March 2026

HEALTH FUNDERS ASSOCIATION

Monthly MATTERS

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Our Member Consultative Forum, held on Friday, 20 March, was extremely well received and provided a valuable platform for engagement on a number of important developments affecting the medical schemes environment.

The session brought together a strong line-up of speakers who shared practical insights across regulatory, governance and investment-related matters. These included Dr Theo Nodikida, CEO of SAMA, who provided feedback from the recent SAMA dialogue sessions on FWAE, offering important perspectives from the practitioner community.

We were also pleased to welcome Esmé Prins-van den Berg of Healthcare Navigator, who unpacked the implications of King V for medical schemes, and highlighted key governance considerations.

On the investment front, Selwyn Kahlberg, COO of DHMS, together with Jonathan Brummer from RisCura, explored the introduction of FLAC instruments and their potential impact on medical schemes' investment strategies.

In addition, Kedibone Sono, Head of Financial Reporting at SAICA provided a timely overview of mandatory Audit Firm Rotation, sharing insights from the SAICA Medical Scheme Project Group and highlighting what schemes should be considering in preparation.

As part of the session, we also provided an update on HFA's recent activities and key developments across the healthcare funding landscape. Below are the highlights from that update as well as a summary and key themes emerging from the presentations.

1. HFA UPDATE: HIGHLIGHTS

1.1 NHI

There have been no further substantive developments since the consent order granted in February, which effectively pauses the implementation of the NHI Act pending the outcome of the Constitutional Court's consideration of the public participation challenges. In terms of the agreement, the Minister of Health undertook not to request the proclamation of any provisions of the Act, and the President agreed not to bring any provisions of the Act into operation. In addition, the Minister committed that the NHI Act will not be implemented pending the outcome of the Constitutional Court proceedings.

The Concourt matter is expected to be heard during May, with judgement anticipated approximately six to nine months thereafter. This effectively places a pause on implementation, creating space for engagement and collaboration, while also establishing legal certainty on this procedural matter before any further steps are taken.

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1.2 PCR TEST COMPLAINT

HFA's complaint to the Competition Commission regarding the excessive pricing of PCR tests during 2020/21 has reached an important milestone, with pleadings now closed.

The matter has moved into the information gathering phase, marking the next stage in what is a significant case for the sector. HFA is representing 36 medical schemes, including both member and non-member schemes, collectively covering approximately 5.6 million beneficiaries.

A pre-hearing is scheduled for 13 April, where any outstanding issues may be addressed and, importantly, where a date for the main hearing is expected to be set.

HFA will continue to engage closely on this matter as it progresses.

1.3 UBP APPEAL PROCESS

HFA's Section 50 Appeal against the Undesirable Business Practice (UBP) Declaration remains underway, with the points in limine scheduled to be heard on 14 April. While the legal process continues, HFA remains firmly of the view that litigation should be a last resort.

In this context, HFA has submitted a proposed guideline on DSPs to the CMS, aimed at supporting clarity and consistency in DSP arrangements relating to PMBs.

DSP arrangements are central to ensuring that medical schemes can meet their obligation to fund PMBs in full, while maintaining the affordability and sustainability of cover. Without these mechanisms, PMB costs would place increasing pressure on contributions, ultimately affecting member access.

A key principle underpinning the guidelines is that DSP arrangements must be developed and implemented in the best interests of members, balancing affordability, access, quality of care, and long-term sustainability. Participation in DSP networks is therefore based on objective, pre-defined criteria, with medical schemes retaining discretion to contract fairly and transparently in line with member interests.

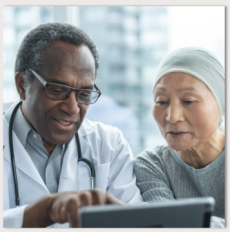
The guidelines distinguish between two broad types of arrangements:

- ◊ Fee-for-service networks, typically in primary care, which are generally open to providers who meet defined criteria and support affordability through predictable pricing; and
- ◊ Alternative reimbursement mechanism (ARM) networks, typically for hospital and specialist care, which focus on value by incorporating cost, quality and patient outcomes through more tailored contracting models.

These guidelines also recognise that effective DSP arrangements rely on the appropriate use of co-payments to encourage utilisation of network providers, thereby supporting affordability across the membership base.

Importantly, there appears to be alignment across HFA, CMS and ICPA on the need to find a constructive, non-litigious path forward. HFA looks forward to engaging further on the guidelines, with the aim of reaching a practical resolution that protects members while supporting a sustainable healthcare funding environment.

1.4 EXPANDING ACCESS: THE CASE FOR AFFORDABLE PHC OPTIONS



HFA continues to advocate for reforms that would allow medical schemes to offer affordable primary healthcare benefit options, aimed particularly at the more than 10 million South Africans earning between R7 700 and R30 000 per month who are unable to afford comprehensive cover. Many of the individuals and families pay out of pocket for primary healthcare while relying on an already overburdened public sector when their conditions worsen. While we await feedback from the Minister on our formal submission, this work is being actively advanced through BUSA's Health Policy Unit and through engagement with organised labour.

The proposed options would provide access to essential primary and preventive care, including GP visits, chronic medication, maternal care and screening, within a regulated, not-for-profit medical scheme environment. Crucially, they offer an immediate, practical solution at a time when full NHI implementation is still many years away.

These options also serve as a stepping stone towards universal health coverage, aligning with the primary care focus of NHI while helping to build system capacity.

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EXPANDING ACCESS: THE CASE FOR AFFORDABLE PHC OPTIONS, cntd.

At the same time, they would reduce pressure on public facilities and support healthier, more productive workforces.

A key advantage is that lower-income workers would gain access to medical scheme tax credits, significantly reducing the cost of cover - often to a negligible level for families.

HFA believes that medical schemes, as not-for-profit, community-rated entities, are best positioned to deliver these benefits in a fair and regulated manner. Enabling these options would represent a practical, immediately implementable reform that expands access to care while supporting the sustainability of the healthcare system.

1.5 QUARTERLY ENGAGEMENT WITH CMS: KEY TAKEAWAYS

HFA recently held a constructive quarterly engagement with the CMS, in line with our MOU. The meeting covered a wide range of regulatory and industry matters, reflecting a shared commitment to progressing key priorities.

While a number of the items discussed at this meeting are covered elsewhere in this edition, a number of other important issues were also raised.

On the matter of POPIA, CMS confirmed that it is building on HFA's earlier work in developing an updated Code of Conduct, which will be circulated to schemes for input.

We also raised concerns regarding SARS requests for disability information, noting the practical challenges schemes face in verifying compliance with technical tax definitions. CMS acknowledged these complexities and undertook to engage further with SARS.

HFA's proposal to establish an industry technical working group to support CMS with analytical capacity was received positively, although it was noted that such a structure should complement, rather than replace, existing processes.

On tariff-setting, it was noted that the block exemption process has transitioned to the National Department of Health, which is now exploring appropriate mechanisms under Section 9 of the National Health Act, supported by the Medical Schemes Act, to advance this work.

On the Section 59 Investigation recommendations, CMS acknowledged HFA's contribution in developing a Code of Good Practice and in seeking industry alignment on guidelines for the sharing of patient information.

Concerns were raised regarding delays in finalising scheme inspections, with CMS indicating that these are often due to outstanding information. Affected schemes were encouraged to engage directly with CMS to resolve any outstanding issues.

Finally, we highlighted discrepancies in certain COVID-19 vaccination claims data, with CMS advising schemes to verify the information and engage with the National Department of Health where necessary.

Overall, the engagement was constructive and reflected a pragmatic approach to addressing complex issues within the sector.

2. KING V: STRENGTHENING GOVERNANCE IN A CHANGING ENVIRONMENT

Esmé Prins-van den Berg of Healthcare Navigator provided an insightful overview of the King V Code of Corporate Governance, and what it means for medical schemes.

King V builds on the foundation of King IV, responding to evolving regulatory developments, both locally and globally, as well as the rapid advancement of technologies such as artificial intelligence. A key objective of the new iteration is to simplify and clarify the Code, while enhancing transparency and consistency in disclosures.

Importantly, King V remains a voluntary code, albeit one that continues to represent the leading standard of corporate governance, both in South Africa and internationally. While it may set standards beyond what is required by law, legislation will always take precedence.

Of particular relevance to the sector is the inclusion of a dedicated guidance note for medical schemes, translating broader governance principles into a scheme-specific context.

At its core, King V is outcomes-based, focusing on whether governance arrangements result in a well-run, sustainable and ethical organisation. These outcomes include:

- ◊ An ethical culture
- ◊ Effective performance and value creation
- ◊ Adequate controls, compliance and accountability
- ◊ Legitimacy and trust within society

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KING V, cntd.

The concept of legitimacy extends beyond regulatory compliance, recognising that schemes operate within a broader social context and must maintain a social licence to operate.

The Code places strong emphasis on integrated thinking, recognising that medical schemes form part of a wider system. This includes consideration of economic, social and environmental factors, as well as the principles of Ubuntu and Botho, which underscore the importance of relationships and stakeholder inclusivity.

For trustees, the implications are clear. The Board of Trustees carries ultimate accountability for governance and must set the strategic direction of the scheme, while balancing internal performance with external realities. Central to this is acting in the best interests of both the members and the scheme, even where competing considerations may arise.

King V also highlights the importance of transparent and meaningful disclosures, enabling stakeholders to assess the quality of governance. This includes integrated reporting and clear communication, with platforms such as Annual General Meetings playing a key role in member engagement.

While not all practices will apply equally to every scheme, particularly given differences in size and complexity, schemes are expected to apply the principles thoughtfully and explain where practices are not adopted.

Ultimately, King V reinforces that good governance is not simply a compliance exercise, but a continuous process of reflection, oversight and improvement, driven by capable, informed and accountable leadership. Esmé will be hosting training sessions on King V, and medical schemes boards are welcome to engage with her directly for their schemes.

3. SAMA DIALOGUE SESSIONS

Mzulungile Theo Nodikida, CEO of the South African Medical Association, provided valuable feedback on the ongoing industry dialogue sessions initiated by SAMA following the release of the Section 59 Investigation Panel Report.

These sessions, which bring together healthcare providers, industry bodies such as HFA, SAMA and BHF, as well as regulators including the HPCSA and CMS, have created an important platform for open and respectful engagement across the healthcare sector. As Dr Nodikida emphasised, all stakeholders have a shared interest in the sustainability of the industry, which requires constructive and candid engagement.

The first session, held towards the end of last year, was described as eye-opening, with healthcare practitioners speaking openly about their experiences. Importantly, the discussions were non-confrontational, with both practitioners and medical scheme representatives engaging meaningfully and in good faith.

Several key themes emerged. Practitioners highlighted concerns around the tone and language used in communications from medical schemes, particularly in the context of audits. In addition, patient consent and the sharing of patient information were identified as areas requiring greater clarity and alignment.

In response, HFA has developed a guidance note on patient consent, which has been shared with stakeholders participating in the dialogue process. This represents a practical step towards improving consistency, transparency, and trust across the sector.

The second dialogue session took place on 26 March in Cape Town, and we will provide feedback on this

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4. BANKING REGULATORY CHANGE IMPACTING SCHEME INVESTMENTS

At our CF, members received an important update on developments in the investment landscape, specifically the introduction of Financial Loss Absorbing Capacity (FLAC) instruments and their unintended implications for medical schemes.

FLAC instruments arise from post-2008 global banking reforms, which aim to ensure that banks can absorb losses in a crisis without relying on taxpayer support. In South Africa, this has resulted in the country's largest banks issuing certain types of debt through their holding companies, rather than the banks themselves.

While this is a regulatory requirement, it has created a challenge for medical schemes. Under Annexure B of the Medical Schemes Act Regulations schemes are required to hold at least 20% of their assets in specified banking instruments. Category (1)(a)(i) refers to cash in a current or savings account with a registered bank, typically including short-term, high-liquidity instruments such as call deposits, while (ii) refers to deposits with a registered bank, typically including short-term, high-liquidity instruments such as call deposits

However, FLAC instruments, despite effectively replacing traditional senior unsecured bank debt, do not qualify under these categories, as they are issued by holding companies and the regulations predate this structural shift.

As traditional bank paper matures and is replaced by FLAC instruments, schemes may therefore be forced to allocate capital into lower-yielding or less suitable alternatives in order to remain compliant. This has several implications:

- ◊ Reduced investment returns, with a direct impact on contribution levels
- ◊ A shrinking pool of qualifying instruments, leading to reduced diversification and increased concentration risk
- ◊ Spread compression, as increased demand chases fewer compliant assets

Loss of term exposure, given that FLAC instruments typically span a range of maturities not easily replicated elsewhere
The financial impact is material, with conservative estimates indicating a reduction of approximately R2 million per R1 billion invested annually in qualifying cash portfolios. Across the industry the effect is conservatively estimated at R90 million per year in lower investment income.

This is ultimately a technical regulatory misalignment, rather than a reflection of increased risk. A relatively straightforward update to the definitions within Annexure B would allow FLAC instruments to be appropriately recognised, restoring alignment with the current banking framework.

HFA has already raised this issue with CMS and will be coordinating a formal engagement with CMS with the aim of ensuring schemes are shielded from this impact. Members are also encouraged to access the full presentation, explanatory video and accompanying clarifying paper, authored by Jonathan Brummer of RisCura, which will be made available on the HFA website shortly.

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5. MAFR: NAVIGATING INDEPENDENCE AND PRACTICAL CONSTRAINTS

At the HFA Member Consultative Forum, Kedibone Sono from South African Institute of Chartered Accountants shared insights from the Medical Schemes Project Group (MSPG) on auditor firm rotation, in response to Circular 44 of 2025.

Mandatory Audit Firm Rotation (MAFR) was first introduced by the Independent Regulatory Board for Auditors in 2017, with the objective of strengthening auditor independence and addressing risks associated with long audit tenure. The framework proposed a maximum tenure of 10 years, with a five-year cooling-off period, applicable to Public Interest Entities (PIEs), and was intended to take effect for financial years beginning on or after 1 April 2023.

However, the Supreme Court of Appeal found that IRBA had acted outside its scope, and MAFR was set aside on procedural grounds. Despite this, IRBA continues to support the principle of auditor rotation and is exploring ways to embed independence safeguards within its Code of Professional Conduct.

In the medical schemes environment, the issue is particularly pertinent. A CMS survey found that approximately 90% of open and restricted schemes are audited by just two firms, raising concerns around concentration and independence. This has informed CMS's proposal to introduce rotation requirements through Circular 44, applying to both PIE and non-PIE schemes.

While there is general support for the principle of 10-year rotation, practical challenges remain. There are currently only around 15 CMS-approved audit firms, which limits choice and may lead to higher transition costs, inefficiencies, and increased audit fees, ultimately impacting members' funds.

In light of these constraints, the MSPG has proposed a more pragmatic approach, including:

- ◊ Aligning requirements with IRBA, potentially limiting mandatory firm rotation to PIE medical schemes
- ◊ Applying alternative safeguards for non-PIE schemes, such as audit partner rotation, the use of Audit Quality Indicators (AQIs), and enhanced audit committee oversight
- ◊ Reducing the cooling-off period from five years to two years, in line with recent amendments to section 92(2) of the Companies Act

On non-audit services, the MSPG recommends alignment with the IRBA Code, which allows certain non-assurance services subject to appropriate safeguards. Blanket prohibitions, it was noted, may increase costs and reduce access to auditors with the necessary sector expertise.

The role of audit committees is central in this context. As independent structures, they are responsible for safeguarding auditor independence, overseeing rotation, approving non-audit services, and ensuring that audit quality remains a key focus. Tools such as AQIs can support more informed and transparent decision-making, particularly in assessing tenure, familiarity risks, and auditor capability.

While there is strong support for CMS's objective of encouraging new entrants into the audit market, practical limitations remain. One potential approach is to support smaller or newer firms through non-audit work and skills transfer initiatives, such as those facilitated by SAICA.

Overall, the discussion highlighted the need to balance robust independence safeguards with the practical realities of the medical schemes environment, ensuring that governance enhancements do not come at the expense of efficiency or member value. HFA will be making a formal submission to CMS during April on this matter.

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6. CIRCULAR 10 REGARDING THE SECTION 59 INVESTIGATION REPORT

Over the past several years, the healthcare funding industry has made meaningful progress in strengthening processes to address fraud, waste, abuse and error (FWAE), while ensuring fairness, transparency and due process. This progress has been the result of sustained and constructive engagement between funders, providers and regulators.

These engagements have begun to yield practical outcomes. Among these dialogue sessions hosted by SAMA where healthcare providers are able to air their pain points with medical schemes, regulators and industry associations in a safe environment. Out of these dialogue sessions has come a shared recognition of the need for greater clarity on the appropriate use and sharing of patient information. In response, HFA has developed a guidance note on patient consent, which has been shared with stakeholders such as SAMA, HPCSA and CMS as a step towards establishing a common industry approach. In parallel, HFA has been actively involved in developing a Code of Good Practice, intended to address recommendations from the Section 59 Report and provide a coherent framework to support fair and consistent processes across the sector.

It is against this backdrop of collaboration and progress that Circular 10 of 2026 has raised significant concern across the industry.

Circular 10 carries substantial operational, legal and reputational implications for medical schemes and the broader healthcare funding environment. While the CMS has previously emphasised the importance of protecting member funds and maintaining zero tolerance towards unethical conduct, these principles are not clearly reflected in the Circular as currently framed.

Moreover, feedback provided at CMS' recent FWAE Advisory Committee, that the Circular was intended to "test the waters" and should not detract from collaborative processes, is not evident in the language of the Circular itself. Instead, it is presented in directive terms, referring to "immediate regulatory expectations", which creates uncertainty and may compel trustees to act defensively in order to fulfil their fiduciary duties.

Misrepresentation and omissions

One of the most concerning aspects of Circular 10 is its apparent mischaracterisation of the findings of the Section 59 Investigation Report.

The Report, published in July 2025, did not find evidence of racial profiling or unfair racial discrimination as defined in law. However, the Circular introduces references to "systemic disparities", a term not used in the Report, which risks creating the impression that such findings were made. This divergence carries real reputational consequences for medical schemes and risks deepening divisions within the healthcare sector.

Equally concerning is the omission of the Panel's clear acknowledgement that medical schemes face significant financial losses due to irregular claims, and that they have a legal and fiduciary obligation to investigate and recover such funds. The absence of this context risks downplaying the importance of these processes in ensuring affordability and sustainability for members.

Legal uncertainty and methodological concerns

The Circular's reference to the Promotion of Administrative Justice Act (PAJA) raises further questions. Constitutional Court jurisprudence has clarified that decisions taken by medical schemes do not automatically constitute administrative action under PAJA, making its inclusion in this context unclear and potentially misleading.

In addition, the continued reliance on risk ratios and racial classification methodologies, despite acknowledged limitations in the Section 59 Panel's own findings, introduces further uncertainty. Medical schemes do not hold race-based data on providers, and the methodologies used in the investigation were themselves noted to be imperfect. This raises important questions about the evidentiary basis for regulatory actions that may follow.

Language, fairness and unintended consequences

The reintroduction of the term "clawbacks", despite prior agreement that "recoveries" is the appropriate and legally consistent term, risks mischaracterising legitimate efforts to recover funds that were never rightfully due.

Similarly, the Circular's emphasis on provider hardship, without equal consideration of the financial impact on members, risks creating an imbalance. Medical scheme members ultimately fund the system, and delays or limitations in recovering irregular payments effectively shift this burden onto them through higher contribution increases.

Proposals that may require schemes to notify providers prior to initiating investigations are particularly concerning. In cases involving suspected fraud, such requirements could compromise the integrity of investigations and weaken the ability of schemes to fulfil their statutory obligations.

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CIRCULAR 10 REGARDING THE SECTION 59 INVESTIGATION REPORT, *cntd.*

Risk to collaboration and system stability

The Circular also introduces new concepts such as CMS-supported mediation processes and expanded Section 44 inspections, without sufficient clarity on their legal basis, operational capacity or funding. This lack of detail adds to the uncertainty facing schemes and administrators.

More broadly, there is a real risk that Circular 10 could undo the progress made through collaborative industry efforts. Instead of reinforcing alignment, it may drive stakeholders back into defensive positions, potentially leading to increased disputes, appeals and legal processes, outcomes that are unlikely to serve the interests of members or the healthcare system as a whole.

A call for clarity and course correction

Given the seriousness of these concerns, HFA has requested the withdrawal of the Circular, or at a minimum, clear communication clarifying the intent and status of it, as well as alignment with the actual findings of the Section 59 Investigation Report.

In addition, HFA has called for urgent engagement with the Registrar and Chairperson of CMS well before the planned CMS Indaba where the Minister of Health is scheduled to address participants on the Section 59 Report and the implications of the recently published Circular 10 of 2026.

7. A NEW ERA IN COMMUNICATION FOR HFA

HFA is entering an exciting new phase in how we engage with our members and the broader healthcare community.

We will soon be launching our podcast, "*Building the healthcare system we deserve*", aimed at fostering informed discussion, sharing insights, and strengthening thought leadership around the role of medical schemes and the future of healthcare in South Africa. If you would like to contribute to these conversations or suggest a potential guest, we would welcome your input.

In addition, we are pleased to introduce audio versions of our newsletters, including both *From the Desk of the CEO* and *HFA Matters*. A note of thanks goes to Rudolph Botha from Mediscor who suggested this innovation. This will allow members to stay up to date with key developments in a more flexible way, whether while driving, exercising, or going about their daily routines.

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