ANNEXURE 5.2 MEDICAL SCHEME GOVERNANCE

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1. Introduction

1. The Medical Schemes Act (MSA)[1], provides the legal framework for the governance of medical schemes. It states that the board of trustees and principal officer are the representatives of the medical scheme members and are legally responsible for the administration of the medical scheme on behalf of its members.[2]

2. According to the requirements laid out in the MSA, trustees and principal officers have to maintain a level of independence in order to ensure that they act as agents for the members of medical schemes in the purchasing of healthcare services, rather than for their own personal gain. Trustees and the principal officer are in a position to influence the activities of a medical scheme, for instance, in the way the medical scheme purchases services and contracts with service providers. In this regard, the trustees and principal officer have the ability to influence the performance, sustainability and efficiency of the medical scheme. Through this, they influence competition in the medical scheme, administrator and managed care markets.

3. The proposed amendments to the Medical Schemes Amendment Bill, 2008[3] sought to fill some of the gaps in the overall regulatory framework to bring about a stronger, more clearly defined, and substantive governance framework for medical schemes.The Medical Schemes Amendment Bill included provisions on strengthening corporate governance,[4] active member participation,[5] management of conflict of interest and inappropriate incentives. However, these provisions have not yet come into effect.

4. The Amendment Bill does not adequately address deterrence of conflicted relationships, negligent conduct and fraudulent conduct of the trustees and principal officers. The provisions on the penalties and removal from office in the MSA may not serve as a sufficient deterrence. Rather a more stringent and effective penalty system may be required. This could include, for example, that individual trustees may be held personally liable for losses resulting from negligent conduct or fraudulent activity. Other issues that require attention include performance measures of trustees at the board and individual level as well as trustee and principal officer remuneration.

5. The HMI examined how the board of trustees and principal officers promote medical scheme members' interests. In particular we are interested in whether trustees and principal officers have sufficient incentives to drive competition in the administrator and

[1] Medical Schemes Act no 131 of 1998.
[2] Section 57 of the MSA.
[3] It is not clear whether the intention is to still promulgate some of the proposed amendments made in the Bill.
[4] Chapter 12 of the Amendment Bill; section 57E(2).
[5] Section 57E of the Amendment Bill.

medical scheme market. This annexure identifies the relevant legal framework. It then looks at the role of trustees and communication between medical schemes and their members. The annexure looks at the trustee election process, the skills and competencies trustees should have as well as trustee training and remuneration. The annexure then looks at the role of trustees and principal officers in the contracting with third party service providers.

2. The relevant legal Framework

6. The trustees and principal officer have to manage the business contemplated by the medical scheme in accordance with the MSA and the medical scheme's rules.[6] Many factors influence the construct of the medical scheme's rules such as the size of its membership, whether it is restricted or open, the financial muscle it enjoys, and whether it is self-administered or not. The rules need to be consistent with the operation of the MSA and CMS directives. The CMS approves all medial schemes' rules.

7. Section 29 of the MSA sets out certain minimum requirements that medical schemes must have in their rules. These requirements seek to protect the interests of members through 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[7] of a medical scheme. This section also includes provisions related to the process of appointing or electing of a board of trustees that consists of members who are fit and proper, to manage the affairs of the medical scheme, on behalf of the members.[8] The MSA does not prescribe exactly how many trustees the medical scheme should appoint. The number of trustees as well as the schemes rules are left to the discretion of the board of trustees.

8. The MSA also provides duties that trustees must fulfil. For example, Section 37(1) of the MSA requires trustees to prepare annual financial statements in respect of every financial year. Trustees must provide a copy of the financial statements together with a report of the board to the CMS annually. The trustees' report is required to deal with every matter which is material to members of the medical scheme. This report must contain relevant information indicating whether or not the resources of the medical scheme have been applied economically, efficiently and effectively. In this way, the CMS

[6] Section 57(1) of the MSA.
[7] "officer" means any member of a board of trustees, any manager, principal officer, treasurer, clerk or other employee of the medical scheme, but does not include the auditor of the medical scheme.
[8] Section 29(1)(a) of the MSA.

is able to monitor the medical scheme's financial affairs and to report on this in its annual report.

9. Section 57 of the MSA provides a list of the specific duties of the board of trustees.[9] These include: appointing a principal officer to manage the day-to-day affairs of the medical scheme; accountability for operations of the scheme and resolutions passed by the board; ensuring that proper control systems are in place; communicating 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.

10. In addition, the trustees must disclose annually, in writing, to the Registrar any payment made to trustees and the principal officer in that particular year by the medical scheme.[10] The provision is aimed at ensuring that such consideration does not amount to a conflict of interest that comes at the expense of the medical scheme member. However, apart from the requirement to disclose any remuneration, the MSA currently does not prescribe a trustee and principal officer remuneration framework.

11. Given that the trustees have a fiduciary responsibility over financial affairs of others, at common law, they are expected to adhere to certain requirements and acts as fiduciaries on behalf of beneficiaries.[11] In order to avoid conflict of interest, the MSA stipulates that a person may not be a trustee of a medical scheme if that person is an employee, director, officer, consultant or contractor of the administrator of the medical scheme concerned, or of the holding company, subsidiary, joint venture or associate of that administrator or a broker.[12]

12. Over and above the provisions of the MSA, the King III Code clarifies the role and functions of boards and directors generally, as well as legal compliance and standards of governance that should be adhered to. These provisions would similarly be applicable to boards of trustees and principal officers of medical schemes.[13] The Supreme Court of Appeal ("SCA") has affirmed that there is no reason why a trustee of a medical scheme should owe a lesser fiduciary duty than a director would owe to a company.[14]

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[9] Section 57(4) of the MSA.
[10] Section 57(8) of the MSA.
[11] *Bristol and West BS v Mothew*1996 [4 All ER 698 711j]; and *Randfontein Estates Gold Mining Co, Ltd v Robinson* 1921 AD 168, at 177-178. These cases clarify what is expected of someone who holds a fiduciary duty.
[12] Section 57(3) of the MSA.
[13] King Report on Governance for South Africa 2009 (King III); Chapter 2 Boards and Directors.
[14] *Afrisure v Watson* (522/07) [2008] ZASCA 89 at 27.

13. Where there is a clear breach of fiduciary duties by a trustee, the trustee may be removed from the board[15], however, it is equally important to ensure that the medical scheme is not left unable to manage its affairs to the detriment of beneficiaries.

3. Stakeholders views on the role of trustees

14. Medical schemes told the HMI that it is challenging for trustees to ensure that the medical scheme can provide affordable and optimal medical cover that enables the medical scheme to grow. They also face the challenge of appointing the best service providers at affordable rates whilst keeping healthcare and non-healthcare costs including administration fees as low as possible.

15. Trustee interaction between medical schemes and members is crucial. Medical schemes indicated that the most common forum for interaction between members and trustees is at their annual general meetings (AGM). Some medical schemes stated that members could interact directly with trustees. Others were of the view that members should rather interact with the medical scheme administrator particularly on issues pertaining to complaints procedure.

16. Some stakeholders criticized AGMs as ineffective as attendance and participation are usually low. The CMS has suggested that medical schemes should actively mobilise members to attend AGMs, through among other things, negotiating with employers to release employees for purposes of attendance and requiring brokers as part of their ongoing service obligations to notify, remind and encourage members to participate in AGMs.

17. The interaction of trustees and medical scheme members is different for employer-based restricted schemes compared to open medical schemes. Trustees in employer based restricted medical schemes are usually known within the company and are therefore accessible to members.

18. During the public hearings, the panel heard from various members regarding their experiences with schemes' complaints' processes.[16] Many members of medical schemes are not aware that there is a difference between the scheme and its administrators, and usually associate both entities as one and the same when lodging complaints or making enquiries.

[15] Section 46 of the MSA provides that Council may remove a Board member from office if there is sufficient reason to believe that such member is not fit and proper to hold office. The scheme rules may also make provision for the removal of Board members in appropriate circumstances.
[16] For example, Health Market Inquiry Public Hearing 1 Day 1: Angela Drescher p 95-96 of the transcript; Health Market Inquiry Hearing 4 Day 2: Jessica Narunsky p 37-38 of the transcript

19. Apart from the complaints process, medical schemes embark on various ways to communicate with members. This includes through emails with brochures, cell phone messaging, road shows, post etc. This communication includes, among other things, information on latest developments related to the medical schemes and details on benefit options, including access to chronic care.

20. Stakeholders raised the concern that rolling out communication strategies are expensive and members may not even engage with the material they distribute. However, ineffective communication between medical schemes and their members affects the ability of members to hold trustees accountable for the manner in which they run the medical scheme

4. HMI's view on the role of trustees

21. The HMI has learnt that members are not aware that they can engage directly with trustees regarding scheme-related queries.[17] Even if members did want to contact trustees directly, they would battle. Although medical schemes publish the names of the trustees on their websites, contact details are omitted. The HMI found that obtaining direct access to the trustees' contact details such as telephone numbers and email addresses proved challenging, even for the HMI. In some cases, the HMI had to undertake a number of follow up telephone calls and emails to the principal officers to get trustees contact details. For members to gain access to trustees' contact details they would have to approach the principal officers. The CMS publishes the names of the principal officers on their website. It is important for members to receive direct access to trustees to ensure that trustees hear members' voices and that they can make decisions that are in the best interests of members.

22. While the HMI does recognise that, depending on the nature, severity and volume of complaints, it may be efficient for such matters to be outsourced to an administrator. However, trustees should also actively ensure that beneficiary interests are protected. Although trustees receive reports from administrators on how they handle complaints,[18]

[17] This was the narrative of a number of scheme members at the public hearing who were discussing the problems they encountered with complaints against medical schemes. Health Market Inquiry Public Hearing 4 Day 2; Jessica Narunsky Presentation pg. 36.
[18] The reports relate specifically to how the administrators meet their particular targets as set out in the service level agreements such as the number of calls dropped and the number of disputes resolved.

these reports may not be sufficient to ensure that trustees do not become complacent about their duty to act in the interest of members.

23. The inquiry found that information members receive is not necessarily sufficient to assess the quality of the services they receive from their medical scheme. The HMI found that some medical schemes provide some useful information to members with PMBs and chronic conditions. However, more could be done to ensure that members are well enough informed to navigate the system without facing unnecessary co-payments and to help members understand why the medical scheme did not pay a particular claim. Members should also receive information in relation to the providers the schemes contract with, in the form of outcomes measures (see Chapter 9 titled "Outcomes Measurement and Reporting) and how the medical scheme selected the providers on their networks.

24. The type of information and the method of communication are both important in empowering members and reducing member apathy. If members are able to discern the value of the services they are obtaining from their scheme, they are more likely to keep their trustees accountable and make informed purchasing decisions when choosing a scheme.

5. Election of trustees

25. Elections are one of the more direct ways in which members can participate in the medical scheme. Given the important role trustees play in the governance and performance of medical schemes, it is crucial that their apponitment is fair, credible and transparent. Stakeholders are concerned that the process of electing trustees in some instances is not always fair and transparent as there are features of administrator capture, manipulation and undue influence. The CMS investigated cases where managing directors of administrators allegedly solicited votes with brokers. The CMS stated that medical schemes often do not provide members with timely and adequate information on the election process to enable them to make informed decisions.

26. While the MSA requires the appointment or election of a board of trustees, it does not prescribe the manner or form that the election or voting process should take.[19] Many medical schemes use their AGMs to hold elections for trustees. However, some medical schemes use different voting methods as a way to increase member participation. These

[19] Section 29(a) of the MSA.

methods include distributing voting stations to members' place of employment (particularly for restricted medical schemes), and allowing voting via the postal service and telecommunication services (SMS/ Email). Medical schemes told the inquiry that while these methods were expensive, they were more effective in getting members to participate.

27. The CMS encourages separating the election process from AGMs and thought that a single date could be selected for the election of trustees across all medical scheme as is done, for example, in Belgium.[20] The election date and venues for elections would be widely publicised both in medical scheme communications to members and by the CMS. It is proposed that this would ensure greater standardization and transparency of the election process. In this way, elections for trustees would not be dependent on members' ability to attend AGMs. It would also decrease the susceptibility of manipulation that could occur at AGMs through, for example, the abuse of proxies. Some stakeholders proposed that, if elections are to be held at AGMs, then the number of proxies which may be held by one person should be limited.

6. HMI's views on the elections of trustees

28. Restricted medical schemes that limit membership to particular employer groups may have a better environment for elections. Employees are more likely to know the candidates and the candidates may be able to lobby their fellow colleagues for votes. This also allows employees to hold the elected trustees to account as they know who they are. Some restricted medical schemes have come up with creative ways to hold elections outside of AGMs to allow for greater participation.

29. Elections within the open medical scheme environment tend to not be ideal. There is significant member apathy with very low numbers of voters in elections. While some open medical schemes have introduced alternative methods of voting, many still rely on the AGM. The inquiry found that DHMS, even with its sophisticated data and communication tools continue to conduct elections at their AGM. This is in contrast to smaller, less sophisticated medical schemes implemented innovative voting methods. Relying on AGMs for voting is particularly problematic for members located in different provinces. Even if members wish to vote, they do not always have sufficient information about the proxy process to make informed decisions. Members tend to receive a long list of names of trustee candidates accompanied by a summary of each of the candidate's experience. While candidates can canvass votes, it is difficult within the

[20] Findings and Recommendations of Governance Theme Project by CMS, published (May 2006) page 14.

open medical scheme environment as medical schemes cannot provide candidates with membership lists. Members then have to use this very inadequate information to select who the trustees who will represent them at the medical scheme (in essence putting the trustee in control of large sums of money).

30. The HMI believes that the process of electing trustees may need to be revisited and that the CMS should provide better regulation of this process as it is susceptible to abuse.

7. Skills, competence and training

31. Trustees are expected to understand the healthcare market and have the necessary skills and expertise to run the business of a medical scheme.[21] The MSA does not prescribe the qualifications trustees should have. Therefore the skills and competencies vary widely between schemes. Medical schemes tended to identify the following skills, experience and background as being important: legal; finance and auditing; clinical; marketing; and trade union (particularly for restricted medical schemes).

32. Many medical schemes boards of trustees comprise of 50% elected trustees and 50% appointed trustees.[22] In order to ensure that trustees with the relevant background are elected, some medical schemes have a nomination committee that assess the potential trustees skills, conflicts of interest, criminal records, debt default, and social media activity. The nomination committee usually outsources the vetting process to an auditing firm. Medical schemes will then appoint trustees with particular skill requirements that the elected trustees do not necessarily have.

33. The CMS offers a training course for trustees which covers legislation, medical scheme rules, ethics, and sustainability of medical schemes, among other related topics. The CMS trained 73 out of a total of 1038 trustees (or 7% of active trustees) who sat on boards in 2014. In the same year, a further 239 (23%) received "other training" whilst a majority 726 (70 percent) received no training at all. The CMS assumes that the medical schemes themselves are also training trustees.[23] Some medical schemes indicated that the CMS training is too basic as it is pitched at an entry level. This was particularly the case for those medical shames where the trustees have a strong legal, governance or medical background.

[21] The skills mix required may vary widely including areas of expertise such as medical, legal, financial, accounting, economic, actuarial, strategy, human resources, etc. In this regard, a set of minimum core competencies required needs to be clearly set out.
[22] In terms of section 57(2) of MSA, at least 50% of the members must be elected from among the scheme members. Some medical schemes, particularly restricted medical schemes, allow the entire board to be elected from their membership base.
[23] Public Hearing 4 Day 6; Presentation by the Council for Medical Schemes (9 March 2016) pg. 109.

34. Medical schemes tend to offer formal induction training for all new trustees. Many medical schemes also have a formal training policy in place. They assess the qualifications of their trustees and identify possible gaps. They then find and fund relevant formal training or courses for the trustees to attend.

8. HMI's views on skills, competence and training

35. The HMI found that the skills and competence of trustees varies widely across the medical schemes, and that there are no clear standard criteria for appointing candidates for trusteeship. A board of trustees that is lacking in skills and competence may rely heavily on third-party administrators, and consequently not provide adequate oversight or review of their services.

36. The HMI is of the view that the CMS's training is an important way to ensure that trustees have a sufficient understanding of their roles and responsibilities. However, the number of trustees that receive training is concerning.

9. Remuneration

37. The trustee and principal officer remuneration is left up to the discretion of the medical scheme. There are in essence two methods for remunerating trustees, either they receive a monthly fee, or they receive payment for their time spent preparing and attending meetings which includes a stipend for travelling, accommodation etc. Some medical schemes benchmark their pay by trying to compensate trustees based on the foregone income that the trustee would earn from their current employer.

38. Stakeholders have raised concerns regarding the level of the remuneration medical schemes pay trustees and principal officers. It is claimed that often these salaries and stipends are excessive due to lack of regulation or salary caps. The concern is that the trustees and principal officers may be incentivised to maintain the status quo, particularly the relationship with their administrator, or risk losing these substantial benefits. Accordingly, the CMS is of the opinion that the MSA should be amended to allow it to develop a trustee remuneration framework with remuneration caps/guidelines.

10. The HMI's views on trustee and principal officer remuneration

39. The HMI found that the amount trustees and principal officers earned varied significantly across medical schemes. Table 1 shows the top 10 medical schemes with the highest

average fees for trustees for 2015 and 2016. There are 4 restricted medical schemes and 6 open medical schemes that constitute the top 10. The restricted medical scheme, GEMS, paid the highest in trustee remuneration at R 7 543 000 for 12 trustees for 2016. This equates to an average fee of R580 000 per trustee. When looking what individual trustees earn, the inquiry found that DHMS pays the highest average fee per trustee at R 673 000 and R 603 000 for 2015 and 2016 respectively.

Table 1: Ten medical schemes with highest trustee fees: 2015 and 2016

Medical scheme	**Type**	**Trustee remuneration and other considerations**		**Number of trustees**		**Average fee per trustee**	
		2016 R'000	**2015 R'000**	**2016 R'000**	**2015 R'000**	**2016 R'000**	**2015 R'000**
Government Employees Medical Scheme (GEMS)	Restricted	7 543	7 161	13	12	580	597
Discovery Health Medical Scheme	Open	5 430	4 037	9	6	603	673
South African Police Service Medical Scheme (POLMED)	Restricted	4 931	2 251	14	16	352	141
Medshield Medical Scheme	Open	4 615	3 810	9	7	513	544
Bonitas Medical Fund	Open	4 596	3 524	14	10	328	352
Sizwe Medical Fund	Open	3 857	3 431	10	11	386	312

Fedhealth Medical Scheme	Open	3 678	3 457	10	11	368	314
Profmed	Open	3 394	2 861	10	10	339	286
LA-Health Medical Scheme	Restricted	3 038	2 492	16	19	190	131
Hosmed Medical Aid Scheme	Restricted	2 791	152	11	11	254	14

Source: CMS Annual Report 2016-2017, p 191.

40. Table 2 shows the top ten medical schemes with the highest remuneration for principal officers for 2015 and 2016. There are five restricted and five open medical schemes that constitute the top 10. The open medical scheme LMS Medical Fund principal officer remuneration increased significantly from R 3 484 000 in 2015 to R 9 733 00 in 2016, an increase of 179%. During the year, LMS Medical Fund switched administrators from V-Med Administrators to Medscheme. It then amalgamated with Bonitas. POLMED's principal officer has the second highest remuneration in 2016 at R 9 417 000, an increase of 63% from 2015.

Table 2: Ten schemes with highest remuneration for Principal Officers: 2016

Medical scheme	**Type**	**2016 R' 000**	**2015 R' 000**
*LMS Medical Fund	Open	9 733	3 484
South African Police Service Medical Scheme (POLMED)	Restricted	9 417	5 744
Discovery Health Medical Scheme	Open	5 706	5 126
Bestmed Medical Scheme	Open	4 657	3 752

Medshield Medical Scheme	Open	4 349	2 837
Government Employees Medical Scheme (GEMS)	Restricted	4 223	4 223
Transmed Medical Fund	Restricted	3 607	3 345
Umvuzo Health Medical Scheme	Restricted	3 495	3 267
Bonitas Medical Fund	Open	3 116	3 523
Profmed	Restricted	3 074	2 749

Source: CMS Annual Report 2016-2017, pg 192.

** Principal Officer remuneration includes curator fees.*

** LMS Medical Fund amalgamated with Bonitas Medical Fund effective from 01 October 2016.*

41. The HMI found that trustees and principal officers earned the stipulated remuneration regardless of the performance of the medical scheme. There is therefore little incentive for the trustees or principal officer to ensure that the medical scheme grows, or that healthcare and non-healthcare costs are retained as they will get their remuneration regardless.

42. The proposed CMS framework seems plausible to ensure that the remuneration for trustees and principal officers is proportionate with their work and performance (including the performance of the scheme). In this regard, the HMI supports the proposal that the remuneration of trustees and principal officers should be capped.

11. Medical scheme role in relation to administrators and other third parties

43. Self-administered medical schemes conduct administrative functions such as the negotiation of payment arrangements with healthcare providers, the processing and payment of claims from members, maintaining the call centre, and the marketing and promotion of the schemes services in-house. Other medical schemes outsource some of these functions to third-party administrators. In certain circumstances medical

schemes outsource all administrative functions to the third-party administrators and managed care organisations (MCOs) and brokerage firms.

44. The principal officer and trustees are responsible for overseeing these third-party entities by ensuring that they meet the requirements specified in the service level agreement (SLA). Regulation 18(d) of the MSA requires administration contracts to allow for termination at the instance of either party after a period of not more than twelve (12) months. In terms of the SLA, the scheme and the service provider agree on various things, including; for example, that, call centres must be able to communicate with the members in the official languages; the specified turnaround times to respond to calls, as well as resolving complaints. The administrator reports these statistics to the medical scheme for review on a monthly basis. There are penalties for the service providers if they do not meet the requirements set out in the SLA.

45. Ultimately the trustees have to ensure that the medical scheme receives value for money in respect of the services it receives. Trustees, therefore, have a duty to hold administrators and other third-party service providers to account in terms of the SLA. Where the administrator is not providing any value-add to the medical scheme or is failing to perform, the scheme should terminate or not renew the contract. It's important to note that by outsourcing administrative services, the scheme does not relinquish its management responsibilities to the administrator. The administrators perform specific contracted operational activities, however management, oversight and decision-making rests within the control of the scheme. Where there is governance failure through trustees abdicating their responsibilities by not holding the administrator to account, this may be detrimental to members' interests and competition.

46. Stakeholders raised the concern that trustees abdicate their responsibilities to administrators or other third-parties whilst they continue to earn sizable salaries. In response to this, medical schemes advised the HMI that trustees assessed their service providers annually. The medical scheme can decide to change administrators at any time and only need to provide three months' notice. Generally, the principal officer meets with the service provider on a monthly basis. During this session the principal officer and service provider go through the monthly reports and identify any areas that raise possible concerns. These include a review on the turnaround time on claims processing, circulars to members and risk analysis of different aspects to determine level of service.

47. When discussing their role in relation to administrators, some trustees expressed the view that even though running a medical scheme requires innovation it was not the job

of the board of trustees to design ideas but only to review ideas that it receives from its administrator.

48. During the stakeholder engagements, it was stated that the decision to change an administrator can occur as a result of the following, among other factors:

    48.1. a contract coming to an end;

    48.2. where members indicate that they are unhappy with costs and the benefits that the scheme offers (in which case the decision on which new administrator to choose can be based on premiums and benefits being offered);

    48.3. where switching provides for a larger provider group to enable the medical scheme to gain better access to practitioners and specialists;

    48.4. increase in complaints due to service/performance failure.

12. The HMIs view on the trustees role in relation to administrators and other third parties

49. The HMI has considered the extent to which trustees are invested in the business of the medical scheme and, as an extension, to what extent the members of a medical scheme are protected by the trustees when they interact with third parties.

50. The HMI found that, in some instances, it appeared that the medical schemes abdicated their duties to the administrators. For instance, a lot can be gleaned from the circumstance surrounding the CMS's investigation into prescribed minimum benefit (PMB) compliance by medical schemes. Many medical schemes relied on their administrator to provide responses to the CMS and were not able to do so themselves. Similarly, when the HMI was collecting information at the start of the Inquiry, many medical schemes initially referred us to their administrator, and only later engaged with the information request.

51. With regard to specific functions such as tariff negotiations, some medical schemes administered by third parties outsource this entirely to administrators. In these instances, the trustees give a mandate to the administrator to negotiate on the scheme's behalf. The HMI is of the view that, in some instances, this could benefit the medical scheme as the administrator may have better skills and negotiating power than the trustees. This could result in lower tariff outcomes than if the medical scheme conducted the negotiations itself. However, the HMI notes that there remains a duty on the board of trustees to review the outcomes of such negotiations and ensure that they provide value for money. Furthermore, the trustees should pace greater pressure on their

administrators to enter into value based alternative reimbursement type contracts that could ultimately lower the cost and increase the quality of the healthcare services their members receive.

52. Many trustees are of the view that the administrator and not the medical scheme should devise products and services that increase the value proposition for medical scheme members. This affirms the point that the value of administrators lies in their ability to be innovative and creative in providing administration services. Furthermore, an administrator that is able to promote itself as being highly innovative is likely to win more tenders for medical scheme business. Trustees seem to assess administrators on this basis and are, with time switching to administrators that they perceive to offer more value.

53. Finally, the HMI notes that there are instances where open medical schemes and administrators are very closely aligned that it is difficult to distinguish between the two entities, for example, the relationship between DHMS and Discovery Health (in its vested outsourcing model). Both Discovery Health and DHMS have gone to lengths to highlight the benefits of their vested outsourcing model. In addition, they provided the Deloitte review that illustrated the value that DHMS gets from its administrator. Regardless of this, it is unclear to the HMI if, in these instances, medical schemes with such close alignment to their administrators are able to hold their administrators to account. Rather, these close relationships seem to highlight that the current governance model which implements a separation between schemes and administrators is not, in fact, real but merely an administrative construct with no real significance.

13. Conclusion on Medical schemes governance

54. Ultimately, good medical scheme governance that can drive competition in the market for private healthcare funding requires:

    54.1. implementation of effective regulatory mechanisms and checks and balances to mitigate against risks of scheme capture;

    54.2. a regulatory environment in which trustee independence can be maintained to ensure that member interests are prioritised and protected;

    54.3. implementation of transparency measures in the schemes processes; (to ensure that trustee appointments are transparent and without favour; as well as transparency in the way in which administrators are contracted and retained by the scheme);

54.4. effective oversight by the board of trustees over administrators (reporting and evaluation of performance); as well as

54.5. effective regulatory enforcement and oversight by the CMS.

55. The HMI provides interventions to promote governance in the recommendations chapter.