IN THE NORTH GAUTENG HIGH COURT, PRETORIA

(REPUBLIC OF SOUTH AFRICA)

Date: 2011-05-20

Case Number: 28532/11

REPORTABLE

In the matter between:

TSHWANE PHARMACY (PTY) LTD Applicant

and

GOVERNMENT EMPLOYEES MEDICAL SCHEME Respondent

JUDGMENT

SOUTHWOOD J

[1] The applicant applies as a matter of urgency for the following final relief:

(1) An order that the respondent pay to the applicant the sum of R197 683,18;

(2) An order that the respondent make payment to the applicant directly and not to its members within 30 days on compliance with all the following:

(i) the applicant has supplied goods to the respondent's members;

(ii) the applicant has obtained from the respondent prior authorisation for the specific transaction.

[2] Since the applicant seeks final relief on notice of motion and there are disputes of fact on the affidavits the principles set out in ***Plascon-Evans Paints Ltd v Van Riebeeck Paints (Pty) Ltd*** **1984 (3) SA 623 (A)** at 634F-635C must be applied. See also ***National Director of Public Prosecutions v Zuma*** **2009 (2) SA 277 (SCA)** para 26.

[3] The applicant conducts business as a pharmacy. The respondent is a medical scheme registered in terms of the Medical Schemes Act 131 of 1998 ('the Act'). The respondent conducts its business subject to the provisions of the Act and the rules which it adopted. The respondent's members are current and retired government employees. The respondent's primary responsibility is to assume liability for and guarantee benefits to its members. The respondent can discharge its obligations to its members by reimbursing them for expenditure incurred by them in respect of medical services and goods provided by

service providers or by paying the service provider direct. In this regard section 59 of the Act provides:

> ’59. Charges by suppliers of service –
>
> (1) A supplier of a service who has rendered any service to a beneficiary in terms of which an account has been rendered, shall, notwithstanding the provisions of any other law, furnish to the member concerned an account or statement reflecting such particulars as may be prescribed;
>
> (2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme;
>
> (3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of –
>
> (a) any amount which has been paid *bona fide* in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled; or
>
> (b) any loss which has been sustained by the medical scheme through theft, fraud,

negligence or any misconduct which comes to the notice of the medical scheme,

deduct such amount from any benefit payable to such member or supplier of health service.'

[4] Consistent with this section the respondent's rules provide in rules 15 and 17:

'15. CLAIMS PROCEDURE

15.1 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules must be accompanied by an account or statement as prescribed from time to time.

15.2 If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme must, in addition to the payment contemplated in section 59(2) of the Act, despatch to the Member a statement containing at least the following particulars –

15.2.1 The name and the membership number of the Member;

15.2.2 The name of the supplier of service;

15.2.3 The final date of service rendered by the supplier of service on the account or statement which is covered by the payment;

15.2.4 The total amount charged for the service concerned; and

15.2.5 The amount of the benefit awarded for such service.

15.3 In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct and must be submitted to the Scheme in any prescribed manner as may be acceptable by the Scheme not later than the last day of the fourth month following the month in which the service was rendered.

15.4 Where a Member has paid a service provider, he shall submit a claim for reimbursement and, in support of his claim, he shall submit a receipt.

15.5 If the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the Member and the relevant healthcare provider, within 30 days after receipt thereof and state the reasons for such an opinion. The Scheme shall afford such Member and provider the opportunity to resubmit such corrected account or statement to the Scheme within sixty days following the date from which it was returned for correction.

15.6 The Scheme shall suspend the payment of a claim to a provider in the event of an investigation pertaining to alleged fraudulent activity, except where to do so in particular circumstances would

not be in the interests of the Scheme, in the absolute discretion of the Board.

15.7 The Scheme shall, where an account has been received and subject to a member's entitlement in terms of his applicable benefit option, pay the Scheme Rate in respect of any benefit due to a Member, either to that Member or to the supplier of the relevant health service who rendered the account, within 30 (thirty) days of receipt of the claim pertaining to such benefit.' and

'17. PAYMENT OF ACCOUNTS

17.1 Payment of accounts or reimbursement of claims is restricted to the net amount payable in respect of such benefit and maximum amount of the benefit to which the Member is entitled in terms of the Member's Benefit Option.

17.2 Any discount whether on an individual basis or bulk discount received in respect of a relevant health service shall be for the benefit of the Member in determining the net amount payable for the service and appropriate deductions shall be made from the applicable benefit limit, or medical savings account, as the case may be.

17.3 The Scheme may, pay any claim in accordance with the Member's Benefit Option, directly to the supplier (or group of suppliers) who rendered this service.

17.4 Where the Scheme has paid an account or portion of an account or any benefit to which a Member is not entitled, where the payment is made to the Member or to the supplier of service, the amount of any such overpayment is recoverable by the Scheme, either from the supplier, or the Member, at the discretion of the Scheme.

17.5 Notwithstanding the provisions of this rule, the Scheme has the right to pay any benefit directly to the Member concerned.'

It is clear from these rules that the respondent at all times retains a discretion (and a right) to pay either the member or the provider of the goods or services directly.

[5] It is common cause that from the time the respondent was registered in 2005 until 4 April 2011 the applicant has provided goods to the respondent's members and recovered payment from the respondent therefor in accordance with the following procedure:

(1) A member of respondent ('the member') approaches the applicant with a doctor's prescription.

(2) The member furnishes his or her membership card, containing the relevant membership number issued by the respondent, to one of the applicant's pharmacists.

(3) A 'claim' is thereupon electronically submitted to the respondent. The claim reflects *inter alia* the details of the patient, his or her membership number in respondent and details of the medical practitioner such as his practice number, the medication prescribed and the price of the prescription.

(4) The respondent's system thereupon verifies that the relevant customer is in fact a member with available funds as well as the medical practitioner's registration.

(5) Authorisation is thereupon electronically transmitted to the applicant to dispense the relevant prescription together with an authorisation number.

(6) On the strength of this authorisation the applicant then dispenses the medicine to the member without seeking payment from the member directly. A hard copy of the claim is filed in the applicant's offices for audit purposes.

(7) A large number of claims is submitted on a daily basis in respect of which the respondent effects electronic payment every two weeks.

As far as this procedure is concerned the respondent says that as from 5 April 2011 the procedure described was no longer followed and this

fact was conveyed to the applicant electronically on a daily basis as a result of its history of questionable claim submission and the respondent's concerns in that regard; claims duly made were paid in accordance with the respondent's liability to the member in question; mere submission of a claim by a pharmacy would not oblige the respondent to pay the applicant and thereby exclude the respondent's discretion and the authorisation referred to by the applicant is simply confirmation by the respondent that the member in question is a member in good standing and that it is liable to the member for all or part of the relevant claim and nothing more. It does not confirm which portion of the claim will be paid (this depends on the member's benefits and how much of these have been used) nor does it create a debtor/creditor relationship between the applicant and the respondent.

[6] In addition, the respondent alleges that on 4 April 2011 it addressed a letter to the applicant in which it advised the applicant that henceforth the respondent would pay its members for goods purchased from the applicant and that every day after that the respondent advised the applicant by the following message on its computer screens: 'Indirect payment has been implemented.' The respondent alleges and this is accepted by the applicant that since 4 April 2011 it has paid its members a total of R197 683,18. The applicant restricts its claim for payment to that amount.

[7] The applicant claims relief on two bases:

(1) that it has a right to payment in terms of section 59(2) of the Act; alternatively

(2) that it has a right to payment by virtue of a tacit contract.

Interpretation of section 59(2)

[8] It is submitted that the key phrase in section 59(2) of the Act is 'benefit owing to the member or provider of the service' and that on a common sense interpretation of the section it means that where a member has not paid the supplier of the service the medical scheme has no discretion but is obliged to pay the supplier. I do not agree.

[9] The subsection must be interpreted in its context. Subsection (1) provides that a supplier of a service who has rendered a service is obliged to furnish the member concerned with an account containing prescribed particulars. Subsection (2) then provides that when such an account has been rendered the medical scheme may pay to the member or the supplier of the service the benefit owing to that member or supplier of the service. In the context of the section the 'benefit owing' must refer to the amount owing by the member to the supplier for the service rendered. It is irrelevant that the benefit becomes owing to the member by virtue of the agreement between the member and the medical scheme and, to the supplier, by virtue of the agreement

between the member and the supplier. The subsection does not create an obligation for the medical scheme to pay the supplier.

[10] In any event, the subsection clearly provides that payment is subject to the rules of the medical scheme which state unambiguously that the respondent has the right to pay either the member or the supplier of the service (rules 15.7, 17.3 and 17.5).

Tacit agreement

[11] It is clear that the grant of the relief sought depends upon a finding that a tacit contract came into existence between the applicant and the respondent in terms of which the applicant would be entitled to payment for goods supplied by the applicant on the authority of the respondent.

[12] The applicant contends that a tacit agreement must be found in the light of the facts which are common cause relating to the procedure followed for payment up to 4 April 2011. The applicant referred to the 'no other reasonable interpretation test' formulated in ***Standard Bank of South Africa Ltd v Ocean Commodities Inc*** **1983 (1) SA 276 (A)** at 292 and the 'preponderance of probability test' formulated in ***Joel Melamed and Herwitz v Cleveland Estates (Pty) Ltd*** **1984 (3) SA 155 (A)** at 164 and the synthesis suggested by the learned author of

The Law of Contract in South Africa **RH Christie 5 ed** at 85 and following.

[13] The applicant is faced with two difficulties. The first is that the terms of the tacit agreement are not alleged in the applicant's affidavits. The second is that to find the tacit agreement contended for would require a finding that the respondent abandoned its right to pay the member which is contained in section 59(2) of the Act and the rules. In my view both difficulties are insurmountable.

[14] It is trite that the affidavits in motion proceedings contain both the pleadings and the evidence. It is equally trite that a party alleging a contract must set out the terms of the contract on which he relies. This has not been done and it does not assist the applicant that the procedure described in the affidavit does not tally with the relief sought in prayer 3 of the notice of motion.

[15] As far as inferring a tacit contract from the facts is concerned, the court is required to take all the facts into account. These facts include the provisions of the Act and the rules which have been referred to which reserve to the respondent the right to pay the member for the service supplied and the respondent's own reliance on that right. The Act and the rules make provision for a flexible procedure whereby the need for the member to pay the supplier of the service and then obtain reimbursement from the medical scheme is rendered unnecessary.

This allows for a quick and efficient provision of services. But that is a far cry from entering into an agreement where the medical scheme is bound to pay the supplier simply because it has confirmed that it will be responsible to the member for the service to be provided. The respondent obviously did not consider that it had given up that right and gave notice to the applicant on the 4th of April 2011 and thereafter every day. It therefore cannot be found that a tacit agreement was entered into.

[16] The application is dismissed with costs.

B.R. SOUTHWOOD
JUDGE OF THE HIGH COURT

CASE NO: 28532/11

HEARD ON: 19 May 2011

FOR THE APPLICANT: ADV. F.J. ERASMUS

INSTRUCTED BY: J.S. Grobler of Cilliers & Reynders Attorneys

FOR THE RESPONDENT: ADV. N. JELE

INSTRUCTED BY: T. Malatji of Gildenhuys Lessing Malatji

DATE OF JUDGMENT: 20 May 2011