successful external penetration attempts through the CMS firewall as well as attempts internally by both staff as well as visitors to access information that they are not entitled to access. This indicator does not consider planned penetration attempts as part of annual security audits performed. These planned penetration attempts will be recorded separately as part of the IT Change Management process on the document management system. Days: 1 day equals 24 hours, includes working and non-working hours, therefore on conversion from hours to days, the formula is (number of hours of the incident/24) Incidents: The number of security incidents calculated in days. These do not include planned attempts. Formula: (Security incidents/days) multiplied by 100. Annual: (Security incidents/365) * 100. Q1: (Security incidents) / 91) * 100. Q2: (Security incidents) / 92) * 100. Q3: (Security incidents) / 92) * 100. Q4: (Security incidents) / 91) * 100.
Source of data	Firewall security incidents reports are submitted monthly to CMS by the Service Provider. Data is collected by the Network Manager.
Method of calculation or 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
Assumptions	• Cybersecurity Threats from external hackers • Data breach from internal personnel • POPIA; and • Lack of proper monitoring tools and budget for implementing the Cybersecurity plan will all affect the target
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	<5%
Indicator Owner	Chief Information Officer
Indicator Updater	Chief Information Officer

Indicator Title	5.3 Number of successful IT Disaster Recovery (DR) tests.
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.
Source of data	Externally issued Disaster Recovery Certificate.
Method of calculation or assessment	Counting of externally issued DR Certificate(s).
Assumptions	Backup tapes corrupted; and Lack of resources will affect the target
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	10 (2 annually)
Indicator Owner	Chief Information Officer
Indicator Updater	Chief Information Officer

Indicator Title	5.4 Number of Successful Backups Tested.
Definition	This tests the backups that occur weekly at CMS on the network and critical business applications
Source of data	System & network reports
Method of calculation or assessment	Automated reports from network tests and system tests • Network backup report on network testing • System backup report on backup testing per system/s
Assumptions	Backups and network testing is operable
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	10 (2 annually)
Indicator Owner	Chief Information Officer
Indicator Updater	Chief Information Officer

Indicator Title	5.5 ICT Engagement to Enable Digital Transformation and Mature the Digital Culture of CMS.
Definition	This indicator is to measure how IT is enabling Digital Transformation and improving the Digital Culture of CMS
Source of data	Survey
Method of calculation or assessment	Likert Scale Survey Designed and aggregated results calculate to satisfactory
Assumptions	ICT & KM engagement sessions will be well attended
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	60%
Indicator Owner	Chief Information Officer
Indicator Updater	Chief Information Officer

Indicator Title	6.1 Modernise the ICT Applications Portfolio per the prioritised project heatmap in the Digital Strategy of the CMS.
Definition	This indicator measures the Digital Transformation Journey per the project heatmap as defined in the ICT Digital Strategy
Source of data	Project plans
Method of calculation or assessment	Percentage completion: 60% means vendor has been appointed, and supply chain processes completed whereby scoping of the project is underway to kick off its systems development life cycle (SDLC) implementation
Assumptions	Budgets & resources will be allocated per prioritised projects on the heatmap
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	60% completion of Project
Indicator Owner	Chief Information Officer
Indicator Updater	Chief Information Officer

Indicator Title	6.2 Design and implement ICT Governance per ICT Policies
Definition	ICT governance is a “framework for the leadership, organizational structures and business processes, standards and compliance to these standards, which ensure that the organisation's IT supports and enables the achievement of its strategies and objectives”.
Source of data	Policies approved per ITGC Governance Committee recommendations to the Board
Method of calculation or assessment	Number of ICT policies recommended per ICTGC Governance committee to the Board These policies include, per the ICT Policy Framework: - ICT Demand Management Policy - ICT Project Management Policy - ICT Acceptable Use Policy for End Users/Staff - ICT Asset Management Policy - ICT Software and Applications Management Policy (which will include freeze periods and release and deploy scheduling for the year) - ICT Access Management Policy - ICT Change Management Policy - ICT Backups, Disaster Recovery and Failover Policy (for business continuity) - ICT Network Policy - ICT Cloud Policy - ICT Cybersecurity Policy - ICT Information Classification Policy - ICT Risk Management Policy - ICT Vendor Management Policy (this will include SLA, OLA, ULA and Contract Management)
Assumptions	All IT policies taken to ITGC Governance committee will be approved
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	20 (4 annually)
Indicator Owner	Chief Information Officer
Indicator Updater	Chief Information Officer

Outcome 5: Good governance and ethical leadership
Sub-programme 1.4: Corporate Services

Indicator Title	7.1 Percentage of written and verbal legal opinions provided to internal and external stakeholders, attended to within 14 days.
Definition	Render prompt internal, reliable written and verbal legal opinions and representations to the Council and other business units instead of soliciting external legal opinions. The Unit provides legal opinions to internal stakeholders (that is, the Council and business units of the CMS) and external stakeholders (anyone who writes to the office and enquires about the medical schemes industry and the laws that govern it). In this instance, we express an opinion on the law relating to the MSA.
Source of data	All written and verbal legal opinions are registered electronically on M-Files. A dedicated email address is 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 or assessment	Written and verbal legal opinions provided to internal and external stakeholders attended to within 14 days DIVIDED BY Total number of requests for legal opinions received from internal and external stakeholders X100
Assumptions	Functional legal system
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	100%
Indicator Owner	Executive: Corporate services
Indicator Updater	Senior Manager: Legal Service

Indicator Title	8.1 Percentage of court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days.
Definition	Take responsibility for litigation against the Registrar and the Council to enforce the Medical Schemes Act (1998).
Source 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 or assessment	Court and tribunal appearances in legal matters received and action initiated by the Unit within 14 days DIVIDED total number of matters received x 100
Assumptions	• Functional legal system • Existence of a Litigious environment
Disaggregation of beneficiaries (where applicable)	Not applicable.
Spatial Transformation (where applicable)	Not applicable.
Desired Performance	100%
Indicator Owner	Executive: Corporate services
Indicator Updater	Senior Manager: Legal Service

Indicator Title	9.1 Percentage staff turnover rate per annum
Definition	The percentage rate at which an employer attracts and loses employees.
Source of data	Excel spreadsheet. List of staff members as per succession planning framework.
Method of calculation or 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. $2/20 \times 100 = XX$).
Assumptions	The assumption is that HR will retain the 10% staff turnover rate based on previous years' experience.
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	<15
Indicator Owner	Executive: Corporate Services
Indicator Updater	Senior Manager: Human Resources

Indicator Title	9.2 Percentage of vacancies filled within 90 working days of the vacancy existing
Definition	Time spent filling a vacancy.
Source of data	Approved and funded positions. Termination and appointment letters. Excel spreadsheet with the number of employees.
Method of calculation or assessment	Existing positions: count the number of working days from the date of advertisement to the date a job offer is made (letter of appointment) (a vacancy should not take more than 90 working days to fill) New positions: The number of days from the date of advertisement of the new position or approval of the budget should be no more than 90 working days. Vacancies that arise in the previous financial year will be carried over into the new financial year; this will be the actual number of days taken to fill the vacancy, irrespective of the financial year, from the date it was advertised to the date a job offer is made. Exclusion: The positions of Registrar/CEO & Executives. The positions of Executives are subject to Council and processes
Assumptions	The assumption is that HR will retain the 90 working days turnaround target to fill the vacancy based on previous trends. Decision on unfunded posts.
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	90%
Indicator Owner	Executive: Corporate Services
Indicator Updater	Senior Manager: Human Resources

Indicator Title	10.1 Percentage of employee performance agreements are signed by no later than 31 May of each year.
Definition	Employee performance agreements signed by each employee to ensure achievement of CMS's objectives for the year.
Source of data	Performance agreement and performance appraisal document agreed and signed between staff and line managers
Method of calculation or assessment	Count the number of performance contracts signed by 31 May of each year and divide by the total number of employees
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 (where applicable)	All employees in the office during the quarter under review.
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	95%
Indicator Owner	Executive: Corporate Services
Indicator Updater	Senior Manager: Human Resources

Indicator Title	10.2 Percentage of employee performance assessments concluded, bi-annually.
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
Source of data	Performance agreements and performance review documents agreed between employee and line managers. The bi-annual assessments are conducted and finalised by October and April of each year. The target for quarter 1 will be the assessments concluded for the previous financial year. The target for quarter 3 will be the assessments concluded for the first half of the current year.
Method of calculation or assessment	Number of all performance contracts signed by employees / Number of employees legible to participate in the appraisal cycle x100. Only employees in the employment of CMS for at least a period on 9 months are eligible to participate in the performance assessment and rewards. Employees employed for less than 9 months (by the second assessment period) are considered too new to be assessed. Employees who resign during the first performance assessment cycle will not be considered for bonuses. However, those who resign during the second assessment cycle, and have completed a full 12 months of service, will be eligible for consideration. Their performance bonuses will be pro-rated accordingly.
Assumptions	The assumption is that HR will achieve the 95% target of signed performance agreements by all employees in office during the period under review, except in exceptional circumstances where there are disputes underway. 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 (where applicable)	All employees in the office during the quarter under review.
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	All employees are assessed as per HR schedule
Indicator Owner	Executive: Corporate Services
Indicator Updater	Senior Manager: Human Resources

Indicator Title	11.1 Number of stakeholder awareness activities conducted.
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 summits and conferences; Principal Officer Forums; • Publications (CMS News and CMScripts).
Source of data	Media engagement: Newspaper adverts will be kept. Advertorials (the content of advertorial will be kept). Content production (media monitoring reports will be used to show media coverage on the CMS). Stakeholder engagement: Exhibitions (letter from the host for exhibitions). CMS-hosted summit and conference (attendance register or list of delegate report), Principal Officer forums (attendance registers and agendas). Publications (CMS News and CMScripts copies of the publication will be kept).
Method of calculation or assessment	Sum of stakeholder activities undertaken for the period.
Assumptions	That budget for the listed activities is available.
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	175 (35 annually)
Indicator Owner	Executive: Corporate Service
Indicator Updater	Senior Manager: Communication Marketing & SHR

Indicator Title	12.1 Number of CMS Annual Reports submitted to the Executive Authority by 31 August.
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.
Source of data	The information contained in the CMS Annual Report is sourced internally from the respective business units-based performance against targets set out in the APP. The information in the industry section of the annual report is sourced by the respective business units from the medical schemes, analysed and repackaged for inclusion in the report.
Method of calculation or 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
Assumptions	That all contributing documents, such as the Auditor-General's Report will be completed and approved by 31 August.
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	5 (1 per annum)
Indicator Owner	Executive: Corporate Service

Indicator Updater	Manager: Communication
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Sub-programme 1.5 Council Secretariat

Indicator Title	13.1 Council meeting packs to be circulated at least 7 days before the meeting (Excluding Special Meetings).
Definition	This indicator measures the timeous delivery of information packs to the Council for quarterly meetings
Source of data	Council and committee meetings packs and minutes
Method of calculation or assessment	The review takes place quarterly, and the calculations are based on the number of days the information pack was received by the Council and committee prior to the meeting and are divided by 7
Assumptions	Management will submit the information pockets from the governance committees within 9 days before the Council meeting.
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	80%
Indicator Owner	Council Secretariat
Indicator Updater	Council Secretariat

Indicator Title	13.2 Minutes of Council and Committee meetings to be included in the meeting pack of the subsequent meeting.
Definition	This indicator measures the timeous submission of meeting minutes to the Council
Source of data	Council and committee minutes
Method of calculation or assessment	Number of Council and committee minutes submitted in respect of ordinary quarterly meetings
Assumptions	Council and committee will have meetings
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	80%
Indicator Owner	Council Secretariat
Indicator Updater	Council Secretariat

Indicator Title	13.3 Percentage of Communicated Council resolutions within 3 days of the meeting to the affected internal stakeholders.
Definition	This indicator measures the support given to the execution of the decisions and resolutions and matters arising from Council and Sub-Committee meetings.
Source of data	Council & Sub-Committee standing agenda and minutes derived from Council & Sub-Committee charters; Minutes; Resolution register; Communiques of Council Resolutions to the relevant executive managers; Matters arising action lists; Feedback reports at each Council meeting for past and outstanding resolutions and matters arising;
Method of calculation or assessment	Actual communication of rulings to relevant stakeholders is matched with the resolutions made by the Council or the relevant Committee.
Assumptions	Not applicable.
Disaggregation of beneficiaries (where applicable)	Not applicable.
Spatial Transformation (where applicable)	Not applicable.
Desired Performance	90%
Indicator Owner	Council Secretariat
Indicator Updater	Council Secretariat

Indicator Title	13.4 Number of training sessions held for Council and/or Committee/s.
Definition	This indicator measures the training and development of the Accounting Authority.
Source of data	Training Attendance Register or Training Certificates.
Method of calculation or assessment	Consider 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 (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	10 (2 per annum)
Indicator Owner	Council Secretariat
Indicator Updater	Council Secretariat

Indicator Title	13.5 Percentage of signed annual declaration of financial interest by Council Members (excluding Council Members out of office on extended absence)..
Definition	To declare and manage conflict of interests.
Source of data	Declaration of interest forms completed by Council members.
Method of calculation or assessment	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).
Assumptions	The assumption is that some Council members might be on extended leave during the period under review, and their forms will be submitted as soon as they are available.
Disaggregation of beneficiaries (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	90%
Indicator Owner	Council Secretariat
Indicator Updater	Council Secretariat

Indicator Title	14.1 Support the publication of rulings of the Appeals Committee and the Appeal Board within 14 days of receipt from the Presiding Officers.
Definition	This indicator measures the number of rulings published once finalised by both the Appeals Committee and the Appeal Board
Source of data	Appeals Ruling as received from the presiding officer
Method of calculation or assessment	Number of rulings received/number of rulings sent for publication within 14 days*100.
Assumptions	The right to be heard on appeal is legislated. Therefore, there will always be appeals that should be adjudicated.
Disaggregation of beneficiaries (where applicable)	Not applicable.
Spatial Transformation (where applicable)	Not applicable.
Desired Performance	100%
Indicator Owner	Council Secretariat
Indicator Updater	Council Secretariat

Programme 2: Regulation

Indicator Title	15.1 Percentage of broker and broker organisation applications finalised within 30 working days on receipt of complete information.
Definition	Indicates the percentage of broker and broker organization applications (meeting the accreditation requirements) accredited within 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 five key requirements for accreditation: • Fit and proper requirements. • The qualification requirement, including qualification verifications. • The appropriate experience. • Financially sound legal entities. • License verification with FSCA Once processed, applicants are either accredited for a period of two years whilst unsuccessful applicants are notified of the findings and are provided with reasons of not being accredited. Incomplete applications remain pending for a period of six months. Thereafter, such applications expire, and application fees are forfeited.
Source of data	Applications for accreditation of brokers and brokerages are captured on the on-line accreditation system. All supporting documentation is filed on the CMS document management systems which is M-Files. The accreditation certificates are available on the accreditation system for audit purposes. A list of all accredited and non-accredited brokers and brokerages is drawn from the system.
Method of calculation or assessment	Number of valid applications accredited within 30 days after receipt of all information required and documented on the system as a percentage of the total number of applications recorded with all information to enable accreditation based on an age analysis drawn from the accreditation database. Ensure applications rolled over due to incompleteness are finalized within 30 days of receipt of all relevant information. Number of Finalised Applications/Number of Received Complete Applications*100 Ensure unsuccessful applications are responded to and reasons provided for not being accredited. Incomplete applications remain pending for a period of six months. Thereafter, expired and application fee forfeited. Each quarter's target and related output is reflected specifically for that quarter. The annual output is an aggregation of each quarter's output.
Assumptions	Brokers applying for accreditation are still actively in business. Numbers may vary according to likely acquisitions and retirements
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	85%
Indicator Owner	Executive: Regulation
Indicator Updater	Manager: Broker Accreditation.

Indicator Title	16.1 Percentage of managed care organisations and schemes providing own managed care services' applications analysis completed within three months of receipt of complete information.
Definition	Percentage of managed care organisation accreditation applications and schemes providing own managed care services' compliance certificate applications analyses completed within three months of receipt of complete information. New and renewal applications are included. Relevant information includes: • Completed accreditation application form. • Group structure. • Copies of managed care agreements with medical schemes in place. • Copies of sub-contracting agreements (where applicable). • Latest audited annual financial statements and most recent management accounts. • Tax compliance confirmation. • Copies of managed care protocols and formularies. • Proof of payment of the prescribed application fee. Additional information may be requested during the analysis of the applications. Applicants must meet the three key requirements for accreditation: • The applicant must be fit and proper. • The applicant must have the necessary systems, resources, skills, and capacity to provide the managed care services. • The applicant must be financially sound. Once the evaluations have been completed, applicants are either accredited for a period of two years, or unsuccessful applicants are informed of the reasons for non-accreditation. Schemes providing own managed care services are issued with compliance certificates, which are valid for three years if all the requirements are met in respect of the managed care services provided to members.
Source of data	Acknowledgement letter of receipt of application, Regulation Senior Management Meeting (SMM) and Regulatory Decisions Committee (RDC) minutes and accreditation/compliance certificate are available on SharePoint / OneDrive The Council Executive Committee minutes are available from the Council Secretariat. The list of accredited MCOs and self-administered schemes is available on the CMS website. Paper trail of all documents received, interacted with, and concluded on SharePoint / OneDrive
Method of calculation or assessment	Number of valid applications evaluated within 3 months of receipt divided by the total number of applications received as a percentage during the quarter. Ensure applications rolled over due to incompleteness are finalised within 3 months of receipt of all relevant information. Number of Finalised Applications/Number of Received Complete Applications*100 Ensure unsuccessful applications are responded to and reasons provided for not being accredited.
Assumptions	• Entities applying for accreditation are actively in business • Numbers may change due to acquisitions or closures
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	100%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Administrators & MCO Accreditation

Indicator Title	17.1 Percentage of administrators and self-administered schemes applications' analysis completed within three months of receipt of all relevant information.
Definition	Indicates the percentage of Administrator accreditation applications and self-administered schemes' compliance certificate applications analysed within 3 months of receipt of all relevant information. New and renewal applications are included. Relevant information includes: • Completed accreditation application form. • Group structure. • Copies of administration agreements with medical schemes in place. • Copies of sub-contracting agreements (where applicable); • Latest audited Annual Financial Statements and most recent management accounts. • Tax compliance confirmation. • Proof of payment of the prescribed application fee (third party administrators). Additional information may be requested during the analyses 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 processed, 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, which are valid for three years if all the requirements are met in respect of the administration services provided.
Source of data	Acknowledgement letter of receipt of an application, , Regulation Senior Management Meeting (SMM) and Regulatory Decisions Committee (RDC) minutes, as well as Accreditation Certificates of administrators and Certificates of Compliance for self-administered schemes are available on SharePoint / OneDrive and the CMS Website. Paper trail of all documents received, interacted with and concluded on SharePoint / OneDrive.
Method of calculation or assessment	Number of valid applications evaluated within 3 months of receipt divided by the total number of applications received as a percentage during the quarter. Ensure applications rolled over due to incompleteness are finalised within 3 months of receipt of all relevant information. Number of Finalised Applications/Number of Received Complete Applications*100 Ensure unsuccessful applications are responded to and reasons provided for not being accredited
Assumptions	• Entities applying for accreditation are actively in business • Numbers may change due to acquisitions or closures
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	100%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Administrators & MCO Accreditation

Indicator Title	18.1 Percentage of interim rule amendments processed within 30 working days of receipt of all information.
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 to ensure that rules are effective and up to date, they need to be processed with 30 working days of the receipt of all information.
Source of data	• Hardcopies of interim rule amendments submitted. • Excel spreadsheet register. • Evaluation memoranda and letters communicating the decision of the Registrar.
Method of calculation or assessment	$\frac{\text{Number of amendments processed after receipt of all information 30 working days or less}}{\text{Number of amendments received in the period under review (excluding those with outstanding information)}} * 100$ The calculation considers all rule amendment requests received from 1 April to the End of March of each financial year.
Assumptions	Adequate capacity to conduct the review interim rule amendments, ICT systems availability
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	80%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Benefits Management

Indicator Title	18.2 Percentage of annual rule amendments processed before 31 December of each year.
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.
Source of data	• Hardcopies of annual rule amendments submitted. • Excel spreadsheet register. • Evaluation memoranda and letters communicating the decision of the Registrar.
Method of calculation or assessment	$\frac{\text{Number of amendments processed by 31 December}}{\text{Number of amendments received (excluding those with outstanding information)}} * 100$
Assumptions	Adequate capacity to conduct the review of annual rule amendments, ICT systems availability
Disaggregation of beneficiaries (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	95%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Benefits Management

Indicator Title	18.3 Contributions and Benefits Changes Guidance Note published as a Circular annually.
Definition	The Contribution and Benefit Changes Guidance outlines the requirements that medical schemes must adhere to when determining the annual contribution increases and benefit changes for the relevant benefit year. One of the primary statutory mandates of the Council for Medical Schemes (CMS), as enshrined in Section 7 of the Medical Schemes Act (131 of 1998), is to always protect the interests of beneficiaries and to coordinate the functioning of medical schemes. To this end, CMS' key objective is to ensure that annual medical scheme contribution rate increases remain affordable to enable equitable access to quality healthcare and the industry's long-term financial sustainability.
Source of data	CMS Circulars on the CMS Website
Method of calculation or assessment	Simple count
Assumptions	Consumer Price Index (CPI) data published by Stats SA; Inflation forecast data for the following benefit year, published by the South African Reserve Bank, Monetary Policy Committee (MPC); Global and Domestic macroeconomic analysis conducted by CMS Policy Research Monitoring; Single Exit Price data published by the Pricing Committee of the National Department of Health; Employment Statistics (Labour Force Survey) published by Stats SA.; Medical Schemes utilisation assumption analysis done by CMS Policy Research Monitoring; Document editing work done by CMS Communication and Stakeholder Relation; Publishing done by CMS IT.
Disaggregation of beneficiaries (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	5 (1 annually)
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Benefits Management

Indicator Title	18.4 Number of Model Rules reviewed and published.
Definition	The model rules serve as a guide for stakeholders in complying with the Act, its regulations, common law provisions, sound corporate governance practices, and various internal policy decisions, which provide practical clarity on matters affecting the scheme-member relationship. The primary goal is to establish a uniform set of logical principles that regulate the medical scheme's legal relationship with its members.
Source of data	Approved Model Rules published on the CMS website
Method of calculation or assessment	Simple count
Assumptions	Adequate capacity to conduct the review of the Model Rules, Functional Rules Task Team, ICT systems availability
Disaggregation of beneficiaries (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	5 (1 Annually)
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Benefits Management

Indicator Title	19.1 Percentage of routine inspections conducted and draft reports issued, as identified through the risk-based approach framework.
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.
Source of data	Routine inspection in terms of Section 44(4)(b) : _____ • Memorandum signed by the registrar approving the number of routine inspections to be conducted for the year (the initial stage of inspection). • Count the appointment letters to the appointed investigator (the initial stage of the inspection). • Number of draft inspection reports issued to schemes following the conclusion of the routine inspections
Method of calculation or assessment	The sum of the appointment letters issued / The number of routine inspections as per the Registrar's approved memo. The calculation considers all inspections conducted from 1 April to end of March of each year, excluding those with outstanding information Excludes routine inspections with • outstanding information; • under any form of legal review (Appeals Committee or Appeal Board or Court process)
Assumptions	The assumption are that all identified I risks have been taken into account in determining the schemes to be subjected to routine inspections for the year. .
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	80%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Compliance and Investigations

Indicator Title	20.1 Percentage of warranted commissioned inspections initiated and draft reports issued to affected entities during the year.
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 identified..
Source of data	The Unit cannot predict the number of commissioned inspections in terms of Section 44(4)(a) that will be required to be carried out in any given year. Commissioned inspections are based on information received or uncovered through various sources which could include tip-offs, referrals or irregularities suspected. The Unit uses the appointment letters of the investigators as evidence for this indicator. The appointment letters are signed by the Registrar. Commissioned inspections can exceed a reporting period, and it is difficult to anticipate the duration of such an inspection. Count appointment letters to the appointed investigator (the initial stage of the inspection).
Method of calculation or assessment	Sum of draft commissioned inspections issued to affected entities during the year Number of warranted inspections identified through tip-offs, referrals and or irregularities suspected /received*100. The calculation takes into account all inspections initiated from 1 April to the end of March of each financial year. Excludes commissioned inspections with - outstanding information. - under any form of legal review (Appeals Committee or Appeal Board or Court process
Assumptions	The assumption is that all identified suspected/reported irregularities or non-compliance have been evaluated and commissioned inspections initiated where warranted
Disaggregation of beneficiaries (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	80%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Compliance and Investigations

Indicator Title	21.1 Percentage of enforcement actions Initiated during the period.
Definition	When schemes or insured entities are found to be non-compliant with the Medical Schemes Act (1998), the unit will initiate the following enforcement actions (other than inspections): conduct an enquiry, impose penalties, request insurance entities to apply for demarcation exemption, or issue directives to schemes to enforce compliance.
Source of data	Below are measures for possible non-compliance cases that could lead to enforcement actions being initiated:: • <u>Section 43 enquiry</u>: count the letters sent to the scheme requesting information in relation to any matter connected with the business or transactions of the medical scheme.. • <u>Section 45 enquiry</u> counts the correspondence (letters or email) sent to the person requesting information to conduct the business of a medical scheme without due registration. • <u>Penalties in terms of Section 66(3)</u>: count the letter sent to the scheme imposing the penalty). • <u>Directives</u>: count the letter sent to the scheme enforcing compliance with a directive. • <u>Demarcation exemptions</u>: count the exemption letter issued to insured entities communicating the result of an application.
Method of calculation or assessment	Sum of enforcement actions initiated (count the number of letters sent to entities on non-compliance/enforcement cases)/ Number of valid non-compliance incidents recorded*100.
Assumptions	Section 45 enquiry counts the correspondence (letters or email) sent to the person requesting information to conduct the business of a medical scheme without due registration.
Disaggregation of beneficiaries (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	80%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Compliance and Investigations

Indicator Title	22.1 Percentage of governance interventions initiated during the period
Definition	This indicator is intended to show how many forms of governance intervention were initiated against medical schemes and other regulated entities.
Source of data	Below are measures for possible interventions that could be undertaken: • Curatorship monitoring: count the number of meetings scheduled per quarter 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. • Exemptions in terms of Section 8(h) (excluding those of a financial nature): Count the number of exemption letters sent to schemes communicating the result of an application.
Method of calculation or assessment	Sum of governance interventions undertaken/Sum of governance transgressions identified*100
Assumptions	Non-Compliance with the Act at Medical schemes may occur due to misinterpretation or non-adherence to the Act;
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	80%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Compliance and Investigations

Indicator Title	22.2 Percentage of scheme member meetings attended (including virtual meetings) as identified through the risk-based approach framework.
Definition	Monitor and observe scheme member meetings and trustee elections to ensure compliance with the Medical Schemes Act (1998) and scheme rules and that improved member participation is encouraged. This indicator is intended to show the process which the sub-programme undertakes to monitor the scheme meetings. (AGM, SGM and trustee elections, including virtual meetings)) from the submission of scheme notification to the CMS, to the participation of the sub-programme at scheme meetings as observers of the proceedings. The meetings attended can be convened in person or virtually. Meetings to be attended are identified through the risk-based approach framework.
Source of data	Meetings attended: • Annual General Meetings, Special General Meetings and Elections of Trustee Meetings: • notification submission to the CMS • Reports issued post attendance of meetings
Method of calculation or assessment	Sum of member meetings attended quarterly (count the number of reports produced from attendance of meetings) /number of meetings identified through the risk-based approach framework and notices received.
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 (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	85%
Indicator Owner	Executive: Regulation

Indicator Updater	Senior Manager: Compliance and Investigations
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Indicator Title	23.1 Percentage of business plan decisions processed in respect of Regulation 29.
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.
Source of data	The business plan is counted when a business plan is either approved/rejected by the Senior Management Committee. Content Management System on OneDrive – FSU folder. Medical schemes submit financial information as part of the CMS Early Warning System; from which analysis is undertaken to determine the cases requiring regulatory intervention. Further, the Act requires medical schemes to notify the Registrar of the nature and courses of failure (business plan) should they not be in compliance with Regulation 29. The business plan is analysed, and a recommendation made for approval/rejection.
Method of calculation or assessment	Number of business plans processed / number of business plans received*100. Where there are no Schemes fitting the category of below 25% solvency, the assumption is that the target is not applicable.
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 (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	100%
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Financial Supervision

Indicator Title	23.2 Number of financial sections prepared for the Annual Industry Report.
Definition	This indicator measures the number of financial sections prepared in respect of the annual industry report. The Annual Financial Statements of schemes are analysed, and a consolidated report is prepared as part of the annual industry report in the CMS Annual Report.
Source of data	Financial sections of the annual report submitted for inclusion in the annual industry report. Publication of the Annual Industry Report on the CMS website.
Method of calculation or assessment	A simple count
Assumptions	One financial section of the annual industry report will be submitted for inclusion in the annual industry report.
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	5 (1 annually)
Indicator Owner	Executive: Regulation
Indicator Updater	Senior Manager: Financial Supervision

Indicator Title	24.1 Number of stakeholder education and training sessions.
Definition	To effectively educate and train stakeholders to understand their relevant roles and responsibilities in the medical scheme environment.
Source 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 or assessment	A simple count of the number of sessions held through source documents filed.
Assumptions	That budget for the listed activities is available.
Disaggregation of beneficiaries (where applicable)	Not Applicable.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	300 (60 per annum)
Indicator Owner	Executive: Member protection
Indicator Updater	Manager: Education & Training

Indicator Title	25.1 Percentage of customer care interventions resulting from calls, e-mailed queries and walk-in consultations handled by the customer care centre.
Definition	To effectively handle telephone enquiries and queries from beneficiaries of medical schemes.
Source of data	System generated reports and manual recording of walk-ins
Method of calculation or assessment	To calculate the percentage of calls, e-mails and walk-ins handled vs total calls & e-mails and walk-ins received.
Assumptions	That budget for the listed activities is available.
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	85%
Indicator Owner	Executive: Member protection
Indicator Updater	Manager: Customer care

Indicator Title	26.1 Percentage of complaints older than 120 calendar days adjudicated during the reporting period in accordance with complaints standard operating procedures (SOP).
Definition	As per the provisions of section 47 (2) of the Medical Schemes Act (1998), complaints must be resolved as soon as possible after receipt of comments from parties complained against or referred to the Council for resolution if they cannot be resolved by the Registrar's Office. The sub-programme determined its own turnaround time of 120 calendar days as none is provided for in the legislation. This output indicator enables active reporting of complaints that may have aged beyond 120 calendar days during the reporting period.
Source of data	CMS Complaints Adjudication IT system (database)
Method of calculation or assessment	Number of resolved complaints older than 120 calendar days divided by Total number of complaints older than 120 calendar days x 100 Complaints are received daily and logged onto the complaints database. The sub-programme starts counting the 120 calendar days from the day a response is received from the regulated entity, therefore the targets are determined based on complaints resolved from the date of receipt of responses from regulated entities. When a decision on a complaint is made, the complaint is closed on the system and that particular complaint is considered resolved.
Assumptions	Complaints will be received continuously since resolution of member complaints is a legislated right. Complaint volumes and levels of complexity cannot be predetermined, and a functional M-files and complaints system is a key requirement for target achievement.
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	75%
Indicator Owner	Executive: Member Protection
Indicator Updater	Senior Manager: Complaints Adjudication

Indicator Title	26.2 Percentage of category 2 complaints adjudicated within 120 calendar days and in accordance with complaints standard operating procedures (SOP).
Definition	Category 2 complaints are clinically and/or legally complex, requiring extensive investigation, collation of evidence as well as secondary referral for inputs within CMS and externally. Category level can only be determined after conclusion of investigations.
Source of data	CMS Complaints Adjudication IT system (database)
Method of calculation or assessment	Category 2 resolved performance: Number of category 2 complaints resolved within 120 calendar days divided by Total number of category 2 complaints x 100 Complaints are received daily and logged onto the complaints database. The sub-programme starts counting the 120 calendar days from the day a response is received from the regulated entity, therefore the targets are determined based on complaints resolved from the date of receipt of responses from regulated entities. When a decision on a complaint is made, the complaint is closed on the system and that particular complaint is considered resolved.
Assumptions	Complaints will be received continuously since resolution of member complaints is a legislated right. Complaint volumes and levels of complexity cannot be predetermined, and a functional M-files and complaints system is a key requirement for target achievement.
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	75%
Indicator Owner	Executive: Member Protection
Indicator Updater	Senior Manager: Complaints Adjudication

Indicator Title	26.3 Percentage of category 1 complaints adjudicated within 60 calendar days and in accordance with complaints standard operating procedures (SOP).
Definition	Category 1 complaints are uncomplicated but may 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.
Source of data	CMS Complaints Adjudication IT system (database)
Method of calculation or assessment	Category 1 resolved performance: Number of category 1 complaints resolved within 60 calendar days divided by Total number of category 1 complaints x 100 Complaints are received daily and logged onto the complaints database. The sub-programme starts counting the 120 calendar days from the day a response is received from the regulated entity, therefore the targets are determined based on complaints resolved from the date of receipt of responses from regulated entities. When a decision on a complaint is made, the complaint is closed on the system and that particular complaint is considered resolved.
Assumptions	Complaints will be received continuously since resolution of member complaints is a legislated right. Complaint volumes and levels of complexity cannot be predetermined, and a functional M-files and complaints system is a key requirement for target achievement.
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	75%
Indicator Owner	Executive: Member Protection
Indicator Updater	Senior Manager: Complaints Adjudication

Indicator Title	27.1 The number of CMS Scripts published.
Definition	The number of CMS Scripts guidelines published.
Source of data	CMS Scripts guidelines are published on the CMS website
Method of calculation or assessment	Count the number of CMS Scripts guideline publications released from Clinical Consulting Services to Stakeholder Relations for publication on the CMS website. (Including revised and updated versions).
Assumptions	Availability of Resources.
Disaggregation of beneficiaries (where applicable)	CMS Scripts affecting vulnerable groups such as Women, Children, the Disabled and the Elderly will be prioritised for guidelines. High financial impact conditions such as oncology are prioritised.
Spatial Transformation (where applicable)	Not Applicable.
Desired Performance	50 (10 per annum)
Indicator Owner	Executive: Member Protection
Indicator Updater	Senior Manager: Clinical Consulting Services

Indicator Title	28.1 Percentage of category 1 clinical opinions provided within 30 working days of receipt of a request from Complaints Adjudication Sub-programme
Definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit with the view to ensure that members' complaints are resolved.
Source of data	M-Files Complaints referrals and Clinical Opinion Workflow Database.
Method of calculation or assessment	The clinical opinions are to be weighted based on their complexity and allocated a category. Category 1 clinical opinions will be uncomplicated clinical opinions that are expected to be analysed. 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 Opinion 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: Number of completed opinions in ≤ 30 working days / Total number of clinical opinions referred in ≤ 30 working days X 100.
Assumptions	Availability of Resources (Human & systems)
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	90%
Indicator Owner	Executive: member protection
Indicator Updater	Senior Manager: Clinical Consulting Services

Indicator Title	28.2 Percentage of category 2 clinical opinions provided within 60 working days of receipt of a request from Complaints Adjudication sub-programme
Definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit with the view to ensure that members' complaints are resolved.
Source of data	M-Files referrals and the Clinical Opinion Workflow Database.
Method of calculation or assessment	The clinical opinions are to be weighted based on their complexity and allocated a category. This categorisation will be carried out by the most experienced Clinical Analysts in the Unit. A category 2 clinical opinion will be a more complex clinical opinion compared to a category 1 requiring more in- depth analysis and time less than 60 working days for full completion. Count of clinical opinions electronically via the Clinical Opinion Workflow Database. The calculations of the proposed indicators will be according to the formula below: Completion of 90% of clinical opinions referred within 60 working days calculated by: Number of completed clinical opinions between 30-60 working days /total number of clinical opinions referred in ≤ 60 working days *100.
Assumptions	Availability of Resources (Human & systems)
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	90%
Indicator Owner	Executive: Member protection
Indicator Updater	Senior Manager: Clinical Consulting Services

Indicator Title	28.3 Percentage of category 3 clinical opinions provided within 90 working days of receipt of a request from Complaints Adjudication sub-programme
Definition	Provide clinical opinions on formal complaints received from the Complaints Adjudication Unit with the view to ensure that members' complaints are resolved
Source of data	M-Files Complaint referrals and Clinical Opinion Workflow Database
Method of calculation or assessment	A Category 3 clinical opinion will be a more complex clinical opinion compared to a Category 2, requiring more in-depth analysis and time less than 90 working days for full completion. Count of clinical opinions electronically via the Clinical Opinion Workflow Database. The calculations of the indicator will be according to the formula below: Number of completed clinical opinions between 60-90 working days /Total number of clinical opinions referred in ≤ 90 working days* 100.
Assumptions	Availability of Resources
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	95%
Indicator Owner	Executive: Member protection
Indicator Updater	Senior Manager: Clinical Consulting Services.

Indicator Title	28.4 Percentage of clinical enquiries received via e-mail or telephone and responded to within 7 days
Definition	Provide responses to informal clinical enquiries received from internal and external stakeholders via e-mail, telephone or walk-in, to ensure timely and effective resolution of all queries.
Source of data	Clinical enquiries e-mail database, telephonic and walk-ins.
Method of calculation or assessment	Sum of clinical enquiries, electronically received via email, telephonic, and walk-ins. Enquiries are captured by each clinical analyst on a spreadsheet. (The number of completed clinical enquiries responded to within 7 days /total number of clinical enquiries received *100).
Assumptions	Availability of resources
Disaggregation of beneficiaries (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	95%
Indicator Owner	Executive: Member protection
Indicator Updater	Senior Manager: Clinical Consulting Services

Programme 4: Policy, Research and Monitoring

Indicator Title	29.1 Number standardisation of options implementation reports
Definition	Through the standardisation of scheme options, the consolidation of medical schemes with less than 6000 members; the consolidation of government-funded schemes, risk based capital solvency framework and the development of a comprehensive Primary Health Care benefit package, the CMS will ensure effective risk pooling and will be measuring the impact of co-payments exposure to beneficiaries. This work will be done through a consultative approach and by being mindful of the risks to scheme members, employers, trade unions and other key stakeholders
Source of data	CMS website, under publications and M-Files/OneDrive.
Method of calculation or assessment	Simple count
Assumptions	Availability of resources
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	5 (1 annually)
Indicator Owner	Executive: Policy, Research & Monitoring
Indicator Updater	Executive: Policy, Research & Monitoring

Indicator Title	30.1 Number of PMB Review Reports on PMB review activities and progress
Definition	A report on the activities related to the PMB Review project which includes establishing and implementation of PHC into the PMBs and the development of a base benefits package.
Source of data	M-Files/OneDrive.
Method of calculation or assessment	Simple count
Assumptions	Availability of resources
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	5 (1 annually)
Indicator Owner	Executive: Policy, Research & Monitoring
Indicator Updater	Executive: Policy, Research & Monitoring

Indicator Title	31.1 Number of reports on the consolidation of medical schemes with a membership base of less than 6 000
Definition	Through the consolidation of medical schemes with less than 6000 members the CMS will ensure effective risk pooling . This work will be done through a consultative approach and by being mindful of the risks to scheme members, employers, trade unions and other key stakeholders.
Source of data	CMS website, under publications and M-Files/OneDrive.
Method of calculation or assessment	Simple count
Assumptions	Availability of resources
Disaggregation of beneficiaries (where applicable)	Not applicable
Spatial Transformation (where applicable)	Not applicable
Desired Performance	5 (1 annually)
Indicator Owner	Executive: Policy, Research & Monitoring
Indicator Updater	Executive: Policy, Research & Monitoring

Indicator Title	32.1 The number of draft benefit definitions guidelines developed.
Definition	The number of draft PMBs benefit definitions guidelines developed for possible publication..
Source of data	Draft Benefit definitions guidelines capture in M-Files for stakeholder input and possible publication.
Method of calculation or assessment	Count the number of draft or finalised PMB definitions guidelines. (Including revised and updated versions, including emerging conditions of public health importance where proactive guidelines are being developed and including those draft guidelines published for comment or stakeholder engagement).
Assumptions	Availability of Resources
Disaggregation of beneficiaries (where applicable)	Benefit Definitions will be prioritised based on a number of criteria (e.g. high OOP payments, high burden of disease, high rate of complications, high expenditure conditions, emerging diseases of public health importance, conditions affecting vulnerable populations, etc).
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	50 (10 annually)
Indicator Owner	Executive: Policy, Research & Monitoring
Indicator Updater	Executive: Policy, Research & Monitoring

Indicator Title	33.1 Number of research projects and support projects published in support of the National Health Policy.
Definition	Undertake strategic research to inform national health policy interventions like the National Health Insurance and Health Market Inquiry.
Source of data	CMS website, under publications and M-Files/OneDrive.
Method of calculation or assessment	Total number of research projects completed. Research projects are undertaken for internal and external consumption. For internal projects, the project is counted when sent to the sub-programme 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 scholarly journals for publication, publication through a circular and/or as part of a circular.
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 (where applicable)	Not Applicable
Spatial Transformation (where applicable)	Not Applicable
Desired Performance	60 (12 annually)
Indicator Owner	Executive: Policy, Research & Monitoring
Indicator Updater	Executive: Policy, Research & Monitoring

Indicator Title	34.1 Non-financial report submitted for inclusion in the annual report (industry report)
Definition	The analysis of clinical, demographic, utilisation and benefits paid data received through the Statutory Return by medical schemes.
Source of data	Non-financial report included in the published Annual and Industry Report.
Method of calculation or assessment	The Annual Report contains the non-financial report submitted by the sub-programme. The non-financial report section in the CMS Annual Report and Industry report must be counted.
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 (where applicable)	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 (where applicable)	Not applicable
Desired Performance	5 (1 annually)
Indicator Owner	Executive: Policy, Research & Monitoring
Indicator Updater	Executive: Policy, Research & Monitoring