History of the definition of the "business of a medical scheme" in Section 1 of the Medical Schemes Act 131 of 1998

Stephen Harrison[1]
Senior Specialist: Strategy
Council for Medical Schemes

On 28 March 2008, the Supreme Court of Appeal (SCA) handed down its decision in the matter of Guardrisk Insurance Company Limited (Guardrisk) and the Registrar and Council for Medical Schemes. The decision overturned an earlier High Court decision in the Registrar and Council's favour, which had interdicted Guardrisk from marketing its AdmedGap and AdmedPulse policies based on their doing the business of a medical scheme while not being registered in terms of the Medical Schemes Act, 1998.

The SCA effectively found that paragraphs (a), (b) and (c) of the definition of "business of a medical scheme" in the Act should be read conjunctively [(a) AND (b) AND (c)] instead of disjunctively [(a) OR (b) OR (c)]. As it stands at the time of writing this article, the SCA ruling reflects the accepted legal interpretation of the definition – which will prevail until such time as the legislation is amended.

In terms of Section 1 of the Medical Schemes Act, 1998, the "business of a medical scheme" means the business of undertaking liability in return for a premium or contribution –

(a) **to make provision for the obtaining of any relevant health service;**

(b) **to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and**

(c) **where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme."**

The Council and Registrar are on record as expressing their concerns regarding the likely adverse implications of a conjunctive interpretation for the ongoing protection of a community-rated medical schemes environment. They have recommended to government that an urgent amendment should be made to the definition of "business of a medical scheme" in the Medical Schemes Act to ensure that these implications are averted.

These recommendations have not been made in a vacuum, but come against the backdrop of a 30-year history of development of this definition, during which time a disjunctive definition was always applied. As this matter is of significant public interest, *CMS News* considers it appropriate to contextualise the proposals against this historical background.

[1] This article extensively reproduces material included in the Registrar's founding affidavit in the application for leave to appeal the SCA judgment in the Guardrisk matter to the Constitutional Court.

Medical Schemes Act 1967

The origins of the contemporary definition lie in the definitions of "medical scheme", "medical benefit scheme", and "medical aid scheme", as contained in Section 1 of the Medical Schemes Act 72 of 1967 (the predecessor to the 1998 Act).

By way of background, the first medical scheme in South Africa was established by the employees of the De Beers Consolidated Mines in 1889; there had been a proliferation of medical scheme-type entities in various forms. By the time of passage of the 1967 Bill, there were 256 such schemes, covering 1.87 million of a total white population of approximately 3.25 million.[2] From 1956, schemes had to register as "friendly societies" under the Minister of Finance in terms of the Friendly Societies Act 25 of 1956, but there was no statutory control or coordination of these entities by the Ministry of Health from a perspective of health policy.[3]

It is apparent from the Minister of Health's speech to Parliament on the tabling of the Medical Schemes Bill in 1967 and the accompanying debate recorded in Hansard that the new Bill sought to regulate and coordinate the functioning of the two most important types of medical scheme-type entities providing financial protection in respect of health services, namely: ***medical aid schemes*** and ***medical benefit schemes***.

Medical aid schemes were akin to medical schemes with which we are familiar today. In return for a regular membership fee, these schemes paid providers on a fee-for-service basis based on a predetermined or pre-negotiated tariff schedule, potentially leaving members liable to pay the difference between what was charged and what was paid. Members of medical aid schemes could attend the provider of their own choice.

Medical benefit schemes did not pay on the basis of a fee-for-service tariff schedule. Instead, members were restricted to a panel of healthcare providers who were paid by the medical benefit scheme either on a salaried basis or on a capitation basis (a predetermined fixed monthly or annual fee based on the number of scheme members and their dependants on the books of the relevant provider). In other words, when a member attended a panel doctor, no invoice was rendered – essentially making the health service free to the member at point of service.

---

[2] Hansard, 7 April 1967, p. 3842-6 and 5438-82, *The History and Development of Medical Schemes in South Africa,* paper prepared for the Melamet Commission of Inquiry into The Manner of Providing for Medical Expenses.

[3] From 1967 to 1975, medical schemes were concurrently regulated by the Ministries of Finance and Health in terms of the Friendly Societies Act and Medical Schemes Act respectively. But the application of the Friendly Societies Act to medical schemes was brought to an end through the Medical Schemes Amendment Act 43 of 1975.

The 1967 Act brought both medical benefit schemes and medical aid schemes under the jurisdiction of the Act. From a definitional perspective, the Act included a definition of "medical scheme" (which incorporated both medical benefit schemes and medical aid schemes) as well as specific individual definitions of "medical aid scheme" and "medical benefit schemes" – the two different types of medical schemes covered by the Act. In terms of the original 1967 Act:

> *"medical aid scheme" means a medical scheme of which the rules provide for the rendering of medical and dental services to the members thereof and to the dependants of such members by medical practitioners and dentists of their own choice and at fees not exceeding the fees calculated in accordance with the tariff of fees;*
>
> *"medical benefit scheme" means a medical scheme of which the rules provide for the conclusion of an agreement between such scheme and any medical practitioner or group of medical practitioners or any dentist or group of dentists, as the case may be, as to the periodic remuneration payable by such scheme to such medical practitioner or any member of such group of medical practitioners or to such dentist or any member of such group of dentists, as the case may be, by way of a salary or by way of an amount calculated on the basis of the number of members of such scheme and dependants of such members for whose treatment such medical practitioner or such member of such group of medical practitioners or such dentist or such member of such group of dentists, as the case may be, is under such agreement responsible;*
>
> *"medical scheme" means a scheme established with the object of making provision for –*
>
> *(a) the rendering, free of charge, to members thereof and to dependants of such members, of medical, para-medical, nursing, surgical or dental services;*
> *(b) the supply, free of charge, to members thereof and to dependants of such members, of medicines or of medical, surgical, dental or optical requirements or appliances or of accommodation in hospitals or nursing homes; or*
> *(c) the granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of such services or the supply of such medicines, requirements, appliances or accommodation.*

Provisions of the Act dealing with generic statutory obligations applicable both to medical aid schemes and to medical benefit schemes simply referred to "medical schemes" (see for example Section 14(1)). Provisions dealing with the setting of tariff schedules did not use the generic word "medical scheme" but instead referred specifically to "medical aid schemes" because, as discussed above, tariff

schedules were irrelevant to medical benefit schemes (see for example Section 29(1)). The Act also established separate entities called the National Association of Medical Aid Schemes and the National Association of Medical Benefit Schemes respectively (Section 12).

It is clear that in the definition of a "medical scheme", paragraphs *(a)* and *(b)* referred to ***medical benefit schemes*** (in relation to professional service benefits in *(a)* and medical supplies and accommodation in *(b)*), whereas paragraph *(c)* referred to ***medical aid schemes***.

Medical Schemes Amendment Act 95 of 1969

The definition of a medical aid scheme was amended in 1969 as follows:

> *"medical aid scheme" means a medical scheme of which the rules provide for the rendering of medical and dental services to the members thereof and to the dependants of such members by medical practitioners and dentists of their own choice* **[and at fees not exceeding the fees calculated in accordance with the tariff of fees].**[4]

The deletion of the words **"and at fees not exceeding the fees calculated in accordance with the tariff of fees"** related to amendments providing for health practitioners the voluntarily "contract out" of statutorily determined tariff schedules – and did not affect the essential nature of medical aid schemes. There was accordingly no need for consequential amendments to paragraph *(c)* of the definition of a "medical scheme".

Medical Schemes Amendment Act 59 of 1984

This Amendment Act added a new definition of service, namely:

> *"service" means any medical, psychological, paramedical, nursing, surgical or dental treatment, and includes the supply of medicines or of medical, surgical, dental or optical requirements or appliances, or of accommodation in a hospital or maternity or nursing home.*

There was a consequential amendment to the definition of a "medical scheme" as follows:

> *"medical scheme"* means a scheme established with the object of making provision for –
> *(a)* the **[rendering]** <u>obtaining</u>, free of charge, **[to]** <u>by</u> members thereof and **[to]** <u>by</u> dependants of such members, of **[medical, para-medical, nursing, surgical or dental services]** <u>any service</u>; or

[4] The convention in drafting amendments, which is followed in this article as well, is that deletions are noted in **[bold italics]** whereas additions are <u>underlined</u>.

[*(b)* the supply, free of charge, to members thereof and to dependants of such members, of medicines or of medical, surgical, dental or optical requirements or appliances or of accommodation in hospitals or nursing homes; or]

(c) the granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of **[such services]** any service **[or the supply of such medicines, requirements, appliances or accommodation].**

This amendment was simply a technical amendment to accommodate the new definition of service, and does not affect the original legislative intent in so far as paragraph (a) still refers to medical benefit schemes and paragraph (c) refers to medical aid schemes.

Medical Schemes Amendment Act 23 of 1993

Significant definitional changes were brought by the 1993 Amendment, including deletion of the definitions of "medical aid scheme" and "medical benefit scheme", and amendment to the definition of "medical scheme" – most notably through the insertion of a new paragraph (c).

> *"medical scheme"* means a scheme established with the object of making provision for –
>
> (a) the obtaining **[free of charge]** by members thereof and by dependants of such members, of any service; **[or]**
>
> *(b)* the granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of any service; or
>
> *(c)* the rendering of a service to members thereof or to dependants of such members, either by the scheme itself or by any supplier of a service or group of suppliers of a service in association with or in terms of an agreement with the scheme.

This amendment was accompanied by the insertion of a new Section 20B(5)(*a*A), which read:

> "(5) A registered medical scheme may, if its rules so provide – …
>
> *(a*A) subject to the provisions of any law, establish or operate, on its own or in association with any other person, any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons, or, with the approval of the Minister, any similar institution."

It is clear from the Hansard record of the debate on the second reading of this Bill[5] that the intention of the new paragraph *(c)* of the definition, read together

[5] Hansard, 9 February 1993, p. 866-938.

with the amendment to Section 20B(5), was to allow for the creation of USA-styled Health Maintenance Organisations in South Africa, whereby medical schemes would become purchasers and providers of care through the ownership of hospitals, pharmacies etc.

In this regard, the following extracts of the Hansard debate are particularly pertinent:

> Dr FH PAUW:
>
> "In Klousule (1)(f) en 1(k) van hierdie wetsontwerp word voorsiening gemaak dat die funksies van mediese skemas wesentlik verander kan word. Die skema is tans in die posisie dat hy as die koper namens die lid van die skema optree. Hy moet die diens van die diensverskaffer koop. Dit is 'n funksie hierdie wat mediese fondse nog altyd vervul het.
>
> Wat nou verander is dat die skema nou ook kan optree as die verskaffer van die diens. Hy kan nou die diens verskaf en verkoop deur doktors te huur wat die diagnose maak, die behandeling voorskryf of toepas. Hy kan die apteker huur, hy kan die apteek oprig, hy kan die hospital bedryf of hy kan enige ander aspek van dienslewering aanpak en dit verkoop en bemark. …
>
> Wat inderdaad gebeur, is dat die skema nou ook die verkoper van die diens word, en dit terwyl hy nog steeds die koper van die diens is. …
>
> Klousule 1(k) maak voorsiening vir hierdie sg HMOs of gesondheidsbestuurstelsels wat die agb Minister na verwys het. Daar kan geen beswaar wees teen meganismes wat 'n diens goekoper kan aanbied nie. Noodwendig sal dit die gehalte van die diens beinvloed. Dit sal die keuse en die verskeidenheid van die verbruiker beperk. 'n Mens moet dit aanvaar as jy 'n goedkoper diens wil he, want dit is noodwendig so."[6]

On page 904 of the Hansard debate, when an opposition party member attempted to compare the new HMO-type entity with the old medical benefit scheme-type arrangements which made use of panels of doctors, the following strong retort is made by Dr JJ Vilonel:

> "Hierdie is nie 'n paneelstelsel nie!"

In so far as the deletion of the definitions of "medical benefit scheme" and "medical aid scheme" goes, reference is made on page 911 of Hansard that the explanatory memorandum of the Bill[7] asserted that these definitions were no longer necessary because the distinction between medical benefit schemes,

---

[6] Hansard, 9 February 1993, p. 874-5. See too p. 867, 871, 887, 895-8, 903-911, 919-920.
[7] We do not have a copy of the memorandum.

medical aid schemes, and medical schemes had significantly diminished – a fact which was disputed by the opposition member Mr RT Rhoda.

Nevertheless, while it is clear that the definitions of "medical benefit scheme" and "medical aid scheme" were too rigid for the way these entities were developing, there is no indication that paragraphs (a) and (b) (which were retained with virtually unchanged wording) were no longer intended to refer broadly to the business of medical benefit schemes and medical aid schemes respectively.

In this regard, it is instructive that honourable member Dr JJ Vilonel quotes statistics from a contemporary report of the Registrar of Medical Schemes, as follows:

> "South Africa currently has 239 medical schemes of which 139 are registered under the Medical Schemes Act … and 47 are so-called exempt schemes. Of the 192 registered schemes, 172 are medical aid schemes while the remaining 20 are medical benefit schemes."[8]

The only amendment to these paragraphs was the deletion of the words "free of charge" in paragraph (a), which is almost certainly as a result of the fact that medical benefit schemes had started imposing a (sometimes nominal) point-of-service co-payment on members – essentially to discourage over-utilisation of services which was viewed as a consequence of free point-of-service treatment. This did not, however, change the nature of these schemes in that invoices would still not have been rendered for actual services delivered.

Essentially, therefore, at the time of the 1993 Amendment –

- paragraph (a) of the definition of "medical scheme" still referred broadly to medical benefit schemes;
- paragraph (b) still broadly referred to medical aid schemes; and
- paragraph (c) referred to the new USA-styled HMOs, which the Minister of Health sought to promote.

Medical Schemes Act 131 of 1998

The 1998 Act replaced the definition of "medical scheme" in the 1967 Act, as amended, with the definition of "business of a medical scheme", which substantially incorporated the wording of the prior definition of "medical scheme".

Although this was not an amendment Act, for purposes of this discussion the definition is written below in a way which shows the changes:

[8] Hansard, 9 February 1993, p. 885.

> *"business of a medical scheme"* means **[a scheme established with the object of making provision for]** the business of undertaking liability in return for a premium or contribution –
>
> (a) to make provision for the obtaining **[by members thereof and by dependants of such members,]** of any relevant health service;
>
> *(b)* **[the granting of]** to grant assistance **[to members thereof]** in defraying expenditure incurred **[by them]** in connection with the rendering of any relevant health service; **[or]** and
>
> *(c)* where applicable, **[the rendering of]** to render a relevant health service **[to members thereof or to dependants of such members]**, either by the medical scheme itself, or by any supplier **[of a service]** or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with **[the]** a medical scheme."

In the relevant section of the Bill's explanatory memorandum dealing with this definition, the following explanation is provided:

> "An important new definition relates to the **"business of a medical scheme"** which is being introduced to establish the principle that only registered organisations can do the business of a medical scheme, and seen in conjunction with the recent introduction of the Long- and Short Term Insurance Bills, will ensure that there is proper demarcation between the business of a medical scheme which operates on the basis of social solidarity, and that of other sickness products registered under the Insurance Acts."

The focus of the definitional change was therefore to ensure that insurers doing the business of a medical scheme would be caught in the net of the Medical Schemes Act.

What the Health Ministry at the time of passage of the Bill regarded as the distinguishing characteristic which would result in an insurance product doing the business of a medical scheme is evident from the following extracts of contemporaneous Health Department communications:

> In a memorandum written by then Director of Policy and Planning of the Department of Health, Mr Patrick Masobe (currently Registrar of Medical Schemes) to the then Director-General of Health concerning the status of discussions between the Health Department and the Financial Services Board on proposed amendments to the Long- and Short-Term Insurance Bills, Masobe quotes a fax sent to Messrs Jooste, Schoeman and Swanepoel of the Financial Services Board (FSB) on Friday 22 May 1998 regarding those discussions. In this fax, the Department states *inter alia*:

"In the new Bill[9] the definition of a medical scheme has been changed to deal in an effective manner with organisations that 'do the business of a medical scheme' but are nonetheless not registered under the Medical Schemes Act. *This clearly does not mean that all insurers have to fall under this bill.* The new definition says that:

"'medical scheme' means any organisation, institution, fund or plan established, or any arrangement or agreement entered into with the object of making provision for –

(a) the obtaining by members and by their dependants, of any relevant health service;
(b) the granting of assistance to members in defraying expenditure incurred by them in connection with the rendering of a service; or
(c) the rendering of a service to members or to dependants of such members, either by the scheme itself or by any supplier of a service or group of suppliers of a service in association with or in terms of an agreement with the scheme.

"Therefore, my understanding is that in interpreting what is a medical scheme or what is medical schemes business, the Registrar would put emphasis on:

- Any person, organisation, fund or plan that assists somebody who has been ***admitted as a member*** of such an organisation, fund or plan ***with respect to loss arising*** out of a liability to pay fees or charges in relation to the provision of ***relevant health services. (The question is: has the member incurred a medical cost related to the provision of a service? If so, the fund pays or helps defray such medical costs.)***

"This, to our minds, does not include undertaking liability to pay a ***lump sum on the happening of a personal accident, disease or sickness, on condition that such lump sum is in no way connected with the loss associated with medical costs."*** (original emphasis included)

Two key issues arise from that memorandum. The first was that as at 22 May 1998, the definition in the draft Bill retained the disjunctive reading (even though it was already drafted in a manner intended to give effect to the legislative intent of creating a demarcation between medical schemes and valid insurance products).

The second is that the key differentiating criterion in this demarcation distinction from the Health Department's perspective (noting that the Health Department was responsible for the development of the Bill) was the issue of defrayal of

[9] This must be interpreted as referring to an earlier draft of the Medical Schemes Act 1998.

medical expenses – in other words, the criterion described in paragraph (b) of the definition.

Clearly, by the time the Bill made its way to Parliament, there had been some additional changes to the definition – which then referred to the current "business of a medical scheme". The specifics of these changes seem not to have been recorded in Hansard as having been debated in Parliament (which would most likely have been the case if a major change to the original policy intent of the Bill had been intended).

In fact, perhaps the most significant change to the preamble of the definition reinforces that understanding by making specific reference to a "premium or contribution", where "premium" is associated with an insurance product.

The other seemingly significant change was to change the word "or" between paragraphs *(b)* and *(c)* to "and *(c)* where applicable". There was, however, no explanation to this effect in the explanatory memorandum, and no record of specific debate on this issue in Parliament.

It is likely that this change was a recognition of the fact that, after the 1993 amendments, the medical schemes environment had not been characterised to any significant extent by the emergence of HMO-type products as the Minister of Health at the time of the 1993 Amendments (Rina Venter) had predicted. It was in fact clear by that time that South African medical schemes would not be evolving into USA-type HMO entities. Instead, many traditional medical schemes involved in the defrayal of medical expenses had incorporated into their business aspects of managed healthcare, which involved a range of different types of contractual and other relationships with healthcare providers relating to the provision of service to their members.

Conclusion

The historical context of the legislation suggests that:

- paragraph *(a)* was originally intended to refer to entities of the nature of the old "medical benefit schemes";
- paragraph *(b)* was originally intended to refer to entities of the nature of the old "medical aid schemes" – which are essentially the same as medical schemes in existence today; and
- paragraph *(c)*, while originally intended (through the 1993 amendment) to refer to HMO-type entities, since 1998 was intended to also refer to a broader range of managed care-type arrangements which by today have been entered into in one form or another by the majority of medical schemes.

Clearly though, the drafting of this definition in the 1998 Act was imperfect, which has given rise to the SCA judgment that now considerably narrows the ambit of the definition of the “business of a medical scheme” compared to the manner in which it was previously interpreted and applied. It is now time for the legislature to step in and rectify this imperfection. The final chapter of the story of the evolution of this definition has yet to be written.