REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

(1) REPORTABLE: ~~YES~~/NO
(2) OF INTEREST TO OTHER JUDGES: ~~YES~~/NO
(3) REVISED.

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DATE SIGNATURE

CASE NO: A203 / 2021

In the matter between:

KEYHEALTH MEDICAL SCHEME **APPELANT**

and

THE HONOURABLE MR JUSTICE SM NGOEPE N.O. **First Respondent**
(First Respondent a quo)

REGISTRAR OF MEDICAL SCHEMES **Second Respondent**
(Second Respondent a quo)

WILLIAM REED **Third Respondent**
(Third Respondent a quo)

JUDGMENT

BARIT AJ

Introduction

[1] This is an appeal by KeyHealth Medical Scheme with respect to a judgment in the Court a quo. In her judgment, Constantinides AJ dismissed an application to review and set aside a decision of the Appeal Board constituted in terms of Section 50 of the Medical Schemes Act 131 of 1998, which application was brought by KeyHealth. The appellant (KeyHealth) is now appealing against this judgment.

[2] KeyHealth Medical Scheme (the appellant) is a not-for-profit medical scheme, duly registered under Section 24 (1) of the Medical Schemes Act 131 of 1998 as amended.

[3] Dr William David Reed (the third respondent in this appeal), a non-practicing attorney, who is representing himself in this matter, describes himself as an "elderly gentleman". He is a member of KeyHealth Medical Scheme.

Substance of the Appeal by KeyHealth

[4] The crisp factor to be decided in this matter is whether KeyHealth Medical Scheme can apply prescribed minimum benefits (PMB) to the day-to-day benefits (DTD) that a member of the scheme is subscribed to. Simply stated, KeyHealth in terms of what they call their "rule", would first deduct any prescribed minimum benefit (PMB) from the day-to-day benefits (DTD) which in turn is funded by the member's saving account (MSA), and only after the MSA was depleted would KeyHealth then take the funds from what they refer to as their PMB "risk pool" which exists for PMB items.

[5] Reed maintains this practice is wrong being contrary to the Medical Schemes Act and PMB items must be funded from the scheme's risk pool, which exists for PMB items.

[6] The importance of this can be seen from two stark facts. Firstly, chronic expenses (e.g. chronic medication) is included under the heading of PMB's. Secondly, once the MSA is depleted by PMB's, the member will not have funding for his or her day-to-day medical expenses – like dentists, chemists, physiotherapists and house doctor.

Background

[7] The history of this appeal by KeyHealth goes back a number of years.

[8] During 2016, Reed objected to KeyHealth paying for his cardiologist consultations with his DTD benefits. Reed contended that this was not permissible as he claimed that Prescribed Minimum Benefits had to be funded from PMB (referred to by KeyHealth as their risk pool) and cannot be funded by his DTD benefits, which are funded from his (i.e. Reed's) MSA.

[9] Basically, the contention of Reed was his chronic condition was meant to be funded from the PMB risk pool only. KeyHealth stated that this is not so and that it first takes the funds from the DTD benefits and only when that fund (effectively the MSA of the member) is depleted does it take the funding from the PMB risk pool.

[10] This would mean a disadvantage for Reed. With the day-to-day funds drawn from the MSA, Reed would not have funds for other medical expenses, or less funds. Reed maintains that this amounts to him being prejudiced.

The historical facts

[11] In 2016 Reed filed a complaint with the Council for Medical Schemes (CMS). This was based on Reed believing that the appellant (KeyHealth) did not comply with legislative instructions relating to "prescribed minimum benefits" as promulgated in the Medical Schemes Act of 1998 (The Act) and other relevant legislation.

[12] The CMS found against Reed. Their ruling was in favour of KeyHealth, and they based their finding on the contentions of KeyHealth.

[13] Reed then appealed the ruling of CMS to the Appeals Committee of the Council for Medical Schemes. Again the ruling was against Reed and in favour of KeyHealth. The Appeals Committee's finding was that KeyHealth was correct in utilising the DTD benefits to pay Reed's PMB claims. This confirmed the finding of the CMS. Their view was that the Regulations of the Medical Schemes Act do not prohibit the scheme from doing so. They believed the only express

prohibition concerning the PMB's is found in Regulation 10 (6), of the Medical Schemes Act, which provides that the funds in the member's MSA should not be used to pay for the costs of a PMB. Hence, given the express prohibition in regulation 10 (6) it was the appeals committee's view that if the legislature had intended to prohibit the funding of PMB claims from a member's day-to-day benefits then it would have said so in the Act. Similarly, if the Minister of Health had intended to prohibit the funding of PMB claims from a member's day-to-day benefits then she too would have done so when she made the Regulations. In the absence of such a prohibition, in both the Act and the Regulations, it follows that the scheme was entitled to fund the claims from DTD benefits.

[14] Reed then appealed to the Appeal Board of the Medical Council, comprising of three members with Judge Ngoepe as the chairperson and the other two members being Dr NB Jada and Dr D Ramagole. The finding, of the Chairman, was in favour of Reed, hence setting aside the decision by the appeal committee of the CMS.

[15] The Appeal Board rejected KeyHealth's contention that the KeyHealth's rules authorised KeyHealth to fund PMB's from a member's DTD benefits and held that Regulation 8 of the Medical Schemes Act obliges a Medical Scheme to fund PMB's from its PMB risk pool. The Appeal Board concluded that KeyHealth's conduct "amounted to an attempt to contrive and escape from its liability to the full payment of PMB benefits out of its pool". Further, it constituted a stratagem to avoid dipping into the risk pool from which the PMB contributions are meant to be paid for, by deflecting such debits to what KeyHealth referred to as a "member's day-to-day benefits".

[16] Quite simply, the KeyHealth Medical Scheme therefore could not apply the funds available as part of the day-to-day benefits of Reed for purposes of funding Reed's PMB's.

[17] KeyHealth was ordered to refund all the fundings it had made for prescribed minimum benefits from Reed's day-to-day benefits as from 15 March 2015 which was the date that Reed discovered what he described as the "irregularities".

[18] Subsequently, KeyHealth applied to the High Court, for an order as follows:

(a) The decision of the Appeal Board dated 3 April 2019 be reviewed and set aside;

(b) Reed's Appeal to the "Appeal Board" of the Medical Council be dismissed;

(c) In the alternative to paragraph (b) above, the matter be referred back to the Appeal Board for reconsideration having regard to the fact that firstly nothing in the Act and Regulations prohibits a scheme to fund PMB's from a member's DTD benefit. Secondly Rule 17.7 read with rule 17.8 of the applicant (KeyHealth) rules authorises the applicant to fund PMB's from a member's DTD benefits.

[19] The matter was heard by Constantinides AJ, in the High Court, who ruled in favour of Reed, confirming the ruling of Judge B M Ngoepe, the Chairman of the Appeal Board of the Medical Council.

[20] KeyHealth then applied for leave to appeal. Constantinides AJ, passing judgment in the application gave judgment against KeyHealth.

[21] As a result of an application made by KeyHealth, the Supreme Court of Appeal on 1 March 2021 granted KeyHealth leave to appeal to the "Full Court of the Gauteng Division of the High Court of South Africa, Pretoria".

Legislative provisions

[22] The Regulations of the Medical Schemes Act 131 of 1998 contains the following provisions.

In the Definitions section:

> *"'prescribed minimum benefits' means the benefits contemplated in section 29.1 (o) of the Act and consist of the provisions of the diagnosis, treatment and care costs of –*
>
> *(a) The diagnosis and treatment pairs listed in Annexure A, subject to any limitation specified in Annexure A;*
>
> *(b) Emergency Medical condition;*

(c) *Prescribe minimum benefit condition means the condition contemplated in the diagnosis and treatment parts listed in annexure A or any emergency medical condition."*

Regulation 8 of the Medical Schemes Act 131 of 1998 describes PMBs further as:

> *"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, diagnoses, treatment and care costs of the prescribed minimum benefit conditions".*

Regulation 10 (6) reads as follows: *"The funds in the member's Medical Savings account shall not be used to pay for the costs of prescribed minimum benefit."*

Section 32 of the Act states:

> *"The rules of a medical scheme and any amendments thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules and whose claim is derived from a person so calling".*

Day-to-day benefits

[23] What are "day-to-day" benefits?

1. From factors currently available, it is evident that day-to-day benefits are not a separate fund, but it is the terminology used to describe the day-to-day services utilised by members on a day-to-day basis (e.g. medical expenses such as house doctor visits, optometry, dentistry, physiotherapy), which are funded from the MSA of the member.

2. In simple terminology, the payment of services rendered by a service provider is either paid for from the member's MSA (e.g. physiotherapist) or from the medical scheme's "risk pool" which includes the PMB's (e.g.

chronic medication). DTD benefits can be seen not to be a separate pool and therefore it can lend itself to ambiguity in an inter-play of words. It simply, by all accounts, are the words used for what transpires on a day-to-day basis, and then funded from the member's savings account.

3. Hence there is one source of funding for day-to-day benefits and this is the MSA. The use of two terms – day-to-day and member's savings account – creates ambiguity. In terms of funding, it is one and the same.

No prohibition

[24] KeyHealth maintained that there was no prohibition on the using of the day-to-day benefits. Hence, it was not a question of whether there was permission to use it, but whether there was a prohibition on the use of it.

[25] This formed the basis for the finding in favour of KeyHealth by the Medical Schemes Appeals Committee which stated that:

> *"In the absence of such prohibition in both the Act, and the Regulations, it follows that the scheme is entitled to fund the claims from the DTD benefits."*

[26] Simply stated, this ruling would mean that the members of KeyHealth, which include Reed, would find themselves having the day-to-day benefits depleted, which funds are drawn from their savings account.

[27] Constantinides AJ in her judgment (para 35) stated that the "Appeal Board Chairman" took into account KeyHealth's initial argument that it was entitled to do as it did because there was nothing in the Act, Regulations or the Rules prohibiting it from doing so and found that it was a flawed argument in two respects:

> *"Firstly, its approach to the issue was wrong: the question was not whether there was any prohibition not to utilise the DTD account, but whether there was any authorisation (in the Act, Regulations or the KeyHealth's Rules), to do that."*

"Secondly, in any event, what it did amounted to an attempt to contrive and escape from its liability for the full payment of PMB benefits out of the risk pool and... Regulation 8 dealing with PMB's stated: '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 cost of the prescribed minimum benefit conditions.'"

[28] Constantinides AJ pointed out that KeyHealth was not able to point out any authority for its proposition. The Chairman of the Appeal Board stated in that respect that KeyHealth could not do as it pleased, to the detriment of a member simply because there was nothing which prohibited it from doing that.

[29] Further, Constantinides AJ pointed out that the Chairman of the Appeal Board emphasised that the scheme cannot avoid full liability to pay for the PMB condition out of the risk pool. He found that what KeyHealth did was to "employ a stratagem, indirectly if not directly, (to) achieve just that." Further the Chairman of the Appeal Board stated that:

"Through this stratagem, it avoided dipping into the risk pool from which PMB conditions are paid for by deflecting such debits to day-to-day account".

Rule 17

[30] In her judgment, Constantinides AJ, came in strongly with respect to the switch that KeyHealth made with respect to their argument to support their contention to the prejudice of Reed. KeyHealth's initial argument was that there was no prohibition on the utilisation of DTD funds for PMB accounts. However, KeyHealth then switched their argument to bring in "Rule 17" as being in support of their contention.

[31] KeyHealth maintained that in terms of their Rules, they were entitled to do so. Particular reference was made by KeyHealth to what they called their "Rule 17". This was mentioned extensively by KeyHealth. A study of Rule 17 shows that it is a very long section, with some 16 clauses, many of these clauses having their

own subsections. Though reference is made in Rule 17, to prescribed medical benefits, Rule 17.5 is quite clear in what it states:

> *"No limitations or exclusions will be applied to the Prescribed Minimum Benefits."*

[32] The reading of this Rule is completely against any contention that KeyHealth has made with respect to Rule 17 supporting their use of the so-called DTD benefit account. KeyHealth particularly referred to their Rule 17.7 (which however refers to benefit year) and Rule 17.8 (which refers to the "date on which services were rendered"). Hence Rule 17.7 and Rule 17.8 has no relevance to the prescribed minimum benefits. The applicable paragraph is rule 17.5. of the KeyHealth set of rules.

The Appeal Board Chairman found that upon reading "Rule 17", the interpretation contended to by KeyHealth was unsustainable.

[33] I agree with the Constantinides AJ support for what the Appeal Board Chairman contended. Nowhere in Rule 17 is there any form, of support for what KeyHealth has stated. On the contrary the simple English reading of "Rule 17.5", as quoted above, nullifies any attempt to successfully use "Rule 17" as was attempted by KeyHealth.

Simply stated, Rule 17 is completely against any contention that KeyHealth had attempted to make in support of their argument.

[34] The Appeal Board Chairman stated further that it was a disingenuous way of KeyHealth avoiding to "pay in full" for PMB conditions out of the PMB risk pool which resulted in the depletion of the appellant's (Reed's) day-to-day account to his detriment and the detriment of his dependent. According to the Appeal Board Chairman such conduct was wrong and the arguments provided by KeyHealth, that nothing prohibited KeyHealth from doing so, held no water.

[35] An argument by KeyHealth was simply that all the claims were paid, so why is the member complaining. That is equivalent to a bank saying that you have got

money in your account, and as you are not using it we have now transferred it elsewhere.

[36] On a correct interpretation of the words "prescribed minimum benefits", this applies by way of example to where a patient goes into hospital and/or is suffering from a chronic condition. Hence it would only be common sense for such to be taken from the pool specially designated for this purpose. This definitely should not to be part of day-to-day benefits to be funded from the Member's Savings Account.

Legal aspects

[37] In terms of legislation and KeyHealth's rules, the following is relevant:

In Regulation 10 it is stated that "the funds" in the member's Medical Savings Account shall not be used to pay for the costs of a Prescribed Minimum Benefit.

Further, Regulation 8, states that "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".

Rule 17.5 of the KeyHealth rules states that "no limitations or exclusions will be applied to the Prescribed Minimum Benefits".

With reference to Section 32 of the Act, the binding force of a medical scheme's rules is discussed. More specifically it provides that:

> *"The rules of a medical scheme and any amendments thereof 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."*

From the above, in terms of both the Act and KeyHealth rule 17.5, prescribed minimum benefits must be paid from PMB.

[38] Should, rule 17 of KeyHealth rules have any provision otherwise – which it has not – the following dicta, from the English case of *Johnson and Another vs*

Mareton 1918 AC 37 (HL), cited in the matter of *The Counsel of Medical Schemes v Genesis Medical Scheme* 2015 ZASCA 161 para 42, would in any event apply.

> *"(It) can no longer be treated axiomatic that, in the absence of explicit language, the Courts will permit contracting out of the provisions of an Act of Parliament where the 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 this weakness as a negotiating party from which Parliament wishes to protect him."*

[39] Based on both the Act and the rules of KeyHealth, the conclusion that must be drawn is that KeyHealth is obliged to pay prescribed minimum benefits from what they refer to as the PMB pool.

Tacit Acceptance

[40] Any allegation by KeyHealth of an alleged acceptance by Reed of the use of the DTD benefits, (which means funding from the MSA) of PMBs must be rejected. There can be no tacit acceptance by Reed of KeyHealth's prior actions in funding his PMBs (chronic treatment and/or medication) from Reed's MSA, by virtue of Reed having no knowledge of KeyHealth's actions and being totally unaware that KeyHealth was utilising his MSA to fund his PMBs. At no time did KeyHealth make its intentions clear to Reed, that it intended to utilise his MSA to fund his PMBs. In light of the fact, that it is prescribed that PMBs may not be paid from the member's MSA, KeyHealth acted contrary to what is prescribed by the Act. Hence, it cannot be said that Reed had acquiesced to the utilisation of his MSA for the funding of PMBs.

[41] Therefore, KeyHealth's indication that Reed had accepted the deduction of PMBs as being part of his DTD benefits, (and hence funded from his MSA) must be rejected.

Promotion of Administrative Justice Act (PAJA)

[42] Section 33 (1) of the Constitution gives anyone a right to administrative action that is procedurally fair. Section 6 (2) (c) of PAJA allows review of an administrative action on the ground that the action was procedurally unfair.

[43] Section 6(2)(h) of PAJA has reference to the "exercise of power" of a tribunal. This is particularly important in relation to KeyHealth's contentions with respect to the Appeals Board ruling.

Section 6(1) read with section 6(2)(h) states as follows:

> *"Any person may institute proceedings in a court or a tribunal for review of an administrative action … if the exercise of the power or the performance of the function authorised by the empowering provisions, in pursuance of which the administrator's action was purportedly taken, is so unreasonable that no reasonable person could have so exercised the power or performed the function."*

[44] The test is clear as explained in the *Duma's* case - *RAF v Duma* 2013(6) SA 9 (SCA) paragraph 22 - whether the Appeal Tribunal's decision is so unreasonable that no reasonable person would have reached it. The question that must be answered in the present matter is whether this Court is satisfied that a reasonable person in the position of the Appeal Board, on the evidence before it, could have reached the conclusion that it had reached. The decision maker, in this instance, the Appeal Board, had to take into consideration all matters which a reasonable person would have done, having the same information at its disposal at the time the decision was taken.

[45] The various elements applicable to this matter are:

i. The administrative decision has to be taken on an accurate factual basis.

ii. There must be true facts which are material to the decision. By way of example the considering of relative material and/or all the material provided and/or personal circumstances (*Minister of Home Affairs and Others v Somali Association of South Africa and another* 2015 (3) SA 545 SCA).

iii. That there was no material error of law that influenced the outcome of the decision.

[46] The court a quo went into detail with respect to the above. It concluded that the Appeal Board in its finding had taken all the factors into account, and acted in a manner that any reasonable person would have – when having the same information at its disposal at the time the decision was made.

Medical Schemes Act

[47] The opening section of the Medical Schemes Act states that one of its intentions is "to protect the interests of members of medical schemes". KeyHealth's attempts to evade paying, by all means, especially after rulings by both the Chairman of the Appeals Board and subsequently by the High Court in no way promotes the interests of a member, namely Mr Reed.

Summing up

[48] Reed's savings account in this matter, is being utilised by KeyHealth for PMB's – as what transpires is that such day-to-day expenses (e.g. dentists, physiotherapists, etc) are taken by KeyHealth from the member's savings account resulting in the savings being effectively used for PMB's. Based on this alone, stating that there is no prohibition on the medical aid using DTDs for PMB's is false logic, as, the prohibition of not utilising DTDs for PMB's takes effect. It is purely an accounting administrative procedure flowing directly from the paying of the supplier – which results in a vagueness of words and an

attempt to differentiate day-to-day benefits from the fact that such funds come from the member's (Reed's) saving account.

[49] With respect to all the above:

(a) In terms of Regulation 10(6) of the Act, the use of "the funds in the member's medical savings account shall not be used to pay the costs of prescribed medical benefits."

(b) KeyHealth is attempting to apply Reed's member's savings account for prescribed medical benefit despite the Regulations prohibiting it.

(c) KeyHealth is trying to evade a legislative provision using a disguise of "day-to-day benefits", which if the disguise is removed, it is nothing other than utilising the member's savings account.

(d) KeyHealth's own Rule does not allow for the funding of prescribed medical benefits from the member's savings account.

(e) If KeyHealth's own Rule 17 would allow such, which it does not, same would be trumped by the clear legislation in Regulation 8.

(f) The attempted use of PAJA, in the light of the detailed findings of the Chairman of the Appeals Board has no merit in this matter.

Conclusion

[50] No fault can be found in the original judgment with the Court a quo, on 8 May 2020, where Constantinides AJ gave a detailed and well-reasoned judgment, which confirmed the decision of the Appeal Board of the Council for Medical Schemes dated 3 April 2019.

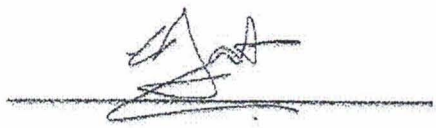
[51] In view of the fact that Reed appeared in person, I don't think that he would be entitled to a cost order in his favour. I am of the view that no cost order should be made.

[52] I can only confirm the final decision of Constantinides AJ where she stated: "The Appeal Board of the Council for Medical Schemes who was the decision

maker in this instance and took into consideration all matter which a reasonable person would have done, having the same information at its disposal at the time the decision was taken".

[53] Therefore the following order is made:

1. The appeal is dismissed.
2. There shall be no order as to costs.



L BARIT

Acting Judge of the High Court, Pretoria.

I AGREE

DS FOURIE 10/10/22

Judge of the High Court, Pretoria.

I AGREE

C SARDIWALLA

Judge of the High Court, Pretoria.

DATE OF JUDGMENT:

Appearances

Counsel for the Applicant:	Adv. Stoop SC
Instructed by:	Kotze & Roux Attorneys Inc.
Appearance for the Third Respondent:	Mr William Reed