

**IN THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL
SCHEMES**

In the matter between:

SF H

Appellant

and

DISCOVERY MEDICAL SCHEME

Respondent

RULING

[1] Mr SFH is aggrieved that Discovery Medical Scheme (“the scheme”), of which he has been a member for many years, requires that he pays 20% of the cost of a drug (Velcade) that his wife’s oncologist says is the only drug that will help her.

[2] He says his wife has suffered from cancer for approximately five years, during which period three different drugs have been prescribed for her, the third being Velcade. The scheme says this is a specialty drug for which it pays up to 80% or an accumulated annual maximum of R200 000. It does not form part of the list of treatments for which the scheme’s formulary makes provision.

- [3] The appeal committee can find no fault with the scheme's decision if one has proper regard to the provisions of the Medical Schemes Act, 131 of 1998 ("the MSA"). Since Mr SFH seems nonplussed as regards why he should be required to make a co-payment for treatment of a Prescribed Minimum Benefit ("PMB") condition, let us start at the beginning.
- [4] Mr SFH is correct in referring us to the definition of a PMB in the MSA and that is a good place to start. A PMB condition is defined in regulation 7 of 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 "**Multiple myeloma and chronic leukaemias**" (code 910S) for which the recommended treatment is "**medical management; which includes chemotherapy and radiation therapy**". The scheme says this is the condition from which Mrs SFH suffers and Mr SFH has not denied this.
- [5] Significantly, Mr SFH has also referred us to regulation 8 of the MSA. The relevant part of that regulation says:

"(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.*"

(Emphasis supplied)

- [6] What this means, in simple terms, is that a medical scheme may not require a member to make a co-payment for the treatment of a PMB condition, as in the case of the treatment of multiple myeloma or chronic leukaemia. If that is all the regulations said, Mr SFH would have been absolutely correct in requiring the scheme to pay for the full cost of Velcade (putting aside for the moment arguments on what “pay in full” means in the context of PMBs). But that is not where the enquiry ends.
- [7] Regulation 8(1) begins with the phrase “[s]ubject to the provisions of this regulation”. That phrase has been interpreted by the Supreme Court of Appeal to convey a limitation or qualification of the provisions contained in the section that bears that phrase. The Appellate Division (as it was then known) said the following in this regard in **S v Marwane 1982 (3) SA 717 (A) at 747H-748A**:

“The purpose of the phrase “subject to” in [a statutory] context is to establish what is dominant and what subordinate or subservient; that to which a provision is “subject”, is dominant – in case of conflict it prevails over that which is subject to it. Certainly, in the field of legislation, the phrase has this clear and accepted connotation. When the legislator wishes to convey that that which is now being enacted is not to prevail in circumstances where it conflicts, or is inconsistent or incompatible, with a specified other enactment, it very frequently, if not almost invariably, qualifies such enactment by the method of declaring it to be “subject to” the other specified one.”

- [8] Much later, the Supreme Court of Appeal (as the Appellate Division has come to be known) made the position even clearer in **Premier, Eastern Cape and Another v Sekeleni 2003 (4) SA 369 (SCA) at 375H** when it said:

“While it is often used in statutory contexts to establish what is dominant and what is subservient its meaning in a statutory context is not confined thereto and it frequently means no more than that a qualification or limitation is introduced so that it can be read as meaning “except as curtailed by”.

- [9] The provisions of regulation 8(1) are “curtailed by” or “limited by” or “qualified by” any other regulation (under regulation 8) which is in conflict with it. Thus, regulation 8(5) provides that where a scheme’s treatment regime for a specified PMB condition includes use of a specified drug, but the member or beneficiary prefers another drug not included in the scheme’s list of drugs that are clinically appropriate and effective for the treatment of that condition, then the scheme has every right to impose a co-payment on the member for the cost of that other drug. Because regulation 8(1) is “subject to” or is “qualified by” or is “curtailed by” or “limited by” regulation 8(5), it must be read together with regulation 8(5) and yield in its meaning to the latter regulation to the extent of inconsistency. The inconsistency between the two regulations is this: regulation 8(1) says no co-payment may be imposed for treatment of a PMB condition; but regulation 8(5) says a co-payment may be imposed where the member prefers a drug not included in the scheme’s treatment regime for a specified PMB condition. Therefore, the scheme is acting within the law in imposing a co-payment in the circumstances of this case.

[10] Having said that, however, it must be pointed out that regulation 8(5) does not compel the scheme to impose a co-payment in these circumstances. The regulation simply says the scheme has a discretion to do so. It may, in the exercise of that discretion, decide either to impose a co-payment or not to do so in each case. And it cannot do so according to a template in all cases but has to consider each case on its own merits. Considerations of cost-effectiveness and affordability for the scheme would then have to be considered. No evidence has been led in this regard by either party and so this committee is in no position to determine whether or not the discretion was properly exercised with due regard to all the relevant considerations. It is not enough for the scheme in the exercise of that discretion to limit its focus on what drugs its treatment regime recognises. That is a fetter of the discretion which is in law impermissible. The scheme will do well to give its practice in this regard serious consideration.

[11] If that were all we needed to consider in this case, then the appeal would have had to succeed because the scheme bears the onus to prove that full payment by it for Velcade is not cost-effective or affordable. But the enquiry does not end there. In order for the scheme to exercise its discretion in favour of not imposing a co-payment for a drug not contained in its treatment regime, Mr SFH would have to prove that his wife had tried the drugs contained in the scheme's treatment regime but that they were ineffective or they caused adverse reaction in her. That is what regulation 15I(c) requires of him. He unfortunately has not done that. All he says is that his wife's Oncologist told

them that the only drug that can help her is Velcade. That is not enough. He must prove that the other recommended drugs have been ineffective or cause an adverse reaction in his wife.

[12] In these circumstances, the appeal cannot succeed.

V NGALWANA for the appeal committee

Date of Hearing: 08 May 2008

Date of Ruling: 27 May 2008