

DRAFT GOVERNANCE REPORT

**SURVEY OF GOVERNANCE PRACTICES AND CAUSES OF
GOVERNANCE FAILURE IN MEDICAL SCHEMES**

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1. INTRODUCTION

During 2002, the Council for Medical Schemes (“the Council”) commissioned the University of Pretoria to conduct a survey of governance processes among trustees of medical schemes, with a view to better understanding governance practices and providing information to allow trustees to benchmark their governance practices against best industry practice. The study reinforced the view that sound governance of medical schemes was critical to their successful operation and to the best interests of members. The study found many aspects of board function that were working well. At the same time, there were many gaps in board performance against reasonable expectations, some widespread and serious. Specific recommendations were made as to how improvements could be effected, which were widely communicated to trustees.

Since then, there have continued to be unacceptable levels of governance failure within medical schemes. Governance failure, for purposes of this report, is defined as the violation of the principles of good governance. This often results in the total collapse of the medical scheme or severe difficulties encountered by the scheme. However, the effects of governance failure need not be immediately apparent in the operations and performance of a medical scheme. Left unchecked, though, such failures are likely to lead to tangible adverse effects on the scheme.

Governance failures undermine the statutory objective of the Council to protect the interests of beneficiaries of medical schemes. It was therefore considered necessary to follow the 2002 survey with a more limited review of key aspects of current governance practices within medical schemes, and to focus more specifically on key determinants of governance failure. Key objectives of the project were:

- a. to identify causes of governance failure;
- b. to assess the extent to which the existing governance model, and/or misapplication of the model, contribute to the identified causes; and
- c. to recommend additional strategies to improve medical scheme governance and mitigate the risk of governance failure.

This report details the findings of the study. The recommendations include potential remedies to improve governance and reduce the risk of failure, which may be implemented by medical schemes or through regulatory or policy development. These measures are not exhaustive of possible remedies, but are intended to provide the basis for further consultation and inputs on the issues raised.

2. THEORETICAL, LEGAL AND POLICY FRAMEWORK

Corporate governance is the system by which business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different participants in the corporation, such as the board, managers, shareholders and other stakeholders, and spells out the rules and procedures for making decisions on corporate affairs. By so doing, it also provides the structure through which the company’s objectives are set, and the means of attaining those objectives and monitoring performance.

In the context of medical schemes, corporate governance is concerned with promoting independence, transparency, accountability and discipline within the management and operation of the schemes. It covers the structures and systems that a medical scheme has in place to oversee its affairs. This involves a number of elements, including a clear understanding by board members of the scheme’s

strategic objectives, systems to ensure the effective management of risks, and mechanisms to ensure that the scheme's obligations are identified and discharged effectively.

Sound corporate governance in medical schemes is essential not only to the wellbeing of the individual medical scheme, but also as a critical ingredient in maintaining a financially sound and robust private health care industry that ensures the protection of beneficiaries.

Responsibility for maintaining sound corporate governance within medical schemes rests with the Board of Trustees. Trustees are the representatives of the medical scheme members and their dependants, and are legally responsible for the direction of the scheme on their behalf.

These responsibilities can be best met through a sound medical scheme governance philosophy and through policies and practices that maximize the board's overall focus, effectiveness, and efficiency. Board policy and practice should in particular promote good decision making, proper and timely execution, clear accountability and regular performance review.

The responsibilities of trustees of medical schemes derive primarily from two sources: the common law, in particular as it has been amplified through the King Report; and statute, in this case the Medical Schemes Act, 131 of 1998, the requirements of which are incorporated into scheme rules.

2.1. Common Law

As persons who exercise fiduciary responsibilities over the financial affairs of others, at common law trustees are expected to meet certain duties:

- a. First, they have a duty of care. In other words, they should exercise the same level of care, diligence, and skill over the affairs of others that an ordinarily prudent person would exhibit over her or his own affairs. This requires that decisions should be taken with honesty and integrity and with due consideration to all relevant facts.
- b. Secondly, they have a duty of loyalty. In other words, they must always ensure that the interests of members of their medical scheme remain paramount in their decisions and dealings, and that they do not use their positions for personal gain. Loyalty to members also entails scrupulous protection of the confidentiality of individual member information.
- c. Thirdly, they have a duty of obedience. They are required to act in accordance with the relevant legislation and with the rules of the medical scheme.

The common law has been expanded and amplified by the King Commission, which produced a code of conduct and guidelines for good corporate governance for use by South African industries. The guidelines covered a variety of issues including: the role and functions of boards and directors; risk management and internal audit; accounting and auditing; and legal compliance.

Of particular relevance to medical schemes is the King report's description of the respective roles of the board, chairperson, executive and non executive directors and the chief executive officer. It also details particular conditions for good corporate governance in relation to: director selection and development; appraisal of boards and directors; disqualification of directors; and board committees.

Central to all of these issues are seven principles of good corporate governance identified by King, namely: discipline; transparency; independence; accountability; responsibility; fairness; and social responsibility.

2.2. Medical Schemes Act, 131 of 1998

In terms of section 24(2) of the Medical Schemes Act ("the Act"), no medical scheme shall be registered unless the Council is satisfied that members of the board of trustees and the principal officer of the proposed medical scheme are fit and proper persons to hold the office concerned. The statutory duties of the board of trustees of a medical scheme, however, derive primarily from the provisions of section 57 of the Act.

In terms of that section, all medical schemes shall have a board of trustees who shall be fit and proper to manage the business of the scheme. At least half the members of the board shall be elected from amongst members of the medical scheme.

To reduce opportunity for conflict of interest, certain categories of person may not serve as trustees of a medical scheme. These include (a) brokers; and (b) employees, directors, consultants or contractors of the administrator of the medical scheme concerned, or of the holding company, subsidiary, joint venture or associate of that administrator.¹

The Act imposes certain general obligations on trustees, arising from their common law obligations. These duties are: to protect the interest of members at all times; to act with due care diligence, skill and good faith; and to act with impartiality in respect of all beneficiaries.

Section 57 also lists a number of specific duties of boards of trustees. These include: appointment of the principal officer; accountability for operations of the scheme and resolutions passed by the board; ensuring that proper control systems are in place; communication to members on rights, benefits, contributions, and duties in terms of rules of the scheme; ensuring timeous payment of contributions to the scheme; procuring professional indemnity insurance and fidelity guarantee insurance; obtaining expert advice on legal, accounting, and business matters as required; ensuring compliance with the Act; and protecting the confidentiality of member information.

Further obligations on trustees arise from the rules of medical schemes, which set the legal parameters of the relationship between members and medical schemes. Section 29 of the Act sets out certain minimum requirements to be contained in the rules of a medical scheme, with a view to protecting the interests of members and providing a framework for good governance. For example, rules are required to include provisions relating to: the appointment, removal from office, powers and remuneration of officers of a medical scheme; processes for the execution of contracts and other binding documents; custody of securities, books, documents and other effects of medical scheme; and the appointment of auditors of a medical scheme.

3. STUDY METHODOLOGY

The study was conducted in the latter half of 2004, in two parts. In the first part, a survey was conducted in a cross-section of medical schemes to develop an understanding of generally prevailing governance practices in the industry. In the second part, a more focused case study methodology was employed to identify causes of governance failure in medical schemes which had experienced significant governance problems within the preceding two years.

In the **first part**, twenty four registered medical schemes participated in the survey. A non-probability convenience sampling was used to select schemes. The schemes were stratified by type (open or restricted) and included a cross-section of schemes in terms of governance and financial performance.

¹ Similar restrictions are placed on persons who may serve as principal officers of medical schemes.

Six administrator and 24 medical scheme representatives were interviewed using a semi-structured questionnaire on a range of governance related issues. Quantitative data analysis was limited, and was intended for exploratory purposes. Qualitative data analysis allowed for an in-depth interpretation of the data and thematic coding of the results.

In the **second part**, an explanatory multiple case study approach was followed. This approach allowed for in-depth investigation of issues, as well as for the assessment of causal factors of governance failure from more than one scheme using data from several sources. Eight medical schemes which had experienced some form of governance failure in the preceding two years were selected for the study.²

Data sources included: court papers; inspection documents; audit reports; statutory returns; medical scheme rules; financial reports and correspondence. The advantage of using multiple sources of information was that it allowed for the evaluation of a broad range of historical, attitudinal and behavioural issues.

Quantitative indicators included membership, board size and financial soundness. Qualitative indicators included: managerial culture; board effectiveness (composition, committees, and compensation); influence of the chairperson; internal control systems; key strategic issues, such as choice, clarity and execution of strategy, and ability to adjust to regulatory or market changes. They also included extent of strategic oversight in relation to, evaluation of the scheme and board, use of performance measurement systems and board dynamics.

Independent variables from the various cases were compared in order to determine why and how these schemes ended up with the same outcome of governance failure. Various tests were also used to assess the quality of the research design.³

4. PREVAILING GOVERNANCE PRACTICES (FINDINGS OF PART 1)

4.1. Board Structure and Composition

a. Structure

Structures of the boards of schemes surveyed generally varied in terms of the number of elected versus appointed trustees. The number of trustees ranged from three to sixteen, although there was no statistically significant correlation between the number of trustees and the size of membership of schemes. It was, however, standard practice for a minimum representation of elected members to be not less than 50 percent (as required by the Act) with the balance being appointed trustees. There

² In each of these cases, the Council had intervened by using various remedies available to it, including: inspections; meetings with trustees; removal of trustees; curatorship; and deployment of a compliance officer to the scheme. The interventions had mixed results. In some instances, trustees resigned before any action could be taken against them. In such situations, new trustees were elected to safeguard the stability of the schemes.

³ **Construct validity** was used to establish correct indicators for the objectives of the study. This was assessed using multiple sources of data, establishing chain of evidence or having key informants review draft case study report. **Internal validity** allowed for the establishment of causal relationships where one set of conditions was shown to lead to other conditions, thus separating them from spurious relationships. This was done during the data analysis phase. **External validity** helped in the establishment of the domain to which the study's findings can be generalised. This will necessitate the use of replication logic. This was done during the study design phase. **Reliability assessment** ensured the repeatability of the operations of the study particularly, data collection procedures, leading to the same results.

were some cases, where elected trustees represented 60% or more of the total membership of the board.

Board composition also differed in other respects. Some schemes made provision for a pensioner representative on the board, as they considered pensioners to have special needs. Certain boards also included regional representation. In these cases, regional representatives typically formed part of the board, resulting in a larger board. Other schemes used alternate trustees to replace those who might not be able to attend meetings.

Board committees also varied in terms of number and focus. Typical committees included: disputes; audit; executive management; marketing; product development; finance; risk management; medical; remuneration; investment; *ex gratia*; and rules committees.

In most schemes, trustees were required to participate in at least one of the committees, although not all schemes had a formal policy of participation in committees. Committees are delegated specific tasks by the board, which they then discharge on behalf of the board. The committees can only report findings and make recommendations to the board. The board has the power to make the final decisions. All committees are chaired by trustees who would have been selected from among committee members.

The maximum term of office for a trustee in all schemes was 3 years, which could be extended depending on whether the trustee was re-elected or re-appointed.












b. Skills and Experience

The skills mix in most surveyed schemes varied widely. It included the following areas of expertise: legal, medical, financial and accounting, economic, actuarial, strategy, and human resources. The experience of trustees ranged from little or no experience at all, to experience spanning twenty or more years in the health care or medical schemes industry. Trustees reported that it was not possible to have all the expertise needed within the board. They often depended on external expertise to compensate for the unavailability of the expertise from within the board.

Despite the variability in skills and experience of trustees, the majority of schemes surveyed did not have a formal induction programme for new trustees. Induction usually took place informally, through provision of board packs, and continued support of the trustees by the principal officer. Board packs typically included documents on governance, administration activities, scheme rules, government charters, the King 2 report, terms of reference of subcommittees, and relevant sections of the Act and policy documents.

A few schemes did offer formal induction programmes. The programmes entailed formal training of new trustees, usually for a maximum period of one day. Training typically covered the issues listed in Table 1.

Table 1: Issues typically covered in trustee induction programmes

-  Fiduciary duties of trustees
-  Information on scheme and administrator
-  Recent annual report
-  Details of current board members
-  Details of executive management
-  Composition of board committees
-  Schedule of board meetings
-  Pack of most recent board meeting
-  Medical Schemes Act & regulations
-  Details of administrator's organizational structure
-  Delegation of authority

Schemes also relied on induction and training programmes offered by their third party administrators. These programmes generally focused on legislative, industry and operational issues.

Most schemes did not have a formal process for continued learning for trustees. They relied on training offered by the Council or the Board of Healthcare Funders, *ad hoc* industry seminars and training programmes, information sessions by industry stakeholders, and international conferences.

Trustees reported that a major challenge with regard to their training and continued learning is that they are non-executive trustees who carry out their duties on a part-time basis. In some instances, their employers are reluctant to release them to attend to medical scheme activities such as training.

c. Fit and proper status of trustees

Schemes saw it as their responsibility to ensure that trustees were fit and proper. In some schemes, a full assessment is made to ensure that new trustees are fit and proper to serve on the board. Typical tools used by schemes to assess whether trustees are fit and proper include: a trustee charter; *curriculum vitae*; regulatory provisions for the various professions; reference checks; relevant provisions in the Companies Act; credit checks; and checks for criminal history. There were however, schemes that had no policies for screening new trustees in terms of fit and proper requirements.

d. Procedural Issues

The maximum number of scheduled board meetings ranged from four to nine per annum. These excluded committee meetings, as well as special or ad-hoc board meetings held as and when needs arose. Special meetings would be arranged at the request of the members of the scheme.

All schemes reported that they made decisions based on information presented to them, either by the principal officer, fund manager or another relevant party. They normally arrived at a decision through consensus. Where consensus was not possible due to differing opinions among trustees, matters were put to the vote. When urgent decisions had to be taken that could not














wait for a board meeting, the “round robin” method was used. Decisions taken by the board were communicated to the principal officer or fund manager for execution.

e. **Remuneration**

Different practices exist in terms of remuneration of trustees by schemes. Trustees in certain schemes receive an honoraria and disbursements. In others, there is fixed remuneration with increments linked to inflation. Other schemes only reimburse such representatives as the medical advisor and the pensioner representatives.

4.2. Strategic Planning

Some of the surveyed schemes had a formal strategic planning process, while others did not. Common objectives of schemes’ strategic planning processes are listed in Table Two.

 Ensure the financial soundness of the scheme
 Comply with legislation
 Develop new products
 Adjust to healthcare developments
 Ensure good governance of the scheme
 Monitor the effect of prescribed minimum benefits on the scheme
 Grow the membership
 Improve client service and effective administration
 Develop an effective communication strategy
 Ensure that the scheme is sustainable
 Ensure that the contribution to benefit ratio is fairly balanced
 Ensure that medical scheme cover is affordable
 Pass on the benefits of an increased solvency to members

Less commonly stated objectives of strategic planning processes included to: limit membership growth; limit the number of brokers; improve risk profiles; and reduce administration costs.

Strategic planning processes were either reactive to market or regulatory developments in the private healthcare environment or were routine components of scheme planning processes. Trustees reported that the flexibility within which they approach strategic planning allowed revisiting plans from time to time or as and when things changed.

Various methods were used by schemes for strategic planning, which sometimes resulted in strategic planning sessions in order to review past performance relative to goals and to set new goals. Some schemes employed the services of health consultants to keep up to date with changes in the environment once a year. Internal audit and risk management units of schemes, or their administrators, were also used to identify changes in the environment.

With the assistance of the administrator, some schemes conducted SWOT (strengths, weaknesses, opportunities and threats) analyses and evaluated financials, procurement, human resources and labour issues. This would then be reported to the board which would consider any changes before decisions are made and implementation effected. The administrator would in

many instances provide advice and guidance to the board on all issues pertaining to regulatory and market changes. In certain cases, the internal audit or risk management department of the administrator would carry out comprehensive research into a wide range of issues and use this as input to manage potential changes. Internal audit systems were increasingly used as part of risk management strategies, allowing schemes to regularly evaluate the scheme's and/or administrator's internal processes.

Schemes reported that once all the regulatory and market changes have been identified, detailed presentations are made to the board, and these often include proposed action plans. The board would consider all options before approving the most appropriate plan. Subsequent to this, they would then give mandates to parties that are required to execute the decisions or resolutions.

Different processes are utilised by schemes to operationalise strategies. In some schemes, the executive management executes the strategic decisions of the board. In schemes with third party administrators, execution is typically done by the administrator.

Monitoring of the execution of strategies is done through quarterly reports or six monthly reviews of budgets, business plans and benefits. In a minority of schemes, it is also done on a monthly basis, according to the service level agreement with the administrator. Additional monitoring tools used by schemes were Council for Medical Schemes circulars and inputs from the various consultants and service providers.

Certain schemes, despite having a third party administrator, developed and monitored their own strategies. They were able to do this through their research and development section which was also responsible for product development and monitoring of service level agreements.

4.3. Scheme Management

Self-administered schemes generally had a fully-fledged executive management structure and a full staff complement. Business divisions typically included: human resources and finance; business development; operations; managed health care; and information technology.

Only two participating third party administered schemes had a formal executive management structure, which took charge of all the operational activities of the scheme. These management structures included a principal officer, company secretary and executives responsible for finance, risk management, client liaison and product development. Restricted schemes typically used the employer's infrastructure for financial, procurement, human relations and labour relations issues.

In some schemes, the executive management committee served in an advisory capacity to the board of trustees and attended all board meetings.

Trustees generally demonstrated understanding of the role of the principal officer, which were typically described as: ensuring compliance with Acts and rules; managing the scheme's office; administration; managing trustee business; implementing board resolutions; communicating with members; making recommendations to the board; managing subcommittees; managing staff; and ensuring appropriate investment of funds. The relationship between the principal officer and the board was considered to be good by all the medical schemes in the survey.

In most third party administered schemes, the principal officer was the only executive manager within the scheme, possibly supplemented by a clinical advisor. The board of trustees sometimes assumed executive responsibilities and together with the principal officer formed the executive structure of the scheme. In most cases, the principal officer served in this capacity for a single

scheme, although in one case a person served as principal officer for three schemes. While some principal officers were full-time employees of the scheme, in third party administered schemes part-time positions were more common, as management functions were largely performed by fund managers of the administrator. In some restricted schemes, principal officers are also employed by the company and generally hold fairly senior positions within the employer organization.

In some schemes the principal officer managed all the operational activities and legislative responsibilities of the scheme. In certain third party administered schemes, however, all the management and operational responsibilities of the scheme were delegated to the administrator and were typically performed by the fund manager. In some of these schemes, the fund managers attended all the meetings of the board and liaised directly with it. They were also responsible for advising the board on legislative developments, strategic issues and investment options. In these instances, the principal officer was rendered ineffective and was regarded more as a statutory requirement than an operational necessity. In one case, the chairperson of the board did not see the need for a principal officer as "the administrator was doing everything."

Self administered schemes, and third party administered schemes with executive management structures, typically had in place human resources and labour relations policies, financial management policies and procurement policies. Execution of many of these policies was sometimes delegated to a third party administrator.

Human resource policies would normally cover such areas as recruitment, remuneration, retrenchment, disciplinary, leave, and labour relations. Financial policies tended to cover such issues as debt collection, investment, travelling, fixed assets, and so on. Procurement policies typically entailed a schedule of authority and sign off.

Not all schemes had a formal policy on procurement. Some of these schemes commented that "certain consistent selection criteria are used to identify appropriate persons or service providers for appointment". These criteria were, however, not formalized in any manner. In other schemes, the principal officer was charged with the responsibility of identifying procurement agencies which would then be taken to the board for approval.

4.4. Relationship with Members

Most schemes reported that members had easy access to the principal officer and trustees, although they might need to contact trustees through the principal officer. In some instances, members are allowed to write to the trustees or make appointments to see them. To facilitate such a process, schemes would provide members with all trustee names and contact details such as telephone numbers and emails. In employer-based restricted schemes, the trustees would be well known within the company and would also be accessible to members. Some schemes also include provision in their rules for member access to trustees.

There are schemes where access to trustees is less institutionalised and is usually relegated to contact with members at the AGM, although even in these cases, some trustees have reported having been approached informally by members outside the AGM.

More generally, most schemes reported having comprehensive, objective and understandable communication processes, which allowed them to effectively communicate all relevant changes to members. Typical communication processes are listed in Table Three.

Table 3: Typical processes for communication with members

- ✚ Welcome packs for new members
- ✚ Magazines
- ✚ Benefit brochures
- ✚ Statements and letters
- ✚ Annual reports
- ✚ SMS
- ✚ Site visits, open forums and members information sessions
- ✚ E-mails
- ✚ Fact files sent to members
- ✚ Training of employers and brokers
- ✚ Walk in centres
- ✚ Web site
- ✚ Call centre
- ✚ Union representatives
- ✚ AGM
- ✚ Newsletters

Communication to members could be done by the administrator, executive management, brokers, or by using the infrastructure of the employer, depending on the scheme's contractual arrangements. Restricted schemes sometimes communicate with members through the human resources departments and internal billboards of employers. Responses were mixed with regard to attitude to brokers. Various respondents regarded them as "a necessary evil" to the industry; one that nonetheless had to be tolerated.

A particularly important opportunity for scheme interaction and communication with members is provided by the Annual General Meeting (AGM). Procedural requirements for AGMs are typically set out in the rules of schemes. Theoretically, AGMs provide an opportunity for direct member involvement in scheme governance through election of trustees. In most cases, members who do not attend the AGM are not eligible for nomination to the Board. The AGM is also a forum through which schemes engage members directly on issues pertaining to benefits and contributions. In most schemes, the AGM or special general meetings provided the only effective opportunity for members to participate in discussion on changes in benefits and contributions.

Typical issues which form part of AGM agendas included: declaration of a quorum; the annual report; matters arising; election of trustees; honoraria; concerns pertaining to the scheme; members' issues; regulatory issues; financial statements; remuneration of trustees; the chairperson's report; the auditor's report; and tabling of motions. Provision also exists in the rules of most schemes for the removal of trustees at the AGM (and sometimes outside the AGM too), as well as for the passing of a motion of no confidence on the board at a meeting.

In general, the level of participation of members in AGMs was very low, despite initiatives by some schemes to actively encourage members to participate. The participation rate in AGMs ranged from 5% in some open schemes to 17% in some restricted schemes. In one instance, only three members out of a total membership base of more than 10 000 beneficiaries attended the AGM, resulting in more board and scheme representatives than members at the AGM. In some schemes, members who attended were mostly pensioners and members with specific concerns. Some trustees described member participation in AGMs as "passive."

Trustees pointed out that, while attendance at AGMs is actively encouraged, a contributory factor to poor attendance is the location of venues, which constrains member participation because of distance, time and costs involved. Schemes reported that they compensate for low attendance of AGMs by interaction with members through regional committees, client liaison officers, brokers, and employee group leaders.

A key component of scheme relationship with members relates to resolution of complaints, although all the schemes interviewed reported that the number of complaints was generally small and manageable. Complaints received generally related to: inadequate benefits; affordability of contributions; non-payment of claims; service quality; benefit option changes; addition of new dependants; exclusions; termination due to non-disclosure; and condition-specific waiting periods. Recently however, most of the complaints to schemes reportedly had to do with changes in the medicine pricing legislation.

Complaints were dealt with on the basis of their nature and severity, which determined the approach to be undertaken by the scheme in resolving them. Depending on the nature of the complaint, it could be dealt with by: an onsite employee of the administrator; client liaison officers; the principal officer; the chairperson of the board; executive management; the administrator; brokers; a customer care department; or at the AGM.

Most schemes also had a dispute resolution committee, which was either permanent or convened on an *ad hoc* basis. The dispute resolution committee usually comprised three members, including a person with legal knowledge, medical knowledge and a third person. Some schemes did not see the need for such a committee, believing that complaints could adequately be dealt with through normal scheme processes.

Some trustees reiterated that not all members contact the scheme to complain; some members call to compliment staff.

4.5. Performance Management

In relation to the performance of trustees, certain schemes conducted formal performance evaluations while others did not.

Those that did not have a formal evaluation system for trustees considered it adequate to monitor performance of the scheme through benchmarking quarterly financial returns against the market and service level agreements. Some restricted schemes reported that their performance measurements for trustees were more implicit than explicit. These schemes used their employer's internal audit system to evaluate scheme compliance with legislation, indirectly evaluating trustees in the process.

Schemes that reported having a performance system for trustees focused primarily on indicators of scheme solvency levels and financial performance, and number of complaints. They also focused on membership growth (particularly in open schemes), compliance with statutory obligations and attendance of board meetings. In this regard, trustees were measured against indicators in strategic documents, specific benchmarks contractually agreed with third parties or operational objectives, all of which enable the board to "quickly see and gauge themselves on the direction the scheme is going".

Various methods were used to evaluate trustee performance against these indicators. Some schemes required all new trustees to sign performance agreements. Schemes also reported using monthly customised statistical reports which display performance in various areas and are

considered within the first seven days of each month by the Principal Officer and the administrator, with input from consultants.

Performance monitoring is sometimes carried out by way of a periodic review of monthly financial performance by the trustees and finance committee in consultation with consultants and the Principal Officer. In other schemes, the performance of the board was measured through an adapted version of the King Report questionnaire. The chairperson, in some instances, had a "360° evaluation", while the executive committee of the scheme was assessed by other members of trustees. It was suggested by some schemes that peer review among trustees is ideal.

In relation to performance of the principal officer, again there were some schemes which had a formal evaluation system, while others did not.

Where no formal performance evaluation system was in place, reasons given included the fact that the person's competence was not in question, and in some cases that the role of the principal officer was not sufficiently significant in light of the scheme's reliance on the administrator for managerial and administrative functions of the scheme. In some schemes, there was informal ongoing assessment of the principal officer by the chairperson of the board, through regular feedback on developments in the scheme. In other cases, there was no formal or informal method of measuring the performance of the principal officer.

In other schemes, there was a formal performance measurement system for the principal officer, usually formalised by performance agreements against which they were evaluated. Evaluations were conducted annually by the trustees, in some cases based on a presentation by the principal officer to the Board. In addition to this, various committees of the board also reviewed performance indicators monthly.

In relation to performance of third party administrators, service level agreements form part of all contracts and administrator performance is monitored constantly in terms of such agreements. Administrator performance is also assessed against financial savings to the scheme, rates of benefit utilization, and adequacy of membership growth. Performance assessments of administrators are conducted during board meetings based upon reports given.

Assessment of the performance of fund managers is generally also a proxy for the measurement of the performance of the administrator. Fund managers typically handle operational activities and provide advice to the board on a variety of scheme related issues. They are monitored by the administrator and their performance is discussed with the scheme's board at board meetings. In other schemes, the fund manager is evaluated on a monthly basis.

4.6. Conflict of Interest

While some respondents had little or no understanding of the concept, most trustees and principal officers interviewed had a reasonable understanding of what would constitute conflict of interest in a medical scheme setting. They gave several of the examples of conflict of interest situations where trustees would be unable to take an impartial view on a matter in which they had vested interest.

Certain schemes had no formal policy on conflict of interest, sometimes arguing that it was not considered to pose a significant threat to scheme business. There were nevertheless implicit policies and processes which they considered adequate to deal with the issue, including: terms of reference of various subcommittees; recusal of interested members from specific deliberations of the board; general legal and business principles; and relationships of trust. In at least one case,

the scheme had a conflict of interest policy that was never signed. Certain schemes undertook to develop a formal policy in response to the survey.

In schemes that did have policies on conflict of interest, some were explicitly based on the King 2 report. Issues typically covered by scheme conflict of interest policies are listed in Table Four.

Table 4: Issues typically covered by conflict of interest policies

- ✚ Definition of conflict of interest
- ✚ Compliance with scheme policies on governance
- ✚ Declaration of all interest and potential conflicts through:
 - standard agenda items
 - signature of declaration and confidentiality forms
- ✚ Exclusion of members from specific board deliberations and forfeiture of votes
- ✚ Discouragement of any links to related parties
- ✚ Background checking through CVs
- ✚ Declaration of all gifts
- ✚ Disciplinary action against those who fail to comply

Respondents reported that their relationship with third party contractors such as administrators, managed care organisations, brokers, and auditing firms were at arms length, independent and “business like”.

Schemes reported that their relationship with their administrators was healthy, open, transparent and sometimes “positively confrontational”. Issues were confronted and debated intensively and, although there were sometimes disagreements, this always ended up in a common understanding of issues. One trustee said of the scheme’s administrator: “we make them sing for their supper.”

In a few instances, members of the board were previous employees of third party contractors with whom their current scheme was contracted.

4.7. Attitudes and Conformance to Corporate Governance Requirements

Understanding of the governance model laid out in the Medical Schemes Act was varied, although all schemes reported that they conformed to good governance principles as outlined in the Act. Certain schemes demonstrated strong awareness of governance principles among the board, largely as a result of the involvement of trustees in the senior management structures of affiliated employers.

In one interview, however, the chairperson of the board was not familiar with the governance provisions of the Act, although the scheme claimed that the board conformed to governance principles as espoused in the Act. Other trustees believed governance principles extended no further than transparency. Trustees who were not fully aware of governance practices as they applied to medical schemes indicated that they sought guidance from the scheme’s principal officer or chairperson of the scheme, while others relied on the principles of governance as practised in their respective professions.

Schemes also reported that they conformed to King 2 principles, although not everyone was familiar with the principles enshrined in the King 2 report. Certain schemes however, were keen

to improve their understanding of governance and had, on occasion, invited Mr Mervin King to make presentations to their board. Others had organised seminars on good governance for trustees. There were, however, certain trustees who felt that King's governance principles were being forced on them.

There was a difference of opinion among trustees on whether or not it was possible and appropriate for a scheme to fully comply with the governance model of the Act. Some stated that it was possible to apply the model in its entirety, and that some of the problems being experienced in schemes were due to the fact that the current governance model was not being applied appropriately.

Others felt that schemes cannot fully implement the governance model of the Act without negatively impacting on the scheme, arguing that it was impossible to attract the right skills mix with a minimum requirement of 50% of trustees elected from among members. Trustees reported that in open schemes, members are sometimes elected on the basis of popularity, with no requisite skills or knowledge of the industry. In restricted schemes, on the other hand, rank and file employees are reportedly reluctant to participate, resulting in management filling most if not all of the board positions. The resultant effect is reportedly that the balance of skills is sometimes better.

Various other governance challenges were experienced by schemes and attributed to the current governance model. First, the governance model was considered to unduly add to non-healthcare expenditure and lessen efficiency. Committee structures cost money and could increase non-healthcare expenditure. Some schemes were reluctant to introduce a clinical governance committee, as proposed by the Council, because this would require costly recruitment of external people with appropriate skills. The reporting requirements of the Council were also perceived by some to unduly add to cost, as they were considered to be too detailed.

Secondly, some respondents considered the governance model to militate against entities with vested financial interest, such as administrators, resulting in them being reluctant to engage in high capital investment for entities in which they exercised no executive power. This created a challenge to the development of an effective relationship between the board and third party contractors like administrators.

Thirdly, there was a perception that the "good guys who fully comply with the Act always come second". The feeling was that playing fields were uneven and this unfairly favoured those that failed to comply.

Some respondents believed that change to the current governance model was unnecessary, but there rather needed to be higher levels of understanding of the current governance model. Others were of the opinion that there was a need for a new model. In this regard, various suggestions were made as to potential changes to the governance model. Some of these suggestions were motivated by a desire to place scheme governance on a more sound business footing, by creating a limited for-profit environment.

Some respondents suggested that investors, including consumers, should be given opportunity to access a guaranteed return from scheme, with appropriate statutory protection for consumers against abuse and profiteering by industry players. It was argued that this model could allow for innovation without a complete loss of accountability to the regulator. Regulatory attention could focus on providing assistance and guidance to boards, with more direct intervention only in circumstances where consumers stand to be severely prejudiced.

Various other suggestions were made in relation to improvement of scheme governance structures. Some respondents suggested the creation of a multi-tier board, which would

supplement the board of trustees with an advisory board without voting or decision-making powers. Others suggested that smaller boards are easier to operate and are generally more accountable, resulting in a better class of trustees. It was also felt that principal officers should become full members of the board, given the significance of their role in the affairs of the scheme. Some trustees stated that, whatever changes were made, the model should ensure that people within the system have a more active interest in the success of the scheme.

5. CASE STUDIES OF GOVERNANCE FAILURE (FINDINGS OF PART 2)

An analysis of the individual case studies of schemes which had experienced governance failures revealed various governance practices which appeared to contribute to these failures.

5.1. Dominance of Related Parties

Some of the boards of the medical schemes concerned were found to be dominated by the third party administrator, which had a strong influence on the affairs of the scheme. This often went beyond the contractual mandate and the role of administrators as contemplated by the Act. The administrator exerted its influence through its fund managers. Fund managers sometimes had a “permanent” seat on the board even though they did not have voting power.

There were also instances where trustees delegated their own statutory and fiduciary responsibilities to the administrator, which was unlawful or amounted to a dereliction of duty. For example, the trustees allowed the administrator to enter into contracts on behalf of the scheme with related parties such as brokers.

In other schemes, contracted marketing organisations exercised undue influence on the running of the scheme. The independence of the judgement of trustees was thereby seriously undermined. This resulted in decisions being made for the benefit of the contracted party, and not in the best interest of members.

5.2. Weaknesses in Leadership

There were schemes where the chairperson was considered to be domineering and reportedly exercised excessive control on the affairs of the scheme. The chairperson single-handedly ran the scheme, and trustees allowed the chairperson to make decisions that went unchallenged. There was also often no objective debate in board meetings and no positive criticism. As a result, there was no active participation by trustees at a time when they should have been acting in the best interest of members.

Other schemes allowed divisions within the board to render it ineffective, in some instances also resulting in resignations of certain members of the board.

5.3. Insufficient Knowledge and Experience

There were other schemes where trustees did not have the knowledge or experience to run the scheme. In some instances, the principal officer also did not have the necessary experience to run the affairs of the scheme. This resulted in all the responsibilities being passed on to the administrator, who managed the scheme on behalf of the trustees. In other schemes, incumbent

trustees were unable to perform their functions in terms of the Act due to lack of appropriate skills and expertise. This resulted in poor managerial and strategic oversight.

5.4. Prolonged Trusteeship

The governance practices of some schemes allowed trustees to hold office for a prolonged period of time. There were certain trustees who had served as members of the board for more than twenty years. While the scheme benefited from their "institutional memory," in some instances they exerted disproportionate and undue influence on the affairs of the scheme solely as a result of being the longest serving member.

5.5. Poor Financial Oversight

In some of the schemes which experienced governance failure, there was evidence of poor financial oversight by trustees and weak internal financial controls. This resulted in: misuse of members' money; double payment of claims; poor assessment of claims; poor internal controls; and inadequate reconciliations of billings and contributions. Poor financial oversight by trustees sometimes resulted in excessive contribution increases.

5.6. Poor Management and Misuse of Scheme Assets

Some boards were found to be guilty of irregularities and mismanagement of the resources of the scheme. There were instances where such boards were subsequently replaced by newly elected ones, although ensuing legal challenges had the propensity to render the scheme dysfunctional.

Some trustees were paid excessively given their responsibilities within the scheme, the performance of the scheme and the time they engaged in scheme activities. In other instances, the chairperson was paid consultancy fees in addition to normal trustee remuneration. There were also instances where trustees were paid an honorarium or received other benefits in contravention of the scheme rules.

Some trustees used scheme monies for their personal and social benefit, including subscription fees for social and sporting clubs. There was also inappropriate use of the financial resources of the scheme for activities that were of no benefit to members, or which were to the detriment of the scheme. These included: obtaining prime property in prime locations; purchase of expensive office furniture; and excessive expenditure in organising the AGM.

In one instance, an administration company that rightfully belonged to members was sold with the asset not reflected in the financial results of the scheme.

In another instance, a special general meeting was convened to pass a vote of no confidence on the board, but the meeting collapsed and the issues were never discussed as per the agenda. A group of concerned members joined the administrator in applying to the court for an interdict to prevent the trustees from awarding the administration contract until such time that various allegations, including bribery, had been investigated. The court dismissed the application on technical grounds but failed to address the irregularities.

5.7. Inadequate Communication

There were problems in the manner by which some of the schemes communicated with members, including the provision of misleading information relating to contributions.

5.8. Poor Legislative Compliance

Schemes which experienced governance failure typically demonstrated poor compliance with legislative provisions. In some cases, unregistered benefit options were run, and there were allegations of unauthorised deductions from members.

In the case studies, non-compliance was also identified with the following provisions of the Act or regulations: section 26(5), prohibiting payment of dividends, rebates or bonuses; section 57(4), concerning timeous payment of contributions; section 57(6) (c), relating to conflicts of interest; regulation 15(1), regarding managed health care arrangements; and regulation 18(3), concerning agreements between schemes and administrators.

5.9. Conflict of Interest

A number of instances of conflict of interest among trustees were identified, which adversely impacted on their ability to execute their duties in the best interest of members. In certain instances, conflict of interest arose as a result of association with brokers and administrators. In other cases, there were allegations that some of the trustees had awarded administration contracts in return for bribes or other favours. The principal officer of one scheme was also an employee of the administrator, in contravention of the Act. In another instance, a trustee who was also a broker used his position to defraud the scheme of a substantial amount of money.

5.10. Compliance with scheme rules

The legislation stipulates that the rules of a medical scheme are binding on members and trustees of the scheme. As a result, most medical schemes require approval of certain matters by members of the scheme before they could be implemented or amended. The rules would require that a minimum number of members constitute a quorum as pre-determined before a motion could be tabled and passed. Problems have however arisen where certain schemes failed to consult with members when deciding on such issues as the remuneration of trustees and other matters that require approval by members.

In one instance, the BOT approved an "excessive" salary package of a trustee without the prior approval of members as stipulated in the scheme rules. The rules of the scheme stated that any reimbursement of trustees would be determined by members from time to time. Members were denied the opportunity to engage in a matter that they legally should have been consulted on and one that had a bearing on their scheme.

5.11. Representation of constituency

Legislation contemplated a situation where members of a medical scheme would choose trustees to represent them as members of that medical scheme. However, there are schemes that have opted for representation of constituencies in the election of board of trustees. Typical

representation is usually done on the basis of union membership, continuation members and pensioners.

5.12. Regional boards

There are medical schemes that use regional boards based largely on provinces, in the election of trustees. The practice is that the chairpersons of the regional structures are ex-officio members of the board. The effect of this is that technically, members in one region or province are only able to elect one member based in their region, to the board. Such practices are not in compliance with legislation in that members cannot directly elect trustees in other regions. They do not have any influence in all other trustees in their boards other than the one they would have elected in their regions.

5.13. Elected vs. appointed trustees

The medical scheme legislation requires that at least 50% of the trustees should come from members. Elected members are elected on the basis that their trusteeship will be limited mostly to a maximum period of three years where-after they could stand for re-election. Appointed trustees are in certain instances, not subjected to the same set of rules as they are able to stay on the boards for a prolonged period of time. There is no mechanism of changing them unless they resign, retire or are expelled. They tend to have undue influence on the activities of the board and sometimes, they represent the interests of the employer, particularly in restricted schemes. This could unduly prejudice elected members who incidentally represent member interests.

6. RECOMMENDATIONS

The following recommendations are made to stimulate discussion on potential options to improve scheme governance and reduce the risk of governance failure.

6.1. Structure and composition of the board

The study found that few boards comprised more than the statutory minimum of 50% of elected trustees. In the context of concerns of conflict of interest leading to governance failure, as well as the reported disproportionate influence of appointed trustees, the appointment of trustees by mechanisms outside the control of scheme membership becomes an issue of potential concern. These trustees may, for instance, be incentivised to represent the interests of employers rather than the interests of members, where these interests diverge. It is important to ensure that board members are not representative of specific constituencies, but that member interests always dominate.

At the same time, it is acknowledged that there may not necessarily be the required skills, expertise and experience among scheme members for all trustees to be elected from among scheme membership.

It is therefore recommended that consideration be given to requiring 100% of trustees to be elected by members, although incumbents would not necessarily themselves need to be members of the scheme. The election of all the trustees by members of the scheme could also reduce the disproportionate influence of appointed trustees of the decisions of the board. At the

same time, the practice of appointment of alternates by individual trustees is also regarded as potentially subversive of the power of members to choose who will represent their interests, and reduces individual accountability. It is recommended that this practice should be eliminated.

Leadership weaknesses identified in schemes which had experienced governance failures may be exacerbated by dysfunctionally small boards, which do not allow adequate deliberations to occur within the board and which could impede effective member access to trustees. On the other hand, costs of board expenditure may be inflated by unnecessarily large boards. It is therefore recommended that the size of boards should be based on some predetermined criteria, most likely linked to size of scheme.

At the same time, there is a need to develop “fit and proper” criteria to enable schemes to determine the suitability of candidates for trusteeship of the board, and increase the likelihood that trustees will act independently, with integrity and with accountability toward medical scheme members. A set of core competencies for trustees also needs to be developed, taking into account the diversity of expertise required for the efficient running of schemes. Ideally, there needs to be a balance of skills, knowledge and experience among trustees for the scheme to function effectively.

Of course, it must be acknowledged that skills required to oversee the affairs of medical schemes will sometimes only be acquired in the course of trusteeship, and this underscores the importance of effective induction programmes and optimal opportunities for in-service growth and development. In this regard, many of the informal learning processes employed by some schemes at present are considered ineffective. Formal training programmes for trustees are therefore encouraged.

6.2. Executive management of the scheme

A key concern arising from this study was the relinquishment of management responsibility from the scheme to third party contractors such as administrators. Whereas administrators should perform specific operational activities for which they are contracted, management oversight and decision-making should always remain within the control of the scheme for the best interests of its membership. It is not appropriate that the huge budgets of medical schemes are managed by a part-time board, a single principal officer and one or two clerical staff.

It is therefore recommended that all schemes should have an executive management structure adequate to execute the decisions of the board, and to oversee the day-to-day management of its affairs. It is further recommended that the principal officer becomes an ex officio member of board. Supported by such an executive structure, the board could remain non-executive and would focus on strategic issues pertaining to the scheme as well as monitoring performance and conformance to sound governance principles.

Boards nevertheless need to be reminded that they ultimately remain accountable for the performance and management of the entity under its control, and that delegation of responsibility to board committees or management structures does not relieve boards of their responsibilities for the delegated functions. Accordingly, delegations should all be clearly and carefully defined and documented to ensure proper and effective monitoring.

6.3. Remuneration practices

In the context of a properly constituted board of trustees and an effective executive management structure, in most cases decisions on remuneration practices within medical schemes are likely to take into account the best interests of members. Regrettably, however, in many of the identified instances of governance failure within medical schemes, seemingly inappropriate financial incentivisation of scheme office-bearers was a concern.

It is therefore recommended that criteria for the remuneration of trustees and employees of schemes should be developed by the Council, in consultation with industry. At the same time, the powers of the Registrar should be strengthened to enable effective intervention when remuneration is found not to be in the best interest of members.

Remuneration should be performance related, taking into account the performance of the scheme, the performance of the individual, and any other criteria deemed appropriate. To avoid conflict of interest, it is recommended that trustees should not be contracted to perform paid work for their schemes, and should not be remunerated for undertaking executive duties for the scheme.

6.4. Relationship with Members

Poor member participation in the affairs of medical schemes was repeatedly raised as a concern by respondents, particularly in the context of attendance at AGMs and election of trustees. There is definitely a need to explore means to facilitate and encourage greater member participation in these processes, and to ensure that election of trustees as far as possible reflects the will of the membership. Fairly far-reaching changes are therefore proposed to the electoral system, especially through the use of the Council for Medical Schemes' resources to publicise and promote fairness in elections.

It is specifically recommended that there should be greater standardization of election processes, which will facilitate member education and simplify participation. This would include, for example, standardized periods for nomination of trustees and greater uniformity of voting forms. Given the inaccessibility of AGM venues to many members, provision should be made for postal votes.

It is proposed that a list of nominations should be sent to the Council within a prescribed period preceding the elections, accompanied by notice of acceptance by the nominees and affidavits concerning their fit and proper status. The Council, by way of its website and newspaper advertisements, would advertise the dates of trustee elections in the various schemes and publish the list of nominees. Consideration could also be given to standardizing election dates across schemes.

It is also proposed that there should be some form of independent oversight of election processes, and that the Registrar of Medical Schemes should be able to nullify elections where there is substantial evidence that they were not "free and fair." The names and details of successfully elected trustees would be entered into a Trustee Registry, maintained by the Registrar, which would be made public.

Where trustees are found not to be acting in the interests of members, it is recommended that processes should exist whereby members and fellow trustees should be able to remove trustees without waiting for an AGM. This process should however be subject to vetting by the Registrar, to ensure substantive and procedural fairness and to prevent whistleblowers being victimized. Other forms of protection for whistleblowers may also need to be considered.

These interventions would be intended to contribute to the greater democratisation of governance of medical schemes, the enhancement of member involvement in scheme affairs, and greater prioritization of member protection by boards.

These objectives can only be met if the proposed changes are supplemented by effective communication with members by schemes. It is recommended that member understanding of medical scheme issues would be enhanced by greater industry-wide standardization of communications on issues such as prescribed minimum benefits, designated service providers, preferred provider networks and benefit option design.

Where members are aggrieved by the conduct of their schemes, they should have confidence in the effectiveness, fairness and independence of dispute resolution processes. It is submitted that the *ad hoc* internal processes of certain schemes are inadequate to provide these assurances. It is therefore recommended that all schemes should have an independent dispute resolution committee and that minimum standards for dispute resolution processes at scheme level need to be prescribed. These standards would cover issues such as: time frames for resolution of disputes; composition of dispute resolution committees; and appeal processes.

6.5. Conflict of Interest and Relationship with Third Parties

Given the significant role which conflict of interest appeared to play in scheme governance failures, it is recommended that a more substantive regulatory framework is developed for the management of conflict of interest in medical schemes, and the institution of appropriate checks and balances. This should be accompanied by a clearer legislative definition of "related parties" in the context of medical schemes. Protections against conflict of interest should be applied in the same manner for trustees and for the executive management structure of the scheme.

Given the potential for conflict between the interests of members and the financial interests of third party administrators, it is recommended that there should be no amendment to the governance model which precludes administrator participation in the governance structures of medical schemes.

At the same time, it is acknowledged that third party administrators have concerns regarding the stability of investments in the context of potentially short-term contracts with medical schemes. Whereas administrators of medical schemes incur significant expenses in pursuit of quality service to schemes, the security of these investments is said to be compromised by the provisions of regulation 18(d), which requires administration contracts to allow for termination at the instance of either party after a period of not more than twelve calendar months. This requirement is said to undermine efficiency in service delivery by these administrators. It is accordingly recommended that this termination period should be extended to two years.

6.6. Management of Performance and Compliance

Finally, good governance is not only about complying with legislative provisions and the rules of the scheme, but also about ensuring optimal strategic direction, financial soundness and sustainability of the scheme. It is recommended that guidelines on performance measures for trustees should be developed by the Council in consultation with industry, to provide a tool whereby trustees can measure their individual performance as well as performance of the entire board.

In those instances where fraudulent or grossly negligent conduct persists within a board, it is recommended that the penalties for the individual should be more immediate and more severe. Unless this is done, the perception will remain that the "good guys always come second." Where a scheme incurs losses due to the fraudulent or grossly negligent conduct of a trustee, it is recommended that the trustee should be held personally liable for those losses.

Comments and suggestions on the findings and recommendations of this report should be marked for the attention of the Head: Research and Monitoring, Council for Medical Schemes, Private Bag X34, HATFIELD, 0028. Email: p.matshidze@medicalschemes.com. Fax: 012-431 7644.

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