



Justice in the provision of healthcare services – a stifled right in the private sector

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Private medical aids are essentially non-profit organisations that aim to fund the delivery of speedy treatment, and should protect members from unexpected, out-of-pocket expenses for medical care. However, although the latest statistics show that 16.2% of individuals in South Africa (SA) are members of medical aid schemes, making the promise of private healthcare accessible to a small percentage of the population, they are not without their own unique set of challenges. The restrictions that exist within the private sector have a direct bearing on the types of healthcare services patients can access, which in turn impacts on the fundamental right to access healthcare. Using a recent High Court decision, this article seeks to explore justice in the provision of healthcare services, specifically within the private sector in SA.

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Seeking justice, specifically the fair and equitable provision of healthcare services in South Africa (SA), is not a new concept. Evidence already exists that shows the public's lack of trust in the healthcare system due to the steady decline in quality healthcare.^[1] Some of the challenges that negatively impact receiving quality healthcare include inefficiencies in service delivery and delays in the delivery of care. Accessing quality healthcare needs to be considered within a broader context, with the relevant links between wealth and health, in which poverty plays a direct role in being able to access quality care.^[2]

Many who can afford to (which equates to a minority of the population) opt for private medical aid cover in the hope of receiving quality care. As of 2021, 16.2% of individuals in SA were members of medical aid schemes. A population group comparison of this percentage shows that over three-quarters of white individuals were members of a medical aid scheme compared with Indian/Asian individuals (at 45.1%), with only 9.3% of black Africans covered in the private sector.^[3] Much has been said about government's failure to provide quality healthcare in the public sector.^[4-6] However, although private medical aids are essentially non-profit organisations that aim to fund the delivery of speedy and effective treatment and that should prevent members from unexpected, out-of-pocket expenses for medical care, they are not without their own set of unique challenges.

Using a recent High Court case decision, this article seeks to explore whether there is justice in the provision of healthcare services, specifically within the private sector in SA. It begins by outlining the right to access healthcare as a fundamental Constitutional imperative. It then provides an overview of the regulation of healthcare services in the private sector, after which it analyses the recent decision of *De Wet and Another v Medihelp Medical Scheme and Another* and the manner in which the relevant medical aid handled the issue of

refusing to authorise medication for a prescribed minimum benefit (PMB) condition. It then seeks to answer whether justice is indeed a stifled right in the private sector, and offers some recommendations towards a more equitable way forward.

The right to access healthcare: A fundamental imperative

Sections 27(1) and (2) of the Bill of Rights of the Constitution, 1996, affirm the fundamental right of everyone to access healthcare services, with an obligation on the state to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right. The National Health Act No. 61 of 2003 (NHA) and the Patients' Rights Charter are examples of legislative and policy measures towards the progressive realisation of this right.

In its preamble, the NHA recognises the need to improve the quality of life of all citizens and to free the potential of each person. The NHA aims to provide uniformity of health services across the country by establishing a national health system that encompasses both private and public providers and that delivers the best possible health services in an equitable manner, within available resources. The right to access healthcare services also extends to children, as outlined in section 28 of the Bill of Rights. However, unlike section 27 of the Bill of Rights, it does not include a restriction based on available resources for its progressive realisation. The Patient Rights Charter includes on page 1 a provision for special needs (*inter alia*) in the case of children and patients in pain. In addition, while the Children's Act No. 30 of 2005 recognises in its preamble the Constitutional mandate to improve the quality of life of all citizens and to free the potential of each person (similar to the NHA), it further emphasises the need to extend particular care to children, as outlined in several international human rights instruments, including the Geneva Declaration on the

Rights of the Child,^[7] the United Nations Declaration on the Rights of the Child,^[8] the African Charter on the Rights and Welfare of the Child^[9] and the Universal Declaration of Human Rights.^[10]

The right to healthcare is inextricably linked to the Constitutional rights to dignity (section 10) and life (section 11), as a lack of access to treatment could result in extreme suffering and even death. As stated above, the government's dismal failure to provide for the right to access healthcare in the public sector was recently accentuated by the Life Esidimeni tragedy where at least 144 psychiatric patients died after being transferred to institutions that were not equipped to look after them – one horrifying example of the devastating consequences of the public healthcare system's collapse in this regard.^[5] However, the restrictions that exist within the private sector also have a bearing on the types of healthcare services patients can access, which in turn impacts on the fundamental right to access healthcare.

Regulation of healthcare services in the private sector

Apart from regulating private health insurers, the Medical Schemes Act No. 131 of 1998 (MSA) also provides for the establishment of the Council for Medical Schemes (CMS), and aims to protect the interests of members of medical schemes. The CMS is a statutory body established under chapter 3 of the MSA. In its mission statement, the CMS purports to regulate the medical schemes industry in a fair and transparent manner by ensuring that complaints raised by members of the public are handled appropriately and speedily.^[11] However, with some complaints taking an average of between 1 and 2 years to be finalised,^[12] this calls into question the so-called 'speedy' nature of the complaints handling process and whether the CMS is indeed able to live up to its own mission.

Another issue highly relevant to the private sector is the scope of benefits that medical aids cover in terms of treatment and care costs, described in the PMBs that appear in annexure A to the regulations under the MSA, also specified in terms of section 29(1)(o) of the Act. The regulations to the Act in section 7 define PMBs as:

- 'the benefits contemplated in section 29(1)(o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of –
- (a) the Diagnosis and Treatment Pairs listed in Annexure A, subject to any limitations specified in Annexure A; and
 - (b) any emergency medical condition.'

In addition, section 8 of the same regulations states that:

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

PMBs include a limited set of 271 medical conditions and 26 chronic conditions.^[13] Thus, as a set of defined benefits ensuring that members of medical aid schemes have access to certain minimum health services irrespective of their individual plan, the aim of PMBs, according to the CMS website, is to: 'provide people with continuous care to improve their health and well-being and to make healthcare more affordable.'^[13] Therefore, a medical aid scheme (in theory) should not refuse to pay for minimum health services in respect of the treatment and care costs of PMB conditions.

However, as straightforward as it may seem, medical aid schemes do not always comply and tend to challenge what may or may not be covered even when a treatment is classified as a PMB. The recent High Court case decision described below outlines how a medical aid scheme contested payment of a PMB and how their reasoning was ultimately overruled by the court.

Case study – De Wet and Another v Medihelp Medical Scheme and Another

On 26 August 2022, Judge A Millar handed down an interim order, pending the outcome of a complaint made to the CMS, directing Medihelp medical scheme to pay for Elaprase, which in accordance with the judgment is the only registered treatment for type II mucopolysaccharidosis (Hunter syndrome) in SA. The urgent application was brought on behalf of Zachary De Wet, a 3-year-old child diagnosed with the rare condition when he was 2 years old. Zachary's mother approached the courts after Medihelp denied authorisation of the drug to her son on two separate occasions – including a denial by the scheme following the CMS's ruling that Hunter syndrome was a PMB condition, in another matter.

Hunter syndrome occurs almost exclusively in males and ranges from 0.3 to 0.71 per 100 000 live births.^[14] If left untreated, the disease results in physical and developmental difficulties. Zachary's condition, which was relatively stable, started declining rapidly around April 2022 with further damage to his heart valves and an enlarging of his liver noted by his specialist paediatric team in July 2022 (para 13 of the judgment). Currently, a cure for the syndrome has not yet been discovered. However, symptoms can be managed and treated with enzyme replacement therapies.^[15]

Although Medihelp conceded that Hunter syndrome is a PMB, it argued that Elaprase was not a 'prevailing predominant public hospital practice' and as such, it was not obliged to authorise payment for the drug (para 21 of the judgment). After affidavits from the heads of the Paediatric Rare Diseases Unit and the Rare Diseases Unit at Charlotte Maxeke Academic Hospital (a public hospital) were provided, and notwithstanding confirmation of the supply of Elaprase to other facilities across the country (para 33 - 36 of the judgment) proving its use in the public sector, Medihelp persisted in arguing that 'availability' should not be equated with 'prevalence' or 'predominance' (para 42 of the judgment). However, and rightfully so, Judge Millar indicated that the concept of prevalence and predominance should be measured in the context of low patient numbers considering the rarity of the condition (para 44 of the judgment).

In handing down his judgment, the Judge held that there is no substantial difference between prescribing Elaprase in the private and public sector, and that if Zachary is not afforded the treatment, his life and quality of life will be irreparably adversely affected (paras 46.1 and 46.2 of the judgment). Pending the outcome of a CMS inquiry, Medihelp was ordered to authorise and pay for all medical interventions required by Zachary and prescribed by his treating practitioners for Hunter syndrome, including Elaprase (para 47.2 of the judgment).

However, just as justice for Zachary seemed to have been met, the CMS registrar ruled on 2 December 2022 that Elaprase did not constitute a PMB level of care for Hunter syndrome. As such, and as of January 2023, Medihelp retracted its authorisation for Zachary's

treatment following the outcome of the CMS ruling, with Zachary receiving his last infusion in early January. The intention to appeal the decision by the CMS was formally lodged on 12 December 2022.^[16] The question that arises is why patients have to resort to the courts to seek justice in the provision of healthcare services for treatment that they should be legally entitled to receive.

Is justice a stifled right?

Post democracy, the right to access healthcare in SA forms part of a broader sociopolitical endeavour^[17] that is reliant on other social determinants, for example, employment, physical environment and nutrition (other health determinants are water, improving living conditions, elimination of marginalisation and exclusion of persons, reduction of poverty and illiteracy). The hurdles that exist regarding ensuring access to healthcare services include the inefficient and inequitable distribution and use of resources,^[18] with even high-income countries being unable to ensure immediate access to every technology and intervention that may improve a patient's health status or save their life.

Corruption is another prominent factor that contributes to the steady decline of SA's public healthcare system. A study across 32 sub-Saharan African countries between 2014 and 2015 found that bribery is a significant barrier towards accessing healthcare, with those paying bribes for medical care considerably less likely to report difficulties in obtaining care.^[19] The consequences of corruption in the healthcare sector come at great cost to tax payers, whose tax money is ironically displaced from being used to improve the quality of healthcare and access to services within the country, towards settling legal disputes.^[20] Corruption spread even more rapidly through the COVID-19 pandemic, where the emergence of COVID-19 millionaires turned the crisis into opportunities for self-enrichment, with little being done to ensure that perpetrators were held criminally accountable.^[21]

Corruption and mismanagement within the public sector make private healthcare even more attractive to those who can afford it. However, the concept of healthcare risks changing from a social responsibility to a marketable commodity when private health insurance is concerned. Even where private health insurance is available, patients often need to contribute towards their healthcare in the form of co-payments or deductibles, including so-called 'gap cover', with private practitioners frequently charging well above standard medical aid rates. This results in barriers to accessing private medical care or even bankruptcy when patients cannot afford gap cover or co-payments to the hospital and private practitioners' fees.

In addition, although the MSA has been amended, the Act does not clearly stipulate the rates that private practitioners and medical providers should charge in respect of PMBs. Section 8 of the regulations clearly outlines that treatment and care costs for PMB conditions must be paid for in full by a medical aid scheme without any co-payment or use of deductibles. This means that medical aid schemes must pay private practitioners and medical providers the rates they charge (without limitation) in respect of PMBs. In the long term, this could place medical aid schemes in a precarious position, as tariffs for PMBs remain unregulated. Medical practitioners can thus charge any fee in respect of a PMB condition. Without standardisation, we may find medical aid schemes bearing the brunt of excessive private practitioner fees in the near future, which would

ultimately affect their operations and service to their members, not to mention the inevitable increase this will add to patients' medical aid premiums.

Furthermore, the failure of the Department of Health to review the PMB provisions every 2 years in accordance with the explanatory note to annexure A (PMB list) as per the regulations to the MSA is a critical oversight, with adverse effects to patients and members of medical aid schemes who are legally entitled to be covered for treatment and care costs in accordance with the PMB list. There is also a discord, as evidenced in *De Wet and Another v Medihelp Medical Scheme and Another*, regarding what types of conditions fall within a specific PMB condition. As a result, patients may have no option but to look to the courts for guidance and direction – a time-consuming and costly endeavour that may have negative side-effects to a patient's health status while waiting for an outcome, and which is not easily afforded.

The long duration that complainants must wait in order for their complaints to be finalised by the CMS is also problematic. Currently, justice in the provision of healthcare services in the private sector is only partially being met. The following proposed recommendations will ensure that access to healthcare is achieved in a more equitable and fair manner.

Recommendations and conclusion

The shortcomings identified above need to be addressed as swiftly and effectively as possible. In order to assist with remedying this unsatisfactory situation, the following recommendations may assist in providing some interim relief.

Firstly, the Department of Health must update the PMB list to reflect the latest PMB conditions with immediate effect. Failure to do so, despite being informed of its omission in this regard, may be regarded as gross negligence on the side of the department, not to mention that the department would be in breach of its own legal requirements, including failing to serve SA patients responsibly, as well as breaching Constitutional obligations regarding access to healthcare services and justice.

Secondly, the Department of Health and the CMS must be held accountable for failing to adhere to their obligations under the MSA. One can only speculate as to the reason for dismissing a critical requirement such as that of updating the list of PMB conditions.

Thirdly, standardising the fees that practitioners may charge in respect of PMB conditions would benefit patients and provide some uniformity and consistency. This could be done by instituting a range of tariffs that medical practitioners must be bound to, when invoicing medical aid schemes for PMB conditions.

Fourthly, the complaints process at the CMS should be streamlined to provide that matters are finalised in a timeous manner.

The aim of this article was to explore whether there is justice in the provision of healthcare in SA, with specific focus on the case of *De Wet and Another v Medihelp Medical Scheme and Another* and the manner in which the relevant medical aid handled the issue of refusing to authorise medication for a PMB condition. We submit that this type of case was to be expected, as a range of factors and omissions made this inevitable. Fortunately, now that the judgment has been handed down, attention has been drawn to all the shortcomings that contribute to the inequitable situation regarding PMBs. However, the most recent appeal of the CMS ruling will determine whether justice in this case is achieved. The

recommendations suggested above will go a long way in bringing some relief to patients in similar situations.

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