IN THE SECTION 59 INQUIRY

WRITTEN LEGAL SUBMISSIONS
BY THE BOARD OF HEALTHCARE FUNDERS OF SOUTHERN AFRICA NPC

INTRODUCTION

1 These written legal submissions are made in response to the updated notice (Notice 2/2023) published by the Section 59 Panel ("the Panel") on 11 May 2023, which invites stakeholders to make legal submissions to the Panel on its Interim Report published on 19 January 2021 ("the Interim Report").

2 The Board of Healthcare Funders of Southern Africa NPC ("BHF") accepts the invitation from the Panel to make legal submissions on the Interim Report.

2.1 As is dealt with in more detail below, with reference *inter alia* to the provisions of the Medical Schemes Act, 131 of 1998 (“the MSA” or “the Act”) the BHF and its members consider themselves statutorily bound to actively take steps against the debilitating theft, fraud, and misconduct prevalent in the medical schemes industry.

2.2 It follows, that the BHF and its members are also concerned with how the findings and recommendations of the Panel might impact efforts to thwart theft, fraud, and misconduct. Ultimately, the MSA is directed principally at protecting the interests of members of medical schemes, which is naturally also where the focus of the BHF is directed.

2.3 The protection of members and beneficiaries is statutorily also the principal obligation resting on the CMS—and, presumably therefore, necessarily the focus of the Panel, too.

2.4 By the same token, the BHF recognises that it is important that complaints lodged under and in terms of the MSA against medical schemes are properly investigated and appropriate relief afforded to complainants. This is especially so if the discriminatory conduct offends against rights entrenched in the Constitution of the Republic of South Africa, 1996 ("the Constitution").

2.5 This includes the investigation of complaints regarding unfair discrimination in the healthcare industry, with reference, in particular, to the complaints about unfair or discriminatory conduct on the part of a medical scheme towards providers of relevant health services. The BHF and its members do not condone, let alone promote, unlawful discrimination against any person; on the contrary, any such unlawful discrimination is to be deprecated.

2.6 It is for these reasons and with these aims in mind that the BHF makes these submissions.

2.7 All of the above said, the BHF does not accept that it was within the statutory powers of the CMS under the MSA to appoint the Panel or for

the Panel lawfully to conduct the Inquiry it has or to make the findings and recommendations it does as set out in the Interim Report or at all. These representations are submitted on behalf of the BHF on the strength of that reservation.

3 These written legal submissions are submitted by Werksmans Inc. ("Werksmans") acting on behalf of the BHF and are intended to supplement the submissions made by the BHF on 5 April 2021 ("the BHF's previous submissions"). These written submissions are not intended to be exhaustive and the BHF reserves the right to supplement its legal submissions at the virtual hearing scheduled for 27 June 2023.

BACKGROUND

4 The BHF is an industry association representing medical schemes, administrators, managed healthcare providers and other healthcare funders in South Africa and other countries in Africa, predominantly in the Southern African Development Community. A number of the BHF’s members stand to be affected by the findings and recommendations made by the Panel.

5 These legal submissions are not intended to replace any submissions made directly to the Panel by members of the BHF.

6 The mandate ostensibly given to the Panel was to investigate Complaints and allegations received by the CMS relating to section 59 of the Act and items 5

and 6 of the Regulations in terms of the Medical Schemes Act, 1998 (“the Regulations”), to identify any trends emerging from and make recommendations in relation thereto.

7 The allegations were defined in the Panel’s Terms of Reference as being public allegations regarding the conduct of medical schemes and their administrators vis-à-vis Black and Indian health care practitioners. By definition, the allegations exclude Complaints as contemplated in section 1 of the MSA.

8 In essence, the Panel construed its mandate as being to investigate two main issues arising from the allegations: namely, whether during the investigation period there was unfair racial discrimination by medical schemes against Black (as that term is defined in the Interim Report, including Indian practitioners) health care providers ("the unfair racial discrimination issue") and whether Black providers were being treated procedurally unfairly ("the procedural fairness issue") (paragraph 699 of the Interim Report).

9 Albeit that the Interim Report is said to be just that, interim, the Panel has reached various conclusions and made recommendations (not all of which fall within its mandate). The Panel has also made various findings of fact on the strength of its investigations and inquiries. It is not apparent that these findings are anything but final.

10 The invitation extended to parties on 11 May 2023 is to make legal submissions to the Panel on the Interim Report. These submissions are therefore limited to legal submissions on certain aspects of the Interim Report.

PROPER INTERPRETATION OF SECTION 59 OF THE MEDICAL SCHEMES ACT NO. 131 OF 1998 ("MSA")

General Submissions

11 At sections 3 and 24 of the Interim Report, the Panel considers the MSA and, more particularly, the meaning of section 59 of the Act.

12 Section 24.3(i) of the Interim Report deals with the principles of interpretation to be applied to the exercise undertaken by the Panel. There is a statement of general principles, which—save in one respect of emphasis—reflects the legal position in South Africa as developed by our Courts.

13 The area of emphasis that the BHF would seek to draw attention to is the principle of context. In *Capitec Bank Holdings Ltd v Coral Lagoon Investments 194 (Pty) Ltd* 2022 (1) SA 100 (SCA) and *University of Johannesburg v Auckland Park Theological Seminary* 2021 (6) SA 1 (CC), our two highest courts have emphasised the importance of context in the interpretation of documents. Although both cases were concerned expressly with contracts, the principle of contextual interpretation is relevant to statutory interpretation too, as a number of the cases referenced in the Interim Report conclude. In *Capitec*

at [25], the SCA said that the triad of text, context, and purpose was foundational in the interpretation of any document.

14 For purposes of investigating the allegations it is not only section 59 of the MSA that is relevant, but the Act as a whole as well as the Regulations that are to be read with the Act. There is no challenge to—and nor could there have been a challenge to—the Constitutionality of the Act or the Regulations. The fundamental issues in question arising from the allegations are factual in nature and do not amount to a challenge to the legislation. In investigating whether there is substance to the allegations, therefore, the Panel was enjoined to do so having regard to a purposive interpretation of section 59 and the applicable Regulations within the context of the Act as a whole.

15 In the Interim Report, the Panel principally explores the meaning of section 59 in isolation. It does not look at that section within the context of the Act more generally or having regard to the application of that section as against the common law.

16 When the Act is looked at within the triad of text, context, and purpose, the starting point must be that the statutory purpose or intention of the MSA is principally the control and regulation of medical schemes in the interests of beneficiaries. The CMS is entrusted with the powers and duties to fulfil this statutory mandate. The provisions of the MSA and the Regulations fall to be interpreted with this in mind.

17 More specifically, the MSA is concerned with the fact that medical schemes receive money from members of the public, in the form of a contribution or premium, in return for accepting liability *inter alia* to grant assistance in providing for the obtaining of or defraying expenditure in connection with the obtaining of any relevant health service. The arrangement of the Act is that the money received is held in trust, by medical schemes, on behalf of members and beneficiaries.

18 The Act establishes the necessary protections and safeguards to ensure that when members and beneficiaries seek to access a relevant health service and to have the costs of doing so reimbursed or paid by the medical scheme to which they belong, then a medical scheme will fulfil its liabilities in that regard. These protections and safeguards are not only for the benefit of those members and beneficiaries who obtain a relevant health service, but for the body of members generally. This includes those members who may never access a relevant health service, but whose contributions go into the trust estate. It is also for the benefit of future members and beneficiaries who will share in the common risk pool.

19 This emphasis is to be seen *inter alia* in the principal function of the CMS in section 7(a) of the Act: to protect the interests of beneficiaries at all times.

20 It is also seen *inter alia* in the provisions of

20.1 section 20(1), which prohibits any person from carrying on the business of a medical scheme unless registered in terms of the Act, which is also to be read with sections 21, 21A, 24(1), and 24(2)(b);

20.2 section 26(1) and 29 regarding the effect of registration and the requirements of the Rules, the binding force of the Rules (section 32), and amendments thereto (section 31);

20.3 the requirements regarding the appointment of trustees, their obligations, and the scrutiny of their activities by the CMS and the Registrar (sections 24(2)(a), 46, and 57);

20.4 the financial control of medical schemes (sections 24(2)(c) and (d), 26(1)(b) and (c), 26 generally, 33(2) and (3), 35 to 38, 44, and 51); and

20.5 those sections that impose strict control on the permitted expenditure allowed to medical schemes across all of their activities, including sections 20(2) to (7), 26(2) to (7), 30, and 65 as well as the Regulations.

21 A breach of any of its obligations by a medical scheme may result in cancellation of its registration (section 27), intervention by the Registrar and/or CMS via High Court proceedings (section 51), the appointment of a curator (section 56) or criminal sanction (section 66).

22 Within this environment, it is hardly surprising that any risk of fraud or misconduct attracts harsh sanction. Indeed, this is plainly evident in the provisions of section 66(1), which read:

> "Any person who-
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> (a) contravenes any provision of this Act or fails to comply therewith;
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> (b) makes or causes to be made any claim for the payment of any benefit allegedly due in terms of the rules of a medical scheme, knowing such claim to be false;
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> (c) knowingly makes or causes to be made a false representation of any material fact to a medical scheme, for use in determining any right to any benefit allegedly due in terms of the rules of the medical scheme;
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> (d) having knowledge of any fact or the occurrence of any event affecting his or her right to receive any benefit in terms of the rules of a medical scheme, and who fails to disclose such fact or event to the medical scheme with the intent to obtain from the medical scheme a benefit to which he or she is not entitled or a larger benefit than that to which he or she is entitled;
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> (e) renders a statement, account or invoice to a member or any other person, knowing that such statement, account or invoice is false and which may be used by such member or other person to claim from a medical scheme any benefit or a benefit greater than the benefit to which he or she is entitled in terms of the rules of the medical scheme,
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> (f) [Para. (f) deleted by s. 27 (a) of Act 55 of 2001]
>
> shall, subject to the provisions of subsection (2), be guilty of an offence, and liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and imprisonment."

23 The strict controls intended to eliminate, as far as reasonably possible, any potential for theft, fraud, and misconduct. The risks to the common trust property of the medical scheme are so great that the Legislature has gone to deliberate and far-reaching efforts to safeguard it. The agents and trustees of a medical scheme are entrusted with the obligation to implement these controls.

24 A medical scheme administrator is subject to the same obligations as the medical scheme and its board of trustees. Not only is there a direct passthrough of these obligations onto an administrator, but an *a priori* approval process that must be undertaken in terms of the Regulations to accredit administrators. Section 58 of the Act and Chapter 6 of the Regulations are self-explanatory and unambiguous in this regard.

25 Medical schemes and administrators are therefore under a statutory obligation to ensure that payments made for the rendering of a relevant health service—the primary function of a medical scheme under the definition—are made strictly in accordance with the MSA and the Regulations. They are statutorily obliged to ensure that payments are made to beneficiaries and service providers strictly for a relevant health service actually rendered to a beneficiary of a medical scheme by a service provider.

26 A failure to meet this obligation may result in the intervention of the Registrar and/or the CMS regardless of whether that failure was negligent or intentional. For administrators in particular, their contracts with medical schemes impose onerous obligations to ensure compliance with the Act and the Regulations at pain of financial penalties. For both trustees and the agents of medical schemes, including administrators, financial and criminal sanctions can follow.

27 Thus, section 59 operates within a context of the MSA and the Regulations as a whole and it is within this context and having these purposes in mind that

section 59 of the MSA, together with items 5 and 6 of the Regulations, must be interpreted.

28 Importantly in this regard, section 59(1) of the Act starts with an obligation on a supplier of a relevant health service to render an account that complies with the prescribed particulars. It is this account that is referenced in section 59(2) and which necessarily leads to the payment/s contemplated in section 59(3).

29 The starting premise on which section 59 is founded is therefore the obligation imposed on the supplier of a relevant health service to comply with section 59(1) and items 5 and 6 of the Regulations. To do that, the service provider must also have registered with the BHF, which is the body that issues “practice code numbers” as defined in the Regulations.

30 Hence, the Regulations form an integral part of the scheme of payment set up by section 59 and therefore, in assessing whether or not a Complaint under the Act is valid or should give rise to relief, the Regulations must also be considered. It follows that if the Panel were investigating Complaints, they too would have had had to consider that Complaint as against the requirements of the Regulations and to assess, in the first instance, whether or not suppliers had complied strictly with the Regulations.

31 In interpreting section 59, it is also relevant that a medical scheme, once established, is “*a body corporate capable of suing and being sued and of doing or causing to be done all such things as may be necessary for or incidental to*

the exercise of its powers or the performance of its functions in terms of its rules" (section 26(1)(a)).

32 This necessarily means that a medical scheme can do all things which any other body corporate (or juristic person) can do, including the exercise of contractual powers in the ordinary course. Seen in this light, the provisions of the Act and the Regulations are generally not empowering or enabling, but restrictive or controlling. The Act does not give powers to medical schemes, but constrains the way in which medical schemes can exercise their powers.

33 Within this context, section 59 does not afford medical schemes the power to pay within 30 days or to set-off against future payments to service providers monies wrongly paid; section 59 obliges medical schemes to pay within 30 days and circumscribes when and how set-off can be applied.

34 Read within the context of the Act as a whole, however, it is clear that section 59 read with the Regulations also imposes obligations on medical schemes and administrators to ensure compliance with the prescripts thereof at pain of otherwise being found to have breached the other provisions of the MSA and rendering themselves susceptible to sanction.

35 Medical schemes and administrators must therefore undertake an exercise to establish, first whether or not there has been a relevant health service rendered. The next steps are to ensure that items 5 and 6 of the Regulations have been

properly complied with. If not, the medical scheme may not pay anything at all, whether to a supplier or a member.

36 In the 2017 reporting year, more than R160 billion in benefits was paid out by medical schemes. For each claim submitted and paid—whether by a member or a provider—compliance with section 59(1) and the Regulations had to be assessed as a precondition to payment being made.

37 The Panel has heard extensive evidence, from all of the medical schemes and administrators involved, that the only way in which this exercise can be undertaken—and the requirements of the Act met and the obligations resting on them fulfilled—is through automated systems. These systems have within them algorithms or mechanised systems that detect possible theft, fraud, and misconduct, which is prevalent within the industry.

38 Faced with these outcomes, arrived at through an automated verification of compliance with the Regulations and the Act, medical schemes and administrators are statutorily bound to take steps, including the steps which are complained about in the allegations. A failure on the part of medical schemes and administrators to respond to these outcomes would be palpably unlawful in terms of the MSA and would warrant the intervention of the CMS and the Registrar.

39 The principal finding of the Panel is that this process indirectly or unintentionally discriminates against Black healthcare practitioners and that this discrimination is unfair. This is evident in paragraph 753 of the Interim Report, which reads

> "We have concluded that some of the current procedures followed by schemes to enforce their rights in terms of section 59 of the Act are unfair. We have also found that Black providers are unfairly discriminated against on the grounds of race. These findings are both serious and far-reaching. But we believe that it is important to stress that we have not found evidence of deliberate unfair treatment – the evidence shows the unfair discrimination is in the outcomes. Our Constitution regards the form of unfairness that we have found to exist as constituting unfair racial discrimination."

40 The Panel complains about a lack of algorithmic transparency, but that criticism cannot detract from the statutory obligation resting on medical schemes and administrators to act in the circumstances which they do. This is especially so in circumstances where there has been no challenge to the MSA or the Regulations and no finding of direct discrimination.

41 The fact of these obligations on medical schemes and administrators is highly relevant to the question of reasonableness and fairness, in respect of both of which the Panel makes findings on the allegations that are adverse to medical schemes and administrators. Making those findings without a proper contextual interpretation of section 59 is therefore flawed.

42 A contextual and purposive interpretation of section 59 and the Regulations read within the context of the MSA as a whole sheds a materially different light on the obligations of medical schemes and administrators and the

reasonableness and fairness of the steps taken by them to comply with those obligations.

Suspending direct payment to providers

43 The Panel's approach to procedural fairness was also premised on an interpretation of section 59 of the MSA. In this regard, one of the issues that the Panel sought to determine was whether or not funders were entitled to suspend direct payment to providers and, instead, make payment directly to members of medical schemes (also known as indirect payment).

44 Once again, as a body corporate, a medical scheme is at liberty to agree to pay whomsoever it chooses for the rendering of a relevant health service, provided it is not precluded from doing so by bound its Rules, the Act, or the Regulations. Indeed, it is a common incident of insurance contracts—which the Constitutional Court in *Genesis Medical Aid Scheme v Registrar of Medical Schemes* 2017 (6) SA 1 (CC) characterised the business of a medical scheme as being—that the insurer pay a service provider in fulfilment of its obligation to indemnify the insured. Moreover, this is expressly provided for in the definition of the business of a medical scheme in section 1 of the MSA.

45 Section 59(2), therefore, does not empower a medical scheme to do something which it could not otherwise do. If a medical scheme can pay a supplier directly as an incident of the contract of insurance and otherwise in terms of the Act, then the thrust of the section lies elsewhere.

46 This interpretation is reinforced by the wording that says that medical scheme can “pay to a member”. There has never been any question surrounding whether a medical scheme (or insurer) can pay directly to the insured, so that wording would then become tautologous if it was an empowering provision—rendering that interpretation unsustainable.

47 Rather, the impetus or purpose behind section 59(2) lies in the requirement that payment be made, regardless of who it is made to, within 30 days of the day on which the claim was received. This is made clear when section 59(2) is read with item 6 of the Regulations.

48 In paragraph 717 of the Interim Report, the Panel expresses its view, based on the reasons provided in the Interim Report, that "although there is no express provision in the [MSA] which allows schemes to place providers on indirect payment, the schemes may do so where either a provider has contracted with the scheme on terms which allow for this; or where the scheme has included such a possibility in its internal system of proper financial controls (section 57(4)(c) of the [MSA] mandates that the schemes must have such systems of control)".

49 Following the reasons set out in the BHF's previous submissions, the BHF submits that the provisions of the MSA place no restriction on to whom payment must be made.

50 The wording of section 59(2) definitely does not do so. On the contrary, that section specifically contemplates that payments by medical schemes may be made to a member *or* a supplier. The decision to pay a provider directly or indirectly may, in turn, be informed by an agreement between the medical scheme and the providers concerned, as well as the specific rules of the medical scheme. It will also be influenced by the terms and conditions on which the supplier renders the relevant health service.

51 The BHF, therefore, supports the position taken by the administrators and medical schemes that they are not required, as a matter of law, directly to pay a healthcare provider who renders a healthcare service to a medical scheme member (paragraph 498).

52 The aforementioned position is also in line with the comments made by Rampai J in the matter of *Mokwena and Others v Government Employees Medical Scheme* [2017] ZAFSHC 154 ("the *Mokwena* judgment"). Although Rampai J ultimately struck this matter off the roll for a procedural issue, Rampai J did provide certain views regarding the payment of healthcare practitioners who submit fraudulent claims. In this regard, the *Mokwena* judgement was concerned with two matters that were ultimately consolidated -

52.1 in the first matter, the applicants (the healthcare practitioners), sought to have the respondent (Government Employees Medical Scheme ("GEMS")) interdicted from declining payment of all future claims which

the applicants contemplate submitting to the respondent for certain medical services rendered or to still be rendered; and

52.2 in the second matter, the applicants (distinct healthcare practitioners) sought an order compelling GEMS to effect payment of all claims which the applicants contemplate submitting to GEMS in the future concerning medical services still to be rendered.

53 Rampai J ultimately held that the relationship between the parties was regulated by an agreement read together the provisions of the MSA, the statutory regulations and the domestic rules of the respondent, GEMS. In this regard, at paragraphs 6 to 7 of the *Mokewena* judgment, Rampai J remarked that -

> "[6] The applicants and the respondent are parties to an agreement termed, 'Gems Network Agreement'. The relationship between the parties is governed *by agreement*, 'anx b', which was concluded on 1 February 2010 in the case of Dr Ramantsi, *read together the provisions of the [MSA], the statutory regulations and the domestic rules of the respondent*. The applicants are required to render health care services to the members of the respondent; to bill them in accordance with the tariff of fees prescribed by the South African Medical Control Council and to submit their valid claims, relative to the health care services rendered, to the respondent for payment.
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> [7] The respondent is required to interrogate a doctor's claim in order to ensure that it is procedurally compliant; to scrutinise a doctor's claim in order to make doubly certain that it is based on a member's actual medical account, to ensure that the medical treatment as specified on the account was actually rendered by the doctor concerned *and to pay to its member or to a doctor as a provider of health care service* within thirty days after date on which the doctor's valid claim was received" (our emphasis).

54 In paragraphs 14 to 16 of the *Mokwena* judgement, Rampai J went on to remark that-

> "[14] The respondent decided to suspend payment of claim's pending further investigation. It is undisputed that the claiming patterns of all the applicants were similar and that the claims they submitted were irregular. The respondent's contractual right to suspend payment is not dependent upon its contractual right to terminate the network agreement. In other words, the respondent is not obliged to first establish its right to terminate the agreement before it can exercise its right to suspend its operation. If this is so, then the applicants are not entitled to a court order, whereby the respondent is compelled to pay all their future claims since the operation of the agreement, from which their right to claim stems, has been put on hold. It would not be proper for me to make a blanket order compelling the respondent to pay all future claims which have not yet been submitted, identified and verified. *Such an order would clearly undermine the respondent's contractual right to suspend as well as its discretion to pay either the doctor or the patient*.
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> [15] I cannot indefinitely sanction payment to the applicants of all future claims before the applicants have actually rendered any health care services to specific members of the respondent. It would be absurd to make such an onerous and final order without knowing what such future claims will be all about. Such an order will effectively deprive the respondent of its rights and obligations to investigate and to interrogate the validity of claims still to be submitted in the future by the applicants. This proposition is untenable.
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> [16] The relief sought, if it were to be granted, would exacerbate the situation. On their own version, the applicants have submitted irregular claims to the respondent in the past. They have already received payments from the respondent. They were not entitled to those previous payments. Such payment were not due. There was no lawful causa for them. Granting the order would basically be tantamount to licensing the submission of further questionable claims and stripping the respondent of any powers to interrogate such claims in the future" (our emphasis).

55 This is also consistent with prior rulings of the Registrar and the CMS Appeal Committee.

55.1 In the decision of the Appeal Board in *Dr TJ Mashamba v GEMS* (CMS 49331 of 17 November 2015). There the Appeal Board upheld the rulings of both the Registrar and the Appeal Committee, finding that the appellant doctor could not compel the medical scheme to pay him directly, because there was no privity of contract between them.

55.2 The finding in *SA Police Service Medical Scheme v Registrar of Medical Schemes and others* (CMS 52609 31 October 2016) was consistent with these principles and with the submissions made elsewhere in these Submissions.

56 Accordingly, the BHF submits that indirect payment is not prohibited under the MSA or at all. On the contrary, it is specifically countenanced by the definition in section 1 of the Act of business of a medical scheme as well as section 59(2) and the Regulations. It is otherwise fact specific, depending on any agreement concluded between the medical scheme and the provider as well as the internal rules of the medical scheme concerned.

Nature of the schemes' powers

57 The Panel also considers the nature of the powers of a medical scheme in the context of section 59(3) of the MSA. Section 59(3) affords a medical scheme the right to deduct an amount from benefits payable by that scheme to a

member or an healthcare provider ("claw-back") in circumstances where the medical scheme -

57.1 paid such amount *bone fide* in accordance with the provisions of the MSA, but the member or healthcare practitioner was not entitled thereto; or

57.2 sustained loss equivalent to that amount through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme.

58 This provision too must be interpreted in the context of the purposive interpretation of the Act as a whole and a medical scheme's common law powers to apply set-off (as to which see *Blakes Maphanga Inc v Outsurance Ins Co Ltd* 2010 (4) SA 232 (SCA) at [14] – [15]).

59 The section therefore delineates the parameters or circumstances in which medical schemes may claw back funds and is hence descriptive or, at worst for medical schemes, permissive. It does not amount to an enabling section affording medical schemes powers that they would not otherwise have.

60 The operation of this section must also be viewed in light of the fact that the overriding purpose of the Act is to protect the interests of beneficiaries and to maintain the financial soundness of the scheme. If a medical scheme were constrained to seek judicial redress against either a member or a provider for

every mistaken payment, there would be no advantage to beneficiaries at all, only to the legal establishment. Plainly this is not a reasonable or fair outcome.

61 In paragraph 558 of the Interim Report, the Panel concludes wrongly that "the powers exercised [by medical schemes] in terms of section 59(3) of the MSA are public powers and are constrained by the principles of administrative justice embodied in sections 1 and 33 of the Constitution and [the Promotion of Administrative Justice Act No. 3 of 2000] PAJA". The reasons for the Panel's findings are summarised in paragraph 557 and include -

61.1 the exercise of the power involves depriving a provider of an amount owed;

61.2 the power is coercive in that the provider is subject to the exercise of the power by the scheme – which power is in turn aimed at rectifying what is identified in the statute as a "wrong";

61.3 a power imbalance exists between the scheme and provider in the implementation of section 59(3) of the MSA as the power is exercised by the scheme unilaterally. The providers have no choice but to accept non-payment and have no effective recourse in relation to non-payment;

61.4 a decision made by a scheme to deduct monies from future benefits both has an immediate effect on the provider (or member) and, on the whole membership of the scheme as the deduction benefits the pool of

members' funds. The schemes submitted that section 59(3) allowed them to act to the benefit of the broader membership of the scheme – a segment of the public; and

61.5 the power to deduct amounts in terms of future benefits is sourced in the MSA.

62 The BHF respectfully disagrees with the Panel's conclusion that the exercise of the power in section 59(3) constitutes a public power. In this regard, the nature, generally of a medical scheme's powers has been considered by our courts. In particular, in *Government Employees Medical Scheme v Public Protector* 2021 (2) SA 114 (SCA) ("the *Public Protector* case"), the second respondent, Mr Ngwato, became embroiled in a dispute with the first appellant, GEMS, about his qualification as a member and his entitlement to a subsidy. He lodged a complaint about this with the Registrar of Medical Schemes. On appeal, the argument was confined to sections 6(4)(a)(ii), 6(4)(a)(v) and 6(5)(b) of the Public Protector Act No. 23 of 1994, which (so counsel submitted) empowered the Public Protector to investigate Mr Ngwato's complaint. The SCA held, on an analysis of a medical scheme's character, that it did not perform a public function, and accordingly that section 6(4)(a)(ii) or (v) did not give the Public Protector the investigative power she claimed. Ponnan JA held as follows for the unanimous Court:

> "[21] Common to both ss 6(4)(a)(ii) and (v) is the expression 'performing a public function'. The debate thus centred on whether it can be said that GEMS performs a public function. 'Medical scheme' is defined in the MSA to mean

any medical scheme registered under s 24(1). A medical scheme is a *sui generis* non-profit entity, which operates for the benefit of its members. According to the MSA, no person shall carry on the business of a medical scheme unless registered as such. The *functions and powers of a medical scheme are limited by its registered rules and the MSA*.

[22] *The business of a medical scheme does not appear to encompass the performance of a public or government function or the exercise of a public power. The relationship between members and the scheme is essentially one of a contractual nature.* The rules of a medical scheme and any amendment thereof are binding on the medical scheme concerned, its members, officers and any person who claims any benefit under the rules or whose claim is derived from a person so claiming. *GEMS is a restricted medical scheme and only employees qualifying to be registered as members and their dependants may be registered as beneficiaries of the scheme. The Rules are thus not of general application. They only apply to a restricted class of persons.* It is so that membership of GEMS is restricted to government employees. But such membership is not compulsory.

[23] GEMS does not itself provide a health service. Like other medical schemes, it operates rather in the nature of a health insurance. As rule 5.1 makes plain, in exchange for the payment of a premium, GEMS 'undertakes liability in respect of health and health-related expenses in respect of its members and their dependants'. Failure by a member to pay any amount due may result in the suspension or termination of membership as provided for in the Rules. *Accordingly, complaints arising from the Rules do not concern the general public. They remain domestic in nature and cannot be described as the exercise of a public power*.

…

[38] Accordingly, the nature of the complaint as well as the nature of the power exercised by GEMS, has the consequence that the jurisdictional preconditions for an investigation in terms of ss 6(4) and (5) *have not* been met. The Public Protector accordingly does not have the statutory power to investigate the complaint…." (our emphasis.)

63 Therefore the business of a medical scheme, registered in terms of the MSA, does not encompass the performance of a public function or the exercise of a

public power, which includes the power afforded to a medical scheme in section 59(3) of the MSA.

64 In the *Public Protector* case, reference was also made to *Calibre Clinical Consultants (Pty) Ltd v National Bargaining Council for the Road Freight Industry* 2010 (5) SA 457 (SCA) ("*Calibre* case"), where the SCA held that the National Bargaining Council for the Road Freight Industry—when procuring services to manage its AIDS programme and "wellness fund"—was *not* performing a public power. Nugent JA held, at paragraph 42, that -

> "...Government does not 'regulate, supervise and inspect the performance of the function', the task is not one for which 'the public has assumed responsibility', it is not 'linked to the functions and powers of government', it is not 'a privatisation of the business of government itself', there is not 'potentially a governmental interest in the decision-making power in question', the council is not 'taking the place of central government or local authorities', and most important, it involves no public money. It is true that a government might itself undertake a similar project on behalf of the public at large – just as it might provide medical services generally and pensions and training schemes to the public at large – but the council is not substituting for government when it provides such services to employees with whom it is in a special relationship."

65 For the reasons set out in the *Public Protector* and *Calibre* cases, the claw back powers recognised by section 59(3) of the MSA are not public powers and that

65.1 section 59(3) delineates when and in what circumstances medical schemes may set-off against future payments past payments erroneously made (where the circumstances in section 59(3)(a) or 59(3)(b) arise);

65.2 this balances the risk created by section 59(2) of the MSA, which creates a 30 day payment period for accounts submitted to medical schemes;

65.3 a power imbalance does not exist between the scheme and provider in the implementation of section 59(3) of the MSA. In this regard,

65.3.1 practitioners are the parties with complete control of their accounts and invoices and with proper accounting should be able to justify a particular claiming pattern and confirm that services were indeed rendered - that knowledge does not reside with the administrator or a medical scheme;

65.3.2 where a medical scheme takes a decision to claw back monies from a practitioner, that process is subject to the complaints processes in the MSA and, potentially, the provisions of the Consumer Protection Act No. 68 of 2008 ("CPA") in so far medical schemes provide services (undertaking liability associated with medical expenses) to their members as consumers;

65.3.3 the BHF respectfully disagrees with the Panel's contention in footnote 643 of the Interim Report that "[a]lthough the complaints mechanism set up by the [MSA] provides a form of recourse, the complaint mechanism is not designed to deal with disputes arising out of the exercise of powers in terms of section 59(3)…". As appears from the website of the Council for Medical Scheme,

(see https://www.medicalschemes.co.za/consumer-assistance/complaintsprocedure/) "[a]ny beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint" - this would include a practitioner who is aggrieved by a decision taken by a medical scheme in terms of section 59(3) of the MSA;

65.4 whilst a decision made by a scheme to deduct monies from future benefits may benefit the broader membership of the scheme, it does not impact the general public; and

65.5 the medical schemes are not "taking the place of central government or local authorities" when making a decision to claw back monies paid to a provider.

66 Returning to the complaints process under section 47 of the Act, this is an important feature that should not be overlooked.

67 Section 1 of the MSA contains a definition of a complaint:

> "**'complaint'** means a complaint against any person required to be registered or accredited in terms of this Act, or any person whose professional activities are regulated by this Act, and alleging that such person has-
> (a) acted, or failed to act, in contravention of this Act; or
> (b) acted improperly in relation to any matter which falls within the jurisdiction of the Council;"

68 The definition is extraordinarily broad and is plainly intended to afford a check or balance against the conduct of all medical schemes. It contains no limitation on who can complain. Nor are complaints limited to contraventions of the Act or the Regulations (the definition of the Act includes the Regulations).

69 There is no doubt that any person who considered themselves to be unfairly discriminated against or in respect of which the allegations could be said to have applied was entitled to pursue a complaint under section 47. The Registrar and the CMS would have been obliged to entertain that complaint.

70 There is, therefore, a remedy afforded to healthcare providers under the Act. This remedy has been exercised by providers in the past, as is apparent *inter alia* from the findings of the Appeal Board referred to above. It is also apparent in the decision of the Appeal Board in *Medscheme Holdings (Pty) Ltd v Ekhanyeni Pharmacy* (CMS 67765 11 July 2020), where the Appeal Board dismissed the medical scheme's appeal against a finding that it had impermissibly clawed back money from the respondent Pharmacy.

71 As is clear from the Terms of Reference and the Interim Report itself, there were no Complaints, as defined, that came before the Panel. If there were Complaints, however, then those can be assessed on their merits and appropriate relief granted.

Time Periods For Making Deductions

72 In relation to the Panel's recommendations, and in the context of section 59(3), the Panel records in paragraph 742 that "[t]he period of time over which the provider is alleged to have engaged in [fraud, waste or abuse ('FWA')] is often lengthy, which makes the production of records much more difficult. The timeframe is entirely within the control of the schemes and administrators". The Panel goes on to recommend, at paragraph 745.1, that healthcare providers "should be notified within three months of any billing irregularity", which would *inter alia* allow the healthcare provider to submit the necessary paperwork to justify the services that had been provided.

73 Notably, section 59(3) applies notwithstanding "anything to the contrary contained in any other law" and contains no time limit within which the medical scheme is required to make a deduction.

74 The reason why there is no time limit is to offset the obligations on medical schemes to pay claims within 30 days, as contained in section 59(2) of the MSA. In practice, it is impossible for medical schemes to verify each member claim within such a 30 day period due to the sheer volume of claims (and claim lines) that are submitted. As a result, the legislature devised a system whereby medical schemes are required fundamentally to pay claims in good faith (to protect the cash flow of members and healthcare providers).

75 The protection afforded to providers and members lies in item 6(4) of the Regulations, which shifts the onus on to medical schemes to show that the claim is in fact erroneous or unacceptable in the event of a dispute.

76 The Panel rejected this argument, on the basis that it does not apply to a claw back under section 59(3). With respect, there is no warrant for doing so.

77 Instead of following this remedy, coupled with the complaint procedure, the Panel's recommends a drastic limitation to the claw back right.

78 This limitation as contemplated in the Interim Report is untenable as to do so would increase the burden upon medical schemes to verify claims to a degree which is practically impossible, whilst simultaneously, diminishing the administrative burden upon healthcare providers to a degree which is completely out of proportion with what is expected of other professionals of business people. It is a proposal that is completely at odds with the overall purpose and tenor of the Act.

79 Medical schemes process thousands, even hundreds of thousands of claims per day. Additionally, the verification of claims is complicated, as a claim may contain several claim lines. To expect medical schemes to be able to detect fraud within 90 days is therefore simply practically not possible. This is particularly so in circumstances where conduct might only be detected through patterns of billing.

80 This revised timeline would not be in line with the normal prescription periods applicable in South Africa either.

81 The reasoning behind the proposed change - i.e. the record keeping by healthcare providers is also flawed. In this regard, and with reference to the BHF's previous submission -

81.1 healthcare providers are in many instances already required to retain pertinent information in terms of tax, company and medical legislation; (see paragraph 2.17 of the BHF's previous submission);

81.2 other professions are similarly required to retain records, as reflected in paragraph 2.18 of the BHF's previous submission; and

81.3 the abovementioned records are required to be retained by persons regardless of their level of sophistication. It makes no sense to absolve highly qualified professionals from such requirements (see paragraph 2.18 of the BHF's previous submission).

82 In the BHF's view, therefore, the recommended limitation on the powers afforded to medical schemes in terms of section 59(3), as proposed by the Panel, cannot be sustained.

UNFAIR DISCRIMINATION BASED ON RACE

83 In paragraph 337 of the Interim Report, the Panel concludes that "[b]ased on an assessment of the evidence, together with the application of antidiscrimination law, the Panel is of the view that the outcome of the FWA investigations, conducted by Discovery, GEMS and Medscheme, on the whole have the effect of unfairly discriminating against Black practitioners".

84 Significantly, this is a factual finding based largely on the opinion of Dr Kimmie and drawn implicitly but, on the Panel's own admission, without sufficient knowledge of the algorithmic systems.

85 The basis for any determination of unfair indiscrimination is grounded in section 9(4) of the Constitution. In this regard, section 9(4) prohibits persons from either directly or indirectly unfairly discriminating against anyone in terms of one or more of the prohibited grounds listed in subsection (3), which includes race. Section 9(5), in turn, creates a rebuttable presumption of unfair discrimination where the discrimination takes place on one or more of the prohibited grounds.

86 Discrimination was broadly defined by the Constitutional Court in *Prinsloo v Van der Linde* 1997 (3) SA 1012 to mean "…the unequal treatment of people based on attributes and characteristics attaching to them" (paragraph 31). According to *Harksen v Lane NO* 1998 (1) SA 300, at paragraphs 42 and 53(a), the test

for discrimination is a two legged test and requires an assessment of whether or not -

86.1 the "impugned provision [or conduct] does differentiate between people or categories of people". If it is established that there is no differentiation, the equality enquiry stops there;

86.2 if differentiation is, however, identified, one must determine whether or not such differentiation amounts to unfair discrimination. In order to determine unfair discrimination, two questions must be answered: (a) whether the differentiation amounts to discrimination; and (b) if so, whether the discrimination is unfair.

87 Notably, in so far as the first step of the inquiry is concerned, which requires the Panel to determine whether or not differentiation exists, the Constitutional Court separates "mere differentiation" from differentiation which arises as a result of unfair discrimination (*Iain Currie & Johan De Waal The Bill of Rights Handbook* (6th ed) (2013) pg. 218). In other words, differentiation that does not amount to unfair discrimination will not raise a cause for concern. However, if the differentiation arises as a result of any of the prohibited grounds listed in section 9(3) of the Constitution (including race), that differentiation is presumed to constitute unfair discrimination. In turn, the person accused of unfair discrimination will have the duty to demonstrate that the discrimination is fair.

88 The BHF is solaced by the Panel's findings that there was no evidence of racial differentiation or profiling by the administrators and schemes. In this regard, the evidence presented by the schemes and administrators suggests that the systems employed by administrators and medical schemes to detect FWA do not analyse race as a basis for a particular claiming pattern. Instead, the claiming pattern itself is analysed. This notwithstanding, the Panel made a finding that discrimination existed, based on the disproportionate impact (or outcome) which the conduct of medical schemes had on Black practitioners.

89 The BHF does not seek to comment, in this submission, on the expert findings of Dr Kimmie (who conducted an empirical analysis of the risk management systems employed by the three administrators who were subject to the majority of the allegations of unfair racial discrimination) nor on the findings of the independent experts appointed by the relevant schemes and administrators, which were prepared in response to Dr Kimmie's report. The BHF has not commissioned an expert report and, therefore, its ability to provide expert submissions is limited.

90 There are, however, at least two difficulties with the Panel's approach in this regard, which the BHF has identified:

90.1 First, these findings are made as general findings applicable across the whole medical scheme industry when they are plainly fact dependent. This epitomises the danger inherent in pursuing allegations rather than Complaints.

90.2 Secondly, there is no proper analysis in the Interim Report for why Dr Kimmie’s opinions are to be preferred over those of any other expert. South African courts, in a line of reasoning consistent with English decisions, have given guidance on how expert evidence should be weighed up and assessed—including where there are competing opinions (*PriceWaterhousCoopers Inc v National Potato Co-operative Ltd* [2015] 2 All SA 403 (SCA), *Twine v Naidoo* [2018] 1 All SA 297 (GJ)).

91 The experts have produced substantially different findings in so far as the difference in FWA outcomes between Black and non-Black practitioners over the period January 2012 to June 2019 are concerned - which may differ further based on the consideration of further "compounding factors".

92 In the BHF's view, a consideration of *all* compounding factors is critical in order to determine where or not a finding of race differentiation on outcomes is, in fact, justified - and the BHF suggests that further engagement in this regard be encouraged. In this regard, where a finding of race differentiation is not justified, no discrimination arises and the question of unfairness becomes irrelevant.

93 One such compounding factor that has been raised by the schemes relates to those providers that receive direct payment, which the BHF submits has been influenced substantially by the current "co-payment system". In this regard, and as explained in the BHF's previous submission, an important shift in the healthcare funding industry occurred as a result of the Competition

Commission's abolishment of collective bargaining in 2004 ("Abolishment"). In particular -

93.1 prior to the Abolishment, medical tariffs were set through collective bargaining and most practitioners were "contracted in" to those rates. In other words, there were no "co-payments" made by members, since the entire collectively bargained fee was covered by medical schemes. Ultimately, this meant that indirect payments were rare, since practitioners' claims were covered by the medical schemes;

93.2 after the Abolishment, pricing became largely unregulated. This means that some practitioners may charge a high premium over the medical scheme tariffs, which premium must be paid by the member. This development led to the skewed system we now see - in affluent areas members often pay up front, as the practitioner wishes to secure the premium.

94 As a result of the "price vacuum" created by the Abolishment (and, the BHF respectfully submits, not as a result of race differentiation), practitioners in affluent areas started charging patients at point of service, in order to ensure that they would receive payment of the amounts due to them in full. This meant that the affluent practitioners essentially became insulated against being placed on indirect payment, because they were being paid in full by clients already.

95 The abovementioned development is relevant because, prior to the shift, placing a practitioner on indirect payment would have had the same effect on both affluent and non-affluent practitioners, as neither would have required co-payments. However, now that co-payments are part of the system placing practitioners on indirect payment does have a disproportionate effect - the less-affluent are far more affected, as patients cannot afford the premiums, whereas in affluent areas members are already making co-payments.

96 For the reasons set out above, therefore, the BHF considers the issue of compounding factors to be critical in any determination regarding unfair racial discrimination - which compounding factors may vary substantially in respect of the inquiry that served before the Panel. The BHF, therefore, suggests that all such compounding factors are rigorously explored before a finding is made that the conduct of the relevant medical schemes and administrators amounts to unfair racial discrimination.

97 This exercise has to be undertaken with reference to a purposive interpretation of the MSA and having regard to the obligations imposed on medical schemes and administrators as identified above.

CONCLUSION

98 The BHF differs with the Panel on the interpretative premise on which the Interim Report is founded, namely the proper interpretation of section 59 of the MSA.

99 The BHF respectfully does not agree that the conduct of medical schemes is unreasonable or unfair and discriminatory having regard to the information before the Panel and the conclusions stated in the Interim Report.