THE SUPREME COURT OF **APPEAL OF SOUTH AFRICA**

JUDGMENT

Reportable

Case No: 238/2015

In the matter between:

THE REGISTRAR OF MEDICAL SCHEMES	**FIRST APPELLANT**
THE COUNCIL FOR MEDICAL SCHEMES	**SECOND APPELLANT**

and

GENESIS MEDICAL SCHEME	**RESPONDENT**

Neutral citation: *Registrar of Medical Schemes v Genesis Medical Scheme* (238/2015) [2016] ZASCA 75 (27 May 2016)

Coram: Cachalia, Seriti, Willis and Dambuza JJA and Tsoka AJA

Heard: 11 May 2016

Delivered: 27 May 2016

Summary: Medical Schemes Act 131 of 1998 – members' funds allocated to members' savings accounts are 'trust property' in terms of the Financial Institutions (Protection of Funds) Act 28 of 2001 and are to be accounted for separately in terms of ss 4(4) and (5) of that Act, read together with s 35(9)*(c)* of the Medical Schemes Act 131 of 1998.

ORDER

On appeal from: Western Cape Division of the High Court, Cape Town (Davis J sitting as court of first instance), judgment reported sub nom as *Genesis Medical Scheme v Registrar of Medical Schemes & another* 2015 (4) SA 91 (WCC):

1 The appeal is upheld with costs.

2 The order of the court a quo is set aside and replaced with the following:

'The application is dismissed with costs.'

JUDGMENT

Cachalia JA (dissenting with Dambuza JA)

[1] This is an appeal from the Western Cape Division of the High Court, Cape Town (Davis J), upholding a review by Genesis Medical Scheme (the respondent) against a decision of the Registrar of Medical Schemes, the first appellant, to reject its Annual Financial Statement (AFS) for the year 2012. The Registrar did so for the reason that the respondent had reflected the funds in its members' personal medical saving accounts (PMSAs) as its own assets, instead of treating them as funds held in trust on behalf of its members.

[2] In a now reported judgment the court a quo upheld the respondent's contention that PMSA funds were correctly reflected as its own assets, and that in

rejecting its AFS the registrar had erred in law.[1] The Registrar appeals this finding with leave of that court. The second appellant, the Council of Medical Schemes, is cited as the organ of state responsible for the functioning of medical schemes.[2]

[3] On 19 June 2013 the Registrar informed the respondent that he had rejected its 2012 AFS because of the manner in which it had reported the funds in the PMSAs. The respondent then instituted review proceedings under s 6(2)*(d)* of the Promotion of Administrative Justice Act 3 of 2000 on the grounds that the registrar's decision was materially influenced by an error of law.

[4] The source of this error, it contended and still contends, was the incorrect construction placed on the relevant provisions of the Medical Schemes Act 131 of 1998 (the MSA), its regulations and the Financial Institutions (Protection of Funds) Act 28 of 2001 (the FI Act) in the judgment of *Registrar of Medical Schemes v Ledwaba NO (Omnihealth).*[3] The judgment pertained to a medical scheme known as Omnihealth Medical Aid Scheme (Omnihealth) that was liquidated. The liquidators contended that PMSA funds were the assets of Omnihealth and fell into the insolvent estate. The court disagreed, holding that these funds constituted trust property of the members as contemplated in s 4(5) of the FI Act and therefore did not fall into the scheme's insolvent estate.

[5] A few years after the *Omnihealth* judgment the Council and the Registrar issued several circulars prescribing the form in which PMSA funds were henceforth to be reported in the AFS of medical schemes. In summary the circulars provided that: Contributions received by medical schemes from their members must be retained in a trust account separate from any of its other bank accounts; interest and other income earned on PMSA funds are to accrue to the members' PMSA balances; and PMSA funds are no longer to be reflected in the balance sheets and income statements of the AFS.

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[1]*Genesis Medical Scheme v Registrar of Medical Schemes & another* 2015 (4) SA 91 (WCC).
[2] Section 7*(b)* of the Medical Schemes Act 131 of 1998.
[3]*Registrar of Medical Schemes v Ledwaba NO & others* [2007] JOL 19202 (T).

[6] The respondent's 2012 AFS and returns did not comply with these prescriptions. The Registrar accordingly rejected them. It is however common ground that these circulars are not themselves legally binding. Based as they are on the *Omnihealth* judgment, they only have the force of law if the judgment reflects the correct legal position.

[7] In the court a quo the respondent contended that the incorrect way in which the *Omnihealth* judgment interpreted the relevant provisions of the MSA in particular leads to what this court has described as 'insensible or unbusinesslike' results.[4] The court a quo upheld this contention, which then gave rise to conflicting interpretations in two provincial divisions. The Registrar supports the construction in *Omnihealth*, and the respondent that of the court a quo.

[8] The MSA and the regulations[5] promulgated thereunder (the regulations) govern the conduct of medical schemes by providing for their rules, finances and for the Registrar's regulatory powers. Section 29 of the MSA lists a number of specific matters for which their rules must provide, while s 30 enumerates the general provisions for which their rules may provide.

[9] An important feature of the MSA and the regulations is their treatment of a medical scheme's finances. In particular, the legislative scheme aims to ensure that the scheme's finances are properly maintained and effectively scrutinised. This is important because a medical scheme is in essence a mutual aid society funded by members' contributions. It has no source of revenue other than these contributions (and the returns on the investment of any surplus after the benefits have been paid) from which benefits are paid to or on behalf of members. These contributions include those made to PMSAs the purpose of which is to provide members with an optional facility to cover health care costs not covered by the scheme.

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[4] *Natal Joint Municipal Pension Fund v Endumeni Municipality* [2012] ZASCA 13; 2012 (4) SA 598 (SCA) para 18.
[5] General Regulations, GN R1262, *GG* 20556, 20 October 1999.

[10] Section 26(1)*(c)* specifies that members' contributions, including any other amounts such as interest, are to be received into a bank account the medical scheme must establish and control. Such contributions evidently become assets of the scheme. Section 26(2) is emphatic that '[n]o person shall have any claim on the assets or rights or be responsible for any liabilities or obligations of a medical scheme, except in so far as the claim has arisen or the responsibility has been incurred in connection with transactions relating to the business of the medical scheme'.

[11] Against this background, s 35 of the MSA provides that a medical scheme shall 'at all times maintain its business in a financially sound condition'. The medical scheme must achieve this by:

(i) having assets, the aggregate value of which, on any day, is not less than the aggregate of (a) the aggregate value on that day of its liabilities and (b) the nett assets as may be prescribed (s 35(1)*(a)* read with s 35(3));

(ii) providing for its liabilities (s 35(1)*(b)*); and

(iii) generally conducting its business so as to be in a position to meet its liabilities at all times (s 35(1)*(c)*).

[12] Section 35(7) provides that a medical scheme may invest its funds in any manner provided for by its rules.

[13] Section 35(9)*(c)*, which lies at the heart of this appeal, says that the amounts standing to the credit of members' PMSAs constitute 'liabilities of a medical scheme' for the purposes of the MSA. These funds must accordingly be taken into account for purposes of the calculations as set out in s 35(3) and must be provided for as required by s 35(1)*(b)* and *(c)*.

[14] Section 37 deals with a medical scheme's AFSs. Sections 37(2)*(a)*, *(b)* and *(c)* require a balance sheet, income statement and cash flow statement. Section 37(4)*(a)* specifies that the AFS must be prepared in accordance with general accepted accounting practice. This means simply that they should present the state of affairs of the scheme fairly.[6]

[15] Section 38 gives the registrar the power reject the annual financial statements of a medical scheme if he is of the opinion that they do not comply with any of the provisions of the MSA or do not 'correctly reflect the revenue and expenditure or financial position' of the medical scheme. The Registrar purported to act under this provision in rejecting the respondent's AFS.

[16] The relevant rules of the respondent, with which we are concerned, are rules 14.5 and rule 1.1 of Appendix 2. The former provides that the balance standing to the credit of a member in a PMSA 'shall, at all times remain the property of the member', subject to the provisions dealing with savings accounts; the latter that the PMSAs in certain benefit options shall be available 'for the exclusive purpose of paying benefits for the member of his or her dependants'.

[17] Regulation 10(1) limits the amount a medical scheme may allocate to a PMSA to 25 per cent of the members' total gross contribution.

[18] Regulations 10(3) and 10(4) prescribe the manner in which the funds deposited in a PMSA are to be dealt with. Regulation 10(3) says that these 'shall be available for the exclusive benefit of the member and his or her dependants', subject however to the proviso that the medical scheme may use those funds 'to offset debt owed by the member to the medical scheme following that member's termination of

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[6] *Novick & another v Comair Holdings Ltd & others* 1979 (2) SA 116 (W) at 140G-141A.

membership of the medical scheme'. Regulation 10(4) provides for the transfer of credit balances in a member's PMSA (as envisaged in s 35(9)*(c)*) to another medical scheme or to a different benefit option with a PMSA, as the case may be, when the member changes medical schemes or benefit options.

[19] The financial matters of medical schemes are further regulated by the FI Act, because a medical scheme is a 'financial institution' as defined in s 1 of the FI Act. I consider its provisions later.

[20] The central dispute between the parties lies in the proper construction given to s 35(9) of the MSA. In *Omnihealth* the liquidators contended that because the liabilities of a medical scheme include the amount standing to the credit of a member's PMSA, as s 35(9)*(c)* requires, the funds in this account had to be an asset of the scheme. This was for the simple reason that from an accounting point view, the financial records of a scheme cannot show a liability without also showing a corresponding asset. PMSA funds were therefore not trust property as defined in s 1 of the FI Act.[7] The court rejected this contention. It found that the legislative framework and Omnihealth's rules required the credit balances in the PMSA's to be treated as trust property and that any accounting difficulties this may cause cannot alter the substantive law.[8] I consider the court's reasoning later in this judgment.

[21] Mr Brett has represented the Registrar in both provincial divisions, and now appears before us. For his main contention – that funds in the PMSAs are trust assets and not the assets of the respondent – he relies heavily on regs 10(1) and 10(3), and also rules 14.5 and 1.1 of Appendix 2. He submits that the fact that these regulations provide that a portion of members' contributions are allocated to an account in the name of a member, held separately, and are available for the exclusive benefit of the member are strong indicia that these funds are trust property.

[7]The relevant portion of s 1 of the FI Act is set out at para 41 below.
[8]*Omnihealth* at 7.

This is buttressed by the rules providing that the funds are 'the property' of members to be used for their exclusive benefit. He submits that the rules comply with reg 10.

[22] Section 30(1)*(e)* permits a scheme to make provision in its rules for the allocation of funds to a member's PMSA '*within the limit and in the manner prescribed* . . . to be used to pay for any relevant health service'. (Emphasis added.) However, neither the rules, which regulate the relationship between a medical scheme and its members, nor the regulations determining the limits of funds to be allocated to PMSAs, and the manner in which they are to be dealt with, have any bearing on the question whether the funds in a PMSA constitute trust property. The nature of these funds can only be determined by examining the relevant provisions of the MSA. The content of the rules and the regulations cannot be used as an aid to the construction of the MSA.[9]

[23] I therefore turn to the relevant provisions of the MSA. It is evident that the MSA does not treat PMSA funds as trust property. If the lawmakers intended PMSAs to be treated as such one would have expected specific language indicating as much.[10] There is none. And Mr Brett relied on none. The MSA simply does not contemplate medical schemes holding any trust property. The only mention of 'assets held in trust' is in s 26(3), which refers to assets held *for* the medical scheme by another person, not *by* a scheme on behalf of another person.

[9] EA Kellaway *Principles of Legal Interpretation of Statutes, Contracts and Wills* (1995) at 208-209; *Moodley v Minister of Education & Culture, House of Delegates & another* 1989 (3) SA 221 (A) at 233E-F.

[10] See eg s 79 of the Attorneys Act 53 of 1979. It reads:

'**Trust property not to form part of assets of practitioner.**—Notwithstanding anything to the contrary in any law or the common law contained, trust property which is expressly registered in the name of a practitioner, or jointly in the name of a practitioner and any other person in his or her or their capacity as administrator, trustee, curator, or agent, as the case may be, shall not form part of the assets of that practitioner or other person.'

[24] The MSA treats members' contributions in the following manner. All contributions are deposited into the bank account established and controlled by the medical scheme as required by s 26(1)*(c)*. Once this happens the member loses ownership of these funds; they become the property of the bank and are the assets of the scheme, regardless of whether a proportion of the funds are allocated to a PMSA afterwards. Members do not deposit earmarked funds with their medical scheme for a PMSA. Contributions are deposited into the scheme's bank account, and the scheme allocates a portion of this amount to the member's PMSA. Any payments of members' benefits, payable under the rules, will be debited to this bank account, as s 26 (4) specifies.

[25] It is apposite to refer to a simple example to explain what happens in the process. If the amount contributed is R100, this will be what is represented in the medical scheme's books as an asset. Of this amount let's say the scheme allocates R25 to the PMSA, which is 25 per cent of the gross contribution of the member, and also the maximum allocation reg 10(1) permits to be made to a PMSA in a financial year.

[26] Section 35(9) says that this R25, once allocated, becomes a liability of the scheme, and s 35(9)*(c)* specifically says this liability is reflected as a credit in the member's PMSA. The credit balance therefore represents a current, not a contingent liability.

[27] Now s 35(1) requires a medical scheme to have sufficient assets as contemplated in s 35(3) so that it is in a position to meet its liabilities at all times. From ordinary accounting principles, the R25 allocated to the PMSA, which is a liability in the books of the scheme, must therefore have a corresponding asset in its books. Otherwise it will not have an asset to meet this liability. The credit entry in the member's PMSA must therefore have a corresponding debit entry in its books. If the asset were the trust property of the member and is not to be reflected in the scheme's balance sheet as an asset of the scheme, as the Registrar contends, the

scheme would not be able to meet this liability for the simple reason that it cannot use the assets of a third person (the member) to meet its own liabilities.

[28] The Registrar's contention has the absurd result that in order to comply with s 35(1)*(b)* and *(c)*, a medical scheme must hold assets equivalent to the total value of the PMSA funds under its control, the PMSA funds themselves not constituting assets of the medical scheme for these purposes. Thus, if the scheme has R20 million in PMSA funds under its control, it would have to show cash on hand in the same amount, but exclude the PMSA funds, to satisfy this legislative requirement. For every rand of PMSA funds under its control, the medical scheme would have to find, elsewhere, a rand to match it. That is unworkable because medical schemes do not have any source of revenue (save for investment returns) other than contributions paid by their members.

[29] Moreover, the interpretation advanced on behalf of the appellants has the result that the member from whose contribution R100 is allocated to his or her PMSA now appears to have an asset worth R200: R100 in the form of cash in the bank and a further R100 in the form of a claim for payment against the scheme.

[30] Furthermore, reg 29(2) requires that a medical scheme maintain accumulated funds expressed as a percentage of gross annual contributions for the relevant accounting period which may not be less that 25 per cent. Gross annual contributions include amounts allocated to members' PMSAs. 'Accumulated funds' is defined in reg 29(1) as meaning the net asset value of the medical scheme. It is incongruous that the regulations should determine the accumulated funds to be maintained as a percentage of contributions if, according to the Registrar, a portion of those contributions do not constitute an asset of the medical scheme.

[31] For a medical scheme to maintain a solvency reserve that is equal to at least 25 per cent of gross annual contributions, and for purposes of calculating the amount

required to be kept in reserve, the medical scheme must include the amounts that are later allocated by it to its members' PMSAs.

[32] It does not make commercial sense for the legislature to have intended savings accounts to be held in trust, outside the reach of the medical scheme, and simultaneously to insist that the medical scheme's solvency reserve must be higher than would otherwise be necessary because savings allocations are included in the calculation. If the intention was to exclude PMSAs from the medical scheme entirely, then PMSAs should form no part of any further calculation regarding solvency.

[33] The solvency reserve is designed for prudential reasons. If PMSAs are held outside the scheme, as postulated by the Registrar, then it makes no sense that the scheme should hold a reserve that includes PMSA funds. To put it differently, not all medical schemes operate PMSAs (because it is optional, in terms of s 30 of the MSA), and yet the solvency reserve applies equally to all schemes. If PMSAs are not the asset or liability of the medical scheme, then there can be no reason for the solvency reserve to apply to them.

[34] Section 35(7) also provides an important contextual indication that PMSA funds are not the members' trust property. It allows a medical scheme to invest 'its funds' in any manner provided for by its rules. The section makes no distinction between PMSA funds and other funds, which one would have expected if the PMSA funds were ring-fenced as trust property and thus precluded from being invested as the scheme's funds.

[35] In my view the plain meaning of the provisions relating to PMSAs in the MSA permits no interpretation other than that the funds allocated to PMSAs are not the trust property of the members, but remain the assets of the medical scheme. The scheme is entitled, indeed obliged, to treat these funds as its own assets and to reflect them accurately as such in its AFSs.

[36] The Registrar's resort to the regulations to interpret the MSA is not only impermissible as I have pointed out, but amounts to pulling himself up by his own bootstraps. Besides, the regulations do not support his construction either. The reference in s 10(3) and rule 1.1 in Annex 11 to the funds in the PMSA being available for the *exclusive benefit* of the member, requires no more than that the scheme maintains funds equivalent to those of in PMSAs for the use of the members concerned, as distinct from the general pool of contributions used to pay for members' benefits generally. Similarly reg 10(4) entitles a member to have amounts standing to the credit in the PMSA to be transferred to another scheme or benefit option, which is consistent with it being for the member's exclusive benefit. By contrast the R75, used in our example earlier, is not for the member's exclusive benefit, and is lost to the member if not used.

[37] The reference in rule 14.5 to the funds in PMSAs remaining 'the property' of the members comes closer to the idea that these funds may be considered trust property. But, as with the regulations the rule also cannot be used to interpret the Act. And in the context of how the MSA and the regulations treat PMSAs, the word 'property' can only mean that these funds must be used in the manner specified in the regulations, ie, for the member's exclusive benefit. It cannot mean that the member has ownership of the funds because as I have explained earlier, ownership is lost when the money is deposited into the medical scheme's bank account. Neither can it mean that it is the member's trust property for the reasons given earlier.

[38] This brings me to Mr Brett's alternative contention: that the funds in PMSAs are trust funds as envisaged in ss 4(4) and 4(5) read with the definition of trust property in s 1 of the FI Act. In *Omnihealth* the court found that Omnihealth's rules, which like the respondent's specify that PMSA's remain the property and are for the exclusive benefit of the member, and reg 10, bring it within the ambit of definition of 'trust property' in the FI Act.[11]

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[11]*Registrar of Medical Schemes v Ledwaba NO & others* [2007] JOL 19202 (T) at 3-5.

[39] However, I have already held that the question whether PMSA funds are trust property must be determined within the four corners of the MSA, and not the rules and regulations. Similarly this question cannot be determined by reference to the FI Act.

[40] The purpose of the FI Act is inter alia to provide for the investment, safe custody and administration of funds and trust property by financial institutions, and to improve the enforcement powers of curators (s 5) and of the registrars of financial institutions (s 6) (defined to include the Registrar).

[41] Section 1 of the FI Act defines trust property as 'any corporeal or incorporeal, movable or immovable asset invested, held, kept in safe custody, controlled, administered or alienated by any person, partnership, company or trust for, or on behalf of, another person, partnership, company or trust . . . .' And a 'financial institution' includes a medical scheme as contemplated in the MSA, which means that the provisions of FI Act apply to the MSA.

[42] It is apparent from ss 2 and 3 that the FI Act deals with both funds and trust property held by financial institutions, and ss 5 and 6 with the enforcement powers of curators and registrars. While the enforcement provisions of the FI Act apply to medical schemes, not all funds held by medical schemes constitute trust property. Only if the nature of the funds held by a medical scheme makes it trust property will s 4 of FI Act apply.[12] And as I have pointed out the nature of the funds held in PMSAs can only be determined by reference to the MSA and not the FI Act.

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[12] Section 4(1) provides that a financial institution that 'administers trust property under any instrument or agreement may not cause such trust property to be invested other than in a manner directed in, or required by, such instrument or agreement', and s 4(2) provides for investment in the absence of such direction or requirement. Section 4(4) provides that trust property must be kept separate from assets belonging to the financial institution concerned, and s 4(5) says that such trust property 'under no circumstances forms part of the assets or funds of the financial institution' concerned, despite 'anything to the contrary in any law or the common law'.

[43] It follows that *Omnihealth's* determination that PMSAs constituted trust property as contemplated in the FI Act, was incorrect. Mr Brett's alternative submission must accordingly also fail.

[44] It is necessary to return to two aspects of *Omnihealth's* reasoning to support its conclusion that a deposit into a trust account is capable of being treated as a liability even though there is no corresponding asset, and that whatever accounting difficulties there may be cannot alter the substantive law. It relied on *Fuhri v Geyser NO*[13] as authority to underpin these findings, and its reasoning proceeded as follows: When a trust creditor hands money to a trustee the former immediately becomes the creditor of the latter for the amount to be held in trust. This is so, said the court, regardless of whether the trustee kept the trust money in a separate account or becomes the owner of the money. The implication is that there is, in the case of a deposit into a trust account, a liability without a corresponding asset.

[45] It must, however, be pointed out that in *Fuhri* the court was concerned with money held in trust by an attorney. Section 33(7) of the Attorneys, Notaries and Conveyancers Admission Act 23 of 1934 then determined how such funds are to be dealt with. In the present matter we are concerned with the prior question, whether the funds in the PMSAs are indeed trust funds. This question, as I have said, is to be determined primarily with reference to the relevant provisions of the MSA. And only if this question is decided in the affirmative would provisions of the FI Act pertaining to trust property apply.

[46] In any event, *Fuhri* does not support the proposition that trust property creates a liability (in the sense of a debt) without a corresponding asset. All that Hefer J said was that when an attorney receives an amount of money 'for the account of the client, a debt immediately arises . . . for the payment of the amount to the client'.[14] But this 'debt' is not a liability in the sense in which the word is used in s 35(9) of the

[13] *Fuhri v Geyser NO & another* 1979 (1) SA 747 (N) at 749A-750A.
[14] Ibid at p 749F.

MSA. Rather, it is an obligation to account for the money deposited. The ownership of money deposited into an attorney's trust vests in the bank.[15] The attorney is entitled to operate the account and make withdrawals from it, and the client is entitled to claim from the attorney the amount due to him.[16]

[47] Secondly, the learned judge's finding that the accounting difficulties presented by s 35(9)*(c)* cannot have a bearing on the substantive law as to how these funds are to be treated in the accounting records rests, with respect, on the incorrect assumption that the proper accounting treatment of these funds is not a matter of substantive law. Section 37(4) requires, as a matter of law, that AFSs be prepared in accordance with general accounting principles. And a failure to do so permits the registrar to reject the AFS for want of compliance with any provision of the Act, including s 37. Section 35, which has been the focus of this appeal, deals with the financial arrangements including the requirement that the business of the scheme is maintained in a manner that is financially sound. The obligation to comply with these provisions, and to ensure that these arrangements are fairly reflected in the financial statements, is a substantive legal requirement. The Registrar's difficulty explaining, in his answering affidavit, where the corresponding asset of the liability in s 35(9) comes from, and how it is to be represented in the accounting books, shows his failure to come to grips with this legal requirement, and cannot be dismissed as a mere accounting difficulty.

[48] I therefore conclude that *Omnihealth* incorrectly determined PMSA funds to be trust property, and the court below correctly reviewed and set aside the Registrar's decision to reject the respondent's 2012 AFS.

[49] For these reasons I would have dismissed the appeal with costs of two counsel.

[15] Ibid at p 749C-D.
[16] Ibid at p 749D-E.

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A Cachalia

Judge of Appeal

Willis JA (Seriti JA and Tsoka AJA concurring)

[50] I have had the privilege of reading the judgment prepared by my brother Cachalia. I regret that I am unable to agree with him. Our differences on the issue are fundamental and irreconcilable. I do accept, however, that this is a technically difficult case because it requires a harmony between the law and basic principles of accounting. In broad terms, despite some points of difference, I side with the judgment of Du Plessis J in *Omnihealth*[17] and disagree with the reasoning of Davis J in the court a quo.[18]

[51] It is clear to me, if one reads the Regulations as a whole, taken together with the answering affidavit, the circulars issued both by and on behalf of the Registrar and the correspondence between the parties, that the system of savings accounts with medical schemes was designed and regulated to assist those members of medical schemes who are not fortunate enough to have full and comprehensive medical cover. The system of savings accounts enables members to put away funds for medical treatment for which they are not covered and also to save funds for medical treatment in their old age – when, in the ordinary experience of humankind, we all tend to be beset by ailments more than when we are young. Over time, the amount that a member may build up in his or her savings account may be considerable. These funds may have taken many years to accumulate.

[52] For reasons that will emerge more fully later, I emphasise that these observations as to how and why the system of savings accounts operates are

[17] *Registrar of Medical Schemes v Ledwaba NO & others* in the Transvaal Provincial Division (unreported case number 18545/06, delivered on 30 January 2007) (*Omnihealth*).
[18] Reported *sub nom Genesis Medical Scheme v Registrar of Medical Schemes & another* 2015 (4) SA 91 (WCC).

conclusions of fact and not of law. This system of provision for future medical treatment by way of savings is recognised by s 35(9)*(c)* of the Medical Schemes Act 131 of 1998 (MSA), which, as I shall later show, provides for specific accounting measures which cater therefor. My reasoning on this aspect is 'top-down' rather than 'bottom-up'. In other words, although the facts emerge from the Regulations, the interpretation of those Regulations derives from s 35(9)*(c)* of the MSA and not the other way round.

[53] It bears repeating that Omnihealth was a medical scheme which had gone insolvent. Critically relevant was whether the amount standing to the credit of members' savings accounts fell to be available for the general *concursus creditorum* (the general body of creditors)[19] or whether it stood outside thereof. Du Plessis J, relying on the definition of trust property in the Financial Institutions (Protection of Funds) Act 28 of 2001 (the FI Act), found that these savings were trust property (and, therefore, necessarily stood outside of the *concursus*). The issue is one of fundamental importance: are members' savings accounts, which may have painstakingly been built up over a number of years, 'ring-fenced' against claims by the general body of creditors or are they not?

[54] It would offend against justice if funds of this nature were available to the predations of the *concursus creditorum* in the event of the insolvency of a medical scheme. Moreover, it requires no financial genius to understand that medical schemes, unless properly managed, can easily become insolvent. Regulation designed to protect members of medical schemes is therefore hardly surprising and, indeed, desirable. In finding that *Omnihealth* was wrongly decided, the effect of Cachalia JA's judgment is that members' savings accounts are indeed available to the *concursus creditorum* in the event of the insolvency of a medical scheme. Of course, no interpretation of law by the courts should be too strained, but the divination of justice is an important aid and is constitutionally enjoined in terms of the

[19] The Latin term *concursus creditorum* means more than 'the general body of creditors'. It means something like this: 'the creditors, coming together and waiting, expectantly, for at least some of their money back'. The density of the Latin term probably explains its retention among lawyers.

39(2) of the Constitution. Besides, the *publica utilitas* of law was recognized by Johannes Voet as being a vital consideration when interpreting the law.[20]

[55] The FI Act is, as its long title makes clear, social legislation designed to protect funds placed with financial institutions. The definitions section defines any medical scheme contemplated in the MSA to be a financial institution. It defines 'trust property' as:

'any corporeal or incorporeal, movable or immovable asset invested, held, kept in safe custody, controlled, administered or alienated by any person, partnership, company or trust for and on behalf of, another person, partnership, company or trust, hereinafter referred to as the principal.'

In my opinion, there can be no question that funds invested by members of a medical scheme in their savings accounts with that scheme constitute incorporeal assets invested, controlled and administered by the scheme for and on behalf of its members. Therefore, Du Plessis J was correct in finding that these saving fund contributions constituted trust property.

[56] Section 4(4) of the FI Act provides as follows:

'A financial institution must keep trust property *separate* from assets belonging to that institution and must, *in its books of account*, clearly indicate the trust property as being property belonging to a specified principal.' (My emphasis.)

Furthermore, s 4(5) of the FI Act provides that:

'Despite anything to the contrary in any law or the common law, trust property invested, held, kept in safe custody, controlled or administered by a financial institution or a nominee company under no circumstances forms part of the assets or funds of the financial institution or such nominee company.'

[57] Thus, in unmistakable terms, this subsection ring-fences items such as the savings accounts of members of a medical scheme from any *concursus creditorum*.

[20] J Voet *Commentarius Ad Pandectas* (1723) 1.3.17. (translated by Sir Percival Gane in *The Selective Voet being the Commentary on the Pandects* (1955)). See also L C Steyn *Uitleg van Wette* 5 uitg (1981) p 124.

Not only does s 4(4) provide that these must be accounted for separately but also provides the indicator as to how the books of account are to show the amounts standing to the credit of a member's savings account as a liability of the scheme with there being a corresponding asset showing these assets as being separate from those of the scheme.

[58] The Registrar was, in my opinion, correct to attempt to apply an interpretation of the applicable statutory framework that was consistent with *Omnihealth*. I also agree with the Registrar that the accounts of the respondent were misleading inasmuch as they did not reflect the special status of funds standing to the credit of the members' savings accounts. After all, one of the important functions of audited sets of accounts is that they inform all those who may be interested in doing business with the person concerned, whether that person is likely to be able to meet his or her intended obligations.

[59] Mr Burger, who appeared for the respondent, relied inter alia, on the fact that when Mr Tegobo Maziya, the Head: Financial Supervision wrote on behalf of the Registrar in a circular to all medical schemes that: 'The savings account and the bank balances representing the savings balances will no longer be reflected in the Statement of financial position (Balance sheet).', he was requiring that the savings account balances of members be 'off balance sheet'. That is incorrect. Section 35(9) *(c)* of the MSA requires that:

'For the purposes of this Act, the liabilities of a medical scheme shall include –

. . . *(c)* the amount standing to the credit of a member's personal savings account.'

[60] Clearly, this requires that a medical scheme's liability to its members in respect of their savings account must be an 'on balance sheet' item. In terms of the first principles of double-entry bookkeeping, for every liability there is a corresponding asset. This is commonly known as a 'contra'. There must and will be a

‘contra’, appearing in the assets of a medical scheme, for its liability to its members in respect of their savings account. I shall deal with this aspect later.

[61] The Registrar was wrong to have required liabilities to be ‘off balance sheet’ when a plain and sensible reading of the MSA required that they should be ‘on’. I am fortified in this opinion by s 37(4)*(a)* of the MSA that requires that the annual financial statements of a medical scheme shall be prepared ‘in accordance with general[ly] accepted accounting practice’ and s 37(4)*(c)*, which requires that these financial statements must ‘fairly present the state of affairs’ of a medical scheme.

[62] The respondent did not, however, make the requirement that *personal medical savings accounts* (PMSA funds) should be ‘off balance sheet’ a basis for the review. Indeed it could not do so. The basis upon which the respondent approached the court and short-circuited the exhaustion of the Medical Council’s internal procedures was the correctness or otherwise of the decision (and therefore the order) in *Omnihealth*.

[63] At this stage, we have no way of knowing whether, had the internal procedures been followed, the issue of ‘on balance sheet’ or ‘off’ would have been satisfactorily dealt with. The only reason that the court a quo gave, when granting leave to appeal against its judgment to this court, was the existence of *Omnihealth*, which it found to be wrong. The fact that the Registrar may have been wrong in requiring members’ savings accounts to be ‘off balance sheet’ was not a ground for the review and cannot be considered at this stage.

[64] Regulation 10(5) of the MSA[21] provides that when a member *terminates* his or her membership and thereby withdraws cash from his or her personal medical savings account, without transferring the funds to a savings account at another

[21] Medical Schemes Act 131 of 1998 Regulations, GN R1262, *GG* 20556, 20 October 1999 (as amended).

medical scheme, he or she is liable to tax. It would not only be absurd but also unjust if a members' savings account was available to the *concursus creditorum* but also taxable at the same time.

[65] In addition, in terms of regulation 10(3), if a member owes a debt to a medical scheme at the termination of his membership of the medical scheme, that member may use PMSA funds standing to his credit to offset such debt. If PMSA belongs to a medical scheme, how can set-off operate against the member's own debt? It makes no sense at all. The issue of set-off can only arise if PMSAs are assets of the members and not of the medical scheme.

[66] I disagree with Cachalia JA insofar as his understanding of the function of that the solvency reserve is concerned. The reserve must be held in proportion to gross *annual* contributions. (The emphasis is my own.) The solvency reserve cannot protect funds saved by members over a number of years. The solvency reserve is designed to ensure that a scheme can meet its *current and relatively short-term future* obligations for medical expenses in terms of its own rules. (Again, the emphasis is mine.)

[67] Both Cachalia JA and Davis J have found that the *Omnihealth* was wrong in holding that the funds in members' saving accounts was 'trust property' within the meaning thereof as defined in the FI Act. For reasons that have been given above, I disagree with them. I also disagree with Davis J in his finding that this interpretation in *Omnihealth* would, if correct, require that for every rand of PMSA funds under its control, a medical scheme would have to find an additional rand (over and above the corresponding contra) in order for its assets to match its liabilities. This is, in my respectful opinion, simply cannot be supported: it does not make sense. Moreover, it contradicts the professional and independent advice of the South African Institute of Chartered Accountants (SAICA). I shall deal with this aspect more fully later. I have similar, but less vivid, reservations concerning Cachalia JA's construction of the

accounting consequences that derive from holding that members' savings accounts constitute 'trust property' in terms of the definition thereof in the FI Act.

[68] I also disagree with Cachalia JA that the Registrar impermissibly resorted to the regulations to interpret the MSA and amounts to his 'pulling himself up by his own bootstraps'. Ever since the judgment of Lord De Villiers CJ in *Chotabhai v Union Government (Minister of Justice) and Registrar of Asiatics*,[22] it has been our law that, unless it would result in repugnancy or a practical impossibility, it is reasonable to construe two or more different pieces of legislation as co-existing and to interpret them in a manner that is mutually consistent.[23] I have no difficulty in reading the MSA, the FI Act and the Regulations harmoniously and in conformity with the conclusion reached in *Omnihealth*. I fully accept, however, in line with *Moodley v Minister of Education & Culture, House of Delegates & another*,[24] that it is not permissible to treat an Act of Parliament and the regulations made thereunder as a single piece of legislation and to use the latter as an aid to the interpretation of the former.[25] Even without reference to the Regulations, the same conclusion that *Omnihealth* was correct can be reached. Indeed, Du Plessis J came to his conclusion without any reference to the Regulations.

[69] It hardly needs be stated that Du Plessis J did not have the benefit of the recommendations of the SAICA, which were made in response to his judgment in *Omnihealth*. He also had the intellectual humility to acknowledge that, in respect of the treatment of the issue in the accounts, he would need expert advice. In my respectful opinion, *Omnihealth* did, however, show considerable confusion about accounting methods and was incorrect in holding that: 'In our law it does not follow, because the amount standing to the credit of a member's personal savings account is regarded as a liability, that the PMSA- funds must be an asset of the scheme'. This criticism does not alter the fact that the order given was the correct one.

[22] *Chotabhai v Union Government (Minister of Justice) and Registrar of Asiatics* 911 AD 13.
[23] At 23.
[24] *Moodley v Minister of Education & Culture, House of Delegates & another* 1989 (3) SA 221 (A).
[25] At 223E-F. See also *Rossouw & another v Firstrand Bank Ltd* [2010] ZASCA 130; 2010 (6) SA 439 (SCA) para 24 and *Trustco Group International (Pty) Ltd v Vodacom (Pty) Ltd* [2016] ZASCA 56 (1 April 2016) para 14.

[70] A proper answer to the issue is, in my opinion, to be found in the concept of *commixtio* in our law. The matter has been dealt with by this court in *Louw NO & others v Coetzee & others.*[26] The money contributed by members to their savings account with a medical scheme inevitably becomes scrambled, jumbled up or mixed up with the other cash contributions which it receives. In *Louw*, the court had to deal with a similar situation – funds deposited with a bank, which it is trite become owned by the bank once they have been deposited therewith.[27] Lewis AJA said:

'As long as the records of the bank show that a particular amount is designated as being due to a particular customer, there would appear to be no difficulty in finding that a bank holds money that is deposited or invested in trust for that customer.'[28]

The cash, of course, is and remains that of the bank. This is the position despite the fact that the funds are held in trust for a customer.

[71] *Mutatis mutandis*, the following would appear to be the position as to how a medical scheme would deal with its contra for the liability in respect of members' savings accounts:

As long as the balance sheet of the medical scheme shows that a particular amount is designated as being due to members in respect of members' savings accounts, there is no difficulty in finding that the scheme holds cash that has been deposited or invested in trust for those members.

[72] By reason of restrictions imposed by ss 4(4) and 4(5), together with the application of the law of *commixtio*, the contra for its liability to members in respect of their savings accounts, to be reflected in the assets of the medical scheme, would be in the cash which it holds. The balance sheet would have to designate, in a manner consistent with generally accepted accounting practice, the extent of which such cash holdings were held for and on behalf of members in respect of their savings

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[26] *Louw NO & others v Coetzee & others* [2002] ZASCA 156; 2003 (3) SA 329 (SCA).
[27] See *Louw* (above) para 12 and the authorities therein cited.
[28] Ibid.

account. The ledgers of the scheme would have to keep account of the amount standing to the credit of each individual member's savings account.

[73] I am mindful of the fact that in *Louw* this court held that the bank continued to be free to deal with the funds as it wishes,[29] whereas in the case of a medical scheme it is not. Of course this is so. In *Louw* the court was dealing with the trust funds of attorney deposited with a bank. Here we are dealing with how the medical scheme accounts for its very own trust funds which it holds, separately and on behalf of others that have invested with itself. The legal consequences of these two separate issues may differ – and indeed do so. The point is, however, that it is quite easily possible, both legally and in the practice of accounting, to hold an asset such as cash, on behalf of another, and to make this fact clear to the world.

[74] It is for this reason that I agree with the submission of the Registrar that *Fuhri v Geyser NO & another*[30] is irrelevant to and finds no application in the present case. *Fuhri* dealt with an attorney's trust account and not 'trust property' as defined in the definitions section and ss 4(4) and 4(5) of the FI Act. The two are not coextensive.

[75] Moreover, in the Registrar's circular letter of 16 February 2001, referring to the audit and accounting guide approved by the SAICA, it is indicated in para 3.2 that funds of the kind in question should be classified as 'reserves', the precise description of which is left to the medical scheme concerned.

[76] In this way, not only can a medical scheme properly account to all who may have an interest in its affairs for how it holds the savings contributions of its members but also justify and ensure the separation of these funds from any claims by a *concursus creditorum* in future.

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[29] Paragraph 13.
[30] *Fuhri v Geyser NO & anothe*r 1979 (1) SA 747 (N).

[77] Just as one can distinguish, in a balance sheet, between assets that are held as 'Land and Buildings' and 'Debtors', for example, so one can distinguish between asset funds that are held as 'Trust Property' (as defined in the FI Act) and other funds. It is as simple as that. In other words, the medical scheme tells the world that it holds the 'trust property' as funds but for restricted purposes. It tells the world that these funds, held as ‘trust property’, are ring-fenced, as a matter of law. In other words, the funds are highly liquid for certain specified purposes (claims in respect of members’ savings accounts) but are otherwise illiquid. Potential creditors, interested in doing serious business with any person can call for that person’s audited balance sheet. Creditors of medical schemes cannot then legitimately complain later that these funds are not available to the *concursus*. They were, in effect, alerted well in advance. Fundamental to the principle of protecting certain assets of a debtor from claims by the *concursus creditorum* (for example, creditors secured by a first mortgage bond registered over immovable property) is the publicity, given well in advance to the world, that these assets may be beyond the reach of the *concursus*.

[78] Accordingly, the following order is made:

1 The appeal is upheld with costs.

2 The order of the court a quo is set aside and replaced with the following:

‘The application is dismissed with costs.’

N P Willis
Judge of Appeal

APPEARANCES

For Appellant:	J J Brett SC Instructed by: Savage Jooste & Adams c/o Bisset Boehmke McBlain, Cape Town Symington & De Kok, Bloemfontein
For Respondent:	S F Burger SC (with him G Cooper) (Heads of argument prepared by E Fagan SC and E van Huyssteen) Instructed by: Clyde & Co, Cape Town Lovius Block, Bloemfontein