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KING V - APPLICATION TO MEDICAL SCHEMES

CONTENTS

Introduction	3
Terminology	3
Typical corporate governance application considerations	4
Principle 1: Leadership	4
Principle 2: Ethics	5
Principle 3: Strategy, performance and sustainable value creation	6
Principle 4: Reporting	6
Principle 5: Composition of the board	7
Principle 6: Committees of the board	9
Principle 7: Appointment and delegation to management	10
Principle 8: Risk	11
Principle 9: Compliance	12
Principle 10: Data, information and technology	13
Principle 11: Remuneration	13
Principle 12: Assurance	14
Principle 13: Stakeholders	15
Conclusion	16

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Introduction

This guidance applies to all medical schemes (schemes) registered in terms of the Medical Schemes Act (the Act) and related regulations, including open schemes and restricted (or closed) schemes.

Medical schemes operate within a highly regulated environment overseen by the Council for Medical Schemes (CMS) whose mandate is to protect the interests of beneficiaries and ensure the financial sustainability of schemes. They are not-for-profit entities established to provide medical cover to their members in return for contributions.

While the King V Code on Corporate Governance (the Code) is voluntary, its application can help medical schemes enhance stakeholder confidence, improve governance practices and ensure ethical and effective leadership. The principles of the Code should be applied proportionately, with appropriate adaptation for the unique regulatory and operational context of medical schemes.

This guidance paper provides detailed interpreting of the Code as it applies to medical schemes, with references to the Act, CMS governance guidance¹, and other relevant regulatory frameworks. Where applicable, sector-specific nuances and areas of emphasis are highlighted.

Terminology

Term used in King V	Relevant term for Medical Schemes
Organisation	Medical scheme
Governing body	Board of trustees
Members of the governing body	Trustees
Chief Executive Officer (CEO)	Principal officer (PO) (or CEO with specific duties per the Act for administrators and broker firms).
Management	Principal officer and any other senior employees (e.g. CEO, compliance officer).
Shareholder	Medical schemes have no direct shareholding, but members may be loosely equated to shareholders in most respects.
Stakeholders	Includes fund members, beneficiaries, CMS, brokers, healthcare providers, administrators and suppliers.

¹ The CMS publishes its guidance on governance and related matters in the Publications section of its website. This includes circulars, regulatory updates, and guidelines for Trustees and Principal Officers.

No direct equivalent in King V	Member A person who is admitted as a member of a scheme in terms of its rules, and who contributes to the scheme (or on whose behalf contributions are made), and is entitled to benefits.
No direct equivalent in King V	Beneficiaries Members and their dependants (as defined in the Act).
No direct equivalent in King V	Council for Medical Schemes (CMS) Statutory regulator and registrar of medical schemes.
No direct equivalent in King V	Administrator Accredited organisation that provides administration services (e.g. contributions, claims, reporting) to a medical scheme under contract.

Typical corporate governance application considerations

The recommended practices of the Code apply to medical schemes, with the following areas of emphasis or nuance.

Principle 1: Leadership

Principle 1: The board leads ethically and effectively as the focal point of corporate governance in the medical scheme.

Characteristics and values (Recommended practices 1-2)

Boards of trustees of medical schemes are required by law to act in the best interests of the scheme and its members, and must do so with care, diligence and skill. Section 57(6)(b) of the Act requires trustees to “act with due care, diligence, skill and good faith”.

Trustees are expected to lead by example, acting with honesty, integrity and transparency; and ensuring that ethical conduct is embedded throughout the scheme’s operations. Trustees are expected to adopt a code of conduct, monitor compliance with it, and take appropriate steps to deal with unethical behaviour or misconduct.

Dimensions of governance obligations (Recommended practices 3-5)

The board of a scheme should fulfil all dimensions of its governance obligations in line these recommended practices. Of particular importance is ensuring that a board charter clearly sets out the role and responsibilities of the board.

Performance evaluation of the board (Recommended practices 6-9)

In line with these recommended practices, medical schemes should conduct regular evaluations of the board's performance. These should ideally cover individual trustees as well as the board collectively, and be used to inform trustee development plans, succession planning and overall board functioning.

Principle 2: Ethics

Principle 2: The board governs the ethics of the medical scheme in a way that enables an ethical culture and responsible corporate citizenship.

Organisational ethics (Recommended practices 10-14)

The board of a medical scheme plays a critical role in cultivating an ethical organisational culture in line with these recommended practices. Although the Act does not prescribe a specific ethics policy, trustees should, in terms of the Code, consider and adopt a code of ethics or conduct to guide behaviour, manage conflicts of interest and reinforce ethical decision-making across the scheme's activities and service provider relationships. By fostering an ethical culture, the board supports stakeholder trust, long-term sustainability and compliance with both regulatory requirements and broader societal expectations.

Responsible corporate citizenship (Recommended practices 15-18)

Beyond internal conduct, medical schemes also have responsibilities as corporate citizens. They manage substantial financial resources on behalf of their members and operate within a regulated environment. As such, they are accountable not only to their members but expected to contribute to the broader national health system and social concerns.

Responsible corporate citizenship for a medical scheme includes:

- Managing contributions and claims in a fair, transparent and sustainable manner.
- Promoting equitable access to quality healthcare services.
- Ensuring non-discriminatory practices and treating members with dignity and respect.
- Contributing to broader public health outcomes through collaboration and responsible operational practices.

As with other organisations, proactive management of ethics and corporate citizenship strengthens stakeholder trust and contributes to long-term legitimacy and sustainability of the scheme.

Principle 3: Strategy, performance and sustainable value creation

Principle 3: The board ensures that the medical scheme's purpose, strategy and business model support performance that creates sustainable value within the medical scheme's economic, social and environmental context.

Strategy, performance and value creation (Recommended practices 19-22)

Medical schemes' primary purpose is the provision of healthcare funding in a manner that is sustainable, equitable and compliant with legal obligations. Medical schemes are thus expected to operate within the broader health and social ecosystem, contributing to ethical and sustainable healthcare access, aligning with the constitutional right to healthcare in South Africa.

Accordingly, the board should adopt a long-term view of strategy, performance and value creation in line with these recommended practices, balancing affordability and benefit richness, and should establish strategic objectives that support sustainability, fairness and operational excellence.

Principle 4: Reporting

Principle 4: The board ensures that external reports issued by the medical scheme enable stakeholders to make informed assessments of how the medical scheme creates, preserves and erodes value within its economic, social and environmental context over the short, medium and long term.

Reporting (Recommended practices 23-27)

Medical schemes are required to produce a range of statutory reports to ensure transparency and regulatory oversight. In terms of section 37 of the Act, a medical scheme must prepare annual financial statements. In practice, medical schemes are required by CMS to submit an Annual Statutory Return, which includes prescribed information, as defined in CMS circulars.

These reports serve as the basis of regulatory oversight and accountability, particularly in light of the fiduciary duty imposed on boards to act in the best interests of the scheme and its members.

While King V recommends the issuing of an integrated report, remuneration report, social and ethics committee report, and corporate governance disclosures, not all of these may be applicable to medical schemes in the strict sense:

- Integrated report: Although not statutorily required, schemes should consider issuing a concise report that integrates key financial results, strategy and operational performance, governance disclosures and social and environmental impacts.
- Remuneration report: Schemes must disclose trustee remuneration in the annual financial statements or trustee report. Where a remuneration committee exists, reporting on its activities and policy may be considered leading practice.
- Social and ethics committee report: Not mandatory for medical schemes but may be relevant where the scheme is large and social impact is material.
- Governance disclosures: Medical schemes that wish to claim application of King V must disclose their implementation using the King V Disclosure Framework.

Effective reporting by medical schemes enhances transparency and enables members, regulators and stakeholders to assess whether the scheme is delivering value, managing risks and operating sustainably.

Principle 5: Composition of the board

Principle 5: The board ensures that its composition is balanced with respect to the mix of competencies, diversity and independence that enables it to discharge its obligations objectively and effectively.

Composition (Recommended practices 28-33)

In terms of section 57(1) of the Act, the board must consist of persons who are “fit and proper to manage the business”. The scheme’s rules generally outline the number of trustees and terms of office.

Boards of trustees should collectively demonstrate independence of thought, a balanced mix of competencies, and diversity that supports effective decision-making. The underlying intent of the recommended practices on board composition should be applied proportionately to the structure and regulatory framework of medical schemes.

Succession planning and staggered rotation of trustees are particularly important for medical schemes to ensure continuity and retention of institutional knowledge. Sudden or wholesale changes in board membership can undermine governance stability, so structured succession processes should be in place to balance fresh contributions with continuity.

Nomination, election and development of board members (Recommended practices 34-37)

While schemes may not have formal nomination committees, good practice includes:

- Clear eligibility criteria and vetting of candidates.
- Transparent election processes.
- Disclosure of trustee credentials to members ahead of voting.
- A nominations panel or oversight mechanism, where practical, especially in large schemes.

Where appropriate, schemes should consider co-opting independent professionals with specialist skills or forming a nominations subcommittee of the board to strengthen the selection process.

During the election process, engagement with members about the eligibility criteria and skills requirements for trustees is critical. The board should ensure that communication to members clearly sets out the competencies, experience and knowledge required for effective governance of the scheme. This can be achieved through pre-election notices, candidate profiles and education initiatives, enabling members to make informed voting decisions.

Trustees should undergo a formal induction process to familiarise themselves with the scheme's governance framework and statutory obligations. Given the complexity of the medical schemes environment, ongoing development in areas such as healthcare funding, regulatory changes, risk management, and governance best practice is essential to ensure trustees remain competent and effective in fulfilling their oversight role.

Independence and conflicts (Recommended practices 38-44)

As the Act requires at least 50% of the trustees to be elected “from amongst members”, independence remains a key governance principle. Independence in this context refers to trustees' ability to exercise judgement free of undue influence or bias.

Trustees must not act as representatives of the particular constituencies that elected them. Rather, once appointed, they must exercise independent judgment in fulfilling their fiduciary duties towards the scheme and its body of members.

To mitigate conflicts of interest:

- Trustees must disclose all personal, financial or professional interests that may influence their decision-making.

- The board should adopt and enforce a robust conflict of interest policy, in line with CMS expectations and as set out in the Code.
- Trustees representing employer groups or unions must act in the best interest of the body of members, not sectional interests.

According to the CMS Guideline for Remuneration of Medical Schemes' Trustees², "no medical scheme should pay any fees for consulting services performed by a trustee for the medical scheme of the Board as this impinges on his/her independence and increases the risk of a conflict of interest between the role of the trustee and that of a consultant. Trustees should remain independent at all times..."

Chairperson and lead independent member of the board (Recommended practices 45-50)

The chairperson of the board plays a critical leadership role and should be elected from among the trustees, based on leadership ability, experience and neutrality.

Although the Act does not prescribe specific requirements for the chairperson, good practice which accords with the Code is that the chairperson should:

- Be an independent member (i.e. not a representative of a service provider or sponsor).
- Not be the PO, to avoid dual accountability.

While the appointment of a lead independent member is not typical in medical schemes, schemes may consider designating a lead independent trustee or deputy chairperson. This can assist in reinforcing independent oversight, balancing power dynamics on the board and enhancing governance.

Principle 6: Committees of the board

Principle 6: The board ensures that arrangements for delegation to committees and individuals within its own structures promote the objective and effective discharge of its obligations.

Committees of the board (Recommended practices 51-75)

The Act prescribes the establishment of an audit committee. In terms of section 36(10) of the Act, every medical scheme must establish an audit committee that is independent and consists of at least five members, two of whom must be members of the board. This committee is responsible for overseeing internal and external audit, financial reporting and related controls.

² <https://www.medicalschemes.com/files/Circulars/Circular41Of2014.pdf>

The establishment of additional committees appropriate to the scheme's size, complexity and risk exposure is recommended. These may include a:

- Committee responsible for remuneration governance: Responsible for advising the board on the remuneration policy of trustees, the PO and other senior executives, especially given member sensitivity to governance costs. This is sometimes combined with the human capital or social and ethics committee in medical schemes.
- Committee responsible for risk governance: May assist the board in overseeing the scheme's risk management practices, including insurance, clinical, operational and reputational risks. In smaller schemes, this function may be combined with the audit committee.
- Committee responsible for nomination governance: Although less common in medical schemes, this committee can support trustee recruitment, succession planning and board evaluations.
- Social and ethics committee: While not statutorily required for medical schemes, larger schemes may consider this where their public accountability warrants more structured oversight of ethics, transformation and stakeholder engagement.
- Investment committee: Schemes with significant reserves may benefit from a committee focused on investment policy, asset allocation and oversight of investment managers.
- Clinical committee or claims committee: Some schemes establish a dedicated committee to oversee the appropriateness of clinical protocols, benefits design and claims review.

Effective communication between the board and its committees is essential, particularly where committees include members who are not trustees and may not have full visibility of board deliberations. Without this linkage, committees risk making decisions without a complete understanding of the scheme's overall strategy, priorities or constraints.

Principle 7: Appointment and delegation to management

Principle 7: The board ensures that the appointment and delegation to management promote operational effectiveness and that the respective roles and decision-making powers of the board and management are clearly defined.

CEO appointment and role (Recommended practices 76-80)

In a medical scheme, management responsibilities are typically carried out by the PO, who is appointed by the board in accordance with section 57(4)(a) of the Act.

The Act requires every scheme to appoint a PO (or CEO in case of an administrator or broker), who acts as the executive officer of the scheme and is responsible for its day-to-day administration. In practice, the board makes the appointment of the PO on behalf of the scheme. The PO is accountable to the board and must act in the best interests of the scheme and its members. The CMS prescribes that the PO must be fit and proper to hold office.

Delegation to management (Recommended practices 81-83)

In larger schemes, the PO may be supported by an executive management team (e.g. CFO, head of risk, head of clinical governance). Where administrative functions are outsourced (common in smaller schemes), the board should still ensure that management has sufficient authority and access to information to effectively oversee third-party service providers.

The board should formally delegate authority to the PO through a documented delegation of authority framework as recommended in the Code. This framework should outline the decision-making powers, operational responsibilities and financial limits delegated to the PO and, where applicable, other members of the executive team. Even where certain functions are outsourced, such as administration or claims processing, the board remains ultimately accountable and must ensure that appropriate authority, oversight mechanisms and reporting lines are in place to monitor the performance of these service providers.

Professional corporate governance services to the board (Recommended practices 84-90)

Medical schemes are not legally required to appoint a company secretary; however, larger medical schemes typically do have this position as a stand-alone role. Good governance requires that the board has access to administrative and governance support.

Where a company secretary is not appointed, this function may be fulfilled by the PO, a governance officer or an outsourced provider. The board should ensure that individuals providing governance support are appropriately qualified and independent of management decision-making where possible.

Principle 8: Risk

Principle 8: The board governs risk in a way that enables the medical scheme to sustain and optimise its strategy and objectives.

Risk (Recommended practices 91-94)

Risk governance, as outlined in these recommended practices, is an essential responsibility of the board of a medical scheme. Given the fiduciary duties imposed by the Act and the oversight role of the CMS, the board must ensure that risk management is embedded in the governance and operational practices of the scheme. In instances where the management function is outsourced, the board is still accountable for the oversight of risk and should obtain assurances on the effectiveness of the system of risk management implemented by the service provider.

While the Act does not prescribe a detailed risk framework, the CMS expects schemes to adopt risk management systems as a matter of good governance practice.

Principle 9: Compliance

Principle 9: The board governs compliance with applicable laws and adopted policies, non-binding rules, codes and standards in a way that promotes ethics and responsible corporate citizenship.

Compliance (Recommended practices 95-99)

Compliance is a critical element of sound oversight by the board of a medical scheme. The board is accountable for ensuring that the scheme complies with all applicable legislation. In addition, schemes often voluntarily adopt codes, policies, standards or guidelines which should then be incorporated into the compliance system to be implemented and overseen.

While the Act does not prescribe a standalone compliance function, schemes should demonstrate the effectiveness of their compliance practices. This includes maintaining a compliance register, tracking developments in the regulatory environment and ensuring that the scheme responds appropriately to changes in legislation or new directives.

Compliance is one of the key focus areas of the CMS and is frequently the subject of investigations, inspections and regulatory enforcement. Weak compliance practices have led to significant penalties and reputational harm for schemes.

In smaller schemes, where dedicated compliance officers may not be feasible, outsourced compliance support or shared functions can be used to meet this responsibility. Ultimately, compliance oversight is not only a statutory duty, but a key enabler of trust and the legitimacy of the scheme in the eyes of its members and regulators.

Principle 10: Data, information and technology

Principle 10: The board governs data, information and technology in a way that enables the medical scheme to sustain and optimise its strategy and objectives.

Data, information and technology (Recommended practices 100-110)

Data, information and technology governance is increasingly important for medical schemes given their data-centric nature and the sensitivity of member data, reliance on digital claims processing and administration systems, and the risks associated with cybersecurity and data breaches. The board remains ultimately accountable for overseeing the use of data, information and technology in a way that supports the scheme's strategic objectives and protects member interests. The Code's recommended practices are useful in this regard.

While schemes may outsource data, information and technology infrastructure and administration to third-party administrators, the board should still ensure that adequate policies, controls and monitoring mechanisms are in place to govern these outsourced functions. This includes ensuring contractual obligations provide for data protection, service levels, cybersecurity, business continuity and compliance with legislation.

Although smaller schemes may not have in-house technology functions, services or information officers, the importance of oversight does not diminish. The board should ensure that outsourced service providers have appropriate systems in place and that their performance and controls are subject to ongoing scrutiny.

As technology continues to shape how medical schemes operate and serve their members, responsible oversight and monitoring of data, information and technology remains an essential part of good governance. Given the sensitivity and confidentiality of member data, boards must ensure its protection, lawful use and ethical management. This includes ensuring that the use of data analytics, artificial intelligence and automated decision-making tools is ethical, transparent and free from bias or discrimination.

Principle 11: Remuneration

Principle 11: The board ensures that the medical scheme remunerates fairly, responsibly and transparently to promote sustainable value creation by the medical scheme within its economic, social and environmental context.

Remuneration (Recommended practices 111-118)

Remuneration by medical schemes should be fair, transparent and be responsible in that it is reflective of the scheme's non-profit status and duty to act in the best interest of members.

The board should approve a remuneration policy that sets out the basis for remunerating trustees and senior executives (where applicable), considering the nature, size, complexity and impact of the scheme. This policy should be aligned with the scheme's strategic objectives, affordability and long-term sustainability.

The implementation of the remuneration policy should be monitored, and although medical schemes may not be required to issue a separate remuneration implementation report, they should provide clear disclosure of remuneration paid to trustees and executives in the annual report. This transparency promotes trust and accountability to members.

Where a remuneration committee exists, it can play a useful role in advising the board and ensuring appropriate oversight of remuneration matters. Where such a committee is not established, the full board retains this responsibility.

Principle 12: Assurance

Principle 12: The board ensures that assurance functions and services promote an effective internal control environment and safeguard the integrity of external reports issued by the medical scheme.

Assurance (Recommended practices 119-131)

Medical schemes operate within a highly regulated environment, and assurance plays a critical role in safeguarding the scheme's assets, protecting members' interests and ensuring reliable external reporting. The board should ensure that appropriate assurance arrangements are in place across all significant areas of the scheme's operations.

Schemes are required to appoint an external auditor who must report annually on the financial statements of the scheme, as prescribed by the Act and overseen by the CMS. The external auditor must be granted authorisation by the CMS. The external auditor's role is central to providing independent assurance on the scheme's financial health and compliance with relevant accounting and regulatory requirements.

Internal audit is not explicitly required for all schemes; however, as a scheme grows in size and complexity, establishing an internal audit function or engaging outsourced internal auditors is encouraged.

Principle 13: Stakeholders

Principle 13: The board adopts a stakeholder-inclusive approach in the execution of its duties in the long-term best interests of the medical scheme within its economic, social and environmental context.

Stakeholder relationships (Recommended practices 132-136)

Medical schemes should build and maintain trust with a broad range of stakeholders, including members, healthcare providers, employees, regulators and service providers in line with the Code. The board is responsible for governing stakeholder relationships in a manner that promotes transparency, fairness and responsiveness to significant stakeholder interests.

Relationships with key stakeholders such as healthcare providers, brokers and administrators should be guided by formal agreements, service standards that include the requirement for adherence with ethical conduct and the values of the scheme.

In addition, schemes should ensure proactive and constructive engagement with the CMS, demonstrating commitment to compliance and collaboration in the public interest.

Shareholder engagement (Recommended practices 137-144)

Engagement with members is particularly important, as they are both the contributors to and beneficiaries of the scheme. The board should ensure that members receive timely and understandable communication on matters affecting their benefits, rights and the financial health of the scheme. This includes benefit changes, contribution adjustments, scheme performance and governance developments.

Medical schemes are required to hold an annual general meeting (AGM) each year, which serves as a key platform for member engagement. The AGM provides members with the opportunity to ask questions, vote on key matters and hold the board accountable. The recommended practices generally also apply to scheme AGMs.

Relationships within groups of organisations (Recommended practices 145-150)

Where a medical scheme exists within a group structure — for example, being linked to a holding company, administrator or healthcare provider group — the board should consider these recommended practices and ensure that the scheme's independence is maintained and that its decisions are made in the best interest of its members. While group synergies may bring operational efficiencies, such arrangements must not compromise the fiduciary duties of the board or create undue influence.

Formalised governance arrangements should be established to manage inter-group relationships, conflict of interests, information flows and shared services. The scheme's board should also ensure that the scheme's strategy, risk appetite and culture are not unduly influenced by group dynamics, and that appropriate mechanisms exist for escalation of concerns or disputes.

Conclusion

Medical schemes play a vital role in South Africa's healthcare system, operating in a highly regulated environment with significant public interest implications. Sound governance is critical to ensure that schemes deliver on their core purpose of providing equitable access to healthcare funding for their members, while remaining financially sustainable and compliant with the applicable legal and regulatory framework.

By embedding good governance practices as espoused by King V, medical schemes can build stakeholder trust and confidence, manage risk more effectively and ultimately improve health outcomes for their members and the broader society they serve.