The establishment of a medical scheme beneficiary registry, presented by Ms Altair Richards, ENS

Ms Richards began her presentation by explaining that the Council for Medical Schemes is currently undertaking a project in terms of which a beneficiary registry (BR) will be created and is intended to be a central repository containing certain personal information in respect of all medical scheme beneficiaries in South Africa, and further, that the information should be furnished to the CMS by medical schemes and their administrators.

She added that amongst others, the NDoH required the information for public health establishments to verify whether patients were members of medical schemes. However, she added that the CMS scope seemed to be much broader as it had requested information such as, names; ID numbers; citizen status; marital status; race; gender; physical addresses; email addresses; cell phone numbers; whether the member is subject to any exclusions; waiting periods, etc.

CMS cited the reasons for collecting such information as:

- assisting the public sector in avoiding fraud;
- mitigating against duplication of medical scheme membership;
- geomapping analysis;
- resource planning;
- membership history;
- understanding health seeking behaviour;
- improving risk profiling;
- improving the CMS annual statutory returns; and,
- being able to assign a unique ID number to each beneficiary.

Ms Richards added that the basket of information called for does not align with the reasons for the information stated by the CMS. She added that there were questions around the need for non-anonymised vs. anonymised data and whether there could be less intrusive ways for health facilities to, for example, perform verification processes on patients.

Ms Richards continued by suggesting that all the reasons cited for needing the information could be achieved through anonymised information and a 'look-up' facility which linked to data held by the various administrators.

She added that several HFA members (previous to the formation of the HFA) had proposed a 'look up' facility to the CMS. The proposed system would be available to all public healthcare facilities. The system would be less costly and would satisfy security concerns. Ms Richards indicated that the CMS had called for a presentation on this proposal.

She further stated that it was her view that the position of medical schemes and administrators under the current legal framework is quite clear in that it would not be legally permissible for medical schemes or administrators to disclose the personal information of beneficiaries, without the explicit written consent of beneficiaries.

Ms Richards commented that trustees of medical schemes were bound by the confidentiality obligations within the Medical Schemes Act and have the duty to take all reasonable steps to protect the confidentiality of medical records concerning any member’s state of health. She added that the fundamental issue for trustees is that for so long as the disclosure of personal information of beneficiaries without written consent is unlawful in terms of section 14 of the NHA, they would be at risk (civilly and criminally) if they disclosed this information.

After analysis, as the law currently stands - to the extent where health info is disclosed - including such information as waiting periods (especially linked to information such as address and age) becomes a security risk. Therefore, written consent would be needed in order for it to be disclosed.

She added that members may also be concerned that the mix of information, e.g. child beneficiaries together with addresses, etc. falls within a private sphere of information that should not be given to a third party.

Ms Richards pointed out that the MSAB provided for such a registry and, when implemented, trustees would be obliged to disclose information. However, the MSA purposes would have to be separated from other purposes, i.e. NHI-related purposes. She added that when the legal framework is in place, schemes would have an obligation to submit the data. At the moment, however, Ms Richards suggested that the CMS had overstepped its mark under current legislation.

Ms Richards said that there are a number of carve outs in the POPI Act which in future could potentially allow for the CMS to be provided with the Personal Information of beneficiaries without their consent, i.e. for research or for public interest purposes. However, the substantive sections of this Act have not come in yet.

Ms Richards added that any provisions of the NHI Act requiring the disclosure of personal information of beneficiaries by medical schemes and beneficiaries would need to pass muster in terms of section 36(1) of the Constitution.

Ms Richards concluded by commenting that it was unfortunate that the CMS labelled medical schemes and trustees ‘irresponsible’ for questioning the process as it is their duty to protect their members.

Mr Boshoff Steenekamp from MMI stated that the CMS had met with state law advisor on the issue and had received some caution. The State law advisor had committed to providing a written opinion by the end of March.

The HFA will keep its members informed of progress on this issue.