

# *A fine balance*



*Medical schemes trustee remuneration and responsibility survey*

*May 2013*





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# Foreword

*Welcome to PwC's survey on medical scheme trustee remuneration and responsibilities. Our team of industry specialists is confident that our analysis will provide a comprehensive overview of the issues and challenges facing the industry today.*





**Ilse French**  
Medical Schemes Leader –  
Africa

The survey covers 57% of the medical scheme industry in South Africa, based on the number of principal members at 31 December 2011. We have identified the major trends, challenges faced and differences in opinions, which I believe you will find useful to benchmark and evaluate your scheme against.

Trustee remuneration is not currently regulated and there are a variety of different approaches to trustee remuneration. The Council for Medical Schemes (CMS) has issued a number of documents/commentaries since 2008 to gain insight into the procedures being applied and to provide guidance in this area. At the same time, governance and poor oversight by trustees have been cited among the main reasons for placing schemes under curatorship.

It is our understanding that the CMS is particularly concerned about the variation between schemes with regard to remuneration decisions pertaining to boards of trustees (BoT). Members of medical schemes also raise questions regarding the extent to which trustees are remunerated and what the standard criteria are for determining the level of trustee remuneration.

In light of this the CMS issued a request for proposal during March 2013 for a service provider to assist with the Trustee remuneration guideline and implementation strategy. In its terms of reference, the

CMS states that “It should be noted that salaries for the board must not only be economically motivated, but rather, essentially inspired by attainment of a social good, public benefit and solidarity. Such remuneration considerations should also not create unnecessary financial burden for beneficiaries.”

If we compare the roles of trustees to those of directors in a company, the trustees of a scheme administered by a third party effectively assume the responsibility of executive and non-executive “directors”.

Applying the corporate governance principles of King III, trustees should be remunerated fairly and responsibly. This implies that remuneration policies should be aligned with the philosophy, size and strategy of each scheme.

However, gaining clarity as to what this means for trustees who effectively assume at least a non-executive role has been rather challenging. Trustees must be appropriately rewarded for their time. They typically have a range of commitments and given their expertise in the industry, their time and knowledge are valuable.

The operating models of individual schemes also need to be considered. For example, certain self-administered schemes operate with a full staff complement, including an executive officer, dedicated to the scheme in addition to the principal officer.

On the other hand, risk must also be considered. The role of the non-executive trustee has become increasingly onerous from a risk

perspective, as trustees can be held personally liable for their actions. In complex environments such as medical schemes, the existence of risk cannot be understated. It is therefore important that remuneration take into account the level of risk assumed by trustees in fulfilling their responsibilities.

One would almost expect to see a reduction in the number of appointments year-on-year due to the increased time commitment and compliance with corporate governance as being the major contributing factors.

I would like to thank the principal officers and executives who participated in the survey. We greatly appreciate the openness, insight and vision you have provided on key topics.

I trust that you will find this survey thought-provoking and insightful. Should you like to discuss any of the issues raised in more detail, please speak to one of your contacts at PwC or those listed in the contacts section of this publication.

Your feedback about the content of this survey would also be appreciated, as this will help us to ensure that we are addressing the issues on which you are most focussed in our future surveys.

**Ilse French**  
Medical Schemes Leader – Africa  
May 2013

# Background

*This is PwC's first survey on medical scheme trustee remuneration and responsibility. The survey specifically focusses on the responsibilities, skills, experience and remuneration of trustees. While the survey aims to provide an industry-wide perspective, where meaningful, it also reports on the differences between restricted and open medical schemes as well as differences between self-administered and third-party administered schemes.*



Where relevant, the survey also draws comparisons to retirement funds in South Africa based on the findings of PwC's *Retirement fund strategic matters and remuneration survey*, released in May 2012.

This report is based on the results of an online survey completed by principal officers in January and February 2013.

### The questions

The survey consisted of 32 questions covering key aspects relating to trustees, with a special focus on these areas:

- Trustee responsibilities;
- Trustee skills, experience and education; and
- Trustee remuneration.

### Participant profile

The survey was completed anonymously by principal officers of 30 schemes of varying size registered in South Africa.

This represents 57% of the industry, based on principal membership of 2 087 793 at 31 December 2011 and 52% based on total trustee remuneration of R29 484 514 at 31 December 2011.

The responses of individual schemes remain confidential.

#### Respondent scheme profiles

	Respondents	Industry*	Representation
Average number of members	2 087 793	3 655 993	57%
Total trustee annual remuneration	R29 484 514	R56 291 536	52%

\* Source: Council for Medical Schemes Annual Report 2011/2012

In this survey a restricted medical scheme is defined by the Act as a scheme in which the rules restrict the eligibility for membership by reference to -

- Employment or former employment or both employment or former employment in a profession, trade, industry or calling;
- Employment or former employment or both employment or former employment by a particular employer, or by an employer included in a particular class of employers;
- Membership or former membership or both membership or former membership of a particular profession, professional association or union; or
- Any other prescribed matter.

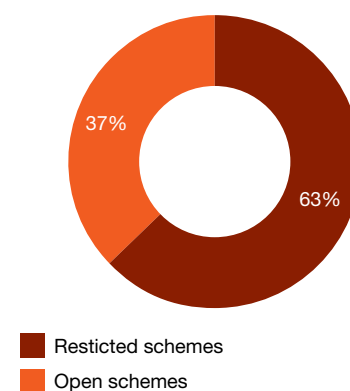
An open medical scheme is open to the general public and anybody can become a member.

Based on the above, the views in respect of trustee responsibility and remuneration can differ materially between different types of schemes and the results should also be interpreted in this manner.

The management model further indicated distinct differences between self-administered and third-party administered schemes. We have endeavored to highlight the major differences.

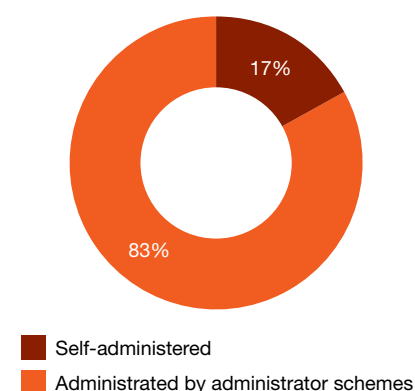
Percentages quoted in this report are based on the number of respondents as a proportion of the total number of respondents of 30, or as otherwise indicated.

Figure 1. Open/restricted scheme participation



Base: 30 respondents

Figure 2. Management model



Base: 30 respondents

# *Findings at a glance*





### ***Trustee responsibilities***

- 30% of respondents from open schemes and 58% of respondents from restricted schemes indicated that trustees do not have individual objectives/deliverables.
- Two key contributing factors impacting the workload/oversight requirements of trustees are governance requirements and the complexity of medical schemes.
- Respondents believe they have adequate fidelity cover and 93% of respondents indicated that they have received appropriate advice.

### ***Trustee skills, experience and education***

- There is currently no definition of 'fit and proper' in the Medical Schemes Act, no 131 of 1998 (the Act) and no specific criteria to measure the skills, experience and education that need to be demonstrated by trustees.
- The level of responsibility and accountability accepted by those who serve as trustees of medical schemes is not taken lightly. Most trustees have between five and 10 years' experience.
- 67% indicated that the BoT sets the skills/expertise requirements for trustees.
- 87% said that their BoT has a formal induction process.
- About one-third of the respondents report that they don't have a policy for continuous learning and education.
- Trustees of open schemes have higher levels of education with 45% of open medical schemes' trustees having a postgraduate qualification, compared to 21% of restricted schemes' trustees.
- 5% of trustees of restricted schemes don't have any tertiary education.
- There is a lack of customised training for trustees of medical schemes.
- Some respondents suggested there should be formalised minimum education levels for trustees by the Regulator and that training should be provided to trustees.

### ***Trustee remuneration***

- All trustees within open schemes are remunerated, but only a quarter in restricted schemes.
- 82% of respondents from open schemes and 47% of respondents from restricted noted that a remuneration committee exists.
- Nearly three-quarters of respondents review remuneration levels annually.
- More than half of the respondents benchmark remuneration either annually or biannually, with 82% of open schemes performing this annually or biannually, compared to 37% of restricted scheme respondents.
- Remunerating trustees attracts a higher calibre of trustee.
- The most common method of trustee remuneration is based on a fixed fee per meeting.
- The majority of open schemes indicated that the average annual remuneration paid per trustee was between R100 000 and R300 000, while the majority of respondents from restricted schemes reported that the average annual remuneration paid per trustee was below R100 000.
- Just over a third of respondents report that they don't obtain approval for trustee remuneration at the annual general meeting (AGM).
- The majority of restricted and third-party administered schemes are in favour of regulation of trustee remuneration, whereas respondents of open and self-administered schemes are opposed to it.
- A blanket approach to trustee remuneration will not be appropriate for the industry. While guidelines would be welcomed, the difference between open and restricted schemes, diversity in operating models and risk should also be considered.

# *Trustee responsibilities*

*The BoT is the representative of the medical scheme beneficiaries and is legally responsible for the direction of the scheme on the beneficiaries' behalf. The BoT must act in the interests of beneficiaries at all time in its dealings with the medical scheme.*



The BoT's responsibilities can be met through the exercise of a sound governance philosophy within the medical scheme as well as through policies and practices that maximise the overall effectiveness, efficiency and performance of the BoT.

This approach is in line with international trends, where many private not-for-profit health insurance companies are expected to meet high levels of corporate governance comparable to those required of publically-listed companies.

The statutory duties of a BoT are provided in Section 57 of the Act.

In terms of the Act, the trustees of a medical scheme are responsible for the good corporate governance of the scheme and their responsibilities, amongst others, include:

- Appointing a principal officer who is 'fit and proper';
- Ensuring that proper registers, books and records of all operations of the medical scheme are kept;
- Seeing to it that proper minutes are kept of all resolutions passed by the BoT;
- Making certain that proper control systems are employed by or on behalf of the medical scheme;
- Ensuring that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and duties in terms of the rules of the medical scheme;
- Taking all reasonable steps to ensure that contributions are paid timeously to the medical scheme in accordance with the Act and its rules;
- Taking out and maintaining an appropriate level of professional indemnity insurance and fidelity guarantee insurance;
- Obtaining expert advice on legal, accounting and business matters as required, or on any other matter about which the members of the BoT may lack sufficient expertise;
- Ensuring that the rules, operation and administration of the medical scheme comply with the provisions of the Act and all other applicable laws; and
- Taking all reasonable steps to protect the confidentiality of medical records concerning any member's state of health.

In terms of the Act, the BoT shall also:

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

In terms of King III, the responsibilities of trustees are closely aligned with those of the board of directors for companies. These include:

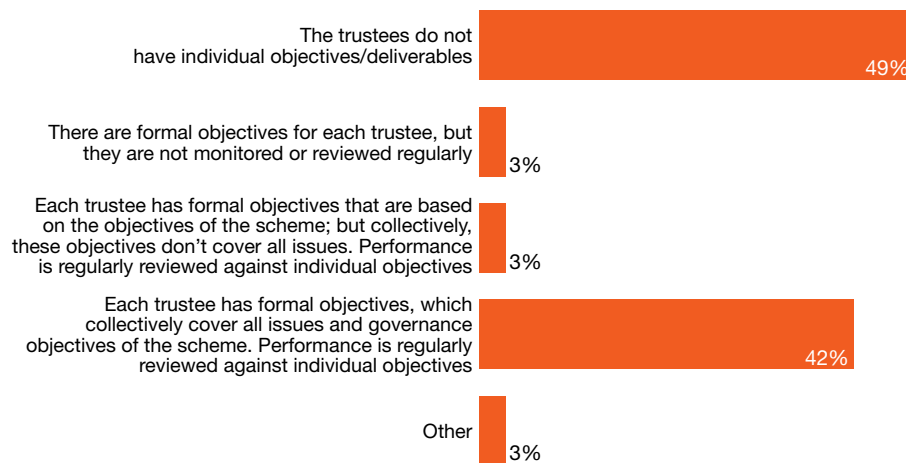
- Strategically directing and promoting a stakeholder-inclusive approach to governance;
- Managing conflicts of interest;
- Taking responsibility for risk management in the organisation and acting as the focal point of governance; and
- Acting in the best interests of the organisation.

In accordance with Section 37(5)(b) of the Act, trustees have a responsibility to ensure economic, efficient and effective use of the medical scheme’s resources. This responsibility can also be linked to the responsibility of the BoT to ensure that remuneration policies and principles are designed to motivate trustees to do their work efficiently and effectively, and without causing unnecessary burden for beneficiaries.

This section of the Act can also be extended to include paying trustees for the time they spend preparing for meetings. A growing international trend is for trustees who do not attend meetings, or who are not adequately prepared for meetings, not to be remunerated for those hours.

*Q: Does each individual trustee have individual objectives/deliverables?*

**Figure 3. Trustee objectives/deliverables**



Base: 29 respondents

Trustees have great responsibility and one would expect that trustees have individual objectives that they are measured against. It is worrying that 49% of respondents (30% of open schemes, 58% of restricted schemes) indicated that trustees do not have individual objectives/deliverables. Only 42% (50% of open schemes, 37% of restricted schemes) of trustees have formal individual objectives/deliverables that are regularly reviewed and which collectively cover all strategic and operational issues.

In self-administered schemes, 80% of respondents indicated that trustees do not have individual objectives/deliverables, while in third-party administered schemes, 44% of respondents indicated that they

each have formal objectives/deliverables that are regularly reviewed against individual objectives/deliverables and collectively cover all strategic/operational issues.

The 3% of participants who indicated that other factors are considered, reported that trustee objectives are not set individually but collectively against the scheme’s strategy.

When it comes to individual objectives setting, it is interesting to note that the trustees of medical schemes do better than their counterparts in retirement funds. A survey of retirement funds carried out by PwC in 2012 found that 73% of funds did not set individual objectives for their trustees and that only 14% of trustees had formal objectives that collectively covered all issues, including the governance of the fund, and performance was reviewed against individual objectives.

The remaining 13% of respondents in the retirement fund survey indicated that there are either formal objectives for each trustee, but they are not monitored or reviewed regularly, or trustees each have formal objectives, but collectively the individual objectives do not cover all issues affecting the fund.

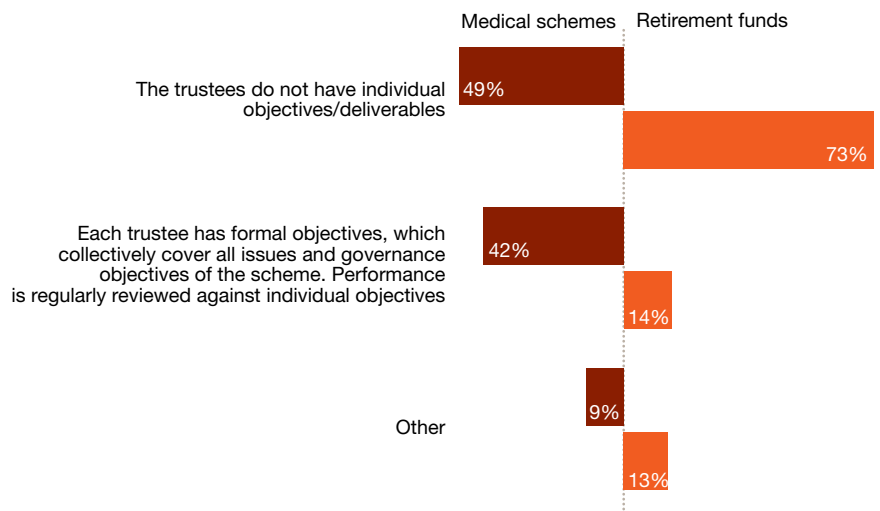
*Q: What are the key contributing factors impacting the workload/oversight requirements of trustees?*

The introduction of King III and with it a focus on combined assurance, in particular risk management, has resulted in trustees having to reassess the current corporate governance structure of schemes as well the services delivered by their assurance providers. The spectrum of knowledge required from trustees is broad and includes sound knowledge of the industry regulations and trends and the wider landscape such as National Health Insurance.

When principal officers were asked what the two key contributing factors impacting the workload/oversight requirements of trustees were, the complexity of medical schemes and their governance requirements were listed.

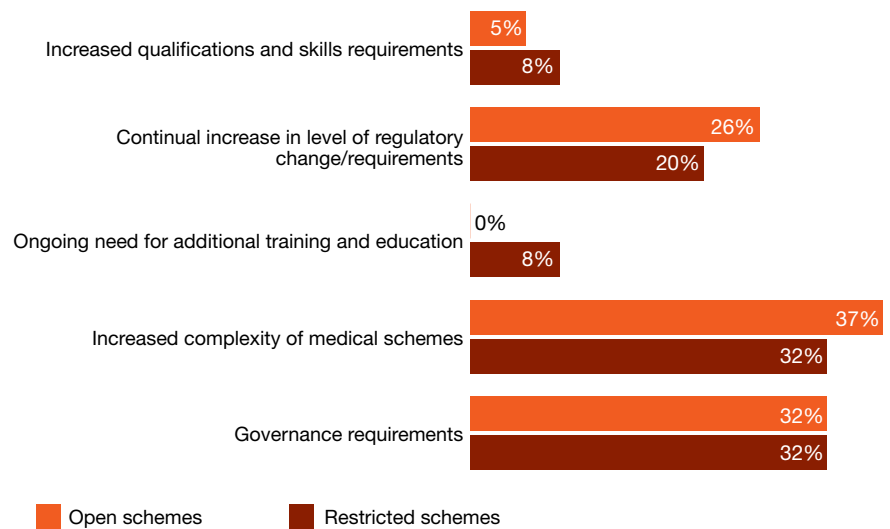
This is in line with the views expressed by respondents of our 2012 survey of retirement funds, who indicated that the increased complexity of retirement funds (35%) and regulatory changes and governance requirements (45%) are the main contributing factors for the increased workloads of trustees.

**Figure 4. Trustee objectives/deliverables: Medical schemes vs. retirement funds**



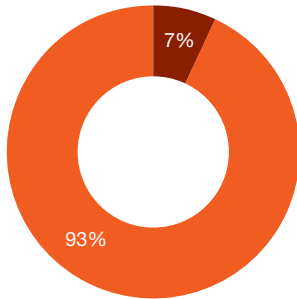
Base: Medical scheme survey: 29 respondents; Retirement fund survey: 288 respondents

**Figure 5. Key factors impacting the workload/oversight requirements of trustees**



Base: 29 respondents

**Figure 6. Are fidelity cover products readily available in the market?**



■ No  
■ Yes

Base: 29 respondents

**Q: Are fidelity cover products readily available in the market?**

The continued focus on corporate governance and the notable increase in awareness by stakeholders of their rights and remedies, have placed the behaviour of directors of companies and trustees of medical schemes and retirement funds under far greater scrutiny.

The law is clear – directors and officers who breach the law, or who breach their fiduciary responsibilities to the organisations they represent, are personally liable for the losses they cause. This personal liability can be limited to a certain extent. Applying these principles to medical schemes, trustees who breach the law, or who breach their fiduciary responsibilities to the schemes they represent, are also personally liable for the losses they cause.

An unquestionable commitment to sound corporate governance, unrestricted access to independent advice and continuous training and education, as well as taking out and maintaining an appropriate level of professional indemnity, are all effective means of reducing personal liability exposure.

The Act requires the BoT to take out and maintain an appropriate level of professional indemnity insurance. Based on the feedback of 29 respondents, 93% indicated that fidelity cover products are readily available in the market. Respondents from open schemes indicated that the average annual cost for fidelity cover per main member of the scheme is R219.

All respondents were of the view that they have adequate cover and 93 % of respondents indicated that they have received appropriate advice.

When respondents were asked how the scheme determined the level of fidelity insurance cover to be taken out, 70% indicated that they use actuaries, advice from insurance brokers, industry standards and advice from the auditors to determine the level of insurance to be taken out. Another 19% base their insurance cover on the value of the average monthly claims or contributions or asset value of the scheme. Three restricted schemes mentioned that they are covered by the employer or an umbrella arrangement in place with the administrator.

A recent example of trustees being held personally liable for contravening the Act is the latest Medshield court order. In terms of the court order, the trustees of Medshield have been ordered to pay legal fees estimated at R1 million out of their own pockets for failing to protect the best interest of the scheme's beneficiaries and for entering into illegal contracts with service providers.

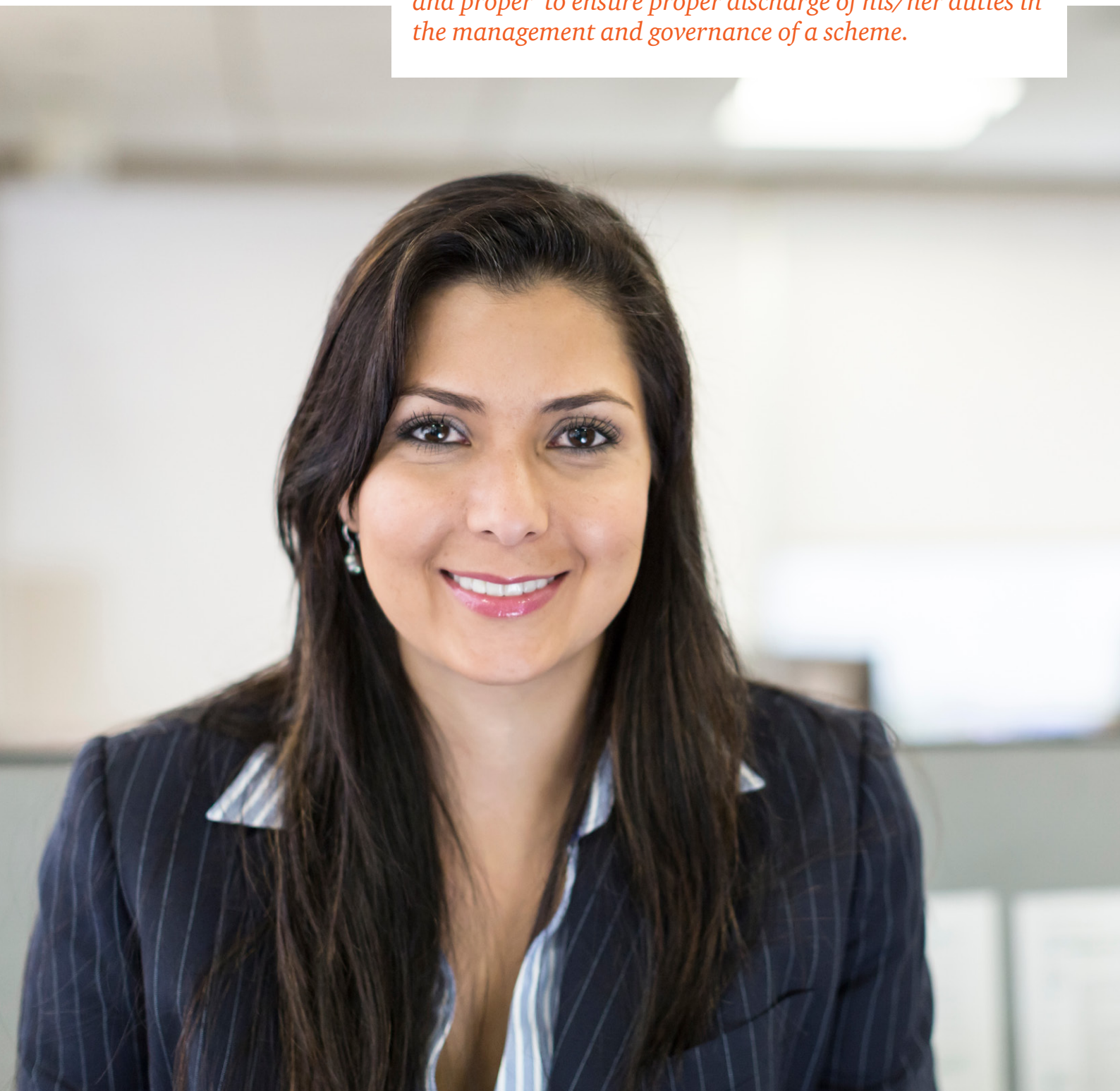
In light of this, the Act is clear that trustees of medical schemes must always take responsible steps to ensure that the interests of beneficiaries are protected at all times, as failing to do this may result in trustees being held personally responsible for paying legal costs.



*The Act is clear that trustees of medical schemes must always take reasonable steps to ensure that the interests of beneficiaries are protected at all times.*

# *Trustee skills, experience and education*

*Section 57 of the Act makes reference to a trustee being 'fit and proper' to ensure proper discharge of his/her duties in the management and governance of a scheme.*





In October 2008, the Office of the Registrar of Medical Schemes issued a discussion document detailing the proposed fit and proper standards for principal officers and to provide some guidance in applying the 'fit and proper' requirement. In this discussion document 'fit and proper' is defined as 'financially sound, honest, reputable, reliable and competent to perform the role in question'.

In assessing the competence and capability of the BoT, the discussion document makes reference to the need for trustees to demonstrate the appropriate skill, knowledge and competence to make informed decisions in the best interests of beneficiaries within a sound governance framework. The purpose of the discussion document, however, was not to set specific educational or technical qualifications, levels of knowledge, skills or experience.

There are currently no specific criteria by which one can measure the skills, experience and education that needs to be demonstrated by trustees, despite the increased focus on the BoT as a result of the successful recent curatorship applications by the CMS, which is based on concerns over the governance of schemes and the 'fitness' of the BoT.

The Minister of Health (the Minister) and the CMS have acknowledged the need for defining such criteria through the inclusion of a provision in the Medical Schemes Amendment Bill, 2008, which allows for regulations relating to the requirements and criteria for the determination of the fit and proper status of a trustee to be made by the Minister in consultation with the CMS.

Guidance with regards to the training and development of trustees can be found in King III, as it is accepted as general practice that trustees of medical schemes also follow the guidance of King III.

According to King III, the board should establish a formal orientation programme to familiarise incoming directors with the company's operations and its business environment, as well as to introduce them to their responsibilities and duties.

King III is clear that an appropriate induction programme should be introduced that will meet the specific needs of both the organisation and the individual, and should enable any new director to make the maximum contribution as quickly as possible.

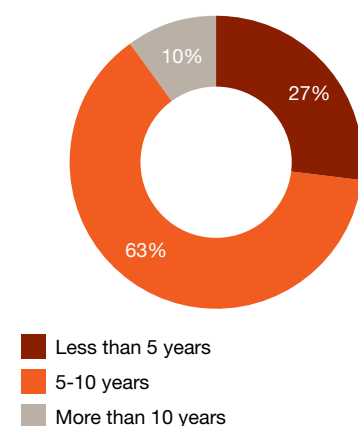
Applying the principles of King III to medical schemes and taking relevant legal and other requirements into consideration, it is clear that incompetent trustees or trustees displaying self interest should be removed from the board.

In terms of section 57 (4) of the Medical Schemes Amendment Bill of 2008, a person is only allowed to serve as a trustee in any one medical scheme for no more than a total of six years. This requirement puts even more pressure on the knowledge sharing between trustees to ensure that trustees are properly skilled to act in the best interest of the scheme.

**Q: How many years' experience in the industry, on average, do trustees have?**

It is evident from survey responses that the level of responsibility and accountability accepted by those who serve as trustees of medical schemes is not taken lightly. The majority of respondents indicated that, on average, trustees had between five and 10 years experience within the medical schemes industry (63% of trustees of restricted schemes and 64% of trustees of open schemes).

**Figure 7. How many years' industry experience do trustees have?**



Base: 30 respondents

Twenty-seven percent of respondents of open schemes indicated that they have more than 10 years' experience, compared to 5% of respondents of restricted schemes.

Twenty percent of respondents of self-administered schemes indicated that they have more than 10 years' experience, compared to 28% of respondents of third-party administered schemes.

In contrast, our survey of retirement funds in 2012 found that 56% of employer trustees and 73% of professional trustees have more than 10 years experience.

*Q: Does the board set the skills/expertise requirements for the trustees?*

Trustees have a responsibility to fulfil an oversight role, promote sound corporate governance, implement strategic objectives and ensure compliance to the regulatory framework and risk management.

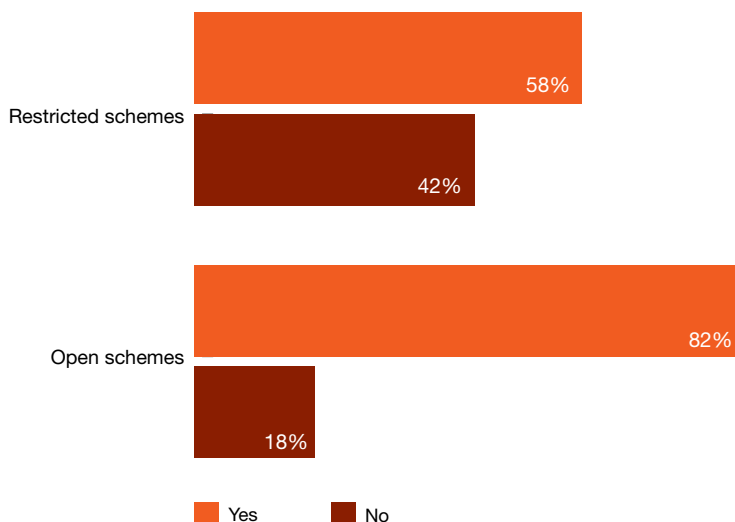
To enable trustees to meet these expectations and for the board to fulfil all its responsibilities, it is of utmost importance that trustees be properly skilled and equip themselves with the required skills and knowledge they need to enable them to discharge their obligation towards medical scheme members in the most responsible manner.

This is aligned to the responsibilities of directors as indicated in King III. In terms of King III, each director of a company has a duty to exercise a degree of care, skill and diligence that would be exercised by an individual who has the general knowledge, skill and experience that may reasonably be expected of an individual carrying out the same functions as are carried out by a director in relation to the company. With regard to a trustee of a medical scheme, these skills may include actuarial, clinical, legal and/or financial expertise.

There are no formalised minimum skills/expertise requirements set by the Act. In addition, the definition of 'fit and proper' is difficult to interpret and is often better defined, in hindsight, in cases where a scheme has been poorly governed.

In terms of the model rules for medical schemes, at least half the trustees should be members of the scheme. This may limit the available skills and knowledge of the BoT. However, it remains the responsibility of the BoT to ensure that the skill set of trustees is balanced. Furthermore, succession planning should take into account an adequate transfer of knowledge.

**Figure 8. Does the board set the skills/expertise requirements for trustees?**



In the absence of formalised minimum skills/expertise requirements, 67% of respondents indicated that the board sets the skills/expertise requirements for trustees.

Base: 30 respondents

**Q: Does the scheme have a nomination committee that scrutinises the nominated/proposed candidates for qualifications, skills and fit and proper requirements?**

The Act makes reference to a trustee being 'fit and proper' to ensure proper discharge of his/her duties for the management and governance of a scheme, but 'fit and proper' is not defined in the Act.

Since King III is most often cited as the most effective summary of best practices in corporate governance, we believe it would be prudent for schemes to adopt the recommendations made in King III, including the establishment of a subcommittee such as a nomination committee.

As indicated in the discussion document on the *proposed corporate governance guidelines for medical schemes* issued in October 2008, it is important to note that the delegation of functions does not relieve the BoT from its fiduciary responsibilities and that the BoT remains accountable for the decisions of its committees.

Nevertheless, delegating specific responsibilities to committees can be an effective way of managing a BoT's workload.

In light of this, a number of schemes (91 % of respondents of open schemes, 21% of respondents of restricted schemes, 80 % of respondents of self-administered schemes and 40% of respondents of third-party administered schemes) have appointed a nomination committee to scrutinise the qualifications, skills and fit and proper requirements of board nominees.

**Q: Does the board have a formal trustee induction process?**

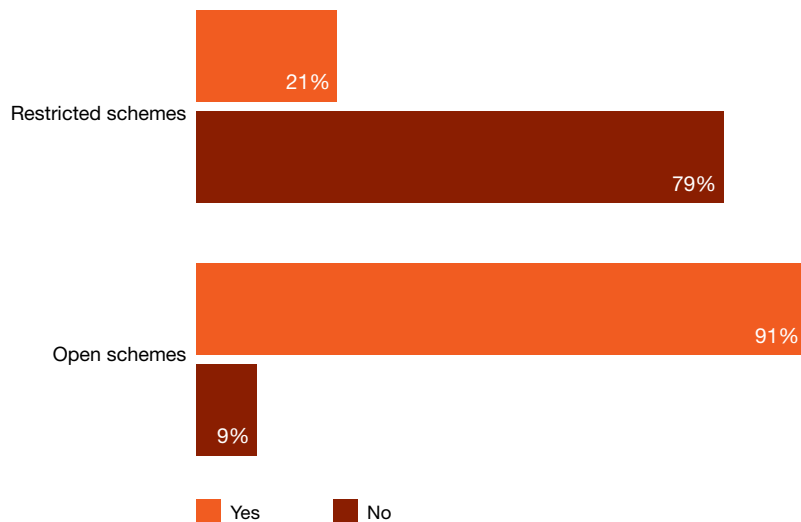
The sheer scale of the responsibilities shouldered by trustees of medical schemes makes it imperative that trustees equip themselves with the required skills and knowledge to be able to discharge their obligation towards medical scheme members in the best possible manner.

Not all new trustees will already be experts in the field of medical scheme governance when they assume their positions. In terms of the discussion document on *Proposed corporate governance guidelines for medical schemes*, issued in October 2008, this places a responsibility on a BoT to ensure that there are adequate orientation processes for new trustees, including reviewing background material, participating in appropriate training activities and meeting with all the relevant parties.

In terms of the discussion document, the orientation programme must aim to familiarise trustees with, among other things, the medical scheme's business environment, strategic plans, risk management issues, regulatory compliance and medical scheme governance as well as the code of ethics and conduct.

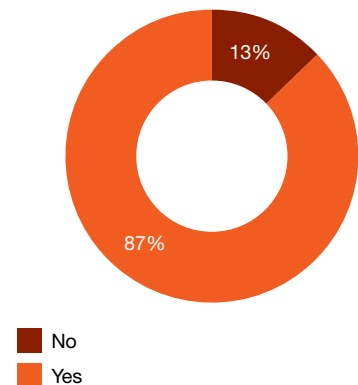
It is encouraging that 87% of respondents (89% of open schemes, 81% of restricted schemes, 100 % of self-administered schemes and 84% of third-party administered schemes) indicated that the board has a formal induction process.

**Figure 9. Does the scheme have a nomination committee that assesses if a board nominee is fit and proper?**



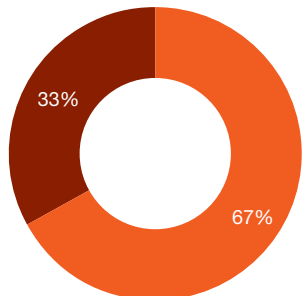
Base: 30 respondents

**Figure 10. Does the board have a formal trustee induction process?**



Base: 30 respondents

**Figure 11. Does the board have a continuous education and training policy for trustees?**



■ No  
■ Yes

Base: 30 respondents

*Q: Does the board have a continuous education and training policy for trustees?*

Although 67% of respondents indicated that they have formal learning and education policies in place, it is concerning that about one-third indicated that they don't have a policy for continuous learning and education.

Responses from open scheme were more positive with 72% of open schemes indicating that they have a policy for continuous learning and education, compared to 63% of restricted schemes.

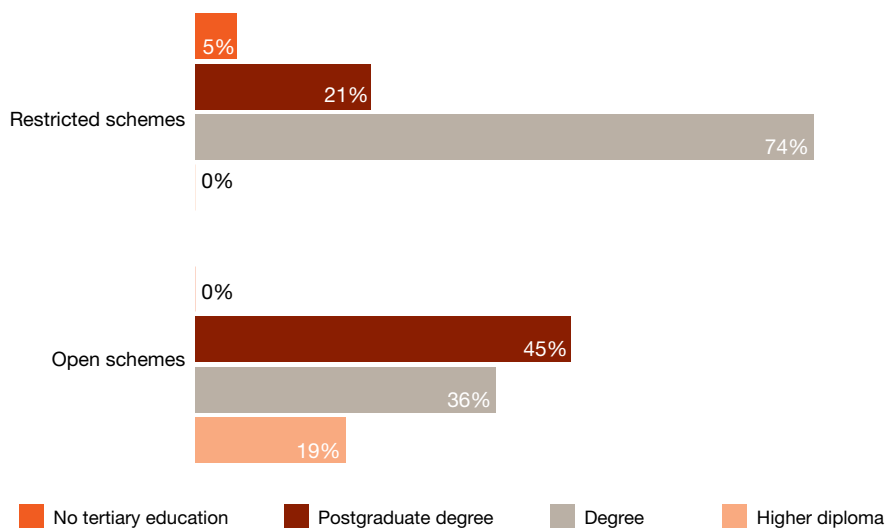
*Q: What is the level of the education of trustees?*

The discussion document on fit and proper standards highlights the fact that it is not the intention to prevent individuals serving as trustees merely because they are not technical experts in a particular field. Nothing prevents trustees from obtaining expert advice to assist in the discharge of their duties.

However, as a minimum, trustees are expected to collectively have a working knowledge of the requirements of the Act, the ability to interpret financial statements, basic investment and analytical skills, clinical disciplines and legal principles, as well as an understanding of the administration and operation of medical schemes.

The expectation is that trustees should be able to demonstrate sufficient knowledge regarding the duties and responsibilities of a medical scheme trustee to make informed decisions in the interests of beneficiaries based on the advice of technical experts.

**Figure 12. Education level of trustees**



Base: 30 respondents

The survey found trustees of open schemes have higher levels of education, with 45% of open medical schemes' trustees having a postgraduate qualification, compared to 21% of trustees of restricted schemes. Within restricted schemes, 5% of trustees don't have any tertiary education.

**Q: How many hours per year does a trustee typically spend on training and attending industry events?**

Training includes formal training events as well as other informal knowledge sharing opportunities such as audit committee and board of trustees meetings.

The importance of industry updates and training specific to the roles fulfilled in subcommittees was also emphasised, while some respondents felt that there is a lack of customised training in the industry.

The results of the survey indicate that, on average, trustees of open schemes spend 32 hours per year on training and attending industry events. Trustees of restricted schemes report spending 27 hours per year on these activities.

This feedback is in line with the responses received in our 2012 retirement fund survey, where respondents reported spending an average of 27 hours per year on training and attending industry events.

Some respondents indicated that trustees must keep up to date with the regulatory and governance requirements, but that there is a lack of customised training for trustees of medical schemes. Furthermore, they believe schemes are too dependent on the level of knowledge of individual trustees due to the lack of formalised training in the industry.

Several respondents felt there should be formalised minimum education levels for trustees imposed by the Regulator and that more training should be provided to trustees.

At the same time, trustees need to ensure that they set enough time aside to equip themselves with the knowledge and skills they may well lack.

**Figure 13. Hours per year trustees spend on training and attending industry events**



Base: 30 respondents

***Factors for trustees to consider:***

- What is my current level of experience as a trustee?
- Do I have the knowledge required to make informed decisions regarding financial reporting, medical scheme product offerings, benefit design and regulatory compliance?
- Can I add value to the risk management process of the scheme and ensure proper focus is placed on critical areas?
- Do I possess the necessary confidence to deal effectively with service providers and to ask the right questions to ensure that proper responses are obtained?
- Can I provide members with the comfort that their health insurance needs are being looked after by a suitably knowledgeable, skilled and experienced BoT?
- Do I have the required knowledge about outsourcing and monitoring service level agreements if the scheme's operating model requires this?

Given the ever-changing regulatory, industry and financial reporting requirements, trustees should ensure that they are at the forefront of these changes and hence well equipped to fulfil their key role.

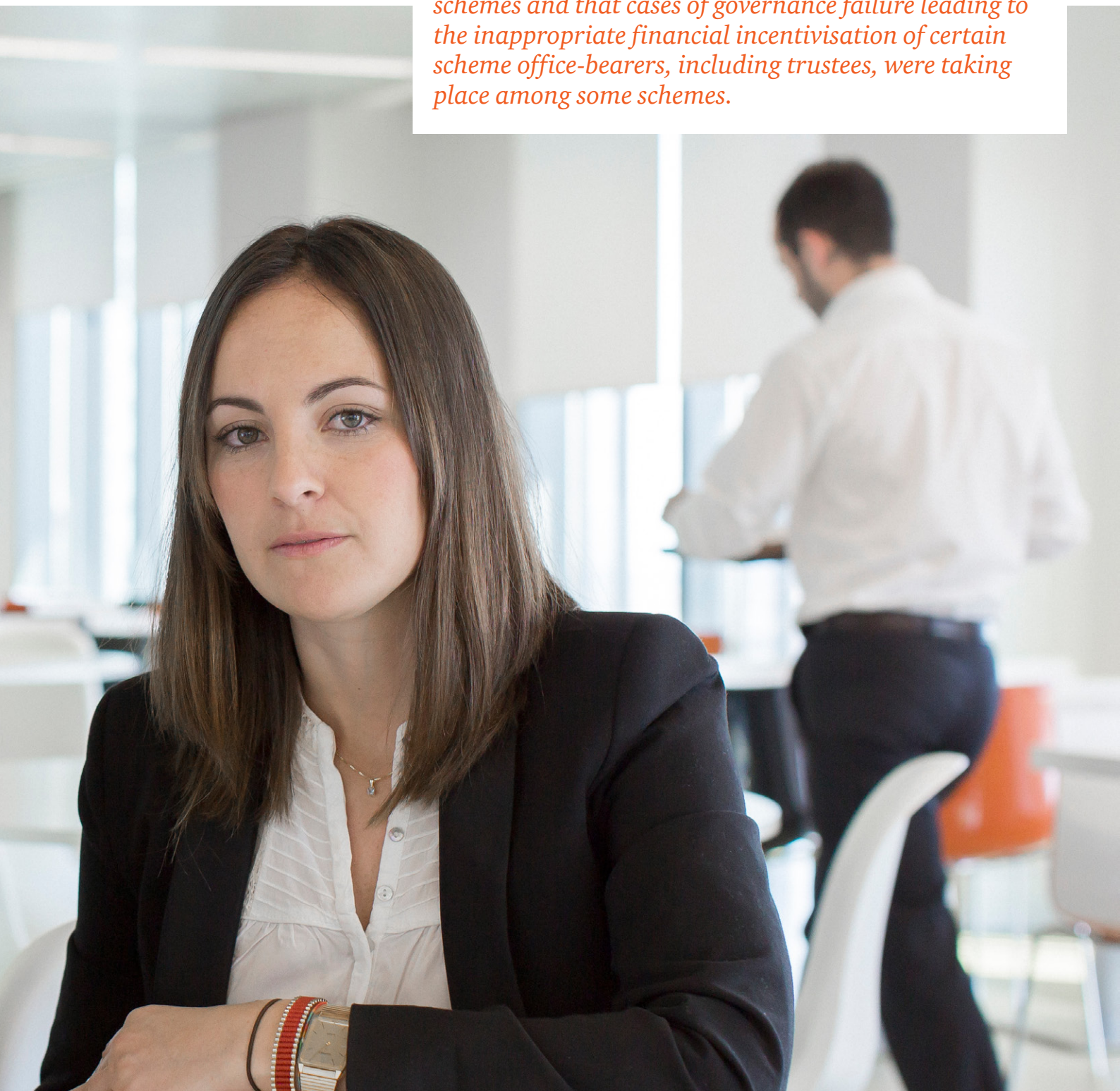
In addition to these considerations, and if it has not done so already, the BoT should consider implementing a formalised succession planning and talent management process that will map the skills and capabilities of trustees and then develop a plan to ensure that there is a pipeline of suitably-qualified candidates coming through in the short, medium and long term. Such a plan should include training and development needs for the individuals concerned.



*Given the ever-changing regulatory, industry and financial reporting requirements, trustees should ensure that they are at the forefront of these changes and hence well equipped to fulfil their key role.*

# Remuneration

*A study on corporate governance conducted by the CMS found that the approach to remuneration differs across schemes and that cases of governance failure leading to the inappropriate financial incentivisation of certain scheme office-bearers, including trustees, were taking place among some schemes.*





In November 2011, the CMS released circular 45 of 2011, 'Medical Scheme's Board of Trustees remuneration'. The circular contained a draft document in which it proposed a framework for the remuneration of medical scheme trustees.

As noted in the 2011/2012 CMS annual report, the remuneration project arose out of concern about the lack of uniformity in the manner in which medical schemes remunerate and reward their board members.

The CMS observed inconsistencies in some instances and is of the opinion that this has resulted in gross abuses of member contributions and the unjust enrichment of some trustees. It concluded that when this happens, non-health expenditure rises and governance problems emerge.

The industry was invited to comment on the framework document by 29 February 2012. The CMS' stated intention was to formulate comprehensive guidelines for trustee remuneration with the primary aim of eliminating abuses, while also ensuring that medical schemes are able to recruit and retain appropriately-skilled individuals to serve on their boards. No final framework has been issued to date and reports of governance failures related to remuneration continue to appear in the media.

The responses from this survey shed some light on current industry practice.

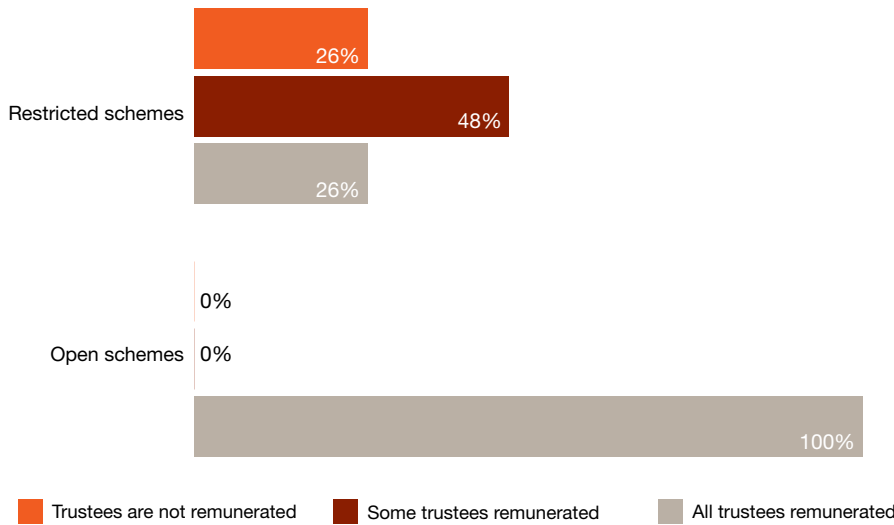
To improve transparency of trustee remuneration, medical schemes are required to disclose any payment or consideration made to trustees in the financial statements. In terms of Regulation 6A the following should be disclosed:

- Fees for attending meetings of the BoT or subcommittees of the board;
- Fees for consultancy work performed for the medical scheme by a trustee;
- Other remuneration paid to a trustee;
- Disbursements, including traveling and other expenses for attending meetings and conferences; and
- Fees for holding a particular office on the board or subcommittees of the board.

Recommended practices in terms of King III include that:

- Entities should adopt remuneration policies aligned with the strategy of the scheme and linked to individual performance.
- The remuneration committee should assist the BoT in setting and administering remuneration policies.
- The remuneration policy should address base pay and bonuses and other long-term incentive schemes.
- Non-executive fees should comprise a base fee as well as an attendance fee per meeting.

**Figure 14. Remuneration of trustees**



Base: 30 respondents

**Q: Are trustees remunerated by the scheme?**

While just over half of survey respondents indicated that all trustees are remunerated, results varied between restricted and open schemes. Predictably, all trustees within open schemes are remunerated, compared to only a quarter in restricted schemes.

Fewer than half of respondents indicated that some trustees are remunerated. Respondents from three restricted schemes noted that only retired member elected trustees are remunerated. For the remaining restricted schemes, trustees are not remunerated.

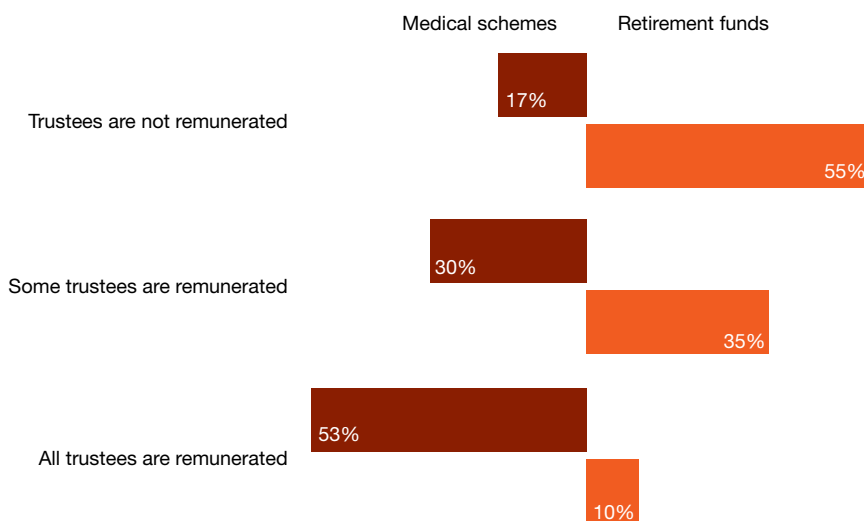
This could be because trustees of restricted schemes are employed by the participating employer and often the

salary they receive from their employer also covers their duties rendered as a trustee. The question remains whether these trustees should receive additional trustee remuneration.

In contrast, our 2012 retirement fund survey found that the bulk of small and medium standalone retirement funds do not remunerate their trustees at all, compared to large funds where more than half do.

Only 54% of large standalone retirement funds remunerated trustees, compared to 91% of specialist funds. This difference mostly reflects a general trend among standalone funds in which employer and member-appointed trustees are on the payroll of the employer and fulfil their trustee roles as part of that employment in a way similar to restricted schemes in the medical schemes industry.

**Figure 15. Remuneration practices: Medical schemes vs. retirement funds**



Base: Medical scheme survey: 30 respondents. Retirement fund survey: 228 respondents

Figure 15 illustrates the differences in remuneration practices between trustees of medical schemes (based on responses from this survey) and trustees of retirement funds (based on responses to the PwC Retirement Fund survey of 2012):

In applying the principles of King III, trustees should be remunerated fairly and responsibly, thus, remuneration policies should be aligned with the philosophy, size and strategy of the organisation.

Gaining clarity as to what this means for trustees who assume a 'non-executive' role has been challenging. Importantly, trustees must be appropriately rewarded for their time. They typically have a range of commitments and given their expertise in the industry, their time is valuable.

*The value that can be derived from linking business strategy, performance management and remuneration strategy, a central theme in King III, should be considered when it comes to developing remuneration policies and principles for trustees of medical schemes. Adopting a homogenous approach without proper regard to schemes' specific long-term and business strategies is unlikely to create such a link.*

The operating model of the individual scheme also needs to be considered. For example, certain self-administered schemes operate with a full staff complement, including an executive officer, dedicated to the scheme in addition to the principal officer. This remuneration is not taken into account in the results shown here as the survey deals only with trustees, who are typically non-executives.

*Q: What factors/criteria are currently used to determine the level of remuneration for trustees?*

All schemes are of the view that workload and the time spent in performing trustee responsibilities are the key determinants of the level of trustee remuneration awarded. Other determinants include independent benchmarking studies and a number of respondents mentioned comparison to listed corporate entities of similar size, as well as the skills and experience of trustees.

The CMS recommended in circular 45 of 2011, 'Medical Scheme's Board of Trustees remuneration', that it believes it would be prudent for schemes to adopt the recommendations made in King III with regards to remunerating their trustees, as King III has been cited as the most effective summary of best practice in corporate governance internationally.

King III recommends that remuneration policies and practices be aligned with an organisation's strategy, reviewed regularly and be linked to executives' contributions to performance. King III recommends that factors outside the influence of executives that affect performance should not be taken into account in assessing the executive's remuneration. This would include factors such as medical inflation, exchange rates and interest rates.

On the other hand, risk is also an important consideration. The role of the trustee has become increasingly onerous from a risk perspective, since trustees can be held personally liable for their actions. In complex environments such as medical schemes, the existence of risk cannot be understated. Therefore it is important that remuneration take into account the level of risk assumed by trustees in fulfilling their responsibilities.

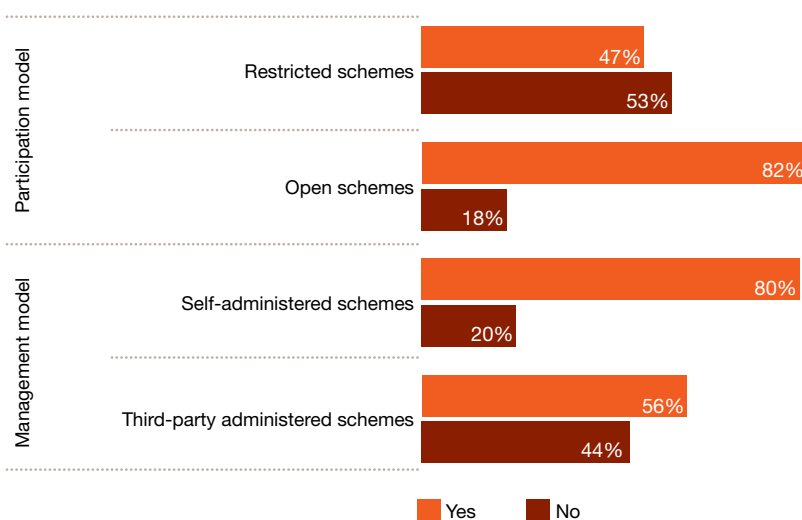
It is also interesting to note that one respondent from a restricted scheme and another from an open scheme both noted that the liability of trustees arising from their fiduciary duties is also a factor in determining the level of trustee remuneration. This could be reflective of the increased risk in performing the role due to increasing regulatory supervision.

*Q: Does the scheme have a remuneration committee responsible for setting the level of trustee remuneration?*

Sixty percent of respondents noted that a remuneration committee exists. Figure 16 depicts responses from restricted and open schemes as well as from self-administered and third-party administered schemes.

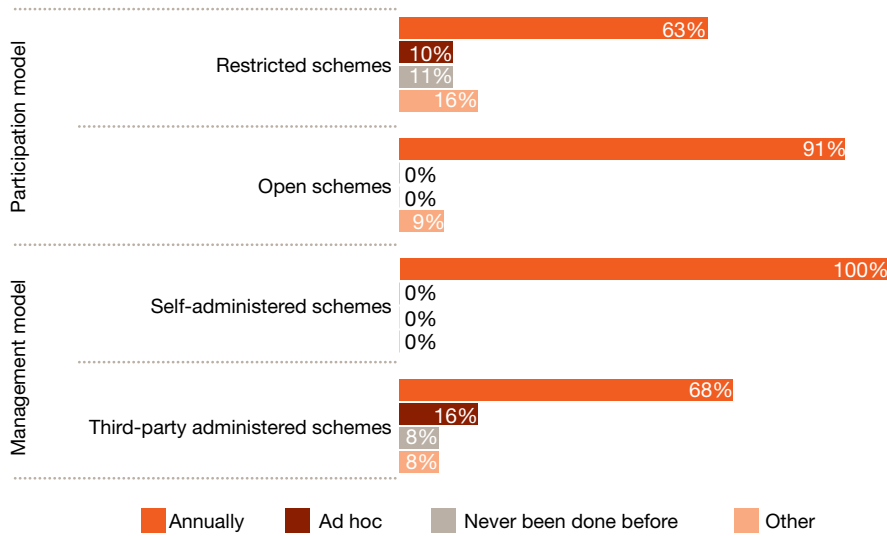
This is in line with the recommendations of King III to appoint a remuneration committee to assist the board in setting and administering remuneration policies.

**Figure 16. Does the scheme have a remuneration committee responsible for setting the level of trustee remuneration**



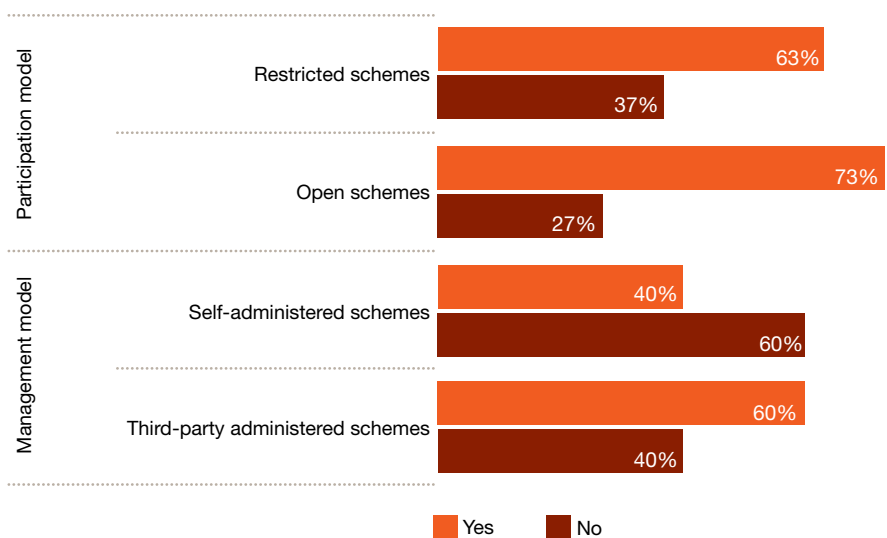
Base: 30 respondents

**Figure 17. Frequency of remuneration review**



Base: 30 respondents

**Figure 18. Benchmarking of trustee remuneration**



Base: 30 respondents

*Q: How often is the level of remuneration reviewed?*

Nearly three-quarters of respondent schemes review the level of remuneration annually. 63% of restricted schemes, 91% of open schemes, all self-administered schemes and 68% of schemes administered by a third party, review the level of remuneration annually.

This corresponds with results from our 2012 retirement fund survey, which found that 83% of funds review the level of remuneration annually.

*Q: Has the scheme benchmarked trustee remuneration*

The majority of survey respondents indicated that trustee remuneration has been benchmarked. Some of the benchmarking criteria used included information available in respect of organisations of similar size in the financial services/insurance industry, CMS annual reports and independent remuneration surveys.

Self-administered versus third-party administered responses is a mirror image of one another on this question. Benchmarking is less prevalent within the self-administered schemes.

*Q: How often is the level of remuneration benchmarked?*

More than half of respondent schemes benchmark remuneration either annually or biannually, including 82% of open schemes, compared to 37% of restricted schemes.

Looking at the different administration models, 60% of self-administered schemes compared to 40% of third-party administered schemes set remuneration on an annual basis.

Nearly a third of third-party administered respondents reported that trustee remuneration has never been benchmarked.

*Q: In your view, what impact will remunerating trustees have?*

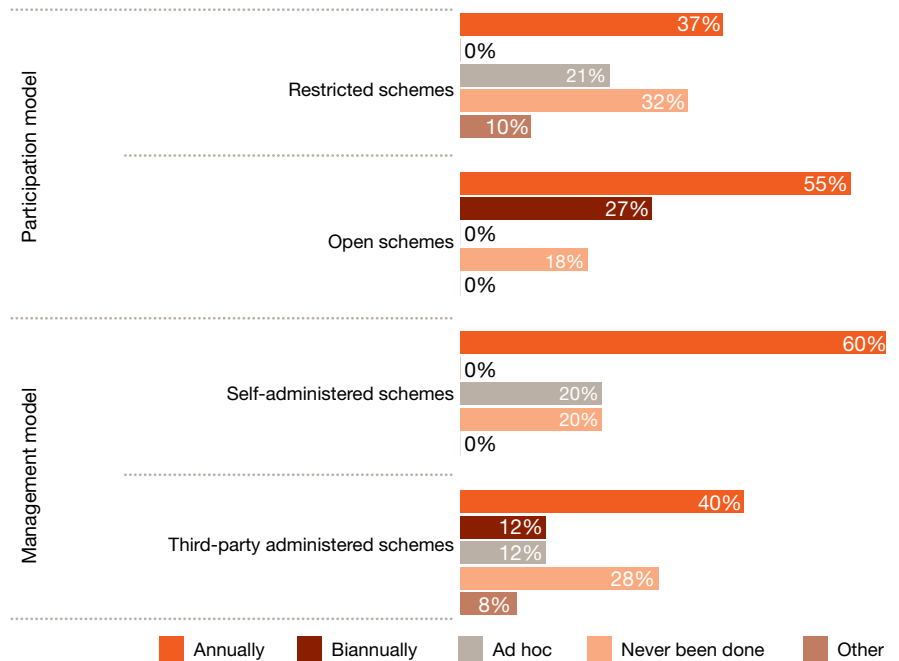
What value do medical schemes derive from remunerating trustees? The majority view is that remuneration attracts a higher calibre of trustee. A fifth (21%) of respondents from restricted schemes are of the opinion that trustees will take on more responsibilities for the remuneration received, while 36% of respondents from third-party administered schemes believe remunerating trustees attracts a higher calibre candidate.

An analysis of survey results indicates that the most popular approach to the remuneration of trustees is to base it on a fixed fee per meeting.

This method of trustee remuneration is consistent across self-administered, third-party administered and restricted schemes:

- 50% of respondents from self-administered schemes;
- 33% of respondents from third-party administered schemes; and
- 44% of restricted schemes.

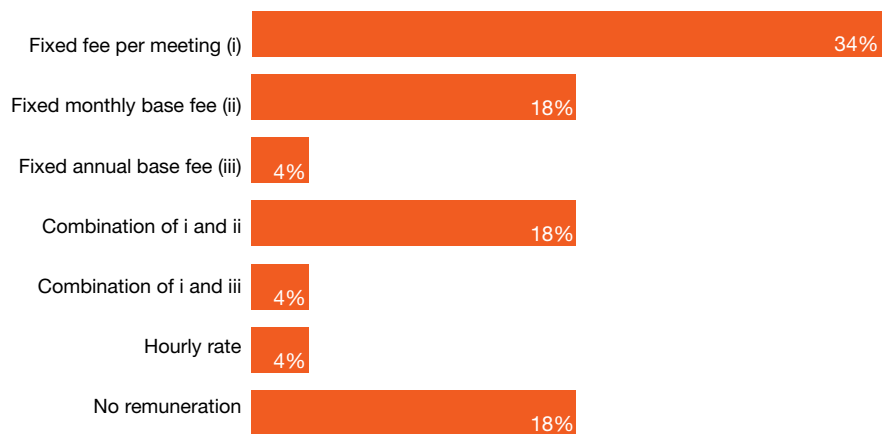
**Figure 19. Frequency of remuneration benchmarking**



Base: 30 respondents

*Changes in the regulatory environment accompanied by increased scrutiny of executive arrangements continue to alter the executive remuneration landscape.*

**Figure 20. Current method of remunerating trustees**



Base: 28 respondents

However, the preferred method of remunerating trustees of open schemes is to apply a combination of a fixed fee per meeting and a fixed monthly base fee (40% of respondents from open schemes indicated that they use this method, compared to 20% who indicated that remuneration is based solely on a fixed fee per meeting). This is in line with King III recommended practice.

In instances where a trustee is not able to attend a meeting, but has prepared for the meeting and provided input to the meeting it should be considered whether the trustee should still be remunerated to some degree with regard to that specific meeting.

*Q: What is the range of total average annual remuneration paid per trustee?*

Fees paid to trustees of schemes have been analysed between open and restricted schemes as well as between self-administered and third-party administered schemes. In each case, the values given are total fees paid as per respondent submissions.

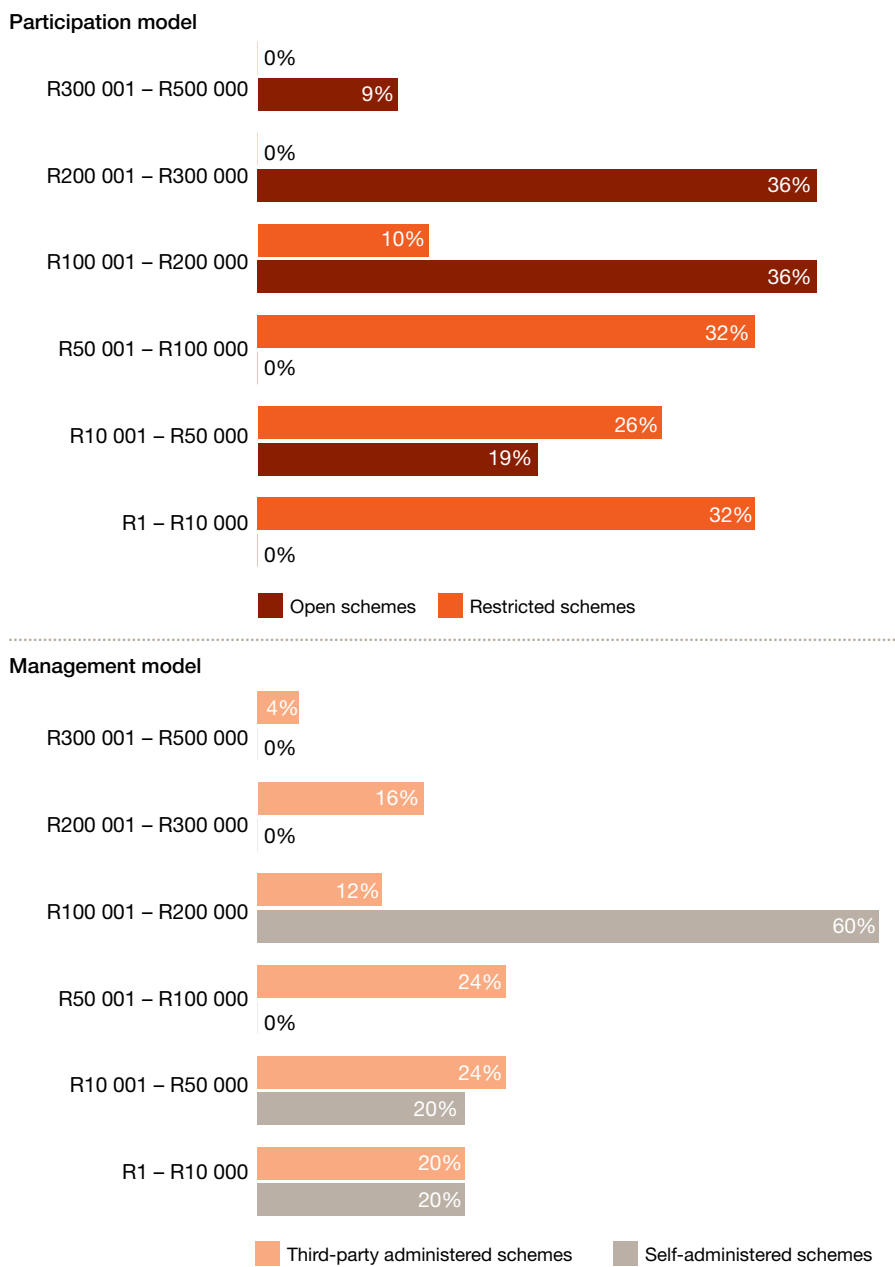
The difference between restricted and open schemes is evident with 90% of restricted schemes falling in the bottom three ranges, while over 80% of open schemes fall into the top three ranges.

This is consistent with the feedback received regarding the value of remunerating trustees, where open scheme respondents indicated that remuneration was necessary to attract a higher calibre of trustee.

Looking at the different operating models, there is a tendency toward the higher ranges for self-administered schemes as opposed to restricted schemes.

The fees paid to trustees are relatively low compared to medium-cap financial services organisations, where the median fee for non-executive directors in 2012 was R291 000.<sup>1</sup> The high level of regulation and supervision within the medical scheme sector are characteristics of the financial services industry and plays an important role in determining the level of pay.

**Figure 21. Range of total average annual remuneration paid per trustee**



Base: 30 respondents

<sup>1</sup>. *Non-executive directors' practices and fees trends report*. PwC, 2013.

When compared to remuneration paid to trustees of retirement funds, our 2012 survey found that for standalone funds, 60% of trustees earned between R1 and R50 000, compared to 77% for specialist funds. The top earning trustees for both specialist funds and standalone funds (4%) earned an average annual remuneration of between R200 000 and R300 000 per annum.

*Q: How many trustees' sole income is based on the remuneration received from the scheme?*

Respondents' answers indicate that the industry does not have many professional trustees. Only three schemes indicated that they had trustees whose sole income was the remuneration received from the scheme.

*Q: Does the annual general meeting approve the trustee remuneration?*

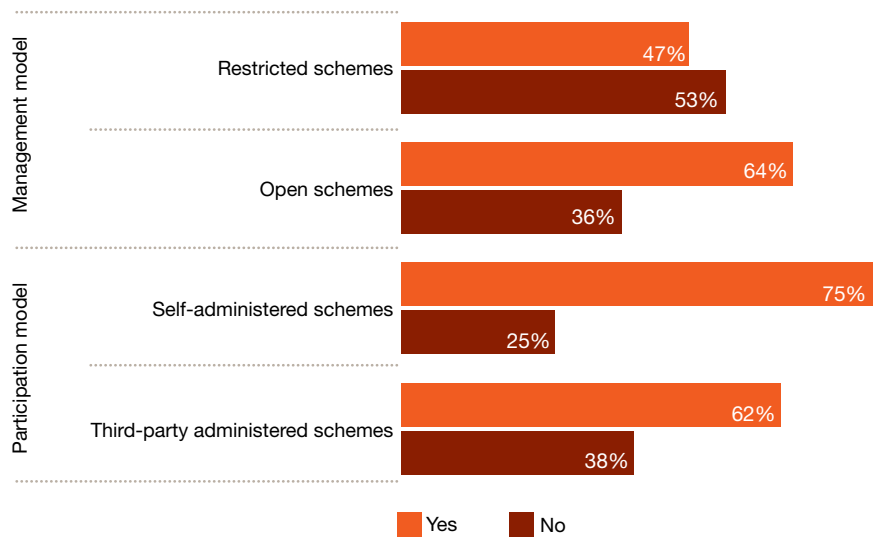
Historically, member apathy has been the norm within the industry and approval of remuneration at the AGM merely a formality. However, recent member activism has been evident and approval at AGMs is becoming more important.

While the majority of schemes do currently have trustee remuneration approved at the AGM, responses indicated that just over a third of respondents do not obtain approval of trustee remuneration at the AGM. This result is consistent for both restricted and open schemes as well as self-administered and third-party administered schemes.

*Q: What is the current method for remunerating the chairperson of the board of trustees?*

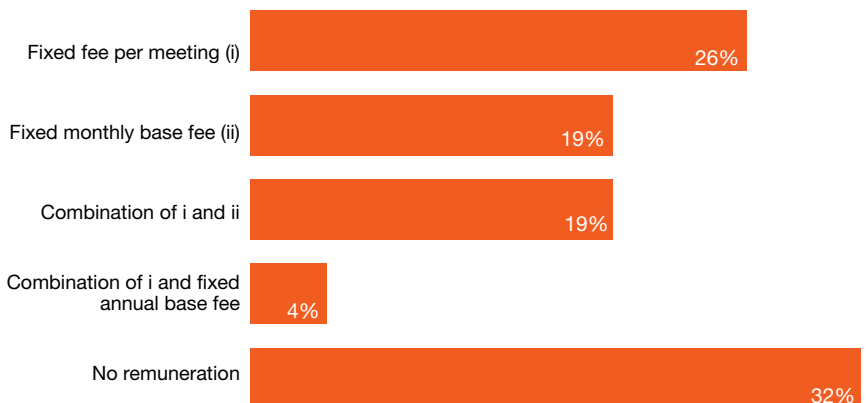
Upon removal of the 'No remuneration' responses to this question, our analysis reveals that the main approach to setting fees for the chairperson is a fixed fee for the attendance of meetings, which is in line with the general approach to remunerating trustees.

**Figure 22. Approval of trustee remuneration at the annual general meeting**



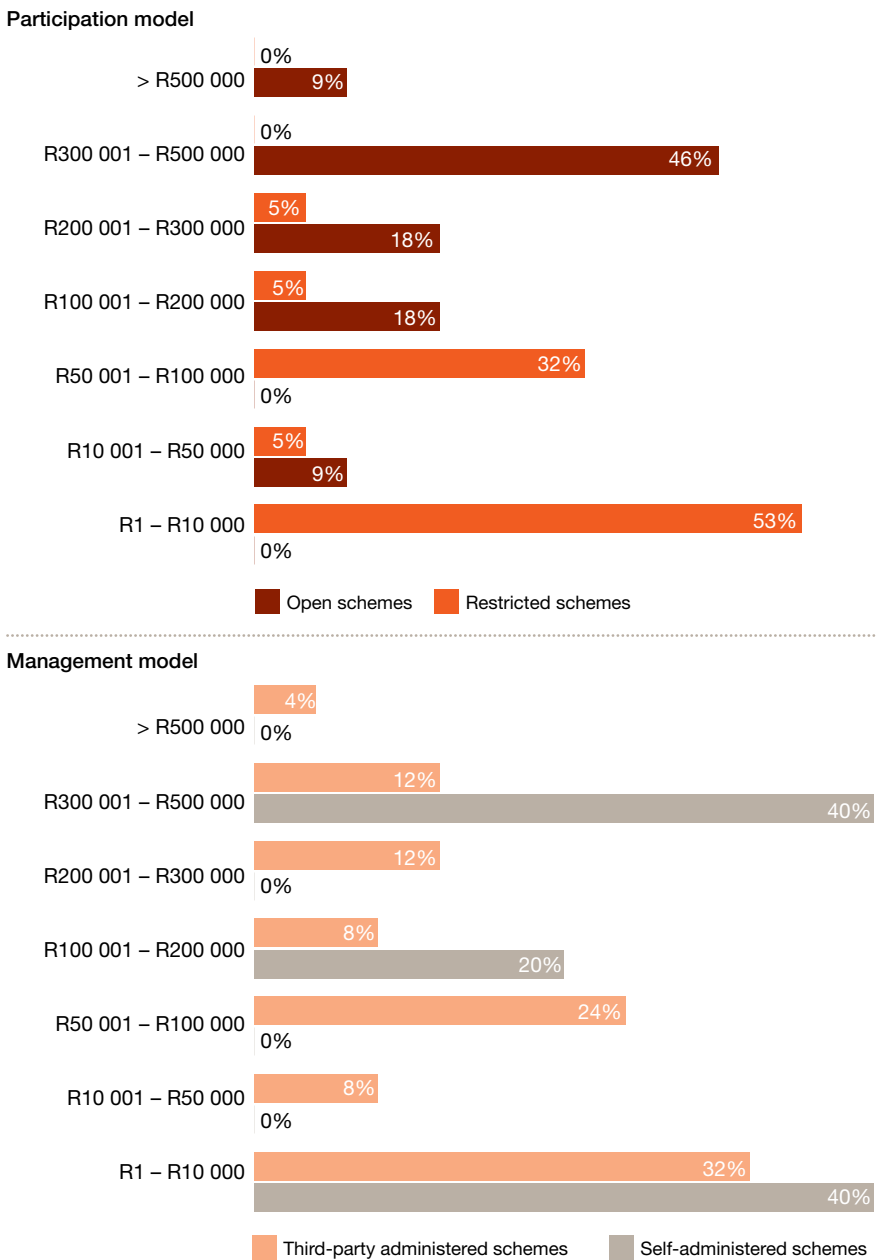
Base: 30 respondents

**Figure 23. Remuneration of chairperson**



Base: 27 respondents

**Figure 24. Range of chairpersons' average total annual remuneration**



Base: 30 respondents

*Q: What is the range of the chairperson's average total annual remuneration?*

Fees paid to chairpersons of schemes follow a consistent trend to that noted earlier for trustees, but there is an even greater difference in remuneration levels between restricted and open schemes.

The contrast between restricted and open schemes is evident with 95% of restricted schemes falling in the bottom four ranges, while 91% of open schemes fall into the top four ranges.

Ranges vary across the spectrum with self-administered and third-party administered schemes indicating that the operating model has little impact on the quantum of the remuneration.

Fees are relatively low compared to medium-cap financial services organisations where the median fee for chairpersons' in 2012 was R432 000.<sup>2</sup>

When compared to remuneration paid to trustees of retirement funds, PwC's 2012 retirement fund survey found the annual remuneration for the majority of chairpersons (57%) that remunerate trustees was in the range R1-R100 000. A further 39% of chairpersons earned between R100 000 and R300 000 and 3% earned in excess of R300 000. The top-earning chairpersons (2%) earned more than R500 000 per annum.

<sup>2</sup>. *Non-executive directors' practices and fees trends report*. PwC, 2013.



*Q: In addition to remuneration paid, are trustees reimbursed for direct costs incurred?*

Based on the responses analysed below, the majority of respondents indicated that the scheme paid directly for trustee-incurred costs. This response was consistent for open, restricted, self-administered and third-party administered schemes.

Trustees' direct costs are paid over and above their remuneration.

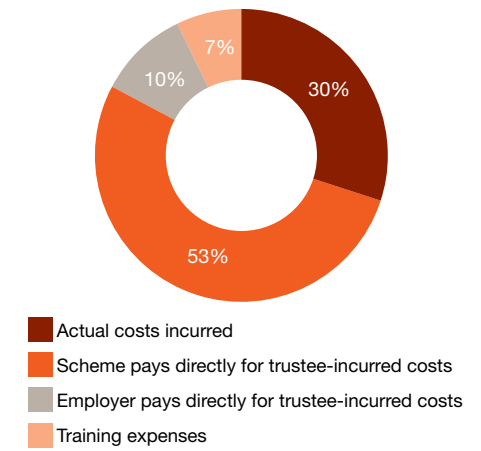
*Q: How much time per year does a trustee spend on average on scheme matters?*

Our analysis of responses finds that trustees of open schemes spend more time on scheme matters than trustees of restricted schemes. This provides further justification for the higher rates of remuneration paid to the trustees and chairpersons of open schemes, when compared to those of restricted schemes as already noted in this report.

The proportion of time spent on the preparation for meetings compared to actual meeting attendance is consistent at about one third of meeting time.

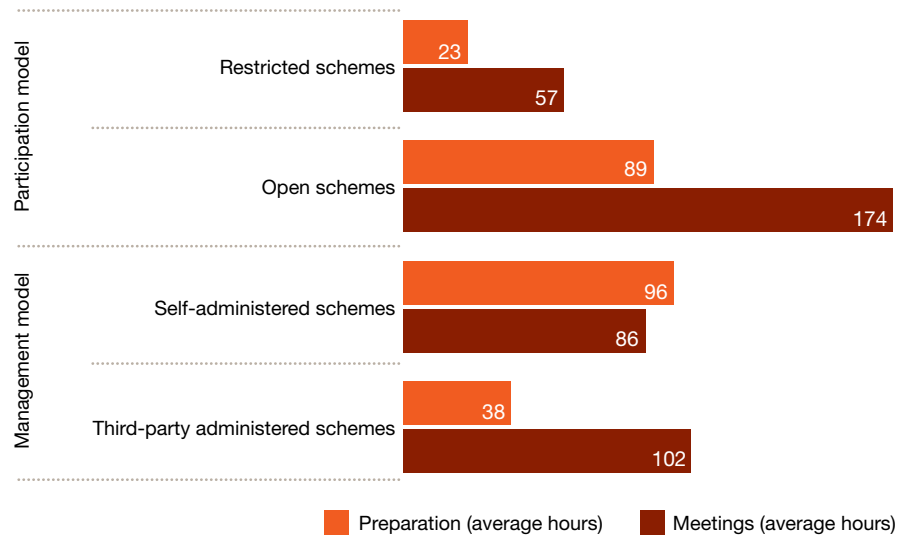
Comparing results for self-administered and third-party administered schemes, it is clear that the trustees of self-administered schemes spend more time preparing for meetings compared to trustees of third party-administered schemes.

**Figure 25. Costs schemes reimburse trustees for**



Base: 30 respondents

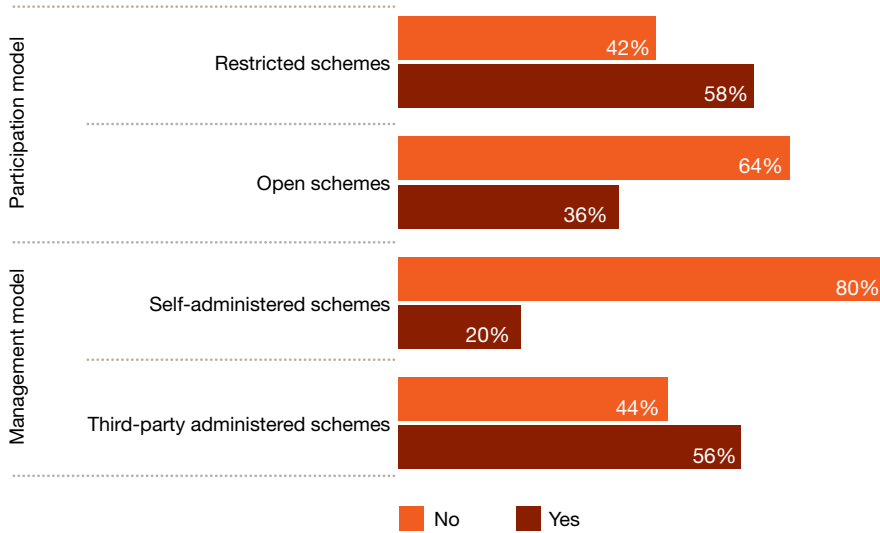
**Figure 26. Hours spent by trustees on scheme matters annually**



Base: 30 respondents

**Figure 27. Should trustee remuneration be regulated?**

*Q: In your view, should trustee remuneration be regulated?*



Base: 30 respondents

There was a mixed response to this question. The majority of respondents within restricted and third-party administered schemes were in favour of regulation, whereas respondents from open and self-administered schemes were opposed.

A possible approach could be for the CMS to issue guidance on the factors to be considered when deciding on the level of remuneration.

Various respondents were of the view that a blanket approach would not be appropriate for the industry. While guidelines would be welcomed, the difference between open and restricted schemes, diversity in participation

models, the use of managed care and capitation agreements, as well as the complexity and size of individual schemes, need to be taken into account in setting appropriate remuneration levels.

Setting fixed levels of remuneration without taking into account responsibilities and risks could have an undesirable impact.

# *Specialist services for medical schemes*



## **Stakeholder relations, research and thought leadership in reward**

Our executive reward team is made up of subject matter experts in all aspects of the design and implementation of remuneration structures, which enables us to take a holistic approach to remuneration.

PwC has one of the leading international reward practices with specialists in over 60 countries. Our multidisciplinary practice is made up of subject matter experts in all aspects of the design and implementation of remuneration structures. These include accountants, actuaries, lawyers, tax specialists and communication practitioners.

We can assist in these areas:

- Tax;
- Governance;
- Legal and regulatory;
- Financial modelling;
- Accounting implications of remuneration structures;
- Performance measurement;
- Benchmarking;
- Job evaluation and grading;
- Pay structure development;
- Reward strategy and policies; and
- Remuneration training.

We invest extensively in bringing thought leadership in the field of executive and non-executive director remuneration to our clients. We believe that we set ourselves apart from the market by not only explaining market trends and developments, but also by providing suggestions for improving practices and raising standards.

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### **Contact**

#### **Martin Hopkins**

Director  
+27 (0)11 797 5535  
martin.e.hopkins@za.pwc.com

#### **Karen Crous**

Associate Director  
+27 (0)11 797 4616  
karen.crous@za.pwc.com

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## **REMchannel**

PwC maintains an extensive, detailed and up to date Internet-based remuneration survey, customised for the complexities of Southern Africa's remuneration practices. The survey is currently carried out in South Africa, Namibia and Botswana, with further expansion into other African countries soon to follow.

REMchannel®, the product, was launched in late December 2000 and since then the participant list has grown to more than 380 organisations. Today, REMchannel® provides benchmark data for more than 1 500 positions across a variety of disciplines and industries.

Our leading-edge survey system allows practitioners to make informed reward and strategy decisions.

For a single annual survey fee and data submission REMchannel® offers participants an exceptional value proposition that gives them access to a number of surveys:

- Top Executive Survey;
- General Staff Survey;
- Industry-Specific Survey;
- Job-Based Survey; and
- Grade-Based Survey (correlated to all major grading systems)

In addition to the exceptional value proposition offered by REMchannel®, our surveys offers additional value-added features:

- Stringent validation of data;
- Job-matching facilitation;
- Geographic analysis;
- Race analysis;
- Gender analysis;
- Age analysis;
- Internal and external equity measure;
- Detailed benefit quantum analysis;
- Selection of own package component analysis;
- Selection of percentile comparison;
- Automatic age correction of data;
- Interactive web-based selection ('what if' scenarios);
- Real-time database; and
- Reports can be copied and exported into Microsoft Office packages for presentation purposes.

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#### Contact

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**Gerald Seegers**

Director

+27 (0)11 797 4560

gerald.seegers@za.pwc.com

**Rene Richter**

Associate Director

+27 (0)11 797 5755

rene.richter@za.pwc.com

## ***Scheme valuations/pricing***

Medical schemes assess the adequacy of contributions charged to the beneficiaries of their funds annually. We are able to provide consulting and actuarial assistance to schemes in performing this function. We have extensive experience extending from small restricted schemes to large open schemes.

We have proficiency in assessing the claiming behaviour of beneficiaries to determine the impact of the scheme's disease burden. The application of statistical modelling allows for a detailed understanding of the factors affecting claims costs. Our team reviews and accounts for all factors faced by the scheme when considering potential premium increases, including member growth trends, medical and consumer inflation, expenses, legislative changes, benefit design, competitive pressures and other external factors, to name a few.

We are also able to provide input to schemes' benefit design as well as determining the adequacy of existing benefits and any revision required. Our modelling allows trustees to test the impact of various assumptions on proposed increases to achieve a balance that ensures both a reasonable increase and the financial stability of the scheme. Our approach incorporates the needs of the trustees, taking into account the long-term strategy of the scheme.

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### **Contacts**

**Mark Claasen**  
Director  
+27 (0)21 529 2521  
mark.classen@za.pwc.com

**Simon Henderson**  
Senior Manager  
+27 (0)11 797 4698  
simon.henderson@za.pwc.com

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## ***Incurred-but-not-reported reserving***

Incurred-but-not-reported (IBNR) reserving is an important financial consideration for medical schemes. At any given time there are claims that have been incurred by scheme beneficiaries, but which have not yet entered the claims payment process. It is therefore essential for a scheme to understand the quantum of these unknown claims. Using actuarial techniques we are able to assist schemes to determine their required reserve.

We assess the historic trends in claims occurrence, and any factors that would impact this development (such as membership and benefit changes) as well as operational changes (such as a change in the claims processing systems). Our approach is not to just calculate the reserve, but to engage with the scheme and the administrator to understand the risks environment facing the scheme in order incorporate all pertinent information when recommending the IBNR reserve.

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### **Contacts**

**Mark Claasen**  
Director  
+27 (0)21 529 2521  
mark.classen@za.pwc.com

**Simon Henderson**  
Senior Manager  
+27 (0)11 797 4698  
simon.henderson@za.pwc.com

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## Wellness

Many employers and schemes are investigating ways to control escalating costs. For an employer, a reduction in unproductive days has a direct impact on its financial position, while the medical scheme wants to minimise annual contribution increases. It is commonplace for the efforts of these two stakeholders to be conducted in isolation, resulting in a duplication of efforts.

Combining the resources of the employer and the medical scheme to create an integrated wellness strategy will result in both stakeholders achieving gains. Our approach is not to create a loyalty programme, but rather a programme in which employees and their families engage to improve their health in a targeted way. As a result there is a reduction in claims frequency and severity and, since the employees are healthier, they are also more productive. We understand that people are different and so are motivated by diverse incentives. We believe that in order to achieve positive results, stakeholders need to understand the health risk of their employees, the drivers of these risks and strategies to mitigate them.

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### Contact

#### Etienne Dreyer

Associate Director  
+27 (0)11 797 4072  
etienne.dreyer@za.pwc.com

#### Nanie Rothman

Senior Manager  
+27 (0)21 529 2419  
nanie.rothman@za.pwc.com

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## mHealth

In contrast to healthcare access, mobile access is becoming almost ubiquitous worldwide. Virtually all developed markets already have mobile penetration greater than 100% and increasingly powerful mobile technology has the potential to address longstanding challenges in healthcare provision.

Mobile health (mHealth) – the use of mobile communication and devices to provide healthcare services or achieve health outcomes – has come of age and PwC can assist providers in the following ways:

- We can assist in creating an mHealth strategy that is solution driven not technology driven;
- We can draw on our international expertise and provide a global perspective on the trends, solutions and challenges faced in both the developing and the developed world;
- We can assess your specific market in terms of membership dynamics, provider relations and demographic trends. This will allow us to define the landscape and identify current hindrances to user adoption;
- We can identify the partners and role-players required to implement your strategy and help you follow a selection process. This will be linked to a detailed functionality, market fit and ROI evaluation that allows for the best partner selection to implement your strategy; and
- We can assist in implementing and advising on the ongoing monitoring and assessment of the mHealth strategy.

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### Contact

#### Etienne Dreyer

Associate Director  
+27 (0)11 797 4072  
etienne.dreyer@za.pwc.com

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## **Controls and processes**

Changes in legislation and regulatory requirements, complexity of plan offerings and stakeholder (members, regulators, employer group and provider) demands will require medical schemes and/ or administrators to implement more robust processes and systems. Costs associated with the implementation of new systems and processes to comply with service levels and regulatory compliance requirements may not be all recoverable or yield a direct return on the investment if service levels do not improve. Systems and processes should be agile and flexible and able to facilitate the efficient implementation of plan and regulatory changes whilst maintaining internal controls.

PwC can assist administrators and schemes by reviewing business processes and controls that may affect internal operations at an administrator or medical scheme. This includes:

- Benchmarking systems and processes to identify areas where there could be possible inefficiencies or where possible operational losses may occur due to system or process overrides or failures.
- Assist with the evaluation and selection of systems to perform claims processing, member administration, financial operations, procurement, management reporting etc.
- Reviewing where systems and processes may be changed to deal with constant changes to regulatory requirements.
- Assisting with implementing processes to manage outsourced activities.
- Assisting with processes to manage high volumes of transactions and cash.

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### **Contact**

#### **Hennie Jansen van Rensburg**

Director  
+27 (0)11 797 5728  
hendrik.jansen.van.rensburg@za.pwc.com

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## **Assurance**

Our Assurance group provides audit assurance to clients on their financial performance and operations, as well as helping them to improve their external financial reporting and adapt to new regulatory requirements. The true value of an audit is not solely in ensuring compliance with exacting rules, regulations and standards. Rather it lies in our focus on substance over form and on progressing towards a reporting and audit model that communicates better information about a company's long-term value and the risks that are being taken to achieve such value.

Our audit approach can be tailored to meet the needs of any size organisation, as evidenced by our appointment as auditor to some of the largest organisations as well as to thousands of small and mid-sized businesses. In every case, our service offering is underpinned by our deep industry knowledge, wide international experience and global network of skilled professionals.

Our teams are aligned to the industry groupings in which they have the most expertise, enabling them to deliver tailored solutions to complex issues in these sectors. Our traditional core competency has been augmented over the years by the development of additional services that address our clients' requirements. Our audit clients include many of the top performing companies on the JSE securities exchange, as well as many small and mid-sized businesses. In addition to audit, other services provided include accounting and regulatory advice, and attest and attest-related services.

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### **Contact**

#### **Brendan Deegan**

Director  
+27 (0)11 797 5473  
brendan.deegan@za.pwc.com

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# *Contact details*



***Financial Services Leader – Africa***

Tom Winterboer

+27 11 797 5407  
tom.winterboer@za.pwc.com

***Short-term Insurance, Investment Management  
and Medical Schemes Leader – Africa***

Ilse French

+27 11 797 4090  
ilse.french@za.pwc.com

***Long-term Insurance Leader – Africa***

Victor Mugoto

+ 27 11 797 5372  
victor.mugoto@za.pwc.com

***Retirement Funds Leader – Africa***

Gert Kapp

+ 27 12 429 0059  
gert.kapp@za.pwc.com

***Actuarial Services Leader – Africa***

Mark Claasen

+ 27 21 529 2521  
mark.claassen@za.pwc.com

***Banking and Capital Markets Leader – Africa***

Johannes Grosskopf

+27 11 797 4346  
johannes.grosskopf@za.pwc.com





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