

THE COUNCIL FOR MEDICAL SCHEMES
APPEAL COMMITTEE

In the matter between:

GENESIS MEDICAL SCHEME

Appellant

and

REGISTRAR OF MEDICAL SCHEMES

Respondent

APPEAL RULING

1. The appellant, Genesis Medical Scheme, has appealed in terms of section 49(1) of the Medical Schemes Act, 131 of 1998 ("the Act") against a ruling of the respondent, the Registrar of Medical Schemes, in terms of which the respondent declined to approve and register the appellant's revised rules and benefit options for 2006.
2. The decision of the respondent that forms the subject matter of this appeal was contained in a letter to the applicant dated 25 April 2006.
3. The appeal is opposed by the respondent.

The respondent's preliminary objection

4. The respondent initially contended that the appeal had not been lodged timeously as it was, in substance, an appeal against an earlier decision by the respondent communicated to the applicant in a letter dated 10 November 2005 in which the respondent declined to register what it describes as the appellant's *"first rule amendment"*.
5. The respondent's contention was that the second rule amendment was *"in substance the same as the first rule amendment"* and that consequently the current appeal is, in effect, an appeal against the initial ruling.
6. The respondent has now abandoned this objection to the validity of the current appeal. In light of the fact that the respondent entertained the second rule amendment independently from the first, and issued a second ruling thereon, rather than declining to rule on the basis that his original ruling applied also to the second rule amendment, it appears that the abandonment of this objection was advisable.
7. There were no further objections to the validity of the appeal or to the jurisdiction of the appeal committee to consider it.

The nature of the appeal

8. Having dispensed with this preliminary objection the first rule amendment has no further relevance to this appeal. The current, or

second, rule amendment with which this appeal is concerned is referred to hereafter as "*the proposed rule amendment*".

9. It is common cause between the parties that the current appeal is a "wide appeal" within the meaning ascribed to that term in **Tikly and Others v Johannes N.O and Others 1963 (2) SA 588 (T)**.

10. In terms of that judgment a wide appeal is:

"A complete re-hearing of, and fresh determination on the merits of the matter with or without additional evidence or information." (at 590G)

11. The effect of the foregoing is that the appeal committee is not constrained to assess the correctness of the respondent's decision to decline to register the proposed rule amendment. The appeal committee must decide whether or not the proposed rule amendment ought to be registered, having due regard to the provisions of the Act.
12. This notwithstanding, the obvious departure point for such an enquiry is an assessment of the contentions advanced by the respondent in support of his ruling, and in his submissions during the course of this appeal.

The proposed rule amendment

13. Before assessing those contentions, it is useful to set out what it is that the proposed rule amendment entails.

14. The appellant's proposed rule amendment, submitted to the respondent for registration on 19 April 2006, seeks to offer the appellant's members three benefit options:

14.1. The first option, known as the "private" option, offers a hospital plan with Major Medical Illness ("MMI") cover limited to R500 000,00. In terms of this option, medical providers treating members will be reimbursed at the private rate as defined in the appellant's amended rules which is equal to the National Health Reference Price List ("NHRPL") plus 250%. Members electing the private option will make no contribution to any personal Medical Saving Account ("MSA") and will not be covered for any out-of-hospital treatments or expenses other than those included in the Prescribed Minimum Benefits ("PMBs").

14.2. The second option, known as the "private plus" option, includes the same benefits and hospital plan as those offered under the private option but also provides for cover for specified out-of-hospital benefits and expenses, to be funded from the member's MSA. MMI cover remains limited to R500 000,00 and the rate of reimbursement to medical providers is the same as that offered under the private option. Annual contributions to the MSA are fixed at R1 740,00 per member.

- 14.3. The third option, known as the "private comprehensive" option, provides members with a hospital plan which differs from the other options in that medical providers are reimbursed at the NHRPL rate plus R350% (as opposed to 250%); and the MMI benefits are capped at R550 000,00 (as opposed to the R500 000,00 offered under the first two options. In addition to the MSA provided for under the private option, the private comprehensive option provides for a Self-Managed Fund ("SMF") to which members selecting this option will contribute an amount of R2 150,00 per annum.

The respondent's objections

15. The basis of the objections that the respondent has to the proposed rule amendment may be summarised as follows:

15.1. In the private comprehensive option (the third benefit option under the proposed amended rule), the SMF is in effect an extension of the MSA, with the effect that contributions to the MSA/SMF exceed 25% of the members' gross contributions, which is impermissible in terms of Regulation 10(1) of the Regulations promulgated in terms of the Act.

15.2. Because the underlying risk benefits in all three benefit options are in essence identical, members' contributions to

the various options vary on the basis of an MSA or SMF, and not on the basis of income or number of dependents as prescribed in section 29(1)(n) of the Act;

- 15.3. The appellant's benefit options are designed in such a manner that the aged and sickly are likely to pay significant amounts for out-of-hospital expenses and are therefore likely to be "*systematically excluded*" from the scheme on a basis which relates to their age and health status, in contravention of section 31(3)(a) of the Act read with section 24(2)(e).

The SMF is an extension of the MSA

16. The question as to whether or not the SMF provided for in the appellants' proposed rule amendment is an extension of the member's MSA is relevant only to the decision as to whether the third benefit option, the private comprehensive option, should be registered. The first and second benefit options do not provide for an SMF.

17. The basis upon which the respondent contends that the SMF is an extension of the MSA is as follows:

- 17.1. As with the MSA, the SMF is a 'rand-for-rand' benefit, in that the value of the benefit equals the value of the contributions.

- 17.2. The element of risk involved in the SMF is insignificant as it

occurs only where the member takes selects the benefit but fails to make use of the full limit thereof.

17.3. Although any surplus that accumulates in a member's SMF is forfeited at the end of each year, this is insignificant in that the possibility that such a surplus will accrue is remote.

17.4. The combination of the low limits in the risk benefits and the 'rand-for-rand' character of the SMF means that it cannot be seen as anything other than an extension of the MSA which has been created in order to circumvent the 25% limitation in Regulation 10.

18. The respondent does not contend that the concept of an SMF is inherently objectionable in all circumstances.

19. As indicated above, MSA's are regulated by Regulation 10 of the Regulations promulgated in terms of the Act. The characteristics of a MSA emerge from that Regulation. They are as follows:

19.1. The limit on contributions into a personal MSA apply to each individual member of a medical scheme (Regulation 10(2));

19.2. The funds in a member's personal MSA may be used by that member and his dependents only. They may not be used to off-set contributions but may be used to off-set debts owed by that member at the date of termination of membership

(Regulation 10(3));

19.3. The funds accrued in a member's personal MSA are never forfeited. They are transferred to new medical schemes or benefit options where applicable, or refunded to the member where a membership of a medical scheme or benefit option is terminated and not replaced with equivalent membership (Regulation 10(5)).

19.4. No part of the funds in a MSA may be used to pay for the costs of prescribed minimum benefits.

20. The appellant has drawn attention to specific features of the SMF provided for in its private comprehensive option that it says have the effect of differentiating the SMF from the MSA. These are as follows:

20.1. SMF funds may only be accessed after MSA funds are exhausted;

20.2. An accumulated balance in a MSA may be withdrawn or transferred whereas an accumulated balance in an SMF is forfeited to the Scheme and used to fund the risk benefits of all members;

20.3. Funds to a member's credit in a SMF at year-end may not accumulate or roll over to the following year;

- 20.4. A deficit in a SMF is not recoverable by the scheme following termination of the member's membership;
- 20.5. The SMF facility is available only in the private comprehensive option in which the risk benefits borne by the appellant are greater than is the case with the other two benefit options;
- 20.6. The increased risk carried by the appellant with regard to members of the private comprehensive option has the effect that contributions to the SMF cannot therefore be considered on a 'rand-for-rand' basis.
21. The respondent contends that no member of the appellant will select the private comprehensive option, which includes the SMF, unless that member expects to use the full benefit afforded thereby. The respondent states that such members will, as a result of the exercise of their discretion, exhaust the cover up to the limit in most cases, and will only in exceptional cases not reach the limit.
22. The respondent has not provided empirical support for its contentions in this regard. Not all members of a medical scheme are similarly placed. Medical expenses differ between members, and differ for each member on a year-to-year basis. The suggestion that members are able to accurately predict and anticipate their medical expenses for a particular year, and on that basis make a reliable

decision as to whether or not they require an SMF seems, to the Appeal Committee, to over-simplify matters.

23. Furthermore, unlike the situation that previously prevailed, where the appellant's rules provided for 12 different contribution levels within a single option, the contribution level to the SMF under the proposed private comprehensive option is fixed. This means that members cannot tailor their contribution to meet their anticipated need, but can, at best, decide whether they will have any need for the benefits for which an SMF would provide or whether they would rather self-fund such risks outside of their membership of the scheme.
24. It has therefore not been shown by the respondent that "*the possibility that a surplus will accrue to the scheme is exceedingly remote*". The resultant conclusion drawn by the respondent, that the distinction between the MSA and the SMF is therefore one of form rather than substance is therefore questionable.
25. There is clearly an element of risk involved in the selection of an SMF by a member, which risk distinguishes the SMF from a MSA, notwithstanding the fact that the two funds are used to pay for benefits only to the extent of the value of contributions.
26. In the above circumstances the Appeal Committee does not accept that the SMF is nothing more than an extension of the MSA, and does not agree that the private comprehensive option should be

rejected solely for this reason.

The basis upon which contributions are determined

27. The next contention by the respondent that requires consideration is that the proposed rule amendment contravenes the provisions of section 29(1)(n) of the Act in that there is no significant difference between the underlying risk benefits in each of the benefit options, but the contributions to each option vary on the basis of the election of a MSA or SMF, a factor which is neither income nor number of dependents nor both.
28. In terms of section 29(1)(n), the Rules of a medical scheme must make provision for

“The terms and conditions applicable to the admission of a person as a member and his or her dependents, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependents or both the income and the number of dependents, and shall not provide for any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant’s dependents, the frequency of rendering of relevant health services to an applicant or one or more of the applicant’s dependents other than for the provisions as prescribed.”

29. The purpose of section 29(1)(n) is clear. It is to prevent schemes from determining the contribution levels payable by members who receive the same benefits on a differentiated basis according to one

of the factors or considerations listed in the sub-section. The provision would, by way of illustration, be breached by a rule that provides that women selecting a particular benefit option would pay a lower contribution than men selecting the same benefit option.

30. It is not contended by the respondent - and it could not be a correct interpretation of section 29(1)(n) - that a scheme is obliged to levy the same contribution in respect of different benefit options offering differing benefits. It is in any event trite that many, if not the majority, of registered medical schemes offer more than one benefit option, with different contributions for each option.
31. The respondent's contention is somewhat different. It contends that there is no material or significant difference between the three options envisaged in the proposed rule amendment. Consequently, it submits, these three options should be treated as if they were one, and the result is that there is a variable contribution level within what is effectively one benefit option, which variation is dependent on contributions to the MSA or SMF, and not on income or number of dependents.
32. The requirements for approval of benefit options are contained in section 33 of the Act.
33. Section 33(2) provides as follows:

“The Registrar shall not approve any benefit option under this section unless the Council is satisfied that such benefit option –

- (a) includes the prescribed benefits;*
- (b) shall be self-supporting in terms of membership and financial performance;*
- (c) is financially sound; and*
- (d) will not jeopardise the financial soundness of any existing benefit option within the medical scheme.”*

34. As has been submitted by the appellant, there is no requirement in the Act that a benefit option, in order to obtain approval from the respondent, must offer benefits that are substantially different from the other benefit options available to members of a scheme. There is thus no statutory basis for the contention by the respondent that benefit options that offer benefits that are similar should for the purposes of registration be treated as one option.

35. In any event, the contention by the respondent that the benefit options are *“in essence identical”* is not sustainable.

36. That contention is based, at least in part, on the assertion that the SMF offered in the private comprehensive option is not a risk benefit but is an extension of the MSA, a contention which, for the reasons set out above, has been rejected by the Appeal Committee.

37. The respondent has urged the Appeal Committee to disregard the

increase in MMI cover from R500 000,00 to R550 000,00, as between the private plus option and the private comprehensive option. It has also urged the Committee to disregard the increase in the rate of reimbursement of medical providers from NHRPL plus 250% to NHRPL plus 350%. The appellant, on the other hand, contends that the effect of these two increases is that members who select the private comprehensive option are provided with a *“considerably enhanced hospital plan which is distinguishable from the hospital plan and risk benefits offered under the first two options”*

38. Given that there is no statutory requirement that requires the options offered under different benefit options to be substantially different, it is not necessary for the Appeal Committee to decide whether the differences referred to above are *“considerable”*, as alleged by the appellant, or *“window-dressing”* as alleged by the respondent.
39. That is a decision for the members of the scheme to make in selecting the benefit option that they prefer. Members who believe that the private comprehensive option does not provide an increase in benefits commensurate with the increase in contributions will decline to select that benefit.
40. In any event, the significant difference between the benefit options and consequently between the contributions payable, arises from the existence of the MSA and, in respect of the third option, the SMF.

There is thus not a situation where members are required to pay different contributions for the same package of benefits, as would be prohibited by section 29(1)(n).

41. The Appeal Committee therefore concludes that the respondent's objection to the proposed rule amendment on the above ground cannot be upheld.

The proposed rule amendment discriminates unfairly

42. The next of the respondent's contentions that requires consideration may be described as the "discrimination" objection. That objection is summarised by the respondent (with reference to the evidence of Van den Heever) in the following terms:

"It is submitted that the evidence presented shows that individuals in the older age category have to pay significant amounts, effectively out of pocket, for out-of-hospital expenses under the second rule amendment. It would become increasingly expensive for older and sicker people to stay in the Genesis benefit options. These people will leave to join genuine comprehensive options in other medical schemes, i.e. they will be systematically excluded on a basis directly related to their age and health status."

43. The respondent proceeds from this submission to argue that the benefit options are, as a consequence, unfair to older and sicker members and are thus in contravention of section 31(3)(a) of the Act.

The respondent contends further that the unfairness in question has a disproportionate effect on the old and sicker members which amounts to unfair discrimination in contravention of sections 24(2)(e) and 29(1)(n) of the Act.

44. The first question to be answered in this regard concerns whether or not “unfairness” or “unfair discrimination” constitutes a basis for the refusal of the registration of an amendment to the Rules of a medical scheme.

45. Section 31(3) of the Act provides as follows:

“On receipt of a written notice from a medical scheme setting out the particulars of any amendment or rescission of its rules, certified by the principal officer, the chairperson and one other member of the board of trustees as having been adopted in accordance with the provisions of the rules of the medical scheme, the Registrar shall –

(a) if he or she is satisfied that the amendment or rescission of the rules will not be unfair to members or will not render the rules of the medical scheme inconsistent with this Act, register the amendment or the rescission of the rules and return it to the medical scheme with the date of registration endorsed thereon.”

46. The section thus envisages two bases for the refusal to register an amendment to the rules of a scheme, namely:

46.1. unfairness to members; and

46.2. inconsistency with the Act.

47. There is, in the view of the Appeal Committee, no question that the respondent can refuse to approve an amendment to the rules of the scheme that is unfairly discriminatory. Section 24(2)(e) provides that no medical scheme shall be registered under this section unless the Council is satisfied that:

“The medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health”.

48. There is, in the Appeal Committee’s view, no merit in the appellant’s contention that this provision is relevant only when the initial registration of a medical scheme is considered. It cannot seriously be contended that the respondent should, for example, be compelled to accept for registration an amendment to the rules of an existing scheme which has the effect of the complete exclusion from membership of the scheme persons of a particular race, gender or sexual orientation. Such an amendment would bring about a situation where a medical scheme is registered under the Act, notwithstanding the fact that it discriminates against certain persons, which is clearly inconsistent with section 24(2)(e) of the Act.
49. That the registration of the amendment would, in those

circumstances, bring about this inconsistency would be an adequate basis for the respondent to refuse to register the amendment.

50. In the above example, the respondent could also refuse to register the amendment on the basis of the second enquiry, namely unfairness to members. The introduction of such an amendment where no equivalent previously existed would be unfair to the existing members of the scheme who belonged to the excluded race, gender or sexual orientation. The amendment would have the effect of precluding their future, or ongoing, membership of the scheme, and this would, unquestionably be unfair to them.
51. The effect of the above analysis is that the respondent would be entitled (and, as contended by the respondent, in fact obliged) to decline to register the proposed rule amendment if its effect is unfair on older and sicker members of the scheme, within the meaning of section 31(3)(a), or if the benefit options are unfairly discriminatory within the meaning of section 24(2)(e).
52. The next question that arises for decision is whether or not the benefit options in question have this effect.
53. The basis for the respondent's contention that the proposed rule amendment is unfair and would introduce unfair discrimination lies in the evidence presented to the Appeal Committee on behalf of the respondent by Alex van den Heever.

54. Disputes have arisen between the parties concerning whether or not Mr Van den Heever should be treated as an expert witness; whether or not all or any of his evidence is admissible; and in the event that any of his evidence is found to be admissible, the weight that should be accorded thereto.
55. To the extent that it is necessary to do so, these questions will be addressed in due course.
56. Van den Heever's contentions may be summarised as follows:
- 56.1. The appellant has designed its benefit options in a manner that excludes from the risk benefits the majority of out-of-hospital expenses;
- 56.2. The aged and the sickly incur higher out-of-hospital expenses than those members who are younger or healthy.
- 56.3. Membership of the appellant will therefore not adequately address the needs of the aged and sickly who will, as a result, *"be systematically excluded from the scheme on bases directly related to their age and health status"*.
- 56.4. That this will occur is demonstrated by reference to the current demographics of the appellant as compared with that of the industry, which demonstrates that the appellant, indeed, has a lower age profile than other schemes.

57. At the outset it should be observed that the submission that the aged and sickly would be “*systematically excluded*” from the appellant cannot be accepted. At best for the respondent, Van den Heever’s evidence, if accepted, would demonstrate that the design of the appellant’s benefit structure favours younger and healthier persons and that the aged and sickly would be disinclined for this reason to join the appellant’s scheme. They are not excluded from doing so, but would, if the evidence is accepted, be disinclined to do so.
58. The question that then arises is whether the structuring of a scheme in a manner that is more attractive to younger or healthier people is either unfair or amounts to unfair discrimination. The appellant’s contention is that it does not.
59. The respondent has referred to the decision in **Langemaat v Minister of Safety and Security and Others 1998 (3) SA 312 (T)** as authority for the proposition that unfair discrimination by a medical scheme is prohibited. The key difference between the situation in **Langemaat** and the current appeal is that in the former dispute, the complainant sought to assert her constitutional right to equality and to be protected from unfair discrimination. The respondent in the current appeal has not sought to assert a constitutional principle, but has relied instead on the internal prohibition against discrimination contained in the Act.

60. Because of the similarity in wording between section 24(2)(e) of the Act and sections 9(3) and (4) of the Constitution of the Republic of South Africa, Act 108 of 1996, there may be an inclination to import the test used to determine discrimination in a constitutional context when considering contraventions of section 24(2)(e).
61. Whilst there can be no doubt that many of the principles and approaches developed in a constitutional context will be of application, the approach taken in those cases cannot be applied to an interpretation of the Act without modification.
62. The reason for this is as follows: The approach developed by the Constitutional Court, as expressed in its judgment in **Harksen v Lane N.O 1998 (1) SA 300 (CC)** provides that the establishment of differentiation on one of the listed grounds contained in section 9(3) of the Constitution is sufficient to raise a rebuttable presumption of unfair discrimination. A finding of unfair discrimination does not conclude the analysis, however, since a provision that is found to discriminate unfairly may still be rescued by the justifiability test enshrined in the limitations clause (section 36) of the Constitution.
63. There has been considerable debate, the details of which need not be reproduced in this ruling, as to whether the assessment of unfairness and the assessment of justifiability require separate enquiries and, if so, what the content of the different enquiries should

be.

64. The Act, however, contains no equivalent to section 36 of the Constitution. The result is that the sole enquiry into whether a discriminatory measure is acceptable concerns the assessment of whether or not it is unfair.

65. The purpose of the fairness assessment in this context is to distinguish between permissible and impermissible discrimination. The test established in **Harksen** in this regard considers the following factors:

65.1. The position of the complainants in society, whether they have suffered from past patterns of disadvantage, and whether the discrimination is on a listed ground;

65.2. The nature of the provision or power and the purpose served to be achieved by it. If it is aimed at achieving a worthy social goal and not at impairing the complainants it may be fair;

65.3. With due regard to (a) and (b) and other relevant factors, the extent to which the complainants' rights or interests have been affected, whether this has led to an impairment of their fundamental human dignity or constitutes an impairment of a comparably serious nature.

66. The test for fairness focuses on the impact of the discrimination on the person complaining of it. It calls for a contextual approach and it emphasises the value of dignity.
67. As has been seen above, if Van den Heever's evidence is both admissible and correct, then the appellant's benefit structure disadvantages the aged and sickly relative to the young and healthy. There is no suggestion of express, or direct discrimination. But a system that favours one group over another differentiates between those groups. That differentiation, Van den Heever tells us, is on the basis of health and age. Since both of these are listed grounds in section 24(2)(e), if the **Harksen** test is applied the differentiation will be presumed to be discrimination and will furthermore be presumed to be unfair.
68. The presumption of unfairness is, however, not conclusive or irrebuttable. An enquiry into the fairness of the discrimination is still required. At best the onus, if there is indeed an onus in these proceedings, may shift.
69. Van den Heever's contention is that the unfair discrimination arises from the design of benefit options in such a way that the majority of out-of-hospital expenses are excluded from the risk benefits and are required to be self-funded by the member, either through the MSA or the SMF.

70. There are, however, a number of factors that would indicate that Van den Heever's contentions, even if accepted, do not establish that the discrimination in question is unfair.
71. The first of these factors emerges from the fact that it is permissible for medical schemes to offer hospital plans only.
72. This emerges from clauses 4.6 and 4.7 of a document entitled "*Analysis of Contributions and Benefits of Registered Medical Schemes for the Year 2006*", produced by the Council for Medical Schemes in May 2006. (Bundle B of the Record, p45).
73. Any scheme that offers only a hospital plan requires its member to self-fund their out-of-hospital expenses (with the exception of the prescribed minimum benefits, to which further reference is made below). Whether such members fund these expenses privately and independently from their medical schemes, or whether they do so through their medical schemes on a 'rand-for-rand' basis using a medical savings account is immaterial.
74. On Van den Heever's thesis, because the aged and sickly have greater out-of-hospital expenses than the young and healthy, every scheme that only offers a hospital plan discriminates unfairly against these people. If that contention were correct, it would be expected that the Act would prohibit schemes from offering hospital plans only, or that the respondent would, acting in terms of section 24(2)(e)

refuse to register such schemes.

75. That this is not the case is an indication that such schemes, whilst discriminatory in the sense that they are less advantageous to the old and sickly, are not unfair.
76. The second factor that suggests that the discrimination that will allegedly be introduced by the proposed rule amendment will not be unfair concerns the prescribed minimum benefits. The purpose of the inclusion of the prescribed minimum benefits in the Act, and the requirement that all schemes are obliged to meet the costs associated with these benefits, is to ensure that no scheme structures its benefit options in such a way so as to require members to self-fund what are considered to be the essential benefits that members can expect from their medical scheme.
77. By defining a category of prescribed minimum benefits, and removing the scheme's discretion with regard to these benefits, the Act creates a structure whereby the decision as to whether or not to include other benefits in the risk benefits is left to the discretion of the scheme.
78. Where a scheme, such as the appellant, exercises that discretion in such a manner that it excludes most out-of-hospital expenses from its risk benefits, it would seem to be unreasonable to accuse that scheme of unfairness. The prescribed minimum benefits themselves must be taken as the yardstick of what is considered to

be fair. There would appear to be no basis for imposing an additional burden on medical schemes by requiring them to provide comprehensive cover beyond the prescribed minimum benefits.

79. The third consideration in assessing the fairness of the appellants' proposed amendments involves an assessment of the impact of the discrimination, within the meaning of the **Harksen** decision.

80. Van den Heever presented no evidence to the Appeal Committee to demonstrate that the appellant's scheme was favoured by healthy as opposed to sickly persons. The evidence presented by him to establish that it was favoured by younger rather than older people was contested, but even if his evidence in this regard is both admissible and accepted:

80.1. the evidence does not show a dramatic difference between the age profile of the appellant's members and the average in the industry;

80.2. the evidence reflects the existing position with regard to the appellant's membership, and is thus of very little value in assessing what the impact of the proposed rule amendment might be;

80.3. the evidence draws no distinction between the personal circumstances of elderly individuals. If Van den Heever's

contentions are accepted then the persons affected by the discrimination are not simply the elderly, but that sub-section of the elderly who have increased medical expenses as a result of their age, and in respect of whom these increased expenses are out-of-hospital expenses that fall outside of the prescribed minimum benefits. Van den Heever's evidence cannot identify or analyse this sub-category of aged members.

81. Thus, even if Van den Heever's evidence were to be accepted, it has not been demonstrated that the discrimination that he contends for has an impact that is severe enough for it to be considered unfair. In any event, since the rules of a medical scheme are not akin to a law of general application, it is always open to the complainants to 'vote with their feet' by selecting another medical scheme.
82. The last factor to be considered in assessing fairness concerns the impact on dignity.
83. The nature of the discrimination contended for by the respondent is such that it has a financial effect on those adversely affected thereby. It is difficult to see how that impact can be elevated to an assault on the dignity of the affected persons. Although dignity is not the only factor to be taken into account when assessing unfairness, the approach of the Constitutional Court has made it clear that it is a

significant factor. No impairment of dignity has been demonstrated in this appeal.

84. Taking into account the factors referred to above, it is the view of the Appeal Committee that even if it can be contended that the provisions are discriminatory they are, in the context of the Act, and the benefits themselves, not unfair.

The admissibility of Van den Heever's evidence

85. The approach taken by the Appeal Committee has the effect that it has become unnecessary to decide whether the evidence of Van den Heever is admissible. This is because such evidence, even if it is admissible, would not have the effect that the respondent's contentions concerning the unfair discriminatory affect of the proposed rule amendment have been established.

Unfairness to members in terms of s31(3)(a)

86. The analysis conducted above with regard to unfair discrimination, and the conclusions reached therein, apply equally, in the Appeal Committee's view, to the question of whether the benefit structure is unfair to members of the scheme within the meaning of section 31(3)(a) of the Act.

87. To this latter question, however, can be added the following: In order to demonstrate that a rule amendment is unfair to existing members of a scheme, it would have to be shown that as a result of that amendment those members were in a worse position than then had been prior to the amendment. Where the complaint is the exclusion of out-of-hospital expenses from the risk benefits, and that exclusion is already in existence in terms of the current rules, any unfairness cannot be argued to be the result of the amendment sought by the appellant.

Conclusion

88. The Appeal; Committee thus concludes that none of the bases upon which the respondent refused to register the appellant's proposed rule amendment has been shown to be justified. The Appeal Committee is not aware of any other basis upon which the proposed rule amendments should be refused.
89. In the circumstances, the appeal succeeds and the respondent is directed to register the appellant's proposed rule amendment.

DATED AT SANDTON THIS _____ DAY OF DECEMBER 2006

P R JAMMY

FOR: THE APPEAL COMMITTEE