THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Reportable

Case no: 216/2014

In the matter between:

SECHABA MEDICAL SOLUTIONS (PTY) LTD	**First Appellant**
JAN JOHANNES LOUIS SPIES	**Second Appellant**
GEN-HEALTH MEDICAL SCHEME (IN LIQUIDATION)	**Third Appellant**

and

WILLIAM SEKETE	**First Respondent**
MASTER OF THE HIGH COURT	**Second Respondent**
LIFE HEALTHCARE GROUP (PTY) LTD	**Third Respondent**
EMH OPERATING COMPANY (PTY) LTD	**Fourth Respondent**
ANTHONY PIETER BROWN NO	**Fifth Respondent**
EUGENE PELSER NO	**Sixth Respondent**
JOHAN CHRISTOFFEL JOUBERT NO	**Seventh Respondent**
PETRUS JOHANNES OOSTHUIZEN NO	**Eighth Respondent**
KLAAS CHRISTIAAN VAN DER WALT NO	**Ninth Respondent**
EDWARD LAWRENCE GURNELL NO	**Tenth Respondent**
HENDA LOOTS NO	**Eleventh Respondent**

(in their capacities as trustees of the LCM TRUST)

PEGLERAE HOSPITAL (PTY) LTD	**Twelfth Respondent**
GLYNNWOOD HOSPITAL OPERATING	

COMPANY (PTY) LTD **Thirteenth Respondent**

WESTCOST PRIVATE HOSPITAL (PTY) LTD

Fourteenth Respondent

PRETORIA NORTH SAME DAY SURGICAL

CENTRE PARTNERSHIP **Fifteenth Respondent**

MIDDELBURG HOSPITAL LTD **Sixteenth Respondent**

LIFE COSMOS HOSPITAL (PTY) LTD **Seventeenth Respondent**

ISIVIVANA HEALTH (PTY) LTD **Eighteenth Respondent**

LIFE BIRCHMED SAME DAY SURGICAL

CENTRE PARTNERSHIP **Nineteenth Respondent**

WILGEHEUWEL HOSPITAL (PTY) LTD **Twentieth Respondent**

WILGERS HOSPITAL LTD **Twenty-first Respondent**

METROPOL HOSPITALS (PTY) LTD **Twenty-second Respondent**

FLOHOC INVESTMENTS (PTY) LTD **Twenty-third Respondent**

BORDER HOSPITALS (PTY) LTD **Twenty-fourth Respondent**

LIFE BAYVIEW HOSPITAL (PTY) LTD **Twenty-fifth Respondent**

ROBINSON PRIVATE HOSPITAL

HOLDINGS (PTY) LTD **Twenty-sixth Respondent**

ST MARY'S PRIVATE HOSPITAL

(PTY) LTD **Twenty-seventh Respondent**

Neutral citation: *Sechaba Medical Solutions & others v Sekete & others* (216/2014) [2015] ZASCA 8 (11 March 2015)

Coram: NAVSA ADP, SHONGWE and WALLIS JJA and DAMBUZA and MAYAT AJJA.

Heard: 27 February 2015

Delivered: 11 March 2015

Summary: Medical scheme – liquidation – proof of claims – claim by healthcare provider – whether claim lies against medical scheme – authorisation of treatment by medical scheme – whether creates a contract

between healthcare provider and medical scheme – ss 26(1)*(b)* and 59 of Medical Schemes Act 131 of 1998 – effect.

ORDER

On appeal from: North Gauteng High Court (Murphy J sitting as court of first instance):

1 The appeal is dismissed with costs, such costs to be paid by the first appellant and the liquidators jointly and severally, the one paying the other to be absolved.

2 No costs in relation to the appeal shall be recovered or paid out of the assets of Gen-Health Medical Scheme.

JUDGMENT

Wallis JA (Navsa DP, Shongwe JA and Dambuza and Mayat AJJA concurring)

[1] Gen-Health Medical Scheme (Gen-Health), the third appellant, was a medical scheme with some 13 000 members duly registered in terms of the Medical Schemes Act 131 of 1998 (the Act). On 12 October 2010 it was placed in final liquidation. Prior to that it had been under curatorship since at least 2008. The first appellant, Sechaba Medical Solutions (Pty) Ltd (Sechaba), was the administrator in respect of Gen-Health. After Gen-Health's liquidation, and pursuant to a court order obtained by the liquidator, Sechaba was appointed to compromise or admit claims by Gen-Health's members against the scheme in liquidation. Claims totalling some R28 million had been proved in the liquidation pursuant to its efforts in this regard. Although Mr Spies is reflected in the heading to this judgment as the second appellant he played no role in the litigation and had settled his dispute with the third respondent.

[2] The third respondent, Life Healthcare Group (Pty) Ltd (Life Healthcare) represents 18 medical facilities and hospitals that rendered services to Gen-Health's members prior to its liquidation. On its own and their behalves it submitted 19 claims totalling in the aggregate a little over R5 million for proof at a special meeting of creditors on 20 February 2012. In due course the first respondent, Mr Sekete, an assistant master of the high court, admitted those claims as proved claims in the liquidation. That prompted Sechaba and Gen-Health to bring review proceedings to challenge his decision. The application failed before Murphy J in the high court and this appeal is with his leave. Neither the Master nor Mr Sekete have played any part in the appeal.

[3] Originally the application was pursued on a variety of grounds. Sechaba and Gen-Health said that Mr Sekete committed a number of irregularities in relation to the conduct of meetings of creditors and the admission of Life Healthcare's claim. His actions were said to be contrary to the provisions of the Insolvency Act 24 of 1936[1] (the Insolvency Act) in regard to the conduct of meetings of creditors and to constitute unlawful administrative action in terms of PAJA.[2] None of these grounds were pursued in the high court. Instead the proceedings were treated as a review in terms of s 151 of the Insolvency Act. Sechaba and Gen-Health contended that Mr Sekete should not have accepted Life Healthcare's claim as a proved claim on the ground that the affidavit in proof of the claim failed to disclose any lawful basis for a claim by Life Healthcare against Gen-Health.

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[1] These provisions are applicable to the liquidation of Gen-Health by virtue of the provisions of s 53 of the Act read with s 339 of the Companies Act 61 of 1973.
[2] The Promotion of Administrative Justice Act 3 of 2000.

[4] Before turning to the merits, I must examine the entitlement of Sechaba to institute these proceedings, whether as the primary applicant or at all. Its involvement in the liquidation arose from a court order authorising it to prepare and submit on behalf of members of the scheme claims in liquidation in respect of their unresolved claims against Gen-Health. It had discharged that duty and the claims submitted on behalf of members had been admitted to proof. Its interest thereafter is unclear. Yet it was the first applicant in the review and the first appellant in this appeal. It claimed to represent the members on whose behalf it had submitted claims, but it disclosed no basis for doing so and, on the face of it, its opposition to the admission of Life Healthcare's claims was not in the interests of those members. Their interest was for Gen-Health to provide the benefits to which they had been entitled by virtue of their membership of the scheme and the contributions they had made. To the extent that Life Healthcare's claims were satisfied their obligations to Life Healthcare would be *pro tanto* discharged. Resisting Life Healthcare's claims meant leaving members to pay their own medical bills to Life Healthcare in full, and to do so before receiving whatever dividend would be paid by Gen-Health. A far more sensible solution for members of Gen-Health would have been to arrive at a situation in the liquidation where the maximum amount was paid to Life Healthcare leaving them with as little as possible to pay over and above that amount.

[5] Sechaba had no interest of its own for instituting the review proceedings. Counsel could furnish no explanation for Sechaba's involvement in this litigation, much less for the clear impression that it was the driving force behind it. Over and above that, Mr van der Westhuizen, one of the liquidators, deposed to the founding affidavit,

without any affidavit from a representative of Sechaba. This is quite extraordinary. As pointed out in the only text on the law governing medical schemes in South Africa:[3]

'The relationship between a scheme and its administrator is usually so close that without its administrator, the scheme cannot fulfil its obligations to its members or in any other manner conduct business as a scheme. In practice, it is the administrator that conducts the daily affairs of a scheme and the acts or omissions of the administrator are the acts and omissions of the scheme. A medical scheme does not have its own employees to pay claims and process membership applications and changes in beneficiaries. It does not have its own information technology systems, financial reporting and management systems and human resources … Most medical schemes are little more than paper entities with a principal officer, a board of trustees and a bank account, and therefore they are literally dependent on their administrators for their daily operations.'

[6] Mr van der Westhuizen's affidavit was extremely cryptic as to the manner in which Gen-Health had dealt with claims by healthcare providers prior to its liquidation. He did not say whether it received claims directly from those healthcare providers or whether, as many medical schemes do, it had facilities for the healthcare providers to submit claims directly to it by electronic means, which claims would be processed through its computer systems. He made no mention of its previous dealings with Life Healthcare. This was in the face of evidence that the latter would contact its staff telephonically on admission of a patient to obtain pre-authorisation for the rendering of services to that patient. The statement that these allegations were too general to attract a response was simply evasive.

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[3] D Pearmain *The Law of Medical Schemes in South Africa* (Loose-leaf, Original Service, 2008) para 8.3.1, pp8-5 to 8-6.

[7] The liquidator had standing to challenge the decision by the assistant master to admit Life Healthcare's claims to proof. However, his reasons for doing so are obscure and do not appear from the affidavits, which were principally directed at attacking the manner in which the assistant master dealt with the claims. In argument it was suggested that the liquidators were concerned about payments being duplicated by being made to both Life Healthcare and members in respect of the same claims. It was also said that the liquidators were concerned whether the services had in fact been rendered and whether the correct tariffs had been charged. But Sechaba did not say that there would be any difficulty in examining the claims by Life Healthcare and correlating them with those of individual members. Nor did it say that there would be any difficulty in verifying those claims, whether as to validity in terms of the scheme's rules, or as to quantum. Counsel could not refute the suggestion from the bench that it would have been a relatively straightforward practical matter to compare Life Healthcare's claims with Gen-Health's records and to match the claims of members with those submitted by Life Healthcare. Where claims overlapped they could be treated as one for the purpose of determining the dividend payable on the global claim and paying it to the party entitled thereto. In any event this type of logistical issue was not raised as the reason for instituting review proceedings.

[8] Against that background it is necessary to express disquiet at the fact that time, better spent on winding up the affairs of the scheme, has been wasted on this litigation, which does not appear to benefit the people most disadvantaged by Gen-Health's liquidation, namely its members. No other creditor has come forward in opposition to the admission to proof of Life Healthcare's claims. What is more, the admission of the claims was merely for the purposes of proof. After investigation the liquidator could

have approached the Master to reject them if a basis for rejecting them had emerged. Having said that I turn to deal with the merits of the litigation.

[9] A review of a decision by the Master in terms of s 151 of the Insolvency Act is the broadest kind of review, where the court enters upon the question decided by the functionary and determines it afresh.[4] The question before Mr Sekete was whether Life Healthcare had provided proof of a valid claim. It must be remembered that, in deciding that it had, Mr Sekete was not determining the validity of the claim. The claim still needed to be scrutinised by the liquidators, who could, if not satisfied with it, ask the Master to reconsider it.[5] Thereafter both Gen-Health and any other interested person would still be entitled on proper grounds to object to the liquidation and distribution account, including Life Healthcare's claim,[6] and, if not satisfied with the Master's response to their objection, could challenge that decision before the high court.[7]

[10] It is no doubt for that reason that the cases say that all that a creditor need do, in submitting a claim to proof, is to provide proof on a prima facie basis that it has a valid claim. The matter was dealt with by Roper J[8] when he said:

'The admission of a claim by the presiding officer is in a sense only provisional, because under sec. 45(3) the trustee may dispute the claim notwithstanding its admission by the presiding officer. Furthermore, the presiding officer does not adjudicate upon the claim as if he were a Court of Law; he is not required to examine

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[4] *Nel and Another NNO v The Master (Absa Bank Ltd and Others Intervening)* 2005 (1) SA 276 (SCA) paras 22 and 23.
[5] Section 45 of the Insolvency Act.
[6] Section 111(1) of the Insolvency Act.
[7] Section 111(2) of the Insolvency Act.
[8] *Cachalia v De Klerk NO and Benjamin NO* 1952 (4) SA 672 (T) at 675E-F. See also *Marendez v Smuts* 1966 (4) SA 66 (T) at 72 D; *Rabinowitz v De Beer NO* 1983 (4) SA 410 (T) at 412E.

the claim too critically (*Hassim Moti & Co v Insolvent Estate Joosub & Co*., 1927 T.P.D. 778 at p. 781), or to require more than *prima facie* proof (*Aspeling v Hoffman's Trustee*, 1917 T.P.D. 305 at p. 307). It is by no means inconceivable that he might be satisfied, on the evidence advanced by the creditor, that the latter had a *prima facie* case, or even more than such a case, notwithstanding the declared opposition of the trustee to the claim.'

The proper approach is to decide whether the claimant has disclosed sufficiently the essential particulars of the claim being advanced. Technical objections are not lightly upheld.[9] Even if the claim is admitted as a proved claim at the meeting of creditors it must then be scrutinised by the liquidator in terms of s 45(2) of the Insolvency Act and if the liquidator disputes the claim a report must be made to the Master, who will either confirm or alter the previous decision admitting the claim as a proved claim. If the Master confirms that decision then the liquidator must include the claim in the liquidation and distribution account, but the account is subject to objection by the insolvent – in this case – Gen-Health, and any other interested person.[10]

[11] Under s 44(4) of the Insolvency Act Life Healthcare's claim had to be proved by way of an affidavit in a form corresponding substantially with Form C and setting out the nature and particulars of its claim. The affidavit stated that Life Healthcare operated a number of divisions and subsidiaries and through these it operated medical facilities and hospitals to which patients were admitted for treatment. The affidavit went on as follows:

'5 In respect of each division … the patients admitted for health care signed admission forms in terms of which they:

5.1 recorded that their medical aid to which they belonged was Gen-Health;

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[9] *Hassim Moti & Co v Insolvent Estate Joosub & Co* 1927 TPD 778 at 781.
[10] Section 111 of the Insolvency Act.

5.2 indicated which form of cover they had with Gen-Health;

5.3 warranted that they were a *"currently, paid-up member of Gen-Health"* and furthermore authorised the creditor to submit its statement of account to Gen-Health for payment on his/her behalf.

6 It is submitted that the very purpose of a party holding medical aid cover is so that when they are admitted to any medical facility of the creditor for care and medical treatment, the costs associated with such medical treatment and particularly the medical facility's costs in providing such treatment are insured by the medical aid concerned.

7 If regard be had to section 59 of the Act, a medical scheme such as Gen-Health could, subject to the provisions of the Act and the rules of the medical scheme concerned, pay to a member or a supplier of a service any benefit owing to that member or supplier of the service within 30 days after the day on which the claim in respect of the benefit was received by the medical scheme.

8 Accordingly, and by virtue of the provisions of the Act and the fact that each of the patients who received medical treatment from the medical facilities of the creditor … were paid-up members of Gen-Health, it is submitted that the creditor has the right to claim payment of the monies due, owing and payable to it consequent upon the medical services rendered from Gen-Health.'

[12] Sechaba and Gen-Health argue that the claim advanced by Life Healthcare was based on the provisions of s 59 of the Act and that the section does not entitle a healthcare provider to claim directly from its patient's medical scheme, even if the patient authorises the healthcare provider to submit its account directly to the medical scheme. Life Healthcare disputes this contention. In addition it had another string to its bow. In its answering affidavit filed in the review it said:

'The claims submitted by and on behalf of the Life Group are premised on medical and hospital services that were rendered by the Life Group to members of Gen-Health prior to its liquidation. Those services are rendered, firstly, upon a declaration by the member concerned that he is a fully paid up member of a medical scheme (in this case Gen-Health) and, secondly an authorisation by Gen-Health itself (via its

administrators) that the services may be provided and will be paid for by Gen-Health. These authorisations take the form of telephonic confirmation of various codes that identify the service or procedure to be undertaken by the member concerned.'

Neither Sechaba, which was the claims administrator for Gen-Health, nor Gen-Health itself, disputed these allegations. Life Healthcare argued that on these facts their claims were underpinned by contracts concluded, in relation to each patient and member of Gen-Health, between Life Healthcare and Gen-Health, in terms of which the latter accepted liability for and agreed to pay for the services rendered to its members.

[13] Murphy J upheld that submission and he was correct to do so. The whole purpose of a healthcare provider seeking pre-authorisation from a medical scheme before rendering services to a patient is to obtain the assurance that the medical scheme of which that person is a member will pay its account once the treatment has been rendered. Gen-Health's own schedule of benefits, as set out in various of the documents in the papers, showed that pre-authorisation was a requirement for many forms of procedure and particularly a requirement in respect of services rendered in hospitals and clinics. It is the hospital or clinic that seeks this authorisation and it does so in its own interests, not those of the patient. That is what was said in the answering affidavit and that alone sufficed to establish a contractual foundation for these claims.

[14] In my view, Hugo J correctly described the consequences of a healthcare provider seeking and obtaining authorisation from a medical scheme to render services to a member of that scheme, when he said in *Margate Clinic*:[11]

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[11] *Margate Clinic (Pty) Ltd v Genesis Medical Scheme* 2007 (4) SA 639 (D) at 642E.

'When the scheme gives the hospital an 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. … 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 its member.'

[15] The review had to fail on that simple ground alone, but there was a more fundamental reason why it had to fail, flowing from s 26(1)*(b)* of the Act dealing with the relationship between a medical scheme and its members and the obligations assumed by the scheme towards its members. This spells out the obligations that a medical scheme bears towards its members. It provides that it shall 'assume liability for and guarantee the benefits offered to its members and their dependants in terms of its rules'. This makes it clear that the liability of the medical scheme does not exist in substitution for the liability of the member, but as an adjunct to it.[12] But a meaning must be attached to the statement that the scheme 'assumes liability for' the benefits to which the member is entitled.

[16] The benefits to which members of a medical scheme are entitled are the benefits set out in its published schedule of benefits. The scheme assumes liability for those benefits. The effect of the appellants' argument is that it merely assumes a liability to reimburse the member for the amount of such benefit, once quantified. In other words, adopting an expression applicable to some insurance policies, it is a 'pay to be paid' form of insurance. On the other hand, Life Healthcare's argument is that

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[12] According to D Pearmain, op cit, para 7.1, p 7-2 there can be contractual relationships between healthcare providers and medical schemes that release the member from any liability to the healthcare provider, but these are not the norm.

the obligation goes further and is an obligation to pay the healthcare provider to the full extent of the benefit. The undertaking given, and statutory obligation owed, to its member is that it will pay the healthcare provider itself, not that it will reimburse the member for what the member has paid. On that argument the 'benefit' referred to in s 26(1)*(b)* is the act of discharging the obligation incurred by the member to the healthcare provider when receiving medical treatment. When a medical scheme authorises the provision of services, on enquiry by a service provider, and undertakes to pay the service provider it is discharging its obligation to its member to provide the benefits set out in its schedule of benefits .

[17] A reading of Gen-Health's schedule of benefits makes it clear that the benefits it provided were not restricted to refunding the member with the amount of the benefit, leaving the member to pay the healthcare provider. The benefits were that the scheme would itself pay the healthcare provider to the extent reflected in the schedule of benefits. That is apparent from those items dealing with situations where the cost of the service exceeded the amount of the benefit. The schedule said that in that event the member would 'co-pay' the difference between the cost of the service and the stipulated benefit. If the scheme were not itself going to pay the service provider the reference to 'co-pay' would not make sense.

[18] To understand the nature of a benefit conferred on a member under a medical scheme as being primarily to pay the member's health service providers for their services, is reinforced by the fact that in addition to assuming liability for the benefit the scheme must 'guarantee' the benefit. The expression 'guarantee' does not make sense in a situation where the scheme's only obligation is to reimburse its member for the amount of

any benefit. What then would it be guaranteeing? A guarantee is an obligation given by one party on behalf of another to discharge that other's liability to a third party. And that seems to me precisely what a medical scheme is obliged to do. It is obliged to guarantee to its members that it will discharge, to the extent of the benefits set out in the schedule of benefits, their liability to the healthcare providers who render services to the members.

[19] This approach accords with the ordinary way in which medical schemes function in this country. The member consults a healthcare provider and the latter submits an account to the member's medical scheme, which pays the healthcare provider.[13] Sometimes it will pay the account in full and debit its member with any shortfall and sometimes it will pay the benefit only, leaving the healthcare provider to recover the balance from the member.[14] In either event it assumes liability for and guarantees the benefit by paying the healthcare provider.

[20] Construing the obligations of medical schemes in that way constrains them to function in a manner that is consonant with the social realities of this country. By far the majority of people are not in a position, after paying their medical aid subscriptions, to fund medical treatment from their other resources and seek reimbursement from their medical scheme. They are dependent for their ability to obtain such treatment on the fact that the cost will be borne by the medical scheme. And that is reinforced by the fact that the schemes enter into agreements

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[13] Pearmain, op cit, para 7.1, p 7-2.
[14] Pearmain op cit, para 7.11, p 7-44 says that some medical schemes will not pay any claim in excess of the tariff in the schedule of benefits but will pay the member the amount of the tariff benefit. Whether that is permissible is not a question that arises in this case.

with doctors, pharmacies, clinics and other healthcare providers to establish preferred provider networks and other systems for the provision of medical services.[15] Gen-Health did this as appears from its schedule of benefits, which refers to its 'Preferred Provider Network' and its 'Managed Care Provider'. The founding affidavit described these arrangements as 'Designated Service Provider Agreements' and accepted that services rendered by service providers under such agreements would be paid for directly by Gen-Health.

[21] But a construction of s 26(1)*(b)* is not the only basis for reaching the conclusion that medical schemes are obliged to pay their members' medical bills in accordance with the scheme benefits. Sections 59(1) and (2) of the Act are explicitly to this effect and, in addition, make it clear that this obligation is one owed to the service providers themselves. They read:

'**CHARGES BY SUPPLIERS OF SERVICE**

(1) A supplier of a service who has rendered any service to a beneficiary in terms of which an account has been rendered, shall notwithstanding the provisions of any other law, furnish to the member concerned an account or statement reflecting such particulars as may be prescribed.

(2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.'

[22] Section 59(1) recognises that a healthcare service provider will ordinarily render its account directly to the medical scheme. That is why

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[15] D Pearmain, op cit, para 7.3, pp 7-6 to 7-7 describes a variety of such relationships.

it obliges the service provider, in addition, to furnish an account or statement directly to the member. This it does 'notwithstanding the provisions of any other law'. One law that springs to mind immediately is the provisions of s 20(1)*(i)* of the Value-Added Tax Act 89 of 1991, which prohibit a supplier from issuing more than one tax invoice for each taxable supply. The medical scheme will want such an invoice, as the VAT payable to the service provider will then be included as input tax in its VAT returns. So the second invoice issued to the patient is issued notwithstanding the provisions of that other law. But that in turn indicates that the medical scheme is liable to pay the service provider.

[23] Section 59(2) of the Act expressly recognises that the medical scheme may pay the service provider directly. It was submitted that it was only obliged to do so when the service provider was party to a designated service provider agreement. However, there is nothing in the language or the context of the section that warrants us reading such a limitation into it. The section says that what is payable is 'any benefit owing to that member or supplier of service'. It is plain therefore that a benefit may be owing to the service provider. That can only be because the claim of the service provider arose in circumstances where the service provider was entitled to advance that claim against the medical scheme and the scheme was obliged to pay it. A claim cannot be owed if the party that owes it is not obliged to pay it.

[24] The shift in language between s 59(1) and s 59(2) is a helpful pointer to this being the correct interpretation of this section. Section 59(1) refers to the account or statement of the service provider. But s 59(2) says that where an account has been rendered it is the benefit that is payable, not the account. That in turn refers back to the benefit

mentioned in s 26(1)*(b)* of the Act, for which the scheme assumes liability and payment of which it guarantees.

[25] The high court thought that the effect of s 59(2) was to give the medical scheme a choice between, paying the amount of the benefit to the member, or paying it to the service provider. But if the benefit is owing to the service provider, which is what the section says, I fail to see on what basis it can be said that the medical scheme is not obliged to pay the service provider. To my mind that is in accordance with the relationship between the member and the medical scheme. Scheme members are not primarily expecting to receive a sum of money from the scheme, as a result of their having sought medical treatment. They become members in the expectation that the scheme will pay their medical bills to the extent of the benefits for which they contract. It seems to me that when a member obtains medical services and arranges for the service provider to submit their account to the medical scheme, they are authorising the medical scheme to pay the service provider and not the member. The position is different where the member pays the service provider directly and seeks reimbursement. That is the alternative contemplated by s 59(2), namely payment to the member. Again this reflects common practice in the industry. Where a member seeks reimbursement of the account of a service provider the medical scheme will not ordinarily sanction such payment without receiving proof that the service provider has been paid.

[26] We were referred in argument to the provisions of regulations 5 and 6 of the regulations made under the Act.[16] These are the regulations dealing with the rendering of accounts and the manner of payment of

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[16] Medical Schemes Act Regulations, GN R1262, GG 20566, 20 October 1999.

benefits. I do not intend to set them out or canvass them in any detail. It suffices to say that they entirely support the exposition of the legal obligations of a medical scheme set out above.

[27] For those reasons I am satisfied that the appeal must fail. I make the following order:

1 The appeal is dismissed with costs, such costs to be paid by the first appellant and the liquidators jointly and severally, the one paying the other to be absolved.

2 No costs in relation to the appeal shall be recovered or paid out of the assets of Gen-Health Medical Scheme.

M J D WALLIS
JUDGE OF APPEAL

Appearances

For appellants: B H Swart SC
Instructed by:
Jaco Roos Attorneys, Pretoria
E G Cooper Majiedt Inc, Bloemfontein

For third to twenty-seventh respondents:
M A Chohan SC
Instructed by:
Werksmans Attorneys, Johannesburg
Symington & de Kok, Bloemfontein.