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Ethics, Governance & Accountability in Contracting: From Principles to Practice

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Disclosures

- Present FWAE Ethics talks (independent) in GEMS Provider Summits
- Matched Media - Universal Care for GEMS subcontracted services
- Presentation is based on independent views

Overview

- What is contracting?
- Promise-keeping in contracting
- Member experiences
- Outcomes-based contracting
- Contracting as an ethical tool

What is contracting?

- Translates scheme governance and ethics into operational decisions
 - Governs decisions and processes it does not make itself
 - Outsourcing operations but not accountability.
- Not just a legal document but a ***clinical and ethical*** instrument
- A bridge for promise-keeping

Promise-Keeping in Medical Scheme Contracting

Accountability, Ethics, and Governance

The Promise Made

When members join a **medical scheme**, the system promises that:

- Care will improve their ability to function **independently**
- Suffering will **relieved, not prolonged**
- Clinically necessary care will be **accessible** when needed
- Members will not face **financial fear or harm**
- Decisions will be made fairly, transparently, and in their best interests

Where Promise-Keeping Becomes Invisible

- Benefits are designed
- Contracts are signed
- Co-payments & limits are approved
- Authorisation rules are set
- Networks are selected

Yet these **everyday decisions** shape outcomes and risks.

What Promise-Keeping Demands

- Measure **outcomes** not just cost
- Monitor harm indicators
- Avoid delays & prescription abandonment
- Embed ethical checks into funding rules



Patients are invisible when benefits are designed and contracts are signed.

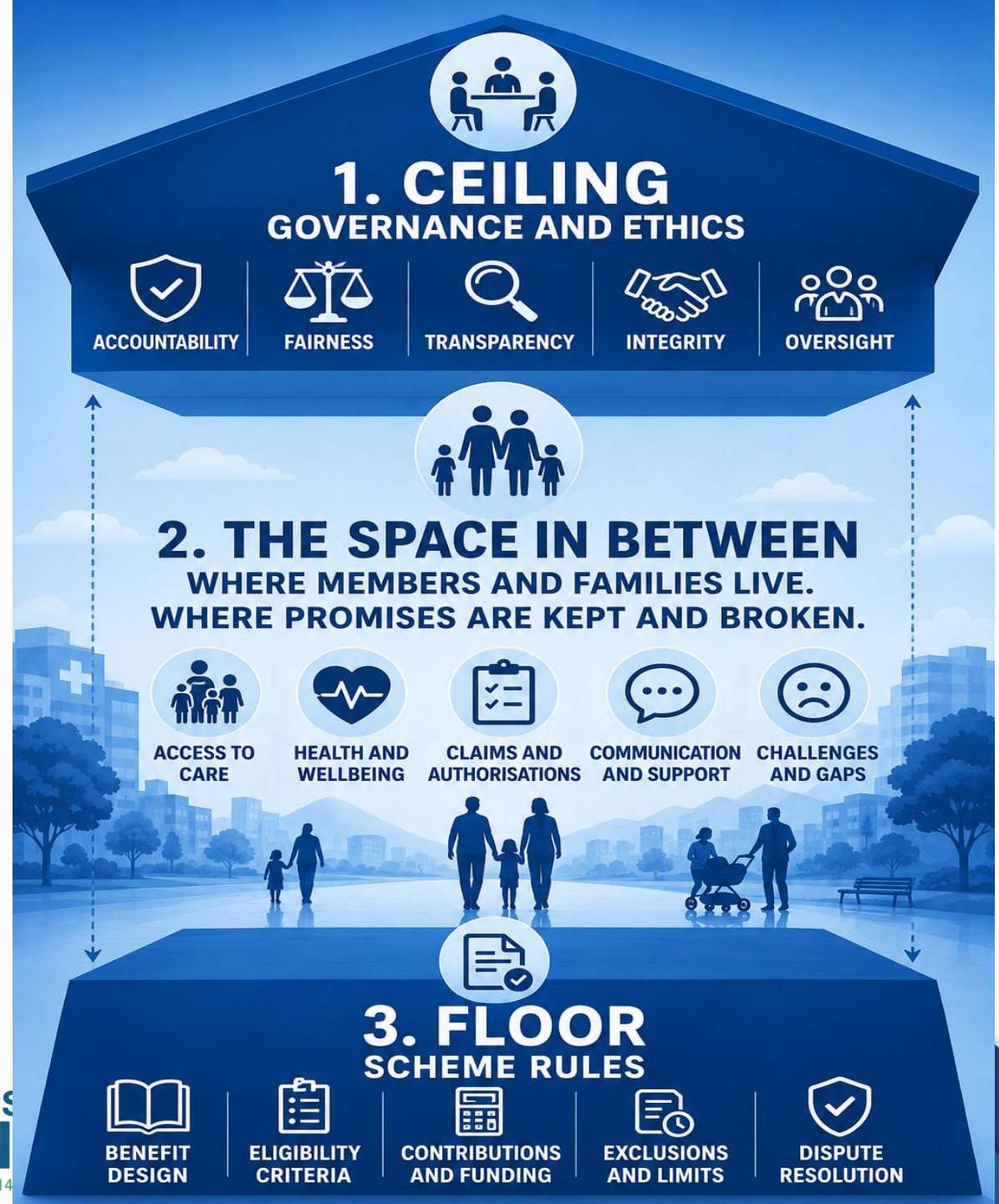
So who is accountable for whether everyday funding decisions actually improve outcomes, protect function, relieve suffering, and prevent financial harm?

Value-based healthcare is defined by what members can do, feel, and afford, not just what schemes pay.



Where members live?

A scheme operating at the floor only, may be legally compliant but equity neutral.



Meet the members



Meet Mr Parks

- 73-year-old, retired admin clerk
- Registered for diabetes, hypertension, and hypercholesterolaemia > 15 years
- Progressive poor eyesight affecting independence
 - Cataract surgery (Ophthalmologist) - **approved**
 - Pre-op Pathology tests ordered by OPTH – **claim rejected**
 - ECG by a physician – **claim approved**
- No understanding of rejections reasons and can't afford OOPP
- Daughter calls to postpone surgery to avoid more OOPPs
- Surgery is delayed.

The ophthalmologist sees the whole patient.

Value-based or value-blind

VBHC should improve patients' capability to function independently, free from pain and discomfort, and not worry about the out-of-pocket cost of care (Teisberg, Wallace, & O'Hara, 2020).

Patient arrives
as a whole
person

Scheme splits
into body parts

Each system
has an owner

Outside the
"owner's lane"
= REJECT

Who pays the
price?

Meet Ms Zulu

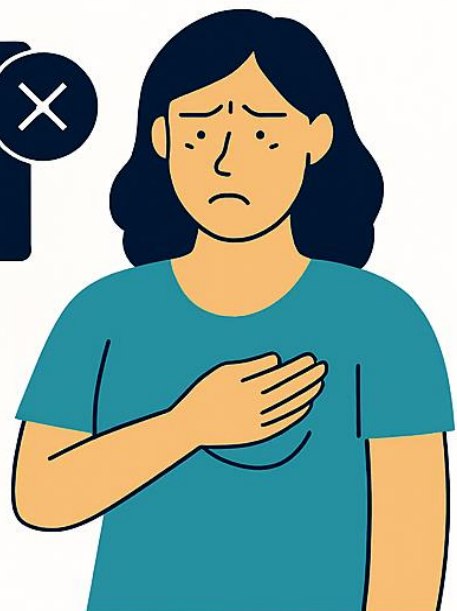
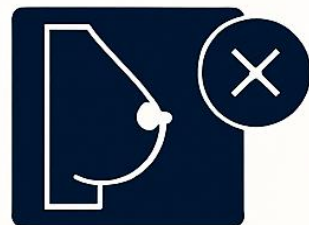
35-Year-Old Member with Breast Lump

System Reality

- Out-of-hospital radiology benefit depleted
- Mammography funded from risk only from age 40
- Request for imaging rejected or member liable for full cost

Equity & Epidemiology Insight

- 35-year-old African woman
- Triple-negative breast cancer (TNBC): more common in Black women, women under 40/premenopausal
- TNBC is more aggressive, diagnosed at later stages



Contracting failure:

- No clinical override pathway
- No recognition of clinical presentation vs. population rule
- Contract fails to translate ethics to decision = equitable access
- Equity risk (age + race + biology)

How can a scheme govern effectively if it does not analyse outcomes by demographics such as race, age, gender, postal code, and option?

WHERE BENEFIT DESIGN MISALIGNS WITH DISEASE RISK

Why PMB Rules Must Align with Epidemiology, Not Averages



Epidemiological Risk Profile

- Early onset in a subset of members
- Aggressive and rapid progression
- Asymptomatic early disease
- Risk is not evenly distributed

Disease progression doesn't conform to age-based benefits.



Current PMB Funding Rules

- Screening tied to fixed eligibility
- Diagnostics gated by symptoms or referral
- Oncology cover activated *after diagnosis*
- Limits aligned to average norms

PMBs activate at diagnosis. Diagnostic access is often delayed.



Impact on Scheme Outcomes

- Early-stage disease undetected
- Diagnosis occurs later in the path
- Members enter care at higher acuity
- Treatment costs escalate

Outcomes depend on access before diagnosis.



PMBs Protect Members After Diagnosis. Outcomes Depend on Access Before Diagnosis.

Implications for Funders:

- Align screening with risk profiles
- Enhance diagnostic access
- Fund prevention before symptoms

Meet Ms Anderson

- Similar to Ms Zulu
- She knows the decision should be challenged
- Her treating Dr advocates for her and writes an appeal letter.
- She appeals the decision
- The decision is overturned.
- Funding for the mammogram plus ultrasound-guided biopsy is approved.

They both belong to the same scheme and option, but face different funding decisions.

Do you know who is appealing or applying and granted ex-gratia funding?

Are overturned decisions tracked and analysed to test the integrity of policies and processes?

Meet the Smiths family

- Elderly parents (pensioners) caring for an adult son addicted to drugs
- Son is divorced, lost employment, and survives through theft to sustain addiction
- Family faces stigma, blame, and social isolation from neighbours
- Parents experience depression, fear, and emotional exhaustion
- Mental health benefits are exhausted due to prolonged social stressors
- In 2025, Mrs Smith had 8 unrelated hospital events

Ethics and social impact analysis of benefit design and changes:

Reducing or excluding social worker benefits without real-world testing risks worsening outcomes for vulnerable families.

A scheme that considers members only as individuals, while disregarding that they exist within families, households, and communities, is governing without social insight.

Contracting for accountability

Equity and Effectiveness Dashboard

DEMOGRAPHICS



Race 45% 52%
Age Gender

UTILISATION



Utilisation Rate: 70%
Exclusions: 250

HEALTH OUTCOMES



Treatment Effectiveness: 68%
Recovery Rate: 58%
Relapse and Readmission

FINANCIAL IMPACT



High OOP Rate
Co-payment Care Deferral
and Harm Monitoring

SERVICE QUALITY



User Satisfaction: 80%
Complaints: 45

EQUITY GAPS



Access Difference: 12%
Outcome Gap: 22%

KPIs that matter

Rejection and appeal rates

Care actually received rates (impact of co-payments and appeals)

Late presentation for cancers with screening benefits

Emergency vs. primary care utilisation ratio

Benefit design or change equity impact measures

Targeted communication measures

Polypharmacy reduction

Contracting as an Ethical Tool

A three-pillar architecture for moving from the regulatory floor to ethical practice

I Substantive Clauses

What the contract must protect

● Clinical Override Pathway

Individual clinical presentation must be able to override population rules — protecting complex, elderly & multi-morbid members

● Procedure-Linked Pre-op Bundling

Authorisation logic follows the procedure, not the specialty — preventing rejections that delay PMB care

● Harm & Equity Clause

Every benefit design change requires an equity impact assessment before implementation

Anchored in MSA s.29 (Scheme Rules) & Reg 15 (PMBs)

II Governance Mechanisms

How accountability is structured

● Disaggregated Outcomes Reporting

Rejections, appeals & ex gratia outcomes published by option, age, race & postal code

● Active Appeal Outreach

Members proactively informed of MSA s.47 dispute rights — in plain, inclusive language

● Ethics at the Decision Table

Ethics consults embedded in contracting, benefit design & exception decisions

Anchored in MSA s.57 (Trustee Duties) & CMS Circulars on disclosure

III Accountability Loops

How the system learns from itself

● Promise-Keeping as KPI

Track whether the funded care actually reached the member — the test of contractual purpose

● Post-Overtake Policy Review

Every overturned rejection triggers review of the underlying rule for validity & equity

● Equity Impact Tracking

Continuous measurement of benefit-change effects on vulnerable cohorts

Anchored in MSA s.44–46 (CMS oversight) & Trustee fiduciary duty

Conclusion

Ethical and accountable healthcare funding is:

- Not just about **what gets funded** —it is about **what is enabled**
- Not just **claims processed** —but **care accessed**
- Not just **rules applied** —but **people protected**

Contracting is not an administrative function. It is a:

- **Care enabler**
- **Member protector**
- **Equity safeguard**
- **Trust builder**

Thank you!

- You will sign contracts
- You will design benefits
- You will sit in governance committees
- You will operationalise scheme rules.

So, who is accountable for whether everyday funding decisions actually enable access to care, improve health outcomes, relieve suffering, prevent harm to **members, while safeguarding the **scheme's** sustainability?**