

The Council for Medical Schemes'

CMS News

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FIT AND PROPER

BOARD OF TRUSTEES

Plus

2013/14 CMS

ANNUAL REPORT

SCA CONFIRMS NEED
FOR ETHICS AND
GOOD GOVERNANCE

ADMINISTRATORS ROLE
IN THE GOVERNANCE OF
MEDICAL SCHEMES

the ethics and
governance issue



CMS

Council
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EDITORIAL

This issue will be unpacking the important topic of ethics, which is so crucial in everyday life but more importantly in the way we run organisations.

Ethics, simply put, are standards that put reasonable obligations on leaders of organisations to do what is right. Ethics are simply a consideration of what is good for self, that which should also be good for others. It's about self, good and others.

The concept of ethics sounds simple and yet we see a number of corporate failures mainly attributed to lack of ethical leadership.

Organisations have a good understanding of ethics but the challenge is to walk the path of ethical conduct. If we look around in recent weeks, there was a problem in the Independent Electoral Commission (IEC), the South African Broadcasting Corporation (SABC), was news itself and also in the National Prosecuting Authority.

These organisations are unstable mainly because things were not done right, policies were not followed etc. The CMS has also not escaped these challenges. As an organisation we are painfully aware that the recent developments in our organisation has done great harm to our image and reputation.

We are therefore working very hard to completely obliterate this unfortunate episode from our proud history; because as a regulator we have a rich history.

- a history of accountability,
- a history of transparency,
- a history of being accountable to our actions and;
- most importantly, our history of being an effective and efficient regulator.

We are a regulator which pays particular attention to the basic principles of corporate governance. We are committed to working very hard to restore our image and reputation in the industry.

Enjoy and reflect on the contents of this edition, as our young democracy is crying for ethical leadership — Acting Chief Executive and Registrar.



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GOVERNANCE IS ONLY AS GOOD AS THE WILL TO DO IT



BY YUSUF DUKANDER

PROJECT DIRECTOR: FINANCIAL

SERVICES AND RISK - SAICA



Ethics and governance lies at the heart and soul of any successful venture. It defines which organisations will be sustainable and informs the conduct of management and the organisation, both in terms of strategy and operations.

Ethics is defined as ‘moral principles that govern a person’s behaviour or the conducting of an activity’. From the definition, it is easily applied to medical schemes and the healthcare environment. In particular, medical schemes comprise of a Board of Trustees as well as a Principal Officer as governance structures to direct the strategy and operations of the scheme based on an ethical foundation.

The King Report on Governance for South Africa 2009 (King III) is an ideal set of principles which medical schemes should be applying or aspire to as it sets out in an integrated manner:

- An illustration of how a scheme, both positive and negative has impacted on the social, environmental and economic life of the community in which it operates for the period under review
- How the scheme intends to enhance the positive impacts and has strategised to mitigate the negative impacts for the year ahead.

King III also emphasises the inclusive approach of governance and highlights the term ‘stake-

holder inclusive model' of governance – implying that the Board of Trustees should also consider the legitimate interests and expectations of stakeholders other than members in the best interest of the medical scheme, its members and all other stakeholders.

All Board of Trustees of medical schemes should provide effective leadership in:

- Directing the strategy and operations of the scheme
- Conducting business ethically
- Considering the scheme's impact on internal and external stakeholders.

Board of Trustees also have a duty in setting the tone for the values and culture in which the scheme should be managed, regardless of its size. This should result in the formulation of a Code of Conduct which must be adhered to.

Good governance ensures that the operations of medical schemes are not isolated from society, the environment and the broader economy in which the scheme operates, thereby contributing to responsible leadership and good corporate citizenship. Governance practices must include accountability, social responsibility, fairness and transparency in order to meet strategic objectives. It also places a large responsibility on the Board of Trustees and the Principal Officer to manage the scheme diligently as they are seen as custodians of the scheme. They must act in the best interests of scheme members considering what is best for the scheme and its members and stakeholders whilst balancing sustainability considerations of the scheme now and into the future.

The South African Institute of Chartered Accountants (SAICA) views ethics as the foundation underpinning the accountancy profession and has an official Ethics Committee. This committee's purpose is to provide leadership and guidance on ethics-related matters to SAICA and its members, so that they are able to comply with their responsibilities to act in the public interest, with integrity, objectivity, professional competence, due care, confidentiality, and in compliance with all relevant laws, codes and regulations.

The committee's functions and responsibilities span across:

- 1. Maintenance of the Code of Professional Conduct for Chartered Accountants** – this includes monitoring, considering and responding to proposed modifications to the Code published by the International Ethics Standards Board for Accountants (IESBA)
- 2. Monitoring, considering and addressing emerging ethical issues** – relevant to the public interest responsibility of SAICA and its members
- 3. Provision of leadership on behalf of SAICA** – ethics-related communication, education and guidance.

SAICA requires that its members comply with the following fundamental ethical principles:

- to be straightforward and honest in all professional and business relationships
[integrity]
- not to allow bias, conflict of interest or undue influence of others to override professional or business judgments
[objectivity]
- to maintain professional knowledge and skill at the level required to ensure that a client or employer receives competent professional services based on current developments in practice, legislation and techniques and act diligently and in accordance with applicable technical and professional standards
[competence and due care]
- to respect the confidentiality of information acquired as a result of professional and business relationships and, therefore, not disclose any such information to third parties without proper and specific authority, unless there is a legal or professional right or duty to disclose, nor use the information for the personal advantage of the chartered accountant or third parties
[confidentiality]
- to comply with relevant laws, codes and regulations and avoid any action that discredits the accountancy profession
[professional behaviour]

We should pride ourselves in ensuring ethical standards and governance practices within medical schemes are clearly articulated, measured and aligned to performance. Governance is only as good as the will to do it!

FIT AND PROPER BOARDS OF TRUSTEES



BY ALICIA SCHOEMAN

LEGAL ADVISOR

COUNCIL FOR MEDICAL SCHEMES



Fitness and propriety defined

Adherence to corporate governance standards plays an important role to ensure board members tasked with the duty to protect the interests of members do so in the most prudent manner. King III states that good corporate governance is essentially about effective leadership characterised by the ethical values of responsibility, accountability, fairness and transparency. As recognised in our Constitution, this can only be achieved if the people tasked with this responsibility have the required knowledge, qualifications or experience to fulfil their specific roles. In other words a board should consist of persons who are fit and proper to perform the required functions and roles.

The Pension Funds Act considers the following factors when assessing if a principal officer is fit and proper:

- a) the person's competence and soundness of judgment;
- b) the diligence with which the person is likely to fulfil those responsibilities;
- c) previous conduct and activities of the person in business or financial matters and
- d) any evidence of previous convictions or contraventions of relevant rules and legislation

Furthermore, the Principal Officer Association of South Africa has issued a step by step guide for the vetting and appointment of principal officers within the retirement industry. As part of the personal information and declaration form one of the sections contain a specific test that is used to assess the fitness and propriety of the applicants. The latter is required to complete 16 specific questions and to provide references where applicable. The contents of the questions are aligned with requirements set out in section 8 of the Pension Funds Act.

The Financial Services Board has also issued a determination of fit and proper requirements for financial service providers in 2008. The four main requirements for fitness and propriety are honesty and integrity, competence, operational liability and solvency requirements. Continuous Professional Development is also required to ensure that service providers develop and maintain a high standard of service.

In 2008 an Enquiry into the fitness and propriety of Adv. Pikoli to hold office as the National Director of Public Prosecutions (NDPP) was established by the President acting in terms of s. 12(6)(a) of the National Prosecuting Authority Act. The terms of reference

for the Enquiry required a determination of whether Adv. Pikoli was a fit and proper person to hold the office of NDPP. Paragraph 51 of the Ginwala report dealt with fitness and propriety and stated that “Whether one is fit and proper to practice as a lawyer or any other discipline will depend on the context in which that notion is used.” An academic qualification is not the only criterion that has to be considered, the incumbent must also be a person of experience, integrity and conscientiousness to be entrusted with the responsibilities of the office concerned. In *Pikoli v The President* 2010 (1) SA 400 (GNP) the court said that “As the head of the National Prosecuting Authority the NDPP has a duty to ensure that this prosecutorial independence is maintained. It follows that a person who is fit and proper to be the NDPP will be able to live out, and will live out in practice, the requirements of prosecutorial independence. That he or she must do without fear, favour or prejudice.”

More recently the Supreme Court of Appeal also made a finding on the fitness and propriety of Mr. Menzi Simelane following his appointment as NDPP in the matter of the Democratic Alliance v The President of the RSA & others (263/11)[2011]. The court found that the qualities required of a candidate are jurisdictional facts that must exist before an appointment can be made and it has to be assessed objectively. The president should have properly interrogated Mr. Simelane’s performance in his previous position to make such an assessment. The conclusion should have been based on facts and not on his discretion. The appointment was subsequently declared inconsistent with the Constitution and set aside.

From the above it is clear that there is no ‘one size fits all’ standard when it comes to fitness and propriety. One has to look at the nature and requirements of the specific industry or position and set the standards accordingly.

The Medical Schemes Act

Section 57 of the Medical Schemes Act 131 of 1998 (the Act) contains the general provisions on governance and requires that every medical scheme shall have a board of trustees (BOT)

who are fit and proper to manage the scheme. One of the duties of the BOT is to appoint a principal officer (PO) who is also fit and proper to hold such office. The legislature anticipated that in some instances the BOT members may lack sufficient expertise to perform their functions and therefore section 57(4)(g) provides that they may obtain expert advice on legal, accounting and business matters or any other relevant matter as required. Subsection (6) provides that the BOT shall a) take all reasonable steps to ensure that the interests of beneficiaries are protected at all times; b) act with due care, diligence, skill and good faith; c) take all reasonable steps to avoid conflicts of interest; and d) act with impartiality in respect of all beneficiaries. Although the Act sets out the duties of the BOT as well as the disqualification criteria it does not specifically define fitness and propriety.



...it is very expensive and time consuming to remove trustees who are not fit and proper.”

The process going forward

The Medical Schemes Amendment Bill seeks to improve corporate governance and makes provision for the publication of corporate governance guidelines in Gazette as well as formal training for all newly elected BOT members. It also codifies the fitness and propriety requirements that were derived from a number of sources. In preparation for this process the CMS published a draft set of requirements and criteria for the determination of the fit and proper status of trustees and principal officers. The discussion document is dated 2008 and can be found on the CMS website. The current legislation and case law, standards of

other Regulators in South Africa and abroad as well as inputs from CMS stakeholders were considered and collated to inform the contents of the document. In terms of the publication “fit” relates to a person’s competence and ability to do the job while “proper” relates to the character and integrity of the person.

There has to be a predetermined standard which has to be met by a trustee. This standard is measured against disqualification and evaluation criteria. Non-compliance with a single criterion will not necessarily result in a person not being fit and proper. Each matter will have to be dealt with on its own merits while regard is given to the time since the event, the seriousness of the event, the relevance of the event to the role or proposed role of the responsible person, the explanation offered by the responsible person, and evidence of the person’s rehabilitation, where applicable.

Boards of Trustees should ensure that prospective trustees are fit and proper by requiring them to complete a standard declaration and by obtaining a certificate which provides details of any criminal activity from the South African Police Service. Further the BOT should verify and evaluate the provided information before the appointment is confirmed. After the appointment has been made it is advisable to provide induction and ongoing training to the trustee or PO. A code of conduct should also be in place to address all the relevant issues.

The proposed fit and proper standards for BOT members of medical schemes are:

Honesty, integrity and reputation

“The responsible person must possess the character, diligence, honesty, integrity and judgment to perform the duties of trustee or principal officer.”

In terms of this standard a trustee should not have any prior convictions or disqualifications as a director or trustee at another institution. Past behaviour and the reputation of the person play an important role.



...medical scheme members should actively participate in Annual General Meetings where BOT members are elected.”

Competence and Capability

“The responsible person demonstrates the appropriate skill, knowledge and competence in fulfilling the managerial and professional responsibilities in the conduct of the duties of a trustee, in order that she or he can make informed decisions in the best interest of beneficiaries within a sound governance framework.”

Each scheme should have a policy in place that sets out what qualifications and capabilities are required from trustees. It is not a requirement that trustees should be experts in any field; however they should have sufficient knowledge to perform their functions. Persons who are mentally incapacitated, under the age of 18 and not residents of South Africa will be disqualified as trustees.

Financial soundness

“The responsible person must demonstrate ability to manage his or her own financial affairs properly and prudently, in order to provide confidence in his or her ability to manage the financial affairs of others.”

Even though the financial position of the trustee is irrelevant, the person should not be an unrehabilitated insolvent or have a judgment concerning debt against his or her name.

Each BOT should create its own governance policies and supplement the standards and criteria set out above according to its own needs and requirements.

Interventions

Section 46 of the Act states that the Council may remove a BOT member from office if there is sufficient reason to believe that the person concerned is not fit and proper to hold the office concerned. In terms of section 29(1) (c) a medical scheme should also provide in its registered rules for officers to be removed from such an office.

The Appeal Board heard a matter in November 2013 where three interim trustees of Hosmed medical scheme challenged their removal from office in terms of section 46. The allegations brought against these trustees were that they selectively wrote off debts owed to the scheme by a third party, two of the appellants had poor credit records, false statements were made under oath, members were selectively put on higher salary bands and marketing material was procured in an irregular manner.

After hearing the matter the Appeal Board upheld the decision of the Council to remove them and stated that the case gave a clear impression that the Appellants do not have sufficient insight into the nature of the office of a trustee and the responsibilities connected therewith. It was further noted that these trustees sought to benefit themselves personally and failed to disclose their own interests and to recuse themselves where needed. They further provided unsatisfactory explanations for making false statements and mistakenly thought that their poor credit records are irrelevant when it comes to trusteeship.

The ruling is in line with the judgment made by the court in the case of *Afrisure v Watson* (522/07)[2008] ZASCA 89 where it made reference to the fiduciary duties of directors and stated that directors may not exceed their powers; exercise their powers for an improper or collateral purpose; fetter their discretion; or place themselves in a position in which their personal interests conflict, or may possibly conflict, with their duties to the company. The same view was taken by the court years ago in the matter of *Robinson v Randfontein estates Gold Mining Co Ltd*(516/02)[2003] where a director did not have unfettered discretion,

had a clear conflict of interest and exercised his power for his personal benefit.

Three medical schemes were placed under curatorship as a result of governance failures during the last couple of years. Save for the litigation involved in obtaining the curatorship most of these cases were also associated with further litigation where penalties levied against trustees and illegal payments made to former trustees had to be recovered.

From the above it is clear that it is very expensive and time consuming to remove trustees who are not fit and proper. It therefore cannot be stressed enough that medical scheme members should actively participate in Annual General Meetings where BOT members are elected. They should also ensure that adequate policies are in place so that appropriate persons, who are fit and proper to hold office as BOT members, are appointed.

Trustee training sessions are offered annually by the Education and Training Unit of the CMS. The training is aimed at equipping newly appointed trustees. The topics covered include:

- The Medical Schemes Act & other relevant legislation
- Accreditation
- Clinical Governance and PMB's
- Corporate Governance
- Complaints & Resolution Procedures
- Understanding of Financial Statements
- Financial Soundness
- Investments for Medical Schemes
- Financial Examples and Activities
- Management of Benefits and Scheme Rules

The training is provided for free and participants gain 9 CPD point for Knowledge and 1 CPD point for Ethics. For more information and dates, please visit our website.



TRUSTEE FIDUCIARY RESPONSIBILITIES

Trustees of medical schemes have fiduciary responsibilities, but what exactly does this mean? It means in essence that trustees must exercise their powers and perform their functions in good faith and in the best interests of the medical scheme.

BY ESMÉ PRINS-VAN DEN BERG

HEALTHCARE NAVIGATOR



Trustees' duties are informed by common and statutory law as supplemented by case law and the King Report on Corporate Governance for SA (King III). Although King III uses the terminology "company" and "director", it is also applicable to the not-for-profit environment. The recommendations contained in King III would, however, be subject to the legislative requirements of a particular sector. The Supreme Court of Appeal, (*Afrisure v Watson* (522/07) [2008] ZASCA 89 (11 September 2008)), has on occasion held that the fiduciary duties of a trustee were similar to those of a director of a company. The principles of corporate governance, including the duties of directors as listed in King III, are therefore relevant for medical schemes. References to principles and recommendations in King III have been customised for the medical schemes' environment for purposes of this article.

"Fit and Proper"

Section 57(1) of the Medical Schemes Act 131 of 1998 requires trustees to be "fit and proper" persons. The terms "fit" and "proper" are, however, not defined in the Act. King III advises that when considering the skills and suitability of a proposed trustee, the following dimensions require consideration:

- The knowledge and experience required to fill the gap on the Board;
- The apparent integrity of the individual; and
- The skills and capacity of the individual to discharge his/her duties to the Board.

Trustees should be individuals of integrity and courage and have the relevant knowledge, skills and experience to bring judgment to bear on the business of the scheme. Where trustees lack experience, induction, mentoring and support programmes should be implemented.

Trustees must also have the time required to attend to their duties properly. This means in general that they should:

- Prepare adequately for Board and Board Committee meetings;
- Attend Board and Board Committee meetings; and

- Acquire and maintain a broad knowledge of the environment, industry and business of the scheme.

Trustees' Responsibilities

In terms of the common law trustees have duties of care, loyalty and obedience. This entails amongst others that they should:

- Act with honesty and integrity;
- Avoid conflicts of interest;
- Act in the members' interests;
- Keep members' information confidential;
- Comply with the scheme rules and relevant legislation.

The common law duties are to a certain extent mirrored in section 57(6) of the Medical Schemes Act. This section requires the Board of Trustees to:

- Take all reasonable steps to ensure that the interests of beneficiaries in terms of the rules of the medical scheme and the provisions of the Medical Schemes Act are protected at all times;
- Act with due care, diligence, skill and good faith;
- Take all reasonable steps to avoid conflicts of interest; and
- Act with impartiality in respect of all beneficiaries.

The Medical Schemes Act also contains specific duties for the Board of Trustees in section 57(4), namely to:

1. Appoint a Principal Officer who is a fit and proper person and advise the Registrar of such appointment within 30 days;
2. Ensure that proper registers, books and records of all operations of the scheme and proper minutes of all resolutions passed by the board are kept;
3. Ensure that proper control systems are employed by or on behalf of the scheme;
4. Ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the rules of the scheme;
5. Take all reasonable steps to ensure that contributions are paid timeously in

- accordance with the Medical Schemes Act and the scheme rules;
6. Take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance;
 7. Obtain expert advice on legal, accounting and business matters or on any other matter of which the members of the board of trustees may lack sufficient expertise, as required;
 8. Ensure that the rules, operation and administration of the scheme comply with the provisions of the Medical Schemes Act and all other applicable laws; and
 9. Take all reasonable steps to protect the confidentiality of medical records concerning members' state of health.

The duties of trustees as specified in the Medical Schemes Act are largely incorporated in the duties specified by King III. However, the duties specified by King III are more extensive. According to King III the Board of Trustees should direct, govern and be effectively in control of the medical scheme. It should also play a prominent role in the development of strategy and not merely be a mere recipient of the strategy as proposed by management. The strategy development process should consider the dynamics of the changing external environment and be responsive to changing market conditions. Furthermore, King III recommends that trustees should:

1. Provide effective leadership based on an ethical foundation;
2. Ensure that the scheme is and is seen to be a responsible corporate citizen;
3. Ensure that the scheme's ethics are managed effectively;
4. Ensure that the scheme has an effective and independent Audit Committee;
5. Be responsible for the governance of risk;
6. Be responsible for information technology (IT) governance;
7. Ensure that the scheme complies with applicable laws and considers adherence to non-binding rules, codes and standards;
8. Ensure that there is an effective risk-based internal audit;
9. Promote a stakeholder-inclusive approach and consider the legitimate interests and



The Supreme Court of Appeal has on occasion held that the fiduciary duties of a trustee were similar to those of a director of a company."

- expectations of the schemes' stakeholders in its deliberations, decisions and actions as stakeholders' perceptions affect the scheme's reputation;
10. Ensure the integrity of the scheme's integrated report;
 11. Report on the effectiveness of the scheme's system of internal controls;
 12. Act in the best interests of the scheme, i.e. the best interests of the collective membership;
 13. Consider turnaround mechanisms as soon as the scheme is financially distressed;
 14. Elect a chairperson who is an independent non-executive trustee. It should be noted that trustees of medical schemes are generally all non-executive officers of the scheme. The Principal Officer should also not act as chairperson of the Board;
 15. Appoint a Principal Officer;
 16. Establish a framework for the delegation of authority. The Board should define its own levels of materiality, reserving specific powers for it and delegating other functions to management and well-structured Board Committees, but without abdicating its own responsibilities;
 17. Be assisted by a competent, suitably qualified and experienced company secretary. This recommendation might not be achievable in a particular medical scheme's circumstances;
 18. Disclose their remuneration and that of senior executives;
 19. Conduct an evaluation of the Board, its committees and individual trustees every year; and
 20. Conduct training and development of trustees through a formal process.

King III also advises that the Board or individual trustees should at the expense of the scheme be entitled to take independent professional advice in connection with their duties, if it was considered necessary. The process to be followed should be agreed to by the Board.

Standard of Conduct

The Companies Act 71 of 2008 has introduced a standard of directors' conduct. Since medical scheme trustees' duties are akin to those of directors of companies, this standard of conduct as specified in section 76 should also be noted by trustees. This standard not only applies to directors or trustees, but also to members of Board Committees, including the Audit Committee.

Pursuant to section 76 a trustee must exercise the powers and perform his/her functions:

- In good faith and for a proper purpose;
- In the best interests of the scheme; and
- With the degree of care, skill and diligence that may reasonably be expected of a person
 - Carrying out the same functions in relation to the scheme as those carried out by that trustee; and
 - Having the general knowledge, skill and experience of that trustee.

Section 76(4) of the Companies Act provides that a director and therefore a trustee would satisfy the statutory obligations if he/she:

- Has taken reasonably diligent steps to be informed about the matter;
- Had no material personal financial interest in the matter or disclosed such interest; and
- Had a rational basis for believing the decision was in the best interests of the scheme.

A trustee would be able to rely on the performance of:

- Employees of the scheme whom the trustee reasonably believes to be reliable and competent in the functions performed as well as the information, opinions, reports or statements provided;
- Legal counsel, accountants, other professional persons retained by the scheme in respect of matters involving skills or exper-

tise that the trustee reasonably believes to be within that person's professional or expert competence or to which that person merits confidence;

- A Board Committee of which the trustee is not a member unless the trustee has reason to believe that the actions of the Committee do not merit confidence; including information, opinions, recommendations, reports or statements such as financial statements and other financial data prepared by the aforementioned persons or committees; or
- A person to whom the board may reasonably have delegated an authority to perform a particular function.

King III advises that trustees have:

- A duty to exercise the degree of care, skill and diligence that would be exercised by a reasonably diligent individual who has
 - The general knowledge, skill and experience that may reasonably be expected of an individual carrying out the same functions as are carried out by a trustee in relation to the scheme; and
 - The general knowledge, skill and experience of that trustee; and
- A fiduciary duty to act in good faith and in a manner that the trustee reasonably believes to be in the best interests of the scheme.

Personal Liability

Since trustees could be held personally liable for a failure to perform their duties properly and even be removed by the Council for Medical Schemes from the Board of Trustees if the Council had sufficient reason to believe that a person was not fit and proper to hold the office as a trustee, it is of utmost importance that trustees understand their duties and perform them in terms of the required standard. To this end trustees should continuously subject themselves to ongoing training and development. Annual performance evaluations of individual trustees could also assist in identifying the training needs of the trustees.

BRAVERY NEEDED TO CALM THE PERFECT STORM

Administrators have a key role to play in improving the governance of medical schemes – but only when a culture of trust between the players is established. To do that will require the courage needed to become more transparent.

BY ROHAN LAIRD

CHIEF EXECUTIVE OFFICER

THEBE YA BOPHELO HEALTHCARE



I doubt whether anyone could deny that the medical scheme industry is currently facing some severe governance challenges. One reason is the old human one: there's a lot of money in the industry — medical schemes manage funds worth millions of rands — in excess of R129 billion and that kind of money will potentially attract unscrupulous people.

South Africa's history of discrimination and exclusion also complicates the dynamics of the industry. One could argue that, as in the economy and society as a whole, efforts to redress past wrongs have had the unintended consequence of creating an enabling environment for mistrust and corruption.

I'd like to interrogate these issues a little more closely in the hope of casting some light on them and suggesting a few solutions that medical scheme administrators, in particular, might contribute.

From where I sit, it seems that three inter-relating factors are responsible for creating the majority of the governance challenges our industry faces: Self-interest on the part of both trustees and administrators; trustees' lack of knowledge and skills; and industry corruption. As noted, these issues are not watertight, but for the purposes of discussion it helps to treat them as such.

Where to begin?

The starting point has to be the regulatory requirement that medical schemes cannot be for profit — in other words, a business cannot set up (and capitalise a medical scheme). A medical scheme therefore is a non-profit organisation owned and controlled supposedly by its members. The rationale behind this legislative requirement is admirable in the sense that medical cover is not regarded as a normal economic commodity and therefore consumers need to be protected from possible abuse driven by the profit motive.

Whether or not, one agrees with this standpoint (and this is a substantial topic in its own right), there can be no doubt that there are a number of unintended consequences that

flow from this governance model.

Money and power, there's a toxic mix

Charity, they say, begins at home — so, by definition, does self-interest. With regards to administrators, the question of self-interest is brutally clear. To prosper, administrators need to win contracts from medical schemes, and thus face the temptation to use all the tricks in the book to land the contract. These tricks run the full gamut from barely defensible (tickets to a soccer match, a sponsored visit to a conference) to downright criminal (the traditional brown envelope, a good deal on a new car).

For trustees, this kind of pressure can be bewildering and difficult to resist. The move to ensure that members should be elected onto medical scheme boards was intended to ensure that schemes were run democratically and truly represented their members. However, for many trustees, their new role represents a significant new revenue stream, one that sometimes exceeds what they get paid for their "day jobs" and in a position for which they are often not adequately qualified. Moreover, they then find themselves in positions of considerable power, with the awarding of multimillion rand contracts within their grasp, which in turn opens them up to the blandishments of unscrupulous administrators.

The nett result is that their interests start to diverge from those of the members they are supposed to represent— a problem that stretches beyond our industry to poison the public sector and the trade union movement as well.



It seems that three factors are responsible for creating governance challenges: Self-interest; lack of knowledge and skills; and industry corruption.

Mind the gap

The second challenge is also related to trustees, and is an unintended consequence of laudable efforts to make medical schemes more representative. It's the same road that pension funds have travelled, and the basic problem is the same: in general, trustees drawn from the ranks of ordinary members simply do not have the knowledge and skills needed to understand what is a highly complex regulatory and financial environment — one in which bad decisions will have immediate and disastrous consequences for members denied the right levels of healthcare.

Aside from these gaps in the professional expertise of trustees, one also has to mention the fact that many of them are also unversed in ethics. You might say that we all know right from wrong, but in business as in politics there are plenty of grey areas. In addition, experience in the corporate sector has shown that ethics cannot simply be prescribed; they have to be integrated into the way that business is done, to become part of the corporate DNA.

This is easier said than done, which is why King III makes it a board responsibility to manage the company's ethics.

If you are watching the current season of the mini-series *The good wife*, it's interesting to see how the new ethics officer on the governor's staff is now a constant storyline. On one level, she's treated as a bit of a joke but a serious point is being made: ethical behaviour doesn't just happen, and even (maybe especially) the highest in the land need professional help in ensuring that they think through the ethical implications of what they do.

Add it all together and you get corruption

All of these issues come together to create an enabling environment for widespread corruption. While I wouldn't go so far as to say that corruption is endemic, the conditions are there for it to become so. As we have seen in other spheres of our public life, once these patterns become established, they are extremely hard to eradicate.

Of course, as I'm all too aware, it's easy to identify the problems. But I'd like to at least put on the table some of the actions we could, as administrators and as an industry, take to start turning the ship around. They are offered with all due humility, in the hope of sparking debate to build consensus, with deeds hopefully following rapidly thereafter — that's where the bravery will come in!

Administrators must get their own house in order. Administrators have to start taking ethics seriously, and working with professional organisations like The Ethics Institute of South Africa to create genuinely ethical organisations. This will require commitment from the top down. It's no use complaining about corruption or decrying the lack of trust in the industry if we are the ones who set the ball rolling in the first place. Yes, we have to compete for business, but we must act in good faith to protect our long-term — as opposed to short-term — interests.

Administrators must become partners to the medical schemes. One of the ways to build a relationship built on trust would be to go beyond our contractual reporting obligations — we should also be providing useful information relating to, for example, legislative changes, industry developments and the like. We are the experts and should be working on ways to make that expertise available to trustees as part of the value-add we offer.

Specifically, administrators can provide expert help when it comes to procurement policies and procedures, risk and governance frameworks, and fraud detection. A major stumbling block in this regard will be the natural suspicion of the regulator towards close ties between the administrator and the scheme.

Despite clear evidence of abuse in some circumstances, it seems to me that the success of both the scheme and the administrator are intertwined and that abuse ultimately is to the detriment of both.

The industry therefore needs to build credibility. Closer engagement with the Council for Medical Schemes (CMS) would be a good

starting point, particularly by establishing clear industry guidelines around core governance policies and procedures and the training (both of trustees and administrators) to support these.

Administrators must insist on better contracts. It's imperative that contracts are clear and unambiguous, with clearly defined roles and responsibilities. This is the kind of thing that easily gets swept aside in the rush to sign a deal.

Administrators must insist on regular meetings with trustees. I would argue that administrators have a duty to ensure that trustees have read and understood their reports via regular face-to-face meetings with trustees. If something goes wrong, the regulator is anyway liable to assume that the administrator should have identified it first, so the common "arms-length" relationship between trustees and administrators is sometimes counter-productive.

Administrators must report wrongdoing. We have a moral and legal responsibility to report transgressions, even by our clients. This can seem like professional suicide in the short term, but over the long term it's the way to build up a reputation for integrity - both with the regulator and our client base. It would also clean up the industry in much less time.

Trustees need better regulation. I believe that CMS should give serious consideration to legislating trustee remuneration and responsibilities. This should include a definition of what constitutes a "fit and proper" person to act as a trustee and perhaps even introduce a trustee accreditation process. Here, of course, one needs to balance member representation and professional expertise, which goes back to my point about training.

Boards of trustees should be measured against King III. The corporate sector is making steady progress when it comes to implementing King III, and is seeing the performance benefits that stem from good governance. I think our medical schemes have some catching up to do.

In this regard, the concept of a regular 360 degree performance assessment of the board and each trustee (including by the administrator) would be a good starting point. Arguments that the administrator may be conflicted in providing such an assessment could be counteracted by placing greater pressure and responsibility on the administrator to ensure good governance.

One particular area of concern is succession planning. At present, it's too frequently the case that entire boards are replaced at a time, which means that valuable institutional knowledge is lost.

The Institute of Directors in Southern Africa (IoDSA) recently updated its annual benchmarking statistics on board performance, and I was interested to see that this practice is highlighted as a challenge in the public sector, where boards tend to be replaced every three years, or at the whim of a new minister. This practice means that boards are always on the back foot. Being an effective board member or trustee is, in itself, something that needs to be learned, and in this regard medical schemes should work more closely with institutions like the IoDSA.

At a minimum, board elections should be staggered to retain experience and maintain board capacity.

I realise that some of these proposals may be controversial, and that many apparently go against the short-term interests of several stakeholders. But we need to take the long-term view and act decisively to return our industry to health. It's an approach that will make for a more stable business environment in the long term — and it will certainly promote better service to the members, who are the end-customers of the medical industry.

BY CLAYTON SWART

COMMUNICATIONS MANAGER

COUNCIL FOR MEDICAL SCHEMES



SCA CONFIRMS NEED FOR ETHICS AND GOOD GOVERNANCE

Ethics and good governance are compromised where Board of Trustee (BOT) members put their own interest ahead of that of members of medical schemes. The Supreme Court of Appeal (SCA) was unequivocal in its recent judgement which found that the material irregularities at Medshield medical scheme justified the removal of the BOT. The appointment of a curator by

the Registrar of the Council for Medical Schemes (CMS) was in the best interest of the beneficiaries of the scheme.

The BOT, as stewards and ultimately guardians of the hundreds of millions of rands paid by Medshield members, flailed the most basic tenants of ethics and good governance as envisaged in the Medical Schemes Act 131 of 1998 (MSA). The

BOT of 10 members allowed a service provider, Sapling, to run roughshod over the rules of the scheme to manipulate BOT elections in their favour – to help secure a three year contract of R132 million.

Some of the myriad of material irregularities Medshield Trustees were found guilty of according to the North Gauteng High Court and confirmed by

the SCA on 16 September 2014 were in short:

- "...the rules of the scheme were indeed disregarded and Mabeta was appointed to the BOT while he was not eligible for election. He therefore served on the BOT unlawfully from June 2008 until his re-election in 2011. Apart from the aforesaid, the BOT appointed Mabeta as the chief executive officer (CEO) of the scheme for the period September 2011 to February 2012 at a monthly salary of R99 290.00, for a three-day workweek."

- "Particularly disconcerting is the current contract with Sapling, in terms of which Sapling stands to gain R132 million over the three year life of the contract."

- "The registrar's directive to terminate this contract has fallen on deaf ears. The way in which the Sapling trustees have been elected to the BOT, and the fact that Sapling has undertaken to pay the trustees' legal costs, leave scant hope that the BOT will be able objectively to deal with the Sapling contract and its consequences in an unbiased manner."

- Illegally paying brokers "research fees" amounting to an estimated R28 million in order to incentivise them to sign up only young members to the scheme. This is unfair discrimination based on age and illegal in terms of both the Medical Schemes Act 131 of 1998 and the Constitution.

- The scheme has also been paying broker fees to unaccredited brokers illegally. Acting SCA Judge PB Fourie, whose judgment was unani-

mously concurred with by the full bench of judges, found "...in view of the material irregularities detailed above, it is in the interest of the beneficiaries of the scheme and desirable to appoint a curator to the scheme. The registrar has also shown that he has objective grounds to believe that it is desirable to appoint a curator."

"In my view, the grounds of concern raised by the registrar, particularly when viewed cumulatively, constitute material irregularities which have to be addressed urgently, to avoid possible prejudice to the members of the scheme. The evidence paints an alarming picture of contracts being concluded which do not appear to add value to the scheme, but rather benefit third parties. In the process, provisions of the MSA Act were breached."

Ethics and good governance presumes that a BOT of a medical scheme will not act unreasonably when the CMS wishes to conduct an inspection on suspicion of irregular activities. The court found that the Medshield BOT "...adopted a confrontational stance by refusing the inspectors access to the premises; failing to furnish them with documentation and denying them the opportunity to consult with employees of the scheme."

"I should add that I have paid particular attention to the exchange of correspondence to which we have been referred by appellants' coun-

sel, but my reading thereof rather strengthens the view that the BOT was not only unwilling to allow a proper investigation of the affairs of the scheme, but unjustifiably regarded the attempts of the council in relation thereto with suspicion and distrust." The Medshield BOT remained belligerent throughout the process ignoring directives from the Registrar to cancel contracts and recoup monies paid. The court once again was scathing on the conduct of the BOT. "In fact, the BOT has made it clear that they do not wish to co-operate with the registrar in resolving the governance issues which have given rise to this litigation."

"If regard is had to the facts underlying the application, it is clear that there is no justification for allegations of this nature to be levelled against the registrar and the provisional curator. The relevant facts, discussed above, raise serious concerns regarding the well-being of the scheme and its members and the registrar would be shirking his statutory duties if he merely ignored these concerns."

This case elucidates the need for trustees, principal officers, administrators and service providers of medical schemes to act above reproach and to be guided by the highest standards of ethics in discharging their duties in the interest of members. *The judgement can be found under Barnard & others v The Registrar of Medical Schemes (628/13) [2014] ZASCA 111 (16 September 2014) Case No: 628/13.*

ANNUAL REPORT 2013-14 IN BRIEF



The CMS Annual Report contains a summary of CMS activities as well as an overview of the operations of medical schemes in their 2013 financial year.

This overview not only considers the CMS's activities in key regulatory areas – such as registration of medical schemes, accreditation of administrators, brokers and managed care organisations, enforcing compliance with statutory provisions and investigation and adjudication of complaints – but also describes the CMS's engagement with the development of national health policy and measures to improve the quality and impact of healthcare.

Number of medical schemes and beneficiaries

During the 2013 financial year medical schemes continued to merge. Such developments are an expected response to market forces and are not necessarily a negative development or an indication of instability in the South African medical schemes environment.

On 31 December 2013 there were 87 registered medical schemes, of which 24 were open and 63 restricted. These schemes had a total of 8 776 279 beneficiaries, comprising 3 878 267 principal members and 4 898 012 dependants.

Age of beneficiaries

A matter of considerable concern is the increasing number of medical scheme beneficiaries who require treatment for chronic conditions.

This is in large part due to the increasing average age of members, as older people tend to require more healthcare than younger people. However, it is also clear that increasingly unhealthy lifestyle choices made by many South Africans are contributing to the increase in chronic conditions.

Contribution income healthcare expenditure

Scheme contributions increased by 10.4% over the course of 2013, standing at R129.8 billion as at December 2013. Contributions for the whole of 2012 amounted to R117.6 billion.

The total gross relevant healthcare expenditure by medical schemes increased by 8.9% to R112.9 billion (IBNR and the results of risk transfer arrangements included) from R103.7 billion in 2012.

Expenditure on hospitals and specialists

Of the R112.5 billion total benefits paid to healthcare providers, medical schemes spent R35.4 billion or 36.1% on hospital services.

Payments to medical specialists amounted to R27.5 billion, an increase of 8.4% in real terms when compared to the R25.4 billion spent on this item in 2012.

These expenditure increases continued to be very high in 2013 and further substantiate the urgent need to regulate the fees of private hospitals and medical specialists in particular. The use of medical savings accounts in the benefit

designs of medical schemes from 2000 - 2013 shows a marked increase. When adjusted for inflation, risk contributions and claims pabpm have increased by 57.1% and 52.1% respectively. Medical savings accounts contributions and claims have risen by 10.2% and 14.3% respectively on a pabpm basis.

It is clear from these figures that the vacuum left after the National Health Reference Price List (NHRPL) was set aside still needs to be filled.

Exploitation of prescribed minimum benefits (PMBs) is a major concern to the CMS and finalisation of the revision of these benefits is urgently required.

Other healthcare expenditure

General practitioners received R6.9 billion or 7.1% of healthcare benefits paid, representing an increase of 6% on the 2012 figure of R6.5 billion.

The most significant increase in benefits paid in 2013 was in respect of support and allied health professionals. The amount increased by 8.6% from R7 billion in 2012 to R7.6 billion in 2013. This category accounted for 7.8% of all benefits paid by schemes in 2013.

Expenditure on medicines dispensed by pharmacists and providers other than hospitals amounted to R5.5 billion or 15.9% of total healthcare benefits paid. This was an increase of 8.8% compared to the R14.3 billion spent in 2012.

Non-healthcare expenditure

Administration expenditure for all medical schemes grew by 7.1% to R9.4 billion at the end of December 2013 from R8.8 billion in 2012.

Expenditure on benefits management (managed healthcare management fees) increased significantly by 19.9% to R3.2 billion in 2013 from R2.7 billion in 2012.

Brokers were paid an additional 9.3% in 2013 from R1 449.1 million in 2012 to R1 583.2 million. Broker costs represented 11.0% of total non-healthcare expenditure in 2013 as in 2012.

Impaired receivables (previously known as bad

debts) decreased by 0.7% to R188.3 million for the year under review from R189.7 million in 2012.

Total non-healthcare expenditure (i.e. administration fees, fees paid for managed care, broker fees, impairments, and reinsurance) rose by 9.8% from R13.1 billion in 2012 to R14.4 billion in 2013.

Before 2006, the increase in non-healthcare expenditure was consistently higher than the Consumer Price Index (CPI). The rate of increase was reversed in 2006 and since then there has been a real decrease in non-healthcare expenditure, from R1 940.9 in 2005 to R1 645.8 per average beneficiary per annum (pabpa) in 2013 (prices adjusted to 2013 prices).

Net healthcare results and impact on reserves

The net healthcare result of all medical schemes in 2013 was a surplus of R1 551.8 million in 2013 (2012: R29.0 million surplus). Open schemes incurred surpluses of R626.5 million (2012: R61.1 million deficit), and restricted schemes generated surpluses of R925.2 million (2012: R90.1 million surplus). This improvement is mainly due to the reduced claims ratios of all schemes from 87.7% in 2012 to 86.4% in 2013.

Investment income and consolidation adjustments increased by 1% to R3.7 billion in 2013 and resulted in medical schemes making a final surplus of R5.3 billion (2012: R3.7 billion) in the financial year under review.

Net assets or members' funds, defined as total assets less total liabilities, rose by 13.3% to R46.3 billion at the end of 2013.

Accumulated funds (reserves as defined by Regulation 29 of the Medical Schemes Act) grew by 13.4% to R44.3 billion from R39.1 billion recorded at the end of 2012. This translated into the industry average solvency ratio increasing by 2.1% to 33.3% from 32.6% in 2012. This level remains higher than the prescribed solvency level of 25.0%.

The solvency ratio of open schemes increased by 2.1% to 29.7% in 2013 (2012: 29.1%). Restricted

schemes experienced an increase of 2.1% in solvency ratio, which increased to 38.2% (2012: 37.4%)

In relation to CMS operations during the 2013-2014 financial year:

Supporting the NHI process

The CMS remains fully supportive of the process of establishing a national health insurance (NHI) system for South Africa. A member of the CMS's Strategic Management Team on NHI serves on a technical sub-committee of the Ministerial Advisory Committee (MAC) on NHI.

Promoting a medical schemes market that is efficient, orderly, and fair

The CMS has found it necessary to strengthen certain provisions of the Medical Schemes Act, including provisions on the governance of medical schemes and prescribed minimum benefits (PMBs). Proposed amendments were approved by Council in 2012/13 and the draft amendment bill was submitted to the Department of Health (DoH) in October 2013. We look forward to the approval of this bill in order to address a number of gaps in the industry.

While the South African medical schemes environment remains stable, the growth of the industry is worrying, with a year-on-year increase of only 1.1% in the total number of medical scheme beneficiaries between 2012 and 2013.

The provision that entitles all members and beneficiaries of medical schemes to a set of PMBs remains the most striking feature of the Medical Schemes Act. This guarantee protects members against health events which could otherwise result in financial ruin. The Medical Schemes Act makes provision for the review of PMB regulations every two years. Draft regulations reviewing PMBs were submitted to the Ministry of Health in 2010 and were expected to be published in the Government Gazette in 2012/13. This has not happened by March 2014. The CMS has further undertaken to review the definition of various PMBs including preventative and primary care measures.

During 2013/14 a multi-year project on measuring the impact of managed care interventions gained significant momentum. The project is a collaborative initiative involving the CMS and the Managed Care Working Group of the Industry Technical Advisory Panel (ITAP). In 2013, a study reviewing international best practice models on managed healthcare was undertaken by the Office of the Registrar. It shows the South African medical schemes market has a long way to go in documenting health outcomes within managed healthcare. In future the CMS will make changes to the annual data specification in order to start collecting more process indicators and information on health outcomes.

On the crucial matter of price escalation in the private healthcare sector and the determination of prices the CMS dedicated task team continued to provide support to the Market Inquiry Committee of the Competition Commission (CC). The CC has complemented CMS on its high quality input to the draft Statement of Issues and draft Guidelines for Participation. The CMS team also submitted a large number of documents and data to aid the CC in its inquiry. We will continue to support the CC in this important piece of work.

14th unqualified audit

The Auditor-General of South Africa (AGSA) provided the CMS with its 14th unqualified audit report in a row for the manner in which the CMS managed its financial affairs and complied with the requirements of the Public Finance Management Act 1 of 1999 (PFMA) and other applicable legislation.

The CMS looks forward to another year of success in 2014/15, as it continues to fulfil its mandate to protect members, guide medical schemes and contribute to the attainment of a more equitable national health system.

The full CMS Annual Report is available for download on www.medicalschemes.com

PRO BONO SERVICES TO MEMBERS IN MEDICAL SCHEME DISPUTES



The CMS, together with ProBono.Org have set-up a Pro Bono Panel for medical scheme members. Legal representatives will render free services to members of medical schemes who are in dispute with their funds and have suffered hardship or cannot afford their own legal representation in cases serving before the CMS Appeals Committee or Appeal Board.

Mr Daniel Lehutjo, Acting Chief Executive & Registrar, said “we identified the need for pro bono legal representation as many members attend hearings without legal representation, and as most medical schemes are very well represented, this can potentially leave members vulnerable, not well informed and jeopardise the outcome of the case.”

This is why CMS approached ProBono.Org to assist beneficiaries of medical schemes in selected cases. CMS selects and refers certain cases to ProBono.Org who in turn facilitate the provision of free legal services through the volunteerism of a panel of private attorneys.

ProBono.Org promotes, protects and realises the rights established in the Constitution by improving access to justice to poor, vulnerable and marginalised South Africans.

The partnership between ProBono.Org and CMS will realise vulnerable members’ rights to proper legal representation, access to quality healthcare,

access to information and equality.

While medical scheme members are served through these pro bono services it also presents the opportunity for members of the legal profession to gain practical experience in what is considered to be a specialised field of law, which is unique in nature. Some of the leading South African law firms are already showing interest in joining the Pro Bono Panel.

Not all cases will be referred to the Pro Bono Panel. The CMS Legal Services Unit together with ProBono.Org will use their discretion to refer matters where members have clearly suffered hardship. Some of the considerations will include the monetary value involved as well as the condition the member suffers from.

The CMS Appeal Board has the powers of the High Court to summon witnesses, to cause an oath or affirmation to be administered by them, to examine them, and to call for the production of books, documents and objects.

According to ProBono.Org providing members of medical schemes with pro bono assistance at these hearings, will result in equal representation of all parties. This will enable members to have access to legal representation which makes the right that all people have to a fair hearing to resolve disputes, set out in Section 34 of our Constitution, a reality.

THE 4TH CMS INDABA

The fourth CMS Indaba, and the inaugural use of CMS' Auditorium named, Imbizo, was held in July.

The Indaba saw close to 200 industry players attending the conference, which aimed to discuss Ethics in the Medical Scheme environment. Mr Dan Lehutjo, the Acting Chief Executive & Registrar officially opened the auditorium and Indaba where he stressed the importance of ethics in the running of business. "The concept of ethics sounds simple and yet we see a number of corporate failures mainly attributed to lack of ethical leadership. Organisations have a good understanding of ethics but the challenge is to walk the path of ethical conduct," he said.

Dr Elsabé Conradie, Head of Stakeholder Relations explained that the aim of the Indaba was to provide some insight to the challenges faced by the healthcare industry. "We partner with well-recognised

industry experts and speakers to unpack the complexities of the industry in which we operate. We also use the platform to inform the industry of the latest developments from the regulator's side of things."

The Indaba saw presentations from amongst others Ms Tamara Paramoer from the Competition Commission, who contextualised the Market Inquiry into health, Dr Guni Goolab, Principal Officer of GEMS who spoke on Trustee Remuneration; Mr Malcolm Brown, the former Chairman of SAICA, who presented on Ethics in governance. Adv Janet Ehlers, the Specialist Analyst of Treating Customers Fairly (TCF) for the Financial Services Board (FSB) also explained the regulatory approach of TCF.

The next CMS Indaba is expected to take place in February 2015. The theme and date will be communicated early 2015.

WHAT TO CONSIDER WHEN JOINING A MEDICAL SCHEME

Only medical schemes offer comprehensive cover for both chronic as well as unplanned medical incidents. South Africa has about 8,77 million people who are members of 87 medical schemes.

The Council for Medical Schemes (CMS) came into existence through the Medical Schemes Act (131 of 1998) to protect this large group of medical scheme members.

The CMS' mandate is to regulate the medical schemes industry and to ensure that people receive fair and equal access to medical care. The CMS has to inform people about their rights as well as solve disputes as it relates to medical schemes free of charge.

The refrain that is often heard is that medical schemes are expensive but it is a reality that an unforeseen medical emergency and hospitalisation can easily run up medical bills that can amount to hundreds of thousands of rands.

It is therefore important to choose the right medical scheme not only based on price but by doing research to ensure that the scheme meets your needs.

Advice on choosing a medical scheme

This advice is not only applicable to potential medical scheme members but current members who have the option of selecting a different benefit option each year.

Ensure that the scheme is duly registered in terms of the Medical Schemes Act 131 of 1998. The names, addresses and telephone numbers of all registered schemes are published on the website of the Council for Medical Schemes at www.medicalschemes.com. The list is furthermore published annually in the Government Gazette for general information.

The office of the Registrar will also provide you with information on registered schemes such as their financial statements etc.

Identify a few schemes and request information about their benefits, contributions, limitations and exclusions. Compare this information given to see which one meets your needs.

Besides the healthcare benefits also find out what the schemes reserves are (solvency ratio), and non-

healthcare expenditure, such as administration costs, to ensure they are in good financial health. Understand what prescribed minimum benefits (PMB's) are and under what circumstances the chosen scheme provides such cover for you. Here you can look at designated service providers and their proximity to you as well as other networks that provide benefits to members.

Advice for current medical scheme members

If you are already a member of a scheme, read all the material such as options to change plans. Ensure that you understand how the benefit options operate and elect according to your healthcare needs and what you can afford.

The registered rules of medical schemes fully disclose detailed information regarding the relevant benefits and contributions. It is essential that you obtain the rules of the scheme or a summary thereof to verify all information relevant to enable you to make an informed choice.

Some people choose to make use of an agent or broker (intermediary). Remember it is not compulsory to use a broker, but if you do ensure that he/she has been accredited by the Council for Medical Schemes and that your selection of scheme is based on informed consent.

Contact CMS

How to choose a medical scheme, PMB's, rights of scheme members, complaints procedure and further relevant information on medical schemes can be found on www.medicalschemes.com.

As a medical scheme member, it is your right to complain whenever you feel that you have been treated unfairly. Complainants are advised to follow the due process tabulated below for an efficient resolution of their disputes.

To initiate the complaint process the complainant must:

- Lodge a complaint with the scheme – with the principal officer then the dispute committee if you're not satisfied with the response from the principal officer;
- If no resolution was reached, lodge the complaint with the Registrar's Office at the Council for Medical Schemes (CMS);
- CMS will escalate the complaint to full Council in cases of no resolution; and
- If there is still no resolution, the matter will be served at the Appeal Board

Consumers are reminded to always be cognisant of their rights and responsibilities in order to make the right decisions which impact their financial and health situation.

CONTACTING THE REGISTRAR, COUNCIL & APPEAL BOARD

Website
www.medicalschemes.com

Physical Address
Block A, Eco Glades 2 Office Park,
420 Witch-Hazel Avenue,
Eco Park,
Centurion,
0157

Postal Address
Private Bag X34,
Hatfield,
0028

Phone & Fax
0861 123 CMS (267)
(012) 431 0584 (Complaints Call Centre)
(012) 431- 0560 (Complaints Fax)

Email
complaints@medicalschemes.com

OTHER COMPLAINTS RELATED TO HEALTH

For complaints against Health Professionals (Doctors) - www.hpcs.co.za

For complaints against Private Hospitals - www.hasa.co.za

For complaints against Nurses - www.sanc.co.za

For complaints against brokers - www.faisombud.co.za

For complaints in respect of other health insurance products - www.osti.co.za (for short term) or www.ombud.co.za (for long term insurance)

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Council for Medical Schemes



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Council for Medical Schemes



Council for Medical Schemes
Government Organization
The Council for Medical Schemes is a statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.

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In our latest Circulars, read up on Discovery Health Medical Scheme's merger with PG Bison Medical Aid Society and AfroX Medical Aid...



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CMS News

COUNCIL FOR MEDICAL SCHEMES

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