COUNCIL FOR MEDICAL SCHEMES

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Fair Treatment Project

DRAFT DOCUMENT

for discussion purposes

A workshop, open to all relevant stakeholders, will take place on 19 and 20 February 2004

After input has been received on this report in the course of this workshop, the report will be finalized and its contents will be used as a blueprint for actions by the Council for Medical Schemes in relation to promotion of fair treatment in the short, medium and longer terms.

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OUR VISION

A medical schemes industry which is regulated to protect the interests of members and to promote fair and equitable access to private health financing in order to maximise the health of South Africa.

OUR MISSION

The Council will act in an administratively fair and transparent manner with integrity and professionalism and will achieve this vision by:

- Informing the public about their rights and obligations in respect of access to medical schemes;
- Ensuring that all entities conducting the business of medical schemes comply with the Act;
- Ensuring that complaints raised by members and the public are handled appropriately and speedily;
- Contributing to improved management and governance of medical schemes; and
- Advising the Minister of appropriate regulatory interventions that will assist in attaining national health policy objectives.

Contents

Preface **3**

Chapter One: Understanding unfairness **5**

Chapter Two: Gap analysis: What more can be done to protect consumers? **33**

Chapter Three: From analysis to action **52**

Preface

The first function of the Council for Medical Schemes listed in section 7 of the Medical Schemes Act, 1998[1] is to "protect the interests of the beneficiaries [of medical schemes] at all times." Inherent in this function is the notion that the Council for Medical Schemes must ensure that beneficiaries of medical schemes are fairly treated by those medical schemes[2]. This understanding is translated into the Council's vision, which is:

> A medical schemes industry which is regulated to protect the interests of members and to promote fair and equitable access to private health financing in order to maximise the health of South Africans.

To carry out this mandate, it is necessary to derive a shared understanding of what constitutes unfairness in this environment. This is by no means an easy task because fairness inevitably entails balancing the interests of different parties – and perceptions of fairness inevitably differ from one person to another. Nevertheless, we need to develop an objective basis for evaluating whether a perceived unfairness should indeed be regarded as unfairness for the regulatory purposes set out in section 7 of the Medical Schemes Act.

To this end, we have looked to the law, the literature and the experience of other jurisdictions for guidance. Based upon this review, we have determined a set of guidelines and principles that help to define what should objectively be considered to constitute unfairness for our regulatory purposes. We have then applied these guidelines and principles to a list of alleged unfairnesses compiled from brainstorming sessions and focus group discussions with a range of stakeholders to determine what should be regarded as actual unfairnesses warranting the prioritised attention of the Regulator.

Developing an understanding of unfairness in the medical schemes environment comprises the first phase of the project. The next phase entails a gap analysis of determining what is already being done to address these unfair practices by the Council for Medical Schemes or other bodies, and whether there are gaps or inadequacies in the way they are being addressed. This gives rise to a set of recommendations on what more should be done by Council to reduce unfairness to consumers in the medical schemes environment.

1 Act No 131 of 1998

2 For the purposes of this discussion, when reference is made to fairness or unfairness of activities of medical schemes, this should be understood to include where applicable the activities of intermediaries acting on behalf of medical schemes – such as administrators, managed-care organisations, and brokers.

Chapter One

Understanding Unfairness

1. A Dictionary definition of unfairness

When trying to understand the concept of unfairness, a dictionary definition is as good a place as any to start.
In terms of the Concise Oxford Dictionary, "fair" (adjective) means "just, unbiased, equitable; in accordance with the rules," with the noun fairness bearing a corresponding meaning. "Unfair" (adjective) means "not equitable or honest" or "not impartial or according to the rules," and the noun unfairness bears a corresponding meaning[3].

2. Is unfairness equivalent to unlawfulness?

The question may be asked: Should our consideration of whether or not a practice is unfair should stop at the point of asking if there has been some specific legal contravention?

It is our submission that an unlawful act is not necessarily unfair, and that an unfair act is not necessarily unlawful. For example, failure of a person to convert her driver's license from the old ID book to a credit card license is unlawful, but probably not unfair. On the other hand, depriving informal traders of the right to trade in busy commercial areas of a city may be regarded by some as unfair, but is not necessarily unlawful.

However, if one accepts that, generally speaking, the law is there to lay down rules of general application so that all subjects can be treated impartially and therefore fairly, then it is submitted that **there should be a presumption that unlawful action is also unfair, unless it can be specifically demonstrated that it is not**.

Nevertheless, if the Council for Medical Schemes is to fulfil its mandate to protect the interests of beneficiaries of medical schemes, it needs to extend its enquiry into unfairness beyond the narrow confines of whether or not there has been a specific statutory contravention.

Of course, unfair action that is clearly a contravention of the Medical Schemes Act is far more easily actionable than unfair action which does not entail specific statutory infringement. However, even in those cases which are not patently unlawful a range of actions could be taken by the

3 Allen RE (ed). The Concise Oxford Dictionary of Current English (8th ed). 1990. Oxford University Press.

Council for Medical Schemes which may form part of the recommendations of the final phase of this report, including *inter alia*:

- Promoting the development by the industry of a code of conduct to ensure that fair practices are voluntarily adhered to and maintained;
- Developing guidelines for the industry of specific ways in which fairness in treatment of beneficiaries can be enhanced – including possible developments to the model rules;
- Supporting consumer bodies in providing assistance to aggrieved beneficiaries of medical schemes;
- Declaration of undesirable business practices in terms of section 61 of the Medical Schemes Act; and
- Development of recommendations to the Minister of Health for the strengthening of the regulatory and statutory framework to render those unfair practices specifically unlawful.

Approaching a legal understanding of unfairness

The heading to this section of the report should alert readers to the fact that there is no single textbook legal definition of "unfairness" – probably because the notion is so context-specific. There are, however, certain legal doctrines which take us some way toward understanding the concept. We now turn our attention to these doctrines. There have also been some legal cases that have explored aspects of unfairness in the context of medicine, general insurance and health insurance. We consider some of these in turn, with a view to extracting some principles that can be translated into criteria for the determination of unfairness.

Legally recognised principles

Substantive versus procedural fairness

Our law makes the distinction between substantive fairness and procedural fairness.

Principles of procedural fairness are typically applied in the context of administrative decisions being taken which adversely impact on a person. The basic principle of procedural fairness is that the person affected by a decision must have sufficient notice of the contemplated action, as well as being afforded adequate opportunity to be heard, before the decision is taken. Exactly what constitutes sufficient notice and an adequate hearing will depend on the facts of the specific matter. However, a fair amount of case law has developed on this topic, particularly in the labour-law arena.

4 For more discussion on this topic, see for example: Rycroft, Barney and Jordaan. *A Guide to South African Labour Law*. 1992. Juta. 204ff. For discussion of principles of procedural fairness in contexts other than labour law, and framed within the *Constitution of South Africa*, 1996, refer to the following decisions of the Constitutional Court: *Premier, Mpumalanga v Executive Committee of the Association of Governing Bodies of State-Aided Schools: Eastern Transvaal 1999 (2) SA 91 (CC)*; *Permanent Secretary, Department of Education and Welfare, Eastern Cape v Ed-U-College (PE) Section 21 Inc 2001 (2) SA 1 (CC)*.

5 Unreported. SCA 25 May 2001.

Some more general principles in relation to procedural fairness were set out in C*hairman: Board of Tariffs and Trade v Brenco Incorporated* . Here the court stated that:

- The standards of fairness are not immutable. They may change with the passage of time, both in the general and in their application to decisions of a particular type.
- The principles of fairness are not to be applied by rote identically in every situation. What fairness demands is dependant on the context of the decision, and this is to be taken into account in all its aspects.
- An essential feature of the context is the statute that creates the discretion, as regards both its language and the shape of the legal and administrative system within which the decision is taken.
- Fairness will very often require that a person who may be adversely affected by the decision will have an opportunity to make representations on his own behalf either before the decision is taken with a view to producing a favourable result or, after it is taken, with a view to procuring its modification or both.

A fair procedure, however, does not ensure a fair outcome – and that is why one still needs to consider whether a decision is substantively fair. That means whether the decision adequately takes account of, and protects the person's legal rights and duties. There is no single recipe for substantive fairness, which will differ entirely from one context to the next. So it is indeed the issue of defining substantive fairness in the context of the actions of medical schemes vis-à-vis their members and the public at large that occupies much of the discussion in this paper and which will no doubt be the source of the most contention in the debate around the output of this project.

The basic principle, nevertheless, is that actions by medical schemes which potentially adversely affect the rights of beneficiaries or members of the public must be both procedurally and substantively fair.

Legitimate expectation

Although the phrase "legitimate expectation" may suggest a broad doctrine circumscribing a legal interpretation of fairness, the application of this concept is actually rather narrow and in consequence of limited assistance in understanding the concept of unfairness.

The doctrine of legitimate expectation dictates that: "If a decision-maker, either through the application of a regular practice or through an express promise, leads those affected legitimately to expect that he or she will decide in a particular way, then that expectation is protected and the decision-maker cannot ignore it when making the decision."[6]

Rycroft *et al* list certain conditions which must be met for this doctrine to apply. First, the expectation "must have some reasonable basis." Secondly, fulfilment of the expectation must lie within the powers of the person or body creating the expectation. Thirdly, the decision must have been unfair. Finally, considerations of public policy could override an individual's legitimate expectations in appropriate circumstances.

Nevertheless, as a principle, if a legitimate expectation (as legally defined) of an individual is not met, this may give rise to unfairness.

6 Rycroft, Barney and Jordaan. *A Guide to South African Labour Law. 1992*. Juta. 111

Rationing of limited resources

In the context of limited resources, situations invariably arise in which the interests of the individual are at odds with the interests of the greater community. This is generally because, if each person were given resources to meet his or her needs in their entirety, there would simply be insufficient resources to go around for everyone. So trade-offs need to be made between the interests of the individual and the interests of the community – otherwise called rationing of resources.

Denial or limitation of resources to an individual may well constitute unfairness. However, to deny an individual access to unlimited resources may be justified, and therefore fair, if granting of those resources would result in adverse consequences for the broader community.

In relation to the public sector, this principle was well articulated in *Soobramoney v Minister of Health, KwaZulu-Natal*[7], a matter decided in the Constitutional Court. In this matter, Sachs J held the opinion that "the rationing of access to life-prolonging resources is … integral to, rather than incompatible with, a human-rights approach to health care." However, the acceptability of such rationing was contingent upon predefined and clearly articulated policies and protocols which were reasonable, and applied fairly and rationally.

Although the Soobramoney matter concerned the public health sector, it is our view that similar principles would be applied in respect of allocation of the limited resources of a medical scheme between its beneficiaries.

Accordingly, the principle which can be derived from this discussion is that limitations on resource-allocation to a beneficiary may not be unfair if they are:

- Lawful;
- Clearly and unambiguously communicated to the beneficiary in advance, at a time that the beneficiary is able to make choices about whether or not to purchase or continue purchasing the product;
- Reasonable, in the sense that it is consistent with the overall objective of improving access to health care for everyone; and
- Applied in a rational and non-discriminatory manner.

Relevant statutory provisions

Framed within the South African Constitution, South African legislative development is increasingly reflecting an emerging human-rights culture – and within this context, consumer protections is becoming more entrenched. This is occurring within the health discipline too. Accordingly, the draft National Health Bill, 2001, includes a chapter dedicated to the rights and duties of patients when obtaining healthcare from health-service providers.[8] Legislation establishing statutory bodies in respect of various categories of health professionals is also evolving toward creating a far-more consumer-protectionist environment. In the discussion below, we concentrate on those pieces of legislation that assist in the development of an understanding of unfairness in the context of the relationship between medical schemes and their beneficiaries.

7 1998 (1) SA 765

8 This includes protections relating to, amongst others: informed consent for treatment; treatment for experimental or research purposes; access to medical records; and laying of complaints within health establishments.

Constitution of the Republic of South Africa, 1996

Chapter 3 of the Constitution – the 'Bill of Rights' – ultimately provides the backdrop against which legal doctrines and principles will be measured, and ensures that a human-rights culture pervades the development of our law. In considering the Bill of Rights, cognisance must be taken on section 8(3), which provides that a "provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right."

Particularly important provisions in relation to the fair treatment of beneficiaries, and which may be referred to in later phases of this project, include:

- Section 8: "(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

  (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

  (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair." (emphasis added)
- Section 10: "Everyone has inherent dignity and the right to have their dignity respected and protected."
- Section 12(2): "Everyone has the right to bodily and psychological integrity, which includes the right –
  - to make decisions concerning reproduction;
  - to security in and control over their body; and
  - not to be subjected to medical or scientific experiments without their informed consent."
- Section 14: "Everyone has the right to privacy, which includes the right not to have … (d) the privacy of their communications infringed."
- Section 27: "(1) Everyone has the right to have access to –
  - health care services, including reproductive health care; …
  - No one may be refused emergency medical treatment."
- Section 30: "Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights

9 Legislation to give effect to this right was passed in the form of the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000). The rationale behind the Act is that there is a fundamental connection between access to information and South Africa's effort to create a constitutional democracy based fundamentally on the principle of openness. The right to any information held by a public or private body may be limited to the extent that the limitations are reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, as contemplated in section 36 of the Constitution. A member of a medical scheme would therefore have recourse to this Act whenever he or she requires information, required for the exercise or protection of her or his rights, that a scheme or service provider refuses to release. The Act sets out in detail the procedure that has to be followed when requesting information. There are exclusions that apply to certain information. The Act also provides for the imposition of fines or penalties on persons that fail to comply with requests for information. An interesting question arises whether a medical scheme itself could be regarded as a requester in terms of this Act to gain information from a health care provider in respect of the medical condition of a patient, if such information is required for legitimate purposes by the medical scheme.

may do so in a manner inconsistent with any provision of the Bill of Rights."

- Section 32: "(1) Everyone has the right of access to –
  - any information held by the state; and
  - any information that is held by another person and that is required for the exercise or protection of any rights."
- Section 33: "(1) Everyone has the right to administrative action that is lawful, reasonable and procedurally fair.
  - (2) Everyone whose rights have been adversely affected by administrative action has the right to be given written reasons."[10]

Medical Schemes Act, 1988

Section 24(2)(e) of the Medical Schemes Act contains a provision similar to section 8 of the Constitution, providing 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."

Although there is no specific provision in the Medical Schemes Act analogous to section 8(5) of the Constitution, section 24(2)(e) was clearly intended to give effect to the non-discrimination clause in the Constitution.

It is accordingly submitted that for our purposes discrimination on one or more of the grounds listed in section 24(2)(e) of the Medical Schemes Act is unfair unless it is established such discrimination is fair.

Harmful Business Practice Act, 1988[11]

The Harmful Business Practice Act defines a harmful business practice as "any business practice which, directly or indirectly, has or is likely to have the effect of: (a) harming the relationship between business and consumers; (b) unreasonably prejudicing any customer; or (c) deceiving any customer."[12]

If one accepts the view that the Harmful Business Practice Act was designed to promote fair treatment of consumers, the above definition may

10 The Promotion of Administrative Justice Act, 2000 (Act No. 3 of 2000) was passed to give effect to this right. This Act applies to every administrative action or power exercised by a public authority such as government departments at national, provincial and local levels; the police and the army, and parastatals such as the SABC. There are two schools of thought on whether the actions of medical schemes are governed by this Act. The one view is that the actions of medical schemes are not governed by the Act as this relationship is a private one governed by a contract between a scheme and a member, and subject to the common law relating to rules of natural justice. The other school of thought argues that where a medical scheme exercises a power derived from the provisions of the Medical Schemes Act, such as the power to suspend a member (section 29(2) of the Medical Schemes Act), the provisions of the Administrative Justice Act would apply.

11 Act No. 71 of 1988. This Act was introduced to facilitate effective consumer protection. In t in large measure it replaced the Trade Practices Act, 1976 (Act No. 76 of 1976) which was considered to provide inadequate protection for consumers against harmful business practices by unscrupulous entrepreneurs. The 1988 Act provides for the prohibition of certain business practices that may be regarded as harmful to consumers. It also provides for the establishment of consumer courts, to provide consumers with an impartial forum in which to be heard in relation to consumer grievances.

12 This definition is somewhat more useful than the definition of "unfair business practice" in Gauteng's Consumer Affairs (Unfair Business Practice) Act, 1996 (Act No. 7 of 1996), which is: "Any business practice which, directly or indirectly, has or is likely to have the effect of unfairly affecting any consumer."

be regarded as a reasonably satisfactory indication of the legislature's understanding of unfairness.

As a general principle therefore, for our purposes a practice of a medical scheme may potentially be unfair if it harms the relationship between medical schemes and consumers, unreasonably prejudices any consumer, or deceives any consumer.

Specific issues in case law

Confidentiality of medical information

A fair number of important decisions have been made by our courts in relation to confidentiality of medical information.

In the case of *Jansen van Vuuren And Another NNO v Kruger*[13] one M, who had contracted AIDS, instituted an action for damages for breach of privacy against his general medical practitioner because the practitioner had allegedly disclosed M's condition to two of his colleagues. M had been required to submit a blood sample for an HIV test in order to qualify for life insurance. The result was positive and M was notified accordingly. M in turn arranged an appointment with his medical practitioner and informed the practitioner of the test result. M requested him to keep it confidential, which the respondent agreed to do. The next day, however, the respondent disclosed M's condition to one H, another general practitioner, and one V, M's dentist during the course of a game of golf. The news spread and after realising the leak, M instituted action on the basis that his general practitioner owed him a duty of confidentiality. The court held in M's favour. It was stated in casu that as far as the public disclosure of private medical facts is concerned, the Hippocratic oath, formulated by the father of medical science more than 2 370 years ago, is still in use. It requires of the medical practitioner "to keep silence" about information acquired in his professional capacity relating to a patient, 'counting such things to be as sacred as secrets'. It was further noted that according to the rules of the then South African Medical and Dental Council, it amounts to unprofessional conduct to reveal "any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient."

The above principle was recognised in the English case of *X v Y and Others*[14] where Rose J said "In the long run preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients will not come forward if doctors are going to squeal on them. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self treatment does not provide the best care …".

A similar view was expressed by the Supreme Court of New Jersey in *Hague v Williams*[15]: "A patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfiled."

It is to be noted, however, that the court in the matter of *Colonial Mutual Life Assurance Society Ltd v de Bruyn*[16] held that, in the case where an insurance company refers an applicant to a doctor for medical examination, and that doctor has been appointed for that purpose by the insurer,

13 1993 (4) SA 842 (A)

14 [1988] 2 All ER 648 (QB) at 653 a-b

15 [1962] 181 Atlantic Reporter 2d 345 at 349

16 1911 CPD 103

the doctor is not in breach of his or her obligations to the patient if she or he discloses to the insurer medical information discovered by the doctor (either through examination of the applicant or the applicant volunteering that information). However, it would be unlawful for the doctor to disclose medical information to the insurer which is obtained in some other capacity – for example if the applicant chose to consult the doctor later in a personal capacity.

Status of disputes committee decisions

The matter of *Consolidated Employers Medical Aid Society (CEMAS) and Others v Leveton*[17] concerned termination of membership from CEMAS. The respondent had approached the disputes committee who decided in his favour, but the decision of the disputes committee was ignored by the board of trustees of the scheme. The court found that the board of trustees was bound by a decision of the disputes committee, because the board could not be a judge in its own cause. The board was not entitled to behave as if it were a court of appeal.

Pre-authorisation

The matter of *Margate Clinic (Pty) Ltd v Genesis Medical Scheme 2001*[18] dealt with the legal effect of the granting of pre-authorisation. In this particular case, the scheme had erroneously provided a hospital authorisation to treat the infant grandchild of the principal member (who was legally not a dependant of the principal member and therefore not entitled to benefits in terms of the rules of the scheme).

The court found that if, after granting pre-authorisation for a medical procedure, a medical scheme comes across information to the effect that the member was in fact not entitled to the benefit in terms of the rules of the scheme, the scheme was not bound by that pre-authorisation. The court considered the law of contract in conjunction with section 59(3) of the Medical Schemes Act. The court held in favour of the medical scheme. Hugo J found as follows:

> "When the scheme gives the hospital authorisation to treat, that authorisation must clearly be limited by the scheme's own rules. What the scheme undertakes to do as against the hospital is to comply with its contractual obligation as against its member. It can never be a part of that undertaking that it will also pay to the hospital monies to which its member would not be entitled by virtue of the contract between scheme and member and also by virtue of the statutory provisions.
>
> "…The upshot of this is that what the scheme undertakes to do, is to pay the hospital in accordance with the applicable tariff provided it is bound to do so as against the member. If it turns out that the person treated was not a member or a dependant of the member then there is no undertaking in my view, that the fund would nevertheless pay the hospital. Such an undertaking would be contrary to the scheme's rules and therefore *ultra vires*.
>
> "… The onus is therefore on the hospital to ensure that the person it treats is entitled to the benefits by virtue of membership of the scheme. …[A]n authorisation given by the scheme extended no further than the contractual obligations of the scheme as against its member."

17 1999 (2) SA 32 (SCA)

18 Case no 2521/2001 (DLCD)

Determination of unfairness in other jurisdictions

Although in certain limited instances what is regarded as unfair may be culturally- or country-specific, it is always instructive to look to other jurisdictions for examples of what may be regarded as universally-unfair business practices. In this regard codes of good business practice, particularly in the insurance sector, are useful because they begin to define what consumers of these services should reasonably be able to expect. The corollary of this is that unfairness may result if those defined standards are not met by the insurer or other business entity.

Consumer Bill of Rights and Responsibilities (United States)[19]

During his tenure as President of the United States, Bill Clinton established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry to advise him on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure healthcare quality and value, and protect consumers and workers in the healthcare system. The efforts of the commission resulted in a Consumer Bill of Rights and Responsibilities. Major themes in the Bill of Rights and Responsibilities included:

- **Information Disclosure:** Consumers have the right to receive accurate, easily-understood information and some require assistance in making informed healthcare decisions.
- **Choice of Providers and Plans:** Consumers have the right to a choice of healthcare providers that is sufficient to ensure access to appropriate high-quality health care.
- **Access to Emergency Services:** Consumers have the right to access emergency healthcare services when and where the need arises.
- **Participation in Treatment Decisions:** Consumers have the right and responsibility to fully participate in all decisions related to their health care.
- **Respect and Non-discrimination:** Consumers have the right to considerate, respectful care from all members of the healthcare system at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality healthcare system.
- **Confidentiality of Health Information:** Consumers have the right to communicate with healthcare providers in confidence and to have the confidentiality of their individually identifiable healthcare information protected.
- **Complaints and Appeals:** All consumers have the right to a fair and efficient process for resolving differences with their insurers, healthcare providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.
- **Consumer Responsibilities:** In a healthcare system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality-improvement, cost-conscious environment.

The work of Clinton's commission sparked a reaction from the health plans as well. A group consisting of health plans and consumer organisa-

19 *Consumer Bill of Rights and Responsibilities. Report to the President of the United states, prepared by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. November 1997.*

tions in USA got together and drafted an agreement that identified 18 consumer protection principles to promote quality and restore trust in the health are system.[20] Here is a brief summary of those 18 principles:

- **Accessibility of Services:** Health plans should ensure the consumer's access to quality healthcare.
- **Choice of Health Plans:** Consumers should be given a choice of health plans.
- **Confidentiality of Health-Plan Information:** There should be a strong protection against improper disclosure by health plans of medical information.
- **Continuity of Care:** Members should be allowed to choose their own healthcare providers
- **Disclosure of Information to Consumers:** Health plans should provide consumers with information, such as: a description of the coverage provided and excluded, how to obtain service, select providers and obtain medically-necessary referrals; members' cost-sharing requirements; the names and credentials of the plan's physicians; a description of the methodologies used to compensate physicians; procedures for utilisation management; a description of restrictive prescription drug formularies; procedures for receiving emergency care and out-of-network services; procedures for determining coverage for investigational or experimental treatments; use of arbitration; disenrollment data; and how to appeal decisions, file grievances, and contact consumer organisations, such as ombudsman programmes, or government agencies regulating the health plan.
- **Coverage of Emergency Care:** Health plans should cover emergency services, including services provided when a prudent layperson reasonably believes he or she is suffering from a medical emergency.
- **Determinations of When Coverage is Excluded Because Care is Experimental:** Health plans should have an objective process for reviewing new drugs, devices, procedures, and therapies. Plans should also have an external, independent review process to examine the cases of seriously-ill patients who are denied coverage for experimental treatments.
- **Development of Drug Formularies:** Health plans that cover prescription drugs and use restrictive formularies should allow physicians to participate in the development of the formularies and provide for an exception process when non-formulary alternatives are medically necessary.
- **Disclosure of Loss Ratios:** In order to allow consumers to learn what percentage of their premiums are paid out in medical benefits, health plans should uniformly calculate and disclose how much of premium dollars are going for healthcare delivery costs rather than for plan administration, profits, or other uses.
- **Prohibitions Against Discrimination:** Health plans should not discriminate in the provision of healthcare services on the basis of age, gender, race, national origin, language, religion, socio-economic status, sexual orientation, disability, genetic make-up, health status, or source of payment. Health plans should develop culturally-competent provider networks. Health-insurance reform should address discriminatory practices that discourage enrollment of high-risk, high-cost or vulnerable populations in health plans.
- **Ombudsman Programs:** Consumers should have access to, and health plans should cooperate with, an independent, external non-profit ombudsman program that help consumers understand plan-marketing materials and coverage provisions, educate members about their rights within

20 www.kaiserpermanente.org/newsroom/releases/currentpr970924p2.html

health plans, investigate members' complaints, help members file grievances and appeals, and provide consumer education and information.

- **Out-of-Area Coverage:** Health plans should cover unforeseen emergency and urgent medical care for members travelling outside a plan's service area.
- **Performance Measurement and Data Reporting:** Health plans should meet national standards for measuring and reporting performance in areas such as quality of care, access to care, patient satisfaction, and financial stability. There should be a collaborative effort to develop a national core-data set of outcome-oriented, scientifically-based measures, building on existing efforts. Standards should ensure appropriate confidentiality and protection of individual privacy. Health plans should disclose the results of performance assessments and be subject to independent audit to ensure accuracy.
- **Provider Communication with Patients:** Health plans should not limit the exchange of information between healthcare providers and patients regarding the patient's condition and treatment options. Health plans should not penalise providers who in good faith advocate for their patients, assist patients with claims appeals, or report quality concerns to government authorities or health-plan managers.
- **Provider Credentialing:** Health plans and provider groups should develop written standards similar to those used by the National Committee for Quality Assurance for hiring and contracting with physicians, other providers and healthcare facilities. Health plans should not discriminate against providers who treat a disproportionate number of patients with expensive or chronic medical conditions.
- **Provider Reimbursement Incentives:** Neither health plans nor provider groups should use payment methodologies that directly encourage providers to over-treat patients or to limit medically-necessary care. Full-risk capitation should not be used for an individual provider. Where capitation is used for an individual provider, it should only apply to services directly provided by that provider. Appropriate safeguards, such as reinsurance or stop-loss coverage, should be used when individual providers or small groups of providers are capitated or when providers are placed at substantial financial risk. General information about the types of reimbursement methodologies used for providers should be disclosed.
- **Quality Assurance:** All health plans should be subject to comparable comprehensive quality assurance requirements. National standards for quality assurance should be non-duplicative and should provide latitude in the specific methods and activities employed to meet the standards to reflect differences in health-plan organisation. Standards should provide for external review of the quality of care, conducted by qualified health professionals who are independent of the plan and accountable to the appropriate regulatory agency.
- **Utilisation Management:** Utilisation management activities of health plans should be subject to appropriate regulation, including requirements to use appropriately-licensed providers to evaluate the clinical appropriateness of adverse decisions. Health plans should make timely and, if necessary, expedited decisions, and give the principal reasons for adverse determinations and instructions for initiating an appeal. Health plans should be prohibited from having compensation arrangements for utilisation management services that contain incentives to make adverse review decisions.

European Union (EU) Council Directive on Unfair Terms in Consumer Contracts [21]

The EU Council Directive on Unfair Terms in Consumer Contracts provides a comprehensive set of rules to govern the enforcement of terms found

21 EU Council Directive 93/13/EEC of 5 April 1993

in pre-printed consumer contracts involving the sales of goods and services. The directive includes an Annexure of sample terms indicative of unfairness, which should be addressed by consumer protection legislation of member states. The Annexure contains an illustrative and not-exhaustive list of terms often found in consumer contracts that would violate the terms of the directive. These include terms that have the object or effect of:

- Excluding or limiting the legal liability of a seller or supplier in the event of the death of a consumer or personal injury to the latter resulting from an act or omission of that seller or supplier;
- Inappropriately excluding or limiting the legal rights of the consumer vis-à-vis the seller or supplier or another party in the event of total or partial non-performance or inadequate performance by the seller or supplier of any of the contractual obligations, including the option of off-setting a debt owed to the seller or supplier against any claim which the consumer may have against him or her;
- Making an agreement binding on the consumer whereas provision of services by the seller or supplier is subject to a condition whose realisation depends on his or her own will alone;
- Permitting the seller or supplier to retain sums paid by the consumer where the latter decides not to conclude or perform the contract, without providing for the consumer to receive compensation of an equivalent amount from the seller or supplier where the latter is the party cancelling the contract;
- Requiring any consumer who fails to fulfil his obligation to pay a disproportionately high sum in compensation;
- Authorising the seller or supplier to dissolve the contract on a discretionary basis where the same facility is not granted to the consumer, or permitting the seller or supplier to retain the sums paid for services not yet supplied by him where it is the seller or supplier himself who dissolves the contract;
- Enabling the seller or supplier to terminate a contract of indeterminate duration without reasonable notice except where there are serious grounds for doing so – although this should not be construed to limit the ability of a supplier of financial services to reserve the right to terminate unilaterally a contract of indeterminate duration without notice where there is a valid reason, provided that the supplier is required to inform the other contracting party or parties thereof immediately;
- Automatically extending a contract of fixed duration where the consumer does not indicate otherwise, when the deadline fixed for the consumer to express this desire not to extend the contract is unreasonably early;
- Irrevocably binding the consumer to terms with which he had no real opportunity of becoming acquainted before the conclusion of the contract;
- Enabling the seller or supplier to alter the terms of the contract unilaterally without a valid reason which is specified in the contract, although this should not be construed to hinder terms under which:–
  - A supplier of financial services reserves the right to alter the rate of interest payable by the consumer or due to the latter, or the amount of other charges for financial services without notice where there is a valid reason, provided that the supplier is required to inform the other contracting party or parties thereof at the earliest opportunity and that the latter are free to dissolve the contract immediately; or
  - A seller or supplier reserves the right to alter unilaterally the conditions of a contract of indeterminate duration, provided that he or she is

required to inform the consumer with reasonable notice and that the consumer is free to dissolve the contract.

- Enabling the seller or supplier to alter unilaterally without a valid reason any characteristics of the product or service to be provided;
- Providing for the price of goods to be determined at the time of delivery or allowing sellers of goods or supplier of services to increase their price without in both cases giving the consumer the corresponding right to cancel the contract if the final price is too high in relation to the price agreed when the contract was concluded;
- Giving the seller or supplier the right to determine whether the goods or services supplied are in conformity with the contract, or giving him the exclusive right to interpret any term of the contract;
- Limiting the seller's or supplier's obligation to respect commitments undertaken by his agents or making his commitments subject to compliance with a particular formality;
- Obliging the consumer to fulfil all his obligations where the seller or supplier does not perform his;
- Giving the seller or supplier the possibility of transferring his rights and obligations under the contract, where this may serve to reduce the guarantees for the consumer, without the latter's agreement, and;
- Excluding or hindering the consumer's right to take legal action or exercise any other legal remedy, particularly by requiring the consumer to take disputes exclusively to arbitration not covered by legal provisions, unduly restricting the evidence available to him or imposing on him a burden of proof which, according to the applicable law, should lie with another party to the contract.

The Safe Harbour Privacy Principles

Unjustified invasion of individual privacy is widely regarded as a source of unfairness in business activities. In recent years, the EU has enacted strict regulations on consumer privacy, whereas the government of the United States (US) is still promoting the self-regulatory approach to this issue. The difference in approaches led to negotiations to establish a "safe harbour," or standards to protect consumer privacy for US companies doing business in the EU countries. The Safe Harbour Privacy Principles require a US company to follow these requirements:

- **Notice:** Inform individuals about the purposes for which the business collects and uses information about them, types of third parties to which it discloses the information, and how individuals can limit its use and disclosure.
- **Choice:** Allow individuals to choose (opt out) whether their information can be disclosed to a third party or used for purposes other than for which it was originally collected.
- Onward Transfer: Ensure that the third party receiving the transmitted information also adheres to these Safe Harbour Privacy Principles or is subject to the EU Directive.
- Security: Take reasonable precautions to protect personal information from loss, misuse and unauthorised access or alteration.
- Data Integrity: Ensure that personal information is used for the purposes for which it was collected.

22 Safe Harbour Privacy Principles, issued by the US Department of Commerce on 12 July 2000 (www.europa.eu.int/comm/internal_market/en/dataprot/news/shprinciples.pdf)

- Access: Grant individuals access to personal information and to be able to correct or delete inaccurate information.
- Enforcement: Establish dispute-settlement processes available to individuals who believe their personal information has been misused.

The British General Insurance Standards Council (GISC) General Insurance Code for Private Customers

The GISC is an independent organisation which was set up to regulate the sales, advisory and service standards of members (insurers, intermediaries and agents) and anyone acting for them. Its main purpose is to make sure that general insurance customers are treated fairly. The Private Customer Code sets the minimum standards of good practice that all members of GISC must follow when they deal with private customers. It covers all types of general insurance products and services that are sold to private customers, including private medical and dental insurance. The following are some extracts from the Code:

OUR COMMITMENTS

As members of GISC, we promise that we will:

- act fairly and reasonably with you; ...
- make sure all the information we give you is clear, fair and not misleading;
- avoid conflicts of interest or, if we cannot avoid this, explain the position fully to you;
- give you enough information and help you so you can make an informed decision before you make a final commitment to buy your insurance policy; ...
- handle claims fairly and promptly;
- make sure you receive all the documentation you need;
- protect any personal information, money and property that we hold or handle for you; and
- handle complaints fairly and promptly.

MARKETING

We will make sure that all our advertising and promotional material is clear, fair and not misleading.

Helping you find insurance to meet your needs

We will give you enough information and help you so you can make an informed decision before you make a final commitment to buy your insurance policy.

Explaining our service

We will explain the service we can offer and our relationship to you, including:

- the type of service we offer;
- whether we act for an insurer or act independently for you as an intermediary;
- whether we act as an agent or another intermediary or agent; and
- choice of products and services we can offer you.

Matching your requirements

We will make sure, as far as possible, that the products and services we offer you will match your requirements:

- If it is practical, we will identify your needs by getting relevant information from you.
- We will offer you products and services to meet your needs, and match any requirements you have.
- If we cannot match your requirements, we will explain the differences in the product or service that we offer you.
- If it is not practical to match all your requirements, we will give you enough information so you can make an informed decision about your insurance.

Information about products and services

We will explain all the main features of the products and services that we offer, including:

- who the insurer is;
- all the important details of cover and benefits;
- any significant or unusual restrictions or exclusions;
- any significant conditions or obligations which you must meet; and
- the period of cover.

Information on costs

We will give you full details of the costs of your insurance, including: ...

- details of any fees and charges other than the insurance premium, and the purpose of each fee or charge...;
- when you need to pay the premiums, fees and charges, and an explanation of how you can pay; and
- if we are acting on your behalf in arranging your insurance, if you ask us to, we will tell you what our commission is and any other amounts we receive for arranging your insurance or providing you with other services.

23 www.gisc.co.uk. Within the Code, 'you' means the private customer and 'we' and 'us' means the member of the GISC. Interestingly, the Code bears the Crystal Mark – a symbol indicating that the clarity of the Code has been approved by the Plain English Campaign.

Advice and recommendations
If we give you any advice or recommendations, we will:
- only discuss or advise on matters that we have knowledge of;
- make sure that any advice we give you or recommendations we make are aimed at meeting your interests; and
- not make any misleading claims for the products or services we offer or make any unfair criticisms about products and services that are offered by anyone else.

Consumer protection information
- We will explain the consumer-protection benefits under our GISC membership, including:
- our complaints procedures, together with details of who you should contact first if you want to make a complaint; ...

Your duty to give information
We will explain your duty to give insurers information before cover begins and during the policy, and what may happen if you do not. ...

CONFIRMING YOUR COVER
We will confirm your insurance arrangements and provide you with full policy documentation.
When we put insurance arrangements in place, we will give you written confirmation of cover, including:
- enough information so you can check the details of your cover;
- the date when your cover starts and the period of cover;
- any certificates or documents which you need to have by law...

Proof of payment
We will make sure that you have proof that you have paid the premiums, fees and charges.
Full policy documents
We will send you full policy documentation promptly.

PROVIDING OUR SERVICE TO YOU
We will make sure that our service meets the GISC's standards.
Questions
We will answer any questions promptly and give you help and advice if you need it.

Changes to your **policy**
We will deal with any changes to your insurance policy promptly. We will:
- give you written confirmation of any changes to your policy;
- give you full details of any premiums or charges that you must pay or we must return to you; ...
- send you refunds of the premiums, fees or charges that are due to you. ...

Expiry or cancellation
When your policy ends or is cancelled, we will send you all the documentation and information that you are entitled to, if you ask for it.

CLAIMS
We will handle claims fairly and promptly.
Information on claims procedures
When you first become a customer, we will give you details of how you can make a claim and tell you what your responsibilities are in relation to making claims.
If you make a claim
If you make a claim:
- we will respond promptly, explain how we will handle your claim and tell you what you need to do;
- we will give you reasonable guidance to help you make a claim under your policy;
- we will consider and handle your claim fairly and promptly, and tell you how your claim is progressing;
- we will tell you, in writing, and explain why, if we cannot deal with all or any part of your claim; and
- once we have agreed to settle your claim, we will do so promptly.

DOCUMENTATION
We will make sure you receive all the correct documentation you need.
Information in writing
We will give you information in writing, especially if there is a lot of information or if it is very complicated.
Standards of written information
We will make sure that all the written information and documents we send you are clear, fair and not misleading.
Sending you information
We will send you all the documentation you need promptly.
Withholding documentation
We will not withhold any insurance documentation from you without your permission, unless we are allowed to do so by law. If we do withhold documents, we will make sure that you receive full details of your insurance cover and any documents that you need to have by law.

CONFIDENTIALITY AND SECURITY
We will protect your personal information, money and property.
Confidentiality
We will treat all your personal information as private and confidential to us and anyone else involved in providing your insurance, even when they are no longer a customer. We will not give anyone else any personal information about you, except:
- when you ask us to or give us permission; ...
- if we have to by law.

Security
We will take appropriate steps to make sure that any money, documents, other property or information that we hold for you is secure.

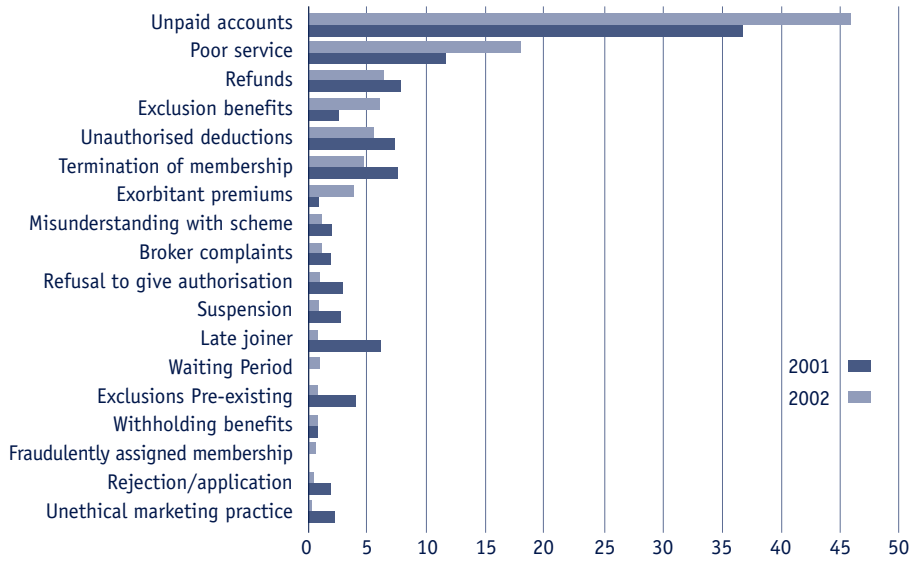
COMPLAINTS
We will handle complaints fairly and promptly.
Information on complaints procedure
When you first become a customer, we will give you details of our complaints procedures in our policy or service documentation.
If you make a complaint
If you make a complaint:
- we will acknowledge it promptly, explain how we will handle your complaint and tell you what you need to do; and
- we will consider and handle your complaint fairly and promptly, and tell you how your complaint is progressing.

Dispute resolution scheme
We are a member of a recognised independent dispute resolution scheme. If you are not happy with our final response to your complaint, we will tell you how you can contact this scheme."

Sources of unfairness

In order to identify potential sources of unfairness, several processes were undertaken. First, a review of data from the Complaints Division of the Council for Medical Schemes was made, to ascertain the broad categories of complaints that are made to the Council by beneficiaries of medical schemes. Table 1 provides a broad summary of categories of complaints received by the office of the Registrar of Medical Schemes between 2001 and 2002, and is included as a broad indication of frequency of types of complaints. In addition, for illustrative value, extracts of actual complaints have been included in text boxes as part of this report. Secondly, brainstorming sessions were held with staff members in the office of the Registrar of Medical Schemes who were identified as having substantial contact with members of the public complaining about unfair treatment by their medical schemes. Thirdly, focus group discussions were held with representatives of various labour organisations and consumer advocacy groups, to understand their concerns in relation to unfair treatment by medical schemes.

Table 1: **Categories of complaints received by the office of the Registrar of Medical Schemes between 2001 and 2002**



Due to the high degree of repetition between these processes, the findings have been combined into an overall report on sources of alleged unfairness, below. Broadly, the sources of alleged unfairness can be categorised into seven main areas, namely:

- information and marketing;
- contributions;
- benefits;
- administration;
- intermediaries; and
- member participation.

Having determined the sources of alleged or perceived unfairness, a process was undertaken to apply the various principles, guidelines and criteria for the determination of unfairness, which has formed the bulk of the discussion above, to these alleged sources of unfairness to come to a decision regarding whether or not are actually unfair. While as much objectivity as possible has been brought to the process of making these determinations, we have seen that there is no absolute definition of unfairness which may be applied with certainty to every scenario. A measure of subjectivity and opinion has therefore inevitably formed part of the assessment – and will no doubt be the source of disagreement. To promote healthy debate about these conclusions, and in the spirit of transparency of process, we have made as explicit as possible the basis of our determinations – in terms of legal doctrines, policy principles, assumptions and suppositions. These can then be debated with a view to arriving ultimately at greater consensus on what is indeed to be regarded as unfair in the medical schemes environment.

Table 2 below sets out the sources of alleged unfairness, the determination of whether or not the conduct complained of is actually unfair for purposes of this project, and the reasoning for this decision.

Information and marketing

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
1. Complex, legalistic and user-unfriendly information on application forms, rules, marketing materials, scheme circulars or monthly statements to members. In particular, definition of benefits in a manner which lacks clarity for the layperson.	Unfairness arises due to the fact that asymmetry of information between contracting parties (scheme and member) increases, resulting in one party (the member) being in a weak position to exercise rights and enjoy entitlements. This is not equitable, and therefore unfair. Significantly, in the US Consumer Bill of Rights and Responsibilities (see para 4.1 *supra*), the first principle is that consumers have the right to receive accurate, easily-understood information and some require assistance in making informed decisions. This theme is repeated in the voluntary code of conduct adopted by health plans in the US. The provision of clear and adequate information is the most important theme throughout the GISC Code (see para 4.4 *supra*).	Yes
2. Application forms, rules, marketing materials, scheme circulars or monthly statements to members not translated into language of choice of beneficiaries.	This may result in unfairness, depending on the circumstances. It would be unreasonable to expect medical schemes to cater for every possible language of its members. Yet unfairness may arise similar to the instance in item 1 above, if material information becomes less understandable to significant numbers of members as a result of unavailability in the language of choice.	Depends
3. Misleading, inaccurate or false advertising or marketing materials.	Misleading, inaccurate or false advertising or marketing materials may give rise to legitimate expectations of beneficiaries that are subsequently not met by the medical scheme. This could result in unfairness (see para 3.1.2 *supra*). This could result in severe prejudice to beneficiaries who may join a medical scheme in the belief that their most pressing healthcare needs are met, only to find out that they do not have the expected cover when they most need it. This could also be regarded as a harmful business practice (see para 3.2.3 *supra*), and offends basic principles of good business. The GISC Code, for example, explicitly commits its members to advertising and promotional material that is “clear, fair and not misleading".	Yes
4. Excessive use of member funds for large-scale advertising campaigns.	The injudicious use of member funds for non-health purposes may be negligent or reckless on the part of the trustees, and accordingly wrongful and culpable. It can also be to the detriment of members, who get less health care from their contributions as a result. If this is gross and unjustified, it could be viewed as unreasonably prejudicing consumers, and therefore potentially falling within the definition of a “harmful business practice (para 3.2.3).” Potentially, in the most severe cases of prejudice due to squandering of trust funds, this could be regarded as unfair. In less severe cases, it could nevertheless remain negligent.	Depends
5. Conditional selling with non-medical scheme related products.[24]	Conditional selling is unlawful (see sections 21A(2) & (3) of the Medical Schemes Act). These provisions were specifically legislated to protect consumers from unfair marketing practices, and is regarded as unfair.	Yes

24 The Council has taken note of an allegation made by one of the union representatives in this regard, alleging that a named medical scheme is still engaging in the mandatory conditional selling of funeral policies. This matter will be investigated.

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
6. Provision of inaccurate, incomplete or misleading information by call centre or other agents of the scheme – especially in relation to such issues as waiting periods, exclusions, benefit limitations, and late joiner penalties.	For the same reasons as cited in the explanations to items 1 to 3, this can give rise to unfairness, and substantial prejudice to beneficiaries who act in reliance on the information provided to them.	Yes
7. Intrusive questions on application forms, requiring information which is not material to membership of the scheme.	The requiring of non-material personal information by a medical scheme could constitute an invasion of privacy, and therefore contrary to the protection intended by section 14 of the Constitution. *Prima facie*, this could be unfair. The seriousness of this unfairness depends on the use to which this information is put. If it is, for example, used to make decisions about the benefits of membership of the medical scheme, this would be regarded as very serious. If, on the other hand, the information is stored, and not used, it would be less serious.	Yes
8. Signature on application forms gives schemes carte blanche to do what they like, especially in relation to – • very broad consent provisions; • liability waivers; • authorisations for unlimited deductions off bank accounts.	Unfairness would result from one party to the contract (the medical scheme), which is in a far stronger negotiating position than the member (for whom negotiating the terms of the contract is often unrealistic) further strengthening its own contractual position at the expense of the beneficiary. This is inequitable, and results in the beneficiary signing away important legal protections. Many instances of such clauses would fall foul of the provisions of the EU Council Directive in Consumer Contracts (see para 4.2 *supra*). Due to the potential prejudice to consumers, and the inequities that result from these practices, it scores highly on the priority rating.	Yes
9. Failure to inform callers to call centres that their calls are being recorded.	Failure to inform callers that calls are being recorded can constitute an invasion of their privacy – and therefore *prima facie* unfair. Given the fact that this practice is largely to ensure an accurate record of conversation, for the protection of both the consumer and the call-centre operator, an omission to inform the consumer, while potentially unfair, may not be particularly severe. If it was standard policy of a call centre not to inform consumers of the fact that calls are being recorded, this could become a serious problem.	Yes
10. Insufficient information provided to beneficiaries on how to utilise the benefit system, including information on – • tariffs (BHF, SAMA, HASA etc) and the tariff system; • balance billing and co-payments; • patient liability for payment of bills; • health decision-making (especially where responsibility for management of health expenditure and benefits is passed onto members, e.g through medical savings accounts).	If the effective exercise of rights and enjoyment of entitlements depends on information of this nature being provided to beneficiaries, failure to provide such information could be regarded as unfair – especially because the less-educated consumer would be relatively more adversely affected than the more-educated consumer. Consumers, when being sold a product, have a reasonable expectation to receive all the necessary information to allow effective use of the product. The GISC Code (para 4.4 *supra*), for example, extensively commits members to providing background information necessary for the proper use of benefits. At the same time, however, beneficiaries retain some responsibility for educating themselves – and this burden cannot be entirely laid at the door of the medical scheme.	Yes
11. Non-communication of vital information regarding contributions, benefits, rights and duties of beneficiaries, including a failure to communicate protocols, policies, preauthorisation requirements and formularies on which decisions are made whether or not to pay a benefit, prior to such decisions being made.	Non-communication of information of this nature is regarded as very serious, due to the fact that such information could have influenced whether or not to purchase the product, may result in unexpected denial of health care or the obtaining of health care only to find oneself financially embarrassed when the scheme later refuses to pay. For the same reasons as item 3, this in regarded as potentially giving rise to severe unfairness.	Yes

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
12. Focus of information provision primarily to urban and electronically literate beneficiaries, with comparatively far less access to information of rural or less educated beneficiaries.	For reasons discussed above, deprivation of information to beneficiaries may be regarded as unfair – and the inequitable provision of information to one subset of beneficiaries (urban dwellers) in relation to others (rural dwellers) adds to the unfairness. Nevertheless, provided reasonable efforts are made to ensure that all beneficiaries are reached equitably, the fact that remote locations have less access to mainstream media and communications possibilities, cannot be blamed on the medical scheme. This becomes especially unfair when schemes and/or brokers sign up rural dwellers for membership of schemes without appropriate benefits and/or without providing them with appropriate information to be able to utilise the benefits.	Yes
13. Obtaining beneficiary medical information from providers without the explicit consent of those beneficiaries.	This would constitute invasion of privacy, in contravention on section 14 of the Constitution. Except in the narrow circumstances set out in the Colonel Mutual Life Assurance Society case, (para 3.3.1 *supra*), courts have taken a very-restrictive view on when medical practitioners are permitted to disclose medical information of their patients (see other cases cited in para 3.3.1). The general rule is that there should be explicit consent by the beneficiary to every such disclosure. Failure to obtain such consent would be regarded as seriously unfair.	Yes
14. Failure to keep personal information of beneficiaries confidential, either by means of inadequate security in their data systems, sale of beneficiary information, or use of member information for related company business (e.g. the life insurance arm of an administrator).	Breaches in confidentiality of personal (and especially medical) information are an indisputable source of unfairness (see discussion in item 13 above). It is also a major issue in the various Codes developed in various jurisdictions to promote fair treatment of consumers. A fundamental tenet of the Clinton Consumer Bill of Rights and Responsibilities is that consumers have the right to have the confidentiality of their individually identifiable healthcare information protected. The Code adopted by health plans in response to this Bill indicates the need for strong protection against improper disclosure by health plans of medical information (see para 4.1 *supra*). Protection of data integrity is a key component of the Safe Harbour principles (para 4.3 *supra*), and confidentiality and security of personal information is also a major clause in the GISC Code (para 4.4 *supra*).	Yes
15. Absence of suitable channels for complaint by members and/or insufficient information provided to members of how to complain.	It was seen in the discussion of procedural fairness (para 3.1.1 *supra*) that fairness demands that persons adversely affected by decisions should have adequate opportunity to make representation not only before the decision is taken, but also after it is take with a view to procuring its modification. Appropriate and accessible complaints procedures are therefore a prerequisite for fairness. In this regard, the CEMAS decision (para 3.3.2 *supra*) is instructive as it emphasises the need for recourse to a disputes resolution process with independence from the decision-making process.	Yes
16. Failure to reflect member copayments on tax certificates.	Although this would be a value-added service to beneficiaries, there is no legal or moral obligation on medical schemes to reflect member copayments on tax certificates. Failure to do so would not be unfair in our view.	No
CONTRIBUTIONS		
17. Unaffordably-high contribution levels.	The setting of unaffordably-high contribution levels per se is not unfair, provided that contribution levels are not structured in such a way as to disproportionately affect certain groups of members. If premiums are set at high levels in relation to other medical schemes, the market should dictate that such premiums are not viable.	No

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
18. Disproportionately loading contributions for reserve building purposes to benefit options with highest proportions of chronically-ill or older members.	This offends principles of equity within medical schemes, and in effect contravenes section 24(2)(e) of the Medical Schemes Act (see para 3.2.2 *supra*) by being tantamount to unfair discrimination on the basis of state of health. It is regarded as seriously unfair.	Yes
19. Increases in premiums mid-year, particularly where members are only permitted to change between benefit options at the end of a year.	Increases in premiums mid-year may be unavoidable to save a medical scheme from collapse, although optimal planning should ensure that these circumstances are reduced to a minimum. However, if the material conditions for which a member contracted change in the course of the contract, it is only fair and equitable that the member should then have the election to choose a more-affordable option at that time. This would be tantamount to allowing one party to unilaterally change the conditions of the contract, without the other party being able to alter the terms on which he or she has contracted. This would offend a number of principles of the EU Council Directive on Unfair Terms in Consumer Contracts (see para 4.2 *supra*), including the provision stating that a term would be unfair if it makes an agreement binding on the consumer whereas provision of services by the seller is subject to a condition whose realisation depends on his or her will alone. The harm to a consumer could be great, as that consumer may have no option but to resign from the scheme, and then face waiting periods if attempting to rejoin that or another scheme at a later date. It should, however, be borne in mind in considering this issue that allowing mid-year changes between benefit options could be complex from a perspective of proration of benefits.	Yes
20. Failure to differentiate contribution levels on the basis of income (i.e. low-income earners pay the same as high-income earners in the same benefit option).	From a policy perspective of attempting to expand access to medical scheme coverage, differentiation of premiums by income is favourable. It is also sensible in the sense that, on average, lower-income persons tend to consume less healthcare than higher-income persons. However, from a commercial perspective, it is probably difficult to argue that it would be unfair to expect higher- and lower-income persons to pay the same for the same benefits. On balance, failure to differentiate contribution levels on the basis of income is regarded as undesirable, but probably not unfair for our present purposes.	No
21. Hidden costs, like add-on administration fees.	Terms on which a member contracts must be explicit at the time of contracting. Any such hidden costs would be regarded as deceptive and unreasonably prejudicial to customers, and therefore probably fall within the definition of a harmful business practice in terms of the definition of a Harmful Business Practice Act. Upfront provision of full details of costs of insurance is a key commitment of the GISC Code for Private Customers. Consumers should have the confidence that the price that they are quoted (and appears in the contribution table of the relevant medical scheme) is the price they must pay.	Yes
22. Possible failure of administrators to plough fraud recoveries back into the schemes.	If this indeed happens it would be fraudulent, criminal and prejudicial to members.	Yes
BENEFITS		
23. Unused benefits are forfeited rather than accruing to the member for future years.	A basic principle of insurance is that members pay for coverage in the event of an unforeseen event happening, and contributions are not refunded if claims are not made. In addition roll-over of benefits are now specifically prohibited by the regulations made under the Medical Schemes Act, to prevent healthier members accumulating access to greater benefits over time than less-healthy members – and consequent use of roll-over benefits in benefit design in a manner which would unfairly discriminate against less-healthy members.	No

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
24. Benefit structure designed to ring-fence the chronically ill or older people into specific benefit options (generally the highest cost option), thereby excluding them from benefits of cross-subsidisation from younger members.	This would constitute a breach of section 24(2)(e) of the Medical Schemes Act, and would undermine basic tenets of the Act designed to ensure community rating and cross-subsidisation.	Yes
25. Unreasonably-low financial limits for certain benefit categories.	Obviously this is not applicable to prescribed minimum benefits, which are not subject to financial limit. In respect of all other benefits, provided that the financial limits are explicitly stated upfront, the member has freedom to contract or not to contract on this basis. *Caveat emptor*! [25]	No
26. Failure to provide coverage for African traditional healers.	By failing to provide coverage for African traditional healers, medical schemes are currently not acting unfairly because, legally, they are not permitted to do so given that these healers are currently not registered in terms of any law. Nevertheless the broader question does arise whether or not the legal impediment itself is fair. It is our view that for as long as there is no registration of these practitioners in terms of a statutory process, the prohibition on reimbursement is reasonable and necessary to protect consumers from unscrupulous practitioners or charlatans. The question of whether it would be fair for medical schemes to continue not to provide reimbursement for traditional healers once they have statutory recognition accordingly does not arise at present, but will have to be reviewed if the Traditional Health Practitioners Bill is passed.	No
27. Failure to provide coverage for specific conditions and interventions, e.g: • obesity • assisted reproductive technology • plastic surgery • vitamin supplements • depression • hearing aids • special geriatric care.	To the extent that specific conditions are not provided for in the prescribed minimum benefits, medical schemes have flexibility in benefit design, provided that benefit design is not specifically used as a method to target particular risk groups indirectly and so contravene sections such as 24(2)(e) of the Medical Schemes Act. In the absence of specific evidence of such behaviour, failure by a medical scheme to provide certain benefits – provided that these limitations are explicit and obvious to members – is not unfair. Again, the *caveat emptor* principle applies.	No
28. "Too-generous" benefits are provided to HIV/AIDS sufferers, at the expense of others who are not at risk of the disease.	A decision by a board of trustees to devote significant resources to combating a world epidemic, which is probably the most important public health crisis facing South Africans, cannot be regarded as unfair. Cross-subsidisation between people suffering from HIV or AIDS and others in the scheme falls squarely within the legislative intent of the Medical Schemes Act – to protect vulnerable groupings in society.	No
29. Discrimination against HIV/AIDS sufferers – e.g. an HIV/AIDS diagnosis reducing hospitalisation benefits, or schemes allegedly refusing to pay for treatment of non-related conditions (e.g. malaria) in persons with HIV/AIDS.	The singling out of a vulnerable grouping belonging to a particular disease group, and applying adverse conditions to that group, is regarded as arbitrary and grossly unfair.	Yes

25 A legal maxim translated as "beware the purchaser," which essentially means that the purchaser must exercise due caution in entering into a transaction, and will be held responsible for that transaction even if it is prejudicial to the purchaser, provided that the conditions of the transaction were reasonably obtainable at the time of transacting.

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
30. Restrictions on access to benefits through managed-care interventions which are unreasonable, hidden, unduly onerous, or arbitrarily applied – this would include, for example, in the case of pre-authorisation, lack of transparency, lack of professionalism, use of unqualified personnel, or arbitrary decision-making.	Arbitrariness and unreasonableness in benefit decisions and hidden limitations can results in legitimate expectations not being met, and cause severe prejudice to consumers whose ability to exercise their rights and entitlements is compromised as a result.	Yes
31. Failure to base formularies and protocols on evidence-based medicine.	This is now unlawful (see regulations 15H and 15I under the Medical Schemes Act) and therefore *prima facie* unfair.	Yes
32. Insisting on pre-authorisation, because members are at their most vulnerable at these times and do not need the added burden of obtaining authorisation.	Pre-authorisation can serve a legitimate administrative purpose for medical schemes. Provided that time frames are reasonable and exceptions are made in emergency situations, this is not unfair.	No
33. Failing to honour pre-authorisations, by later refusing to pay or reversing payments.	This matter has already been determined in the *Margate Clinic* case (para 3.3.3 above).	No
34. Where benefits are provided through preferred provider networks, such networks are inadequate in certain areas without appropriately-sufficient out-of-network benefits (or where members face penalties without having reasonable access to designated providers).	This would be in contravention of regulation 15E(2)(b) of the Medical Schemes Act, which provides that a "managed-care organisation or a medical scheme, as the case may be, may place limits on the number or categories of healthcare providers with whom it may contract to provide relevant health services, provided that … selection of participating healthcare providers is based upon a clearly-defined and reasonable policy which furthers the objectives of affordability, cost-effectiveness, quality of care and member access to health services." As such it is unlawful, and therefore *prima facie* unfair.	Yes
35. Where provision is made for designated providers, members are not given the choice of opting out and paying more for a provider of their choice.	Subject to compliance with the amended regulation 8 under the Medical Schemes Act (regarding designated service providers for prescribed minimum benefits) and regulation 15E(2)(b) (quoted above) – and such restrictions being made explicit upfront – a condition such as this would not be unfair. Caveat emptor.	No
36. Failure of medical schemes to take responsibility for transferring beneficiaries to a public hospital when funds run out and those beneficiaries remain covered for prescribed minimum benefits only in a public hospital.	The need for transfer of the patient is a consequence of the benefit design of the medical scheme in question. It would be reasonable to expect a medical scheme to provide necessary services to enable its members to effectively utilise their benefits, especially because the medical scheme has far more resources required to effect this transfer (through their case managers, for example) than an individual patient. Failure to assist members in this regard could result in significant prejudice when members face huge out-of-pocket payments to private hospitals. On balance, this is regarded as unfair.	Yes
37. Lack of special protection for people with disabilities (in terms of access to specific providers, and information provision).	If the failure of a medical scheme to institute reasonable measures to accommodate members with disability results in those members effectively enjoying less benefits than able-bodied members, this would be inequitable and therefore unfair. This could apply, presumably, in the case of exceptions to designated providers for people who are unable to travel far due to disability. It could also apply perhaps to the provision of benefit information in Braille for blind members. The question, though, would be whether requiring such measures would be reason-	Yes

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
	able under the circumstances. This matter is important because of the vulnerability of this sector of the population, but it will require considerably more work before any definitive guidelines can be developed.	
38. Non-discretionary benefits being paid out of medical savings accounts (MSAs).	Regulation 10(6) prohibits the funds in a member's MSAs being used to pay for prescribed minimum benefits – failure to comply with this would be unlawful and *prima facie* unfair. In respect of non-discretionary benefits beyond PMBs, it is our view that payment of such benefits from MSAs would also be unfair, even though not unlawful. The reason for this is that the stated rationale for introducing MSAs (and accordingly deviating from the principle of community rating to this extent) is to promote the effective management of health and resources by members – and thereby introduce greater efficiencies into the system – by requiring them to make decisions about allocation of resources within their control. This same rationale does not apply in respect of non-discretionary benefits – in respect of medical necessities which members cannot do without. In respect of such benefits members should have the benefit of cross-subsidisation by other members, and compelling them to carry the entire financial burden of such benefits themselves would disproportionately burden more-sickly members and would therefore be unfair.	Yes
39. Interest on medical savings accounts not accruing to members.	The MSA is less akin to an insurance product than to a bank account set aside for specifically medical purposes – and whose balance gets paid to the member on termination. Interest on monies in MSAs therefore properly vests with members, rather than accruing to the risk pool. Failure to ensure that interest accumulates in MSAs is accordingly an inappropriate allocation of funds with financially-detrimental consequences to members and is therefore regarded as unfair.	Yes
40. Outstanding balances on medical savings accounts not paid to members on termination of membership (or transferred to MSA of member's new scheme).	This is unlawful, and can result in serious financial prejudice to members given the large amounts that can potentially accumulate in MSAs. For this reason it is accorded a higher-priority rating than the preceding item.	Yes
41. Failure to make members aware of tax implications of payment of savings account balances.	Educating consumers on their tax obligations in respect of MSA balances would be a value-added service to members, but ultimately responsibility for finding out about tax obligations is an individual responsibility – with the assistance of the South African Revenue Service.	No
42. Some schemes do not recognise "partners" (same sex or different sex) for benefit entitlement, and still recognise only spouses.	Unlawful, in terms of the definition of "dependant" in the Medical Schemes Act, and therefore *prima facie* unfair.	Yes
43. Failure to provide reasons (or adequate reasons) for denial of benefits.	This offends basic principles of procedural fairness (see discussion in para 3.1.1 above), and can involve substantive unfairness to members.	Yes

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
44. Reduction or cancellation of chronic benefits without (adequate) notice to members.	This may amount to enabling the seller or supplier to alter unilaterally without a valid reason any characteristics of the product or service to be provided, a practice identified as unfair in terms of the EU Council Directive on Unfair Terms in Consumer Contracts (para 4.2 above). Unless adequate notice is given, and members are provided assistance is finding reasonable alternatives to accommodate their specific needs, this could be unfair and tantamount to breach of contract. It would also differentially impact on the more sickly members of a scheme, and would therefore have inequitable results.	Yes
ADMINISTRATION		
45. Unreasonable delays in processing applications – as a result of administrative inefficiencies or deliberate attempts to discourage sickly people from joining.	Proof that unreasonable delays result from deliberate action as opposed to inefficiencies would be virtually impossible. In any event, the effect on members is the same. They are potentially very seriously prejudiced by not having coverage due to unreasonable delays on the part of the scheme or administrator. These delays will impact most seriously on applicants with the most need for coverage. This is regarded as being inequitable and unfair.	Yes
46. Unauthorised deductions from bank accounts.	This is unlawful, tantamount to theft, and *prima facie* unfair.	Yes
47. Late- or non-payment of valid accounts.	Members have a legitimate expectation arising from the rules of the scheme (the terms on which they contracted), read together with a medical scheme's statutory obligations in terms of section 59 of the Medical Schemes Act, to receive prompt and timeous payment of accounts. Prejudice to members resulting from schemes not meeting their contractual and statutory obligations in this regard can be immense, as members face credit blacklisting and damages claims.	Yes
48. Non-availability of pre- authorisation facilities after hours.	Provided that members are not adversely affected by such non-availability (e.g. admissions may still occur, with preauthorisation obtained the following day), this should not be regarded as unfair.	No
49. Informing members late or not at all that certain accounts have been declined for payment.	In terms of regulation 6 under the Medical Schemes Act, medical schemes must inform the member that an account is erroneous or otherwise unacceptable for payment within a specified time frame. Members would therefore have a legitimate expectation that, unless they are so notified, the claims that they submit will be paid. Failure to notify members can result in significant harm as members face credit blacklisting, damages claims, and accounts becoming stale for payment by medical schemes.	Yes
50. Sending back claims for corrections, and then rejecting them when resubmitted on the basis that they are stale.	This matter is prescribed by regulation 6(1) under the Medical Schemes Act. Failure to comply with this would be unlawful, and *prima facie* unfair.	Yes
51. Rejection of claims for alleged trivialities, such as insertion of wrong codes by providers.	This would depend on the circumstances. Insertion of wrong codes by providers may undermine the administrative process, and therefore may not be trivial at all. Certain other omissions on accounts may be more trivial – in which case rejection of accounts on this basis might be unreasonable and unfair.	Depends

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
52. Failure to supply, or hold for sufficiently-long periods, historical membership records.	Given the need for members to provide proof of medical scheme membership for, inter alia, purposes of late-joiner penalties – and the severity of the consequences of failure to provide such proof, maintenance of member records for sufficiently-long periods would seem to be intrinsic to the business of medical scheme administration. In the absence of specific legislation governing this issue, the industry should have the benefit of appropriate guidelines for member protection.	Yes
53. Failure to provide monthly statements to members, or when they are provided, overly-complex or insufficiently-detailed statements.	Failure to provide accurate, understandable and regular statements to members is likely to be in breach of the contractual obligations of schemes to their members, as set out in the rules of the scheme. It also places the member in a disadvantageous contractual position, because it is made more difficult for the member to ascertain whether or not the scheme is meeting its contractual obligations. This is considered to be unfair.	Yes
54. Insufficient details on membership cards (e.g. not including the name of the relevant benefit option).	For all practical purposes, the membership card constitutes the proof of membership that the member must use in interaction with healthcare providers. It should therefore contain the information prescribed in regulation 3(1). Failure to do so would be unlawful and would negatively effect members' ability to effectively utilise their benefits. As such, it would be unfair.	Yes
55. Double payments (to both providers and members), resulting in subsequent unanticipated recovery of monies from members.	In principle, members should be querying such payments. However, in circumstances where statements are complex or insufficiently-detailed, it may be unreasonable for members to clearly identify and keep track of various payments from their medical schemes. If such errors arise from fault of the medical scheme or administrator and in the circumstances the member cannot reasonably be expected to detect the error, this could result in unfairness if members are subsequently financially embarrassed as a result of unanticipated recovery.	Depends
56. Unreasonable waiting times for call centres to answer incoming calls.	This presents an obstacle to access to assistance in the utilisation of benefits and in recourse to avenues for complaint and redress. Given the fact that call centres are generally only open during working hours, and many people do not have the luxury of spending long periods on telephone during their work time, on incurring the expense of protracted phone calls, it may actually result in a complete barrier to necessary interaction with the medical scheme. It also gives rise to huge frustration on the part of beneficiaries, and thus harms relationships between medical schemes and their members. As ready access to information, assistance and channels of complaint is intrinsic to fair treatment of beneficiaries of medical schemes (see for example the GISC Code of conduct in para 4.4 above), unreasonable barriers such as this can be regarded as unfair.	Yes
57. Lack of courtesy and professionalism by call centre agents.	As an extreme, this can become a barrier to access to information and channels of redress, and so could result in unfairness in much the same manner as the preceding item. In general though this would be regarded as poor business practice, but not necessarily unfair.	Depends
58. Imposition of waiting periods or late-joiner penalties in a manner contrary to the Medical Schemes Act.	This is unlawful and potentially extremely prejudicial to consumers.	Yes
59. Cancellation or suspension of membership, alleging non-disclosure of a pre-existing condition of which the member had no knowledge prior to joining the scheme.	To the extent that the member had no knowledge of the pre-existing condition, the member could not conceivably have disclosed it, and therefore cancellation or suspension of membership under these circumstances could not be fair.	Yes

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
60. Extremely broad definition of pre-existing conditions, and very-wide interpretation given to related conditions for purposes of exclusions.	Members must have certainty regarding the ambit of exclusions – otherwise the terms on which they have contracted may well be void for vagueness and they certainly would not be provided with sufficient information to make an informed decision. In addition, clear causal nexus must be established between the excluded condition and the condition that presents itself – otherwise unfairness can result. It would also be tantamount to giving the medical scheme the exclusive right to interpret a term of the contract – which is identified as unfair in terms of the EU Council Directive (see para 4.2, item m, above).	Yes
61. Insisting that beneficiaries apply to the scheme through a broker.	This is a violation of regulation 28A under the Medical Schemes Act, and as such is *prima facie* unfair.	Yes
62. Limited period (e.g. 30 days) to register newborns does not take account of difficulties of people in remote locations.	This is a provision typically instituted by medical schemes to give parent members the opportunity to receive dependant benefits for their infants as of date of birth – with some time in which to register the dependant. The typical period of one month would appear to be reasonable, provided that there is provision for exceptions in truly unusual cases.	No
63. Termination of membership of individuals who joined as part of a group, when the group moves to another scheme.	There is no legal recognition at present to 'group membership' as opposed to 'individual membership." Provided that the member is eligible to remain on the scheme as an individual member, the medical scheme cannot unilaterally terminate that member's membership if that member chooses not to terminate along with the rest of the group with who she joined the scheme. To do so would be unlawful, and therefore *prima facie* unfair.	Yes
64. Termination or suspension of membership without informing the member.	This would amount to breach of contract and could have severe consequences to members who are under the mistaken impression that they have medical scheme coverage when they do not.	Yes
65. Continued deductions from member bank accounts following termination of membership.	This is unlawful and can result in serious financial prejudice to members.	Yes
66. Beneficiaries left without cover or with outstanding claims when a scheme merges or liquidates.	This is clearly unfortunate. Whether or not it is unfair will depend on the circumstances of every case – to determine whether beneficiaries were given proper notice and equal opportunity to protect themselves prior to a liquidation. In the case of a merger, any arrangements for a merger should ensure that liabilities already incurred towards members are met. Otherwise the fairness of the merger would be called into question.	Depends
67. Distribution of reserves to members remaining on a scheme at the time of liquidation, to the exclusion of long-contributing members who may have left the scheme.	This is a vexed legal issue and whether or not there is a legal vehicle to effect such distribution of reserves is highly questionable. Generally, there is no basis to expect any "return" on contributions made to medical schemes over any period of time – on the basic insurance principle of what you do not use you lose. Conceptually, though, there may be circumstances in which serious inequities may result. Take for example a scheme in rapid decline where long-standing members, in order to protect their best interests, terminate their membership leaving behind a handful of remaining members who may have just joined the medical scheme. If those remaining members then opt for voluntary liquidation and were to distribute the scheme's reserves amongst themselves, this may be severely inequitable and therefore unfair towards the members who left.	Depends

Alleged Unfairness	Discussion	Determination of unfairness (yes/no/depends)
INTERMEDIARIES		
68. Brokers providing biased or partial advice motivated not by the interests of the member (or potential member), but by personal financial interests vested in touting particular products – or alternatively as a result of ignorance on the part of the broker.	This is clearly a breach of trust by the broker, and is potentially deceitful. It contravenes principles of best advice, intrinsic to basic notions of fairness, and which forms the basis of, for example, the GISC Code (para 4.4 above).	Yes
69. Medical schemes disincentivising or threatening brokers who bring poor risk to the scheme.	This gives rise to unfair discrimination on the basis of age or health status, in contravention of section 24(2)(e) of the Medical Schemes Act, and may result in brokers not providing best advice to clients (see preceding item).	Yes
70. Brokers using non-accredited agents to do their business.	This is unlawful and therefore *prima facie* unfair.	Yes
71. Brokers failing to provide post-sales service to clients.	If brokers undertake to provide such ongoing service to clients, and fail to do so, a legitimate expectation of such clients will not be met.	Yes
MEMBER PARTICIPATION		
72. Frustration of member participation in AGMs through: inaccessible venues, late notice, timing which coincides with public holidays, or agendas which do not allow for effective participation or which amount to a mere rubber-stamping exercise.	Effective member participation in governance is a cornerstone of the governance model intended by the Medical Schemes Act. Annual general meetings are one of the major vehicles for such participation. Frustration of effective member participation in AGMs deprives members of an intrinsic right inherent in membership of the medical scheme.	Yes
73. Trustees being perpetually unavailable to members.	If this results in a breakdown of accountability of trustees to the scheme membership, or the failure of trustees' fiduciary duties toward their members, this could result in members being deprived of basic rights of membership.	Yes
74. Lack of specific union representation on boards of trustees.	The Act does not provide for representatives of constituencies to be represented on boards of trustees and to serve those constituencies. Provided that there are fair and democratic procedures in which members have equal opportunity to serve on boards of trustees, the lack of representation of any particular constituency is not regarded as unfair.	No
75. Member opinion not being taken into account in formulation of contributions and benefit structures.	Trustees are ultimately accountable to their members on decisions taken in respect of contributions and benefits. Adequate opportunity must be provided for members to provide input (e.g. through AGMs, questionnaires etc) and such input must be taken into account. Unresponsive trustees will deprive members of their right to participate in the affairs of the scheme. However strategic and governance decisions ultimately must be made by the trustees in the best interests of all members	Depends

In addition to the alleged unfairnesses identified above as being perpetrated by medical schemes and their agents, respondents identified a number of broader policy, regulatory and environmental factors which, in their view contributed to unfairness in the environment. While these broader issues are not the focus of this study, it is nevertheless appropriate to mention them so that they can be taken into account when developing recommendations for an overall fairer environment.

In some instances, respondents said that the Council for Medical Schemes could do more to counter unfairness in the environment. Suggestions included: a toll-free number for people who do not have access to a website; issuing of cautionaries to the public when schemes get into financial difficulties; and streamlining of complaints procedures. The perceived continued tolerance of health-insurance products which beneficiaries bought as a substitute for medical-scheme coverage was raised as problematic.

In relation to the regulatory environment, some respondents questioned the appropriateness of the imposition of waiting periods for persons changing between medical schemes, and particularly argued that people who have been retrenched or who are self-employed experience undue burden in relation to both waiting periods and late-joiner penalties. The lack of provision for medical schemes to allow pre-funding for retirement was raised as a concern. In addition, some respondents did not appreciate medical schemes being permitted to restrict change of benefit options to the beginning of a calendar year.

In relation to the provision of healthcare, some respondents claimed that it was unfair that medical schemes directed them to public hospitals, when they argued that they were already paying for public hospital care through taxation. Respondents complained of over-servicing by healthcare providers, and the failure of doctors to display tariffs and tariff information prominently in their consulting rooms.

In the employment relationship, those respondents that commented felt most aggrieved at having their choice of medical scheme restricted by employers.

Chapter Two

Gap analysis: what more can be done to protect consumers?

As discussed above, the Council for Medical Schemes has a broad mandate to protect consumers from unfair practices in the medical schemes industry. Having identified unfairnesses that are still experienced by consumers, this chapter of the report considers whether the Council is doing enough to protect consumers against these unfairnesses. Although Council is the primary statutory body charged with oversight of the medical-schemes industry, it is acknowledged that there are other statutory and non-statutory bodies who are also playing a role in this regard. Their contributions are also taken into account in our assessment, because it may be that in some instances sufficient intervention is being made by these other bodies to protect consumers without Council needing to devote resources to those issues, while in other cases, consumers could be optimally protected by strategic partnerships being developed between Council and these other bodies. Options available to Council for active or more-passive intervention are identified in this chapter, using the same tabular format as the previous chapter for purposes of convenience. This is followed in the next chapter by an assessment of the appropriateness and feasibility of these options, together with a prioritisation of the recommended action consistent with the prioritisation of unfairnesses in chapter one.

Information and marketing

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
1. Complex, legalistic and user-unfriendly information on application forms, rules, marketing materials, scheme circulars or monthly statements to members. In particular, definition of benefits in a manner which lacks clarity for the layperson.	The Registrar's office has endeavoured to provide a simple set of model rules for schemes to follow in development of their own rules. Beyond that, this issue has not yet been addressed by the office. Internationally, there is a movement toward plain-language drafting of laws, contracts, business brochures and so on. This movement has government sponsorship in several countries. Support and resources for plain language initiatives are provided via the "Plain-Language Network" (website: www.plainlanguagenetwork.org).	• Organisation of a series of workshops for industry participants on plain-language drafting • Inclusion of a module on plain-language drafting in the trustee training programme • Training of Registrar's rules analysts in plain-language drafting • Commissioning of a plain-language practitioner to review model rules • Development of a model application form, applying principles of plain-language drafting • Publication of an advertisement inviting members of the public to submit examples of complex language in medical scheme materials, which will be posted on the Council website

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
2. Application forms, rules, marketing materials, scheme circulars or monthly statements to members not translated into language of choice of beneficiaries.	This issue has until now not been addressed by the Council, nor by any other organisation of which we are aware.	• Publication of a circular setting out guidelines in this regard, for example that medical-scheme documentation should appear in at least two official languages, and that if any language group constitutes 10% or more of the membership of the medical scheme, scheme information should be available in that language • Amendment to the Medical Schemes Act and/or regulations to legislate the use of alternative languages in appropriate circumstances
3. Misleading, inaccurate or false advertising or marketing materials.	The Medical Schemes Amendment Act 55 of 2001 introduced regulation of marketing and advertising insofar as unregistered operations are concerned, as well as conditional selling (section 21A of the Medical Schemes Act, as amended). Misleading, inaccurate or false advertising is currently addressed through the Advertising Standards Authority of South Africa (ASA). The Council has previously referred complainants concerned about unethical advertising by medical schemes to the ASA. The ASA is an independent body set up and paid for by the marketing communications industry to regulate advertising in the public interest through a system of self-regulation. The ASA works closely with government, statutory bodies, consumer organisations and the industry to ensure that the content of advertising meets the requirements of the Code of Advertising Practice. All advertising on electronic broadcast media is subject to the Independent Broadcasting Authority Act (Act No 194 of 1993). In terms of this Act all electronic broadcasters must adhere to the ASA Code as determined and administered by the ASA. Most complaints are quickly and effectively resolved by the ASA Directorate (level 1), but there are times when it may be necessary to refer consumer complaints to the Advertising Standards Committee or competitor complaints to the Advertising Industry Tribunal (level 2). An aggrieved party may refer any decision of the Directorate to the Advertising Standards Committee or the Advertising Industry Tribunal. The decisions of these two Committees may be appealed to the Appeal Committee (level 3). This Committee is chaired by a former judge of the High Court. If an advertiser does not co-operate with the ASA an Ad-Alert is issued to the media. As the media support the Code of Advertising Practice, they will not accept advertising for which an Ad-Alert has been issued. The ASA is also entitled to impose sanctions on an advertiser that breached the Code.	• Entering of a memorandum of agreement between the Council and the ASA, with a view to facilitating effective monitoring of advertising practices within the medical-schemes industry, and the effective referral of complaints between the Council and the ASA • Approaching the ASA to jointly develop a section in the Code of Advertising Practice specifically addressing advertising and marketing practices within the medical-schemes industry

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
4. Excessive use of member funds for large-scale advertising campaigns.	There is ongoing monitoring of non-health expenditure of medical schemes by the Registrar's office. Where abuse or excessive administrative and other non-health expenditure is found to have occurred, there is active interaction between the office and the trustees of the scheme concerned, to address the problem. In some instances, Council has exercised its powers in terms of section 44(8) of the Act to restrict the administrative costs of a medical scheme, and to prescribe the basis on which those costs must be calculated. Although this provision has not previously been used in the specific context of advertising costs, it is our view that it could be.	• Inclusion of a specific line item in annual and quarterly statutory returns disclosing amounts spent on advertising • Monitoring of expenditure on advertising by the financial supervision division of the Registrar's office to determine excessive expenditure, with a view to flagging it as part of the risk-mitigation plan of the relevant medical scheme, interaction with trustees and possible intervention in terms of section 44(8) of the Act where expenditure is excessive and thereby jeopardising the financial position of the scheme
5. Conditional selling with non-medical-scheme-related products.	Section 21A of the Act explicitly prohibits conditional selling. The Registrar's office has acted decisively to prevent conditional selling of various products like funeral policies and will continue to do so.	• Additional concerns relate to the emergence of loyalty programmes, wellness products and discount ventures which are associated in the minds of the public as adjuncts to membership of particular medical schemes. There is a need to investigate the extent to which marketing of these products is separate from medical scheme marketing, whether or not contributions to the medical scheme and to these products are completely separate, and whether or not the medical scheme unlawfully subsidises or financially contributes toward these ventures.
6. Provision of inaccurate, incomplete or misleading information by call centres or other agents of the scheme – especially in relation to such issues as waiting periods, exclusions, benefit limitations, and late-joiner penalties.	This has previously been dealt with in terms of routine complaints resolution processes. Proficiency of call-centre operations will be evaluated in terms of the administrator accreditation process being undertaken in 2003.	• Conducting of spot checks on call centre and other agents by posing as prospective members and requesting certain information • Development of simple practical guides for call-centre operators and other agents on the application of statutory or regulatory provisions dealing with certain complex issues • Organising training seminars for call centres and other agents of medical schemes on key aspects of the Medical Schemes Act • Development of model clauses for service-level agreements between medical schemes and administrators
7. Intrusive questions on application forms, requiring information which is not material to membership of the scheme.	This has previously been addressed through routine complaints-resolution procedures.	• Conducting a review of all application forms of medical schemes to determine potential problems • Issuing of a circular providing guidelines on what sorts of questions are considered to be legally permissible on medical scheme application forms, and what are considered legally impermissible • Development of a model application form for use by schemes • Inclusion of a module on application forms in the trustee training programme • Amendment to the Act and/or regulations – - explicitly setting out legal standards for application forms; and/or - making approval of application forms of medical schemes by the Registrar mandatory

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
8. Signature on application forms gives schemes carte blanche to do what they like, especially in relation to – • very broad consent provisions; • liability waivers; • authorisations for unlimited deductions off bank accounts.	This has previously been addressed through routine complaints resolution procedures.	• The same recommendations apply as in item 7 • In addition, a circular should be developed clearly defining the legal parameters of liability and consent waivers, the legal requirements for informed consent, as well as the relationship of consent to privacy and confidentiality protections • In respect of authorisations for deductions off bank accounts, please see item 46
9. Failure to inform callers to call centres that their calls are being recorded.	This has previously been addressed through routine complaints resolution procedures.	• This matter may be checked during administrator-accreditation processes • Conducting of spot checks on call centres by posing as prospective members • Issuing of a circular emphasising the importance of call- centre operators being trained and monitored for compliance
10. Insufficient information provided to beneficiaries on how to utilise the benefit system, including information on – • tariffs (BHF, SAMA, HASA etc) and the tariff system; • balance billing and co-payments; • patient liability for payment of bills; • health decision-making (especially where responsibility for management of health expenditure and benefits is passed onto members, e.g through medical savings accounts).	Medical schemes typically provide brochures and/or newsletters on how to utilise the benefit system, and members acting through brokers may be able to obtain this sort of advice through the brokers. Members are often also assisted in claims processes by their healthcare providers. Council runs an extensive ongoing consumer education programme at venues throughout the country to educate consumer groups and trade union representatives of their rights and responsibilities in relation to medical schemes. Information sheets and brochures on member rights and responsibilities have also been produced.	• Development of a comprehensive easy-to-use guide for consumers on the medical-schemes industry, rights and obligations, accessing benefits, limitations on benefits, tariffs and copayments, use of medical savings accounts and so on, and – - publishing this guide on the Council website - advertising availability of this guide in newspapers and on radio - supplying sufficient copies of this guide to all medical schemes to distribute in mailings to their members
11. Non-communication of vital information regarding contributions, benefits, rights and duties of beneficiaries, including a failure to communicate protocols, policies, preauthorisation require-	Member access to this sort of information is protected by the Act and the regulations made thereunder: • Section 41 of the Act deals with member access to key documents, including the rules of a scheme. • Regulation 15D(e), which took effect on 1 January 2003 provides that: "If any managed health care is undertaken by the medical scheme itself or by a managed healthcare organisation, the	• Conducting an intensive consumer-education drive on their legal entitlements to receive this information through consumer workshops, dissemination of the guide proposed in item 10, mailings to medical scheme members via their schemes, advertisements and so on • Monitoring of complaints received to identify contraventions in this regard

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
ments, and formularies on which decisions are made whether or not to pay a benefit, prior to such decisions being made.	medical scheme must ensure that healthcare providers, any beneficiary of the relevant medical scheme or any member of the public are provided on demand with a document setting out – (i) a clear and comprehensive description of the managed healthcare programmes and procedures; (ii) the procedures and timing limitations for appeal against utilisation-review decisions adversely affecting the rights or entitlements of a beneficiary; and (iii) any limitations on rights or entitlements of beneficiaries, including but not limited to restrictions on coverage of disease states; protocol requirements and formulary inclusions or exclusions."	
12. Focus of information provision primarily to urban and electronically literate beneficiaries, with comparatively far less access to information of rural or less-educated beneficiaries.	This issue has not previously been specifically addressed, other than the consumer education efforts of the Council which have attempted to reach those sectors typically deprived of ready access to information.	• Development of administrator accreditation standards document to include standards about provision of information to remote and less-educated members • Provision of guidelines to trustees on mechanisms to facilitate provision of information to remote and less-educated members, as well as the limits of electronic communication • Development of an undesirable business practice declaration declaring as undesirable the practice of mass-membership sign-ups of illiterate rural dwellers without ongoing provision of support and information to those members
13. Obtaining beneficiary medical information from providers without the explicit consent of those beneficiaries.	This has previously been addressed through routine complaints resolution procedures. Confidentiality requirements are specified in regulation 15J(g) of the regulations made under the Act. Privacy and confidentiality requirements in medical schemes were dealt with as a chapter in the report of the Registrar's office on standardisation of data and billing practices. The National Health Bill contains provisions strengthening patient-confidentiality protections.	• Establishment of a joint task team with the Health Professions Council of South Africa to enhance member-confidentiality protections • Review the adequacy of legal protections afforded to medical schemes in terms of, inter alia, the Medical Schemes Act, the Promotion of Access to Information Act, the proposed National Health Bill and the common law, with a view to: - recommending improvements in the legislative framework where these are inadequate; - issuing a circular to medical schemes and administrators advising them of legal limits on the way in which member information may be used; - writing an article in SAMJ on provider obligations, and limits thereof, in respect of provision of member information to medical schemes; - communicating with providers via SAMA and HASA in respect of this legal review. • Monitoring of complaints received to identify contraventions in this regard • Inclusion of a module on confidentiality and access to data in trustee-training programmes • See item 8 in relation to broad-consent provisions on application forms
14. Failure to keep personal information of beneficiaries confidential, either by means of inadequate security in their data systems, sale of	This has previously been addressed through routine complaints resolution procedures.	The same proposals made in item 13 apply

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
beneficiary information, or use of member information for related company business (e.g. the life insurance arm of an administrator).		
15. Absence of suitable channels for complaint by members and/or insufficient information provided to members of how to complain.	At medical-scheme level, every medical scheme is required by law to include provision for complaints and dispute-resolution procedures in their rules. Unresolved complaints may be referred to Council for resolution, in terms of the relevant provisions of the Act (sections 47 to 50). The consume- education programmes run by Council referred to in item 10 focus intensively on complaints procedures, and brochures on these procedures are available.	• Requesting medical schemes and administrators to include copies of the Council brochure on complaints procedures in their mailings to their members.
16. Failure to reflect member copayments on tax certificates.		
CONTRIBUTIONS		
17. Unaffordably high contribution levels.		
18. Disproportionately loading contributions for reserve- building purposes to benefit options with highest proportions of chronically-ill or older members.	The addition of the chronic-disease list to the PMB package will reduce (but not eliminate) the potential for ring-fencing sufferers of chronic diseases in particular benefit options, and so will reduce potential for this form of discrimination.	• Issuing of a circular indicating that this approach to contribution setting is considered unfair and unlawful • Conducting more in-depth analysis of statutory return data on a per-benefit-option level to identify potential instances of this occurring, and publish analyses on our website and through CMS News • Expansion of statutory returns, where necessary, to provide appropriate data to allow this practice to be more-easily identified – in particular to request detail from schemes on the quantum of funds set aside for reserve-building purposes, per benefit option • Approaching ASSA for professional guidelines to be developed on appropriate contribution setting practices • Expansion of statutory returns to include information to allow such practices to be identified • Introducing rate-filing provisions in the Medical Schemes Act, similar to provisions in the USA • Introducing amendments to the Medical Schemes Act and/or regulations specifying how contributions may be affected by reserve- building requirements

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
19. Increases in premiums mid-year, particularly where members are only permitted to change between benefit options at the end of a year.	Prior approval by our office is required for such increases, as they cannot be introduced without rule amendment. Motivations accompanying the proposed rule amendment are considered before approval is given.	• Issuing of a circular indicating the need for schemes to allow benefit-option changes at the time of mid-year increases, and the circumstances under which mid-year contribution increases are appropriate • Changing the model rules to allow for mid-year benefit-option changes in these circumstances – taking cognisance of complexities around pro-rating of benefits • Introducing amendments to the Medical Schemes Act and/or regulations requiring medical schemes to allow benefit-option changes at the time of mid-year contribution increases • Applying more intense scrutiny of the need for mid-year increases in line with the guidelines set out above, and developing set criteria for approval of these changes based on detailed motivation provided by schemes • Introducing rate-filing provisions in the Medical Schemes Act, similar to provisions in the USA
20. Failure to differentiate contribution levels on the basis of income (i.e. low-income earners pay the same as high-income earners in the same benefit option).		
21. Hidden costs, like add-on administration fees.	All-inclusive contributions are required to be registered in the contribution tables of scheme rules. No hidden fees are permitted.	• Monitoring of complaints received to identify contraventions in this regard • Aggressive prosecution of offenders
22. Possible failure of administrators to plough fraud recoveries back into the schemes.	Primarily this is a responsibility of trustees of medical schemes. It is not currently monitored by the Registrar's office.	• Liaising with BHF-initiated fraud task team to ensure policies are in place to prevent this • Issuing a circular to trustees indicating that this practice must be closely monitored • Including the need for monitoring in trustee-training programmes • Writing to all administrators requesting information about amounts recovered through fraud-detection activities, and corresponding amounts retained and reimbursed to schemes • Initiation of inspections and investigations in instances where problems are suspected or identified • Initiation of legal proceedings to recover monies which may have been wrongfully withheld from medical schemes • Review of fraud-prevention and detection processes of administrators during the administrator accreditation process • Development of guidelines for trustees on appropriate clauses in service-level agreements to ensure value-added services and appropriate safeguards for schemes
BENEFITS		
23. Unused benefits are forfeited rather than accruing to the member for future years.		

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
24. Benefit structure designed to ring-fence the chronically ill or older people into specific benefit options (generally the highest- cost option), thereby excluding them from benefits of cross-subsidisation from younger members.	Addition of the chronic-disease list to the PMB package.	• Audit of all existing scheme rules to identify benefit structures which may have the effect of discriminatory ring-fencing of older or chronically-ill people • Inclusion of specific evaluation criteria in office-rule approval process to explicitly assess whether or not the benefit design has this discriminatory effect • Identification and monitoring of all related complaints
25. Unreasonably low financial limits for certain benefit categories.		
26. Failure to provide coverage for African traditional healers.		
27. Failure to provide coverage for specific conditions and interventions, e.g: • obesity • assisted reproductive technology • plastic surgery • vitamin supplements • depression • hearing aids • special geriatric care.		
28. "Too-generous" benefits are provided to HIV/AIDS sufferers, at the expense of others who are not at risk of the disease.		

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
29. Discrimination against HIV/AIDS sufferers – e.g. an HIV/AIDS diagnosis reducing hospitalisation benefits, or schemes allegedly refusing to pay for treatment of non-related conditions (e.g. malaria) in persons with HIV/AIDS.	An investigation was conducted into HIV/AIDS benefits in the medical-schemes industry, culminating in a recommendation to the Minister of Health to extend these benefits to include the provision of chronic ART. Various prima facie unfair practices were identified, including in some schemes the reduction of other benefits for persons receiving HIV benefits.	• Tighter monitoring of complaints. • Follow up on schemes identified in survey as perpetrating unfair or unlawful practices. • Circular to all schemes indicating unacceptability of those practices. • Review of rules for clauses with potential discriminatory effect.
30. Restrictions to access to benefits through managed care interventions which are unreasonable, hidden, unduly onerous, or arbitrarily applied – this would include for example in the case of pre-authorisation, lack of transparency, lack of professionalism, use of unqualified personnel, or arbitrary decision-making.	This has previously been addressed through routine complaints-resolution processes. New managed-care regulations (regulations 15 to 15J) which took effect 1/1/2003 now provide legal basis for more-stringent interventions by the Registrar. Implementation of accreditation requirements for managed-care organisations with effect from 1/1/2004 will provide additional powers to ensure compliance with the legal requirements.	• Close scrutiny of capacity, systems and resources in accreditation process – and strengthening accreditation capacity within the Registrar's office • Incremental expansion of the accreditation process for managed-healthcare organisations to monitor issues of access, quality and cost effectiveness • Specific monitoring of complaints received to identify contraventions • Strengthening of capacity within the clinical- service division of Council to facilitate effective review of managed-care protocols, formularies and other limitations • Regular updating of managed-healthcare policy documents published on the website to deal with any problems that may be identified in implementation
31. Failure to base formularies and protocols on evidence-based medicine.	Commencement of new regulations with effect from 1/1/2003 (especially regulations 15G, 15H and 15I)	Same interventions as item 30.
32. Insisting on pre-authorisation, because members are at their most vulnerable at these times and do not need the added burden of obtaining authorisation.		
33. Failing to honour pre-authorisations, by later refusing to pay or reversing payments.		

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
34. Where benefits are provided through preferred-provider networks, such networks are inadequate in certain areas without appropriately-sufficient out-of-network benefits (or where members face penalties without having reasonable access to designated providers).	This has previously been addressed through routine complaints processes. Regulations which took effect on 1/1/2003 now provide a legal basis on which to ensure reasonableness of preferred-provider networks. This should also be seen in conjunction with regulations 8(2) and 8(3) dealing with designated service-provider networks for prescribed minimum benefits, which take effect on 1/1/2004.	• Inclusion of specific evaluation criteria in office-rule approval processes to explicitly assess the adequacy of networks and/or out-of-network benefits • Requiring separate motivations to be provided as an annexure to scheme rules submitted for approval in this regard • Training of rules analysts to assess these criteria • Specific monitoring of complaints received to identify contraventions
35. Where provision is made for designated providers, members are not given the choice of opting out and paying more for a provider of their choice.		
36. Failure of medical schemes to take responsibility for transferring beneficiaries to a public hospital when funds run out and those beneficiaries remain covered for prescribed minimum benefits only in a public hospital.	This has previously been addressed through routine complaints processes.	• Amendment of model rules to address this issue specifically. • Requesting the medical-advisors' forum to ensure that specific protocols are developed and implemented by case managers to facilitate appropriate transfers of patients. • Specific monitoring of complaints received. • Introduction of amendments to the Act and/or regulations to reinforce scheme obligations in this regard. • Issuing of a circular stating Council's position in this regard.
37. Lack of special protection for people with disabilities (in terms of access to specific providers, and information provision).	This has previously been addressed through routine complaints processes, but has largely been unmonitored.	• Review of legislation to identify any legal requirements on schemes for the protection of persons with disabilities • Issuing of a circular providing guidelines to trustees on: - disabled access to medical-scheme offices - availability of scheme literature in Braille - appropriate provisions in contracts with administrators and other intermediaries - special benefits for persons with disabilities - requirements for disabled access to buildings of scheme, administrator, designated service providers etc • Appropriate amendments to the Medical Schemes Act and/or regulations to specifically protect the interests of members with disabilities.

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
38. Non-discretionary benefits being paid out of medical savings accounts (MSAs).	The implementation of regulation 10(6), with effect from 1/1/2003, is designed to ensure that MSAs are not used by the medical scheme to pay for the costs of prescribed minimum benefits, which by definition are regarded as non-discretionary.	• Amendment of model rules to specifically address this issue, with model rules being amended to incorporate a specific section on rights, obligations and limitations in respect of medical-savings accounts • Inclusion of specific evaluation criteria in office-rule approval processes to explicitly assess whether or not this restriction is in place • Specific monitoring of complaints received to identify contraventions • Inspections of medical schemes to identify contraventions
39. Interest on medical-savings accounts not accruing to members.	This has previously been addressed through routine complaints processes, but has largely been unmonitored.	• Amendment of model rules as suggested in item 38. • Inclusion of specific evaluation criteria in office rules-approval processes to explicitly assess whether or not appropriate provision is made in scheme rules for interest payment • Specific monitoring of complaints received to identify contraventions • Inspections of medical schemes to identify contraventions
40. Outstanding balances on medical savings accounts not paid to members on termination of membership (or transferred to MSA of member's new scheme).	This has previously been addressed through routine complaints processes.	• Amendment of model rules as suggested in item 38. • Inclusion of specific evaluation criterion in office rules-approval processes to explicitly assess whether or not appropriate provision is made in scheme rules for MSA balance pay-outs where legally required • Specific monitoring of complaints received to identify contraventions • Inspections of medical schemes to identify contraventions
41. Failure to make members aware of tax implications of payment of savings account balances.		
42. Some schemes do not recognise "partners" (same sex or different sex) for benefit entitlement, and still recognise only spouses.	Inclusion of definition of dependant, as in the Act, is strictly enforced by the Registrar's office. Where legitimate complaints have been received of continued unlawful discrimination by medical schemes in this respect, they have been decisively resolved in favour of the member.	• Specific monitoring of complaints received to identify contraventions • Issuing of a circular to trustees and principal officers indicating that such discrimination is completely unacceptable
43. Failure to provide reasons (or adequate reasons) for denial of benefits.	This has previously been addressed through routine complaints processes.	• Issuing of a circular explaining schemes' legal obligations in terms of natural justice and procedural fairness to give reasons for denial of benefits • Introducing a module in trustee-training programmes and consumer-education seminars on procedural fairness • Specific monitoring of complaints received to identify contraventions • Amendment of model rules to set out specific procedures for the provision of reasons • Inclusion of specific evaluation criteria in office rules-approval process to ensure adequate safeguards are in place

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
44. Reduction or cancellation of chronic benefits without (adequate) notice to members.	Introduction of chronic-disease list in regulations, with effect from 1 January 2004, reduces potential for reduction and cancellation of benefits. The model rules also provide that members must be given 30 days advance notice of change of benefits, and office processes require similar provisions in rules submitted to the office for approval. This is consistent with section 29(1)(l) of the Act. This has previously been addressed through routine complaints processes.	• Specific monitoring of complaints received to identify contraventions • Issuing of a circular to the effect that benefit changes will be regarded as invalid unless medical schemes can prove that the necessary advance notice was provided to members, and clearly specifying procedures for changes to benefits and contributions • Inclusion of specific assessment criteria for approval of amendments in office procedure to determine if all procedural requirements have been met • Review of model rules to determine if 30-days advance notice period is adequate • Amending the Act and/or regulations to specify an appropriate period, as well as more-clearly detail the consequences of this period not being observed
ADMINISTRATION		
45. Unreasonable delays in processing applications – as a result of administrative inefficiencies or deliberate attempts to discourage sickly people from joining.	This has previously been addressed through routine complaints processes.	• Close monitoring of complaints on a scheme-by-scheme basis to find evidence of persistent problems which may be indicative of (a) administrative problems or (b) targeting against high-risk applicants • Where evidence is found of persistent delays, especially where these are targeted against certain risk groups, suspension or withdrawal of the accreditation of the administrator • Amending the Act and/or regulations to set specific time limits for the processing of applications, coupled with specific penalties for schemes that fail to comply with those penalties
46. Unauthorised deductions from bank accounts.	This has previously been addressed through routine complaints processes, and in some instances has been checked in inspections. A banking industry body has been established to deal with problems between clients and their banks. This is the Banking Council, whose role it is to establish and maintain the best-possible platform on which banking groups can do responsible, competitive and profitable banking. As a representative body, the Council interacts with government departments, consumer bodies and other interests regarding banking issues. The Banking Adjudicator is responsible for mediating in disputes between member banks and their clients.	• Entering of a memorandum of agreement between the Council and the Banking Council, with a view to facilitating effective monitoring of practices regarding medical scheme deductions from bank accounts, and the effective referral of complaints between the Council and the Banking Council for Medical Schemes • Close monitoring of complaints on a scheme-by-scheme basis to find evidence of persistent problems in this regard, and using this as a basis for inspections with a view to: - instituting corrective action; - withdrawing or suspending registration or accreditation; and - potential prosecution

27 Please note that in respect of most of the unfairnesses identified in this section, the administrator accreditation process which wais being rolled out in 2003 is designed to assist in addressing the problems.

28 www.banking.org.za

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
47. Late- or non-payment of valid accounts.	Timeframes for the payment of accounts are specified in section 59 of the Act, read with regulation 6. This has previously been addressed through routine complaints processes, and in some instances has been checked in inspections. This matter has also previously been investigated in a report to the Minister, and formed the basis for various actions taken by the Registrar, including the committee on standardisation of billing practices and data collection.	• Closer monitoring of complaints on a scheme-by-scheme basis • Close scrutiny of claims-paying processes through the administrator-accreditation process, and suspension or withdrawal of accreditation in instances of persistent problems • Regulating the use of ICD10 industry-wide • Reviewing the statutory 30-day time limit for claims payment, to determine if it needs to be reviewed
48. Non-availability of pre-authorisation facilities after hours.		
49. Informing members late or not at all that certain accounts have been declined for payment.	This is a contravention of regulation 6(2). This has previously been addressed through routine complaints processes.	• Closer monitoring of complaints on a scheme-by-scheme basis • Close scrutiny of claims-rejection processes through the administrator-accreditation process, and suspension or withdrawal of accreditation in instances of persistent problems
50. Sending back claims for corrections, and then rejecting them when resubmitted on the basis that they are stale.	The timeframes for resubmission of queried accounts are dealt with in regulation 6(3). Contraventions have previously been addressed through routine complaints processes.	• Inclusion in the consumer guide proposed in item 10 information to consumers and providers on prescribed times in which accounts must be submitted to medical schemes following their being sent back for correction • The same recommendations apply as in item 49
51. Rejection of claims for alleged trivialities, such as insertion of wrong codes by providers.	This has previously been addressed through routine complaints processes.	• The same recommendations apply as in item 49
52. Failure to supply, or hold for sufficiently long periods, historical membership records.	This has previously been addressed through routine complaints processes.	• Review of existing practice through a questionnaire to schemes and checking through the administrator-accreditation process • Review of other legislation and international practice to determine if there are existing best practice standards in this regard • Development of a set of guidelines for trustees and administrators on appropriate periods for the holding of various types of records (and the security of storage of those records), and issuing a circular to this effect • Amendment to the Act and/or regulations making provision for this

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
53. Failure to provide monthly statements to members, or when they are provided, overly-complex or insufficiently-detailed statements.	This has previously been addressed through routine complaints processes, and in some instances has been checked in inspections.	• Closer monitoring of complaints on a scheme-by-scheme basis • Close scrutiny of relevant processes through the administrator- accreditation process • Expansion of model rules to include clear responsibilities of medical schemes in respect of monthly statements to members • Review of regulation 6(5) to include clear reference to frequency of statements to members • Development of a model member-statement format, consistent with the principles of plain language alluded to in item 1
54. Insufficient details on membership cards (e.g. not including the name of the relevant benefit option).	This matter is dealt with in regulation 3, which specifies what details must be included on proof of membership provided by medical schemes, and this matter is also addressed in the model rules. This has previously been addressed through routine complaints processes.	• Closer monitoring of complaints on a scheme-by-scheme basis • Close scrutiny of cards which are issued through administrator accreditation processes • Expansion of model rule 10.1 clearly specify the details which must be included on membership cards • Development of a model membership-card format
55. Double payments (to both providers and members), resulting in subsequent unanticipated recovery of monies from members.	This has previously been addressed through routine complaints processes, and in some instances has been checked in inspections. This is indicative of a system problem, which standards in the administrator-accreditation process are specifically designed to address.	• Closer monitoring of complaints on a scheme-by-scheme basis • Close scrutiny of system protection against double payments through the administrator-accreditation process, and suspension or withdrawal of accreditation in instances of persistent problems
56. Unreasonable waiting times for call centres to answer incoming calls.	This has previously been addressed through routine complaints processes.	• Review of the extent of this problem through: - requesting medical schemes to provide information on their call-answering times and call-drop rates - conducting a survey through placing calls to call centres • Publishing results of the survey on our website with a view to establishing industry best-practice benchmarks, and encouraging schemes to go on a drive to better their answering times • Review of call-centre capacity through the administrator accreditation process • Developing model clauses in this regard for service-level agreements between medical schemes and their administrators
57. Lack of courtesy and professionalism by call centre agents.	It is understood that medical schemes and administrators typically include skills development in these areas as part of the training of their call-centre agents. This issue has however not previously been addressed by the Council.	• Setting up a noticeboard on the Council website, where members of the public are invited to post comments on either good or bad experiences with the call centres of their medical schemes – and where other members of the public can view their comments • Inviting medical schemes and administrators to provide details of particularly-useful courses or programmes which have improved the courtesy and professionalism of their call-centre agents, and sharing this information more broadly with the industry. • Inviting nominations from the public through a media advertisement for the most helpful and courteous call-centre agent of a medical scheme, and giving an award to the successful nominee.

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
58. Imposition of waiting periods or late-joiner penalties in a manner contrary to the Medical Schemes Act.	The circumstances in which waiting periods may be imposed are specified in terms of section 29A of the Act, and circumstances in which late-joiner penalties are permitted are specified in regulation 13. This has previously been addressed through routine complaints processes. In addition, consumer-education programmes of Council focus on these issues.	• Closer monitoring of complaints on a scheme-by-scheme basis to find evidence of persistent problems which may be indicative of (a) administrative problems or (b) targeting against high-risk applicants. • Where evidence is found of persistent incorrect application of waiting periods, especially where these are targeted against certain risk groups, suspension or withdrawal of the registration of the scheme or accreditation of the administrator, or institution of prosecutions • Publication of an undesirable business practice relating to unfairly-discriminatory practices in the application of waiting periods and late-joiner penalties • Reviewing correct knowledge or waiting periods and late-joiner penalties by call-centre operators through spot-check phone calls to call centres of medical schemes, and interaction with trustees and administrators to address problems identified • Intensifying consumer-education efforts in this regard, including clear statements of the law to this effect in the consumer guide proposed in item 10, and requesting space in a newspaper advertorial or an article by a health journalist to properly educate consumers in this regard
59. Cancellation or suspension of membership, alleging non-disclosure of a pre-existing condition of which the member had no knowledge prior to joining the scheme.	The circumstances in which membership may be cancelled or suspended are dealt with in section 29(2). This has previously been addressed through routine complaints processes.	• Closer monitoring of complaints on a scheme-by-scheme basis to find evidence of persistent problems which may be indicative of (a) administrative problems or (b) targeting against high risk applicants • Where evidence is found of persistent problems in this regard, especially where these are targeted against certain risk groups, suspension or withdrawal of the registration of the scheme or accreditation of the administrator, or institution of prosecutions • Publication of Council decisions in resolving complaints of this nature on the website and in CMS News, and briefing journalists on specific decisions, to heighten consumer awareness of their rights and duties in this regard
60. Extremely-broad definition of pre-existing conditions, and very-wide interpretation given to related conditions for purposes of exclusions.	This has previously been addressed through routine complaints processes, with specific attention being given to complaints of this nature by the Council's medical advisor.	• Publication of a circular to trustees indicating Council's view on the ambit of exclusions that may be imposed in respect of pre-existing conditions, including guidelines on the specificity of the exclusions as well as the need for a clear causal link to be established between the condition which is being excluded from payment and the pre-defined pre-existing condition • Amendment of the Act and/or regulations to provide clearer statutory parameters for the definition of pre-existing conditions • Closer monitoring of complaints on a scheme-by-scheme basis to find evidence of persistent problems which may be indicative of (a) administrative problems or (b) targeting against high-risk applicants • Where evidence is found of persistent problems in this regard, especially where these are targeted against certain risk groups, suspension or withdrawal of the registration of the scheme or accreditation of the administrator, or institution of prosecutions

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
61. Insisting that beneficiaries apply to the scheme through a broker.	This has previously been addressed through routine complaints processes, applying the provisions of regulation 28A in determination of these complaints.	• Closer monitoring of complaints on a scheme-by-scheme basis to find evidence of persistent problems which may be indicative of (a) administrative problems or (b) targeting against high-risk applicants • Where evidence is found of persistent problems in this regard, especially where these are targeted against certain risk groups, suspension or withdrawal of the registration of the scheme or accreditation of the administrator, or institution of prosecutions • Where evidence is found of broker collusion in this unlawful practice, suspension or withdrawal of the accreditation of the broker • Intensifying consumer education around the the consumer's right not to use a broker when joining a medical scheme
62. Limited period (e.g. 30 days) to register newborns does not take account of difficulties of people in remote locations.		
63. Termination of membership of individuals who joined as part of a group, when the group moves to another scheme.	This has previously been addressed through routine complaints processes.	• Issuing of a circular to trustees emphasising the requirements for termination of membership of individuals who joined as part of a group • Closer monitoring of complaints on a scheme-by-scheme basis
64. Termination or suspension of membership without informing the member.	This has previously been addressed through routine complaints processes.	• Closer monitoring of complaints on a scheme-by-scheme basis to find evidence of persistent problems which may be indicative of (a) administrative problems or (b) targeting against high-risk applicants. • Close scrutiny of relevant processes through administrator-accreditation processes. • Where evidence is found of persistent problems in this regard, especially where these are targeted against certain risk groups, suspension or withdrawal of the registration of the scheme or accreditation of the administrator, or institution of prosecutions
65. Continued deductions from members' bank accounts following termination of membership.	This has previously been addressed through routine complaints processes.	The same recommendations apply as in item 46.
66. Beneficiaries left without cover or with outstanding claims when a scheme merges or liquidates.	As part of the merger process approved by the office of the Registrar, specific arrangements are made to ensure that beneficiaries are protected in the merger process. In any event, the Registrar is obliged by section 63 of the Act to ensure that member interests are protected before approving mergers.	• Amendment of waiting-period provisions of the Medical Schemes Act to make it explicit that new waiting periods cannot be imposed on members who are compelled to move schemes due to liquidation of their existing scheme • Establishment through legislative amendment of an industry fidelity fund, to which all medical schemes must contribute, to protect members against lack of cover for outstanding claims in the event of liquidation

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
	As far as possible, similar arrangements are made through the facilitation of the Registrar when liquidation of a medical scheme is imminent – although the risk to beneficiaries in circumstances of liquidation of a scheme cannot be entirely mitigated.	
67. Distribution of reserves to members remaining on a scheme at the time of liquidation, to the exclusion of long-contributing members who may have left the scheme.	This has not previously been addressed by the Council.	• Commissioning of a study on the alternative approaches to distribution of reserves, from a legal and actuarial perspective
INTERMEDIARIES		
68. Brokers providing biased or partial advice motivated not by the interests of the member (or potential member), but by personal financial interests vested in touting particular products – or alternatively as a result of ignorance on the part of the broker.	2002 amendments to the Medical Schemes Act, and amendments to the regulations regarding broker commission and conduct (which took effect from 1 January 2003), sought to reduce the potential for perverse financial incentives influencing advice provided by brokers. These amendments are being reinforced through inspections of medical schemes. As part of the process of broker accreditation, the Council for Medical Schemes reviews contracts between medical schemes and brokers. The interface between the Financial Advisory and Intermediary Services Act and the Medical Schemes Act is designed to ensure that brokers who fail to provide best advice to members of the public are identified and penalised. An inter-regulatory liaison committee exists between the Financial Services Board and the Council for Medical Schemes to facilitate effective transfer of information between regulators and cross-regulatory efficiency. Many medical schemes endeavour to ensure sound knowledge of their products by internal "accreditation" of brokers in respect of their specific products Various voluntary healthcare-intermediary associations have been established to represent broker interests and to maintain standards of professional conduct. These include, amongst others, the Financial Planning Institute (FPI), the South African Healthcare Intermediaries Association (SAHIA), and the Independent Brokers Council (IBC). They follow internal disciplinary procedures where members are found guilty of unprofessional conduct.	• Stricter enforcement of commission structures to level the playing fields and reduce unfair competition between medical schemes, including: - continuation of programme of commission inspections indefinitely; - swift suspension / withdrawal of accreditation where offenses are found to have been committed by brokers and/or administrators; and - criminal prosecution of offenders • Strengthening the existing cross-regulatory liaison structures with the FSB, to ensure optimal cooperation and collaborative processes • Introduction of broker-training programmes run by the Council, similar to the trustee-training programme currently being undertaken • Establishment of formal channels of communication and referral between the Council for Medical Schemes and broker- representative organisations for sharing of information on legal infringements and unprofessional conduct • FPI recommends that brokers should be legally required to become members of a professional association, because this will ensure ongoing education of brokers and adherence to minimum standards • FPI also recommends that the regulations be amended to make provision for an industry competency examination • Specific monitoring of complaints received to identify contraventions

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
69. Medical schemes disincentivising or threatening brokers who bring poor risk to the scheme.	The introduction of regulation 28(3), with effect from 1 January 2003, was intended to prevent perverse incentivisation of brokers to bring only good risks to schemes. Broker contracts are also reviewed as part of the accreditation process. Routine complaints resolution processes are followed.	• Investigating the necessity for the regulatory framework to be supplemented by an undesirable-business-practice declaration in relation to specific practices which directly or indirectly have this effect • Introducing a toll-free hotline to allow customers to report infringements of the Act confidentially, and specifying this area as one particularly requiring whistleblowing • The introduction of formal channels of communication between the Council and the various representative organisations, as proposed in item 68 should result in instances of abuse such as this coming to the attention of the Council much earlier • Specific monitoring of complaints received to identify contraventions • Supporting processes towards the establishment of a risk-equalisation fund • Widely publicising disciplinary action and/or prosecutions in respect of violations in this regard, to serve as a warning to other offenders
70. Brokers using non-accredited agents to do their business.	This has previously been addressed through routine complaints processes. It is unlawful in terms of section 65 of the Act.	• The same proposals as in item 69 apply in relation to: - whistleblowing - channels of communication between Council and representative bodies - monitoring of complaints - publicising of disciplinary action • In particular, high profile should be given to the withdrawal of accreditation of offending brokers • Consumer-awareness efforts should include specific education on the need to check validity of accreditation of brokers, and of reporting offenders to the Council
71. Brokers failing to provide post-sales service to clients.	Regulation 28(6) was designed to ensure that trustees of medical schemes take responsibility for ensuring that quality ongoing-service continues to be provided by brokers if medical schemes continue to make ongoing payments to brokers, whereas regulation 28(7) provides that ongoing payments must immediately stop if members or employers notify the scheme that they no longer require the services of a broker. These regulations both took effect on 1 January 2003.	• Development of a model service-level agreement between medical schemes and brokers • Inclusion of management of broker contracts as a component of the trustee-training programme • Focus consumer-education efforts on member rights in respect of the brokers servicing them, including their right to terminate reimbursement of brokers by medical schemes in the event that the broker fails to provide ongoing service
MEMBER PARTICIPATION		
72. Frustration of member participation in AGMs through: inaccessible venues, late notice, timing which coincides with public holidays, or agendas that do not allow for effective participation or which amount to a mere rubber-stamping exercise.	Sections 26 and 27 of the model rules provide a model for procedure in respect of calling general meetings, and procedure at meetings. Assistance is provided to boards of trustees who require additional guidance. A study on governance practices was also commissioned by the Council which looked at these issues at quite a high level.	• Conducting more in-depth research into governance practices by medical schemes, including a survey of member opinion on the extent to which there is member satisfaction with participation in their schemes – and publication of those results • Reviewing model rules in light of King IN report, to ensure that the principles set out in the code of corporate practices and conduct are adequately reflected – and also in view of international literature • Inclusion in model rules of specific grievance procedures for people unhappy with election and decision-making processes in AGMs • Publication of an undesirable business-practice in relation to practices which may be designed to frustrate member participation in the affairs of their schemes • Specific monitoring of complaints received to identify abuse

Alleged Unfairness	Existing Interventions	Options for Possible Additional Intervention
73. Trustees being perpetually unavailable to members.	The Council's website includes a list of contact details of schemes. Names of trustees are kept on file by the office, and are available on request.	• Through trustee-training programmes and/or by means of a circular, encouraging trustees to make arrangements to respond to queries from members, e.g. - if trustees are reluctant to provide their personal contact details, schemes should have a central mailbox administered by the principal officer where members can leave requests for specific trustees to contact them - visits by trustees to employers whose employees form part of the medical scheme • Encouraging schemes to include trustee details in scheme newsletters • A zone on our website providing names and background of trustees of each medical scheme, and monitoring of this zone to ensure that it is kept up to date
74. Lack of specific union representation on boards of trustees.		
75. Member opinion not being taken into account in formulation of contributions and benefit structures.	Safeguards are provided in the model rules to the extent that the board of a scheme cannot alter contributions or benefits by more than 25% in any particular year unless approved by the majority of members in a general or special meeting, or by ballot. Beyond that, trustees are expected to be kept accountable to members through, inter alia, annual general meetings	The same recommendations apply as in item 72

Chapter Three

From Analysis to Action

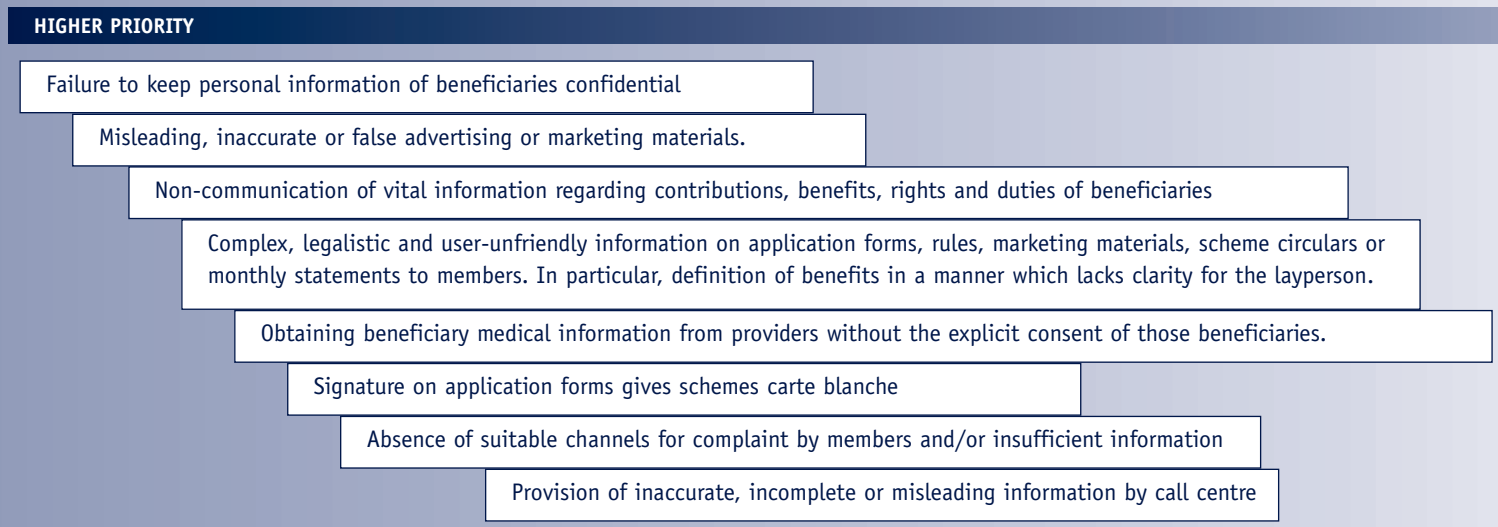
Having identified possible options for further intervention by Council to address the identified unfairnesses, this chapter begins the process of assimilating these activities into a viable plan for action by Council, taking into account the feasibility and desirability of the activities presented. Each section is ascribed to a particular Division of Council as a primary responsibility, and the key interventions extracted from the above options that are considered to have most effect are identified.

It is clear, though, that limited resources preclude all the issues being tackled at once. Accordingly, each section begins with an ordering of each category of unfairness from most- to least-urgent, for purposes of prioritising interventions by Council. The priority is based *inter alia* upon considerations of severity of impact on members, specific legal contraventions, prevalence of the practice, degree of unfairness, potential effect on industry stability, likelihood of useful outcome of intervention, and so on. The priority rating is, however, entirely subjective, and input on these ratings would accordingly be particularly valuable. It is important also to note that a low priority given to an issue for the present is not necessarily an indication that the issue is not considered important – but is merely pertinent to current resource-allocation decisions by Council.

In order to address the unfairnesses in relation to Information and Marketing, the following interventions are considered to be of particular value:

- Expansion of trustee training and a series of workshops open to representatives of medical schemes, administrators and Council employees (and targeted particularly at trustees, principal officers, fund managers and, where applicable, call-centre agents) with sessions on:
  - confidentiality and access to data
  - plain-language drafting
  - application forms
  - key aspects of the Medical Schemes Act
- Further development of model rules
  - commissioning plain-language review
  - supplementing with:
    - model application form
    - model service-level agreements with administrators
- Issuing of a detailed circular to medical schemes, providing guidance on:
  - use of alternative languages in scheme materials
  - formulation of application forms
  - legal parameters of liability and consent waivers and confidentiality issues
  - legal limits on the way member information may be used
  - the importance of call-centre operators being trained and monitored for quality
- Strategic liaison with key stakeholders
  - memorandum of agreement with Advertising Standards

Information and marketing



Authority (ASA)
  - working with the ASA to develop a section in the Code of Advertising Practice relating to the medical schemes industry
  - strengthening the taskteam between the Council and the HPCSA
- Development of guides, accompanied by intensive publicity and education drives
  - for call-centre operators on key regulatory issues
  - for consumers on the industry, and their rights and obligations
  - for trustees on the means to facilitate provision of information to remote and less-educated beneficiaries
- Investigations
  - marketing of non-medical-scheme products (such as loyalty programmes)
  - review of application forms
- Increased monitoring of complaints to identify problem areas

The following interventions should be considered where appropriate, but it is expected that they are less likely to be as effective relative to the resources required to implement them as the aforementioned recommendations:

- Further development of the administrator-accreditation process
  - expansion of standards regarding provision of information to beneficiaries
- Enhancing legal framework
  - amendments setting out standards and requirements for application forms
  - statutory provisions on the use of alternative official languages
  - undesirable business practice on mass rural membership sign-ups without follow-up
- Spot checks
  - On call-centre agents to determine accuracy of information disseminated
- Publication of an advertisement inviting the public to submit examples of complex or confusing language in medical scheme, and publication on the Council website
- Further development of statutory returns
  - disclosure of expenditure on advertising

The major **benefits** to consumers that should be derived from the above-mentioned interventions include:

- greater accessibility of information
- greater consumer and public understanding of benefits, rights, obligations and opportunities for redress
- greater protection of confidential member information

Particular resources required to implement the recommended interventions include human resources, and budget – the extent of which should be determined by the responsible units in their annual operational planning.

The success or otherwise of these interventions in achieving their objectives should be assessed through measurement of such indicators as:

- number of related complaints received by the Council for Medical Schemes
- number of scheme rules amended in terms of plain-language principles
- number of attendees at workshops and other training opportunities
- number of schemes revising application forms from a consumer-rights perspective
- number of beneficiaries surveyed expressing satisfaction with scheme information and marketing practice

In order to address the unfairnesses in relation to Contributions, the following interventions are considered to be of particular value:

- Provision of more-comprehensive professional guidelines on contribution-setting practices, in association with ASSA
- Improved Council review procedures and closer scrutiny of motivations for contribution increases
- Amendment of model rules to allow benefit-option changes at the

time of mid-year contribution increases
- Further development and analysis of statutory returns
- Enhancing the legislative framework to include:
  - Rate-filing provisions similar to those in the USA
  - provision for benefit-option changes at the time of mid-year contribution increases
  - greater specificity on contribution-setting procedures in relation to reserve-building requirements
- Closer monitoring of complaints to identify problem areas
- Aggressive prosecution of contraventions of the Act

The following interventions should be considered where appropriate, but it is expected that they are less likely to be as effective:

- Issuing a circular, indicating:
  - the unlawfulness and unfairness of disproportionately loading contributions for reserves on options with the highest proportion of chronically-ill beneficiaries
  - the need for schemes to allow benefit-option changes at the time of mid-year increases, and the circumstances such increases would be appropriate
  - the need for trustees to monitor fraud recoveries closely

The major **benefits** to consumers we hope to derive from the above-mentioned interventions include significant reductions or elimination of practices which unfairly and detrimentally affect consumers.

Particular resources required to implement the recommended interventions include human resources and budget – the extent of which should be determined by the responsible units in their annual operational planning.

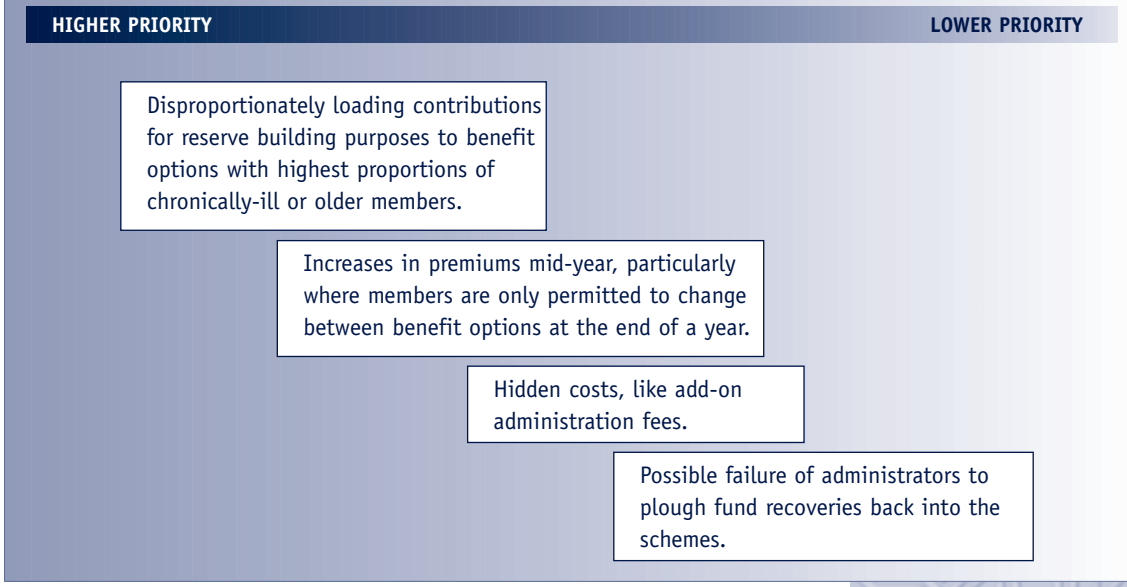
The success or otherwise of these interventions in achieving their objectives should be assessed through measurement of such indicators as:

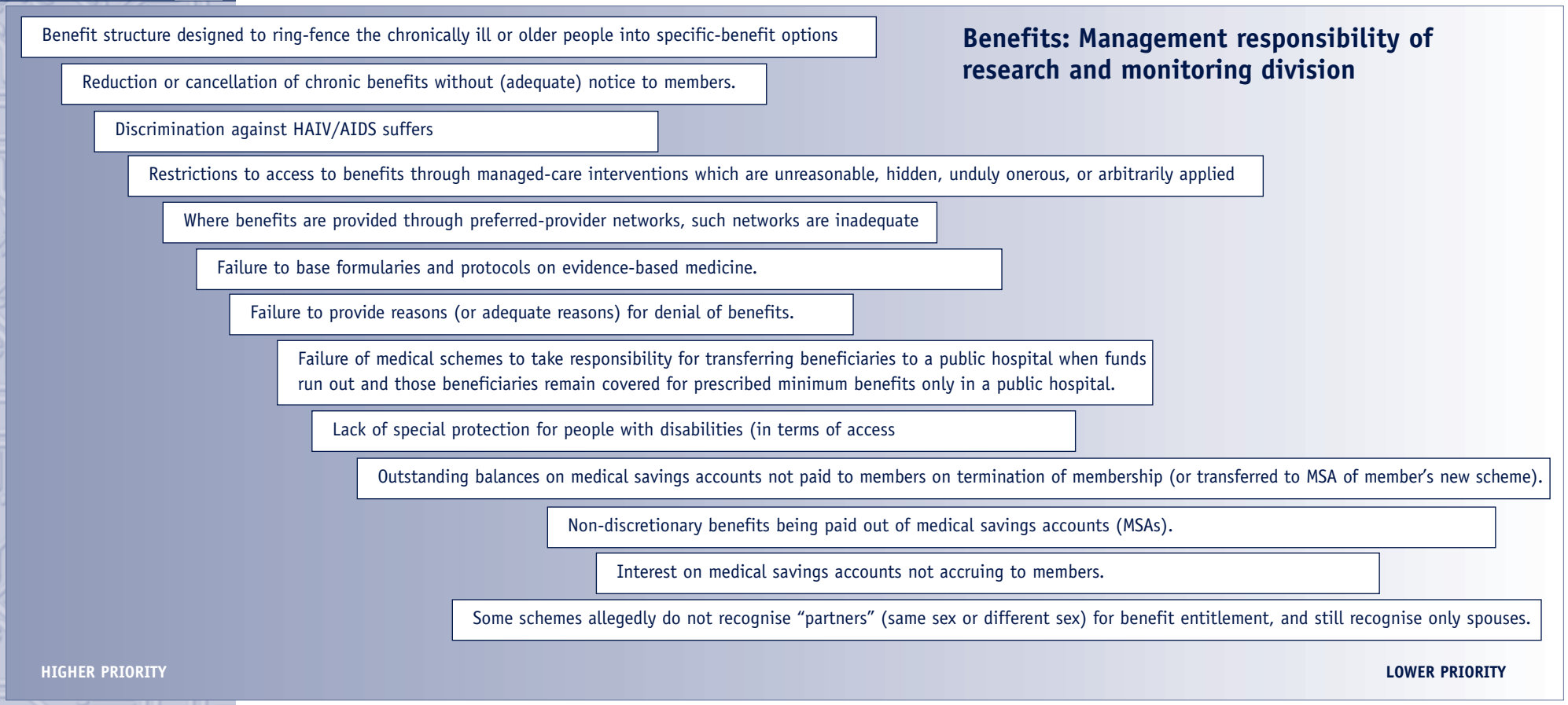
- number of related complaints received by the Council for Medical Schemes
- number of schemes demonstrating adherence to professional guidelines on contribution setting

In order to address the unfairnesses in relation to Benefits, the following interventions are considered to be of particular value:

- audit of all scheme rules to determine discriminatory practices, combined with more in-depth scrutiny of benefit design from a discrimination perspective in rule-approval processes
- suitable amendments to model rules, and expansion of rule-approval process to ensure:
  - non-discriminatory benefit design (in relation to age, gender, sexual orientation, disability etc)
  - greater specificity on medical savings accounts
  - adequacy of networks and network benefits
  - appropriate formulations around medical savings accounts
  - mechanisms are built in for procedural fairness in decision-making processes

Contributions: management responsibility of financial supervision division





- increasing capacity within Council to:
  - monitor issues of access, quality and cost-effectiveness in the process of accreditation of managed healthcare organisations
  - effectively review managed-healthcare protocols, formularies and other limitations for compliance with legislative requirements
- circular to schemes:
  - requesting information about PMBs and the CDL to be made explicit in marketing materials
  - indicating unacceptability of practices designed to, or with the effect of, frustrating cross-subsidisation
  - providing guidelines on transfer of PMB patients between settings
  - providing guidance on benefits in relation to persons with disabilities
  - providing guidance on schemes' legal obligations in respect of procedural fairness and providing reasons for adverse decisions, and in benefit and contribution changes
- closer identification and monitoring of related complaints, and use as a basis for inspections where appropriate

Relevant statutory amendments could be considered where appropriate, but as a secondary measure.

The major **benefits** to consumers we expect to be derived from the above-mentioned interventions include:

- significant reductions or elimination of benefit designs which unfairly discriminate against consumers
- improved consumer awareness of legislative protections in relation to benefit design

Particular resources required to implement the recommended interventions include human resources and budget – the extent of which should be determined by the responsible units in their annual operational planning.

The success or otherwise of these interventions in achieving their objectives should be assessed through measurement of such indicators as number of related complaints received by the Council for Medical Schemes.

In order to address the unfairnesses in relation to Administration, the following interventions are considered to be of particular value:

- closer identification and monitoring of related complaints, and use as a basis for inspections, where appropriate
- expedited and effective implementation of administrator-accreditation procedures (including suspension and withdrawal where appropriate)
- enhancing the legislative framework:
  - mandating the use of ICD10 industry-wide, with provision for exceptions where necessary
  - setting requirements for period and security of storage of information
  - providing for frequency in which statements must be sent to members
  - by publication of undesirable business practice declaration on unfair discriminatory practices in the application of waiting periods and late joiner penalties
  - to provide greater specificity in statutory parameters on application of pre-existing condition waiting periods
  - providing greater protection to beneficiaries compelled to move schemes due to winding up of their existing scheme
- development of guidelines to trustees on such issues as:
  - acceptable times for processing applications
  - appropriate periods for holding records
  - a model statement to members
  - a model membership-card format
  - model clauses for service-level agreements with administrators
  - ambit of exclusions that may be placed on pre-existing conditions
- conducting a survey of call-centre answer times, and publication of results on Council website
- setting up noticeboards on the Council website for:
  - consumers to air compliments and grievances over administrative services they have received
  - medical schemes and administrators to share experiences of best practices
- publication of Council decisions on complaints on website
- commissioning of a study on alternative approaches to distribution of reserves following winding up of a scheme

The following **interventions** should be considered where appropriate:

- entering into a memorandum of understanding with the Banking Council
- amendment of Act and regulations to:
  - set time limits for processing applications, and setting out con • sequences of failure to comply

The **major benefits to consumers** expected to be derived from the above-mentioned interventions include:

- improved quality of service to consumers
- greater efficiency and cost effectiveness in administration, translating

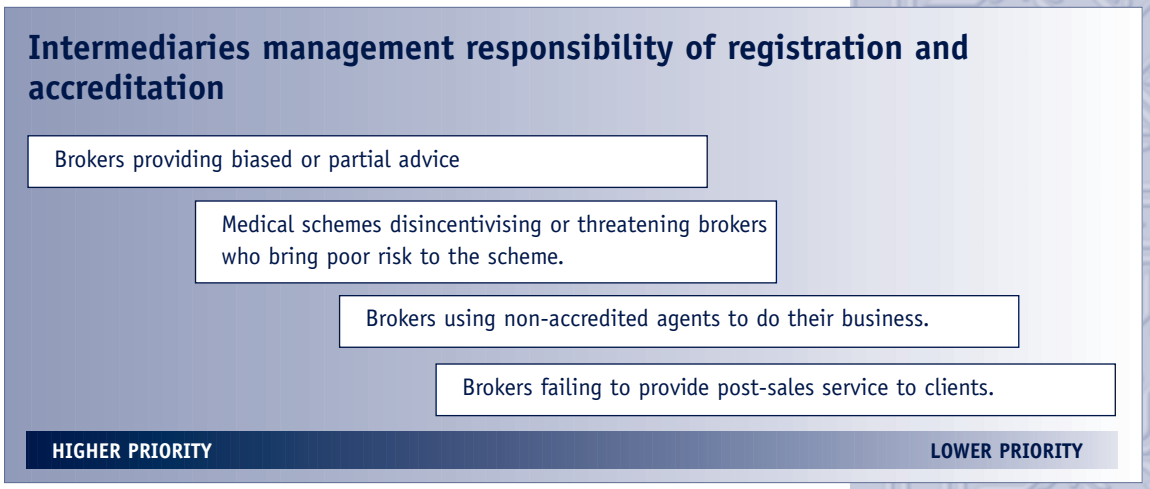
Administration: Management responsibility of compliance and complaints

into reduced non-health costs to medical schemes

Particular **resources** required to implement the recommended interventions include human resources and budget – the extent of which should be determined by the responsible units in their annual operational planning.

The success or otherwise of these interventions in achieving their objectives should be assessed through measurement of such indicators as:

- number of related complaints received by the Council for Medical Schemes
- number of applications for administrator accreditation accepted or declined
- degrees of consumer satisfaction measured through use of surveys



In order to address the unfairnesses in relation to Intermediaries, the following interventions are considered to be of particular value:

- continued intensification of enforcement and prosecution actions in relation to commission structures
- further strengthening liaison structures with:
  - the FSB
  - broker-representative organisations
- enhancing the regulatory framework with appropriate undesirable-business-practice declarations
- expansion of training initiatives for brokers, and trustees in relation to scheme relationships with brokers
- closer identification and monitoring of related complaints
- enhanced consumer education awareness about legal obligations and service expectations of brokers
- widespread publication of prosecution and disciplinary actions, such as suspension or withdrawal of accreditation
- development of a model service-level agreement between schemes and brokers

The following interventions could be considered where appropriate:

- introduction of an industry-wide competency examination for health brokers
- introduction of a toll-free whistle-blowing hotline

The major **benefits to consumers** expected to be derived from the above-mentioned interventions include:

- improved quality of service to consumers
- more-accurate and relevant information provided to consumers
- less incentivisation for discrimination against high-risk beneficiaries

Particular **resources required** to implement the recommended interventions include human resources and budget – the extent of which should be determined by the responsible units in their annual operational planning.

The success or otherwise of these interventions in achieving their objectives should be assessed through measurement of such indicators as:

- number of related complaints received by the Council for Medical Schemes
- number of applications for broker accreditation accepted, declined, suspended or withdrawn
- degrees of consumer satisfaction of broker service measured through use of surveys

Member participation management responsibility of legal

Frustration of member participation in AGMs

Member opinion not being taken into account in formulation of contributions and benefit structures.

Trustees being perpetually unavailable to members.

HIGHER PRIORITY LOWER PRIORITY

In order to address the unfairnesses in relation to member participation, the following interventions are considered to be of particular value:

- Reviewing model rules from member-participation perspective in light of King IN report and international literature
- Inclusion in model rules of specific grievance procedures for members unhappy with election and decision-making processes in AGMs
- Specific monitoring of complaints received to identify problems
- Through trustee training and circulars, encouragement of greater responsiveness among trustees and better communication with members
- Encouraging schemes to include trustee details in scheme newsletters
- A zone on Council's website providing names and background of trustees of each medical scheme, and monitoring of this zone to ensure that it is kept up to date

Additional interventions which could be considered, if appropriate include:

- Conducting more in-depth research into governance practices by medical schemes, including a survey of member opinion on the extent to which there is member satisfaction with participation in their schemes – and publication of those results
- Publication of an undesirable business practice in relation to practices which may be designed to frustrate member participation in the affairs of their schemes
- The major benefit to consumers expected to be derived from the above-mentioned interventions is greater participation of members in scheme-governance processes.

Particular **resources required** to implement the recommended interventions include human resources and budget – the extent of which should be determined by the responsible units in their annual operational planning.

The success or otherwise of these interventions in achieving their objectives should be assessed through measurement of such indicators as:

- number of related complaints received by the Council for Medical Schemes
- degrees of consumer satisfaction of participation measured through use of surveys.

The next step ...

Prior to finalisation of this report, a workshop will be held on its contents open to all relevant stakeholders. This will take place on 19 and 20 February 2004.

After input has been received on this report in the course of this workshop, the report will be finalised and its contents will be used as a blueprint for actions by the Council for Medical Schemes in relation to promotion of fair treatment in the short, medium and longer terms.