South African Police Service Medical Scheme

"POLMED"

SUBMISSIONS TO THE SECTION 59 INVESTIGATION PANEL

---

27 June 2023

TABLE OF CONTENTS:

INTRODUCTION

1. These legal submissions are in response to the Notice released by the Section 59 Investigation Panel ("the Panel") dated 9 May 2023. The Notice invited stakeholders to make legal submissions pursuant to the release of the Panel's Section 59 Investigation Interim Report ("Interim Report"), dated 4 December 2020.

2. In addition to the draft presentation prepared by Counsel, the client provided counsel with written instruction the gist of which is to advise on possible regulations or amendment to the regulations to deal with some of the issues raised by the Panel when dealing with the complaints raised against the Medical Schemes.

PROCEDURES ON THE IMPLEMENTATION OF SUSPENSION OR CANCELLATION OF A MEMBER'S MEMBERSHIP IN TERMS OF SECTION 29(2)(c) of the MS ACT and ABSENCE OF PROCEDURES FOR PROVIDER SUSPENSION OR CANCELLATION

3. Those issues are in relation to suspension of members and cancellation of membership in instances of FWA claims. There is no corresponding requirement for the service providers. The Panel having found that there are risky service providers who may be liable for blacklisting, possibly by the CMS. The Panel interpreted section 57(4)(c)[1] of the Medical Schemes

[1] *"… (c) ensure that proper control systems are employed by or on behalf of the medical scheme;…"*

Act, 2013, (the Act) to be wide enough to allow the medical scheme to blacklist the delinquent service providers.

4. There is also no procedure stipulated wherein the proposed cancellation and/or suspension of such delinquent service provider can be implemented. Polmed will obviously touch thereon including the cancellation or suspension of a member.

5. Client requires Counsel to consider the provisions of section 67(p) and (q) which enables the promulgation of the regulations to the MSA to stipulate the procedure that that a medical scheme should follow and implement in this process.

6. As a start, the MS Act, through section 29(2)(c), makes provision for either the cancellation or suspension of a member's membership based on the grounds of that member having submitted fraudulent claims. The section reads as follows:

> *"(2) A medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependants, except on the grounds of—*
>
> *…*
>
> *(c) submission of fraudulent claims;"*

7. Thus, instances where a member submits a fraudulent claim are dealt with in the abovementioned provision.

8. However, when it comes to service providers, the Panel in the Interim Report found that medical schemes employ several sanctions[2] in circumstances where a provider has been found to have committed FWA. The medical scheme can either:

    8.1. Suspend or end the direct payment relationship with the provider.

    8.2. Blacklist a provider and inform its members of such blacklisting; or

    8.3. Report the member to the appropriate regulatory body.

9. The MS Act does not specifically provide for the manner and procedure to deal with instances where providers found to have submitted fraudulent claims. This could be because there is no clear understanding of the concept of fraud, and that it is often a times mixed or mistaken for something else other than fraud. The legal elements of fraud are often not involved in what is regarded as fraudulent claim.

10. Polmed submits that whatever the definition ascribed to the crime, the procedure as detailed herein below must apply to this accusation. The

[2] Interim Report page 41 at paragraphs 89 and 91; page 42 at paragraph 92.

regulations ought to clarify the issue, the concept and the requirements thereof.

11. In any event, as Polmed noted, there appears to exist therefore, a lacuna, in that there are no regulations that deal with mechanisms or procedures to implement the cancellation, suspension or blacklisting of a delinquent provider.
12. Presently, medical schemes appear to have unfettered power in this regard.
13. The Panel lamented the lack of procedural fairness in the handling of the suspension of direct payments to providers. The Panel found that, in most instances:

    13.1. A medical scheme can request confidential patient information and if the provider refused to provide. This can lead to being placed on indirect payment;[3] and

    13.2. providers were informed of the suspension of direct payment and that they were being audited or investigated simultaneously.[4]

    13.3. This conduct has the effect of contravening a provider's right to be afforded an opportunity to be heard.

[3] Interim Report paragraph 141.1
[4] Interim Report paragraph 141.2.

14. The unfortunate scenario above can be ameliorated by drafting of regulations that stipulate procedures on how to sanction providers found to have submitted fraud.

15. The Minister of Health ("*the Minister*"), under section 67(1)(q) of the MS Act, is empowered to make regulations which he/she deems expedient to achieve the purposes of the MS Act. The section provides as follows:

> *"(1) The Minister may, after consultation with the Council, make regulations relating to—*
>
> *…*
>
> *(q) all other matters which he or she considers necessary or expedient to prescribe in order that the purposes of this Act may be achieved."* (Own emphasis)

16. Underpinning the powers of the Minister to make these regulations, is the principle of the rule of law which forms the bedrock of the exercise of the public power in South Africa since the advent of the constitutional dispensation.

17. Several constitutional court decisions have served to add to the normative content of what the rule of law principle entails. In ***Fedsure Life Assurance Ltd v Greater Johannesburg Transitional Metropolitan***

Council,[5] the Constitutional Court held that the rule of law in the form of legality was implicit in the interim Constitution.[6] The text of that Constitution did not refer to the rule of law or legality explicitly. Legality was interpreted to mean that "the legislature and executive in every sphere are constrained by the principle that they may exercise no power and perform no function beyond that conferred upon them by law".[7] This interpretation of legality requiring officials to act within the four corners of the law was confirmed by the Court in ***Pharmaceutical Manufacturers Association of South Africa: In re Ex parte President of the Republic of South Africa***[8] and ***Affordable Medicines Trust v Minister of Health***.[9]

18. To enable one to fully understand whether the Minister will be acting within his/her powers as envisioned by the abovementioned section, it is important to understand what the purpose of the MS Act is.

19. The preamble to the MS Act provides the following:

"To consolidate the laws relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes as a

[5] 1998 12 BCLR 1458 (CC)
[6] Fedsure at paragraphs 58-59
[7] 2000 3 BCLR 241 (CC); 2000 2 SA 674 (CC) paragraphs 19-20, 44.
[8] Fedsure at paragraph 58.
[9] 2005 6 BCLR 529 (CC); 2006 3 SA 247 (CC) paragraphs 48-50.

juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the coordination of medical schemes; and to provide for incidental matters." (Own emphasis)

20. From the analysis of the preamble, it is then clear that the Minister has the power; and will be well within the confines of his/her powers when making regulations which he/she considers necessary or expedient in order to achieve the purpose of controlling of activities of a medical scheme.

21. It is submitted that the regulations would seek to regulate the mechanisms of dealing with the imposition of sanctions on providers found to have submitted fraudulent claims.

22. The Panel, under paragraphs 621 – 622 of the Interim Report, interpreted that section 57(4)(c) of the MS Act empowers a medical scheme to blacklist a provider found to have submitted fraudulent claims:

"621 Section 57(4)(c) of the Act provides that:

"(4) The duties of the board of trustees shall be to— (c) ensure that proper control systems are employed by or on behalf of the medical scheme". (our emphasis)

622 It seems to us that a proper control system would include a proper system of financial control. It further seems to us that a proper system of financial control would include systems which prevent payments being made to providers where it is reasonably certain that such providers are engaged in fraud, theft, professional misconduct or negligent behaviour which is causing the scheme loss."

23. Further, the Panel, defined the meaning of "proper" to entail a financial system that:

"(635.1) treats providers procedurally fairly before they are placed on indirect payment; and

(635.2) ensures that the decision to place a provider on indirect payment is reasonable."[10]

24. Therefore, the proposed regulations would provide for a system that is procedurally fair before suspending the benefits of a provider such as direct payment benefit.

[10] Interim Report page 275.

25. In the Constitutional Court ("*CC*") decision of ***Masetlha v President of the Republic of South Africa and Another***,[11] has been held that procedural fairness incorporates the right to be heard ahead of an adverse decision.

26. Further, in the same decision, the CC stated that:

> "[190] …*In Zondi, we said the following of and concerning procedural fairness:*
>
> *"Procedural fairness, by its very nature, imports the element of fairness. And fairness is a relative concept which is informed by the circumstances of each particular case. In each case the question is whether fairness demands that steps be taken to trace the identity of the person against whom a decision is to be made.[12]"*

27. It is thus submitted that the regulations must, at the very least, incorporate the following *inter-alia* requirements before a sanction is handed:

---

[11] 2008 (1) SA 566 (CC) at paragraph 65.
[12] See paragraph 190.

27.1. Adequate notice of allegations of having submitted fraudulent claims;

27.2. Adequate notice of a request for reasonable patient information; and

27.3. Adequate notice of the opportunity to make representations.

28. On the assumption that the Panel's interpretation of section 54(4)(c) of the MS Act, these regulations can flow from the provisions of that section.

29. In our view and upon perusal of the Report, it is evident that a lot of thought and analysis went into the uneven power dynamics, on the one hand, between the scheme and providers with those being uneven and mostly not favouring the providers.

30. The picture painted for us is of a dictatorial or top-bottom finding of guilt by a complainant, player, referee, judge, jury and an executioner against the docile and dependent service provider.

31. Given the possibilities, as provided in Dr Kimmie's report and instructions obtained with client that in some cases, there is a legitimate and genuine answer to the complaint by the provider, the existing approach does not work to enhance peaceful cooperation. It only serves, as the Panel has

determined, to benefit the Scheme and leave them, at the end with unwarranted huge profits at the expense of the service provider.

32. Polmed have considered the case law prepared by the Panel in so far as this issue is concerned and Polmed accepts that the *prima facie,* the *modus operandi* contravenes the constitution and the principles of fairness.

33. Section 9 of the Constitution requires that every person be treated equally. This equality of treatment, Polmed finds, entail fair treatment. In the contexts of administrative justice as is the position in this space, despite the Medical Scheme being a private entity, Polmed is able to confidently advise that section 33 of the Constitution require Administration Action that is fair, lawful and reasonable.

34. Furthermore, section 34 of the Constitution requires that where there is a dispute that can be resolved by application of the law, that such be put before judge or quasi judge for these purposes.

35. Furthermore, all of the above rights can not be realised where the is an infringement of a lawful legitimate expectation from a service provider that he or she will be heard before any such harsh consequences may be meted against him or her. In other words, Polmed is dealing here with the violation of a long-standing principle of *audi alteram partem*.

36. These principles of fairness, equality, *audi* and under PAJA, state as follows:

NATURAL JUSTICE PRINCIPLE OF AUDI ALTERAM PARTEM

37. Nkabinde AJ as she then was, in ***Kock and Another v Department of Education Culture & Sport Province of the Eastern Cape and Others***[13] dealt extensively with the principle as follows:

> *"**A brief analysis of the traditional 'natural justice'***
>
> *[15] The primary procedural safeguards in South African administrative law are expressed by the twin principles of natural justice: audi alteram partem ("the audi principle") and nemo iudex in causa sua: that is, that a public official should hear the other side, and that one should not be a judge in his own cause. As a general rule it may be said that the principle of natural justice apply whenever an administrative act is quasi-judicial. An administrative act was considered to be quasi-judicial if it affects the rights, liberties (and perhaps, the privileges) of an individual.*
>
> *[16] In the case of 'purely administrative' decisions the decision-maker acts entirely to his discretion (Wiechers Administrative Law 1985 at*

[13] (P317/2000) [2001] ZALC 47 (30 March 2001).

124). As a result of this common law classification (which has found its historical origins in the need to make the English common law writs of certorari and prohibition applicable to acts categorized as quasi-judicial, see in this regard Wiechers, supra, at 122). The approach of the judiciary in South Africa to the question of procedural safeguards and administrative law has not been producing useful result because of its sterility: Where a decision of an administration does not affect rights, or legal rights, or prejudicially affect the rights of persons because the aggrieved person had no right in the first place, it has been held that the audi alterm partem rule was not applicable (see: South African Defence and Aid Fund & Another v Minister of Justice ***1967 (1) SA 263*** *(A); Laubscher v Nature, Piet Retief* ***1958 (1) SA 546*** *A reaffirmed in Administrateur Van Suidwes Afrika v Pieters* ***1973 (1) SA 850*** *(A); Publication Control Board v Central News Agency Ltd* ***1970 (3) SA 479*** *(A) at 488).Minister of Interior v Bechler* ***1948 (3) SA 409*** *(A) at 451). In Down v Malan, NO. en Ander 1960(2) SA 734 (A) at 741 a quasi- judicial decision was said to include one which affects the person's interests. There are, of course, many variants in other cases dealing with this point.*

…

*[19] A notable and commendable exception in the judicial approach in South Africa is found in the statement by M.T Steyn J in Motaung v Mothiba NO **1975 (1) SA 618**(O) where the learned judge said –*

"Being rules of the common law, this much can safely be said of the principle of natural justice, viz: that they have been a part of our system of law for a very long time and that they are capable of further formulation, growth and practical application to meet the needs of a rapidly developing and expanding society which is continually being subjected to an increasing degree of administrative and bureaucratic regulation and control." (At 629D). (Sic)

38. The learned Justice then considered the approach in the English and South African courts and stated that:

*"[20] The English courts have escaped from the right-privilege distinction towards a more realistic and flexible approach to natural justice by invoking the concept of legitimate expectation. In **Ridge v Baldwin [1963] UKHL 2; [1964] AC 40 at 72ff** Lord Reid disagreed with the view that the principle of natural justice applied only if the exercise of administrative powers affected the rights of the aggrieved parties. His speech was quoted with approval, approximately four years later, by Lord Denning MR in **Schmidt & Another v Secretary of State***

***for Home Affairs* [1969]1 AllER 904 at 909** *where the learned Judge said–*

"The speeches in Ridge v Baldwin ***[1963] UKHL 2****;* ***1964 AC 40*** *show that an administrative body may, in a proper case, be bound to give a person who was affected by that decision an opportunity of making representations. It all depends on whether he has some right or interest, or I would add, some legitimate expectation of which it not be fair to deprive him without hearing what he has to say."*

[21] The above approach in the courts of England avoids the temptation of classifying functions, thereby avoiding the conceptualism which had to be exposed in Baldwin's case and enables the courts to give effect to the inherent flexibility of natural justice which is based upon underlying principles of fairness. The feature of modern English administrative law is therefore that the classification of decisions into judicial, quasi-judicial and administrative no longer seems to have much relevance, if any, in this sphere.

[22] In ***Everet v Minister of Interior 1981 (2) SA 453(C),*** *Fagan J (with whom Lategan J concurred) commendably invoked the concept of 'legitimate expectation' to the South African law. The applicant, a British citizen by birth, had desired to become a permanent resident of South*

Africa. She had no intention of returning to England. She applied for an extension of her temporary residence permit for one year, during which she intended to make further representations to the immigration authorities to be granted permanent residence. This application was granted, and her temporary permit was finally extended until 8 July 1980. On 10 June 1980 she was served with a letter in terms of which the Minister of Interior had, under the powers vested in him by section 8(2) of the Aliens Act of 1937, ordered that her temporary residence permit be withdrawn with immediate effect. She was ordered to leave the country on or before 11 June 1980. She then applied to the Supreme Court for an order setting aside the notice purporting to withdraw her temporary residence permit on the ground, inter alia, that it was contrary to natural justice as she had not been afforded an opportunity of making representations. Fagan J concluded that there had been a breach of the principles of natural justice. The Minister's notice was therefore set aside. The decision in ***Everet*** *has established that the rules of natural justice require that an opportunity of being heard must be given before any decision affecting the legitimate expectation of any individual is made. It suffices to say that our courts have begun to give a greater recognition to the broader concept of natural justice.*

[23] The court was, in ***Castel NO v Metal & Allied Workers Union 1987 (4) SA 795 AD),*** *unsuccessfully invited to adopt the approach in vogue in the courts in England. Being mindful of the criticism levelled at several of the court's decisions on the point under discussion, Hefer JA declined the invitation because, he said, 'the legitimate expectation' approach had —*

"no room for its application here... unlike the English and Australian cases on which counsel relied, nothing had happened before the application for authority was submitted and nothing happened thereafter which could have caused the applicant to entertain such an expectation..."

[24] Fortunately, greater recognition is given by our courts to the broader concept of the principle of natural justice. The traditional scope of the principles relating to the observance of natural justice has been extended to decisions affecting a person who has no existing right, but merely a legitimate expectation (Everet's case, supra; Langeni and Others v Minister of Health and Welfare and Others 1988 (4)SA 93 (W); Mokoena and Others v Administrator, Transvaal ***1988 (4) SA 912*** *(W). An illustrative discussion of the topic also appears in the following articles:(1987) 165 SALJ "Legitimate Expectation and Natural Justice: English, Australian and South African Law" by John Hlope, and* ***(1979)***

96 SALJ 607 *"Fairness and Natural Justice in English and South African Law" by L. Baxter)."*[14] (Sic)

39. In general, the application of the *audi alteram partem* rule encapsulate a principle that if the rights of an individual have been violated by the actions of the government, a public body or certain domestic tribunals or associations, such an individual may claim, depending on the circumstances of the particular case, that there has been a breach of the rules of natural justice.[15] The content of these rules can be summarized in the maxim *audi alteram partem*. Translated literally this means "hear the other side or case". The *audi alteram partem* rule is an ancient rule that has existed since the dawn of time.[16] The cardinal principle that no man is to be judged without being heard was known to the Greeks, as can be gleaned from old inscribed-upon images in places where justice was administered.[17]

---

[14] See Bechler's case at page 451; Administrator, Transvaal & Others v Traub and Others [1989] ZASCA at page 90; 1989 (4) SA 731; (1989) 10 ILJ 823; Unilong Freight Distributors (Pty) Ltd v Musser (1998) ILJ 229 (SCA) at page 238A.

[15] Craig PP Administrative Law (Sweet & Maxwell London 1983) at page 253.

[16] Wiechers M *Administrative Law (*Butteworths Durban 1985) *at page* 210.

[17] Tladi, *The audi alteram partem rule in administrative law,* page 1*;* Schwartz, B. *Administrative Law* 4th ed *(Little Brown Boston* 1994) at page 202; Wade *Administrative Law, pages* 444-446.

40. The application of the *audi alteram partem* rule, as is the case with many other concepts, has been eclectic,[18] but it developed certain nuances in the decisions of the civil courts. Polmed submits that the rule entails four principles. Firstly, a party to an administrative enquiry must be afforded an opportunity to state his or her case before a decision is reached, if such a decision is likely to affect his or her rights or legitimate expectations. Secondly, prejudicial facts must be communicated to the person who may be affected by the administrative decision, in order to enable him or her to rebut such facts. Thirdly, the rule also stipulates that the administrative tribunal which has taken the decision must give reasons for its decision. Fourthly, the rule entails that the administrative organ exercising the discretion must be impartial. As a general rule it may be said that the principles of natural justice apply whenever an administrative act is quasi-judicial or judicial. An administrative act may be said to be quasi-judicial if it affects the rights and liberties of an individual.[19] [Underlining ours]

41. It has generally been held that *only judicial and quasi-judicial proceedings need follow the audi alteram partem rule*.[20] [Underlining ours]

---

[18] Tladi, *The audi alteram partem rule in administrative law,* page 1.

[19] Baxter LG "*Fairness and natural justice in English and South African law*" 1979 SALJ at pages 608-609.

[20] Baxter LG "*Fairness and natural justice in English and South African law*" 1979 SALJ at page 610.

42. A quasi-judicial act is an act which resembles a judicial act but is not a judicial act because the organ performing it is not a judicial organ and therefore does not perform a judicial act.[21] In ***R v Nomvet***[22] the Court stated that a function which is judicial or quasi-judicial as opposed to one which may be called purely administrative involves the exercise of powers affecting legal rights and an enquiry into matters relating to such rights.

43. The *audi alteram partem* rule seeks to promote objective and informed decisions. Thus, it is important that it be observed prior to the decision.[23] The rule would normally apply before an administrative organ performs its act.[24]

44. The application of the *audi alteram partem* rule was brought out in the case of ***Board of Education v Rice***,[25] when the Court stated that the Board of Education had to ascertain the facts as well as listen to both sides, for that is a duty upon everyone who decides an issue that may have an impact on a person's rights.

---

[21] Wiechers, M. *Administrative Law (Butterworths Durban* 1985) page 123.

[22] 1960 2 SA 108 (E) page 120F.

[23] Baxter, L. *Administrative Law (Juta Cape Town* 1984) page 587. Wiechers, M *Administrative Law (Butteworths Durban* 1985) page 208.

[24] 24 1911AC at page 182.
[25] 251908 29 NLR 338 at page 341.

45. From the Constitution's point of view, and amongst others, section 24(b) of the interim Constitution was replaced by the unqualified wording of section 33(1)[26] of the 1996 Constitution, which gives a right to administrative action that is lawful, reasonable and procedurally fair.

46. That provision found application in PAJA and that law has taken root in South African legal system.

47. Polmed submits that similarly and outside of judicial review proceedings such as in the CMS or a quasi-judicial structure formed by it, a lawful and procedurally fair process still entails fully and meaningfully hearing the other side. What was done on the other side must be done on the other. This is what is entailed by the Constitution, to which Polmed adverts below.

THE CONSTITUTION

48. The requirements of natural justice oblige a functionary to act fairly whenever a decision which is likely to prejudice another is taken by such

[26] Section 33(1) of Act 108 of 1996.

a person. Section 33[27] of the final Constitution does not distinguish between rights, interests, property and legitimate expectations.

49. The right is so entrenched that legal scholars remind us that *"Even God himself did not pass sentence upon Adam until he had first been called upon to defend himself. "Adam", says God, "where art thou? Hast thou not eaten of the tree, whereof I commanded thee that thee should'st not eat?" And the same question was put to Eve too."*[28]

50. One hastens to add that even section 34 emphatically pronounces that one has a right to approach a Court of law for a dispute that can be resolved with the application of law, to be so resolved.

51. The *audi alteram partem maxim*, was described in the case of ***South African Roads Board v Johannesburg City Council***[29] as follows:

"A rule of natural justice which comes into play whenever a statute empowers a public official or body to do an act or give a decision prejudicially affecting an individual in his liberty or property or existing

[27] Section 33(1) of Act 108 of 1996.

[28] *Wade HWR and Forsyth C Administrative Law* 8th *ed (Oxford University Press Oxford* 2000), page 470.

[29] 1991 (4) SA 1 (A).

rights or whenever such an individual has a legitimate expectation entitling him to a hearing unless the statute expressly or by implication indicates the contrary."

52. Polmed has no issue with the proposition of law that the *audi* principle is but one facet, albeit an important one, of the general requirement of natural justice that in the circumstances postulated the public official or body concerned must act fairly. In the case of ***Du Preez and Another v Truth and Reconciliation Commission***[30] Corbett CJ states the following:

"What does the duty to act fairly demand of a public official or body concerned. In the answering of this question useful guidance may be derived from some of the English cases on the subject. In Doody v Secretary of State for the Home Department and Others (1993) All ER 92 (HL) Lord Mustel stated the following in his speech, concurred with by the remaining members of the court, at 106DH:

'What does fairness require in the present case? My lords, I think it necessary to refer by name or to quote from any of the often cited authorities in which the courts have explained what is essentially an

[30] 1997 (4) BCLR 531 (A) at 542D – I.

intuitive judgment. They are far too well known. From them I derive the following:

1. When an Act of Parliament confers an administrative power there is a presumption that it will be exercised in a manner which is fair in all the circumstances.

2.The standards of fairness are not immutable. They may change with the passage of time both in the general and in their application to decisions of a particular type.

3. The principles of fairness are not to be applied by a rod identically in every situation. What fairness demands is dependent on the context of the decision and this is to be taken into account in all aspects." (Sic)

53. In ***Nxele v Chief Deputy Commissioner, Corporate Services, Department of Correctional Services & Others*****,** dealing with the issue of a transfer that offended the *audi rule*, the Labour Appeal Court stated the following:

"[61] In our law, the general rule is that, where a body or state functionary is obliged to observe the audi rule in a particular case, it is

required to observe that rule before it can take the decision in issue (see Administrator of the Transvaal & others v Traub & others 1989 (4) SA 731 (A) at 750C). In Traub's case, the learned Chief Justice explained the rationale for the requirement that the audi rule should, generally speaking, be observed before an adverse decision is taken against a subject. He said at 750C:

> *". . . that is, while [the body or official or functionary who is to make such a decision] still has an open mind on the matter. In this way, one avoids the natural human inclination to adhere to a decision once taken." (Sic)*

CONCLUSION ON QUESTIONS 1 AND 2

54. Accordingly, Polmed is of the view that the timing of the Panel's existence is perfect and ripe for the issue of procedural fairness be introduced and be part of the medical scheme's fabric. This is possible by relooking at the existing regulations and amend same to specifically regulate the effective controls that the CMS and medical schemes need to put in place to resolve the dispute relating to allegations of FWA. The process Polmed advocates for herein is that of **due process**.

55. There is no limit at however way the CMS or the medical schemes may wish to provide for it. It could be oral and/or based on paper (sworn affidavits).

56. The CMS and/or medical schemes should be able to give the accused service provider and/or member an opportunity, under oath, to deal with the FWA allegations against such person before it can come to the conclusion of suspension or termination, or even blacklisting such a person.

57. The decision of the medical scheme to penalise a service provider should be subjected to some internal appeal or review under mutually agreed system where some justice between the parties must be seen to be done.

58. The Panel talks of an Independent Mediator. Polmed posits a stronger independent position than a mediator, and contemplate a decision-maker who would have heard the two parties to an FWA dispute.

59. In our view, the Panel's interpretation, though not incorrect, requires the regulations to unearth the process.

60. In a case law, the Courts accepted that the functions of regulations is to provide how the Act would be implemented. This is the aim that Polmed advocates for herein above. In the case of ***Minister of Finance v Afribusiness NPC [2022] ZACC 4*** relating to the Procurement Regulations, the majority of the Justices, per Madlanga J, recited the

applicable law *that the purposes of regulations is to make the PPPFA work. The PPPFA itself sets the norm, or it provides framework on the subject matter legislated upon. The Regulations provide the sort of detail that is best left by Parliament to a functionary, usually the Minister responsible, for the administration of the PPPFA, to look beyond the framework and in minute detail, to ascertain what is necessary to achieve the objective of the PPPFA and make the PPPFA work*.[31]

61. Polmed submits that the same applications apply to the Act herein, and the detailed regulations are needed to clarify issues herein. In fact, the Panel itself found that:

> *"Clarity will contribute to the legitimacy of the risk management systems of the schemes."*[32]

RECOVERY OF MONIES PAID DUE TO FRAUDULENT CLAIMS

62. The second issue is recovery of monies paid due to Fraud, Negligence, Misconduct provisions.

63. The Panel determined that section 59(3)(b)[33] allows for the recovery of monies paid to the service provider by means of deduction of amounts

[31] See para [103].
[32] Findings page 306, para 701.3.
[33] "… **(3)** Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of—

paid to the service provider as a result of fraud, theft, negligence or misconduct after such payment has come to the attention of the medical scheme. Polmed reads the provision to state that these funds are deductible from any future benefit payable to a member or supplier.

64. Polmed understands the real issue herein to be the processes in place, if any, is the medical scheme's process to determine whether payment paid because of fraud, theft, negligence or misconduct.

65. Section 59(3)(b) to the MS Act deals with the deduction of monies from providers' accounts in circumstances where claims were paid as a result of fraud, theft, negligence or misconduct on the part of the provider.

66. To that end section 59(3)(b) provides that:

> *"(3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of—*
>
> *…*
>
> *(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme, deduct such*

(a) any amount which has been paid ***bone fide in*** accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or

(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme,

deduct such amount from any benefit payable to such a member or supplier of health service."

amount from any benefit payable to such a member or supplier of health service."

67. Albeit that section 59(3)(b) to the MS Act deals with deductions in circumstances provided above, the Panel found that "*there is no detail about how section 59(3) may be implemented;*". In that respect, it is Polmed's submission and proposition that it would be beneficial to have a panel established, either on an ad hoc basis or otherwise, to deal with the adjudication of deductions. The panel's main duties will be, in instances where disputes arise in relation to deductions, to receive documentation and representations on deductions and to accordingly adjudicate same and make a determination on a case-by-case basis thereon.

68. The absence of the procedures to implement deductions is problematic in that it results in the unilateral deductions of monies by medical schemes. This Panel alluded to this very aspect.[34]

69. The Panel found that the quantum of the deductions is left to be determined by the administrators.[35]

[34] See Interim Report paragraph 537.3.
[35] See Interim Report paragraph 90.

70. To this end, it will be beneficial to have regulations drafted in terms of section 59(3)(b) to fill the procedural vacuum and to cater for the implementation of deductions in a manner that is reasonable and fair. This proposition found support in the opinion of Loxton SC which this Panel highlights in the Interim Report:

> "*This opinion, however, clearly shows that administrators must "act reasonably and in good faith before making deductions", to ensure that there is a fair process and that the finding and quantification are substantively reasonable.*[36]*"*

71. Polmed accepts this *bona fide* laced process as a first step in the process and in the event that there are no disputes arising from this process. And it submits that this first step can benefit from reasoned justification for the recovery/deduction, and reasonable timeframes within which to claw back the undue but paid monies. The absence of arbitrariness is key, herein.

[36] See Interim Report at paragraph 310.

72. It is trite that values of fairness, reasonableness and justice are ideals that are incorporated into public policy. In the seminal decision of ***Barkhuizen v Napier***,[37] it was held that:

> *"[51] In general, the enforcement of an unreasonable or unfair time limitation clause will be contrary to public policy. Broadly speaking, the test announced in Mohlomi is whether a provision affords a claimant an adequate and fair opportunity to seek judicial redress. Notions of fairness, justice and equity, and reasonableness cannot be separated from public policy. Public policy takes into account the necessity to do simple justice between individuals. Public policy is informed by the concept of ubuntu. It would be contrary to public policy to enforce a time limitation clause that does not afford the person bound by it an adequate and fair opportunity to seek judicial redress."* (Own emphasis)

73. The need to act in good faith, was dealt with, albeit in the context of contract law, but applicable herein, in the decision of ***Beadica 231 CC and Others v Trustees for the time being of the Oregon Trust and***

[37] 2007 (5) SA 323 (CC) at paragraph 51.

Others[38] were the court made reference to an Australian decision speaking with regards to good faith:

> *"[69] …The Court described good faith as encompassing a duty to act honestly and reasonably*".

74. It is therefore submitted that:

74.1. In terms of the empowering section, section 67(1)(q), regulations can be drafted to deal with the process of the determination of whether deductions must be made in terms of section 59(3)(b); and

74.2. In addition, a panel, preferably led by a retired Judge, tasked with adjudication of deductions, can be established to deal with such disputes.

75. It is submitted that this proposition is similar to the recommendation made by the panel in its Interim Report at paragraph 346, where it recommended that an independent mediator be appointed to sit in the meetings between providers and medical scheme when they deal with FWA investigations and the amounts to be deducted.

---

[38] 2020 (5) SA 247 (CC) at paragraph 69.

76. The second step or stage, and in the event where there is a dispute on the deduction. Polmed has already advocated for due process especially where a person's rights would be negatively affected. Further, for Polmed this calls for adjudication, in the event of a dispute between the parties, to determine whether payment is paid because of fraud, theft, negligence, or misconduct.

77. Polmed posits a position where someone in a position similar to an arbitrator can sit as an appeal board established in terms of section 50 of the Ms Act, to deal with these disputes.

78. Polmed thus seeks that the regulation could be promulgated to stipulate the procedures that a medical scheme should follow in this regard.

79. Indeed, the answer to this require that medical schemes understand and accept that this process involves, essentially, a dispute resolution and an avoidance of self-help mechanism that the Panel had alluded to.

80. It is common cause that the mechanism of self-help contravenes the Constitution, PAJA, legitimate expectation and *audi alterm partem* on the part of the accused person.

81. The medical schemes cannot be seen to be the judge and the jury in this dispute resolution process and the service provider cannot be seen to be devoid of any constitutional rights and protection in this process.

82. Having considered the above answer to be lying on some internal process that can be reviewed internally, it makes sense that that arbitrator, be empowered to adjudicate those disputes, through the application of law if necessary, even though the process does not need to be formal, and legal representatives may be excluded from this process.

83. The informality of the entire process is driven by a realisation that the process has to be on some expedited basis since these funds are required on urgent basis by both the medical schemes and the service provider.

84. It would, to Polmed, make sense that these disputes be resolved either every week or bi-weekly so that by the end of thirty (30) days, they are resolved and settled.

CONCLUSION ON THE SECOND QUESTION

85. It is on this basis that Polmed submits that the same principles that apply to the above first question for determination, should be equally applicable herein. The actions require similar treatment of due process.

ALGORITHMS

86. Third: on the Algorithm provisions, Polmed notes that the provisions of section 59(3)(b) of the MS Act empowers the recovery of monies paid by medical schemes to providers as result of fraud, theft, negligence and misconduct. However, the there is no provision for the regulation of detection and investigation systems thereof.

87. It is submitted that this omission manifests itself in the resultant unfair discrimination and unfair procedures when medical schemes enforce their rights as found by the Panel.

88. It was found that the various algorithms that medical schemes utilize for the detection of FWA had the unintended impact of discriminating against non-white providers.[39] This was so due to the fact that the Panel found that despite the processes being automated, there was always an element of human intervention:

> *"[702] The sophistication of the detection and investigation systems vary across the schemes and administrators, but all use a combination of data analytics and whistleblower reports as the*

39

basis for investigation. The detection systems employed by Discovery, GEMS and Medscheme all use algorithms to flag providers as so-called 'outliers'. However, despite some automation in the operation of the algorithms, there is always an element of human intervention at some point along the chain of investigation. In other words, the systems are not fully automated and therefore the FWA outcomes are not a product of only machines or their programmers."

89. The Panel, rightly highlighted need for what it termed "algorithmic transparency.[40]"

90. To that extent, it is Polmed's considered submission that the investigation and detection process should be technologically agnostic[41] (refers to something that has been generalized such that it is compatible with various systems) to minimize frequent reviews where possible.

91. To gain a better understanding of this proposition, perhaps it is apposite to briefly discuss how an algorithm works. An ***algorithm*** is defined as a *finite sequence of precise instructions for performing a computation or for*

[40] Interim Report at paragraph 748.
[41] Agnostic, in an information technology (IT) context, refers to something that is generalized so that it is interoperable among various systems. The term can refer to software and hardware, as well as business processes or practices. https://www.techtarget.com/whatis/definition/agnostic

solving a problem. An algorithm is defined on specified inputs and generates an output and stops after finitely many instructions are executed. From each set of input values, an algorithm produces output values from a specified set. The output values are the solution to the problem.[42] Therefore, an algorithm has input values and produces an end result in the form of output values. It is Polmed's proposal that if the factors or input values are standardized across all medical schemes, this will drastically reduce the resultant discrimination that providers are complaining of.

92. Most importantly, as alluded to by the Panel, there is need for algorithmic accountability.[43] This is important to reduce the instances of results that are biased and that are implicitly racially discriminatory. One of the ways to achieve this is by having a standardized or uniform set of the initial input or factors along with a set of instructions.

93. There is clearly a concern globally in relation to the bias which is manifest where there is no such accountability:

> "*Because of the intensifying application of these systems in various social domains, issues of fairness, (in)justice and power relations have*

[42] https://www.cs.purdue.edu/homes/spa/courses/cs182/algorithms-rego.pdf
[43] See Paragraph 749.

become the focus of attention, especially in the form of bias. As a result, "algorithmic accountability" has been suggested as a means to mitigate the risks of bias and inequalities produced by algorithmic systems.[44]" (footnotes omitted)

94. While it is accepted that medical schemes are free to choose algorithms software suppliers of their choices and are entitled to enjoy free enterprise in a constitutional democracy, the Minister, through the CMS, is empowered to draft regulations that prescribe minimum requirements that the algorithms must adhere to. Polmed posits that this aligns with constitutional values and the purpose of the MS Act as discussed to earlier, of protecting the medical schemes members' interests.

95. It is submitted therefore that in terms of section 67(1)(q) of the MS Act, it is within the powers bestowed upon the Minister to draft regulations to ensure fair and just automated detection and investigations systems.

96. The Panel's discussion of the algorithm was limited and focussed only on how those are used or automated to yield, whether by design or automatically, the unfair racially discriminative outcomes. The Panel

[44] Poechhacker N, Kacianka S. Algorithmic Accountability in Context. Socio-Technical Perspectives on Structural Causal Models. Front Big Data. 2021 Jan 29;3:519957. doi: 10.3389/fdata.2020.519957. PMID: 33693408; PMCID: PMC7931883.

found that the discrimination resulting was not by design and was not apparent. In other words, it was implicit. This result was the outcome of the algorithms, or scientific data capturing and computation technology set by human intervention.

97. Indeed, the Panel was informed that the algorithms used by the medical schemes are not from South Africa or that they are not locally sensitive to the issues of race and racial discrimination. This, the Panel did not accept.[45]

98. It thus makes sense, as Polmed submits herein that, in order to deal, first and at the outset, with issues of detection and investigations, these algorithms have to be sensitised to t he variations that in exist locally.

99. Polmed submits that the medical schemes have constitutional obligation, in their commitment to the Constitution, and in their protection of their members' funds, to ensure that effective controls are in place to deter, stop and do away with incidences of FWA. Notwithstanding these obligations, Polmed accepts that in its attempt to achieve these obligation, that should not result in any form of discrimination and in

[45] See the Main Report, page 329, para 752. This is indeed undesirable.

particular, the incidences of racially skewed outcomes and unfair racial discrimination.[46]

100. Polmed submits that the Panel has the power to recommend to the CMS and the Minister that the regulations ought to be promulgated or amended to regulate the use of this necessary tool that is effective in the hands of the medical schemes but has proven to be susceptible to wrongful modification, in the hands of the ignorant.

101. The wording of the proposed law should be along the lines that "*where a medical scheme relies on technological, or scientific programmes and/or dataset captured, analysed and put into use in the administration of a medical scheme, such a medical scheme is obliged to ensure that the said dataset, scientific or technological programmes do not yield outcomes that unfairly discriminates against persons on the basis of race, gender, sexual orientation and other grounds set in the Constitution."*

PROCESSING PAYMENTS

[46] Concluding remarks on page 329, para 753.

102. Fourth payment and coding provisions. Polmed notes that section 59(2) of the Act provides for the manner of processing payments. The section provides that.

"59. Charges by suppliers of service.

(1) …

(2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme."

103. Just to deal first, with the official government and Council's agreed manner of payment of accounts by service providers, it is noteworthy that the regulations took up from section 6 of the Act to elaborate firstly on what the contents of an account from the service provider to the medical scheme should contain in section 5 thereof.

104. Regulation 6 elaborate on the process of payment of the claims. It is quoted herein in full for convenience's sake.

"***6. Manner of payment of benefits****. —*

(1) A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month—

(a) from the last date of the service rendered as stated on the account, statement or claim; or

(b) during which such account, statement or claim was returned for correction.

(2) If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant health care provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion.[47]

(3) After the member and the relevant health care provider have been informed as referred to in sub-regulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or

[47] [Sub-r. (2) substituted by GNR.1360 of 2002 wef 1 January 2003.]

statement within a period of sixty days following the date from which it was returned for correction.[48]

(4) If a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of sub-regulation (2) or fails to provide an opportunity for correction and resubmission in terms of sub-regulation (3), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute.[49]

(5) If an account, statement, or claim is correct or where a corrected account, statement or claim is received, as the case may be, a medical scheme must, in addition to the payment contemplated in section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars—

(a) the name and the membership number of the member;

(b) the name of the supplier of service;

(c) the final date of service rendered by the supplier of service on the account or statement which is covered by the payment;

[48] [Sub-r. (3) substituted by GNR.1360 of 2002 wef 1 January 2003.]
[49] [Sub-r. (4) inserted by GNR.1360 of 2002 wef 1 January 2003.]

(d) the total amount charged for the service concerned; and

(e) the amount of the benefit awarded for such service."[50]

105. The processing of payments is regulated by section 59(2) of the MS Act read with regulation 6 to the Regulations. For completeness's sake, section 59(2) provides that:

"(2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme."

106. It is Polmed's submission that regulation 6 needs to be enhanced to allow for the standardization of coding and tariffs.

107. At this juncture a brief background into the importance of industry wide standardized coding and tariffs.

108. In the Annexure A to the Regulations, one sees a number of coded list of minimum benefits with the provided descriptions thereof. In the entire

[50] [Sub-r. (5), previously sub-r. (4), renumbered by GNR.1360 of 2002 wef 1 January 2003.]

103 pages of the Regulations, there is however no tabulation of coded lists of services, benefits, coded or otherwise which has tariffs or prices.

109. It might be that (i) it is difficult to set tariffs for such coded services given the fact that each individual case differs from one person to another, and the amount of time, tools and medication dispensed differs; and/or (ii) the nature of setting tariffs on its own tends to offend against the competition laws of the Country and result in anti-competitive behavior that is frowned upon by the Competition Commission and the Courts.

110. It is noteworthy that the Competition Commission for example exists to ensure, *inter alia*, policing market dominance, anti-competitive behavior and market abuse, collusion between certain market players as against consumers or competitors. In this regard, the Commission conducted a market inquiry in the private healthcare sector in terms of Chapter 4A of the Competition Act, 89 of 1998 (as amended) (the Competition Act) and in keeping with the purpose and functions of the Commission set out in section 2 and section 21 of the Act respectively.

111. Section 21 of the Competition Act calls on the Commission to, i*nter alia*, *"implement measures to increase market transparency"* and *"advise, and receive advice from, any regulatory authority".* In order to fulfil these functions, and in line with the purpose of the Act, Chapter 4A of that Act

enables the Commission to conduct market inquiries in respect of the *"general state of competition in a market for particular goods and services, without necessarily referring to the conduct or activities of any particular name firm*".

112. A market inquiry is thus a general investigation into the state, nature and form of competition in a market, rather than a narrow investigation of a specific conduct by any particular firm. The Commission has initiated an inquiry into the private healthcare sector because it has reason to believe that there are features of the sector that prevent, distort or restrict competition.

113. The Commission further believes that conducting this inquiry will assist in understanding how it may promote competition in the healthcare sector, in furtherance of the purpose of the Act.

114. In a report by the Competition Commission Health Market Inquiry[51] the Commission published its findings with a view to provide insight into claims and membership trends across the medical schemes industry over the analysis period. This report should be read in conjunction with the previous analysis reports published, which dealt in detail with the dataset being used for analysis conducted for the Health Market Inquiry (HMI),

[51] REPORT ON ANALYSIS OF MEDICAL SCHEMES CLAIMS DATA: A FOCUS ON FUNDERS VERSION: 15 DECEMBER 2017.

the methodology used to build analysis dataset and the overall industry cost trends over the analysis period.

115. It considered numerous pricing variations by numerous schemes and the impact they have on the claims processes, the Competition Commission published a 77-page report highlighting permutations of processing claims and seeking to find whether such in any way prejudices members in terms of the claims submitted and paid.

116. The analysis datasets which have been built by WTW for the HMI and described in the Report on Analysis of Medical Schemes Claims Data – Descriptive Statistics (the Descriptive Statistics Report) have been used. The process of building these datasets was outlined in detail in the Descriptive Statistics Report. The datasets were built using the detailed claims and membership data which was requested by the HMI from the medical schemes and their administrators.[52]

117. The objective of this analysis was to assess whether medical scheme beneficiaries have experienced greater or lesser cover in terms of how claims are paid relative to the amount claimed. The intention was to test how this varies across various funding dimensions. Polmed notes here that only claims submitted to the medical scheme can be included in the

[52] Para 3 thereof in page 2.

analysis, and it is likely that some claims paid out of pocket by members were therefore not be recorded.[53]

118. For the purposes of this sub-section, claim payment sources were defined as follows:

"10.1. A payment from 'Risk' is any amount paid from the schemes' funds, including from hospital benefits or major medical benefits, any insured benefit limits in traditional type options and above threshold benefits;

10.2. A payment from 'Savings' is any amount paid from the personal medical savings account of a member; and

10.3. An 'Unpaid' claim amount is an amount which was claimed by a service provider, but was not paid by the scheme."

119. It came to the conclusion, some of which may be of help to our client herein and to the effect that:

"CONCLUSION

102. This report outlines trends and details relating to funders, notably medical schemes and medical scheme administrators. The report shows that:

[53] Para 9, page 5 thereof.

102.1. There is no evidence of systematic increases in claims not paid by schemes and their administrators, noting that only the claims actually submitted to the schemes can be analysed;

102.2. Although it would be logical for new members to claim at higher than expected levels when they join medical schemes, there is no evidence that this selection effect is worsening over time or contributing to the annual increases schemes have experienced;

102.3. Analyses by option group suggest a net shift from pricier, more comprehensive options to cheaper, less benefit rich options over time, which is leading to a negative so called 'plan mix' effect;

102.4. Analyses by administrator suggest that some administrators and their administered schemes appear to be better able to control costs than others, although this remains very dependent on the schemes' risk profiles;

102.5. Analyses by scheme type and size suggest that the two very large schemes, as well as the smaller restricted schemes, may be more able to control the unexplained factors than schemes in the middle of the size range; and

102.6. These problems are compounded for the smaller open schemes by significant age and disease burden increases which have added to their cost increases, making this group the one subject to the highest inflationary pressure.

CODING

120. It is common cause that Billing codes are used on health care claims to identify the following:

    120.1. the patient's treating diagnosis and relevant medical conditions (e.g., speech, language, or hearing disorder; autism spectrum disorder).
    120.2. services provided (e.g., audiometric testing, swallowing intervention); and
    120.3. durable medical equipment and devices supplied (e.g., hearing aids, speech-generating devices).

121. Currently the medical industry in South Africa uses what is called the ICD-10, which is a coding standard owned and maintained by the World Health Organisation (WHO). This coding standard was adopted by the National Health Information System of South Africa (NHISSA), and forms part of the health information strategy of the Department of Health. The standard currently serves as the diagnosis coding standard of choice in both the public and private sector.

122. The purpose of ICD-10 is to convert descriptions of diseases and other health problems into an alphanumeric code that allows for convenient

storage, retrieval, and analysis of the data. It also enables for the systematic collection, analysis, interpretation, and comparison of morbidity and mortality data obtained inside the country as well as with other countries.

123. In South Africa ICD-10 coding important and helpful for several reasons:

123.1. it lends itself well to the improvement of efficiency of healthcare through appropriate and standardised recording of diagnosis, analysis of information for patient care, research, performance improvement, healthcare planning and facility management.

123.2. enables fair reimbursement for healthcare services provided and communicates health data in a predictable, consistent and reproducible manner.[54]

124. At the heart of providers complaints against medical schemes is the lack of standardized billing codes. The Panel made a finding that *"it was clear that there are no longer standard industry billing codes. Different schemes will make use of different billing".*[55]

[54] https://www.medicalschemes.com/files/ICD10%20Codings/ICD10_Implementation_Review_October2006.pdf

[55] See paragraph 66 of the Interim Report.

125. This effect of this is that it gives rise to suspected fraudulent claims in cases where there are not any. The Panel received evidence of some providers being flagged for FWA in instances where they had unintentionally used the wrong billing codes.[56]

126. The lack of standardization also opens up the potential for abuse where some unscrupulous providers make us of up coding, which involves billing for a more expensive service than the one actually provided.[57]

127. The need for the Competition Commission's Health Market Inquiry Report has already provided insight into the sector and the perverse incentives at play.

128. Polmed posits that there is a need for a framework for coding which is collaborative and all stakeholders across the industry are aware of it. This framework needs to be technologically agnostic and serve to facilitate code development.

129. In the medical world, two common medical coding classification systems are in use — the International Classification of Diseases (ICD) and the Current Procedural Terminology (CPT).[58] ICD is the standard

[56] See paragraph 67 of the Interim Report.
[57] See paragraph 68 of the Interim Report.

[58] https://www.medicalbillingandcoding.org/qnas/what-are-the-different-types-of-medical-coding-classification-

international system of classifying mortality and morbidity statistics, and it's used by more than 100 countries. The system is used by health care facilities to define diseases and allocate resources to provide care. According to the World Health Organization (WHO), 70% of the world's health care expenditures are allocated using ICD. The current version, ICD-10, features more than 68,000 codes for infections and parasitic diseases, neoplasms, and congenital malformations, as well as diseases of the digestive system, respiratory system, and nervous system.

130. Medical billing and coding professionals and providers use these two classifications systems on a daily basis, and they are the "bibles" and building blocks for this industry. Every year, it is mission critical for billers and coders to obtain the new versions of both these code sets to stay abreast of any changes to codes in either of these classification systems, otherwise they will risk denied claims and potential compliance issues.

131. ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings. These classifications are developed, monitored, and copyrighted by the World Health Organization (WHO). In the U.S., the NCHS (National Center for Health Statistics), part of CMS (Centers for Medicare &

systems/#:~:text=ICD%20is%20the%20standard%20international,allocate%20resources%20to%20provide%20care.

Medicaid Services) oversees all changes and modifications to the ICD codes, in cooperation with WHO.

132. The ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) coding system, connects health issues that arise in patients, by using three- to seven-digit alphanumeric codes to indicate signs, symptoms, diseases, conditions, and injuries to payers injuries, diseases, and conditions. These codes are used in conjunction with CPT (procedural) codes to record services rendered by a provider to a patient and is documented in the medical record and then reported to a payer for reimbursement.

133. In around 2009, the South African ICD-10 Coding Standards were developed to assist the clinical coder in the South African environment. The South African ICD-10 Coding Standards, Version 3 (as at March 2009) was Compiled by the National Task Team for the Implementation of ICD-10. It spans over 97 pages of diagnostic coding with the relevant descriptions.

134. The Coding Standards are intended to: 1. Developed to assist the clinical coder. 2. Developed to keep a record and track implementation and changes. 3. To be used concurrently with the ICD-10 manuals and training material.

135. Introduction This document has been compiled with the aim of documenting all coding standards agreed on by the National Task Team. The Council for Medical Schemes and the National Department of Health support the implementation of ICD10 in the public and private health sector. ICD-10 is a diagnostic coding standard that was adopted by the National Department of Health in 1996 as the national standard for South Africa. ICD-10 was implemented in July 2005 under the auspice of the National ICD-10 Implementation Task Team which is a joint task team between the National Department of Health and the Council for Medical Schemes. ICD-10 remains the responsibility of the National Department of Health. It is a diagnostic coding standard that is accepted by all the parties as the coding standard of choice. [Reference – Final Document, ICD-10 implementation, August 2004][59]

136. However, throughout the entire document, Polmed could not find one instance where tariffs are included; and/or where a directive is standardized for these codes to be regularly checked, and updated to real time. Polmed has also not seen further Standardized Coding information beyond the 2009 adopted codes. This immediately informs that these codes are beyond archaic. They are not updated and thus open a room for countless interpretation problems where one practitioner, for

[59] See page 5 thereof.

example, might use the same code which the scheme regards as evidence of FWA.

137. In other jurisdictions, medical billing and coding professionals and providers use these two classifications systems on a daily basis, and they are the "bibles" and building blocks for this industry. **Every year, it is mission critical for billers and coders to obtain the new versions of both these code sets to stay abreast of any changes to codes in either of these classification systems, otherwise they will risk denied claims and potential compliance issues**.

138. Polmed wishes this for South African medical scheme industry.

139. This is so because the tariff classification code is directly linked to the rate of duty payable on that commodity.

140. It is accepted, for example that the SAMA Coding Department[60] appreciates the fact that doctors are often faced with challenging or difficult scenarios when it comes to coding, not only when they are in their practices, but also when getting calls off site, such as on the golf course or relaxing at home.

[60] https://www.samedical.org/private-health/mdcm_interpretations

141. In most of these instances they will not know how to bill for the specific cases in question. So, to assist doctor members with the basic upfront knowledge of coding with which they should be armed, the CMS ought to publish-each month in its News platforms- frequently asked questions, related common scenarios and interpretations submitted by its doctors and the correct codes that should be applied in the specific cases presented. There should be Coding Manuals that differentiates between in doctor's rooms, out of doctor's rooms, in emergency times and non-emergency times etc.

142. Polmed submits that section 67(1)(q) to the MS Act empowers the Minister, through the CMS, to make such regulations or to possible enhance the existing regulation 6 as it relates to the manner of payment. This ties in with the purpose of the MS Act and thus there will be nothing untoward or *ultra-vires* in the Minister's conduct in that regard. Further, Polmed hastens to state that this proposition may find industry wide support on both sides of the divide, that the medical schemes and providers as it will serve to reduce the unnecessary investigations and sanctions therein.

TARIFFS

143. "**Tariff determination**" means tariff, rates and charges approved by Authority under the Act for Service Providers and Market Participants as the case may be.

144. In the context of South Africa, there are numerous institutions dealing with this issue and perhaps from different vantage points.

145. Polmed was able to see, for example, GEMS' tariffs for various services,[61] there is a Government Gazette of 14 September 2012 containing tariffs for the Health Professions Act: Guideline Tariffs for medical practitioners and dentists,[62] and the Competition Commission together with the Council met for a Tariff determination presentation.

146. From the outcome of the above presentation, it does not seem like the CMS took the process further hence it seems GEMS, as a scheme would have its own tariffs, which are different from other schemes.

147. In fact, a consultancy company known as Healthman[63] also provides costing assessment to many of these schemes which tariffs are comparable to current time. Their website documents such tariffs for the year 2023.

---

[61] https://www.gems.gov.za/en/Healthcare-Providers/Tariff-Files/2021-Tariff-Files?year=2021

[62] The Medical and Dental Professions Board intends, under section 53 (3) (d) of the Health Professions Act, 1974 (Act No. 56 of 1974), to determine and publish a fee ("Guideline Tariffs") **to be used as a norm in the adjudication of complaints of overcharging**.

[63] https://www.healthman.co.za/Tariffs

148. In the labour contexts and where it meets with medical practitioners in the format of COIDA, there appears to be an annual determination by the Minister of Labour, in a Government Gazette to determine *inter alia*, issues like medical tariff increase for the year and set a percentage thereof.

149. The Government's Department of Health has published rules and tariffs for specific health services and procedures performed in or out of hospital. These tariffs for the Council for Medical Schemes are called the National Health Reference Price List or NHRPL. They are only a guideline for specialists and anaesthetists to follow when they charge you for a specific procedure performed in hospital.

150. The CMS currently does not show any guidelines on tariffs for the medical schemes. However, it does sit to adjudicate a dispute where allegations of wrong code been relied upon for billing, and a non-payment of items because of a wrong coding.[64]

151. See an adjudication in the dispute between ***O v MOMENTUM MEDICAL SCHEME*** Incorrect tariff code: The complaint concerned the Scheme's non-payment of a hospital account on the grounds that the provided tariff code was incorrect. In its response to the complaint, the Scheme

[64] https://www.medicalschemes.co.za/wpfd_file/o-v-momentum-medical-scheme-incorrect-tariff-code-june-2023/

indicated that the service provider rejected the request to change the tariff code, citing the same was correct as per SAMA codes. The Scheme stated that in terms of its rules it pays in accordance with the NHRPL. The clinical information provided to the Registrar confirmed that the service provider used an incorrect tariff code in his account. A ruling was therefore issued confirming the Scheme's decision to be correct. The Complainant was advised to discuss the issue with his service provider.

152. The above must tell us that there is a real problem of many codes which are obviously susceptible to mis-interpretation, and dispute. Coding interpretation affects billing, tariffs and payments. The two are mutually inclusive and inexorably linked.

153. The reality appears to be no evidence of unified updated codes that all can use. The Authorities appear to have resorted to reactive role of resolving dispute instead of proactively unifying and regulating this crucial element of billing, and payment of services.

154. The Road Accident Fund Act, just like the COIDA provides for the relevant Minister responsible for these industries, to promulgate tariff which will bind medical practitioners who wish to render services within those industries.

155. Unlike those, and in the medical scheme industry, the Minister of Health does not appear to have powers or appetite to promulgate tariffs for the medical scheme industry. This is because this industry is largely seen as based on contractual arrangement between those who voluntarily conclude agreements to be covered by these schemes in exchange for a payment of a monthly premium.

156. Unlike the other two Acts, the medical industry scheme affects largely those who choose to be part of their rules. And the logic would dictate that the parties ought to work together to regulate their affairs.

157. It is for these reasons that the public-focussed-Tariffs in the RAF, COIDA, and Health professional's industries can be challenged in the High Court by being reviewed and set aside, under PAJA or legality, in the event that such tariffs are unreasonable, unfair, and unlawful.

158. The RAF is presently facing such litigation in respect of its 2021/2022 tariffs.

159. With regard to the medical schemes industry, Polmed submits that it is apposite that a trilateral sit down of authorities, suppliers and consumers take place to harmonise the codes, and particularly the tariffs that form a critical part of income and expense transactions in the industry.

160. Numerous medical schemes, large and small, appear to be having their own tariffs, for their own members. This is a cause for concern.

161. It this basis that Polmed notes that it appears not easy to regulate the introduction of tariffs given the complex nature of how they are applied and the potential anti-competitive nature thereof. It will however recommend that the Panel recommend to the Minister and the CMS to consider the introduction of minimum rates as tariffs on all known coded benefits so as to act as a springboard for avoiding or minimising FWAs.

RELEVANCE OF POPI ACT

162. Central to the FWA investigations is the use of algorithms to detect cases of fraud. The investigations gave rise to the issue of the confidentiality of patient's medical records.

163. The Panel dealt extensively with the thorny issue of patient confidentiality, which providers raised complaints about in the investigation process and verification of claims by medical schemes.[65]

164. There is reluctance to provide confidential patient information to medical schemes and providers raised concerns regarding the same issue.

[65] See Interim Report at subtopic 25.4 from paragraph 639.

165. The Panel did not lose sight of the fact that various pieces of legislation speak to the need to preserve patient information confidentiality.[66] What was however common among the legislation is that the consent of the patient is a requirement before such information is processed or disclosed to a Third party.

166. To give effect to the right to privacy enshrined in section 14 of the Constitution, the Legislature drafted the POPI Act. The POPI Act was enacted to, *inter alia,* promote the protection of personal data handled by public and private entities; to introduce some restrictions; and to set basic standards for the handling of personal data.[67]

167. The relevant sections of the POPI Act provides as follows:

    167.1. that the POPI Act applies to information entered in record by or for a responsible party by making use of automated or non-automated means unless any other law that regulates the processing of personal information, if that other law provides for the extensive processing of personal information, then the extensive conditions prevail;[68]

[66] See Interim Report from paragraphs 641-649.
[67] See Preamble to the POPI Act.
[68] See section 3 of the POPI Act.

167.2. the processing of data must align with 8 core principles;[69]

167.3. a data subject has the right to be notified when his personal information is being collected or has been accessed by an unauthorized person as provided for in section 22;[70]

167.4. personal information must be processed lawfully in a manner that does not infringe or violate the privacy of the data subject;[71]

167.5. personal information must only be provided if the data subject consents to the processing;[72]

167.6. that personal information must be collected for a lawful purpose and steps must be taken to ensure the data subject is aware of the purpose of the collection of the information, subject to the exclusions set out under section 18(4) of the POPI Act;[73]

167.7. that the collection of personal information of a data subject concerning race, ethnicity origin, **health or sex life**, biometric information or the criminal behaviour of a data subject to the

[69] See section 4 of the POPI Act.
[70] See section 5 of the POPI Act.
[71] See section 9 of the POPI Act.
[72] See section 11 of the POPI Act.
[73] See section 13 of the POPI Act.

extent that such information relates to the alleged commission by a data subject of any offence is prohibited;[74] and

167.8. that the processing of health and sex life information under section 26 above is permissible only when the data subject has given consent[75].

168. However, as rightly alluded to by the Panel,[76] in terms of section 32 of the POPI Act, the processing of a patient's health life by medical schemes does not fall under the prohibition under section 26. The Panel found that this was not relevant to handing over of patient's files to medical schemes for the purposes of their investigations.

169. Thus, the right to a patient's privacy remains paramount and consent is still a requirement before the information can be shared. The courts have emphasized the importance of privacy in a number of decisions.

170. In ***Smuts and another v Botha***[77] the Supreme Court of Appeal ("the SCA") set out the present state of the law of privacy in South Africa and the importance of the right to privacy by holding that:

[74] See section 26 of the POPI Act.
[75] See section 27 of the POPI Act.
[76] See Interim Report at paragraph 649.
[77] [2022] JOL 51863 (SCA)

"[8] The right to privacy is a fundamental right that is protected under the Constitution. It is a right of a person to be free from intrusion or publicity of information or matters of a personal nature. It is central to the protection of human dignity, and forms the cornerstone of any democratic society. It supports and buttresses other rights such as freedom of expression, information and association. It is also about respect; every individual has a desire to keep at least some of his/her information private and away from prying eyes. Another individual or group does not have the right to ignore his wishes or to be disrespectful of his desire for privacy without a solid and reasoned basis."

171. Further in paragraph 10:

"[10] Privacy enables individuals to create barriers and boundaries to protect themselves from unwarranted interference in their lives. It helps to establish boundaries to limit who has access to their space, possessions, as well as their commercial and other information. It affords persons the ability to assert their rights in the face of significant imbalances. It is an essential way to protect individuals and society against arbitrary and unjustified

use of power by reducing what can be known about, and done to them..."

172. In ***Bernstein v Bester NO***,[78] Ackermann J, writing for the majority, provided a rich account of the right to privacy. He held that:

"[68] In South African common law the right to privacy is recognized as an independent personality right which the courts have included within the concept of dignitas. Privacy is an individual condition of life characterised by seclusion from the public and publicity. This implies an absence of acquaintance with the individual or his personal affairs in this state. In Financial Mail (Pty) Ltd v Sage Holdings Ltd it was held that breach of privacy could occur either by way of an unlawful intrusion upon the personal privacy of another, or by way of unlawful disclosure of private facts about a person. The unlawfulness of a (factual) infringement of privacy is adjudged in the light of contemporary boni mores and the general sense of justice of the community as perceived by the Court.

[69] Examples of wrongful intrusion and disclosure which have been acknowledged at common law are entry into a private residence,

[78] 1996 (2) SA 751 at paras 68-69.

the reading of private documents, listening in to private conversations, the shadowing of a person, the disclosure of private facts which have been acquired by a wrongful act of intrusion, and the disclosure of private facts contrary to the existence of a confidential relationship. These examples are all clearly related to either the private sphere, or relations of legal privilege and confidentiality. There is no indication that it may be extended to include the carrying on of business activities." (footnotes omitted)

173. It is apparent therefore that the right to privacy is fiercely protected by the Constitution and that right can only be limited in very exceptional circumstances as provided for under section 36(1) of the Constitution.

174. At common law, there is also a duty to preserve professional confidence. The obligation of confidentiality goes beyond undertaking not to divulge confidential information; it includes a responsibility to make sure that all records containing patient information are kept securely.

175. The courts have underscored the need for doctor and patient confidentiality and held that only in certain circumstances can that

confidentiality be foregone. In the decision of ***Davis v Additional Magistrate, Johannesburg, And Others***,[79] the Court held that:

> "*As long ago as in 1916 it was held that a medical doctor could not claim privilege in the witness-box if asked about confidential communications from or about the treatment of his patients. (Cf Parkes v Parkes 1916 CPD 702.) In Botha v Botha 1972 (2) SA 559 (N), Leon J is reported as having said:*
>
> > *'It is in the public interest that justice must be done. The confidential relationship between doctor and patient must yield to the requirements of public policy that justice must be done and must be seen to be done.*
> >
> > *…*
> >
> > *The confidential relationship between a doctor and patient must in these circumstances yield to wider considerations of public interest"*

176. The sentiments above were echoed in the decision of ***Jansen van Vuuren and Another NNO v Kruger***[80] where it was held that:

[79] [1989] 4 All SA 195 (W) at paragraph 198.
[80] [1993] 2 All SA 619 (A) at paragraph 14.

"The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law. See Melius de Villiers, The Law of Injuries, p 108. As far as present-day law is concerned, the legal nature of the duty is accepted as axiomatic[81].

177. The Court went on to state that the duty of confidentiality is not absolute in that:

"However, the right of the patient and the duty of the doctor are not absolute but relative.. One is, as always, weighing up conflicting interests and, a doctor may be justified in disclosing his knowledge "where his obligations to society would be of greater weight than his obligations to the individual"[82]

178. Thus, generally, disclosure of confidential patient information to someone other than the patient will be an actionable breach of confidence. There are, however, three circumstances when providers

[81] See e g Sasfin (Pty) Ltd v Beukes 1989 (1) SA 1 (A) 31F-33G.
[82] At paragraph 15.

can release confidential clinical information without the consent of a patient *viz* where:

178.1. disclosure is ordered by a court;

178.2. disclosure is required by law; and/or

178.3. disclosure is in the public interest.

179. Outside of the above exceptions, Polmed concluded by submitting that a patient's consent is required.

END.

Compiled for Polmed by:

T J MACHABA SC

G TIKI

KHR INC.

JOHANNESBURG

22 June 2023