

CMS news

Issue 3 of 2009-2010

**Relationships
in the
industry –
what all
beneficiaries
need to
know**



You sign on the dotted line. The letter arrives. "Welcome to so-and-so medical scheme." But who sent it? Probably not your scheme.

Schemes seldom communicate with their members directly. Instead, most prefer administrators to speak on their behalf.

It was also the administrator who signed you up as a member of the scheme.

Did a broker help you or did you sign up by yourself? Did you know that you don't have to use a broker if you don't want to? And that you can choose who your broker should be?

Did you know that your doctor must tell you how they propose treating you and how much they intend charging? And that you need to consent to both the treatment and the fee they want to charge before they can treat you?

Did you know that your scheme will check whether the treatment you seek is indeed necessary and appropriate? Managed care organisations also test if the scheme can afford to cover the treatment you seek, but it is the administrator who calculates how much will actually be paid and authorises payment as it is the administrator who checks if you are in good standing with the scheme and which benefits you are entitled to. Pre-authorisation, therefore, does not necessarily mean your scheme will cover all costs in full.

One signature – and your world has just grown that much bigger. Meet your scheme, its administrator and managed care organisation. Meet the thousands of independent advisors and marketing agents currently operating as healthcare intermediaries in our country. Make acquaintance with a new group of doctors and specialists, nurses and hospitals. Consider the role of the various regulators and representative bodies – and give some thought to what they can do for you. We acknowledge that this industry is no different to any other: it is not perfect. The law is sometimes ignored; unethical behaviour is not uncommon. But after reading this issue of *CMS News* you should at least have a better idea of where to seek guidance and advice. Speak to patient advocacy groups and support organisations if need be.

One signature – and you have just entered into a complex network of new relationships, where a unique set of rights and responsibilities binds everyone together.

Joining a medical scheme does not need to feel like opening a Pandora's box of surprises. Join prepared.

Editorial Committee

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Beneficiaries and medical schemes

The moment you sign that application form, you enter into a world of new relationships. The one with your medical scheme is the gateway to all the others.

Medical schemes are not-for-profit entities which operate like trusts and undertake liability on behalf of beneficiaries in return for a monthly contribution. The relationship between schemes and beneficiaries is governed by the Medical Schemes Act (Act 131 of 1998) and the registered rules of the scheme.

A scheme is managed by a Board of Trustees. Principal members elect trustees, and at least half the Board must consist of members of the scheme.

The Board and principal officer can amend the rules of the scheme by resolution but any amendments must be registered by the Council for Medical Schemes (CMS) before they can be enforced. As the regulator of the industry, the CMS must ensure that every scheme rule is fair to beneficiaries and does not discriminate against any of their rights.

Every scheme is required to hold a reserve equalling at least three times the total contribution income that it receives in a month.

Each benefit option must be self-sustainable in terms of financial performance and size of membership. Each option must also allow for a minimum set of benefits. These guaranteed benefits are called prescribed minimum benefits or PMBs. PMB conditions must be covered in full if the beneficiary obtains his/her services in the nominated or preferred facilities called designated service providers or DSPs.

Extra benefits over and above PMBs are instituted by the Board. These can be structured in various ways but they are essentially governed by the rules of the scheme. Registered rules must be consistent with the Medical Schemes Act and its Regulations.

What do schemes do, exactly?

The Medical Schemes Act defines the business of a medical scheme as:

- the business of undertaking liability in return for a premium or contribution*
- to make provision for the obtaining of any relevant health service;

- to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
- where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.

Schemes are there for the benefit of beneficiaries. Trustees are entrusted with members' money to manage it well and ensure all beneficiaries enjoy adequate cover based on the principles outlined in the extract of the Act above.

In essence, the cover required in return for contributions is funding for a health service based on the cost of the service and providing access to the service at the relevant provider(s).

The uniqueness of the medical schemes industry is based on the principle of indemnity. The idea is to restore beneficiaries to the same financial position they were in before the medical intervention(s) occurred.

Before and after

The regulatory framework which guided the behaviour of medical schemes had been substantially watered down in the 1990s so it would be accurate to say that before the Medical Schemes Act was introduced in 2000, the funding side of the South African private health sector remained largely unregulated and therefore vulnerable to unscrupulous conduct which did not necessarily respect the rights of beneficiaries.

The Act gives the CMS the mandate to ensure that scheme rules are fair and in the best interests of beneficiaries, and consistent with the Act, its Regulations, and applicable policies.

There are other relevant statutory provisions besides the Medical Schemes Act to protect the interests of the public and explain their rights. These include the Bill of Rights in the Constitution, the Harmful Business Practice Act, the Promotion of Administrative Justice Act, and the Promotion of Access to Information Act.

“ Medical schemes are not-for-profit entities which operate like trusts. ”

By Paresh Prema (HEAD OF BENEFITS MANAGEMENT)

Does the industry need schemes?

Medical schemes exist because they address a need. This need is for a vehicle to guarantee a minimum set of medical benefits in a suitable setting based on need and not affordability.

Schemes are based on the concept of insurance; they offer financial security and hence peace of mind to the individual. Schemes enable the losses of a few to be made good by contributions from many.

Insurance is based on the law of large numbers; risk pools are established with the contributions collected from members. Medical schemes stem from the human need to mitigate the varying costs of healthcare. They also reflect our inclination to find solutions collectively.

Rights of beneficiary

The principle of open enrolment, enshrined in the Medical Schemes Act, stipulates that a scheme may not refuse membership to anyone – unless it is a restricted scheme and the applicant does not meet the admission criteria. The Act also allows members to move between options within their scheme on 1 January of each year.

Beneficiaries have the right to a full copy of the scheme rules and any other scheme-related information. They have the right to privacy and dignity. They cannot be discriminated against unfairly.

Principal members can attend and vote at the Annual General Meeting (AGM) of their scheme. They also have the right to call a Special General Meeting (SGM). Members are required to vote when the rules of the scheme require their consent, e.g. on rule amendments, liquidation, and amalgamation. Voting may occur at the AGM/SGM or by posted ballots.

Rules provide for instances where a beneficiary has a complaint against the scheme; they must describe the procedures for dispute resolution. If the member is unsatisfied with the decision of the disputes committee of the scheme, s/he can lodge a complaint against the decision with the CMS which will then be handled as per Section 47 of the Medical Schemes Act.

Responsibilities of beneficiary

Principal members have an obligation to pay their monthly contribution (and the right to receive benefits in return), as per the registered rules of the scheme. When applying for membership, applicants must provide accurate and complete information and disclose all material information. Members are expected to act honestly and to never submit fraudulent claims; this may result in their membership being suspended or terminated.

Members must ensure that claims for services are submitted to the scheme within four months of the date on which they obtained the service.

Beneficiaries cannot belong to two medical schemes at the same time. The scheme has the responsibility to pay for claims only in respect of registered members and dependants for which contributions were received. Membership is not transferrable. Schemes must provide those services that are registered in their rules and that are consistent with the provisions of the Act.

Rights of scheme

Open schemes cannot deny entry to any person that applies for membership. They therefore face the risk of anti-selection from the public. The measures to manage anti-selection are waiting periods (general or condition-specific) and late-joiner penalties. A general waiting period can last up to three months; condition-specific waiting periods go on for up to 12 months. When members move between schemes, there is a limit to the waiting period that a scheme may apply and how it affects the provision of PMBs (see table). Schemes may terminate your membership if you do not pay your contributions or if you do not disclose material information when applying for membership.

Boards can negotiate with healthcare providers for preferential rates for PMBs and nominate such providers as the preferred or designated service providers (DSPs) of the scheme. Schemes may also use other mechanisms to manage the cost of claims, e.g. pre-authorisation, formularies, protocols, pro-rating benefits for joining the scheme mid-year, and applying deductibles and co-payments.

Responsibilities of scheme

Schemes are required to operate within the bounds of the Medical Schemes Act and their

How schemes apply waiting periods

Uncovered period

(from your last day with the previous scheme to the date of application for membership with the new scheme)

Break in cover of at least 90 days

Break in cover of less than 90 days (0-89 days)

Membership period with previous scheme

Regardless of previous membership	Longer than 24 months	24 months or shorter (previous waiting periods may still be in place)	Regardless of previous membership (change of employment, or employer leaving or changing a scheme)
<ul style="list-style-type: none"> General waiting period of up to 3 months Condition-specific waiting period of up to 12 months Waiting period applies to PMBs (i.e. the scheme may exclude cover for PMBs during this waiting period) 	<ul style="list-style-type: none"> General waiting period of up to 3 months Waiting period does not apply to PMBs (i.e. the scheme may exclude cover for all benefits except PMBs) 	<ul style="list-style-type: none"> Condition-specific waiting period of up to 12 months Waiting period does not apply to PMBs (i.e. the scheme may exclude cover for all benefits except PMBs) 	<ul style="list-style-type: none"> No general or condition-specific waiting periods may be imposed

registered rules. The Board is responsible for ensuring that the rules provide for the benefits that were intended – and certainly all PMBs.

The principle of community rating is another cornerstone of the Act. It requires schemes to base their contributions only on income and/or family composition (number of dependants), or both.

This ensures that beneficiaries are not unfairly discriminated against on one or more arbitrary grounds such as race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability, and state of health.

The lines of communication between beneficiaries and their scheme must always be open. Schemes have the responsibility to provide proof of membership to beneficiaries as well as copies of their rules and financial statements. They must

also always act in the best interest of beneficiaries, e.g. by ensuring that all information is kept confidential and all services are indeed available and accessible to their beneficiaries, especially in cases where the scheme nominates a DSP to provide PMBs to its beneficiaries.

The sustainability of a scheme is of paramount importance. Boards must ensure that their schemes remain solvent. The Medical Schemes Act has further requirements relating to the financial performance of each benefit option and the size of the scheme. Trustees must exercise their fiduciary duty in making business decisions. ■

Regulator

Council for Medical Schemes (CMS) (www.medicalschemes.com)

Representative body

Board of Healthcare Funders of Southern Africa (BHF) (www.bhfglobal.com)

Visit our website for a list of all medical schemes registered in South Africa.

“The uniqueness of the medical industry is based on the principle of indemnity.”

Beneficiaries and administrators

Most medical schemes outsource many of their functions to administrators. What does this mean for beneficiaries?

By **Danie Kolver**
(HEAD OF ACCREDITATION)

Medical scheme administrators are privately owned companies with the skills, infrastructure, and capacity to render a full range of administration services to schemes in compliance with prevailing legislation. They are accredited by the Council for Medical Schemes (CMS) in terms of the Medical Schemes Act if they meet the following criteria – they must:

- be based in South Africa (for jurisdictional reasons);
- be fit and proper;
- provide services that are clearly distinct from others contracted by the scheme (e.g. managed care and broker services);
- maintain a financially sound position; and
- have the requisite resources, systems, skills, and capacity in place.

The Accreditation Unit at the CMS – responsible for overseeing administrators, managed care organisations, and brokers – performs regular on-site evaluations of administrator facilities and operations, and verifies their compliance with accreditation standards.

What do administrators do, exactly?

Administrators perform a variety of administration functions as per their written contracts and service level agreements with schemes.

They utilise comprehensive and integrated information technology systems capable of performing all administration, financial, and management functions.

Medical scheme administrators maintain member records. Their systems can drill down to detailed information on an individual member. It is the administrator who processes your application for membership and also suspends and terminates it.

Administrators collect the monthly member contributions and manage their allocation and reconciling. They ensure that outstanding amounts are collected.

“
Distinguish between your medical scheme and its administrator.”

In terms of claims administration, administrators make sure that their systems operate in accordance with the rules of the scheme, its registered benefit options, and any limitations it may have. Their systems must accurately assess and allocate claims and benefits.

Administrators regularly report on the financial position of their scheme(s). They must produce statutory returns and monthly management accounts.

Their operating and financial management systems must therefore be interfaced on a regular basis, i.e. they must marry financial information with membership, contributions, and claims transactions.

Their information security policy must ensure sufficient access control and confidential treatment of patient information at all times.

Administrator systems must be flexible and capable of taking on additional functions.

Before and after

Before the Medical Schemes Act became enforceable in 2000, administrators were not subject to any form of regulatory oversight. The only legal binding force was the contract between the administrator and the scheme. This arrangement proved inadequate as certain administrators too often held schemes at ransom without proper recourse being available to the schemes.

It thus became necessary to legislate the relationship for institutional safety (to level the playing fields), given the impact of unscrupulous administrators on medical schemes.

The first step was to determine critical performance areas and minimum standards for accreditation to assess the performance of administrators objectively, determine requirements for individual accreditation, and ensure their ongoing compliance with regulatory provisions.

Today, administrators are held accountable for everything they do or fail to do, and if they do not comply with accreditation requirements, the

The administrator answers to the medical scheme, not the other way around. The rules of the scheme always supersede the rules of the administrator.

CMS may suspend or withdraw their accreditation. The regulatory framework governing the behaviour of administrators keeps evolving. Accreditation requirements are enhanced to conform to regulatory changes.

Does the industry need administrators?

Every medical scheme relies on an effective administration function, be it outsourced or in-house.

Third-party administrators are crucial to the proper functioning of schemes. The systems and infrastructure required are sophisticated and expensive, and administrators can utilise economies of scale to offer a more cost-effective administration function.

Administrators act as agents of their client schemes in performing all the essential administrative functions required for the proper functioning of the scheme.

Administrators must be able to provide trustees with reliable and meaningful management information to enable them to manage their schemes effectively and with prudence.

Self-administered medical schemes

Some medical schemes do not use administrators. A self-administered scheme undertakes all administration functions with its own resources.

Self-administered schemes do not need to be accredited, but they must comply with the same administration standards and are subject to the same on-site evaluation of compliance as third-party administrators.

Rights of beneficiary

- 1 You have the right to have your human rights respected at all times.
- 2 Know if your scheme is self-administered or not.
- 3 If your scheme uses a third-party administrator,

Self-administered medical schemes do not need to be accredited but they must comply with the same administration standards as third-party administrators.

“
Administrators are held accountable for everything they do or fail to do.”

know your responsibilities towards the administrator:

- 4 Know who does what: distinguish between your scheme and its administrator.
- 5 Know that the administrator acts as an agent of your scheme and the scheme remains legally liable to you.
- 6 Know the rights and responsibilities of the administrator towards you.
- 7 If you are uncertain about anything or need advice, ask.
- 8 If you are unhappy about anything, speak out.
- 9 Know where to go when you have questions or want to lodge a complaint.
- 10 Insist on factual and accurate information – every time.
- 11 Expect a prompt, honest, and comprehensive response – without fail.
- 12 Expect to be treated in a professional and courteous manner – always.
- 13 Obtain any information upon request, including the rules of the scheme, and receive it within a reasonable period of time or when you need it to make important decisions.
- 14 Insist that the administrator complies with the rules of the scheme and the Medical Schemes Act.

Responsibilities of beneficiary

- 1 Know your rights as far as your relationship with the administrator goes.
- 2 Respect the rights and responsibilities of the administrator.
- 3 If you are applying for membership, answer all questions on the application form – and answer them honestly and in as much detail as you can. (This is for your own good.)
- 4 Disclose any and all healthcare treatment you have ever obtained if the administrator asks for it.
- 5 Read all correspondence – the administrator performs this function on behalf of your scheme.

Beneficiaries and managed care organisations

Managed care is not easy. On the one hand, the scheme wants to fund appropriate care in a prudent way. On the other there is the beneficiary who expects to be treated. MCOs need to look after both.

By **Danie Kolver**
(HEAD OF ACCREDITATION)

- 6 Keep all interaction professional at all times.
- 7 Play by the rules.
- 8 Make sure you are well-informed and keep up to date with the latest developments. You can never know too much.

Do you know the difference between your medical scheme and its administrator? Beneficiaries do not always realise that they are dealing with the administrator and not their scheme.

Rights of administrator

- 1 You have the right to have your rights respected at all times.
- 2 Place your own interests first – but not at the expense of beneficiaries.
- 3 Know your responsibilities towards beneficiaries.
- 4 Ask for the information you need.
- 5 Insist that applicants disclose fully the information you require, including their health history.
- 6 Insist on accurate and comprehensive information from the beneficiary.
- 7 Know the rights and responsibilities of the beneficiary towards you.

Responsibilities of administrator

- 1 “Know thyself” – distinguish between the scheme and yourself.
- 2 Know your rights and responsibilities towards beneficiaries.
- 3 Respect the rights and responsibilities of beneficiaries.
- 4 Play fair.

For a list of accredited administrators and the accreditation standards, visit our website.

Regulator
Council for Medical Schemes (CMS) (www.medicalschemes.com)
Representative body
Board of Healthcare Funders of Southern Africa (BHF) (www.bhfglobal.com)

- 5 Communicate. And do it well: use everyday language; explain technical terms; simplify complex processes.
- 6 Keep beneficiaries informed. Answer their queries; advise; provide guidance.
- 7 Help the beneficiary understand. Clarify.

Administrators must provide trustees with reliable and meaningful management information to enable them to manage their schemes effectively and with prudence.

- 8 Keep it simple.
- 8 Provide accurate information – always.
- 9 Set up an effective call centre.
- 10 Ensure beneficiaries know about the scheme website.
- 11 Publish accurate information on the scheme website.
- 12 Explain prescribed minimum benefits (PMBs) and trends in the industry.
- 13 Clearly communicate requirements about network options, designated service providers (DSPs), limitations, option requirements, drug formularies, pre-authorisation, and protocols.
- 14 Ensure membership card reflects all relevant information.
- 15 Distribute documents to beneficiaries in good time, including the scheme rules and its annual financial statements.
- 16 Do not confuse or mislead beneficiaries.
- 17 Ensure the scheme’s marketing material is factually correct, unambiguous, and relevant to scheme rules.
- 18 Do not withhold information. Place yourself in the beneficiaries’ shoes and tell them everything they need to know to make informed decisions.
- 19 Do not ask inappropriate questions, e.g. about unrelated business such as insurance cover.
- 20 Respond to enquiries timeously.
- 21 Manage complaints effectively and promptly. Address all complaints until the beneficiary has been put at ease.
- 22 Make sure you are always compliant with the Medical Schemes Act and other applicable legislation.
- 23 Provide a reliable and secure administration service in accordance with accreditation standards and your contract with the scheme(s).
- 24 Capture and assess all claims and pay them according to the scheme rules.
- 25 Ensure all financial data is properly recorded. ■

Managed care organisations (or MCOs in industry jargon) are expert contractors to medical schemes that provide clinical and financial risk management solutions to facilitate appropriate care within the constraints of what the scheme can afford.

Put simply, MCOs are commercial entities which determine if the treatment being sought by the patient and his/her healthcare provider is indeed necessary and appropriate, and whether the scheme should fund it or recommend alternative treatment.

MCOs are accredited by the Council for Medical Schemes (CMS) if they meet certain criteria. They must, for instance, be financially healthy. And anyone must be able to access (on demand) information on:

- their protocols;
- their medicine formularies;
- formulary inclusions and exclusions (drugs available to the beneficiary);
- any limitations on the rights of beneficiaries to treatment;
- restrictions on care that the beneficiary can obtain; and
- the services that the MCO provides, including formalities that must be complied with. Formalities determine, for instance, how the beneficiary must register for a health management programme, and how treating doctors should motivate for pre-authorisation.

MCOs use documented clinical review criteria founded on evidence-based medicine to determine the appropriateness of the treatment being sought. At the same time they must take into account cost-effectiveness and affordability. They must also make provision for alternative treatment in exceptional circumstances where a protocol or formulary drug proves ineffective and/or harmful to a beneficiary – without penalising the beneficiary.

MCOs have their own processes and rules but a decision of the scheme can modify these.

What do MCOs do, exactly?

MCOs contract with medical schemes to provide healthcare services to their beneficiaries in a

manner which introduces clinical and financial risk management according to rules- and clinical management-based programmes (clinical expertise based on proven scientific grounds and acceptable best practice).

Managed care implies expert interventions such as:

- pre-authorisation for certain procedures;
- case management (clinical monitoring of patient while s/he is treated in terms of the managed care programme);
- hospital management (observing and managing the recovery of patient in hospital after surgery);
- management of diseases (e.g. cancer, chronic conditions, HIV/AIDS);
- pharmaceutical benefit management (determining if the prescribed drugs are appropriate and effective); and
- applying business intelligence with expert protocols and formularies to verify claims which the scheme has been asked to pay.

MCOs must apply clinical expertise (evidence-based medicine and good clinical practice) and demonstrate that they add value to their client scheme(s) rather than show mere cost savings without improving the health outcomes of beneficiaries. Their interventions must benefit both parties.

MCOs intervene in different ways. They often accept and manage risk for certain services that the scheme has transferred to them. They render or contract specialised services to other expert healthcare providers. They verify claims in terms of managed care interventions to ensure that what the scheme pays, is aligned with such interventions.

Before and after

MCOs were not regulated until 2000. But things changed when the Medical Schemes Act came into effect. MCOs must now be accredited and comply with stringent legal requirements before

Managed care organisations must demonstrate that they add value to their client schemes.

There were 47 accredited MCOs when this article was being written.

they can contract with medical schemes. Their technology and business models are scrutinised and verified with comprehensive standards to protect the interests of beneficiaries.

Nowadays MCOs must accept responsibility for the way in which they provide services, the clinical decisions they make on alternative treatment, and the advice they give their client schemes on the funding of benefits. They must also be transparent; their protocols and formularies must be given to anyone who is interested in them, and they must make provision for appropriate exceptions and alternative drugs where a protocol or drug proves ineffective or causes an adverse reaction in a beneficiary.

The Accreditation Unit at the CMS will soon start with on-site evaluations of the facilities and infrastructure of MCOs as part of their accreditation process.

Does the industry need MCOs?

Our medical schemes industry would be worse off without MCOs.

Without MCOs, the industry would lack specialist attention and care to manage complicated health conditions.

Without managed care skills and expertise, facilities would have to be duplicated and schemes would face increased expenditure as they would have to extend their capacity, both in terms of skills and specialised software, beyond economical means having been forced to provide such



Most medical schemes cannot afford not to use managed care organisations or to provide such services themselves.



Rights of beneficiary

- 1 You have the right to have all your human rights respected at all times (including your right to privacy and access to care).
- 2 Know if your scheme uses an MCO and what their agreement entails.
- 3 Know your responsibilities towards the MCO of your scheme.
- 4 Know who is responsible for what.
- 5 If you need information or advice, ask.
- 6 If something is bothering you, say so.
- 7 Insist on accurate and honest information – every time.
- 8 Expect a prompt, honest, and comprehensive response – without fail.
- 9 Contact the MCO directly – you do not have to go via your scheme.

services themselves.

If managed care services were not available, the fee-for-service remuneration model would have remained unchecked and schemes would not have been able to improve health outcomes.

Most medical schemes cannot afford not to use MCOs or to provide such services themselves.

Not all schemes use MCOs – what then?

Medical schemes do not have to outsource managed care. They may render – and thereby accept responsibility for – some or all managed care services themselves. Some administrators are also capable of providing managed care services.

Key concepts simplified

Formulary: list of drugs that scheme will fund in full; for acute and chronic conditions; based on evidence-based medicine

Pre-authorisation: the MCO allows the beneficiary and his/her healthcare provider to obtain the treatment they seek or makes recommendations to the scheme; based on appropriateness and effectiveness; not a guarantee that scheme will pay for the service(s) outside of what is authorised by the administrator; given if beneficiary is in good standing with the scheme, i.e. his/her contributions are paid up

Protocols: guidelines describing the optimal sequence of diagnostic testing and treatment

- 10 Expect to be treated professionally, with sensitivity and respect – always.
- 11 Obtain any information on request within a reasonable period of time.
- 12 Insist that the MCO complies with the scheme rules and Medical Schemes Act.
- 13 Know the rights and responsibilities of the MCO towards you.

Responsibilities of beneficiary

- 1 Know your rights.
- 2 Respect the rights and responsibilities of the MCO.
- 3 Play fair. There is more than one side to every story.
- 4 If asked to share information, do so promptly and be honest.
- 5 Educate yourself. Understand what MCOs do and how it affects you.
- 6 Familiarise yourself with the programmes, processes, and interventions.
- 7 Comply with managed care procedures to avoid penalties and personal liability, and to ensure that your benefits are never refused or limited.
- 8 For your own peace of mind, be sure the MCO is accredited and thus authorised to provide managed care services.

Rights of MCO

- 1 You have the right to have all your rights respected at all times.
- 2 Place your interests first – but do not prejudice beneficiaries by doing so.
- 3 Know your responsibilities towards beneficiaries.
- 4 Request the information you need.
- 5 Insist on beneficiaries being honest with you.
- 6 Know the rights and responsibilities of the beneficiary towards you.



If managed care services were not available, the fee-for-service remuneration model would have remained unchecked and schemes would not have been able to improve health outcomes.



Responsibilities of MCO

- 1 Know your rights and responsibilities towards beneficiaries.
- 2 Respect the rights and responsibilities of beneficiaries.
- 3 Ensure beneficiary information is kept confidential.
- 4 Conduct yourself ethically and within the bounds of legislation – always.
- 5 Comply with the Medical Schemes Act and other relevant laws at all times.
- 6 Perform contractual obligations in respect of beneficiaries.
- 7 Ensure beneficiary is not held liable for any sums owed in terms of your agreement with the scheme(s).
- 8 Keep beneficiaries in the loop. Do not keep them waiting or guessing.
- 9 Inform beneficiaries of latest developments and treatment for conditions.

- 10 Help beneficiaries understand your role, the programmes you offer, and the outcomes of interventions.
- 11 Clarify processes, reasons, registration on programmes, and pre-authorisation.
- 12 Explain the benefits of health management initiatives.
- 13 Attend to queries promptly.
- 14 Be open, honest, and considerate at all times.
- 15 Use ordinary language – you need to understand each other.
- 16 Balance the interests of your client scheme(s) with those of beneficiaries, treating both the same way.
- 17 Make clinically justifiable decisions.
- 18 Keep proper records of your activities. ■

Regulator

Council for Medical Schemes (CMS)
(www.medicalschemes.com)

Representative body

MCOs have no representative body but they affiliate with the Board of Healthcare Funders of Southern Africa (BHF)
(www.bhfglobal.com)

If you want to know who the MCOs are, and which accreditation standards apply to them, visit our website.

How the beneficiary fits in

- Flow of funds (\$) (Pink dashed arrow)
- Flow of services (Green solid arrow)
- Regulators (Blue box)
- Representative bodies (Yellow box)



Healthcare providers

Public/state or private
 DSPs or non-DSPs
(DSP: Designated Service Provider)

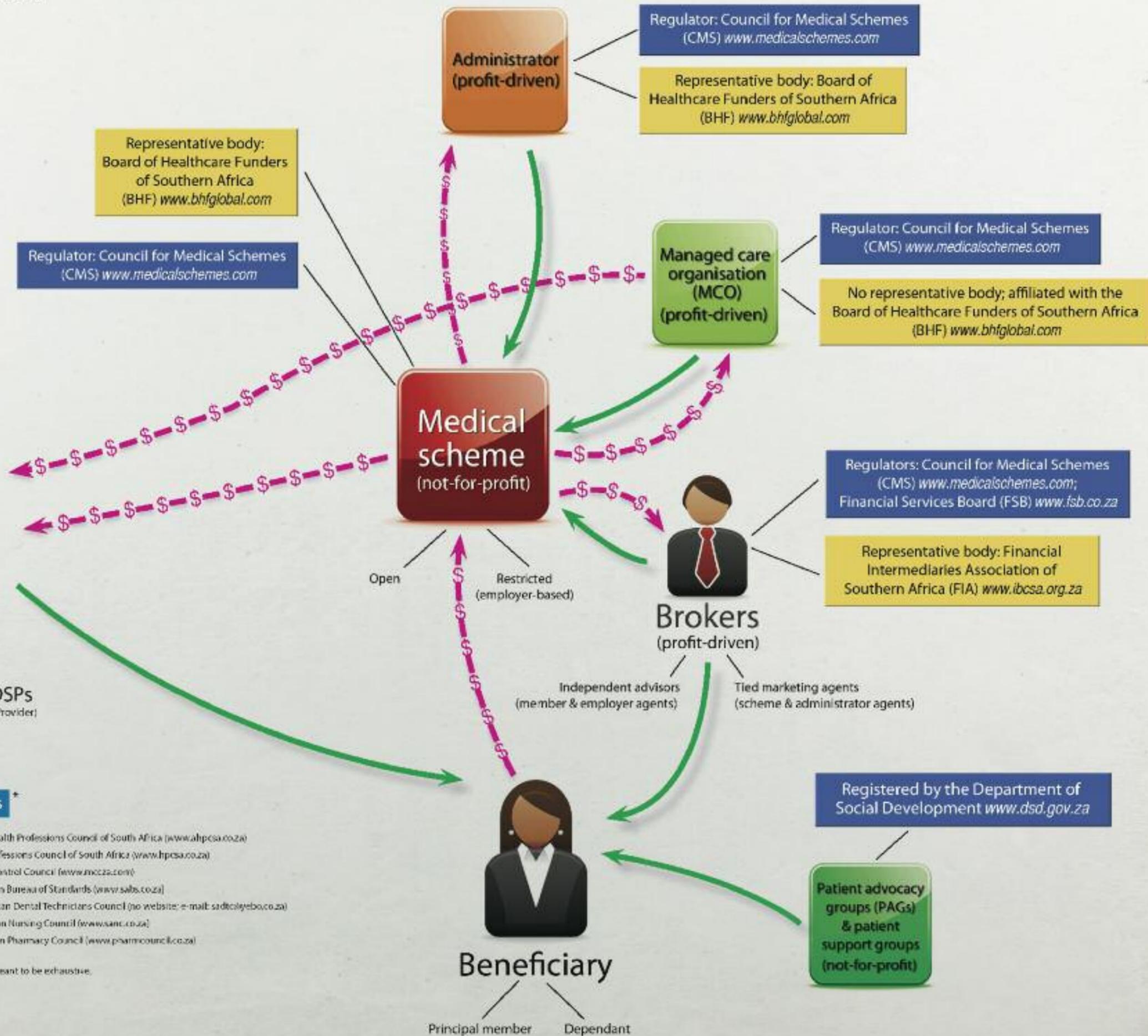
Representative bodies *

- DENOSA: Democratic Nursing Organisation of South Africa (www.denosa.org.za)
- DENTASA: Dental Technology Association of South Africa (www.dentasa.org.za)
- HASA: Hospital Association of South Africa (www.hasa.co.za)
- PIASA: Pharmaceutical Industry Association of South Africa (www.piasa.co.za)
- PSSA: Pharmaceutical Society of South Africa (www.pssamw.co.za)
- SADA: South African Dental Association (www.sadanet.co.za)
- SAMA: South African Medical Association (www.samal.org)
- SAOA: South African Optometric Association (www.saoa.co.za)

Regulators *

- AHPSCA: Allied Health Professions Council of South Africa (www.ahpca.co.za)
- HPCSA: Health Professions Council of South Africa (www.hpcsa.co.za)
- NCC: Medicines Control Council (www.mcc.co.za)
- SABS: South African Bureau of Standards (www.sabs.co.za)
- SADTC: South African Dental Technicians Council (no website; e-mail: sadtc@yeb.co.za)
- SANC: South African Nursing Council (www.sanc.co.za)
- SAPC: South African Pharmacy Council (www.pharmcouncil.co.za)

* This list is not meant to be exhaustive.



Beneficiaries and brokers

If you belong to a medical scheme, you should know that part of your monthly contribution goes to a healthcare broker. Make sure you are getting what you are entitled to.

By **Danie Kolver** (HEAD OF ACCREDITATION) & **Florence Maphanga** (SENIOR ACCREDITATION ANALYST)

Healthcare brokers are highly specialised professionals who play many roles. They introduce you to private health cover. They tell you how to join a medical scheme. They provide ongoing advice to their existing clients – medical scheme members – about the benefits they are entitled to and the services offered by their scheme.

The bottom line is that brokers are there to represent members of medical schemes – and to always act in the members' best interests. As financial service providers, they are accredited to act as agents of their clients.

Upon joining a medical scheme, you can – but you do not have to – appoint someone as your broker. If you do, the broker signs a contract and service level agreement with your scheme.

Schemes pay brokers from the monthly contributions that members make to their scheme. The maximum remuneration of brokers is prescribed by law. The only other form of remuneration that brokers are entitled to is a direct payment from the member for additional services.

There are two kinds of healthcare brokers.

Independent advisors are not attached to any particular scheme. They have contracts with many schemes and provide their clients with a choice of cover. (Member agents and employer agents fall in this category.)

Marketing agents are tied to a particular scheme or group of schemes and promote only the products of their contracted scheme(s). (Here we refer to scheme agents and administrator agents.)

Employers may appoint a broker to advise those employees who belong to a medical scheme. Such a broker has to be independent.

Brokers are accredited by the Council for Medical Schemes (CMS) because they operate in the medical schemes industry. But because they are financial service providers, they must also be licensed by the Financial Services Board (FSB) for "health business" in terms of the Financial Advisory and Intermediary Services (FAIS) Act. FSB legislation provides for subordinate legislation that regulates the conduct of financial service providers and their fitness and propriety.

What do brokers do, exactly?

Healthcare brokers advise their clients on a wide range of issues, including the ways in which you can join a medical scheme – and why you should

do so in the first place. When they introduce you to private health cover, they must consider your healthcare needs and financial situation. Brokers also provide ongoing services to their existing clients in terms of an agreement between the broker and the scheme.

A broker can operate as an independent individual who holds a contract with one scheme only or s/he can function as an employee or representative of a larger entity (the so-called corporate broker working for a brokerage) which has a contract with many schemes.

Since marketing agents promote only the products of a particular scheme, they are expected to tell you the truth about these products. Independent brokers are expected to give beneficiaries best advice, cognizant of their needs and financial circumstances.

Before and after

Before the introduction of the Medical Schemes Act in 2000, healthcare brokers were not recognised by our legislation and schemes were not allowed to contract with them. The FAIS Act came into being soon thereafter, with overarching requirements for all financial service providers; the FSB started serving as a dual regulator for healthcare brokers.

Does the industry need brokers?

Healthcare brokers advise members on relevant and appropriate cover according to need and affordability. The law requires brokers to provide "best advice" and to always act in the "best interests" of their clients. The regulatory framework for intermediaries has developed to the extent that you are now well protected when you decide to use the services of brokers.

Provision is made for an ombudsman for the financial service sector who has powers to adjudicate on complaints. And brokers must comply with both Acts. If one regulator takes action against an intermediary, it also affects the status of said broker afforded by the other regulating authority.

Brokers are important. As case law and rulings develop in this field, we get to understand how regulators determine if brokers indeed act in the best interests of their clients at all times and in so doing, display honesty, integrity, and true expertise.

Brokers must realise that if they do not, they will pay a huge price.

Rights of beneficiary

- 1 You have the right to have all your human rights respected at all times.
- 2 Know your responsibilities towards brokers.
- 3 Know the rights and responsibilities of brokers towards you.
- 4 Decide if you need a broker in the first place – you do not have to use one if you do not want to.
- 5 Join a scheme without using a broker.
- 6 Choose who you want your broker to be, as long as s/he is qualified, accredited, and licensed.
- 7 Insist on the broker telling you if s/he is independent or tied.
- 8 Get clarity on the role and functions of the broker.
- 9 Peruse broker agreement with scheme.
- 10 Switch brokers if you are not satisfied with their service.
- 11 Verify broker credentials. Visit the websites of the CMS and/or FSB or contact our call centre.
- 12 There must be mutual consent between you and the broker in respect of extra services and payment of additional fees.
- 13 If the broker charges you additional fees, s/he must explain the nature and value of the service over and above what is covered by the agreement with the scheme.

Responsibilities of beneficiary

- 1 Know your rights towards brokers.
- 2 Respect the rights and responsibilities of brokers.
- 3 Check if the broker is accredited by the CMS.
- 4 Ensure the broker is licensed by the FSB to sell health business.
- 5 Fully disclose all information required in the membership application form.
- 6 Understand what the broker will do for you in terms of his/her agreement with the scheme.

Rights of broker

- 1 You have the right to have your rights respected at all times.
- 2 Balance your own interests with the best inter-

ests of beneficiaries.

- 3 Know your responsibilities towards beneficiaries who choose to use your services.
- 4 Know the rights and responsibilities of the beneficiary towards you.
- 5 Insist that applicants disclose fully the information you require.
- 6 Insist on obtaining all documentation needed to fill out an application form.
- 7 Insist on accurate and comprehensive information from the beneficiary.
- 8 Insist on the beneficiary being honest with you.

Responsibilities of broker

- 1 Put the beneficiary first.
- 2 Know your rights and responsibilities towards beneficiaries.
- 3 Respect the rights and responsibilities of beneficiaries towards you.
- 4 Introduce yourself properly. Are you an independent advisor? tied agent? medical scheme employee? Do you work for a brokerage which contracts with one or more schemes?
- 5 Establish a relationship of trust.
- 6 Always act in best interests of beneficiaries.
- 7 Obtain duly signed appointment letter from beneficiary.
- 8 Obtain all information to be able to properly assess needs and affordability of beneficiary, and advise him/her accordingly.
- 9 Ensure beneficiary is well-informed about scheme and its rules.
- 10 Do not make promises to the beneficiary on matters over which the scheme decides, e.g. waiting periods, late-joiner penalties, date of admission.
- 11 Clarify which services are excluded, e.g. submitting claims, handling enquiries, administration.
- 12 Keep up to date with developments in the industry, including the financial soundness of schemes, changes to benefits and contributions, and any factors which influence the relationship of the beneficiary with the scheme. ■

Regulators

Council for Medical Schemes (CMS) (www.medicalschemes.com);
Financial Services Board (FSB) (www.fsb.co.za)

Representative body

Financial Intermediaries Association of Southern Africa (FIA) (www.ibcsa.org.za)

Close to 10 000 healthcare brokers operate in South Africa today. To see who they are, visit our website.

Beneficiaries and healthcare providers

Beneficiaries and healthcare providers both have specific rights but also certain responsibilities. What are these and why do you need to know what they are?

By **Ronelle Smit**
(CLINICAL ANALYST)

Life forces us to make decisions about our health almost every day. These decisions influence our quality of life, general well-being, and finances. To protect our wellness and quality of life we often seek advice from professional healthcare providers such as general practitioners and specialists, nurses and pharmacists.

The relationship between a beneficiary and a healthcare practitioner is one of the most important professional relationships we will ever form. To make sure these are healthy, both parties need to play by the rules. The beneficiary and provider should work as partners where each has rights but also responsibilities and must honour their side of the agreement.

The Department of Health has published various documents to assist all stakeholders in the healthcare industry with the forming and nurturing of professional partnerships. It has, for instance, developed the Patients Rights Charter to ensure that the right to access care, as enshrined in the Constitution, is protected at all times; the Charter spells out the responsibilities of patients as well.

The Health Professions Council of South Africa (HPCSA), whose mandate is prescribed by the Health Professions Act (Act 56 of 1974), agreed to the Patients Rights Charter but went further: it published ethical guidelines for healthcare professionals to assist with the manner in which medicine is practised. These guidelines include the rights and responsibilities

of the healthcare professional towards his/her profession as well as patients. If you believe that your provider may have breached any of these ethical guidelines for behaviour and billing, you can lay a complaint with the HPCSA.

Provisions in the National Health Act (Act 61 of 2003) explain the rights and duties of both user and provider of healthcare. Section 6 of this Act states that providers must discuss the cost implications of treatment with you before they treat you – and that you must

consent to both the proposed treatment and the fee the provider wants to charge. The HPCSA provides more detail on which cost information exactly providers must give to patients before any treatment begins.

Important ruling on ethical tariffs

Last year the HPCSA scrapped the ethical tariffs which doctors used as a ceiling for charging patients. Retaining its authority to determine whether a practitioner has overcharged a patient or not, the HPCSA has adopted the following principles:

- If you don't belong to a medical scheme, a practitioner must charge you the National Health Reference Price List (NHRPL) rate, except where you give him/her written and informed consent to charge you more. Any charge above the NHRPL rate without your consent is overcharging.
- If you are a beneficiary of a medical scheme, a practitioner can charge you the rate payable by your scheme even if it is higher than the NHRPL rate. Any rate higher than the rate payable by your scheme shall be deemed as overcharging, except where you give written and informed consent for a charge higher than the medical scheme rate.
- The practitioner must show you three things to allow you to give informed consent: the prevailing NHRPL rate (if you are uninsured) or medical scheme rate (if you are insured), the difference between that rate and what the practitioner intends to charge, and the amount that you may have to pay in addition to the stipulated rate.

Rights of beneficiary

What is the NHRPL?

It may not be prescribed by law but the National Health Reference Price List is published by the Department of Health every year to guide healthcare providers on how much they should charge their patients and medical schemes.

- 1 Have all your human rights respected at all times, including your dignity, confidentiality, and privacy.
- 2 Know your responsibilities towards healthcare providers.
- 3 Know the rights and responsibilities of healthcare providers towards you.

- 4 Access healthcare, including:
 - timely emergency care at any facility that is open, regardless of your ability to pay;
 - treatment and rehabilitation;
 - provision for special needs (i.e. of newborn babies, children, pregnant women, the elderly, the disabled, people in pain, and people living with HIV or AIDS);
 - counselling for cancer, HIV/AIDS, violence, and assault; and
 - palliative care.
- 5 Be treated with respect and courtesy, patience and empathy.
- 6 Know all there is to know, including:
 - your health status;
 - the diagnostic procedures and treatment options available to you; and
 - the benefits, risks, costs, and consequences associated with each option.
- 7 Have information provided in a language you understand (no technical jargon).
- 8 Know the costs of equipment and treatment, including consultations, procedures, and follow-up care.
- 9 Refuse health services and have the implications, risks, and obligations of refusal explained to you.
- 10 Participate in decisions about your health and treatment.
- 11 Choose your health services provided that your choice will not contradict the ethical standards applicable to the provider.
- 12 Be treated only by providers you know and trust.
- 13 Insist on giving informed consent.
- 14 Get a second opinion from a provider of your choice.
- 15 Choose to continue care by a provider or

facility that treated you initially. No person may be abandoned or transferred without proper referral and handover.

- 16 Lay complaints.
- 17 Have your complaints investigated.
- 18 Negotiate the fees you will pay.
- 19 Amend the hospital indemnity form before signing it.

Responsibilities of beneficiary

- 1 You are responsible for your own health!
- 2 Know your rights towards healthcare providers.
- 3 Respect the rights and responsibilities of healthcare providers.
- 4 Use the healthcare system properly.
- 5 Do not initiate or participate in fraudulent behaviour.
- 6 Know thy PMBs (prescribed minimum benefits).
- 7 Know thy DSPs (designated service providers).
- 8 Be honest with your healthcare providers.
- 9 Listen to the providers. Comply with the treatment they prescribe.
- 10 Enquire about the cost of treatment.
- 11 Keep your health records safe.
- 12 Tell your service providers that you belong to a scheme.

Rights of healthcare provider

- 1 Have all your human rights respected at all times.
- 2 Know your responsibilities towards beneficiaries.
- 3 Know the rights and responsibilities of beneficiaries towards you.
- 4 Be treated without unfair discrimination (although conditions may be imposed on your services).

Split-billing v balance-billing

Split-billing (illegal): Provider charges twice for the same service by submitting more than one account for said service, e.g. a GP charges R1 000 for a consultation and submits one account for e.g. R200 to the scheme for the portion that is covered by the member's benefits, and another account for the remaining R800 to the member for the part which the scheme does not cover.

Balance-billing (legal): Provider submits one account for a service to either the scheme or member, or both, e.g. the GP charges R1 000 for a consultation and submits the account for R1 000 to either scheme or member, or both, but keeping both in the loop and ensuring there is transparency in the dealing. This account specifies how much the scheme must pay and the amount that the member must pay.

How you affect healthcare delivery

Patients have the responsibility to insist that their rights are respected. That way, they themselves benefit, their families benefit, and society at large benefits as well. The so-called PAGs are worth a mention.

Patient advocacy groups (PAGs) have become an important facet of healthcare infrastructure, nationally and internationally.

A patient advocacy group is commonly founded by a person living with or affected by a specific disease as a way of gaining control through collecting and disseminating information, educating others on the available care and services, and lobbying decision-makers in the regulatory and political arenas to address identified gaps.

In South Africa, disease-specific organisations register with the Department of Social Development to support patients and carers. The activities of these organisations are endorsed and guided by the Patients Rights Charter proclaimed by the Department of Health to ensure the realisation of a constitutional right; the Charter guarantees access to healthcare for all citizens of South Africa. It allows patients to be involved in policy development and decision-making regarding their health; it gives them the right to interrogate the benefits provided by medical schemes; it enables them to educate themselves about their health and options. The Charter further provides for a lawful, reasonable, and procedurally fair complaints process that can be followed by both public and private patients when seeking redress for poor treatment. The Charter is usually prominently displayed in both public and private healthcare facilities.

Various patient support organisations or "support groups" were instrumental in developing the Charter. They acted as watchdogs and dared to challenge both government and big international pharmaceutical companies in their endeavours to improve access to healthcare.

The beneficiary and watchdog agencies

The right to healthcare is enshrined in the South African Constitution. Recourse when this fundamental human right has been violated can be addressed with the South African Human Rights Commission, a national institution established to entrench constitutional democracy through the protection and promotion of human rights.

In a prominent case where an unemployed person in KwaZulu-Natal applied for state dialysis, the courts found that rationing of healthcare can be compatible with human rights, provided it is done in a transparent manner and the criteria are

reasonable and non-discriminatory. Numerous complaints regarding the appalling state of public healthcare delivery had prompted the Human Rights Commission to conduct a public enquiry into access to healthcare services.

PAGs take education very seriously, as evidenced by the information available on their websites, leaflets, and regular media reports. Through strategic association with experts in medicine, these organisations are able to provide the latest evidence-based information on diseases. Representatives of PAGs participate in the decision-making processes in the South African health landscape and have introduced the much-needed patient-centred approach to the regulatory approval of clinical research protocols, including the development of treatment protocols and guidelines for HIV/AIDS and, more recently, the review of the prescribed minimum benefits conducted by the Department of Health and the Council for Medical Schemes. It is common practice in Europe for PAGs to serve on the expert panels of reputable agencies that develop regulatory applications and treatment guidelines.

But the lack of skills and capacity, consistency and focus, and technical knowledge as well as an imbalance between emotional and fact-based campaigning can hamper the noble efforts of PAGs. These gaps are not unique to South Africa and can be addressed by PAGs forming stakeholder alliances that are based on mutual respect and integrity with ongoing education and information sharing.

Beware of the fakers

Some PAGs are not authentic. Instead, they are used by unscrupulous organisations as a front to promote their products or sell their propaganda.

How do you tell the villains from the law-abiding activists? Credible and capable PAGs share certain characteristics:

- They maintain independence.
- They are transparent about their alliances with stakeholders.
- They support education efforts and willingly share information.
- They refer patients to reputable (public or private) facilities or providers instead of helping fund individual treatments; decent PAGs include this disclaimer on their website and in their marketing material. ■

- 5 Insist on fair labour practices.
- 6 Hold back information if disclosure will not serve the best interest of the beneficiary.
- 7 Refuse to treat those who are verbally or physically abusive.
- 8 Be protected against injury and disease transmission.
- 9 Be compensated for occupational injuries and disease.
- 10 Insist on freedom of expression (which includes protection for whistle-blowing).
- 11 Hospital indemnity forms must be treated like legally binding contracts.
- 12 Hospitals are allowed to contract with ambulance services.

Responsibilities of healthcare provider

- 1 Know your rights and responsibilities towards beneficiaries.
- 2 Respect the rights and responsibilities of beneficiaries.
- 3 Respect patients' beliefs, opinions, wishes, and right to refuse treatment.



The relationship between a beneficiary and a healthcare practitioner is one of the most important professional relationships we will ever form.



- 4 In cases of emergency, take the patient to the nearest facility – do not look for their medical scheme membership card first.
- 5 Provide emergency medical treatment to any person, regardless of their ability to pay.
- 6 Make your patients' health your highest priority.
- 7 Honour your patients' trust.
- 8 Do not abuse your position of power.
- 9 Be open and honest. Tell patients about their condition, available treatment, and prognosis.
- 10 Obtain informed consent before performing any procedure.
- 11 Regard all patient information as confidential.
- 12 Obtain permission from patient to disclose confidential information. Permission from patient is not required only if withholding information can harm the public or if a court orders you to do so.
- 13 Do not discriminate on any grounds.
- 14 Declare any financial interest in institutions or diagnostic equipment.
- 15 Inform patients of the costs of treatment, care, medicine, and equipment. You must obtain written consent from the beneficiary to charge what you intend charging.
- 16 Speak the everyday language of the beneficiary and take into account his/her level of literacy.
- 17 Do not over-service beneficiaries (or over-charge schemes).
- 18 Prescribed minimum benefits (PMBs) are not blank cheques.
- 19 Keep it ethical and legal, e.g. avoid split-billing. ■

Regulators*

AHPCSA: Allied Health Professions Council of South Africa (www.ahpcs.co.za)
HPCSA: Health Professions Council of South Africa (www.hpcs.co.za)
MCC: Medicines Control Council (www.mccza.com)
SABS: South African Bureau of Standards (www.sabs.co.za)
SADTC: South African Dental Technicians Council (no website; e-mail sadtc@yebo.co.za)
SANC: South African Nursing Council (www.sanc.co.za)
SAPC: South African Pharmacy Council (www.pharmcouncil.co.za)

Representative bodies*

DENOSA: Democratic Nursing Organisation of South Africa (www.denosa.org.za)
DENTASA: Dental Technology Association of South Africa (www.dentasa.org.za)
HASA: Hospital Association of South Africa (www.hasa.co.za)
PIASA: Pharmaceutical Industry Association of South Africa (www.piasa.co.za)
PSSA: Pharmaceutical Society of South Africa (www.pssanw.co.za)
SADA: South African Dental Association (www.sadanet.co.za)
SAMA: South African Medical Association (www.samedical.org)
SAOA: South African Optometric Association (www.saoa.co.za)

* This list is not intended to be exhaustive and any omissions are unintentional.

By **Dr Nkuli Mlaba** (REF* CLINICAL ANALYST)

Patient support groups are registered by the Department of Social Development under the Nonprofit Organisations Act (Act 71 of 1997). According to their website (www.dsd.gov.za), there were 768 not-for-profit health organisations and 81 advocacy groups in South Africa in August 2009.

For a list of the support groups available to South African patients, visit www.npo.gov.za.

For a summary of your rights and responsibilities as a South African patient, see the Patients Rights Charter on the website of the Department of Health: www.doh.gov.za/docs/legislation/patients_right/chartere.html.

* REF is the Risk Equalisation Fund.

When you need to object

The Complaints Adjudication Unit at the Council for Medical Schemes (CMS) deals with complaints lodged by members against their medical schemes. The Unit does its part to ensure that beneficiaries are treated fairly.

By **Gugu Blose**
(COMMUNICATION
OFFICER)

Thembekile Phaswane (Manager: Complaints Adjudication)

Thembi describes herself as a hard worker dedicated to her job.

"Without neglecting my family, I continue working even when I am at home. I find nothing



more satisfying than knowing that my team and I protect the public."

How does her Unit work?

"We facilitate the resolution of complaints lodged by members of medical schemes and ensure that they are treated fairly. Where schemes are found to be contravening their rules or the Medical Schemes Act, we make a determination which is binding on both parties unless the party aggrieved by the judgment decides to appeal."

Thembi has been with the CMS since the beginning. She was appointed Manager of the Unit in 2006.

"It's comforting to know that I'm responsible for a team that is supportive and reliable."

Thembi also enjoys spending time with her family, travelling, and reading. She has recently taken up photography.

"I guard the collection of my works with my life. My favourite pieces are those taken during sunsets. I celebrate special moments and breath-taking views with my lens because I know that recorded images last forever."

Nontsikelelo Hlekiso (Administrator)

Known to her colleagues as "Ntsiki", this soft-spoken mother of two joined the CMS in October 2009. She receives and registers all complaints that come to the CMS.

"My job demands that I pay attention to the smallest of details and ensure that all complaints are passed on to the Legal Officers timeously."

Before joining the CMS, Ntsiki – who holds a BAdmin degree – was employed by the South



African Human Rights Commission (SAHRC). "I worked at the SAHRC for seven years. My work there revolved around helping people whose human rights had been violated. What I do here is more focused because the CMS deals only with complaints against medical schemes."

Ntsiki is clearly passionate about helping people and says she finds fulfilment in knowing that she plays a part in making a difference in others' lives. The biggest influence on her life was her grandmother, from whom she has inherited a strong sense of family. "I spend most of my free time with my 9-year-old son and 5-year-old daughter."

Anil Singh (Legal Officer)

Born and bred in Durban, Anil is an attorney. A quick poll among his colleagues in the office reveals

that he has a certain flair – a *je ne sais quoi*, if you will. He describes himself as snazzy and fun.

Although Anil lost his parents at a very young age, he credits them for the grounding and guidance they have given him. "My choice to study law was inspired by my parents. They would always be



lending a helping hand in our community and I think their example cultivated the person I have become and the career I have chosen."

Anil has been with the CMS for three years. He describes each day as a learning curve. Chuckling with delight, he confesses to his other passion: "I love to cook. If I hadn't become a lawyer, I would have been a chef."

Themba Nhlapo (Legal Officer)

Always ready with a joke that is bound to leave you in stitches, Themba hails from Kwa-Thema, a township near Springs on the East Rand. He has been with the CMS for just over a year.

Themba describes his career as his calling. Like Ntsiki, he worked at the Human Rights Commission before joining the CMS family. He says he finds the work at the CMS challenging. "But the fulfilment that comes from successfully assisting a client is what motivates me to keep on doing what I do."

A devout Christian, Themba is blessed with a

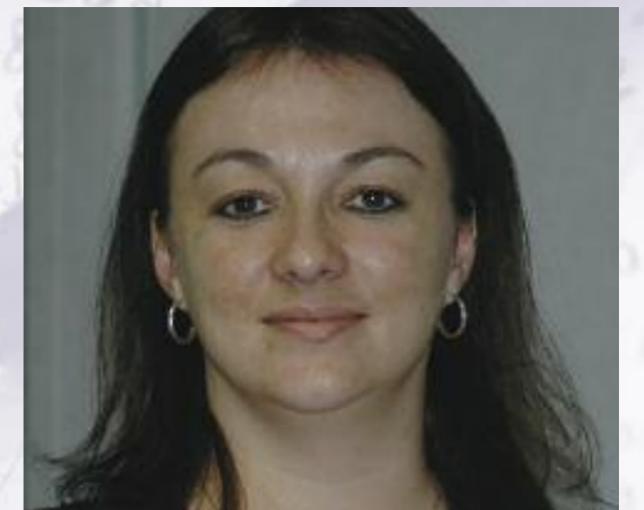


talent for the arts; he is a poet, a singer, and a stand-up comedian. No wonder he thinks of himself as "versatile". And on top of being an accomplished performer, this father of two is a devoted family man who recently married the love of his life, Lindiwe.

Melani Winkler (Legal Officer)

"I am positive and energetic. I enjoy the challenges that life and work throw my way."

Melani is the most recent addition to the



Unit. She joined us in December of 2009 after seven years in the insurance industry.

This recently married lawyer has a soft spot for animals; she listed an impressive catalogue of animal breeds when we asked her about her pets. She also enjoys music and "would love to understand what makes a music legend tick".

"I play the piano in my spare time. But my typical downtime activity is spending time with family and friends and there is no better way to do that than having a braai."

Amos Mavuso (Legal Officer)

After attaining his B.proc and LLB at the then University of Natal, Amos started off his career as a legal practitioner at the Nelspruit Justice Centre. He then moved to the Office of the Public Protector and the Human Rights Commission



where he helped to set up the provincial office in his home province of Mpumalanga. He joined the CMS in 2005.

"The secret to complaints adjudication and management is tenacity and patience," he told CMS

News. "It is our role to be compassionate and persistent."

Although Amos finds the job emotionally taxing and urges the public to differentiate between the CMS and their medical scheme, he has discovered that he is able to give each case his best.

In his downtime Amos enjoys spending time with his family and friends.

Louis Pautz (Legal Officer)

Louis started his career at what was then called the Department of Water and Forestry as a Legal



Officer after attaining his B.proc. He was with them until 2007 when he joined the CMS.

Louis says he enjoys both the challenges and the rewards of his work at the CMS. "I like helping people so this job is ideal for me."

Louis is known for his easy-going nature, dry sense of humour, and love for the great outdoors. He describes himself as "a good bloke to have around".

When he is not at the office, Louis can be found at home, with his wife of 10 years. "My wife and I enjoy a very active lifestyle. We take part in weekend runs or go to the gym. My job is highly stressful so I try to make sure that my personal life relaxes me and keeps me motivated." ■

Reception

t: +27 (0)12 431 0500

f: +27 (0)12 430 7644

Customer Care Centre

t: 0861 123 CMS (267)

Resource Centre

t: +27 (0)12 431 0530

f: +27 (0)12 430 7644

e: information@medicalschemes.com

Use our website to:

- view lists of registered schemes as well as accredited brokers, managed care organisations, and scheme administrators in South Africa;
- download information (forms, the Medical Schemes Act 131 of 1998 and its Regulations etc.);
- read the latest news, developments, and upcoming workshops; and
- lodge a complaint online.

Complaints

t: 0861 123 CMS (267)

f: +27 (0)12 431 0560 / +27 (0)12 430 7644

e: complaints@medicalschemes.com

Complaints procedure

- First, complain to your scheme. Phone the scheme or write to the Principal Officer. Give full details of your complaint and include any supporting documents.
- If you are not satisfied with the outcome of your complaint to the scheme, complain to the Registrar of Medical Schemes (in writing).
- If you are aggrieved by the decision of the Registrar of Medical Schemes or by the decision of the scheme's disputes committee or by any other decision relating to the settlement of your complaint, appeal to the Council.
- If you are aggrieved by the decision of the Council, appeal to the Appeal Board.

How to avoid complaints

- Make sure you know and understand the rules of your scheme.
- Read all correspondence from your scheme.
- Study your benefits guide.
- Familiarise yourself with the terms and conditions of the benefit option that you have chosen.
- Make sure your contributions are paid in full and on time every month.

This newsletter is printed on environmentally friendly paper.

Reading matter

Between 1 November 2009 and 28 February 2010, we published various documents on our website, including:

- One document on the Risk Equalisation Fund (REF)
- 2 documents on the Risk Equalisation Technical Advisory Panel (RETAP)
- One quarterly report on the performance of medical schemes
- 17 Circulars
- 3 press releases
- PDF of the second issue of our paper-based external newsletter *CMS News* for 2009-2010, its theme *Why South Africans join medical schemes – and why they don't*
- 2 issues of CMScript, our e-newsletter dedicated to prescribed minimum benefits (PMBs)
- 10 guidelines and manuals
- 6 judgements on appeals
- 5 documents for administrators
- 2 documents for managed care organisations
- 12 documents for brokers
- 15 different application forms

Visit www.medicalschemes.com for so much more.



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