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The Office of the FAIS Ombud and the investigation of Medical Aid Complaints

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In adjudicating complaints, by clients of financial services against Financial Services Providers ('FSPs'), in respect of the financial service rendered, the Office of the FAIS Ombud is required to not only do so fairly but also so quickly, informally, and economically as prescribed by the Financial Advisory and Intermediary Services Act No. 37 of 2002 ('the FAIS Act'). The financial service rendered must however be in respect of a financial product. One of those financial products as defined by Section 1 of the FAIS Act is, a health service benefit provided by a medical scheme as defined in section 1(1) of the Medical Schemes Act, 1998. In other words, a medical aid scheme.

Whilst the Council for Medical Schemes ('CMS') governs the medical schemes industry and that a member/beneficiary who is aggrieved with the conduct of a medical scheme must submit a complaint related to their medical scheme to CMS, the Office of the FAIS Ombud does investigate the conduct of the FSP who rendered the financial service, in other words the medical schemes broker. Any investigation conducted by the Office of the FAIS Ombud would focus on the appropriateness of the advice provided and the recommendations made, whether the complainant understood the advice provided, as well as whether any and all material disclosures were made in respect of the medical scheme, that would have allowed the client to have made an informed decision. An example of just such a complaint that the Office of the FAIS Ombud can and does investigate is encapsulated in the determination of Daniel & Larissa Steenkamp vs Colonial 1952 (Pty) Ltd, which can be accessed on our website at ww.faisombud.co.za.

Despite having the jurisdiction to investigate complaints in respect of the financial service rendered by medical aid brokers, the Office of the FAIS Ombud receives a negligible number of complaints in respect to issues that may arise as a result of the advice provided in respect of medical aid schemes. A cursory glance at the Annual Report for the 2021/2022 Financial Year indicates that out of 10 552 complaints received by the Office of the FAIS Ombud only 176 complaints or 1.67% were in respect of medical aid/insurance policies. When you consider that a significant number of the 176 complaints received were in fact in respect of medical insurance policies, which are significantly different from medial aid schemes, then this would appear to be rather insignificant numbers for an industry that, as at 2020 numbers, had 76 schemes with a total of 8 890 000 beneficiaries.

The reason for the low number of complaints in respect of medical aids, is not entirely known, and one can only speculate that the beneficiaries of medical aid schemes are unaware of the fact that the Office of the FAIS Ombud can assist in the investigation of medical aid related complaints, and the nature of the services that can be provided.

As previously mentioned, the Office of the FAIS Ombud can assist the members and beneficiaries of medical schemes with complaints in respect of the advice received when becoming a member of the scheme and whether the member understood the advice provided. The recommendations made by the broker must also be appropriate to the members needs and circumstances and the broker must also provide concise details of any material terms of the scheme to enable the prospective member to make an informed decision in respect of the appropriateness of the recommended medical scheme to the members needs and circumstances. This can however best be illustrated by using gap cover as an example of what would be expected from a broker when advising a prospective client in respect of his or her medical aid needs.

When rendering financial services in respect of medical aid schemes, an aspect that is often overlooked by FSPs, i.e., medical aid brokers, during the needs analysis process, is the risk that the prospective client will be left exposed in respect of cover for hospitalisation. The reason being is that a hospital benefit is not as comprehensive as one may want it to be especially when you consider the costs of anaesthetists and anaesthetics themselves, surgical specialists and the hospitals themselves, all of which often exceed the scheme tariff. On a basic level, gap cover pays the difference between the member's specialist charges for an in-hospital procedure and the tariff the medical scheme pays. When an FSP does not recommend that a prospective client consider the benefits of gap cover in relation to the limitations applicable to the recommended medical scheme, the FSP is leaving the client exposed to the potential financial prejudice due to specialists charging in excess of the scheme tariff; expenses that form part of the procedure that the client may not be aware of, especially where the procedure is not in respect of a PMB; and co-payments for procedures in respect of illnesses such as cancer, illnesses which are on the rise in South Africa.

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A broker is primarily the agent of the prospective insured, and the relationship between the broker and the client is governed by the ordinary law of agency. In the decision of Rabinowitz and Another1 the court stated: "Where a person employs an insurance broker to obtain insurance from him, the broker is his agent, and responsibility for the acts and omissions of the broker is governed by the ordinary law of agency. The communication of information relative to the proposed insurance during

the course of negotiations therefore is plainly within the authority of an insurance broker". The obligations of a broker when procuring insurance for his or her clients, are also stated in our common law as follows: "...in our law, as in English law, the duty to exercise reasonable care and skill in appropriate cases extends to the duty to take reasonable steps to elicit and convey material information both from and to the insured. This includes information about terms of the policy which, if contravened, might leave the insured without cover. **It is part and parcel of the broker's general duty to use reasonable care to see that the insured is covered."**(Own emphasis)

To a large extent, the duties of a broker as detailed above are "codified" in the General Code of Conduct for Authorised Financial Services Providers and Representatives ('the Code') under the Financial Advisory and Intermediary Services Act, No. 37 of 2002. The duty of an FSP therefore in rendering a financial service to a client in respect of a medical aid scheme is to firstly make a recommendation that is appropriate to the client's needs and circumstances, and then to advise the client as to the material terms and conditions of the specific scheme, which would include aspects such as the scheme tariffs, exclusions, the use of designated service providers etc. The recommendation of a gap cover policy to mitigate any potential financial prejudice forms part of this duty to ensure that the client has peace of mind in knowing that as far as possible all risks have been addressed in the event of the client's medical needs.

Should a medical scheme member/beneficiary, or in fact any client who believes that they have been financially prejudiced as a result of the financial service rendered then they can visit our Complaints Portal at *www.faisombud.co.za* and select 'Lodge Complaint'. Alternatively, you may submit a complaint in writing to info@faisombud.co.za, Fax: (012) 348 3447 / (012) 470 9097 or via post to P O Box 74571, Lynnwood Ridge, 0040. Alternatively you can call our Client Care Centre on (012) 762 5000 or Sharecall 086 066 3274 for assistance in submitting a complaint.