THE COUNCIL FOR MEDICAL SCHEMES APPEAL COMMITTEE

In the Appeal between:

SAMWUMED	Appellant
and	
PA	Respondent

RULING

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1. This appeal brings into focus a shortcoming in the Medical Schemes Act, 131 of 1998 ("the Act") which has the effect that medical schemes may, in certain circumstances, be obliged to meet the full cost of treatment provided by service providers despite the fact that fees charged may at times be up to three times higher than the National Health Reference Price List (NHRPL).

2. Regulation 8(2)(b) of the regulations promulgated under the Act provides that no co-payment or deductible is payable by a member of a scheme if a service in respect of a prescribed

minimum benefit ("PMB") condition is involuntarily obtained from a provider other than a designated service provider ("DSP").

3. Regulation 8(3) provides that such a service will be deemed to have been involuntarily obtained if:

3.1. it was not timeously available from a DSP;

3.2. medical or surgical treatment for a PMB condition was required under circumstances or applications which reasonably precluded the beneficiary from obtaining such treatment from a DSP; or

3.3. there was no DSP in reasonable proximity.

4. The Respondent in this appeal, rendered services to a member of the Appellant at Kingsbury Hospital in Claremont Cape Town. At issue in the appeal is the Respondent's account for his treatment of the respiratory distress which the member's baby developed shortly after birth. Kingsbury Hospital is a DSP of the Appellant, the Respondent is not.

5. When presented with the Respondent's account the Appellant sought to restrict payment thereof to the maximum amount allowed in the tariff adopted by the Appellant and published in its rules. The Respondent contends that he is not bound by that tariff and that there is no agreement that confines him to those charges, and contends that the Appellant must therefore pay his account in full.

6. It is common cause between the parties that the treatment of the member's baby for respiratory distress was an emergency condition, and further that the treatment fell within the ambit of Regulation 8(1) requiring the scheme to pay for the treatment of the condition in question <u>in full</u>, without co-payment or the use of deductibles.

7. The question that requires determination is whether payment in full, in the context of Regulation 8(1), can be confined to payment in full up to the limit contained in the scheme's rules.

8. The rules of a medical scheme form part of the contract between that scheme and its members. Beyond that they have no legal effect and certainly do not constitute a contract between a

scheme and a service provider. While it is true that schemes often enter into agreements with service providers which regulate the fees to be charged by those providers (be they hospitals or practitioners), in the absence of an enforceable agreement between a service provider and a scheme, a service provider cannot be taken to have consented to or be limited by anything contained in the scheme's rules.

9. There was no evidence before the Appeal Committee of any contract that existed between the Respondent and the Appellant, and indeed it appears that neither party contended for the existence of such an agreement. There was thus no undertaking by the Respondent that he would charge fees in accordance with the Appellant's tariff, or that he had consented to any other limitation on the fees that he would charge.

10. In the circumstances there was nothing to prevent the Respondent from charging fees for the treatment of the Appellant's member's baby that might, in the circumstances, have been excessive. It is important to note that the Respondent asserts strongly that his fees in these circumstances were not excessive, and the Appellants complaint is not that the

Respondent's fees were unconscionable, but that they exceeded the Appellant's tariff.

11. However, this highlights the problem raised by Regulation 8 of the Act, as alluded to at the outset of this ruling. A service provider, safe in the knowledge that a medical scheme would be obliged to meet the fees charged for emergency treatment of PMB conditions, is able to charge substantially more than the NHRPL provided that he or she has not entered into an agreement with the medical scheme in question to the contrary.

12. That this problem is one that the Registrar of Medical Schemes is aware of appears from two circulars that he has published.

13. In circular 9 of 20 October 2003 the Registrar recognised the above problem expressly. He wrote as follows:

"6.2 In those circumstances [where PMBs have been obtained voluntarily from a DSP or involuntarily from a non-DSP and a scheme has an obligation to pay for the costs thereof in full] the scheme is not entitled to limit this in their rules to a particular tariff schedule

which would expose the member to an out-of-pocket payment if the provider were to charge in excess of that tariff. Provision for this is not made in the regulations, and it would defeat the object of ensuring that members have access to minimum benefits in some or other setting without facing out-of-pocket payment. However, schemes are not exposed to unlimited liability in this regard because:

6.2.1 where the public sector is the DSP, these are charged according to the UPFS;

6.2.2 in respect of other DSPs, schemes can enter into specific fee arrangements;

6.2.3 involuntary use of non-designated service providers should be exceptional …… and

6.2.4 excessive or anti competitive pricing can be taken up with the HPCS or Competition Commission."

14. In circular 32 of 2006, the Registrar wrote:

"It should also be understood that provision for full payment of PMB's applicable to involuntary use of non-DSPs is about

guaranteeing access to care, and is not about providing a 'blank cheque' to providers."

15. It is clear from the October 2003 circular that the Registrar understood that, on a correct interpretation of the regulation, a scheme would not be entitled to limit the payment to providers on the basis of a tariff contained in its rules. This is precisely what the Appellant is seeking to do in the current appeal.

16. The Registrar's view is that this would not be permissible and would defeat the purposes of the regulation, because its effect would be that the members would have to pay the balance of the fee charged to the service provider, and Regulation 8 is specifically designed to ensure that members are not obliged to pay any part of the treatment for a PMB condition.

17. That the service provider is entitled to be paid in full for the service rendered at the fee usually charged by him or her is clear. In the absence of a contract with the scheme limiting what he or she can charge, or a contract between him or her and the patient limiting the amount that he or she can charge, the service provider is fully entitled to charge his or her usual fee..

18. Since the primary obligation for the payment of this fee lies with the patient, the effect of allowing a scheme to limit the amount that it will reimburse the service provider would have the effect of shifting the responsibility of the remainder of the payment onto the member. This is clearly contrary to Regulation 8.

19. It then remains to be considered whether this Appeal Committee has the power to limit the amount that could be charged by a service provider in these circumstances. It is clear, however, that this Committee has no such power.

20. Firstly, the limitation of fees charged by service providers is not the function of the Council for Medical Schemes. That is the responsibility of the Health Profession's Council of South Africa (HPCSA), a body established specifically to regulate the practices of health professionals. By contrast, the Council for Medical Schemes regulates the relationships between Medical Schemes and their members. Although section 7(a) of the Act charges the Council with the responsibility of protecting beneficiaries, the remainder of section 7 makes it clear that this protection is in the context of the relationship between said

beneficiaries and their medical schemes. One would have expected the word 'patients' to be used instead of 'beneficiaries', if the intention had been to intrude into the relationship between patients and service providers

21. This is in contrast to the Health Professions Act, 1974, the purpose of which is:

> *"To establish the Health Professions Council of South Africa; to provide for control over the training, registration and practices of practitioners of health professions; and to provide for matters incidental thereto."* (emphasis added)

22. Secondly, even if the Council for Medical Schemes did have this power, it would be an impossible power to exercise. The Council would, in these circumstances, have to determine the extent to which it was prepared to limit a service provider's fees. A scheme may have established a tariff in its rules which set a limit on the payment of service providers' fees that was, in the circumstances, wholly unreasonable. In those circumstances it could not turn to the Council and say that the service provider should be limited to the arbitrary tariff imposed by the scheme.

23. Different schemes may impose completely different tariff limits. In those circumstances, how could the Council be expected to determine a reasonable limitation on service providers' fees?

24. Lastly, where no tariff had been set by a scheme, could the Council be expected to intervene to deny a service provider his or her full fees simply on the basis of an allegation by a scheme that these fees were unreasonable in the circumstances?

25. All of these questions illustrate the difficulty in an approach that contends that the Council should be responsible for limiting the fees charged by service providers. But, primarily, the Council cannot do this because such a limitation would be *ultra vires* the functions of the Council.

26. As the Registrar has correctly recognised, there are steps that schemes can take to protect themselves from unreasonable charges. They can enter into specific fee arrangements with the service providers, and they can contest unreasonable fees through the functions of either the HPCSA or the Competition Commission. And, as recognised by the Registrar, the circumstances in which they will have to pay non-designated

service providers for involuntary use should be the exception rather than the norm.

27. Having said this, the Committee is mindful of the concern expressed by the Registrar in the 2006 circular. It was not the intention of Regulation 8 to give a blank cheque to providers, but it could be that in the absence of adequate control mechanisms the regulation may, inadvertently, have done just that. If this is so, legislative intervention is needed to address this defect.

28. In the circumstances of the current appeal, however, the committee concludes that it cannot limit the fees that the Appellant is obliged to pay to the Respondent. To do so would simply shift the responsibility for the balance of the Respondent's fees to the Appellant's member, something which is expressly excluded by Regulation 8.

29. In the circumstances, by operation of Regulation 8, the Appellant is obliged to pay Respondent's account in full, and the appeal must consequently fail.

DATED at JOHANNESBURG on the day of MAY 2008

PAUL JAMMY
Member: Appeal Committee

I agree,
ZOLA NJONGWE
Member: Appeal Committee

I agree,
ARCHIE PALANE
Member: Appeal Committee

I agree,
ALAN ROTHBERG
Member: Appeal Committee

I agree,
TRACEY FORTUNE
Member: Appeal Committee

DISSENTING RULING

INTRODUCTION

[1] I have read the ruling of Mr Jammy and must respectfully disagree both with its conclusion and the reasons advanced for it.

[2] But before dealing with the issues raised in this matter, I think the parties deserve an explanation from this appeal committee as regards the extraordinary delay in releasing its ruling. Indeed, some three months after hearing of the appeal the Appellant enquired about progress in finalisation of the appeal committee's ruling.

[3] This appeal was heard on 6 December 2007 and this ruling was completed and submitted to the Council for Medical Schemes for delivery to the parties on 18 December 2007. The majority of the panel of three that sat in the appeal found in favour of the Appellant for the reasons advanced in this ruling. However, it was considered prudent that the Full Appeal Committee (comprising six members)

should consider the matter afresh in order to debate the issues and endeavour to reach a consensus.

[4] After long deliberations, largely on matters of policy, Mr Jammy's ruling emerged as the majority ruling of the full appeal committee some five months later. In the result, this is now a dissenting ruling from the ruling of the full appeal committee.

[5] The circumstances of this case demonstrate vividly the incongruence between the right of access to healthcare services enshrined in section 27 of the Constitution of the Republic of South Africa, 1996, Act 108 of 1996 ("the Constitution"), on the one hand, and the harsh daily reality of uncompromisingly high healthcare service costs with which citizens are confronted (even those prudent enough to pool resources in the form of membership of one or other medical aid scheme with a view to ensuring cover for their healthcare service costs when the need arises) on the other. The result is frustrated patients who feel helpless in the face of healthcare service providers who charge what they consider reasonable but is nevertheless in excess of medical scheme rates, on the one hand, and regulation they consider ineffective in its regulation of the healthcare service industry, especially as regards affordability, on the other.

[6] The introduction into the Medical Schemes Act, 131 of 1998 ("the MSA"), and regulations thereto, of Prescribed Minimum Benefit provisions ("PMBs"), clearly intended to limit the cost of the diagnosis, treatment and care in respect of certain medical conditions, appears to have had little, if any, effect. (PMBs, in relation to which the extent of a scheme's liability is at the centre of this case, are defined in the regulations and will be discussed later in this ruling.) The reason, in my view, is discord between Legislative intention, on the one hand, and industry practice on the other.

[7] This is not a healthy state of affairs.

THE PARTIES

[8] The Respondent is a paediatrician who plies his specialist trade at, among others, Kingsbury Hospital in Claremont, Cape Town. He was the attending paediatrician in this case after the member's newborn baby presented with Respiratory Distress. It is the reasonableness of his account that is at the centre of this appeal. The Respondent, who had successfully lodged a complaint with the Council for Medical

Schemes, represented himself at the hearing of this appeal by SAMWUMED against the Registrar's ruling of 12 September 2007.

[9] SAMWUMED ("the scheme") was, according to the scheme, originally formed in 1952 from an assortment of labour organisations for predominantly coloured workers in racially segregated Cape Town City Council. It was registered as a medical aid scheme in November 1968 and is a low cost scheme that is self-administered through a non-profit vehicle. Because of its origins, about 70% of the scheme's low-income membership is located in the Cape Flats region.

[10] Before getting into the merits of the scheme's appeal against the registrar's ruling, it is necessary to sketch a landscape in which the parties operate because their relationship with each other is inevitably informed by that landscape.

<u>OPERATIONAL LANDSCAPE IN BRIEF</u>

[11] On 19 August 2004, the Competition Commission of South Africa ("the Commission") and the Board of Healthcare Funders ("BHF") which represents about 85% of medical aid schemes in South Africa,

concluded a settlement agreement following the Commission's investigation of what it considered as being price fixing. This price fixing charge came about because of the BHF's practice of determining, recommending and publishing benchmark tariffs for healthcare services on an annual basis in the form of the National Health Reference Price List ("the NHRPL") for use by its constituent members. These benchmark tariffs were intended to be a reference point for medical aid schemes (represented by the BHF), hospitals (represented by the Hospital Association of South Africa ["HASA"]) and doctors (represented by the South African Medical Association ["SAMA"]) in the charging for healthcare services.

[12] The prohibition of the NHRPL tariffs by the Commission resulted in medical aid schemes having to engage in negotiations for healthcare rates with healthcare service providers on a bilateral basis. While this has been relatively easier to bed down with primary healthcare service providers such as general practitioners and optometrists, negotiations have tended to flounder on tertiary healthcare, with major hospital groups and specialists adopting a "take it or leave it" approach in their dealings with smaller schemes such as the Appellant. This is further complicated by a situation where a

specialist agrees to a scheme's tariff but the hospital group at which he performs a medical procedure does not.

[13] In the course of these bilateral negotiations, the scheme in this case succeeded in securing Designated Service Provider contracts ("DSPs") with two private hospital groups in Cape Town, Melomed and Life Healthcare. The Melomed group has facilities in the Cape Flats of Athlone, Mitchell's Plain and Bellville where over 70% of the scheme's members reside, while the Life Healthcare group has footprints in previously white areas like Pinelands and Claremont.

[14] The scheme submits that it concluded a DSP agreement with Life Healthcare in order to accommodate those of its members who reside in areas where the Melomed group has no facilities. The Melomed group charges the scheme at 2006 NHRPL tariffs for PMB conditions and at 2006 NHRPL+5% for non-PMB conditions, while the best that could be negotiated with the Life Healthcare group is 2006 NHRPL+15%. Kingsbury Hospital falls under the Life Healthcare group.

THE FACTS

[15] The following facts are not in dispute. Soon after joining the scheme in January 2007, the expectant member attended at a gynaecologist who has rooms at both Gatesville Medical Centre (a Melomed facility) and Claremont Medical Centre (a Life Healthcare facility). The gynaecologist recommended a Caesarean section delivery at Kingsbury Hospital in Claremont, a Life Healthcare facility which is apparently a sister hospital to the Claremont Medical Centre.

[16] As she required prior authorisation for that procedure, the member contacted the scheme on 26 February 2007 for authorisation which was granted for a 1 March to 4 March 2007 stay at the hospital. The baby was born on 1 March 2007 and presented with Respiratory Distress. That is when the Respondent entered the scene as attending paediatrician at that same hospital. His charges are said by the scheme to exceed its 2007 tariff, namely, 2006 NHRPL+5%. It refuses to pay above its own tariff on the basis of an interpretation it gives to the provisions of regulation 8 read in the context and what it terms the “spirit” of the MSA.

[17] On 12 September 2007 the Registrar ruled that the scheme is liable to settle the Respondent’s account in full because his service was rendered in connection with treatment of a PMB condition, and

payment in terms of the 2006 NHRPL+5% tariff is in contravention of both the MSA and the scheme's own rules. Now the scheme appeals against that ruling.

[18] I should mention that the tariff to which the scheme wishes to limit the Respondent's account (2006 NHRPL+5%) applies, on the scheme's own submission, in respect of non-PMB conditions. As will emerge herein, there is no dispute that we are here concerned with a PMB condition. Thus, the applicable rate ought to be 2006 NHRPL+15% negotiated with Life Healthcare to which Kingsbury hospital belongs. In the absence of any evidence or submission as regards whether there was any negotiated rate with the Respondent himself, the rate negotiated with the hospital out of which he rendered his service must be applicable. This, in my view, answers in part the majority ruling's finding that inasmuch as there is no fee arrangement between the scheme, on the one hand, and the Respondent on the other, the doctor's fee cannot be limited by the scheme's tariff rate.

[19] What is more, what the majority loses sight of in finding as it does in this respect is that the rules of the scheme do not serve the sole purpose of regulating health-care affairs between the scheme and its

members. If that were the case, then the rules would be no place for making provision for tariff rates as section 29(1)(q) of the MSA enjoins medical schemes to do. Provision for tariff rates is intended not for members but for service providers because it is service providers, not members, who charge medical schemes for services rendered to members. I deal with this issue in greater detail later in this ruling.

PRESCRIBED MINIMUM BENEFITS

[20] There is no dispute between the parties that the Respondent's services were rendered in connection with a PMB condition. This condition is defined in regulation 7 to the MSA as "**a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition**". Among the conditions listed in annexure A to the regulations is low birth weight of between 1 000 grams and 2 500 grams with respiratory difficulties (code 967N) for which the recommended treatment is "**medical management, including ventilation, intensive care therapy**". Another specified PMB condition is "pregnancy" (code 52N) for which the recommended treatment is "**antenatal and obstetric care**

necessitating hospitalisation, including delivery". That the member was admitted to Kingsbury Hospital with the condition of pregnancy, and that the baby had respiratory difficulties, there is no dispute. There can thus be no doubt that we are here concerned with a PMB condition.

[21] The issue, however, is not so much whether the Respondent charged for a PMB condition; it is rather the proper construction of regulation 8. To that I now turn.

"pay in full"

[22] The relevant parts of the regulation read thus:

> "(1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must ***pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.***
>
> (2) Subject to section 29(1)(p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that –
>
> (a) the diagnosis, treatment and care costs of a prescribed minimum benefit will only be ***paid in full by the***

> ***medical scheme*** if those services are obtained from a designated service provider in respect of that condition;
>
> (b) …"
>
> (Emphasis supplied)

[23] The question that arises is what does "**pay in full**" or "**paid in full**" mean in the context of the MSA? The Respondent maintains that regulation 8 requires that the scheme pays his account in full without reference to the upper limit prescribed by its own tariff. In this regard, he submits that the scheme's tariff cannot trump the regulations, which he clearly understands as not placing a limit on what a healthcare service provider may charge, subject only to considerations of reasonableness as determined by the Health Professions Council of South Africa ("the HPCSA") or the South African Medical Association.

[24] The scheme does not agree with this interpretation. The scheme's representative was at pains to point out that such an argument goes against the very "spirit" of regulation 8 read in the context of the MSA as a whole. He submitted that although the MSA fails to indicate the quantum of the full payment that a scheme is required to make in relation to PMBs, that quantum cannot reasonably be taken as

envisaging a "blank cheque" for service providers. He submitted that what the regulation requires is that the scheme pays the full amount of what its tariff prescribes for PMBs.

[25] The Registrar has himself previously warned against the provision for "full payment" of PMBs being seen by service providers as a "blank cheque". In a circular 32 of 2006 dated July 2006 and addressed to all medical schemes, administrators and other stakeholders, the Registrar for Medical Schemes sought to reflect the Council's interpretation of the PMB provisions in the MSA and regulations. He wrote:

> "It should be understood that provision for full payment of PMBs applicable to involuntary use of non-DSPs is about guaranteeing access to care, and is not about providing a "blank cheque" to providers."

[26] While the Registrar was there addressing the situation that pertains to the proviso to regulation 8(2)(b) (which provides that co-payment by a member is impermissible where a PMB service is obtained involuntarily from a non-DSP), the same applies with equal force in respect of voluntary use of DSPs under regulation 8(2)(a), as in this case.

[27] The starting point to understanding the true purport of any legislative provision is to seek to understand the intention behind it. Understanding the true purport of regulation 8 is no different. The purpose behind the introduction of PMB provisions in the MSA was clearly to make healthcare service affordable. To that end, medical aid members are expressly exempt from paying for any emergency medical conditions and for the diagnosis, treatment and care costs of those conditions listed in the regulations (including pregnancy) out of their own pockets. The medical aid scheme must pay for these from the members' regular premiums.

[28] That this exemption is limited to those PMB healthcare services obtained voluntarily from designated service providers with whom the medical aid scheme would have negotiated favourable rates on behalf of its members (or PMB services obtained involuntarily from non-DSPs with whom there is no such negotiated arrangement) is a clear indication that the Legislature's intention is to encourage the keeping of healthcare service costs down (see regulation 8(2)).

[29] This intention also becomes demonstrably clear from the fact that an out-of-pocket contribution may be imposed on a member who

voluntarily obtains such services from a service provider with whom his medical aid scheme has not negotiated a favourable rate (regulation 8(2)(b)). Thus, only where a member obtains PMB healthcare services from a non-designated service provider involuntarily would the exemption from out-of-pocket contribution remain in place (see proviso to regulation 8(2)(b)). This could arise in a number of ways. One could be an emergency situation, as in this case. Another could be where there is no designated service provider facility in the area in which the member happens to be at the time PMB healthcare services are required.

[30] With this clear intention in mind, the Legislature could not at the same time have intended to nullify the policy framework so carefully crafted to keep healthcare service costs down, by quirkily permitting healthcare service providers to charge whatever fee they please, subject only to their own subjective notion of what is reasonable. The Legislature is presumed to be consistent with itself (see **Principal Immigration Officer v Bhula 1931 AD 323 at 345**). It cannot intend two mutually destructive outcomes.

[31] This carefully crafted policy framework begins with the Constitution. Section 27 of the Constitution not only provides for the right of

access to healthcare (s 27(1)); it also obliges the State to take reasonable legislative measures to ensure the realisation of that right (s 27(2)). That legislative measure has come in the form of a number of Acts of Parliament, among which is the Medical Schemes Act.

[32] Section 29(1)(q) of the MSA obliges medical aid schemes to make provision in their rules for the payment of any benefits "**according to a scale, a tariff or recommended guide**". SAMWUMED's scale, tariff or recommended guide is contained in annexure B to its rules under option B. It provides (mirroring regulation 8(1) read together with 8(2)(a)) that PMBs obtained from designated service providers will be funded by the scheme at 100% of the cost of diagnosis, treatment and care. It provides further (mirroring regulation 8(2)(b)) that PMBs voluntarily obtained from non-designated service providers will attract an out-of-pocket contribution of R600 from the member, and that (mirroring the proviso to regulation 8(2)(b)) PMBs involuntarily obtained from non-designated service providers will be funded at 100% of the cost of diagnosis, treatment and care. In so doing, the scheme gives effect to section 29(1)(q) and to the Legislature's clear grand plan in regulation 8 of keeping healthcare service costs down and affordable.

[33] The Registrar's express concern in circular 32 of 2006 as regards service providers construing the provision in regulation 8 for the full payment of PMB costs as a "blank cheque" was a concern giving expression to the Legislature's intention in introducing PMB provisions into the MSA, namely, to keep healthcare service costs down and affordable. It was a warning against abuse of these provisions. The Registrar wrote:

> "It should also be understood that provision for full payment of PMBs applicable to involuntary use of non-DSPs is about guaranteeing access to care, and is not about providing a "blank cheque" to providers."

[34] However, his assessment of the true position in an earlier circular 9 of 2003 dated 20 October 2003 was, with respect, out of step with that intention. He wrote:

> "6.2 In those circumstances [where PMBs have been obtained voluntarily from a DSP or involuntarily from a non-DSP and the scheme has an obligation to pay for the costs thereof in full] the scheme is not entitled to limit this in their rules to a particular tariff schedule which would expose the member to an out-of-pocket payment if the provider were to charge in excess of that tariff. Provision for this is not

> made in the regulations, and it would defeat the objective of ensuring that members have access to minimum benefits in some or other setting without facing an out-of-pocket payment. <u>However</u>, schemes are not exposed to unlimited liability in this regard because:
>
> 6.2.1 where the public sector is the DSP, fees are charged according to the UPFS;
>
> 6.2.2 in respect of other DSPs, schemes can enter into specific fee arrangements;
>
> 6.2.3 involuntary use of non-designated service providers should be exceptional … and
>
> 6.2.4 excessive or anti-competitive pricing can be taken up with the HPCSA or Competition Commission."
>
> (Underlining in original text)

[35] There are numerous respects in which this position is, with respect, unsustainable. The first, of course, is that the Registrar seems to have departed from it later with the release of the July 2006 circular 32 of 2006. Second, this position proceeds from the incorrect premise that the phrase "pay in full" in regulation 8(1) or "paid in full" in regulation 8(2)(a) is to be construed without reference to the scheme's tariff schedule. In my view, such an interpretation can only have the very effect of a "blank cheque" against which the Registrar warned in the later circular in July 2006.

[36] Third, on a proper interpretation of regulation 8, the limitation of a DSP's charge for PMBs to the scheme's tariff schedule does not – and should not – have the effect of exposing a member to an out-of-pocket payment in the event of the DSP charging in excess of the scheme's tariff. In any event, where the scheme has negotiated a fee arrangement with a DSP for PMBs, a charge in excess of the scheme's tariff schedule should not even arise. A DSP arrangement comes about by reason of a prior fee arrangement between the scheme and a service provider in the first place. Thus, a DSP charging in excess of the scheme's tariff schedule is a contradiction in terms.

[37] A charge in excess of the scheme's tariff schedule ought only to come about where the member voluntarily obtains PMB services from a non-DSP. For that, the member is liable for an out-of-pocket payment. This is consistent with the legislative framework in regulation 8(2)(b). But that is not the position in this case. Both parties agree that the Respondent's service at Kingsbury hospital was obtained involuntarily. Moreover, both parties are agreed that Kingsbury hospital is a DSP, even though the scheme says it is not a "preferred" DSP, to which the Respondent retorted, with respect correctly, that "a DSP is a DSP". The regulation does not

contemplate, whether expressly or by implication, a member making out-of-pocket expenses for PMB services obtained from a DSP, as in this case in respect of Kingsbury Hospital, or involuntarily obtained from a non-DSP, as in this case in respect of the Respondent. In fact, the regulation expressly provides for the opposite.

[38] Fourth, the reasons advanced by the Registrar (now echoed in the majority ruling) for the proposition that schemes are not exposed to unlimited liability on his construction of regulation 8 (that schemes are liable for full payment of PMB charges in excess of their tariff schedules) loses sight of the operational landscape in the healthcare service industry as described earlier in this ruling. For one thing, the suggestion that small schemes (such as Samwumed) can negotiate specific fee arrangements with dominant healthcare service providers is, as the scheme in this case has discovered, very much easier said than done, not least because of lack of economies of scale. For another, the suggestion that excessive pricing for PMBs can be taken up with the HPCSA or the Competition Commission is cold comfort for members given that they would be completely and utterly outgunned (both in respect of the financial outlay such litigation tends to demand, and in the expertise required competently to present a case) in any legal jousting with service providers at the

Competition Tribunal and, ultimately, the courts. For medical schemes to take up the cudgels for their members in such disputes would require that premiums intended for healthcare services are channelled to legal expenses for which they were never intended, thus raising the cost of healthcare even more.

[39] Moreover, the suggestion that recourse may be had to the HPCSA for any excessive charge by healthcare service providers loses sight of one crucial consideration. While section 53(3)(d) of the Health Professions Act, 56 of 1974, empowers professional boards of the HPCSA from time to time to determine and publish a tariff schedule for use by healthcare service providers, such a tariff cannot lawfully exceed those of medical aid schemes determined pursuant to the provisions section 29(1)(q)(i) of the MSA with a view to giving effect to the clear legislative intent (as clearly demonstrated by regulation 8(2)) to keep healthcare service costs affordable. The reason for this is the long-established principle of our law that *lex posterior derogat priori* (a later statute abrogates or repeals [to the extent of inconsistency] an earlier statute: see **Mulaudzi and Others v Chairman, Implementation Committee, and Others 1995 (1) SA 513 (V) at 545G-J; Principal Immigration Officer v Bhula 1931 AD 323 at 345**; see also the *obiter* but very much instructive observation

of Schutz JA delivering a unanimous judgment of the Court in **Sasol Synthetic Fuels (Pty) Ltd and Others v Lambert and Others 2002 (2) SA 21 (SCA) at paragraph [19]**).

[40] The Health Professions Act came into effect in February 1975, while the Medical Schemes Act took effect in February 1999. In putting regulations in place in order to make the cost of healthcare service affordable, as discussed earlier, the Legislature could not have intended that healthcare providers could continue virtually to write their own cheques under older legislation.

[41] In any event, even assuming that the meaning of "pay in full" in regulation 8 clearly and unambiguously connotes full payment without limit based on the scheme's tariff schedule, the absurdity to which such a literal interpretation would give rise is such that the only reasonable conclusion can only be that the Legislature could not reasonably have intended it. As Schutz JA pointed out in a unanimous judgment of the Supreme Court of Appeal in **Poswa v Member of the Executive Council for Economic Affairs, Environment and Tourism, Eastern Cape 2001 (3) SA 582 (SCA) at paragraph [10]**, "**the literal meaning of an Act (in the sense of strict literalism) is not always the true one**". Where that literal

meaning would result in "**absurdity so glaring that it could never have been intended by the Legislature**" (per Innes CJ in **Venter v R 1907 TS 910 at 914**), or in "**absurdity, inconsistency, hardship or anomaly which from a consideration of the enactment as a whole a court of law is satisfied the Legislature could not have intended**" (per Stratford JA in **Bhyat v Commissioner for Immigration 1932 AD 125 at 129**), then a court is justified in departing from the clear and unambiguous meaning of the section (see also **Hanekom v Builders Market Klerksdorp (Pty) Ltd and Others 2007 (3) SA 95 (SCA) at paragraph [7]**). Thus, to the extent that the power granted by the Legislature to healthcare service providers to determine their own tariff schedule under the Health Professions Act is inconsistent with the Legislature's clear intention in introducing PMB provisions into the Medical Schemes Act, the only reasonable conclusion must be that the Legislature could not have intended healthcare providers to determine their own tariff schedule above that of medical aid schemes.

[42] It may be argued that it has been the *practice* in the healthcare service industry, the Legislature's intention notwithstanding, that accounts presented by service providers in respect of PMB services have been paid in full (that is, without reference to the scheme's tariff

schedule where the charge is in excess of that tariff schedule) by medical aid schemes. A similar argument – where industry practice is at odds with the clear Legislature's intention – has been rejected by the Supreme Court of Appeal as "**breath-taking**" and "**cynical**" (see **Mostert NO v Old Mutual Life Assurance Company (SA) Ltd [2001] 8 BPLR 2307 (SCA) at paragraphs [67], [69] – [72]**). Industry practice can never lawfully trump the law.

CONCLUSION

[43] In the result, the appeal must succeed on the ground that the Respondent has no right in law to levy a charge for a PMB condition that is in excess of that prescribed by SAMWUMED in its rules.

[44] The consequence of this is that neither the Respondent nor SAMWUMED has a right to demand the amount that is in excess of the scheme's tariff schedule from the member because the doctor's services were obtained involuntarily under emergency conditions.

DATED at Johannesburg this day of MAY 2008

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VUYANI NGALWANA

MEMBER: APPEAL COMMITTEE

I agree,

ZOLASHE LALLIE

MEMBER: APPEAL COMMITTEE