**REPORT OF THE AD HOC JOINT COMMITTEE ON PARMED**

**1. INTRODUCTION**

In terms of the Parliamentary and Provincial Medical Aid Scheme Act 28 of 1975 (‘the Parmed Act’) Members of Parliament, along with other public office bearers such as judges, are members of Parmed due to the fact that section 1 of the Parmed Act legislatively creates a restricted scheme with compulsory membership.

As the Parmed Act, as well as the reasoning that informed its related legislative prescripts, are dated, the scope thereof calls for re-consideration. Taking into consideration the prima facie number of individuals and groups affected by the resolution of Parliament and its complexity, the Ad Hoc Joint Committee on Parliament and Provincial Medical Aid Scheme (‘the Committee’) had to request both houses of Parliament to extend the reporting deadline —both houses granted the extension. The extensions of the deadline offered the Committee an opportunity to apply its mind to potential risks and crucial issues relating to the Parmed Act.

The Committee is grateful for the extensive cooperation it has received from the stakeholders. In the main the report is structured on 3 sub-themes, the fist subtheme covers the legislative perspective of the Parmed Act, and Parmed Medical Scheme. The second, sub-theme outlined the policy developments. The last sub-theme covered legislative and policy options. Finally, the report outlined the recommendations.

**Composition list of the Members of the Committee**

**National Assembly**

**African National Congress**

Maseko, Ms LM – Chairperson

Tleane, Mr SA

Dambuza, Ms NB

Chauke, Mr HP

Kalako, Mr MU

Nobanda, Ms GN [Alternate]

**Democratice Alliance**

Kalyan, Ms SV

Marais, Mr SJF

**Economic Freedom Fighters**

Thembekwayo, Dr SS

**Inkatha Freedom Party**

Singh, Mr N

**Freedom Front Plus**

Mulder, Dr C

**National Freedom Party**

Shelembe, Mr NL [Alternate]

**African Christian Democratic Party**

Dudley, Ms C [Alternate]

**National Council of Provinces**

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| --- | --- | --- |
| Member | Province | Party |
| Parkies, Mr JP - Chairperson | Free State | ANC |
| Ncitha, Ms ZV - Committee Whip | Eastern Cape | ANC |
| Mlambo, Mr EM | Gauteng | ANC |
| Khawula, Mr M | KwaZulu-Natal | IFP |
| Dikgale, Ms MC | Limpopo | ANC |
| Mhlanga, Mr MT | Mpumalanga | ANC |
| Oliphant, Ms GG | Northern Cape | ANC |
| Mokwele, Ms TJ | North West | EFF |
| George, Dr D | Western Cape | DA |

**1.1. Mandate**

Consequently, the Chief Whip of the Majority Party in the National Assembly on 23 November 2017 moved as follows:

*“That the House –*

*(1) notes that the Parliamentary and Provincial Medical Aid Scheme Act, 1975 (No 28 of 1975) (Parmed) is the compulsory medical aid for retired and current members of Parliament and Judges;*

*(2) further notes that members of Parmed are paying high tariffs;*

*(3) acknowledges the need to enquire into the statutory requirement regarding compulsory membership for members of Parliament; and*

*(4) subject to the concurrence of the National Council of Provinces, established an Ad Hoc Joint Committee to… enquire into and make recommendations [on the impact of Parmed]”.*

The National Council of Provinces subsequently concurred the above motion.

**1.2. Terms of Reference**

The Committee was established and tasked to enquire into and make recommendations on:

1. the tariffs of members of the Parmed medical aid scheme;
2. the need for, and possible options with regard to Parmed and other competitive medical aids for members of Parliament;
3. the necessity of introducing amending legislation; and
4. the impact on retired members of Parmed.

**2. INTEREST GROUPS CONSULTED DURING PUBLIC PARTICIPATION**

In considering the above mandate, the Houses expressly called on the Committee to consult with the Judges and provincial legislatures, as well as exercise those powers as set out in Joint Rule 32 to assist it in carrying out its task.

The Committee duly consulted with the following stakeholders:

* Parliamentary and Provincial Medical Scheme (Parmed);
* Council for Medical Schemes (CMS);
* Judges (through the Office of the Chief Justice);
* National House of Traditional Leaders (NHTL);
* South African Local Government Association (SALGA); and
* Magistrates Commission.

A workshop was held with stakeholders on 13 June 2018 and the Committee invited stakeholders (both at the workshop and at subsequent meetings) to make oral and written submissions to the Committee on various related to the terms of reference. The inputs from stakeholders were therefore obtained and considered by the Committee as part of a continuous participation approach.

**3. HISTORIC DEVELOPMENT OF THE PARMED ACT**

In a 2015, Western Cape High Court ruling, Judge Binns-Ward noted that—

*“The statute is an ‘old order’ enactment and its subsequent amendment has resulted in s 1 containing an awkward mixture of old order and new order terminology. So, when the provision refers to ‘the Senate’, it must be read as referring to the National Council of Provinces; and when it refers to ‘a judge of the Supreme Court of South Africa’, that is a reference to a judge of the Supreme Court of Appeal or of the High Court.”*[[1]](#footnote-1)

To get an understanding of the intention of the Legislature that informed “awkward mixture” amendments that has resulted in the Parmed Act as it currently reads, it is beneficial to reflect on the amendments of the Act since it was first adopted in its original form in 1975.

**3.1. 1975 Original Text and Legislative Intent**

On 8 April 1975, the Leader of the House moved—

*“that leave be granted to introduce a Bill to provide for compulsory membership of the Parmed Medical Aid Scheme of members of certain legislative bodies and of certain other persons; to provide for the deduction of contribution payable to the said medical aid scheme from the salaries payable to certain persons; to repeal the Parliamentary Medical Aid Scheme Act, 1974; and to provide for incidental matters.”* [[2]](#footnote-2)

This was agreed to, and the Bill that resulted in the Parmed Act was read on first and on second time at the same sitting of the Assembly. During the second reading, the Leader of the House explained the purpose of the Bill:

*“If this Bill is passed, the existing Parliamentary Medical Aid Scheme Act, which was passed last year [1974], will be repealed. This step is necessary as it has been decided to admit not only Members of Parliament and Administrators, but also members of the Provincial Council and members of the Legislative Assembly of South West Africa, to the scheme.*

*In terms of clause 2 of the Bill, contributions to the scheme may now be deducted from the salaries of members whose membership is no longer compulsory by virtue of a change of office, but who have decided to remain members of the scheme and to whom a salary is still paid by the Government.*

*These are the two most important provisions of the Bill.”*[[3]](#footnote-3)

During the debate of the 1975 Bill, the concern raised by Members were the opposite of the impact issue currently being considered by the Joint Ad Hoc Committee. Rather than debating the possibility of allowing Members of Parliament the option to opt-out of Parmed, the 1975 Members sought clarity on—

*“whether or not this Bill will interfere in any way with the rights of Members of Parliament who at the present belong to this medical aid scheme. Will their rights be interfered with after leaving Parliament? Will they be able to continue being contributing members of the present medical aid scheme?”* [[4]](#footnote-4)

Upon confirmation that they would be able to remain contributory members of the medical aid scheme after leaving Parliament, the motion was agreed to and the Bill was passed. This is the only record as to the legislature’s original intent, as no explanatory memorandum accompanied the Bill.

**3.2. 1976 Amendment to Include Judges**

The Parmed Act was again amended by Act 61 of 1976, because of representations made by judges of the Supreme Court of South Africa to the Department of Justice for them to be admitted to the scheme. At the second reading of the 1976 Amendment Bill, the Acting Leader of the House on 20 April 1976 during the second reading stated that—

*“members of Parliament and of the provincial councils are not public servants and neither, of course, are judges. Accordingly, they cannot become members of the Public Service Medical Aid Association. On investigation it became clear that Parmed, the medical aid scheme for members of Parliament and members of the provincial councils, was the most suitable scheme to which judges, too, could be admitted. After the management committee of Parmed had given this matter their due consideration, it was decided to recommend that judges be admitted to the scheme. The annual general meeting approved this admission. As a result, the existing Act is being amended to make membership of Parmed compulsory for judges in office on a permanent basis.”[[5]](#footnote-5)*

The opposition supported the Bill, expressing the sentiment that they hoped that the admission of judges to the scheme would strengthen it and that the Legislature would—

*“in due course, find it possible to admit also other people who request this right should they be in line with the position of judges.” [[6]](#footnote-6)*

**3.3. 1984 Amendment and the Need to Strengthen Scheme**

On 4 July 1984, at a second reading of the 1984 Amendment Bill, the Minister of Health and Welfare explained that the amendment was the result of a Parmed meeting held on 24 April 1984, where it was—

*“decided also to make members of the House of Representatives and the House of Delegates subject to membership of the scheme when the relevant provisions of the Constitution Act of the Republic of South Africa, 1983, come into effect. The amendments in this Bill make statutory provision for this.*

*References to the Senate, and to members whose membership is linked to the territory of South West Africa, are being deleted.”*[[7]](#footnote-7)

The opposition parties responded with cost concerns. Dr MS Barnard stated that—

“*It is only right that members of the other Houses and also members of the President’s Council should be in a position to belong to the Parliamentary and Provincial Medical Aid Scheme. The hon the Minister and the majority of the people in the medical world are aware of the fact that the costs of medicine and health services are rising extremely rapidly nowadays. Because of the additional members who are going to belong to this scheme, it is appropriate to point out that hon members who belong to this scheme should not incur medical costs with the idea that the scheme will pay. Parmed, like all other medical schemes, needs members who will have due regard for the financial position of the scheme and act accordingly.”*[[8]](#footnote-8)

To this statement, Mr NW Lighthelm added that—

*“it is necessary to make this medical scheme as strong as possible, particularly in these times of tremendously high medical costs. It is probably generally accepted that when the membership of the medical scheme is being enlarged, this can place the scheme on a firmer footing and can make it a stronger scheme.”*[[9]](#footnote-9)

Dr WJ Snyman, one of the members who also served on the management committee of the scheme at that time emphasised that they—

*“know only too well that costs are escalating tremendously year by year and that we can barely keep pace with the increase in the price of medicines and medical services. Each year it is necessary to increase the contribution of members…”*[[10]](#footnote-10)

Another member of the then management committee of the scheme, Mr BWB Page, added to this sentiment—

*“we would possibly find that the more may be the merrier with our medical aid scheme, in the sense that we could well find that there may be a stabilisation of our monthly commitments towards maintaining the scheme, because any actuary will tell one that the greater the number the less possibility there is of a pattern of continual increase, such as there has been over the past few years.”*[[11]](#footnote-11)

**3.4. 1987 Consequential Amendment**

On 18 February 1987, the second reading of the 1987 Amendment Bill allowed for the consideration of a consequential amendment that was linked to—

*“a proposed amendment of section 28 of the Constitution Act, 1983 that aimed to enable Ministers to assign powers, functions or duties to certain persons appointed by the State President under the last mentioned section for that purpose.*

*In making such appointments, the State President undoubtedly has the tacit power to determine the conditions of service of such persons, including* inter alia *conditions regarding their memberships of the medical aid scheme.”*[[12]](#footnote-12)

Within this context it was—

*“deemed necessary, however, that persons appointed for the purpose mentions above, should become members of the Parmed Medical Aid Scheme and, as section 1 of the first mentioned Act in its present form allows no scope for such membership, the proposed amendment of that Act provides that the State President may approve of any other office-bearer in the service of the Republic not already listed in that section becoming a member of the said Scheme and that such approval be made known in the* Gazette*.”* [[13]](#footnote-13)

**3.5. 1996 Amendment Inclusion of Constitutional Court Judges (compulsory) and Members of Provincial Legislatures (by resolution)**

On 22 February 1996, the Leader of the House introduced the 1996 Amendment Bill for a second reading debate and pointed out that the Parmed Act—

*“makes provision for compulsory membership of the Parmed Medical Aid Scheme by Ministers, members of Parliament and judges of the Supreme Court, etc. However, the rules of Parmed also make provision for the granting of exemptions from compulsory membership.*

*The object of this Bill… is to extend the compulsory membership of Parmed to judges of the Constitutional Court and members of the provincial legislature.*

*With respect to provincial legislatures provision is made that membership to Parmed will only be compulsory for members of a particular legislature if that legislature has determined by resolution that the said Act shall apply to its members. Where a member and spouse both qualify for membership, the Bill allows for restriction of compulsory membership to only one of the two.”*[[14]](#footnote-14)

During the debate, Mr J Chiolé commented—

*“It is significant to note that in terms of clause 1(e) a provincial legislature can resolve whether or not the Act shall apply to its members. It is therefore not obligatory. The reason for this is quite probably that it took two years to draft legislation whereby they could be incorporated in a medical fund. Therefore, they were probably compelled to make other arrangements.*

*It is a good thing that Parmed is being extended. In this way its base of contributors is being broadened and one can accordingly incorporate a lower average age and the fund will, as it were, become cheaper. This will consequently improve the financial capacity of the fund. There will then be a larger number of contributors with a lower average age. We see, for example, that the average age of Parmed contributors is currently between 50 and 55 years, whilst the average age of members of most other medical aid funds in South Africa is between 30 and 35. Furthermore, according to what we hear. Parmed is experiencing financial problems.”* [[15]](#footnote-15)

To which sentiment, Mr J Ellis added that he is—

*“aware of the current financial problems of this fund and the fact that if nothing is done, these problems will grow. There are many medical aid schemes in this country at present which are facing serious financial problems and there are, of course, some that have already been declared bankrupt. We do not want this to happen to Parmed…*

*Consequently, it is vitally important that we expand the base of this fund… in order to protect it and to extend its capability in the members’ favour. It is a sad fact about Parmed that in between elections the average age of member of the fund increases because very few new members are admitted during the five-year span between elections. Any medical fund needs a good mix between young and old members to make it truly viable, and where this does not exist, problems exist.”*[[16]](#footnote-16)

In response to the above arguments raised as to the financial difficulties experienced by Parmed, Dr TJ King opined that—

*“The greatest problem is actually that members do not really understand that the irresponsible or uninformed use of the privileges of the medical fund can eventually lead to all of us having to pay much more or having to forego certain of our benefits in order to allow the fund to succeed…*

*There are surely very few institutions which do not constantly have to take care with their finances. It is also true that there are good and bad times. If we manage this matter responsibility, I do not believe that we have a crisis at this stage. I am asking that the members of this House, as well as the other members who want to join, must be very well informed with regard to the use of the fund.”*[[17]](#footnote-17)

In conclusion, of the second reading debate, Dr SA Nkomo stated that—

*“This Bill also needs to be supported to two reasons: First, it is a necessary unification and equalisation of the benefits available to legislators. Also, it provides a sounder basis for the resolution of the financial problems besetting small and fragmented business schemes as Bonitas and Pro Sano…*

*All that is necessary is to provide Parmed with the necessary tools to be able to enlist all our colleagues who wish to register with this medical scheme.”*[[18]](#footnote-18)

The 1996 Amendment Bill, as passed after the second reading resulted in the Parmed Act as it currently reads:

“*1. Every person who is or becomes—*

*(a) while not being a member of either the National Assembly or the Senate, and Executive Deputy President or a Minister;*

*(b) a judge of the Constitutional Court;*

*(c) a judge of the Supreme Court of South Africa in a permanent capacity;*

*(d) a member of the National Assembly or of the Senate;*

*(e) a member of a provincial legislature in a case where the provincial legislature concerned has resolved that this Act shall apply to its members;*

*(f) any other office-bearer in the service of the Republic approved by the President for the purpose of this Act and made known by proclamation in the Gazette,*

*shall, for as long as he or she holds that office of post, be a member of the Parmed Medical Aid Scheme, subject to the rules of that medical aid scheme as registered in accordance with the provisions of the Medical Schemes Act, 1967 (Act No. 72 of 1967): Provided that if any person and his or her spouse both qualify for compulsory membership of the said Scheme in terms of this section, only one of them shall be obligated to be such a member.”*

**3.6. Additional Observations re the Scope of the Parmed Act**

In light, and in the context, of the above developments the following must also be kept in mind when evaluating the need for possible amendment of the Parmed Act to address concerns regarding the compulsory membership requirement and the financial burden placed on members of the scheme due to its high costs:

a) Judge Binns-Ward in *EFF & Others v Speaker of the National Assembly & Others[[19]](#footnote-19)* observed that—

*“the medical aid benefits that accrue to the affected office bearers by virtue of their compulsory membership of the restricted membership PARMED medical aid scheme do indeed constitute part of the benefits they enjoy in terms of their current conditions of tenure. Whether the value of those benefits could be replicated or bettered at no greater cost to the office bearers were they to join one of the other open registered medical aid schemes is not clear”.*[[20]](#footnote-20)

b) Section 1 of the Parmed Act does not require the dependents of an office-bearer within the ambit of that section to become a member of Parmed. Dependents are at liberty to join any other medical aid of their choice.

c) The Legislature must ensure that office bearers have adequate access to medical assistance so that they can perform their duties to the best of their ability in the public interest. This objective can be met by obligating Members (and current Parmed associated officials) to belong to a medical scheme of their choice. In circumstances where access to alternative schemes are allowed, measures would be required negate the perception of a potential conflict of interest, i.e by monitoring objectivity in light of the Membership of Oath taken through the relevant parliamentary committees overseeing actions of Members in that capacity.

**4. ADMINISTRATION OF THE ACT**

Due to the fact that the Parmed Act is so dated and its text does not indicate a Minister or Department responsible for the administration of the Act, the Western Cape High Court was asked to provide clarity as to the member of the national executive that would be regarded as responsible for the Act.

Judge Binns-Ward upon consideration of the above historic development of the Parmed Act ruled as follows:

*“Differing from the position in most statutes, the PARMED Act does not give any indication of a minister in Cabinet or stator body as being responsible for its administration. That is not surprising, as … it does not require administration. Its provisions are ‘self-executing’… The Act’s provisions are twofold in effect: firstly, they impose an obligation of all members of the categories of office-bearer described in s 1 to become and remain members of the PARMED Medical Aid Scheme for as long as they hold office; and secondly, they impose an obligation on the relevant accounting officers responsible for the payment of the office-bearers’ salaries to make deductions at source in respect of the office-bearers’ monthly membership contribution to the Scheme. The carrying out by a functionary of a prescribed function in terms of a statute entails complying with the instrument; not administering it…*

*The PARMED Act was introduced by the national government in 1975, and it has been amended in the post-Constitutional era at the instance of the national government by means of the Parliamentary and Provincial Medical Aid Scheme Amendment Act 8 of 1996… the Director: Litigation and Law in the National Treasury disowned any responsibility by the Minister of Finance for the PARMED Act. It is not necessary to treat of the reasons given… One of them was that no significance should be attached to the fact that the Act had originally been introduced by the Minister of Finance in 1975 because ‘that… predate[d] the [current] constitutional dispensation.*

*The most recent amendments to the PARMED Act were effected in terms of the Parliamentary and Provincial Medical Aid Scheme Amendment Act 8 of 1996. The amendment Bill was tabled by the Minister of Trade and Industry, but it appears from Hansard that the sponsor of the Bill at the second reading debate was the Leader of the House (a position that currently carries the title ‘leader of government business in the National Assembly). The President is required in terms of s 91(4) of the Constitution to appoint a member of Cabinet as leader of government business. In terms of rule 150(a) of the Joint Rules of Parliament, the leader of government business is responsible for the affairs of the national executive in Parliament, In the absence of a Cabinet minister who is specifically responsible for the administration of the PARMED Act, it seems to me that the leader of government business in the National Assembly is the most appropriate representative of the national executive…”*[[21]](#footnote-21)

**5. OFFICIALS CURRENTLY EXCLUDED**

The officials currently excluded from belonging to Parmed, include:

* Municipal Councillors;
* Magistrates; and
* Traditional Leaders.

During consultations with these representatives, the argument was made that extending the pool of officials that qualify as Parmed members may strengthen Parmed as a sustainable scheme, as well as bring costs down as a larger membership base would allow for more scheme options. There was a willingness expressed by these groups that their members would be open to the idea of joining Parmed, but there was also a concern from the mentioned groups that although inclusion would be preferred that would not be a viable option at the current cost of membership.

During deliberations of the Committee at presentations received by these interest groups, fiscal risks and considerations were also highlighted.

**6. THE MEDICAL AID SCHEME ACT AND PARMED RULES REGULATION**

The Parmed Medical Aid Scheme is a registered medical scheme regulated by and subject to the provisions of the Medical Schemes Act, 1998 (Act No. 131 of 1998) (‘the Medical Schemes Act’).

Membership of the Parmed is regulated by section 1 of the Parmed Act. The membership is restricted to certain persons who by virtue of the holding of a particular office qualify for compulsory membership of Parmed. Beyond sections 1 and 2 of the Parmed Act (with the latter regulating deductions), membership of the scheme is further regulated by its rules.

The rules of a medical aid scheme are subject to the Medical Schemes Act, which seeks to consolidate the laws that regulate medical aid schemes. The Medical Schemes Act sets the parameters of membership to a medical scheme in terms of section 28. Therefore, while the wording of the Parmed Act imparts that membership is compulsory, that compulsory membership is subject to the Rules of Parmed. The compulsory prescription is however not absolute, as Parmed’s rules do make provision for exemption from such membership,[[22]](#footnote-22) as well as allow for the suspension of membership benefits in certain circumstances that include non-payment of fees.[[23]](#footnote-23)

Section 28 stipulates that no person “shall” be a member or a dependent of more than one medical scheme. Apart from that condition, section 28 is silent on how membership or dependency of a particular scheme is determined as this is left to be regulated by the rules of the particular scheme.

The Medical Schemes Act makes provision for “restricted membership schemes”, namely –

*“a medical scheme, the rules of which restrict the eligibility for membership by reference to-*

*(a) employment or former employment or both employment or former employment in a profession, trade, industry or calling;*

*(b) employment or former employment or both employment or former employment by a particular employer, or by an employer included in a particular class of employers,*

*(c) membership or former membership or both membership or former membership of a particular profession, professional association or union; or*

*(d) any other prescribed matter”.*

In the case of Parmed, its membership is restricted by virtue of section 1 of the Parmed Act and may be classified in terms of section 28(d) above. Concerns haven been raised regarding the fact that, for example, members of Parliament “must” belong to Parmed and are not afforded discretion to elect for themselves a medical aid to which they want to belong.

In considering such, it must be kept in mind that the Parmed Act was promulgated in 1975 and its latest amendment (Act No. 8 of 1996) came into effect on 29 March 1996, i.e. prior to the Constitution. The latest amendment, as outlined above, saw the compulsory scope of the Parmed Act extended to include Constitutional Court judges, as well as grant provincial legislatures the opportunity to opt-in to the scheme by way of resolution.

While section 28 of the Medical Schemes Act limits membership to one medical fund, it does not impose upon a person or prescribe to a person which medical aid to belong to. The Parmed Act on the other hand stipulates that membership is compulsory. Reading section 1 of the Parmed Act with section 28 of the Schemes Act, therefore removes the ability of identified office-bearers to become a member or dependent of another medical aid once he or she is a member of Parmed. However, with the exception that Parmed has legislative roots, the idea of restricted and compulsory membership is not unique to Parmed.

In 2017, South Africa had 60 registered restricted schemes. Although Members of Parliament are not employees,[[24]](#footnote-24) it is interesting to note that in *Coop & Others v SA Broadcasting Corporation & Others* the SABC’s compulsory medical aid came under the spotlight. In that case, the High Court found that the membership to the compulsory medical scheme was a condition of service.

Membership to a particular membership can therefore be prescribed if it falls within the framework of the conditions of service and/or if provision is made for a subsidy to the membership payments. In a normal employment relationship, those conditions are part of the employment contract. For Members of Parliament those conditions have been legislated by the Legislature within which they are serving office bearers.

The impact of the Parmed format is two-fold:

a) as a restricted medical aid, Parmed is not open to the general public, meaning only office bearers and people working in the legislatively listed categories can belong to Parmed; and

b) as a compulsory medical aid, members of the scheme are bound to the only, high cost yet comprehensive option that is currently on offer.

As Parmed is a relatively small closed or restricted scheme, the Registrar of the Council of Medical Schemes will not permit Parmed to offer more than one benefit —the membership numbers therefore play a role in the way that Parmed is structured within the ambit of the Schemes Act. In as far as that one benefit option is concerned if appears as if it is comparable to the greatest benefits on offer in other schemes, as well as the costs of benefits to members in those other schemes —these are however highest tier comparisons.

**7. REMUNERATION AND MEDICAL COST**

Before 2008, two-thirds of the medical aid contribution of Members of Parliament were subsidised and not deducted from their salary.

The Independent Commission for the Remuneration of Public Office Bearers (‘the Remuneration Commission’) made a recommendation in favour of the implementation of the total cost remuneration system for senior public office bearers in the executive and legislative branches of government. This recommendation was implement in November 2008, by means of section 4(1) of the Public Office Bearers Remuneration Act.

It is worth highlighting though that in the 2005 Annual Report of the Remuneration Commission stated as follow:

*“Successful implementation of a total remuneration structure for all public office bearers will depend on the thorough job analysis, consistent job evaluation and job grading, appropriate benchmarking, and a total structure based on equity and fair remuneration. It would further be necessary to define remuneration packages in terms of a set of core components and flexible portions for each package, while at the same time addressing the many differences in existing benefit arrangements amongst different public office bearer groups.”*[[25]](#footnote-25)

Consequently, 2008 saw the remuneration structure for Members of Parliament changed from a *cost plus benefit* structure to a *total cost remuneration* package. This had a great impact on the impact medical aid deduction had on Members financially.

The previously separately subsidies two-thirds portion was thereafter included with the full remuneration package and that portion was calculated as (at the time) enough to cover two adults and two children. After this calculation and remuneration inclusion, Members of Parliament now see the medial aid as a full deduction from their salaries.

Subsequent to that calculation and adjustment, Member’s salaries did not increase in proportion with the increase of Parmed medical aid costs. Between 2008 to 2018, the Parmed medical aid costs as a percentage of the total remuneration of members (i.e. their contributions) increased from 10.23% to 14.45%. For example, in the period between 2008 and 2014, Member’s remuneration increased by only 39.14%, while medical aid increased by 75.48%. Taking this into consideration, medical aid as a percentage of the total remuneration package over that period increased from 10.23% to 12.9%, resulting in Member bearing the financial impact of the disparate increases. This is further analysed below in the report, with specific reference to table 3.

**7.1. Chief Whips Forum Concerns**

In 2016, the Chief Whips Forum expressed its dissatisfaction with the unaffordability of the Parmed contributions. The Parmed’s Benefits and Contributions Committee was subsequently tasked to report on the proposed 2017 increase of 10.5%.

In response, in June 2017, Parmed reported that despite the challenges experienced “the Scheme has managed to remain a viable concern with reserve levels of 76% and consistently meet its obligation to its membership base”, while Parmed also acknowledged the Scheme’s “challenges regarding the cost to company salary structures”. Within this context, it was reported that the Parmed Board of Trustees have “been investigating various ways of making the Scheme more affordable” and they confirmed that “[c]omparisons with other schemes has also been done to ensure that the Scheme remains abreast of the changes within the medical industry”.

**7.2. Remuneration of Public Office Bearers Act, 1998**

The Remuneration of Public Office Bearers, 1998 (Act No. 20 of 1998) (‘the Remuneration Act’), read together with the Independent Remuneration Commission Act and the Judges’ Remuneration Act[[26]](#footnote-26) constitute an interlocking legislative framework regulating the remuneration of senior public office bearers in the legislative, executive and justice spheres of government. It should then also be noted that noting that the Judges’ Remuneration and Conditions of Employment Act, 2001 (Act No. 47 of 2001) which —although it regulates the remuneration of office-bearers referred to in section (1)(b) and (c) of the Parmed Act— contains no equivalent provision to that of section 9 of the Remuneration Act.

In terms of the long title of the Remuneration Act it provides a framework for determining the salaries and allowances of various categories of public office-bearers. It stems from section 219 of the Constitution (which provision addresses ‘Remuneration of persons holding public office’) and provides the basis for a transparent process in relation to the salaries, benefits and allowances of public office-bearers. The categories of office bearers listed in section (1)(a) to (d) of the Parmed Act falls within the regulatory ambit of the Remuneration Act.

Section 9(1) and (2) of the Remuneration Act should be read with the Parmed Act and provides as follows:

***9.*** *(1) An office bearer shall be entitled to be a member of a medical aid scheme duly established and registered in terms of a law and such office bearer shall be entitled to receive such medical aid benefits from the medical aid scheme to which he or she contributes as may be determined by the rules of such medical aid scheme.*

*(2) The amount of the contribution to be made to the medical aid scheme by the national government, of which a Deputy President, a Minister, a Deputy Minister, a member of the National Assembly or a permanent delegate is a member, shall, subject to any law, be determined by the Minister of Finance after taking into consideration the recommendations of the Commission, and such amount shall annually form a charge against the National Revenue Fund or be paid from monies appropriated by Parliament for that purpose, as the case may be.”*

Currently, there is a discrepancy in the percentage of salary increases as determined by the President (following the recommendation from the Independent Commission for the Remuneration of Public Office-bearers) and the percentage increase in medical aid contributions set by Parmed, with the latter being much higher than the former.

**8. POLICY DEVELOPMENTS**

During the course of the Committee’s work, the following policy developments were identified.

Recognising that the private health care industry is faced with uncertainty in relation to the *National Health Insurance*, including the *Competition Commission’s Private Health Care Market Inquiry*.

Further, the CMS, in relation to policy developments has highlighted that major policy considerations relate to the National Health Insurance Implementation Policy, which cover some of the policy activities:

* Consolidation of schemes that are non-compliant with the requirement of 6000 members;
* Consolidation of government employee schemes;
* Alignment of the PMBs with the NHI Single Service Benefit Framework;
* Legislative and governance reform.[[27]](#footnote-27)

The challenge of healthcare reform is to broaden access to quality healthcare and manage healthcare resources better. The key issue is to address price escalation which threatens the viability of the sector and limits access to private healthcare. Further, South Africa is faced with socio-economic challenges, such as poverty, inequality and high rate of unemployment that continue to affect social stability. These socio-economic challenges have a direct effect to the country social safety net, and also have an effect to on the medical scheme membership base.

The South African economy continues to undershoot social and economic expectations. The recent 2018/19 Medium Term Budget Policy Statement reveals a blink picture of the South African economy. The Reserve Bank, National Treasury including rating agencies and the World Bank have revised downwards the economic growth rate forecast.

The performance of the economy would affect employment, and thus medical scheme membership base. The South Africa currency movement further add burden to the medical health service providers’ ability to procure imported technology, equipment, goods and services. Ultimately private healthcare consumers would carry the price increases, and thus would cause sharper annual contribution increases. Further, an increase of the Value Added Tax (VAT) would further escalate the financial pressures of consumers, and thus make healthcare services unaffordable. In addition, constant price increases for fuel would have negative transmission effect to food prices, and further erode personal disposable income. The effects would surely be felt by private health care consumers.

The fiscal policy outlook remains tight, and economic growth is at its lowest levels. In general terms, the South African economy affects everyone, particular poor people.

**9. POLICY AND MEDICAL SCHEME OPTIONS**

The briefings with various primary stakeholders emphasised a need to balance affordability, quality and cost efficiency gains. One of the critical issues noted by the legislation review workshop, was to ensure that Parmed must be affordable and sustainable in order to cover the health needs of the members of the scheme.

It was identified that—

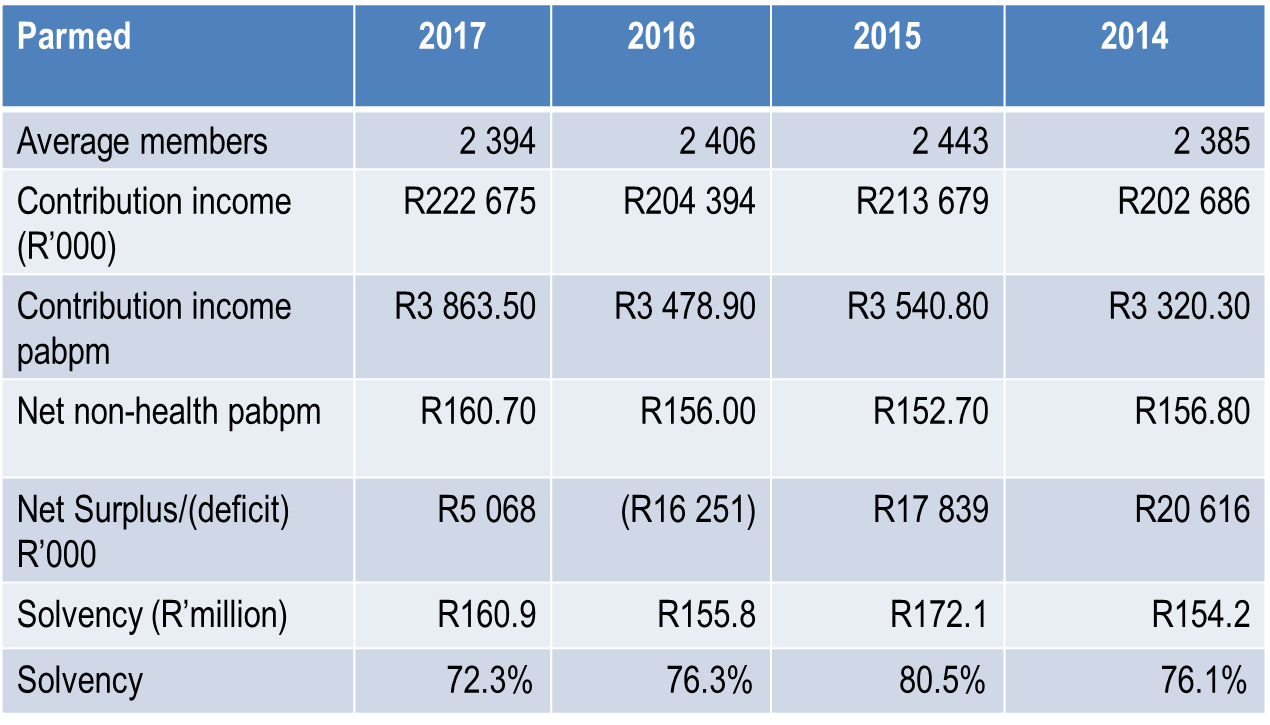
a) Parmed is one of the smallest restricted medical schemes;

b) medical schemes have been consolidating since 2001; and

c) in 2001, there were 144 medical schemes, and to date the number has significantly dropped to 82.

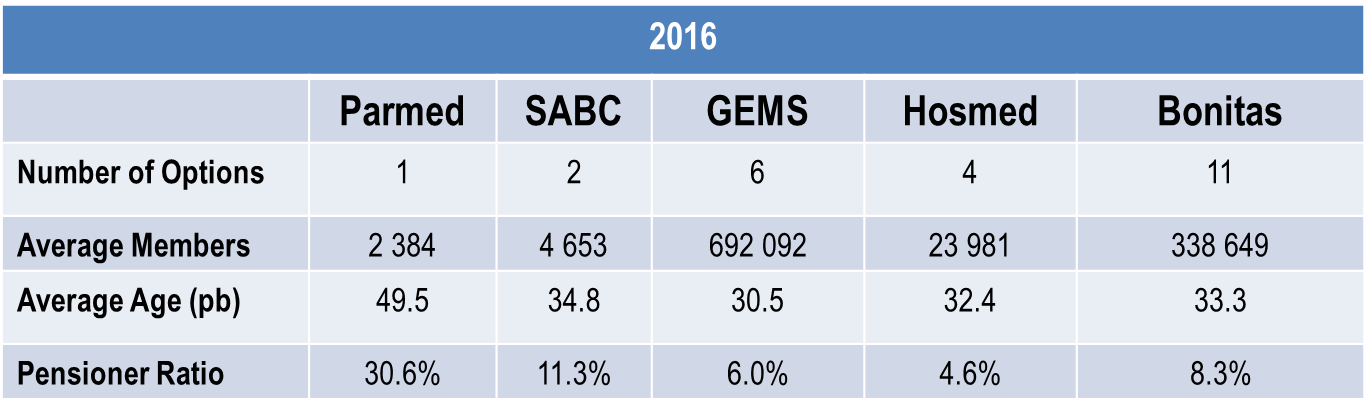
The presentation made by Parmed and the Council for Medical Schemes (‘the CMS’), highlighted that Parmed provides relatively good benefits. Parmed compared fairly well in terms of product offering (Benefits) with other medical schemes such as *Discovery (Executive Plan), Gems (Emerald), Bonitas (Std), Hosmed (Value), Fedhealth, Momentum and SABC.*

**9.1. Parmed’s Financial Health**

 **Table 1: High level Summary of Performance of Parmed[[28]](#footnote-28)**

**Table 1** shows that Parmed’s financial health remains sound. Although Parmed financial health status remains sound, it was identified that that the administrative costs are a red flag that needs to be addressed.

The CMS report further demonstrated that that the administration cost by Parmed exceeds the normal industry costs. It was emphasised that Parmed should find mechanisms to reduce the costs. Efficiency gains need to be achieved.

**Table 2: Parmed Demographic Profile[[29]](#footnote-29)**

**Table 2** indicates that the Parmed is one of the smallest schemes but offers high end services. In terms of the average age, Parmed has the highest average compared to other schemes exhibited in **Table 2.** Further, Parmed has a highest pension ratio. This factor should also be considered in taking any decision whether to repeal or amend the current legislation administering the scheme. The social and financial interests of retired members should be taken into consideration.

The Parmed’s Benefits and Contributions Committee in 2017 reported:

*“[T]he initial 10.5% contribution increase was proposed for the following reasons:*

*1) Parmed had experienced a decrease in membership by 14 members to 2403 principal members and the number of dependants had decreased by 104, which caused a drop in the average family size resulting in the ageing profile of the average beneficiary to 50.2 years, which is significantly higher than that of the other Schemes. Due to the aged demographic profile of the Scheme, reserves need to be higher than normal to be able to absorb the demands of higher risk profile.*

*2) The decision taken in 2015 to reduce the adult dependant contribution by 25%, also resulted in less contribution income from 2016.*

*3) The claims experience for 2016 was much higher and 31.8% of the claims paid were hospital claims with more admissions into hospital and longer lengths of stay. Claims exceeded 8.4% of the budget.*

*4) Investment income dropped due to the poor economy and was 7% below budget.*

*5) Medical Technology costs have escalated and allowances were made for medical cost inflation.*

*All these factors resulted in a projected deficit of R15million or 7.3% of the net contribution income in 2016, and it was therefore necessary to implement the increase of 10.5% to ensure that the reserves remained at a level higher than industry norm to absorb or cushion the Scheme from all these eventualities.”*

**9.2.** **Medical Aid Scheme Comparison**

In comparison with other medical aid schemes, it was submitted that Parmed offered certain advantages to its members including:

* Very competitive benefits;
* Competitive contributions;
* No restrictions in terms of choice of hospital, pharmacy or specialist networks;
* Very comprehensive and flexible medicine formularies;
* Cover for all chronic conditions; and
* There are no co-payments or deductibles on procedures.

It is recognised that the medical aid is an integral component of the total remuneration of Members of Parliament, including other Provincial Legislatures. In the past remuneration increase of Public Office Bearers in this case MPs and MPLs did not increase in line with inflation and most of the time, increases were below inflation.

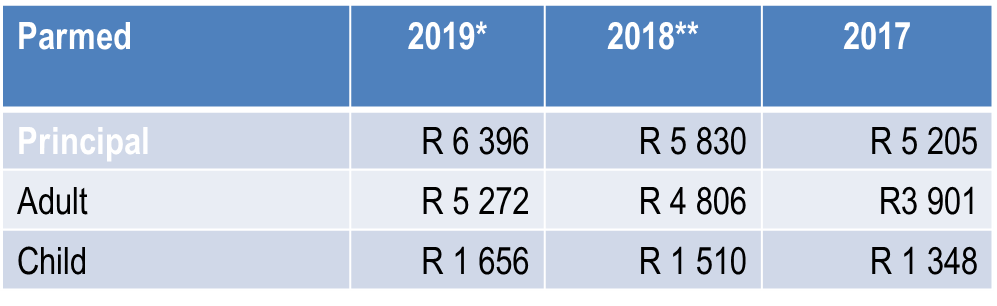
**Table 3: Summary of the Salaries and Medical Aid from 2008-2018[[30]](#footnote-30)**



**Table 3** exhibits that medical aid as percentage of the total remuneration recorded a significant increase. From 2008 to 2018, it increased from 10.2% to 14.5%. Whilst the medical aid increased as a percentage of the total remuneration, percentage increased in salaries recorded a decline from 7% in 2009 to 4.5% in 2017, assumed to reach 5% in 2018. In 2016, salaries did not increase.

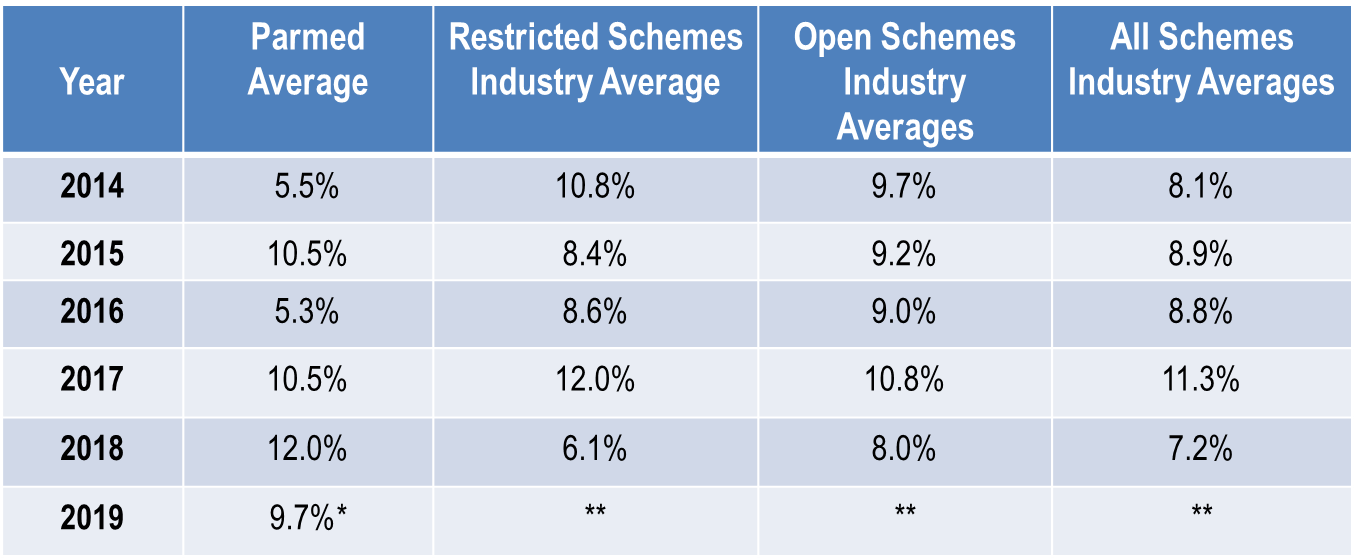
It must be noted that on the other hand, medical aid cost increased significantly. In 2009, medical aid cost registered an increase of 14.3%, and in 2010 increased by 10.5%. It is in 2011, 2012, 2013, and 2015, when medical aid costs registered a single digit (6.9%; 7.5% and 9% and 5.5%).

Further, Table 3 shows that the state contributes a certain portion to the medical aid. Just in 2018, state contributed close to R6,446 per month, and each member is anticipated to contribute R7,210 per month.

**Table 4: Parmed Contributions[[31]](#footnote-31)**

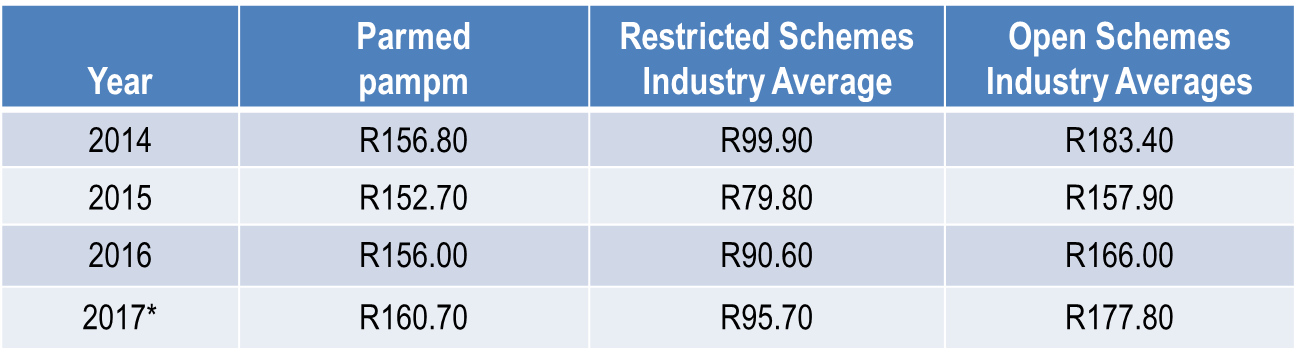
The Council for Medical Schemes submitted that the 2018 Parmed contributions were not approved. CMS, further indicated that Parmed medical contributions for 2019 would increase by 9.7% **(see Table 5).** Private Health care cost increases have always been above inflation. This trend has eroded personal disposable income of medical aid members, in this case, Parmed members.

**Table 5: Comparison of contribution increases of Parmed vs other schemes[[32]](#footnote-32)**



|  |
| --- |
| **Note: \* Parmed proposed increase for 2019**  **\*\* Increase assumptions given to industry is 5.4 per cent inflation and 3.3 per cent utilisation** |

The current economic situation has further exacerbated the crisis, not only for the *Public Office Bearers*, more so for the general population that is not subsidised by the Republic. The primary factors that have caused the outcry about the unaffordability of the medical scheme was the salary increase of public office bearers, which does not accommodate medical costs increases. As noted above, and further emphasised by this statistical analysis, the remuneration pronouncement for public office bearers for the past years has not taken into account private health medical costs increases and, in some instances, the salary adjustments of MPs were below inflation.

**Table 6: Parmed Non-Health Expenditure against industry[[33]](#footnote-33)**

CMS indicated that the Parmed’s non-healthcare expenditure is 67.9% higher than the restricted scheme average. **Table 6** exhibits that that the administration cost charged by Parmed exceeds the normal industry costs. The report advocates that Parmed should find mechanisms to reduce the costs. Efficiency gains need to be achieved. Another option is to undertake a tender process to evaluate what other Medical Aid Administration companies could charge.

**9.3. Scenarios Outlined by Parmed**

***9.3.1. Scenario 1***

*“An outline of what Parmed reserves would look like if we did the predictable industry related increases over the next 3 years with minimal growth of approximately 300 members in the election year of 2019”*

Assumptions used:

* + The members will join uniformly throughout 2019, with the cumulative increases totalling 300 members by December 2019, i.e. the average membership for 2019 is projected to be 2507 (members);
  + Thereafter membership is assumed to stay constant;
  + Increases of 10% in the contribution rate has been assumed (“predictable industry related increases”) for 2019 onwards;
  + Increases of 8% in claims are assumed for 2019 onwards.
  + No change in the demographic profile of members (i.e. age/chronic status/gender) has been assumed;

Response to Scenario 1:

* + The scheme’s reserves in 2019 will drop due to the projected deficit for year-end 2018 as well as the inflow of new members.
  + As the solvency ratio is expressed as accumulated funds divided by membership income, bigger membership income (all else equal) will lead to a percentage-wise drop in the reserves.
  + Over time the slightly bigger membership base will lead to claims experience being slightly less volatile and scheme overheads spread over a bigger membership base.
  + Investment income on a per-member per month basis will be diluted.

***9.3.2. Scenario 2***

*“A scenario of the Scheme based on the exodus of members i.e. those from all the legislatures approximately minus 400 members”*

Assumptions used:

* The members will leave uniformly throughout 2019, with the cumulative decreases totaling 400 members by December 2019, i.e. the average membership for 2019 will be 2 154 members;
* Thereafter membership is assumed to stay constant;
* Increases of 10 per cent in the contribution rate has been assumed (“predictable industry related increases”) for 2019 onwards;
* Increases of 8 per cent in claims have been assumed for 2019 onwards;
* No change in the mix of lives (i.e. age/chronic status/gender) has been assumed.

Response to Scenario 2:

* The scheme’s reserves in 2019 will increase due to exodus of members;
* As the solvency ratio is expressed as accumulated funds divided by membership income, smaller membership income (all else equal) will lead to a percentage-wise increase in the reserves initially;
* Over time the smaller membership base will lead to claims experience being more volatile and scheme overheads spread over a smaller membership base;
* Investment income on a per-member per month basis will be higher initially.

***9.3.3. Scenario 3***

*“A scenario of adding approx. an additional 2000 members (each with an average of 2 dependants) …. with an average age of 48yrs”*

Assumptions used:

* The members will join uniformly throughout 2019, with the cumulative increases totaling 2000 members by December 2019, i.e. the average membership for 2019 will be 3 267 members;
* Thereafter membership is assumed to stay constant;
* Increases of 10 per cent in the contribution rate has been assumed (“predictable industry related increases”) for 2019 onwards;
* Increases of 8 per cent in claims have been assumed for 2019 onwards;
* A change in the mix of lives in terms of age has been assumed;
* The average member age for Parmed will drop from 64.7 to 57.

Response to Scenario 3:

* The scheme’s reserves in 2019 will drop due to the projected deficit for year-end 2018 as well as the inflow of new members;
* As the solvency ratio is expressed as accumulated funds divided by membership income, bigger membership income (all else equal) will lead to a percentage-wise drop in the reserves;
* Over time the bigger membership base will lead to claims experience being less volatile and scheme overheads spread over a bigger membership base;
* Investment income on a per-member per month basis will be diluted;
* Claims – on average – will be lower over the longer term due to the reduction in the average member age.

***9.3.4. Scenario 4***

*“Then adding another benefit option (new generation type) with 100 per cent Hospitalisation, limited benefits and a savings pool for day to day benefits. Option design should ideally be to accommodate younger members.”*

In order to determine the potential impact on the scheme overall, one should consider the current age distribution and associated costs of the Parmed lives. It was assumed that 25% of the existing membership will move to the hospital option. This then inferred what the resultant profile on the rest of the lives will be that remain on the traditional option. Under this scenario, if the new hospital plan is priced competitively, this will lead to increases for the existing traditional option’s claims outgo of approximately 10% on a per-life per month basis. This will imply an approximately 17% increase when also taking into account the tariff 5 per cent and utilisation increases 3%.

If the traditional option’s contribution is not increased substantially, the Scheme will incur a much bigger deficit for 2019 due to the increase in claims cost without the commensurate increase in contributions. The size of the deficit will depend to what degree the proposed hospital plan will be priced competitively or, alternatively, priced to cross-subsidise the losses on the traditional option. Further, there will be second order impacts as well; for example, more members – after the seeing the price differential – might move to the hospital option after the first year.

Other considerations:

* By creating another option, the scheme is splitting the risk pool. This will lead to increased claims volatility on both options.
* Due to the increase in contributions required for older lives, the bigger projected deficit and the increased volatility in results, there is a high chance that the CMS might not approve the new hospital option, especially given the scheme’s small size.

***9.3.5. Scenario 5***

*“Impact on the Scheme and reserves if the member numbers were expanded to include local government councilors and director generals. Kindly note that this scenario should include approximately 395 additional members with an assumption of the average family size of 2 adults and 2 dependents. Average age of 50”*

Assumptions used:

* The members will join uniformly throughout 2019, with the cumulative increases totaling 395 members by December 2019, i.e. the average membership for 2019 will be 2553 members;
* Thereafter membership is assumed to stay constant;
* Increases of 10% in the contribution rate has been assumed (“predictable industry related increases”) for 2019 onwards;
* Increases of 8% in claims have been assumed for 2019 onwards;
* A change in the mix of lives in terms of age has been assumed;
* The average member age for Parmed will drop from 64.7 to 62.6.

Response to Scenario 5:

* The scheme’s reserves in 2019 will drop due to the projected deficit for year-end 2018 as well as the inflow of new members.
* As the solvency ratio is expressed as accumulated funds divided by membership income, bigger membership income (all else equal) will lead to a percentage-wise drop in the reserves.
* Over time the bigger membership base will lead to claims experience being less volatile and scheme overheads spread over a bigger membership base.
* Investment income on a per-member per month basis will be diluted.
* Claims – on average – will be lower over the longer term due to the reduction in the average member age.

**10. MINISTER OF FINANCE RESPONSE TO ENQUIRE REMEDICAL AID CONTRIBUTIONS FOR RETIRED MEMBERS**

On 11 May 2018, the Minister of Finance responded to a request from the Speaker of the National Assembly for assistance and bringing to the attention of the Minister the liability emanating from the post-retirement medical subsidies for Members of Parliament.

The Minister highlighted the complexity of the matter, in that it touches on a broader policy issue, and advised that for purposes of a resolution a joint government investigation approach would perhaps be best, as “[t]he public service is also experiencing similar challenges and currently considering available options to address the liability in the long term”. It was further explained that—

*“The situation facing Parliament is not unique, especially considering that PARMED is a restricted medical aid scheme which also provides for payment of continuation benefits. Fortunately, there is a body of evidence of successful practices introduced by some governments and mostly, private sector companies internationally which provide mechanisms of dealing with the unfunded cost of continuation benefits.*

*In terms of current policy National Treasury indicated that it was “not in a position [to] take over this liability”, as the policy allows for the State to “responsibility for former public servants falling within scope of public service as defined. These are national departments and provincial departments defined under Schedule 2 of the Public Service Act. The post-retirement medical scheme subsidy cost is met on the National Treasury vote (programme 7). Parliament unfortunately falls outside this definition”.*

The Minister of Finance nevertheless urged that Parliament—

*“work jointly with the National Treasury to investigate the underlying structure and risk profile of PARMED… On a related issue, I kindly urge you to agree that we also investigate the sustainability of PARMED starting with a full market review of the scheme”.*

**11. OPTIONS IDENTIFIED**

The work of the Committee revealed that, because Parmed is a restricted compulsory scheme of a very small nature with a disproportional age profile (with the current age average at 64 years), the impact of that structure results in the exorbitant costs. This then affects the remuneration packages of the members. The remuneration structure is one of the primary factors that needs to be observed. Further, the Committee in designing these options was sensitive to the current economic situation and fiscal framework. The Committee further observed the current policy developments, such as the proposed national health insurance and the consolidation of public sector medical schemes, including consolidation of the medical schemes lower than the 6000 membership threshold.

The adverse impact that befalls the compulsory members are primarily because Parmed is—

a) a limited membership scheme in that it is legislatively prescribed which office bearers must belong to it, and thus impossible for other members to join to bring down the cost and make the scheme more viable; and

b) as a small scheme (due to restricted membership) can only offer a single coverage option giving its compulsory members no control over the medical aid coverage they required in accordance to their needs, finances and age.

**11.1. OPTION 1**

**11.1.1. Structural Adjustment**

The unreasonable discrepancy between salary adjustment and medical aid subsidy have an adverse impact on Parmed-contributions payable by members of the scheme. This is due to the fact that the two-thirds state-subsidised contribution that was calculated into the total cost remuneration package in 2008 has not been sufficiently adjusted over time.

The Committee highlighted the urgent need for Parliament to submit formal request (inclusive of a copy of this report) to the Independent Commission for the Remuneration of Public Office Bearers to re-evaluate the status quo and consider reinstituting the pre-2008 position of a *cost plus benefit remuneration* structure, instead of the current *total cost* remuneration. This formal request to the Commission should highlight the need for discussions between the Commission and National Treasury with regard to the impact of any change in remuneration structure to the fiscus, including tax implications. This position was supported in submissions received, including that of the Judiciary.

The implementation of this option as the recommendation would not require the current Parmed Act to be repealed, nor would it require any substantive legislative amendments. Inclusive in this option the Committee however identified technical amendments as suggested in this report.

**11.1.2. Technical Amendments**

Due to the fact that the Parmed Act is outdated, it requires technical amendments, such as replacing the reference to “Senate” with that of “National Council of Provinces”. Furthermore, section 1 of the Parmed Act refers to the Medical Schemes Act, 1967 (Act No. 72 of 1967), which has subsequently been replaced by the Medical Schemes Act, 1998 (Act No. 131 of 1998).

These required technical amendments to update the drafting style of the Parmed Act would have no consequential impact and could be implemented while any recommended structural adjustments are being considered.

**11.2. OPTION 2: AMENDMENT**

**11.2.1. Voluntary Membership**

If membership to Parmed is made voluntarily —in that the section 1 of Parmed Act “must” membership obligation is amended to a discretionary “may” option— without the membership pool expanding, the viability of the scheme could be negatively affected. The impact of this amendment option could be linked to Scenario 2 (with adjustment in forecasting) as outlined in this report.

To address this risk, transitional provisions would need to be put in place in consultation with the Leader of Government Business, National Treasury and the Department of Health. Such transitional provision would have to look at safeguarding the interests of members who choose to remain with Parmed. These interests would not only be financial in nature (in preventing a collapse of Parmed as a whole in response to a foreseeable mass exodus of members), but also in the maintenance of the common benefit advantage they currently get from the scheme.

Furthermore, any collapse of Parmed will not only prejudice the remaining and retired office-bearers, but the disintegration of Parmed (without the necessary legislative, institutional and fiscal safeguards) will be an unfavourable outcome and have an effect on public interest consideration, as public funds are involved.

**11.2.2. Expand Compulsory Membership**

As the Hansard debates relating to the previous Parmed Act amendments indicate, the Legislature has consistently indicated that there is a need to expand the membership scope to ensure that Parmed remains viable as a medical scheme and keeps costs down. This could be achieved by extending the scope of the section 1 Parmed Act membership list to include Magistrates, Municipal Councillors, and Traditional Leaders.

Expanding the membership through such an amendment would have an impact on the fiscus and would require policy discussions with the Leader of Government Business, Treasury and the Department of Health. As this affects the remuneration structure of all public office bearers, consultations with the Independent Commission for Remuneration of Public Office Bearers would also be required.

In the event that the membership pool is expanded, Parmed could introduce additional benefit option(s) (new generation type) to the scheme making provision for compulsory members to have the option to structure their medical aid benefits in line with their personal needs. This option should be designed to accommodate younger members.

This would allow for scenario 4, read along with scenario 5, as discussed in this report, with the added benefit of the membership pool expanding, as the CMS would be more likely to approve the introduction of additional benefit option(s) if Parmed’s membership could be increased to potentially more than 6000 members.

**11.2.3. Voluntary and Expanded Membership**

If scenario 4 is read with scenario 5 as outlined in this report with the necessary contextual adjustment, the Parmed Act could be amended to simultaneously allow for voluntary membership and an expanded membership base.

Although this amendment could be argued as negating the risk associated with some current members opting to join other medical aids (a step that could potentially result in the collapse of Parmed), there will also be new members joining Parmed. However, this recommendation’s potential benefit in ensuring Parmed’s viability is speculative.

As such, an amendment of this nature would still have an impact on the fiscus and would require policy discussions with the Leader of Government Business, National Treasury and the Department of Health. As this affects the remuneration structure of all public office bearers, consultations with the Independent Commission for Remuneration of Public Office Bearers would also be required.

**11.3. OPTION 3: REPEAL PARMED ACT**

If it is the will of the Legislature to dissolve Parmed completely and repeal the Parmed Act, the impact of such a step will have reaching consequences for continuation members and staff employed by Parmed.

Extensive transitional safeguards will have to be put in place in consultation with the Leader of Government Business, National Treasury and Department of Health (which would include the Council for Medical Schemes). Such a step will also trigger labour relations considerations relating to retrenchments, as Parmed is an employer.

As there are less restrictive measures (i.e. the structural adjustment and amendment options) whereby the adverse impact of the status quo could be addressed, a repeal of the Parmed Act should be a last resort.

**12. RECOMMENDATIONS**

Observations of the Committee that the change of the salary structure in 2008 from cost plus benefit to total cost remuneration by the Independent Commission for the Remuneration of the Public Office Bearers had a negative impact on section 1 Parmed Act’s listed Political Official Bearers, as consequentially the increase in Parmed costs have been more than the increase in salaries of affected Political Office Bearers.

Further, the adverse impact that befalls the members of the scheme is as a result that—a limited membership scheme in that it is legislatively prescribed which office bearers must belong to it, and thus impossible for other members to join to bring down the cost and make the scheme more viable; and as a small scheme (due to restricted membership) can only offer a single coverage option giving its compulsory members no control over the medical aid coverage they require in accordance to their needs, finances and age.

The Committee wishes to present—

* Option 1 to the National Assembly and National Council of Provinces as the recommendation to address the immediate unaffordability problem that this salary structure change has caused as it relates to Parmed membership, including consideration by Treasury of the once-off alignment to address the imbalance; and
* further recommends Option 2 to the National Assembly and the National Council of Provinces that the 6th Parliament must be tasked to further investigate the implementation of this option with the aim of making Parmed voluntary and extending its membership base to include amongst others, but not limited to the Municipal Councilors, Magistrates and Traditional Leaders.

Report to be considered

1. *EFF & Others v Speaker of the National Assembly & Others* Case Number: 5554/2015 (Western Cape Division, Cape Town, 8 December 2015) at par 28. [↑](#footnote-ref-1)
2. Hansard, 31 January to 19 June 1975, 3670 – 3671. [↑](#footnote-ref-2)
3. Hansard, 31 January to 19 June 1975, 3670 – 3671. [↑](#footnote-ref-3)
4. Hansard, 31 January to 19 June 1975, 3670 – 3671. [↑](#footnote-ref-4)
5. Hansard, 23 January to 25 June 1976, 5027. [↑](#footnote-ref-5)
6. Hansard, 23 January to 25 June 1976, 5027. [↑](#footnote-ref-6)
7. Hansard, 27 January to 12 July 1984, 10549 – 10552. [↑](#footnote-ref-7)
8. Hansard, 27 January to 12 July 1984, 10549 – 10552. [↑](#footnote-ref-8)
9. Hansard, 27 January to 12 July 1984, 10549 – 10552. [↑](#footnote-ref-9)
10. Hansard, 27 January to 12 July 1984, 10549 – 10552. [↑](#footnote-ref-10)
11. Hansard, 27 January to 12 July 1984, 10549 – 10552. [↑](#footnote-ref-11)
12. Explanatory Memorandum to Amendment Act 21 of 1987. [↑](#footnote-ref-12)
13. Explanatory Memorandum to Amendment Act 21 of 1987. [↑](#footnote-ref-13)
14. Hansard, 15 January 1996 – 31 January 1997, 342 – 353. [↑](#footnote-ref-14)
15. Hansard, 15 January 1996 – 31 January 1997, 342 – 353. [↑](#footnote-ref-15)
16. Hansard, 15 January 1996 – 31 January 1997, 342 – 353. [↑](#footnote-ref-16)
17. Hansard, 15 January 1996 – 31 January 1997, 342 – 353. [↑](#footnote-ref-17)
18. Hansard, 15 January 1996 – 31 January 1997, 342 – 353. [↑](#footnote-ref-18)
19. Case Number: 5554/2015 (Western Cape Division, Cape Town). [↑](#footnote-ref-19)
20. *EFF & Others v Speaker of the NA & Others* Case Number: 5554/2015 (Western Cape Division, Cape Town) at par 45. [↑](#footnote-ref-20)
21. *EFF & Others v Speaker of the National Assembly & Others* Case Number: 5554/2015 (Western Cape Division, Cape Town, 8 December 2015) at paras to 56 – 57 [↑](#footnote-ref-21)
22. Item 6.1.2.5. of the Parmed Rules, “[p]rovide that the Board may on good cause shown grant exemption from membership to any person on receipt of a written application such person setting of the reasons for such exemption”. [↑](#footnote-ref-22)
23. Item 12.2 read with Item 12.2.1. of the Parmed Rules stipulate that “[w]here contributions or any other debt owing to the Scheme have not been paid within 15 working days of the due date, the Scheme shall have the right… [w]ithout prior notice to the member, to immediately suspend all benefit payments which have accrued irrespective of when the claim for such benefit arose”. [↑](#footnote-ref-23)
24. *Parliament of the RSA v Charlton* (2010) 31 ILJ 2353 (LAC) at par 28. [↑](#footnote-ref-24)
25. The Independent Commission for the Remuneration of Public Office Bearers, Annual Report 2005 at par 323. [↑](#footnote-ref-25)
26. In terms of section 2(1)(a) of the Judges’ Remuneration Act any person who holds office as a Constitutional Court Judge or as a “*judge*” as defined in section 1 of that Act (i.e. the President, Deputy President or a Judge of the SCA and the Judge President, Deputy Judge President or any judge of any High Court), whether in any acting or permanent capacity, is entitled to be paid an annual salary and such allowances or benefits which are determined by the President, by notice in the *Gazette*, after taking into consideration the recommendations of the Independent Remuneration Commission and approved by Parliament. Section 2(5) of the Judges’ Remuneration Act provides that any remuneration contemplated in section 2(1) of that Act, shall be paid as a direct charge against the National Revenue Fund. Section 2(2) of the Judges’ Remuneration Act requires the Remuneration Commission, when investigating or considering the salaries, allowances or benefits of Constitutional Court Judges and “*judges*” as defined in section 1 thereof, must consult with the Minister of Justice and Constitutional Development, the Minister of Finance and the Chief Justice or a person designated by the Chief Justice. [↑](#footnote-ref-26)
27. Source: CMS, 2018/19 Annual Performance Plan. [↑](#footnote-ref-27)
28. Source: Council for Medical Schemes. [↑](#footnote-ref-28)
29. Source: Council for Medical Schemes. [↑](#footnote-ref-29)
30. Source: Parliament of the RSA. [↑](#footnote-ref-30)
31. Source: Council of Medical Schemes. [↑](#footnote-ref-31)
32. Source: Council of Medical Schemes. [↑](#footnote-ref-32)
33. Source: Council of Medical Schemes. [↑](#footnote-ref-33)