THE SUPREME COURT OF APPEAL OF SOUTH AFRICA
JUDGMENT

Reportable

Case No: 20518/2014

In the matter between:

THE COUNCIL FOR MEDICAL SCHEMES	**FIRST APPELLANT**
THE REGISTRAR OF MEDICAL SCHEMES	**SECOND APPELLANT**

and

GENESIS MEDICAL SCHEME	**FIRST RESPONDENT**
THE CHAIRPERSON, APPEAL BOARD OF THE COUNCIL FOR MEDICAL SCHEMES	**SECOND RESPONDENT**
NICOLA JOUBERT	**THIRD RESPONDENT**

Neutral citation: *The Council for Medical Schemes v Genesis Medical Scheme* (20518/14) [2015] ZASCA 161(16 November 2015)

Coram: Leach, Petse, Willis, Mbha and Zondi JJA

Heard: 07 September 2015

Delivered: 16 November 2015

Summary: Rules of medical scheme registered under Medical Schemes Act 131 of 1998 seeking to limit payment of expenses for treatment of prescribed minimum benefits envisaged by regulations under the Act to expenses incurred at a public or state institution - medical scheme may not by its rules avoid obligation to pay full costs of treatment even where administered in a private institution.

ORDER

On appeal from: Western Cape Division, Cape Town (Jamie AJ sitting as court of first instance):

1 The appeal is upheld with costs, including the costs of two counsel.

2 The order of the court a quo is set aside and substituted with the following:

'(a) The ruling of the Appeal Board of 3 May 2012 is amended by the deletion of the words "to the level of a public hospital" .

(b) The application to review and set aside the above ruling of the Appeal Board is otherwise dismissed with costs, including the costs occasioned by the employment of two counsel.

(c) No order is made in respect of the counter application.'

JUDGMENT

Leach JA (Petse, Willis, Mbha and Zondi JJA concurring)

[1] As its name suggests, the first respondent, Genesis Medical Scheme (Genesis), is a medical scheme envisaged by the Medical Schemes Act 131 of 1998 (the Act). The third respondent, Ms Nicola Joubert, was at all material times a member of Genesis. She was also entitled under its rules to receive benefits relating to medical treatment administered to her dependant daughter, Roxanne. As more fully set out below, Genesis disputed that it was required to compensate Ms Joubert for certain of the treatment Roxanne received for an injury to her right

lower leg. When Genesis refused to pay, Ms Joubert complained to the second appellant, the Registrar of Medical Schemes (the Registrar), who ruled in her favour. Under s 49 of the Act, Genesis appealed against the Registrar's decision to the Appeal Committee of the first appellant, the Council for Medical Schemes (the Council). When that appeal failed, Genesis then appealed further under s 50 of the Act to the Council's Appeal Board, again without success. For convenience I shall refer to these two appeal bodies as the Appeal Committee and the Appeal Board, respectively. I should also mention that their reasons for their decisions differed somewhat as did the effect of their respective orders.

[2] Still dissatisfied, and relying on the provisions of the Promotion of Administrative Justice Act 3 of 2000, Genesis then applied to the Western Cape High Court (the court a quo) to review and set aside the ruling of the Appeal Board. In doing so it cited the Council, the chair of the Appeal Board and Ms Joubert as respondents. The Registrar, too, was subsequently granted leave to intervene as fourth respondent in the proceedings, and supported a counter application by the Council for certain declaratory relief relating to Genesis's obligation to pay for the treatment of certain conditions whether obtained from either private or public healthcare service providers.

[3] On this occasion Genesis succeeded. The court a quo reviewed and set aside the ruling of the Appeal Board and substituted, in its stead, an order upholding Genesis's appeal against the decision of the Appeal Committee and declaring that it was not obliged to pay for the particular medical treatment in issue. The court a quo further dismissed the counter application. With leave of the court quo, the Council and the Registrar now appeal to this court against those orders.

[4] The background to the dispute is as follows. On 13 January 2008 Roxanne, who was 17 years of age at the time, sustained an injury to her right lower leg at a

motor-cross event held in Durban. The injury was severe. Described as being a 'sub-total amputation of her lower limb' it consisted of a compound, comminuted fracture of the tibia and fibula. Immediately after the accident, Roxanne was rushed to St Augustine's Hospital, a private institution in Durban, where the wound was debrided and the leg stabilised by the fitting of a Jetex fixator, a so-called 'external prosthesis', used to align and stabilise the factures. Three days later, Roxanne was airlifted by private aircraft to Cape Town. There she was admitted to the Vincent Pallotti Hospital, also a private institution, where she was seen by an orthopaedic surgeon, Dr Bernstein. On 19 January 2008, Dr Bernstein operated once more, during which another external prosthesis, known as an Ilizarov frame, was fitted to Roxanne's leg.

[5] It was after these operations that problems first arose between Ms Joubert and Genesis. On 21 February 2008, in an email addressed to the Registrar, Ms Joubert complained that Genesis had refused to pay medical expenses for her daughter's injuries, contending that they had been sustained in an accident on a quad-bike. This, she alleged, had not been the case. In the subsequent review, Genesis conceded that there had initially been some confusion as to whether Roxanne had been injured while riding on a quad-bike, in which event no benefits would have been payable in terms of the scheme's rules, but stated that the issue had been quickly resolved and that in fact it had paid all the expenses incurred in respect of Roxanne's injuries up to that stage. Consequently, on 18 March 2008, Genesis wrote to the Council stating that Ms Joubert's claims 'have been settled'.

[6] Time passed but, unfortunately, by April 2008 union of the fractures had not occurred. As Roxanne wished to travel to Germany later that month, on 17 April 2008 she underwent a further procedure at the hands of Dr Bernstein, again at the Vincent Pallotti Hospital, in order to remove the external prosthesis. In its place she was fitted with a custom made boot which made it easier for her to travel.

[7] Unfortunately, by February 2009, more than a year after Roxanne had been injured, the fractures of her leg had still not united. Consequently, on 16 February 2009, Dr Bernstein performed yet another operation at the Vincent Pallotti Hospital. In an attempt to facilitate union, the leg was again fitted with an external prosthesis, this time a Taylor spatial frame device. Before this procedure was carried out, Ms Joubert had furnished Genesis with what she had been informed by the medical staff at the hospital were the appropriate codes relating to the treatment. On the strength of this information Genesis had confirmed that it would meet the costs of the procedure. It is common cause that, for some reason, the codes Ms Joubert had been given were incorrect and did not relate to any form of prosthesis. It was only when the hospital forwarded its statement of account for payment that Genesis noted that a prosthesis had been used and, even then, the statement was wrong as the code it referred to was for an internal prosthesis and not the external device that had been fitted. As a result, Genesis informed Ms Joubert that it was only prepared to pay a maximum of R30 000 (that being the maximum amount allowed under its rules in respect of an internal prosthesis) and not the amount charged of some R75 000 which related to the cost of fitting the external device.

[8] Ms Joubert was not prepared to accept this without a fight. On 27 February 2009, she sent an email to the Registrar in which, after referring to her initial complaint of 2008 and stating that ‘this is a continuation of the same complaint’, she briefly outlined how she had obtained authorisation for the February 2009 operation before it had been performed. She went on to complain that Genesis had now advised that it was only prepared to pay R30 000 rather than the full amount charged and asked ‘how can they come two weeks after the op and state they are not paying etc?’

[9] The Registrar referred the matter to Genesis for comment. In its response of 6 April 2009, it stated it to be 'self-evident that the current complaint is not a continuation of the first complaint as alleged', that the hospital's account had referred to the code for an internal prosthesis for which its rules allowed an amount of R30 000, that the Taylor spatial frame was in fact an external prosthesis in respect of which its rules provide no benefits, and that in the circumstances Ms Joubert was liable for the entire amount of the hospital's charge.

[10] Genesis then hardened its attitude even further. It decided that it ought not to have paid for the first two external prosthesis that had been fitted to Roxanne's leg in January 2008, the first in Durban and the second a few days later at the Vincent Pallotti Hospital in Cape Town, and reversed these payments, presumably acting under the provisions s 59(3) of the Act.

[11] Although there is no evidence of any written complaint relating to these reversals, Ms Joubert must have raised them with the Registrar as, in an email of 17 June 2009, the Registrar's legal officer called upon Genesis to provide its reasons for making these reversals. The legal officer also stated that Roxanne's condition was a 'PMB' (an acronym for prescribed minimum benefit) the treatment for which under s 29(1)*(p)* of the Act and reg 8 of the regulations promulgated under the Act (reference to all of which will be made below) 'is defined as a reduction/relocation' and that as the treatment had been for a PMB condition 'it is irrelevant whether the scheme's rules make provision for funding of the device in question.'

[12] Genesis did not agree. In an emailed response of 3 July 2009, it alleged:

(a) That the term 'relocation' used in the regulations is 'unfamiliar in medical circles'- an allegation that the Registrar investigated and established was not

correct (in the Registrar's subsequent ruling it is stated the term 'is widely used in the treatment of fractures and is very well known terminology').

(b) That the external fixators had been incorrectly coded by the hospitals and that it was not liable for the costs thereof under its rules.

(c) That if a member elects to have her PMB condition treated at a public rather than a private hospital, 'Genesis will pay for the treatment prescribed in the Act.'

As an aside, Genesis went on to state:

'(I)t is unclear just how almost R60 000 worth of fixators were discarded so easily. The first such one after just three days of use. One can only wonder what impact such a situation is having on the ever rising cost of healthcare that the Registrar is so often quoted as criticising. The most recent external fixator carries a price tag of R75 000 and appears to be very similar to the first two, there even being parts that are common to both.'

[13] The simple answer to this suggestion of the unnecessary use of external fixators is that they were used to save the amputation of Roxanne's lower limb, with all the associated financial costs that would have involved, let alone the physical and mental grief that it would have entailed. Moreover, as appears from a letter of Dr Bernstein dated 4 August 2009, a copy of which Genesis attached to its review papers, the three different fixators were not only listed by their suppliers as 'single use items' but had different properties and were used for different purposes. The initial Jetex device had limited stability and was applied for damage control. The Ilizarov fixator was a more complex device and the Taylor spatial frame allowed for accurate alignment and compression/distraction that was not possible with previous constructs. In any event, I should record that we were informed during the appeal that Genesis now accepts that the use of all three devices constituted reasonable medical practice and not wasteful expenditure. It is accordingly unnecessary to comment further on this aspect of the matter.

[14] After its response of 3 July 2009, further emails passed between the Genesis and the Registrar in which each side expressed its divergent view – the Registrar

stating that as the treatment was for a PMB condition, Genesis was obliged to bear the cost regardless of its rules; Genesis, on the other hand, contending that under its rules it was only obliged to pay for such treatment if it was provided in a public hospital. Eventually, on 16 March 2010, the Registrar issued a written ruling that Genesis 'is liable to fund in full all diagnostic services, treatment and care cost of the conditions (Roxanne) received treatment for in terms of PMB legislation.' It can be accepted this amounted to a finding that Genesis was liable for the cost of all three prostheses used to treat Roxanne.

[15] Genesis proceeded to appeal against this ruling to the Appeal Committee under s 49 of the Act. However, the appeal was associated with more than a hint of chaos. On 17 August 2010, the Appeal Committee upheld the appeal to the limited respect that Genesis 'is liable to pay for the costs of diagnosis, treatment and care that (Roxanne) would have received at a public or state hospital.' It went on to record that there was a dispute between the Registrar and Genesis as to whether a Taylor spatial frame prosthesis was available at public hospitals, a factual dispute that could easily be resolved and that, if it was so available, Genesis 'must pay the cost of that treatment in a public hospital.' Genesis alleges that this ruling was made at a time when the appeal was still part heard. Be that as it may, Genesis filed a supplementary submission in which it conceded that Taylor spatial frame is available in state hospitals but contended that this is not the end of the enquiry and that its rules make no provision for the funding of external prostheses. It stressed that on all three occasions Roxanne had received treatment in a private facility and that its rules require it to pay in full for PMB conditions only when obtained from a state hospital. After receipt of these submissions, the Appeal Committee issued a further ruling which concluded that Genesis was to pay 'for the cost of the Taylor spatial frame prosthesis at public or state hospitals.' In doing so, it appears to have overlooked that the cost of the first two external prostheses had also been the subject of the Registrar's ruling against which Genesis had appealed.

[16] Aggrieved at this, Genesis proceeded to appeal to the Appeal Board under s 50(3) of the Act. In doing so it contended that only its refusal to pay for the third prosthesis (the Taylor spatial frame device) had been properly before both the Registrar and the Appeal Committee, and was then before the Appeal Board. It repeated, once more, its contention that it was not obliged under its rules to pay for an external prosthesis fitted at a private hospital. Again, this contention was rejected. However, although the Appeal Board dismissed the appeal, it issued the following ruling:

'(Genesis) is required to compensate the member for the costs incurred for the diagnosis, treatment and care of a PMB condition to the level of a public hospital for all three external fixators.'

[17] This ruling is not supported by either side. Genesis, of course, contends that only the cost of the third prosthesis was in issue and that it is not obliged to compensate its members for any external fixators fitted at a private hospital. On the other hand, the standpoint of Ms Joubert and the appellants in this appeal is that Genesis is obliged to pay for all three of the external fixators used to treat Roxanne, and that its obligation to do so is not limited to the level of what would have been charged at a public hospital.

[18] In any event, still dissatisfied, Genesis proceeded to apply to the court a quo to review the Appeal Board's decision. And as already mentioned, the Registrar intervened as a respondent and supported the council's counter application for declaratory relief.

[19] In this way the matter came before the court a quo. On this occasion, Genesis enjoyed success, with the court finding:

(a) That the ruling of the Appeal Committee against which Genesis had appealed to the Appeal Board had related solely to the third prosthesis (the Taylor spatial frame device) and not to the first two prostheses;

(b) That absent a cross-appeal, the Appeal Board had no statutory power to exercise jurisdiction in respect of the first two prostheses and, for that reason, the ruling of the Appeal Board insofar is it related to those prostheses could not stand;

(c) That the rules of Genesis did not allow for payment of the cost of an external fixator such as the third prosthesis 'where same was obtained from a hospital other than the public or state hospital' and that the Appeal Board had erred in reaching the contrary conclusion;

(d) That, accordingly, the decision of the Appeal Board relating to Genesis's liability for the external prostheses fitted to Roxanne could not stand;

(e) That for similar reasons the counter application could not succeed; and that both the Council and the Registrar had misconstrued their relief and ought rather to have employed s 31 of the Act (which, inter alia, empowers the Registrar to order medical scheme to amend its rules should they be applied in a manner inconsistent with the Act) or section 51 thereof (which empowers the Registrar to apply to court for relief in the interest of beneficiaries to obtain certain relief including an order that the rules be amended).

[20] In the light of this reasoning, the court a quo set aside the ruling of the Appeal Board and substituted in its stead an order that Genesis 'is not obliged to pay the costs of the Taylor Spatial Framework external prosthesis fitted to (Roxanne) during the period February 2009.' It further dismissed the counter application and ordered the Council and the Registrar to pay the costs of the proceedings. It is against this order that the appellants now appeal.

[21] One of the many issues raised in this appeal may be disposed of without much ado. As appears from what I have already said, Genesis's attitude throughout has been that Ms Joubert's complaint to the Registrar related solely to the costs of the third prosthesis, the Taylor spatial frame device, and not to the two prostheses used earlier. This contention was based on the fact that, by 18 March 2008, Genesis had settled Ms Joubert's claims for the initial treatment, which included the cost of the first two prostheses. Thus, so Genesis argued, only the disputed cost of the third prosthesis, being the subject of Ms Joubert's subsequent complaint of 27 February 2009, could have been the subject of a ruling by, in turn, the Registrar, the Appeal Committee and the Appeal Board; and therefore the latter had erred in ruling in respect of all three prostheses.

[22] Although accepted by the court quo, Genesis's argument on this issue is overly simplistic. As already mentioned, after her written complaint of February 2009 Ms Joubert must have complained further to the Registrar about the reversal of the payment for the first two prostheses as Genesis was requested to provide its reasons for doing so. It complied and provided its reasons, they being the same as those it relied upon to justify its refusal to pay for the third prosthesis. The Registrar then issued his ruling. In the circumstances it would be artificial in the extreme to hold that Ms Joubert's complaint, so ruled upon, only embraced the third prosthesis.

[23] However, this dispute is really something of a storm in a teacup as counsel for Genesis informed us from the bar that, prior to this appeal, Genesis had a change of heart and has paid for all three prostheses (in effect reversing its earlier reversal of its payment for the first two). In the circumstances, as Genesis has since paid for the prostheses, it is only concerned with the principle whether it had been obliged to do so. That being so, it truly matters not whether the Appeal Board

erred in ruling on all three prostheses rather than merely the Taylor spatial frame device.

[24] The subsequent payment made by Genesis and its decision to litigate in respect of the principle of its liability, also renders it in unnecessary to determine the procedural unfairness that it alleged had occurred before the Appeal Board, not only in its failure to limit the inquiry to liability for the third prosthesis, but in not enquiring whether the first two prostheses were available in state or public hospitals and in allowing the Registrar to appear and argue on behalf of Ms Joubert. It is also unnecessary to rule on whether the Appeal Board, in authorising the Registrar to represent it in the main application in the court a quo, made apparent its own bias against Genesis, an argument advanced in the heads of argument in this court.

[25] That being so, I turn to deal with the primary issue of dispute, namely whether the rules of Genesis are such, and fall to be so applied, that it is not liable to compensate a member for the cost of an external prosthesis fitted in a private hospital. In dealing with this issue it is necessary at the outset to consider certain of the relevant statutory provisions.

[26] Under s 20 of the Act, a medical scheme may not carry on business unless it is registered under s 24. Section 29 provides that the Registrar shall not register a medical scheme, and that no medical scheme may carry on business, unless its rules make provision for a number of specific matters. In particular ss 29(1)*(o)* and *(p)* provide that the rules must make provision for:

'*(o)* The scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed.

(p) No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as

contemplated in paragraph *(o)* and may not be different from the entitlement in terms of the service available to a public hospital patient.'

[27] The minimum benefits referred to in s 29(10)*(o)* are those prescribed in regs 7 and 8 of the regulations promulgated in terms of s 67 of the Act by the Minister of Health in Government Notice R1262 of 20 October 1999, and amended from time to time thereafter. At all times material to the present matter, reg 7 contained the following definitions:

' "designated service provider" means a health care provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions;

"emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

"prescribed minimum benefits" means the benefits contemplated in section 29(10)*(o)* of the Act, and consist of the provision of the diagnosis, treatment and care costs of-

(a) the diagnosis and treatment pairs listed in Annexure A, subject to any limitations specified in Annexure A; and

(b) any emergency medical condition.

"prescribed minimum benefit condition" means a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition.'

[28] Regulation 8, in turn, provides:

' (1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.

(2) Subject to section 29(1)(*p*) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that ─

(*a*) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and

(*b*) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

(3) For the purposes of subregulation (2)(*b*), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if–

(*a*) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(*b*) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

(*c*) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.'

[29] Annexure A referred to in the definition of 'prescribed minimum benefits' contains an itemised schedule of medical conditions and the treatment to be allowed for each, these being the 'categories (Diagnosis and Treatment Pairs) constituting the Prescribed Minimum Benefits Package.' Each such 'pair' is allocated a specific code. Code 900H refers to a PMB diagnosis of 'open fracture/dislocation of bones or joints' for which the allowable treatment is 'reduction/relocation, medical and surgical management.'

[30] The compound comminuted fracture Roxanne sustained to her lower limb was clearly a PMB condition falling squarely within that described by code 900H. That, I understand, Genesis accepts. Accordingly, even though Genesis's rules do not make specific provision for an external prosthesis, it would be obliged under the legislative matrix outlined above to pay for such a device if used in treating the injury. After its initial quibble about three such devices having been used, it now accepts, as I have already mentioned, that the treatment administered to Roxanne was reasonable. Accordingly, having regard solely to the legislation, Genesis would appear to be liable to pay in full for Roxanne's treatment, including the

costs of the three prostheses - subject of course to the provisions of reg 8(2) and the proviso thereto, as read with reg 8(3), which would limit its liability to the costs that would have been charged had such treatment been obtained from a 'designated service provider' (DSP).

[31] It is here that things become more complicated. Genesis has been at loggerheads with the Council in regard to the appointment of DSPs. Prior to 2007, clause 1.1 of its rules provided for Genesis to pay '100% of actual cost, in respect of benefits defined as (PMB's) . . . when obtained from a Public or State Hospital'. However, on 4 October 2006 the Council wrote to Genesis in regard to various proposed rule changes for the following year. Inter alia, it stated that it was 'imperative' for its rules to indicate DSP's and that they should further 'clearly provide for the co-payment applicable' in the event of a non-DSP being voluntarily used. It concluded that in the event of no DSPs being identified, 'the rules should state that the members have a free choice of provider.'

[32] Genesis objected to this directive. On 8 December 2006, in a somewhat sarcastically worded letter to the Council, it stated that it had obtained legal advice from senior counsel to the effect that a medical scheme cannot be compelled to appoint DSPs. In the light of this response, on 14 December 2006 the Council informed Genesis that its proposed rule changes for 2007 would not be approved. In so doing, it stated:

'(I)t should be noted that the arrangement whereby the public sector is regarded as the "designated service provider" (DSP) for prescribed minimum benefits (PMBs) is unacceptable . . .. The PMB construct in Genesis is unreasonable and misleading to members as there is no way for a member to determine up-front the true availability of the service provider and consequently the value of the benefits provided by the scheme. The various provincial departments of health furthermore place access restrictions on medical scheme members or members in schemes with no contracts. Given this, no general designation involving the public sector can be regarded as "reasonably available" as the health service has already denied access. Furthermore the extent of

the benefits limits applied by the scheme will result in the beneficiary not receiving the benefits in respect of PMBs he is entitled to thereby undermining the PMB framework.

Based on this, the rules will not be approved, in terms of section 31(3)*(a)* of the Act where there is any designation of the public sector as this would be unfair to members. Given this, all provisions relating to limits and co-payments in respect of PMB's will not apply, irrespective of the service provider used. This would need to be clarified in the rules and communicated properly to members.'

[33] The Council's statement that the arrangement by which the public sector is to be regarded as the DSP was clearly a reference to rule 1.1 of Genesis's rules relating to PMBs[1] seeking to limit liability for PMB's to expenses obtained in the public sector. Be that as it may, the threat not to approve its rules appears to have caused Genesis to back down somewhat as, with effect from 1 January 2008 it amended clause 1 to provide, inter alia, as follows:

'1.1 100% of actual cost in respect of benefits defined as (PMBs) in the Act . . . when obtained from a Public or State Hospital or (DSP).

. . .

1.4 If the beneficiary voluntarily obtains diagnosis, treatment and care in respect of a (PMB) condition from a provider other than a (DSP) , the benefit payable in respect of such service is subject to a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the (DSP) being used.

. . .

1.6 If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a (PMB) condition from a provider other than a (DSP) the benefit will be 100% of the cost in relation to that (PMB) condition.

1.7 For the purpose of 1.6 beneficiary will be deemed to have involuntarily obtained a service from a provider other than a (DSP) if –

(a) the service was not available from the (DSP) or would not be provided without unreasonable delay;

(b) immediate medical or surgical treatment for a (PMB) condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a (DSP); or

[1] These are contained in appendix 1 to its rules.

(c) there was no (DSP) within reasonable proximity to the beneficiary's ordinary place of business or personal residence.'

[34] It is readily apparent that these rules to an extent reflect the provisions of reg 8, particularly in respect of the payment for services rendered by DSPs, the co-payment requirement where another service provider's services are obtained rather than those of the DSP, and the payment to other service providers whose services were involuntarily obtained. However, cynically, Genesis has never appointed DSPs and has remained steadfast in its view that it is not obliged to do so. Accordingly, as it has no DSPs, and although its rules appear likely to deceive its members in that regard, its standpoint is that under clause 1.1 it is obliged to pay for the cost of treating a PMB condition only when that treatment is 'obtained from a Public or State Hospital.' In the context of Ms Joubert's claims, as the three prostheses were provided at private institutions, it argues that it is not liable for their cost even though they were used to treat a PMB condition.

[35] The foundation of this argument is s 32 of the Act. It provides that the rules of the medical scheme 'shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.' Relying on this, Genesis argues that the rules constitute a contract between a medical scheme and its members and that, once such rules are approved by the Registrar, the relationship between the scheme and its members is governed solely by the rules and that the provisions of the Act and the regulations fall away.

[36] Genesis relied heavily upon the judgment in *Nimed Medical Aid Society v Sepp and others NNO* 1989 (2) SA 166 (D) to support this argument. The court in that matter, in dealing with provisions of the predecessor of the current Act, the Medical Schemes Act 72 of 1967 which are substantially similar to those of the current provisions, was called upon to decide whether contributions to medical

scheme were payable under the provisions of a law. Didcott J concluded that they were not as 'the rules of any medical scheme amount to a contract between it and the members that binds both sides'.[2] I accept that this is so, but the finding in that regard, particularly in the context of what was in issue in that case, is no reason to accept that any obligation imposed by the statute upon a medical aid scheme to pay certain amounts becomes unenforceable when its rules, which do not contain such provision, are registered.

[37] One of the underlying purposes of the PMB provisions in the Act and the regulations is to ease the demand upon public resources, which provide hospital and medical services at little or no cost, while at the same time ensuring that members of the medical scheme suffering from PMB conditions are able to obtain treatment at a satisfactory level. Thus in the preamble to annexure A to the regulations it is stated:

'The objective of specifying a set of Prescribed Minimum Benefits within these regulations is two-fold:

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.

(ii) To encourage improved efficiency in the allocation of Private and Public health care resources.'

[38] Section 29(1)*(o)* and reg 8 which, read together, require a medical scheme to 'pay in full' the costs of treatment of PMB conditions at a scope and level as may be prescribed, were clearly designed to ensure that members would not be obliged to bear the cost of providing such treatment. They make no mention of a medical scheme being obliged to do so only in the event of the treatment being obtained from the public sector. Indeed the entire tenor of the legislation is to the contrary effect, the provisions referring to DSPs clearly indicating that private sector treatment was envisaged – such provisions allowing a medical scheme to select

[2] 170H-I.

DSPs with whom it may reach agreement on charges beneficial to it and thereby limit its exposure to liability under reg 8(2).

[39] In the circumstances the Minister, in specifying the table of PMBs and the allowable treatment for such conditions, clearly intended to ensure that members of medical schemes would enjoy cover in relation to those specific medical conditions and encourage them to seek treatment in either private or public hospitals. That objective would be defeated by a medical scheme only providing cover for the treatment of PMBs if obtained from the public sector, thereby effectively shifting the cost of treating PMB's from medical schemes to the State. That is precisely what Genesis has attempted to do by not appointing DSPs. Instead of providing an option for its members to obtain treatment for PMB's in the private sector, it seeks to oblige its members to obtain treatment for those conditions in state institutions at little or no cost to itself.

[40] This, Genesis says, it can do as that is the effect of its contract between itself and its members and that, even if its rules conflict with the Act and the regulations, they are binding upon its members until such time as they are amended. In this regard it drew attention to the powers of the Registrar under s 31(4) and 51 of the Act to compel a medical scheme to amend its rules, and argued that as the Regisrar has not yet done so, its registered rules cannot be interpreted to mean something for which they do not provide.

[41] It would be cold comfort for a member of a medical scheme to know that although the Act and the regulations promulgated thereunder provide for payment of an amount for private sector treatment, the medical scheme is excused from meeting that charge until the Registrar proceeds to take steps to have its rules changed. But in any event, the rules of the medical scheme cannot be viewed in isolation and Genesis's submission is untenable.

[42] Effectively Genesis's argument is that by accepting to be bound by its rules its members have contracted out of the obligations imposed upon a medical scheme under the Act and that, in the circumstances, the full benefit of what was provided by the Act must be regarded as waived by its members. I accept, as a principle, the general rule that any person may waive rights conferred by law solely for his or her benefit but that rule does not apply where both public as well as individual interests are concerned. Thus 'where public as well as individual interests are concerned, where public policy requires the observance of the statute, then the benefit of its provisions cannot be waived by the individual, because he is not the only person interested.'[3] As mentioned above, the provisions of the Act have as their goal the obligation of a medical scheme to provide a prescribed level of treatment for all its members suffering from PMB conditions, whether obtained from the private or public sector. This is clearly a matter involving public interest and in respect of which public policy requires compliance by medical schemes. This is even more the case when one bears in mind the intention to provide protection of certain classes of persons who bargain from an inferior position, as members do in regard to their medical schemes. In this regard the comments of Lord Hailsham in his famous speech in *Johnson and another v Moreton* 1980 AC 37 (HL) go to the point. He said:

'[It] can no longer be treated as axiomatic that, in the absence of explicit language, the Courts will permit contracting out of the provisions of an Act of Parliament where that Act, though silent as to the possibility of contracting out, nevertheless is manifestly passed for the protection of a class of persons who do not negotiate from a position of equal strength, but in whose well-being there is a public as well as a private interest. Such acts are not necessarily to be treated as simply *jus pro se introduction*, a "private remedy and a private right" which an individual member of the class may simply bargain away by reason of his freedom of contract. It is precisely his weakness as a negotiating party from which Parliament wishes to protect him.'

[3] Per Innes CJ in *Morrison v Angelo Deep Gold Mines Ltd* 1905 TS 775 at 781.

[43] In my view these considerations effectively answer Genesis's argument. The relationship between a medical scheme on the one hand and its members on the other, is not governed solely by that scheme's rules but also by the obligations imposed by statute upon medical schemes. These latter obligations cannot be evaded by a medical scheme purporting to contract with its members by prescribing rules having a contrary effect. It is not only, as counsel for the appellants argued, simply a question of legality and the enforcement of an obligation imposed on medical schemes by statute, but the enforcement of public policy that leads to that result. Consequently, DL Pearmain *The Law of Medical Schemes in South Africa*, correctly observes that '(a)lthough the Act states that a scheme is bound by its rules, if one or more of those rules is contrary to law, the law will take precedence.'[4] After all, s 29(1)*(o)* provides that no medical scheme shall carry on business unless it provides for the scope and level of minimum benefits that are prescribed. If Genesis carries on business as a medical scheme, which it does, then it must supply the benefits it is required to provide by the Act and the regulations.

[44] Simply put, the law obliges medical schemes to pay the costs of treating PMB conditions in full, and that is what Genesis must do. Genesis had the opportunity to appoint DSPs. It could even have concluded agreements with the public sector as its DSP, which would not have been offensive if the Registrar was satisfied that there was a clear agreement between it and the relevant public health authorities[5]. But it failed to appoint DSPs, either in the private or public sector. Consequently, as a result of its own failure in that regard, the ameliorating provisions of reg 8(2) are not available to it and it became obliged to pay in full for the treatment administered to Roxanne in respect of the PMB condition from which she suffered. That includes the cost of the three prostheses that were used from time to time.

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[4] DL Pearmain: *The Law of Medical Schemes in South Africa* para 7.1.1.
[5] Pearmain *op cit* para 7.2.

[45] The court a quo therefore erred in reaching the contrary conclusion, and the appeal must succeed. Having said that, as both sides were agreed that the Appeal Board had misdirected itself by ruling that the cost of the three prostheses was to be limited to what their cost would have been had they been supplied in a public hospital, the court quo ought to have ordered the deletion of that portion of the Appeal Board's directive – although that in itself was insufficient success to justify Genesis being awarded its costs a quo.

[46] That brings me to consider the appellants' counter application for declaratory relief. In that regard, on appeal, the appellants sought an amendment of their notice of motion to alter the relief that they sought. This was not opposed by Genesis but, in my view, it seems to be unnecessary to make any order in respect of the counter application. The relevant principles of Genesis's liability have been dealt with in the context of Ms Joubert's claim which was the subject of the review, and it seems superfluous to fashion a further declaratory order. Indeed, counsel for the appellants did not advance his argument for such relief with any vigour and indicated that the appellants' interests would adequately be served by setting aside the order appealed against. In the circumstances the appropriate order is to make no order in respect of the counter application.

[47] The following order will issue:

1 The appeal is upheld with costs, including the costs of two counsel.

2 The order of the court a quo is set aside and substituted with the following:

'(a) The ruling of the Appeal Board of 3 May 2012 is amended by the deletion of the words "to the level of a public hospital" .

(b) The application to review and set aside the above ruling of the Appeal Board is otherwise dismissed with costs, including the costs occasioned by the employment of two counsel.

(c) No order is made in respect of the counter application.’

L E Leach
Judge of Appeal

Appearances:

For the Appellants	J G Wasserman SC (with him A J Lapan) Instructed by: Hogan Lovells (South Africa), c/o Mcloughlin Clark Inc, Cape Town Symington & De Kok, Bloemfontein
For the First Respondent:	E W Fagan SC (with him E van Huyssteen) Instructed by: Clyde & Co, Cape Town Lovius Block, Bloemfontein
For the Second and Third Respondents:	None