

**BOARD OF HEALTHCARE FUNDERS OF SOUTHERN AFRICA**  
**Comments on the Medical Schemes Amendment Bill**

The Board of Healthcare Funders of Southern Africa (BHF) wishes to highlight the following major concerns regarding the Medical Schemes Amendment Bill as published in Government Gazette No 29408 on 24 November 2006 for public comment.

Comments on specific aspects and sections of the Bill are given later in this document.

**A. Timing**

The Draft Bill makes allowance for the Act to be implemented prior to REF transfers. If this occurs, schemes will be required to comply with the “basic” benefit framework whilst no risk equalisation takes place. This can be expected to exaggerate the current risk selection behaviour. Thus it is strongly recommended that the Draft Bill benefit framework not be implemented prior to *full* REF transfers. Should it be a requirement to initially introduce a progressive implementation of REF transfers, the current benefit framework should remain until *full* risk equalisation is implemented.

The introduction of a “basic” benefit framework and risk equalisation will increase the cost of the lower benefit options across the industry. Thus, it is recommended that LIMS be introduced no later than the introduction of the Draft Bill framework and the REF in order to ensure low income families are not lost to the medical scheme industry.

The impact of the Draft Bill has significant IT and reporting implications that will need to be planned well in advance. January 2009 appears to be the earliest date of implementation, given the current time frame for legislation approval.

It is requested that the drafts of regulations contemplated in the Bill be made available as soon as possible for comment. A lot of the detail will be provided in the regulations and in order to meaningfully comment on the proposed changes more clarity is required. For instance, the Draft Bill allows for “efficiency” in the context of contribution rates and it is uncertain what this means. On a similar note, will the scheme be able charge different rates for different formularies, protocols, providers or provider reimbursement rates?

**B. The Bigger Picture**

Much discussion has occurred around the governance issues and technicalities contained within the draft Amendment Bill. However, it is imperative that the Minister and the Department of Health consider the implications of the revised benefit framework within in the wider context

of Social Health Insurance (SHI) and risk equalisation. The revised benefit framework will have significant impact on medical schemes and its members. Thus, the Department of Health could consider the SHI objectives and how well the revised benefit design meets these objectives. Our comments in this regard are briefly set out below:

One of the main objectives of introducing the revised framework is to, as Circular 8 of 2006 states, “remove risk-selection activity in respect of essential health care”. Including non-risk-equalised benefits (non-PMB benefits) into the common package and enforcing community rating results in sufficient motivation for risk selection (cream skimming) behaviour. An analysis of some twenty schemes suggests that the common benefit package could vary by at least 20% between the schemes due to differing risk profiles, even though the REF has risk equalised the PMB’s. Thus, there will still exist sufficient motivation to risk select. The REF should therefore rather not be introduced if the Draft Bill benefit framework is introduced as is, as the additional complications and costs introduced into the system by the REF will serve little purpose.

The problem of risk-selection will always occur where community rating is enforced and where the benefits are not risk equalised. This is endorsed widely by international experts, including the International Review Panel to the REF. The solution is to introduce risk rating for the benefits that are not risk equalised.

Risk rating of non-PMB essential (common) benefits could be seen as an interim but important solution to prevent cream skimming. A formal review of the PMB’s in its entirety is recommended and this revision could lead to a situation where all ‘essential’ benefits are part of the PMBs (and so risk-equalised). This will mean that only PMBs need to form part of the common benefit package with all other benefits being absorbed into the supplementary benefit packages. The common benefits will then be completely risk equalised while the supplementary benefits remain subject to risk rating.

There should be equity in the revised PMB’s (or basic benefit package), since all schemes provide a minimum benefit at the same cost (because it is risk equalised). The design would encourage efficient delivery of benefits, with little incentive to cherry pick healthier lives.

If risk rating is not allowed and the REF certain, then the “basic” benefit package should only include the risk equalised benefits. Then, at least for the basic benefit, there will be little incentive to cream skim and members can make direct comparison across schemes.

### **C. REF Exemption**

The Draft Bill makes allowance for “newly registered” schemes to be exempted from REF transfers. This should not be allowed as it undermines the principles and rationale for the REF. Exempt schemes

will effectively be able to “cream skim” younger, healthier lives. It is reasonable to expect that only schemes with healthier lives or a strategy to attract healthier lives will ask for exemption. This will increase the REF cost of the PMBs for non-exempt schemes and put them at a disadvantage. In Ireland there is a recent perfect example of how this can be manipulated... BUPA removed itself from the market with the introduction of an REF because it was required to pay in. But, BUPA was simply bought and re-registered as a “new” scheme with exemption from the REF.

#### **D. Solvency Definition**

It is unclear how the REF transfers will affect the definition of “gross annual contribution” in the solvency ratio calculation. Since the REF transfers do not change the underlying risks for a scheme, it is recommended that the term “gross annual contribution” be defined clearly in the Regulations in such a way that the REF transfer does not affect the solvency ratio. This is in line with the REF technical team recommendation.

#### **The following more specific comments on the Medical Schemes Amendment Bill -**

##### **1. Money Bill**

The Medical Schemes Amendment Bill satisfies the definition of a money bill in section 77(1) of Constitution which provides as follows –

- (1) A Bill is a money Bill if it-
  - (a) appropriates money;
  - (b) imposes national taxes, levies, duties or surcharges;
  - (c) abolishes or reduces, or grants exemptions from, any national taxes, levies, duties or surcharges; or
  - (d) authorises direct charges against the National Revenue Fund, except a Bill envisaged in section 214 authorising direct charges.

The Medical Schemes Amendment Bill appropriates money from medical schemes.

In view of this, attention must be drawn to the provisions of section 77(2) of the Constitution which read as follows -

- (2) A money Bill may not deal with any other matter except-
  - (a) a subordinate matter incidental to the appropriation of money;
  - (b) the imposition, abolition or reduction of national taxes, levies, duties or surcharges;

- (c) the granting of exemption from national taxes, levies, duties or surcharges; or
  - (d) the authorisation of direct charges against the National Revenue Fund.
- (3) All money Bills must be considered in accordance with the procedure established by section 75. An Act of Parliament must provide for a procedure to amend money Bills before Parliament.

There is every possibility therefore that the Bill as it stands presently is unconstitutional for the reasons given above. This may defeat the passage of the Bill through Parliament. It will be necessary to separate out the elements of the Bill that do not relate specifically to payments into the risk equalisation fund and put them in a second Bill.

**2. The definition of “basic benefits” in section 1 of the Bill is not specific enough.**

Does the term “basic benefits” include the prescribed minimum benefits or does it mean something other than the prescribed minimum benefits? Alternatively is it another name for the prescribed minimum benefits contemplated in section 29 of the Medical Schemes Act? A scheme does provide prescribed minimum benefits to all its members because it is obliged to do so by law. The definition is likely to result in differences of interpretation across schemes. How does a scheme distinguish between benefits of the same type but of varying quantity or intensity? For example is a benefit that allows ten GP consultations with a GP of the patient’s choice the same as a benefit that allows five GP consultations but only with networked GPs?

It is submitted that if “prescribed minimum benefits” were intended by the term “basic benefits” then this should be indicated. Alternatively if prescribed minimum benefits are to be included in the term, then this should also be more clearly indicated. Alternatively if prescribed minimum benefits are excluded from the term “basic benefits” then this should be positively expressed.

There is a great deal of confusion amongst medical schemes regarding the various benefits to be offered and it is requested that the Bill gives absolute clarity on what all medical schemes must provide for all their members as well as what an individual scheme must provide for its members where the scheme elects to provide a richer level of benefits than what the law prescribes.

It is further submitted that the term “basic benefit” should be defined in terms of a particular health intervention but not the manner in which such intervention takes place. For instance one can repair a hernia laparoscopically or by way of less “high tech” surgery the former costing

a great deal more than the latter. It should be for the scheme to decide which procedure it is prepared to fund for purposes of hernia repair. It is also noted in this regard that the stated intention of the Council for Medical Schemes that all hospital procedures must be included in the “common benefits” (presumably the “basic benefits” in the draft Bill) is not acceptable to schemes. The prices of private hospital services are already unacceptably high and the availability of alternatives to such services within the public sector is low for various reasons. Schemes and members should rather be encouraged to offer and purchase benefits that preclude the need for hospitalisation as far as reasonably possible.

At the same time, members of medical schemes should be permitted the discretion of purchasing benefit options that would allow for the more “high-tech” benefits e.g. keyhole surgery, if they wish to reap the benefits from technological advancements in medical science and can afford to do so.

**3. For the sake of convenience and because the term “basic benefits” is only used in the proposed section 29B and nowhere else it is appropriate at this juncture to comment on section 5 of the Bill, proposing section 29B, as follows-**

Section 29B of the Bill seems to achieve no more than the current legislation in that the prescribed minimum benefits (those contemplated in section 29(1)(o)) are already a minimum set of benefits that a scheme must provide to all its members.

Section 29B(1) of the Bill requires a medical scheme to provide in its rules for set of “basic benefits” which must be provided to every beneficiary of the medical scheme. If one combines the logic of this statement in subsection (1) with that of the definition of basic benefits then one obtains the following result –

A medical scheme must provide in its rules for a set of benefits which a medical scheme provides to all of its beneficiaries to every beneficiary of the scheme.

This logic is clearly tautologous. It is suggested that section 29B(1) is amended to read:

“a medical scheme shall provide in its rules for a set of basic benefits”.

Even then this proposed amendment seems to be repeating the provisions of section 29(1)(o) of the Act requiring every scheme to provide the prescribed minimum benefits.

Section 29B(2) then states that such benefits “shall include as a minimum”, the section 29(1)(o) benefits. The section does not render mandatory a set of benefits greater than the prescribed minimum

benefits that must be available to every member of a medical scheme. Section 29B does not indicate what other benefits, if any, must be provided neither does it make it a legal requirement to provide any benefits over and above those contemplated in section 29(1)(o). The section does not achieve the effect of obliging medical schemes to offer what circular 8 referred to as “common benefits” over and above the prescribed minimum benefits contemplated in section 29((1)(o).

The manner in which section 29B(3) is written allows members to participate in more than one benefit option should they choose to do so. Is this the intention behind this subsection or is the intention rather to stipulate that a scheme may offer a number of different benefit options to its members or only one as it sees fit? The wording of section 29(1)(r) which is quoted here for your convenience states that -

“The dependants of a member are entitled to participate in the same benefit option as the member.”

Section 8(1)(f) already allows medical schemes to offer to its members a choice of options to the extent that these have been approved by the Council for Medical Schemes. It reads that the Council shall, in the exercise of its powers, be entitled to –

- (f) approve the registration, suspension, and cancellation of registration, of medical schemes or a benefit option.

There is no statutory limitation imposed on the number of options a scheme may offer. This implication is further reinforced by the provisions of section 29A(4) which state that -

“A medical scheme may not impose a general or a condition-specific waiting period on a beneficiary who changes from one benefit option to another within the same medical scheme unless that beneficiary is subject to a waiting period on the current benefit option, in which case any remaining period may be applied.”

Further reinforcement is to be found in section 33(1) which states that –

“(1) A medical scheme shall apply to the Registrar for the approval of any benefit option if such a medical scheme provides members with more than one benefit option.”

In the light of the foregoing it is difficult to see the need for subsection 29B(3) at all unless it is the intention to allow a member to be a member of two or more options simultaneously. It is submitted that if this is indeed the intention, then allowing membership of more than one benefit option at a time will add significantly to the complexity of medical schemes administration. This is especially true if this same rule applies to dependants and they are not obliged to belong to the same option as the

member. Increased administrative complexity usually translates into increased administration costs.

**4. The definition of “benefit” is not specific enough**

The wording “**in accordance with its rules**” should be inserted after the phrase “accepted by a medical scheme” in the definition. A medical scheme may not accept liability for a claim that falls outside the scope of its rules. The Registrar approves the scheme rules, including benefit changes, each year. Benefits can vary from one year to the next. Does the term “benefit” include *ex gratia* payments by medical schemes?

**5. The definition of “community” is too vague.**

The definition states that ‘community’ means a ‘defined grouping of beneficiaries’ but does not state how or by whom the grouping is defined. According to the definition, it *may*, depending on the context, refer to all beneficiaries within the medical schemes industry as a whole, an individual medical scheme or a benefit option within a medical scheme or “some other grouping of beneficiaries”.

In terms of this definition the term ‘community’ could therefore mean just about any grouping of which a beneficiary of a medical scheme is a member which rather defeats the object of having a definition in the first place. The term “community” does not occur in the Bill except in the context of the definition of the phrase “community rate”. It is also from a legal drafting point of view technically incorrect to include the phrase “depending on the context” in the definition of “community” because the principal Act prefaces the definition section (section 1) with the phrase “In this Act, *unless inconsistent with the context*”.

If the definition of “community” is intended to be used only in the context and community rating or purposes of risk equalisation across the entire industry then it is submitted that the exact nature of the community in question i.e. all beneficiaries of medical schemes, should be stated and if necessary prefaced by the qualification “for purposes of risk equalisation”.

**6. How does the definition of “community” relate to “community rate”?**

If one considers the context in which the word ‘community’ is used, one finds it in the phrase “community rate” which is defined in section 1 of the Bill as “the average expected cost per beneficiary of providing a defined set of benefits to the relevant community of which that beneficiary is a member. However, technically speaking a beneficiary can be a member of community (group of beneficiaries) that are all children or all spouses

for example, as well as a member of a community comprised of beneficiaries on a particular option, a community comprised of all beneficiaries of the particular scheme of which the option is a part as well as the community comprised of members of all open schemes of which the scheme is one as well as the community comprised of beneficiaries of all medical schemes. The context of the definition of “community rate” does not indicate what is intended here. What is in fact meant by “community rate” in the Act?

The term “community rate” also appears in the definition of “risk equalisation” in section 1(g) of the Bill. This gives no indication of what meaning is intended by the term “community rate” with respect to which community is the relevant one. As pointed out earlier “community rate” could refer to the average expected cost per beneficiary of providing a defined set of benefits to all children who are beneficiaries of medical schemes where the beneficiary is a child or it could refer to the average cost of providing a defined set of benefits to all adult dependants since the latter is also a “grouping of beneficiaries”. The reference in section 1(c) (iv) of the Bill to “some other defined grouping of beneficiaries” is not helpful. Defined by whom? The Registrar? The Council for Medical Schemes? The Minister of Health? A medical scheme? If this is left open ended it allows for too many variables within the system which in turn gives the Council for Medical Schemes too much discretionary power over the risk equalisation system proposed by the draft legislation.

The same can be said of the definition of “community rate” which refers to “a defined set of benefits” provide to a relevant community of which the beneficiary is a member. Defined by whom? The scheme? The Registrar? The Council for Medical Schemes? The Minister of Health? In this particular context one would be inclined to say that it is the scheme which determines the defined benefits within a particular option but this is open to debate because the Registrar must approve the scheme rules and there is a right of appeal to the Council for Medical Schemes against decisions of the Registrar. It does make a difference who defines these benefits because this will materially affect what the community rate is. This will in turn determine the manner in which risk equalisation is implemented. The “community rate” is central to the concept of “risk equalisation” which means the definitions of “community” and “community rate” are critical.

## **7. The definition of “material relationship” is incomplete**

The definition is clearly intended to address conflict of interest situations but it does not go far enough. The definition should not only cover a situation where the relationship or interest would interfere with the independent judgment of the officer but also where it might prejudice the rights or interests of a medical scheme or its members. It may not necessarily interfere with the independent judgment of the officer of the

scheme but can nonetheless be prejudicial to the interests of the scheme or its members.

The definition is also a bit clumsy in that the phrase “relevant circumstances” is open to interpretation and too subjective. It will give rise to arguments about what the relevant circumstances are. It is therefore suggested that the phrase is amended to read simply “which, in the view of a reasonable person would interfere with the independent judgment of the officer of the medical scheme or prejudice the interests of the medical scheme or its members”.

**8. The definition of “principal officer’ should contain a reference to the section of the Act in terms of which the principal officer is appointed in addition to the text proposed in the Bill.**

If this is done then there is no risk of misunderstandings leading to separation of the concepts of “principal officer” and “chief executive officer”. It must be said, however, that the advisability of giving the principal officer an additional title is questionable where that title does not really add any clarity to the duties of the principal officer. In the context of a medical scheme, how does a “principal officer” differ from a “chief executive officer” and if they are one and the same then why is it necessary to give that official two different titles? He or she should either be called a chief executive officer or a principal officer. The important point is that the duties of this official, vis-à-vis the Board of Trustees must be clear. A proposed list of duties of a principal officer appears further on in this document. It is noted at this point that the duties of the Board of Trustees are listed in section 57(4) of the Act and are as follows –

- (4) The duties of the board of trustees shall be to —
- (a) appoint a principal officer who is a fit and proper person to hold such office and shall within 30 days of such appointment give notice thereof in writing to the Registrar;
  - (b) ensure that proper registers, books and records of all operations of the medical scheme are kept, and that proper minutes are kept of all resolutions passed by the board of trustees;
  - (c) ensure that proper control systems are employed by or on behalf of the medical scheme;
  - (d) ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the rules of the medical scheme;
  - (e) take all reasonable steps to ensure that contributions are paid timeously to the medical scheme in accordance with this Act and its rules;
  - (f) take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance;

- (g) obtain expert advice on legal, accounting and business matters as required, or on any other matter of which the members of the board of trustees may lack sufficient expertise;
- (h) ensure that the rules, operation and administration of the medical scheme comply with the provisions of this Act and all other applicable laws; and
- (i) take all reasonable steps to protect the confidentiality of medical records concerning any member's state of health.

If the principal officer is to take on some of the responsibilities of the Board of Trustees in terms of legislation then the Bill should be amended accordingly. If this is the view, however, then it is submitted that this will diminish the accountability of the Board of Trustees with regard to the management and governance of the scheme. It is inadvisable to detract from the powers of trustees in favour of the principal officer if the role of the latter, as chief executive officer, is to ensure that the decisions of the Board are executed. If the functions listed in section 57(4) are to remain ultimately the responsibility of the Board of Trustees then the latter must retain the power to delegate certain functions or tasks, as it seems fit, to the principal officer (Chief Executive Officer) depending on the latter's capabilities and relationship with the Board of Trustees. Some suggestions on how to strengthen the role of the principal officer are made later on in this document.

If it is the intention that the role of principal officer is equivalent to that of the Chief Executive Officer of a company for example, then it is submitted that this should rather be specified using wording to the effect that "...principal officer who is a fit and proper person to hold such office *and whose primary duty is to ensure the execution of decisions taken by the Board of Trustees within the context of the Medical Schemes Act and the rules of the relevant scheme and to exercise any powers or fulfil any duties lawfully delegated to him or her by the Board...*" It is submitted that this is preferable to calling the principal officer the "Chief Executive Officer" as it provides more clarity to the principal officer and the Board of Trustees as to his/her role.

A further consideration is that the concept of "accounting officer" exists in the Public Finance Management Act (PFMA) with regard to public entities and government departments. If it is the intention that the principal officer fulfils a similar role, it may be appropriate to indicate this by way of incorporation mutatis mutandis of the duties of an accounting officer into the Medical Schemes Act with reference to the principal officer of a medical scheme. These are to be found in section 38 of the PFMA.

As far as whether or not a person is "fit and proper" to be a principal officer it has been suggested by some members of BHF that guidance in this regard may be had from the provisions of sections 47, 106 and 158 of the Constitution Act No 108 of 1996 which relate to the suitability of individuals to be members of Parliament and other holders of political

office and section 5 of the Medical Schemes Act which indicates when a member of the Council for Medical Schemes is disqualified from being a member. It is the strongly held view of BHF members that it is preferable to list in legislation those qualities which are undesirable or unacceptable in a principal officer or board of trustees rather than to give the Council for Medical Schemes the power to vet persons who are appointed as principal officers or trustees as to their suitability for the position.

**9. The definition of “risk equalisation” refers to a “package of benefits” but it is not clear what is meant by this.**

Does the term “package of benefits” refer to the prescribed minimum benefits? If so then the term should be amended so as to be consistent with the language used in the Act and regulations. “Package of benefits” is inconsistent with the Act which refers to “prescribed minimum benefits”. See section 29(1)(o) and the General Regulations. Otherwise “package of benefits” should be defined in the definition section of the Bill.

**10. In the definition of “risk equalisation” reference is made to “efficiency adjustments” but there is no indication of the basis on which these will be calculated or determined.**

“Efficiency” can mean different things to different people. It can mean efficiency in the sense of effective managed care programmes that reduce the incidence of hospitalization (and PMB claims) for chronic conditions such as asthma, diabetes etc. How will the Council for Medical Schemes reward such efficiency via the risk equalisation mechanism? Alternatively efficiency can mean efficiency in scheme administration which is as much if not more in the hands of the administrator than in those of the scheme itself in most cases. Alternatively “efficiency” can be given a purely academic economics definition, an industrial engineering definition, a social engineering definition or a financial accounting definition. The adjustments for efficiency will be critical to the wellbeing of the medical schemes industry as a whole and therefore the relevant policy parameters should be indicated in the Bill itself.

**11. The wording of section 2 of the Bill allows the Council to subcontract the management and administration of the REF. This is unacceptable.**

This section amends section 7 of the principal Act with the insertion of paragraph (fA) but the wording is incorrect. One does not usually “control” the management and administration of a Fund. One manages and administers a Fund. The word “control” implies that the Council for Medical Schemes could outsource the management and administration

of the risk equalisation fund to a third party. This is something that medical schemes are uncomfortable with since a third party contractor is unlikely to be as knowledgeable and concerned about medical schemes and their members as the Council itself. The fact that the REF can make or break the medical schemes industry means it is too important to entrust its management and administration to an outsider. It should rather be done by the industry regulatory body itself.

## **12. Section 19B is unclear and possibly in conflict section 19D**

Section 19B(1) states that that Fund shall “vest in” and be administered by the Council. The term “vest in” is problematic especially when 19B(2) states that the Fund shall be “held in trust” by the Council for purposes mentioned in section 19D which uses the word “appropriate” in the sense of “appropriation”. The language “vests in” and “held in trust” tends to suggest that the Council might have to establish the REF as a proper trust fund, by way of a trust deed, of which presumably the individual members of the Council are the trustees. A trust usually has specified beneficiaries but there is no express mention of who the beneficiaries are of the “trust”.

There are trust funds in terms of which ownership of the assets vests in the beneficiaries of the trust but the administration and control of the trust vests in the trustees (bewind trust). In other types of trust funds the assets vest in the trustees which in this case would be the Council of Medical Schemes. It is not clear from section 19B whether the Council must set up a trust fund or whether the Council itself must simply administer the funds *as though it were* the trustee of those funds – i.e. with the same level and nature of fiduciary responsibility as that normally imposed upon the trustees of a trust fund.

The other question that arises in this regard is that, if the REF is supposed to be a zero sum game why must ownership of the fund vest in the Council at all? The money taken from some schemes will be paid without delay to other schemes in order to offset their risks. Where there is a mistake in calculation of the risks faced by a particular scheme and that scheme is mistakenly charged too much, the excess funds belong to the scheme and should be refunded immediately.

The need for ownership of Fund that is essentially a clearing house for equalisation of risk across medical schemes is questionable. It also raises the problem which section 19D seeks to achieve – namely ringfencing of the funds in the REF from the other assets and liabilities of the Council. If the Council does not own the funds in the REF to begin with then the need to ringfence them does not arise. It would be preferable, in the language of the law of trusts, for the REF to be a *bewind* type of trust where the money vests in the beneficiaries and the Council simply administers and controls it rather than the other more common type of trust in which the trust funds vest in the trustees. This

would also constitute less of a risk for the Council for Medical Schemes in terms of its own assets and liabilities and their independence from REF moneys. The beneficiaries of the trust would be identified in terms of a set of conditions that they fulfil in order to qualify as such based on their risk profile.

Public funds are governed by the Public Finance Management Act. Is it the intention that the money in the Risk Equalisation Fund will be governed by the provisions of this Act as well? The implications of this may include unnecessary and potentially disastrous delays in payments of REF funds to medical schemes and could defeat the “zero sum game” intentions of the Council. The likelihood of the funds in the REF being governed by the Public Finance Management Act are higher if the Fund expressly “vests in” the Council for Medical Schemes as stated in 19B(1).

Are there any tax implications if the Fund vests in the Council as opposed to the medical schemes industry? The BHF does not have the time or the expertise to explore this option in more detail but it is suggested, if this has not already been done, that the Receiver of Revenue’s views on the matter are sought.

**13 Section 19C of the Bill belies the publicly stated zero sum game approach**

If the Risk Equalisation Fund will be operated on a zero sum game approach in real time terms, why will there be a need to invest money standing to the credit of the REF? Why will there be money standing to the credit of the REF in the first place if the process is going to be as slick as has been suggested by the Council? Money for risk equalisation purposes should not remain the Fund for more than a month. Otherwise it defeats the object of risk equalisation. What other money will be able to be paid into the Fund and on what basis? The Fund should be kept as pure as possible and not polluted by moneys from other revenue streams if it is to be effectively controlled and administered. The Fund should not be used as a storage vehicle for money other than that paid into it for purposes of risk equalisation. There is no indication in the Bill of the basis on which other money can be paid into the fund and this should be remedied.

How will the interest or dividends derived from investments of money in the fund be utilised? This should be expressly stipulated in the Bill assuming that dividends can be earned in the short time in which money should be in the Fund given the real time electronic fund transfers that are supposed to take place.

There is a danger that the moneys paid into the fund could become a tax on medical schemes especially if the Fund retains significant portions of these moneys for any length of time.

**14. Section 19D(1) appears to be superfluous in the light of section 19B(1)**

If the Fund vests in the Council then why is it necessary for the Council to “appropriate” funds for expenditure in accordance with subsection (2). It is noted that the word “appropriate” when used in law has a highly specific meaning and is generally seen in the context of expropriation when it involves dealings with private money.

**15. Section 19E is apparently an attempt to ringfence the money paid into the REF from the Councils other funds but it is badly drafted.**

The provisions of section 19E(2) seem to be saying that, for instance, if the Council is overdrawn on one of its other banking accounts, the bank at which the account for the REF is held may not draw funds from that account in order to offset the debit balance in the other account. However, this does not go far enough in ringfencing the money in the REF. It should be expressly stated that the liabilities of the Council irrespective of who the creditor is, cannot be discharged by means of money in the REF. If the Council is faced with a major lawsuit for example, and has an order made against it for millions of rands to be paid to the successful applicant, the Medical Schemes Act should expressly preclude the possibility that the money can be recovered from the REF. It is noted that the fact that the Bill proposes that the Fund “vests in” the Council gives rise to difficulties in ringfencing money in the REF from the Council’s financial affairs.

**16. Section 19F is not specific enough about the manner in which the money in the Fund should be invested.**

Potentially there could be millions of rands standing to the credit of the fund. The manner in which the funds of medical schemes may be invested by medical schemes is dictated by the Medical Schemes Act. Why should the Public Finance Management Act dictate the manner in which money in the Fund should be invested? As stated previously, the Council should not be the ‘owner’ of the money in the Fund since it is money siphoned off the medical schemes industry. Otherwise the moneys paid into the Fund start to look more and more like a tax on medical schemes where the Council plays the role of the National Treasury. It is submitted that it should only be government itself that can levy taxes and that this power should not be extended to organs of state such as the Council for Medical Schemes.

Section 19F(2) is apparently contradictory of 19F(1) because the former requires that an unexpended balance of the money in the Fund at the end of any financial year shall be carried forward as a credit to the “next

succeeding” financial year. “Incidentally “next succeeding” would seem to be unnecessary repetition. It may be preferable to say “immediately succeeding” financial year or simply “succeeding” financial year.

**17. Section 19H is impractical and problematic because it allows for unfair discrimination between schemes**

Section 19H(1) contains the words “calculated/determined”. This is unacceptable from a legal drafting point of view since it leads to problems of interpretation. One does not juxtapose synonyms in this manner in legislation especially when they are only approximate synonyms at that. “Calculate” means something very different from “determine” so which one does a person seeking to understand the intention of the Legislature use? Furthermore, the fact that section 19I states that the Minister will prescribe the methodology for making the determination is not sufficient. It is proposed that the wording of section 19H should be “..as determined by the Registrar *in accordance with the prescribed methodology contemplated in 19I...*” in order to make it clear that the Registrar may determine the transfers *only* in accordance with the section 19I methodology.

As stated previously BHF members are generally opposed to the idea of *any* exemptions from the REF system. In this regard section 19H(2) is particularly problematic because it allows for exemptions only for “newly registered” schemes and because the term “newly registered” is subjective and open to interpretation. The members of BHF are opposed to this provision as it is too vague, allows for certain schemes to be unfairly favoured over others and contradicts the goals of Risk Equalisation.

The Council is in any event empowered in terms of section 8(h) of the Medical Schemes Act to exempt, “in exceptional circumstances”, a medical scheme other person from complying with any of the provisions of the Act. The provision in section 19H(2) is therefore superfluous.

However, it is of concern that the Council has been given no guidelines in the legislation for the granting of exemptions, whether in terms of the proposed section 19H or in terms of section 8(h) of the Act. It is submitted that the Council should be given specific legislative guidance as to the basis on which exemptions may be granted whether from the REF or from any other provision of the Act.

It is submitted with regard to exemptions from the REF in particular that the power of the Council to grant exemption is limited in the following terms and not with any reference to “newly registered” schemes. The principles of risk equalisation dictate that the extent of the fragmentation of the larger risk pool that is currently reflected in the memberships of a multitude of individual medical schemes must be eliminated at best, or at worst, significantly reduced by way of the REF in order to ensure equity

across schemes in terms of their risk profiles. If exemptions from the REF should be granted at all, it is submitted that the Council's power to exempt any scheme from the REF should be restricted as follows –

The Council may grant an exemption from participation by a scheme in the risk equalization fund only -

- (a) Where transfer payments would result in the scheme's failure to meet its reserving requirements as required by the Act (which includes the Regulations);
- (b) Where transfer payments would result in the inability of the scheme to pay member claims submitted within the period specified in section 59 of the Act;
- (c) Where transfer payments would render the scheme insolvent;
- (d) Where transfer payments would significantly impair a scheme's ability to compete with other schemes for members or relevant health services;
- (e) Where transfer payments would effectively prevent a scheme from providing a low cost benefit option for persons whose annual earnings are less than a prescribed amount;
- (f) If the granting of an exemption would not give an unfair advantage to the exempted scheme over its competitors;
- (g) If the exemption is for a limited time period within which a scheme is required to get its affairs in order so that it can comply with the provisions of the Act and participate in the REF system;
- (h) If the exemption is necessary to facilitate a merger between schemes or the closure of one scheme and the transfer of its members to another scheme;
- (i) If the exemption would open up access to a scheme to persons in a health category or socio-economic grouping that were previously unable for financial or other reasons to be beneficiaries of a medical scheme;

It should also be specified that exemptions should be given only to the extent that they are necessary and so, for instance, it should be possible for the Council to exempt certain options within a scheme, as opposed to the entire scheme, from the REF requirements.

The object of risk equalization is to eliminate or reduce as far as possible inequities across schemes and not to promote such inequities as may already exist or create new or different ones. An exempted scheme may be able to take advantage of such exemption by offering lower contributions or better benefits than non-exempted schemes. Therefore medical schemes are opposed to a situation in which a medical scheme,

such as GEMS, could be given special treatment effectively at the expense of other medical schemes from which it is drawing its membership. The legislation should be written in such a way as to promote access to medical scheme membership and not to unfairly discriminate between one scheme and another.

The period for which an exemption may be granted to a medical scheme by the Council from the REF should have an upper limit of two years. An exempted scheme should be obliged, if it feels the need for a further exemption, to reapply to the Council upon expiry after the two year period for a further exemption.

It is further submitted as a general comment on the Bill that its provisions should not preclude the possibility of competition between schemes.

The provisions in 19H(1) require a scheme to pay within a specified period. This is problematic because the period may vary between schemes in terms of this wording. Some schemes could be subjected to time pressure by the Registrar while others are not. The Registrar is given too wide a discretion by this provision. It is proposed that the specified period should be not less than six months and not more than 12 months and should be expressly stated in the Bill. Schemes may have money that must be paid as a financial transfer invested in vehicles that require notice to be given to the relevant financial institution before they can be released. It is for this reason that the minimum period of six months is suggested.

**18. The provisions of 19I (4)(b) allow the Registrar to circumvent the methodology prescribed by the Minister in consultation with the Minister of Finance in terms of section 19I(1).**

Whilst it is appreciated that this may be in order to assist a scheme that may be prejudiced if the prescribed methodology is applied, it gives the Registrar too much discretionary power where a scheme appeals against a determination made by him under section 19I (1). The words “some other reasonable basis” in section 19I (4)(b) are problematic. The provisions of 19I (4)(b) are also apparently superfluous in the light of those in section 19I(3). The former only allows the Registrar to make a determination on a basis other than that prescribed where “the Registrar is of the opinion that the information submitted by the medical scheme in accordance with section 19L may be incorrect”. Section 19I(3) however states that the Registrar may adjust any assessment made in accordance with subsection (1) to correct an error or to retrospectively effect changes in the number of beneficiaries, prevalence of risk factors or other material changes. The question arises therefore as to why it is necessary to allow the Registrar to make the determination “on some other reasonable basis” in section 19I (4)(b)?

The methodology that is to be prescribed should include provision for the position of a scheme pending the outcome of an appeal. For example, where if the scheme is made to pay the full amount, this will significantly prejudice the scheme in financial terms - e.g. it will not be able to meet its obligations for the next month or more - then the scheme should be made to pay a percentage of the amount determined by the Registrar that does not jeopardize the interests of scheme members but at the same time ensures availability of some funds to the REF. The balance can then be paid or refunded as the case may be once the outcome of the appeal is known. It is not appropriate to have a methodology approved by two Cabinet Ministers circumvented in the event of an appeal, by an official such as the Registrar. The methodology itself should cater for the contingency of an appeal against a determination by the Registrar.

There is an objection to the wording “other material changes” in section 19I (3) in that it gives the Registrar too wide a discretion. What are “other material changes?” Does it matter whether they are specific to a particular scheme or general within the medical schemes environment? If they are general within the medical schemes environment – in other words spread across the entire medical schemes risk pool- should the Registrar be allowed to make adjustments to only one schemes assessment without adjusting the assessments of other schemes? If so, this could potentially give the scheme whose assessment is adjusted an unfair competitive advantage over those who are either still waiting for their adjustment or who have not asked for one for reasons of ignorance.

It is also not clear from section 19(3) and (4) when read together whether the Registrar may only adjust the assessment after an appeal is lodged or whether he may also do so in the absence of an appeal. It would be advisable for the Registrar to be able to correct errors that come to his attention even where there is no appeal made by a medical scheme provided that where the error is corrected by the Registrar, whether after an appeal or not, there should be prior consultation by the Registrar with the medical scheme concerned in order to for both parties to be able to confirm whether or not there was in fact an error and if so its exact nature, cause and extent. Arbitrarily, retrospectively effected changes by the Registrar are undesirable as this will affect the stability and credibility of the risk equalization system.

There is ambiguity in section 19I (4)(a) which says that a medical scheme may lodge an appeal against a determination by the Registrar under subsection (1). There is no reference to appeals in subsection (1) of section 19I. Section 19I (4)(a) is intended to mean that a medical scheme may lodge an appeal against a determination by the Registrar that has been made *in accordance with the methodology* contemplated in subsection (1). Otherwise it looks like it is the appeal itself that must be lodged under subsection (1).

**19. Section 19J of the Act does not indicate whether payments and receipts of financial transfers will be synchronous or asynchronous**

It is not appropriate for the Registrar to have the power to veto decisions of the Ministers of Health and Finance. The phrase “after consultation” means that although the Registrar must hear what these two Ministers have to say, he or she is free to decide on the schedule for progressive implementation contrary to their views. An administrative official in an organ of state should not be given the power to act contrary to the wishes of members of the National Executive in the manner proposed. It is recommended that the wording in section 19J(1) should be altered to read -

“The Registrar may, with the approval of the Minister and the Minister of Finance, determine a schedule...”

It is also recommended that certain criteria for the progressive implementation schedule must be expressed in the Act. For example –

The progressive implementation schedule -

- (a) must not result in money remaining in the Fund for a period longer than 30 days;
- (b) must not give some schemes an unfair competitive advantage over others;
- (c) must not financially disadvantage some schemes in order to advantage others except in accordance with the methodology contemplated in section 19I(1);
- (d) must ensure that the zero sum game rule is observed at all times;
- (e) (e) must not jeopardize the solvency of a scheme

The annual increase in the percentage of the financial transfers must have an upper limit in the sense that one can surely not indefinitely increase the *percentage*. The other question is what is the percentage referred to? Percentage of what? If one annually increases a percentage one will invariably reach 100% over time. What happens when one reaches 100%? Does the next increase exceed 100%? The wording of section 19J(2) is logically unsound. It must be stipulated that the percentage referred to is the maximum amount payable by schemes in respect of risk equalization – i.e. what is sustainable by the medical schemes industry. There is an attempt to express the ceiling in the words “and the total financial transfers referred to in section 19I to become payable within a reasonable period” but unfortunately it is still not stipulated that the percentage in question is *the percentage of the total amount of the financial transfers contemplated in section 19I*.

The BHF stresses that it is vital to the success of REF and the wellbeing of the medical schemes industry that the progressive implementation provisions of the Bill should not be used in such a manner as to effectively exempt some schemes from the REF system.

**20. Section 19M(3)(d) appears to contradict the remainder of section 19M(3)**

Section 19M(3)(d) states that “nothing in this subsection may be construed as conferring upon any person any right of action against an auditor which, but for the provisions of that subsection, such person would not have had”. Firstly there is a drafting error in the second half of this sentence because the word “that” immediately before the second occurrence of the word “subsection” should be altered to “the” in order to avoid confusion about the subsection in question. Secondly there is an error of substance since the words “any person” include the Registrar. Is this section to be interpreted to mean that that the duty imposed on an auditor of a medical scheme in terms of the preceding subparagraphs of subsection 3 of section 19M does not give the Registrar a right of action against an auditor who fails to furnish the relevant information to the Registrar? If so, what is the point of imposing the obligation upon the auditor in the first place? It is not clear what is intended by sub paragraph (d) of subsection (3) in section 19M.

**21. There is a drafting error in the use of the word “its” in section 19N**

Must the Registrar do the projections for each scheme on the financial transfers that relate to it and then inform the scheme of same? If so the wording should read “The Registrar must annually 4 months before the start of the calendar year, inform each medical scheme of *the* projections on financial transfers relating to that medical scheme.”

**22. 19O Administrative Penalties**

The levying of administrative penalties on medical schemes for failures of their boards of trustees or principal officers to comply with the provisions of the Act is prejudicial to the members of the scheme who have no knowledge of or control over its day to day affairs. Administrative penalties can contribute to non-health care costs which are a problem in the medical schemes industry at present. It is submitted that a system for penalizing trustees and principal officers for not carrying out their duties should be investigated instead.

Will administrative penalties concerning the REF also be ‘ringfenced’ from other administrative penalties paid by schemes? If not how are the funds paid in terms of administrative penalties utilized by the Council for Medical Schemes? It is submitted that the penalties should be used to support the REF system and should therefore also be ringfenced.

### **23. Proposed Amendments to Section 29 of the Act (section 4 of the Bill)**

The proposed amendment to section 29 (c) is problematic in that it gives the Registrar the power to override the labour law. If a principal officer, for instance, is disciplined for not carrying out his or her duties or doing so improperly in accordance with the recognized principles of labour law, the Registrar, who is not an expert in labour law, should not be able to override the decision to remove the principal officer. A principal officer is usually an employee of a medical scheme. It is submitted that in order to protect principal officers and individual trustees from being victimized by dishonest or corrupt Boards of Trustees for trying to perform their duties properly, the functions of a principal officer should be set out in the Bill along the following lines -

A principal officer must in addition to any duties that may be contractually be imposed upon him or her by a medical scheme-

- (1) exercise the powers and perform the functions assigned to him or her in terms of this Act and the rules of the medical scheme in respect of which he or she is appointed;
- (2) act with fidelity, honesty, integrity and in the best interest of the members of the medical scheme in performing his duties;
- (3) advise the Board of Trustees of all material facts and information within his or her knowledge necessary to ensure that the decisions or actions of the Board or individual trustees are in the best interests of the members of the medical scheme
- (4) conduct him or herself in such a manner as to prevent prejudice to the interests of the members of the medical scheme;
- (5) without delay inform the Board of Trustees of the existence of a material relationship in respect of one or more trustees where such relationship has come to his or her knowledge;
- (6) without delay declare to the Board of Trustees any material relationship in which he or she is involved;
- (7) bring to the attention of the Registrar any irregularity or illegality in the performance of a trustee of his or her duties as a member of the Board of Trustees that might prejudice the interests of members of the medical scheme where such irregularity or illegality is not promptly and adequately remedied by the relevant trustee or the Board;
- (8) promote knowledge and understanding by the Board of Trustees of the principles and requirements of sound corporate governance of a medical scheme;
- (9) facilitate access by the Board of Trustees to such expert skill and knowledge as may be necessary from time to time to ensure that the Board of Trustees makes decisions which are in the best interests of the members of the scheme;
- (10) inform the Board of Trustees of any procedural, legal or other irregularities in its performance of its functions of which he or she is aware;

- (11) not act in a way that is inconsistent with the duties assigned to him or her in terms of this Act or the rules of the relevant medical scheme;
- (12) not use the position or privileges of, or confidential information obtained as, principal officer for personal gain or to improperly benefit another person;
- (13) take reasonable measures to -
  - (a) preclude a trustee from deriving undue benefit from his or her office as trustee; and
  - (b) prevent fruitless and wasteful expenditure by trustees and other officials of the scheme of scheme funds (the definition of fruitless and wasteful expenditure in the Public Finance Management Act should be used here).

To be on the safe side, one can add a provision to the effect that any person who obstructs a principal officer in the performance of his or her duties as described above shall be guilty of an offence and liable on conviction to imprisonment for a period not exceeding five years or to a fine of R50 000 or both such fine and such imprisonment. Note that it is better not to stipulate amounts of fines because there is already a system whereby the period of imprisonment can be equated to a monetary amount for purposes of a fine. Amounts tend to become outdated quite quickly.

In labour law a person cannot be dismissed or otherwise penalized for fulfilling a legal obligation. The fact that a principal officer is legally obliged to act in a certain way is therefore in itself a deterrent to victimization.

With regard to the amendments proposed to section 29 (n)(ii), the wording is too vague. It is not clear what is meant by the term “efficiency” and since this term can have many different meanings depending on the context it is submitted that the basis on which the efficiency in question is calculated must be stipulated in the Bill. The wording “or any other prescribed factor” is constitutionally problematic since it does not define the Minister’s powers with regard to such other factors or give any indication of the nature, type or purpose of prescribing such other factors.

## **24 The concept of “basic benefits” in section 29B is ill defined**

Unless the basic benefits are something more than the prescribed minimum benefits there is no point to section 29B.

Is it truly the intention that members can participate in more than one benefit option? If so, this will render schemes administration even more complex and expensive than it is already and is therefore not supported by the members of BHF. A definition of “option” or “benefit option” is recommended in order to promote clarity as to the intention behind this

section. The fact that the Minister is given the power to limit the number of benefit options in section 6 of the Bill (proposed amendment to section 33 of the principal Act) is problematic in that it has the potential to restrict the flexibility within medical schemes to design different benefit packages for different funding needs within the South African population. As such it is a proposal that is likely to further stifle the development and growth of the medical schemes industry rather than promoting it.

## **25 Amendment of section 33 of the Act**

Once again the question as to whether it is really the intention for a member to participate in more than one benefit option is raised here.

It is requested that criteria are prescribed in the Act itself as a guide for the Registrar to assist him in deciding whether or not a benefit option should be approved. This also would promote certainty amongst schemes and at the same time give a clear indication of the policy intention with regard to benefit options on the part of government. At present medical schemes are experiencing considerable difficulty in getting their benefits approved by the Registrar due to the fact that there are no clearly specified criteria for either the Registrar or medical schemes to use in evaluating or designing benefit options. This leads to unnecessary expenditure on the part of medical schemes in appealing the decision of the Registrar concerning benefit options and wastes the time and money of both the staff of the Council for Medical Schemes and medical schemes and their administrators.

## **26 The origin of the International Financial Reporting Standards should be indicated e.g. as published by XYZ organisation from time to time. Alternatively the term “International Financial Reporting Standards” should be defined in the definition section of the Bill.**

In March 2001, the International Accounting Standards Committee (IASC) Foundation was formed as a not-for-profit corporation incorporated in the State of Delaware, US. The IASC Foundation is the parent entity of the International Accounting Standards Board, an independent accounting standard-setter based in London, UK. On 1 April 2001, the International Accounting Standards Board (IASB) assumed accounting standard-setting responsibilities from its predecessor body, the International Accounting Standards Committee. The IASB is responsible for the setting of the IFRS. Because this is an international body, it will not have reference to local conditions and laws. In South Africa the Constitution overrides every other law and any law or conduct that is inconsistent with it is invalid.

The International Accounting Standards Board is an independent, privately-funded accounting standard-setter based in London, UK. The

Board members come from nine countries and have a variety of functional backgrounds. The IASB is committed to developing, in the public interest, a single set of high quality, understandable and enforceable global accounting standards that require transparent and comparable information in general purpose financial statements. In addition, the IASB co-operates with national accounting standard-setters to achieve convergence in accounting standards around the world. There are 14 Board members, each with one vote.

There is a distinction between IFRS and International Accounting Standards (IAS). The latter predates the former but is still effective in that it is the basis on which the former are being developed by the IASB. The IAS are currently more developed than the IFRS and contain a number of provisions which the IFRS do not. By way of example the IAS contain provisions on 'related party disclosures' which the IFRS do not.

IAS 24 states for instance –

The objective of this Standard is to ensure that an entity's financial statements contain the disclosures necessary to draw attention to the possibility that its financial position and profit or loss may have been affected by the existence of related parties and by transactions and outstanding balances with such parties.

A party is related to an entity if:

- (a) directly, or indirectly through one or more intermediaries, the party:
  - (i) controls, is controlled by, or is under common control with, the entity (this includes parents, subsidiaries and fellow subsidiaries);
  - (ii) has an interest in the entity that gives it significant influence over the entity; or
  - (iii) has joint control over the entity;
- (b) the party is an associate (as defined in IAS 28 Investments in Associates) of the entity;
- (c) the party is a joint venture in which the entity is a venturer
- (d) the party is a member of the key management personnel of the entity or its parent;
- (e) the party is a close member of the family of any individual referred to in (a) or (d);
- (f) the party is an entity that is controlled, jointly controlled or significantly influenced by, or for which significant voting power in such entity resides with, directly or indirectly, any individual referred to in (d) or (e); or
- (g) the party is a post-employment benefit plan for the benefit of employees of the entity, or of any entity that is a related party of the entity.

A *related party transaction* is a transfer of resources, services or obligations between related parties, regardless of whether a price is charged.

Close members of the family of an individual are those family members who may be expected to influence, or be influenced by, that individual in their dealings with the entity. They may include:

- (a) the individual's domestic partner and children;
- (b) children of the individual's domestic partner; and
- (c) dependants of the individual or the individual's domestic partner.

Relationships between parents and subsidiaries shall be disclosed irrespective of whether there have been transactions between those related parties. An entity shall disclose the name of the entity's parent and, if different, the ultimate controlling party. If neither the entity's parent nor the ultimate controlling party produces financial statements available for public use, the name of the next most senior parent that does so shall also be disclosed.

An entity shall disclose key management personnel compensation in total and for each of the following categories:

- (a) short-term employee benefits;
- (b) post-employment benefits;
- (c) other long-term benefits;
- (d) termination benefits; and
- (e) share-based payment.

If there have been transactions between related parties, an entity shall disclose the nature of the related party relationship as well as information about the transactions and outstanding balances necessary for an understanding of the potential effect of the relationship on the financial statements. These disclosure requirements are in addition to the requirements to disclose key management personnel compensation. At a minimum, disclosures shall include:

- (a) the amount of the transactions;
- (b) the amount of outstanding balances and:
  - (i) their terms and conditions, including whether they are secured, and the nature of the consideration to be provided in settlement; and
  - (ii) details of any guarantees given or received;
- (c) provisions for doubtful debts related to the amount of outstanding balances; and
- (d) the expense recognised during the period in respect of bad or doubtful debts due from related parties.

The provisions of IAS 24 are clearly of importance to corporate governance of medical schemes yet the reference in the Bill only to "International Financial Reporting Standards", without defining this term, could exclude International Accounting Standards since they are

distinguished by the IASB itself. Deloitte's<sup>1</sup> points out that the term International Financial Reporting Standards (IFRS) has both a narrow and a broad meaning. Narrowly, IFRS refers to the new numbered series of pronouncements that the IASB is issuing, as distinct from the International Accounting Standards (IAS) series issued by its predecessor. More broadly, IFRS refers to the entire body of IASB pronouncements, including standards and interpretations approved by the IASB and IAS and SIC interpretations approved by the predecessor International Accounting Standards Committee.

Even if the IAS are included by way of a definition within the term "International Financial Reporting Standards there could be challenges of a constitutional nature. Whilst the provisions of IAS24 are important to sound corporate governance and financial reporting, they do not take into account the Constitutional right of privacy granted by the Constitution. The limitation of a constitutional right must be justifiable in terms of section 36 of the Constitution if it is to be lawful.

The requirement that trustees of medical schemes must disclose the details concerning the claims paid in respect of their registered beneficiaries could potentially infringe the constitutional right of such beneficiaries to privacy. The question therefore is whether the need for sound corporate governance of medical schemes, which is indisputable, is more important than the constitutional right of the beneficiaries of trustees of a medical scheme to privacy. Must a trustee disclose for instance the fact that his wife has been treated for an ovarian cyst or breast cancer? Legally speaking not even the trustee himself necessarily has a right to this information unless his wife agrees that he is told about it beforehand.

Should the minor dependant of a trustee who is sexually abusing that dependant disclose that she has been treated for a sexually transmitted disease or the termination of a pregnancy at the scheme's expense in the financial reporting of that scheme merely to ensure sound corporate governance? In law a trustee does not necessarily have the right to know of health interventions rendered to his or her eighteen year old son or daughter.

The Children's Act No 38 of 2005, which will soon be replacing the Child Care Act No 74 of 1983, gives minors the right to consent to medical treatment in certain circumstances without the assistance or consent of their parent or legal guardian as does the Child Care Act. A trustee does not have the power to waive the rights of his adult dependants, neither would he or she necessarily have the power to waive the rights of his or her minor dependants where this is not in the child's best interests. The parent's legal duty of support does not necessarily imply the power to violate the privacy of his or her child.

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<sup>1</sup> <http://www.iasplus.com/standard/standard.htm>

It is submitted that the nature of the business of a medical scheme is such that more thoughtful consideration needs to be exercised than deciding to simply apply the international financial accounting standards en bloc to medical schemes. Section 57 of the Medical Schemes Act dictates that at least 50% of trustees are members of the medical scheme. It is not therefore a matter of a trustee accepting the position and all that goes with it. If no scheme member wants to be a trustee because it would expose his or her family to unwanted publicity or scrutiny, then there can be no board of trustees for a medical scheme.

Some members of BHF have suggested that the current legal requirement that 50% of members of the Board of Trustees be elected from amongst the members be reconsidered. The view is that if medical schemes are to be run as businesses with all that this implies in terms of financial and reporting standards then the requirements of a Board of Trustees should be expert skill and knowledge in business generally and the business of a medical scheme particularly.

They point out that it is often difficult in practice to find members who are suitably qualified and who are willing to accept the responsibilities and accountability that goes with being a trustee. Members also often change schemes which creates problems from the perspective of continuity within the Board of Trustees. These members propose that while at least 50% of the Board should still be elected by members of the scheme they should not have to elect from amongst themselves. They can then elect suitably qualified persons who they trust to manage the affairs of the scheme whether they are members or not.

**27 There are some queries around the meaning of the proposed amendments to section 57 of the principal Act**

The meaning of the word “directly” inserted in subsection 2 is unclear. Does this mean that proxy votes will no longer be permitted? Do postal votes qualify as “direct” election?

The word ‘eligible’ should be substituted with “given the opportunity”. All members are eligible to vote in terms of the scheme rules and if this is not the case then the Registrar should not approve such rules. There is a difference between being eligible and having an opportunity to vote.

With regard to 2C(b) it is noted that failure to comply with the scheme rules results in a legal nullity in any event since the scheme is bound by its rules and has acted ultra vires if it has not acted in accordance with them. It is therefore not necessary to apply to a High Court for an order contemplated in 2D in this instance and is an unnecessary expense for both the scheme and the Registrar. It is in any event open to a person with *locus standi* to apply to the High Court where there has been an illegal action by a scheme that affects them. There is a constitutional right of access to the courts but also the Medical Schemes Act itself in section 51(3) provides that -

*Any member or one or more creditors of a medical scheme may make an application to the High Court for an order in terms of paragraph (b), (d) or (e) of subsection (5).* The jurisdiction of the High Court is not dependent on the Medical Schemes Act. Section 34 of the Constitution states that everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.

The provisions of section 51(1) and (5) of the Act give the Registrar the power to apply to the High Court with the concurrence of the Council, in regard to any medical scheme apply to the High Court for an order contemplated in paragraph (b), (c), (d) or (e) of subsection (5) if the Registrar is of the opinion that it is in the interest of beneficiaries or because material irregularities have come to his or her notice. It is therefore unclear why it was felt that there is a need to amend section 57 of the principal Act in the manner proposed in sections 9(b) of the Amendment Bill.

Section 2D should be scrapped or at the very least edited so as not to restrict the powers of the court as to the order it may make. It is inappropriate to try and exhaustively list the possible orders that a court of law may make and would be unconstitutionally fettering the court's powers in terms of the doctrine of separation of powers.

With regard to subsection (3)(a) it would be better instead of listing all of the possible contractees of a medical scheme to find criteria for use in determining whether or not a particular relationship, no matter what it is, would create unacceptably high levels of conflicts of interest on a regular basis. For instance if a trustee who is in a material relationship with the medical scheme finds that a conflict of interest arises only occasionally, he or she can recuse himself from the meeting as do directors on a Board of Directors of a company. However, if the trustee is likely to regularly encounter conflicts of interest there is no point in his being a trustee since he or she would constantly have to recuse him or herself. Suitable criteria could be the following –

Where the trustee is in a material relationship by virtue of –

- (a) A service contract or contract of employment with, or appointment as a director to, a person other than the scheme where that person or its subsidiary, business partner or holding company is in the business of rendering services to the scheme;
- (b) a contractual relationship with the scheme for the administration, management or marketing of the scheme or an aspect of its affairs.

The same comment applies to subsection (7)(a). Furthermore, the danger in listing is that one might leave someone out that should be included. The existence of a material relationship as currently defined in the Bill is not necessarily enough to justify the exclusion of a person from the board of trustees. It must be a material relationship of a kind that is

likely to regularly give rise to conflicts of interest. It is unrealistic to exclude even those material relationships in which only the occasional conflict of interest might arise.

There is a severe shortage of all kinds of expertise in South Africa. It is important not to lose sight of this when making provision for sound corporate governance of medical schemes. A person who renders services to a scheme on an ad hoc basis or once or twice a year in a limited area is not likely to have a problem with regular conflicts of interest and may contribute valuable knowledge or expertise to a Board of Trustees that is not available elsewhere. The approach of the Bill at present serves to “throw the baby out with the bathwater”.

## **28 Corporate Governance**

The Minister should rather prescribe the ‘guidelines’ on corporate governance. It is inappropriate for the Council to publish guidelines which trustees are then to account for where they fail to comply with them. Guidelines are guidelines and law is law. If one wants accountability then the rules of corporate governance should be prescribed by the Minister. Otherwise they should remain as guidelines and trustees should only have to account for deviation from them where there are irregularities in the management and control of the scheme. Medical schemes are opposed to legislation by circular and are of the view that there is already too much of this practice taking place within the Council.

It must be emphasised at this juncture that too much rigidity in the regulation of medical schemes reduces the accountability of Boards of Trustees since the decisions they would ordinarily have to take themselves are now being dictated by legislation. If one becomes too prescriptive around issues of corporate governance this will have the effect of diminishing the responsibility of boards of trustees for the sound management and control of the scheme rather than enhancing it. One cannot be penalised for doing something that the law requires. A significant degree of flexibility is necessary for sound corporate governance because all of the possible permutations of fact and law cannot be anticipated by the Legislature.

## **29 “Low Income Consumers” not defined in Section 12 of the Bill**

The proposed amendments to section 67 of the Act lack clarity in that there is no indication given to the Minister as to the policy reasons for the regulations in question. It is not practical for the Registrar to oversee election processes in the same manner as the IEC for instance. There are too many schemes involved. The cost of the Registrar overseeing elections is likely to be significant and will be passed on to medical scheme members via the levies payable by schemes to the Council. This will unacceptably increase the level of non-health care costs faced by

schemes. Furthermore it is not practical for schemes to all hold their elections on the same day as their members are scattered in different parts of the country. Members will not pay to travel to major cities to vote either because they cannot afford to or because they are not prepared to. Members cannot be compelled to vote – only encouraged and assisted to do so. In the experience of medical schemes there is a great deal of member apathy when it comes to voting for trustees in elections.

With regard to (1A) of section 67 it is noted that there is no indication of what a “low income consumer” is neither is the concept “medical scheme products” defined. How do the latter differ from medical scheme options or benefits? What about low income schemes and options that are already in the market? Why should variations from the requirements of the regulations not be applicable to them as well as ‘emerging’ ones? It is not clear whether this section is intended to form part of the LIMS mechanism or whether it is meant to apply to low cost options within existing medical schemes. If the intention is the former then it is the submission that there is no indication yet that LIMS policy has been thoroughly discussed and debated within the Department of Health or accepted by the Minister. What is meant by “low income persons”? This concept is vague and unsuitable for inclusion in legislation.

### **In Conclusion**

We would be happy to meet with officials of the Department of Health or the Council for Medical Schemes as the case may be to further discuss the views stated here in the event that there are any questions of clarity on their part.

**Board of Healthcare Funders  
14 February 2007**