THE COMMENTATOR

1. The commentator is Day 1 Health (Pty) Ltd ("Day 1"), a company with limited liability duly incorporated in terms of the Company laws of the Republic of South Africa. The business of Day 1 relates to medical stated benefit insurance. Day 1 provides short term and long term insurance and preventative healthcare benefits. These benefits are provided under the name and trade mark DAY 1. Day 1 is not and does not profess to be, a medical scheme.

2. Day 1 is directly and adversely affected by the draft Demarcation Regulations ("the regulations") which the Minister on 2 March 2012[1] gazetted and which ostensibly seek to better balance the relationship between medical schemes and health insurance products.[2]

3. It is to be noted that some of the arguments advanced herein are a repetition of certain arguments, suitably amended by the changes called for by the context, already advanced by Day 1 in its submission in respect of the proposed amendment to the definition of "business of a medical scheme" as proposed in the Financial Services Laws General Amendment Bill 2012.

THE LEGISLATIVE FRAMEWORK WITHIN WHICH THE REGULATIONS FALL TO BE CONSIDERED

4. The Media Statement and the Explanatory Memorandum state that the regulations are designed to give effect to the amendments made by the Insurance Laws Amendment Act of 2008, to allow for specific categories of health insurance products which will be allowed to be sold to the public despite such products constituting the "business of a medical scheme" as

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1 The Minister of Finance

2 See Media Statement Minister of Finance releases Draft Regulations on the Demarcation between Health Insurance Policies and Medical Schemes dated 2 March 2012 ("Media Statement")

defined in the Medical Schemes Act (MS Act).[3] (emphasis added)

5. This statement is immediately misleading.

6. The phrase *"despite such products constituting the 'business of a medical scheme' as defined in the Medical Schemes Act (MS Act)"* implies that there are currently health insurance products which are sold to the public which constitute "the business of a medical scheme".

7. This is not the case.

8. The lawful demarcation of products which may be sold as accident and health policies under the STIA and products which on the other hand constitute the business of a medical scheme was clearly set out by the Supreme Court of Appeal in Guardrisk Insurance Co Ltd v Registrar of Medical Schemes and Another 2008 (4) SA 620 (SCA) at par [18], where the SCA held that when the relevant provisions of the STI Act and the MS Act are read conjunctively in terms of the ordinary literal meaning of the words "and" and "or", there is no conflict between them. (emphasis added).

9. It is nevertheless so that subsequent to the handing down of the Guardrisk decision, the legislature commenced a new framework relating to demarcation between insurance business (accident and health policies and health policies) and medical schemes which began with enactment of the Insurance Laws Amendment Act no 27 of 2008 ("Act 27 of 2008").[4] Act 27 of 2008, so it is claimed, introduced provisions in the LTIA and the STIA to facilitate a clear demarcation between what constitutes insurance business (namely "health policies" and "accident and health policies" in the respective

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3 Media Statement issued by National Treasury dated 2 March 2012 par 4

4 R 9706, GG 2 March 2002, no 35114, p. 9

Acts) and what constitutes the "business of a medical scheme".[5] The draft regulations, so it is claimed, are simply the detailed regulation of matters provided for in the STIA. They elaborate on policy and principles entrenched in the Act by prescribing detailed and technical matters.[6]

10. These provisions in Act 27 of 2008, so claims the Explanatory Memorandum, afford the Minister of Finance legislative authority to make regulations that identify certain categories of contracts as health policies or accident and health policies[7], despite the fact that those contracts may be interpreted as doing the business of a medical scheme.[8] The explanatory memorandum goes so far as to state: "the Short-term Insurance Act [and Long Term Insurance Act] ... delegates legislative (law-making) and other authority to implement and enforce the Act to the Minister of Finance".[9]

11. These statements are important. It should be noted that to the extent that the STIA and LTIA indeed delegate legislative authority to the Minister, the STIA and LTIA are unconstitutional. This is dealt with under the second ground of unlawfulness set out below.

12. Before dealing with this, it is necessary to consider the enabling legislation as the regulations make no sense without an understanding thereof. The nature and effect of the original legislation is summarised briefly below.

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5 It should be noted that the date of commencement of these new definitions has yet to be determined by the Minister. (see Insurance Laws Amendment Act 27 of 2008, definitions of "health policy" and "accident and health policy".

6 R 9706, GG 2 March 2002, no 35114, p. 11

7 R 9706, GG 2 March 2002, no 35114, p. 9; The problem with legislative authority bestowed on the Minister is dealt with in the second ground of unlawfulness below.

8 The only contracts which may lawfully be interpreted as doing the "business of a medical scheme" are those which fall foul of the exclusion as conjunctively interpreted in Guardrisk Insurance Co Ltd v Registrar of Medical Schemes & another [2008] 3 All SA 431 (SCA)

9 R 9706, GG 2 March 2012, no 35114, p. 11, par 6.1; See also Explanatory Memorandum in respect of the Regulations under the LTIA, see R 9706, GG 2 March 2012, no 35114, p. 11, par 6.1

THE CURRENT DEFINITION OF ACCIDENT AND HEALTH POLICY AND THE ENABLING LEGISLATION

13. Although the regulations seek to regulate both the "health policy" under the Long-Term Insurance Act 52 of 1998 ("LTIA") and the **"accident and health policy"** under the Short Term Insurance Act no 53 of 1998 ("STIA"), their effect under STIA will be focused on here. As the terms of the relevant wording in the definitions of accident and health policy under STIA and the wording which applies in respect of health policies under LTIA are identical, the analysis in respect the one Act holds good for the other.

14. The current definition of **"accident and health policy"** under STIA reads: -

> **"accident and health policy" means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if a —**
>
> **(a) disability event;**
>
> **(b) health event; or**
>
> **(c) death event,**
>
> **contemplated in the contract as a risk, occurs, but excluding any contract—**
>
> **(d) of which the contemplated policy benefits—**
>
> **(i) are something other than a stated sum of money;**
>
> **(ii) are to be provided upon a person having incurred, and to defray, expenditure in respect**

of any health service obtained as a result of the health event concerned; and

(iii) are to be provided to any provider of a health service in return for the provision of such service; or

(e)

(i) of which the policyholder is a medical scheme registered under the Medical Schemes Act, 1967 (Act No. 72 of 1967);

(ii) which relates to a particular member of the scheme or to the beneficiaries of such member; and

(iii) which is entered into by the scheme to fund in whole or in part its liability to such member or beneficiaries in terms of its rules;

and includes a reinsurance policy in respect of such a policy;

(Editorial Note: Definition of "accident and health policy" to be substituted by s. 27 (a) of Act No. 27 of 2008 with effect from a date to be determined by the Minister by notice in the Gazette – date not fixed.)

15. Excluded from the ambit of the current definition of accident and health policy, are insurance contracts wherein the contemplated policy benefits, when read collectively/conjunctively, are (i) something other than a stated sum of money; (ii) to be provided upon a person having incurred, and to

defray, expenditure in respect of any health service obtained as a result of the health event concerned; and (iii) to be provided to any provider of a health service in return for the provision of such service.[10]

16. Such excluded contracts under the current definition constitute the business of a medical scheme and are hence prohibited.[11]

17. On 15 December 2008, the Council of Medical Schemes ("the CMS"), after having failed to outlaw Guardrisk's policies in the SCA and having failed also to persuade the Constitutional Court that it should be granted leave to appeal against the decision of the SCA, procured the enactment by Parliament of the Insurance Laws Amendment Act 27 of 2008.

18. The relevant purpose of the Act 27 of 2008 is stated as being to amend STIA and to substitute certain definitions and to provide for matters connected therewith.[12]

19. The relevant amendment to the definition of "accident and health policy" seeks to enable the Minister to legislate a new definition of "accident and health policy" by regulation. This process is constitutionally impermissible and the effect hereof is dealt with below under the second ground of unlawfulness.

20. For the moment it falls to be noted that Act 27 of 2008 seeks to amend the relevant definition by means of a bifurcated process that consists in;

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10 Guardrisk Insurance Co Ltd v Registrar of Medical Schemes & another [2008] 3 All SA 431 (SCA)

11 See Guardrisk Insurance Co Ltd v Registrar of Medical Schemes & another (*supra*). It should be noted that the present submission ignores the changes to the definition of "business of a medical scheme" that are proposed in the Financial Services Laws General Amendment Bill of 2012. Representations in respect of those changes have already been made by Day 1 in its submission dated 2 May 2012.

12 See long title to Act 27 of 2008

20.1. firstly amending the definition of "accident and health policy";[13] and

20.2. secondly amending the Minister's power's to make regulations and in particular inserting into the relevant section, two new powers under subsections (2A) and (2B) of section 70 of STIA.[14]

21. As will be shown below, only the second of these statutory amendments has been passed into law.

NEW DEFINITION OF ACCIDENT AND HEALTH POLICY

22. The new definition of "accident and health policy" under Act 27 of 2008 provides: -

> **a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if a disability, health or death event contemplated for in the contract as a risk event occurs, and includes a reinsurance policy in respect of such a contract –**
>
> **(a) Excluding any contract –**
>
> **i. That provides for the conduct of the business of medical scheme referred to in section 1(1) of the MS Act; or**
>
> **ii. Of which the policyholder is a medical scheme registered under the MS Act and which contract-**

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13 Section 27 of Act 27 of 2008
14 Section 52(d) of Act 27 of 2008

1. **Relates to a particular member of the scheme or to beneficiaries of such member; and**

2. **Is entered into by the medical scheme to fund in whole or in part its liability to the member or the beneficiaries of the member referred to in subparagraph (1) in terms of its rules; but**

(b) Specifically including, despite paragraph (a)(i) any category of contracts identified by the Minister by regulation under section 70(2A) as an accident and health policy.

23. The date of commencement of this new definition of "accident and health policy" is still to be determined by the Minister by notice in the *Gazette* and the new definition has in fact not yet become law.[15]

24. The old definition of "accident and health policy" thus continues to remain in force to this day.

25. This is very important.

THE MINISTER'S POWER TO MAKE REGULATIONS

26. A new section 70(2A) was inserted into STIA by Act 27 of 2008.

27. In terms hereof at section 70(2A) of STIA: -

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15 See STIA no 53 of 1998, accident and health policy, see also section 27 of Act 27 of 2008

"The Minister may make regulations not inconsistent with this Act -

....

(a) the Minister despite the definition of "business of a medical scheme" in section 9(1) of the Medical Schemes Act ***[no such definition is to be found in the MS Act at section 9(1)]*** *may make regulations identifying a kind, type or category of contract as an accident and health policy.*

28. In terms of s 70(2A)(b) *Regulations under paragraph (a): –*

"(i) Must be made only –

a. In consultation with the Minister of Health

b. After consultation between the National Treasury, the Registrar and the Registrar of Medical Schemes established under the MS Act; and

c. After having regard to the objectives and purpose of the MS Act including the following principles entrenched therein –

i. Community rating;

ii. Open enrolment; and

iii. Cross-subsidization within medical schemes; and

(ii) ...

(iii) May provide for matters relating to the design and marketing of any product within a kind, type or category of

contract referred to in paragraph (a).

29. In terms of section 70(2A)(c) *Where the Minister has made regulations referred to in paragraph (a), the kind type or category of contract identified as a health policy in the regulations, is subject to this Act and not the Medical Schemes Act.*

30. Finally in terms of section 70(2B) *Before regulations in terms of this Act are promulgated, the Minister must publish the draft regulations in the Government Gazette for public comment and submit the regulations to Parliament, while it is in session, for parliamentary scrutiny at least one month before their promulgation.*

31. The Minister's power to make regulations is defined by Section 70 of STIA.

32. The enabling legislation gives the Minister the power:-

32.1. to make regulations *identifying* a kind, type or category of contract as an accident and health policy (section 70(2A)(a)); and

32.2. provides that the regulations may provide for matters relating to *the design and marketing* of any product within a kind, type or category of contract referred to in paragraph (a). (section 70(2A)(b)(iii))

33. <u>THE REGULATIONS</u>

33.1. The Regulations published in GG no 35114 dated 2 March 2012: -

33.1.1. list categories of contract *identified* as accident and health policies under paragraph (b) of the definition of the [new still to be promulgated definition of] accident and health policy. (see section 7.2(1)) [this list is comprehensive and includes

eg lump sum or income replacement policy benefits payable on a health event; motor third party liability, property third party liability; HIV and aids; travel insurance; emergency evacuation or transport];

33.1.2. state what a contract referred to in sub-regulation (1) may not do (section 7.2(2)).

33.1.2.1. In this regard the critical provision is 7.2(2)(d) "*A contract referred to under sub-regulation (1) may not* -in relation to a contract *referred to in category 1* in the table under sub-regulation (1) *provide policy benefits that are fully or partially related to indemnifying the policyholder against medical expenses in respect of a relevant health service*"

33.1.3. set out Rules relating to the marketing of contracts referred to under regulation 7.2;

33.1.4. set out Rules relating to the reporting of product information; and

33.1.5. set out transitional arrangements which serve to more precisely identify the categories of contract which are affected by the Ministerial identification and to state the consequences flowing therefrom.

REGULATIONS UNLAWFUL

34. The regulations are unlawful for the following reasons.

35. FIRST GROUND OF UNLAWFULNESS – REGULATIONS INCONSISTENT WITH THE ACT

35.1. The Minister has not placed his ducks in a row and the regulations are for this reason unlawful and of no legal force and effect.

35.2. While STIA in its current format does enable the Minister to make regulations identifying a kind type or category of contract as an accident and health policy (section 70(2A)(a)), these regulations are required not to be inconsistent with the Act.

35.3. The Act is STIA.

35.4. STIA has a definition of "accident and health policy". This definition is referred to above and is, it is stressed, the old definition of accident and health policy.

35.5. In terms of the current definition of accident and health policy (namely the old definition), it is to be recalled the only contracts which are excluded from the ambit of an accident and health policy, are insurance contracts wherein the contemplated policy benefits are, when read collectively, (i) something other than a stated sum of money; (ii) to be provided upon a person having incurred, and to defray, expenditure in respect of any health service obtained as a result of the health event concerned; and (iii) to be provided to any provider of a health service in return for the provision of such service.[16]

35.6. To be valid therefore, in terms of the Act, the Minister's regulations must fall within these parameters.

35.7. In terms of regulation 7.2(2)(d), however, it is the presence of only one

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16 Guardrisk Insurance Co Ltd v Registrar of Medical Schemes & another (*supra*)

of the factors referred to in the paragraph but one above – namely a provision in the contract to *provide policy benefits that are fully or partially related to indemnifying the policyholder against medical expenses in respect of a relevant health service* - that is sufficient to render the contract unlawful.

35.8. The regulations are thus clearly inconsistent with the Act – they are inconsistent with the current definition of "accident and health policy" and they are hence *ultra vires* and unlawful.[17]

35.9. The regulations clearly assume wrongly that the new definition of "accident and health policy" has come into effect.

35.10. This invalid assumption is vividly confirmed by Annexure 1 to Schedule B of the regulations, being "Extract from the Short-Term Insurance Act". The definition of "accident and health policy" contained therein wrongly cites the *new definition* as being the relevant definition of the term.[18]

35.11. The assumption of the Minister is thus invalid – the date of commencement of this new definition of "accident and health policy" is still to be proclaimed and the regulations contradict the relevant definition contained in the Act.

35.12. The above submission necessarily has the consequence that even if the Act should be amended, any further amended regulation may not

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17 See R v Hildick-Smith 1924 TPD 69, 75 "the question whether a regulation is reasonable is only a branch of the question whether it is *ultra vires*. In Struben v Minister of Agriculture 1910 TS 903 Mason J stated that *the first question to decide was the whether there was the power to make the regulation at all* and the second question whether the regulation was so unreasonable as to be *ultra vires*."; Pharmaceutical Manufacturers Association of South Africa and another: In re Ex parte President of the Republic of South Africa and others 2000 (2) SA 674 (CC) at par [20]

18 R 9706, GG 2 March 2002, no 35114, p. 16

be promulgated before it is again published for public comment in terms of section 70(2B) of STIA.

36. SECOND GROUND OF UNLAWFULNESS – UNCONSTITUTIONAL DELEGATION OF PLENARY POWER

36.1. And even if the regulations are not inconsistent with the Act, which is denied, section 70(2A) of STIA constitutes an unconstitutional delegation of plenary power to the Minister and is hence invalid. This is because section 70(2A) of STIA is a "Henry VIII" clause, being a provision in an Act of Parliament empowering someone (the Minister) to make regulations amending that Act or another Act.[19]

36.2. The Minister is given the power to make regulations identifying a kind, type, or category of contract as an accident and health policy and to provide for matters relating to the design and marketing of any such product. In so doing he can effectively amend and repeal the existing statutory definition of "accident and health policy". This is indeed exactly what he has sought to do.

36.3. Such clauses are constitutionally impermissible. In terms of the Constitution, the national legislative authority is vested in Parliament (section 43 of Act 108 of 1996) and, save as permitted by the Constitution, Parliament may not delegate plenary power to amend an Act of Parliament.[20] It may certainly not delegate legislative power to any person other than a legislative body in another sphere of government. (section 44(a)(iii) of Act 108 of 1996). The regulations therefore and because they are promulgated under invalid original

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19 Exec Council of Western Cape Legislature v President of RSA 1995 (10) BCLR 1289 (CC) at par [218]

20 Exec Council of Western Cape Legislature v President of RSA (*supra*) at par [62]; see section 44 of Act 108 of 1996

legislation, are, for this reason, also invalid.

36.4. As was stated by the Constitutional Court in Executive Council, Western Cape Legislature, and Others v President of the Republic of South Africa and Others 1995 (4) SA 877 (CC) (1995 (10) BCLR 1289) in para [51]: -

> *"The legislative authority vested in Parliament under s 37 of the Constitution is expressed in wide terms - "to make laws for the Republic in accordance with this Constitution". In a modern State detailed provisions are often required for the purpose of implementing and regulating laws and Parliament cannot be expected to deal with all such matters itself. There is nothing in the Constitution which prohibits Parliament from delegating subordinate regulatory authority to other bodies. The power to do so is necessary for effective law-making. It is implicit in the power to make laws for the country and I have no doubt that under our Constitution Parliament can pass legislation delegating such legislative functions to other bodies. There is, however, a difference between delegating authority to make subordinate legislation within the framework of a statute under which the delegation is made, and assigning plenary legislative power to another body, including, as s 16A does, the power to amend the Act under which the assignment is made."*

36.5. The regulations therefore and because they are promulgated under invalid original legislation which assigns plenary power to the Minister,

(section 70(2A)(a) of STIA) are, for this reason, also invalid.

37. THIRD GROUND OF UNLAWFULNESS – ENABLING LEGISLATION VAGUE AND AMBIGUOUS AND THEREFORE UNCONSTITUTIONAL

37.1. The original legislation in terms of which the regulations are promulgated namely section 70(2A) of the STIA is vague and ambiguous.[21]

37.2. It refers to the Minister, despite the definition of "business of a medical scheme" in section 9(1) of the Medical Schemes Act, having the power to make regulations.[22] Yet there is no definition of "business of medical scheme" in section 9(1) of the Medical Schemes Act.

37.3. Section 9(1) of the Medical Schemes Act is headed "Committees of Council" and deals with committees within the Council for Medical Schemes. The "business of a medical scheme" is elsewhere defined in section 1 of the Medical Schemes Act.

37.4. Because it is vague, section 70(2A) of STIA is unconstitutional and violates the rule of law set out in section 1(c) of the Constitution The vagueness of the original legislation similarly taints the regulations promulgated thereunder.

37.5. A statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process law." *Vide* also National Coalition for Gay and Lesbian Equality & another v Minister of Justice & others 1998 (2) SACR 102

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21 Section 70(2A)

22 See also section 72(2A) of LTIA

(W) [also reported at [1998] JOL 2355 (W) – Ed] where the Court, with apparent approval, *inter alia*, at 118a – b quoted the last sentence in the above quotation from *Connolly's* case and at 118c – e the following *dictum* in another American decision: -

> *"In Papachristou v City of Jacksonville 405 US 156 Douglas J speaking for the Court said at 162: 'This Ordinance is void for vagueness, both in the sense that it "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the Statute" . . . and because it encourages arbitrary and erratic arrests and convictions . . . Living under a rule of law entails various suppositions, one of which is that "all persons are entitled to be informed as to what the State commands or forbids" Lanzetta v New Jersey 306 US 451, 453.'.* [23]

38. FOURTH GROUND OF UNLAWFULNESS – NEW POWERS CONFERRED ON REGISTRAR OF MEDICAL SCHEMES – *ULTRA VIRES* THE STIA

38.1. In terms of regulation 7.5: -

38.1.1. an insurer[24] must 3 months after this Part comes into operation submit a summary of the benefits, terms and conditions and marketing material of all accident and health policies referred to in this Part introduced on or after 15 December 2008 to the Registrar of Medical Schemes;

38.1.2. The Registrar of Medical Schemes may within the 3 months

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23 S v Kubheka [2011] JOL 27424 (GSJ) at par 83 - 84

24 In terms of the regulations "insurer" means a short-term insurer or a Lloyds underwriter. (regulation 7.1)

referred to under sub-regulation (1) or at any time thereafter, advise the Registrar that the Registrar of Medical Schemes is of the opinion that the benefits, terms and conditions or marketing material concerned is contrary to the objectives and purpose of the Medical Schemes Act as set out in that Act, with specific reference to sections 70(2A)(b)(i)(cc)(A) to (C) of the Act, and the reasons for his opinion;

38.1.3. The registrar may within the 3 months referred to under sub-regulation (1) or at any time thereafter, of the Registrar's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to under sub-regulation (2), by notice to the insurer object to any of the benefits, terms and conditions and marketing material of an accident and health policy under sub-regulation (1), and –

38.1.3.1. Instruct the insurer to stop offering or marketing those accident and health policies to the public and within 90 days of the date determined by the Registrar, terminate any accident and health policy; or

38.1.3.2. Instruct the insurer, by a date determined by the Registrar, to amend any of the benefits, terms and conditions and marketing material of an accident and health policy in accordance with the requirements of the Registrar before offering those health policies or renewing any existing accident and health policies to the public.

38.2. Regulation 7.5 is *ultra vires* the statute in that it confers the Registrar for Medical Schemes with a regulatory power over registered insurers which does not exist in the STIA and which has hitherto not existed.

38.3. By conferring the Registrar for Medical Schemes with new a regulatory power over registered insurers, the Regulations contradict the STIA.

38.3.1. A registered short-term insurer under the STIA is governed by the Registrar of Short-Term Insurance referred to in section 2 of STIA.

38.3.2. The Registrar of Short-Term Insurance has the power to register the insurer, to impose conditions on registration, to vary registration conditions, under certain circumstances to prohibit short-term insurers from carrying on business, and to terminate registration.[25]

38.3.3. Such limitations on business, other than the short-term insurance business which it is authorized to carry on by virtue of its registration under section 9, are limitations which may be imposed on the business of a short-term insurer *by the Registrar* of STIA in terms of section 15 of the STIA. STIA prescribes that these limitations may only take place under certain defined conditions including that the limitation *be in the interests of the policyholders* of a particular short-term insurer or short-term insurers in general.[26]

38.3.4. Insurers under the STIA are quite simply neither required to have anything to do with, nor subject to the authority of the

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25 See ss 9, 10, 11, 12 and 13 of STIA

26 Section 15(3)(a)

"Registrar of Medical Schemes".

38.3.5. Yet the regulations by requiring relevant insurers under STIA to submit a summary of benefits to the Registrar of Medical Schemes create a new departure in terms whereof the Registrar of Medical Schemes is granted authority over insurers.

38.3.6. By requiring these relevant insurers registered under STIA to submit a summary of the benefits, terms and conditions and marketing material of all accident and health policies ... to the *Registrar of Medical Schemes*, the Minister has issued regulations which are inconsistent with the registration provisions of the Act.

38.3.7. The regulations are for this reason *ultra vires*, unreasonable and unconstitutional.

39. FIFTH GROUND OF UNLAWFULNESS – RETROSPECTIVITY

39.1. The regulations are also retrospective.

39.2. Regulation 7.5 by potentially outlawing all contracts launched on or after 15 December 2008, being contracts which until now have been lawful, offends against the general rule that statutes should be considered as affecting future matters only.[27]

39.3. There is a presumption against retrospectivity in statutes and unless otherwise provided, a statute is not to be interpreted as extinguishing existing rights and obligations. This is basic to the notions of justice

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[27] Curtis v Johannesburg Municipality 1906 TS 311

and fairness and integral to the rule of law.[28]

39.4. Retrospective statutes interfere with vested rights – they look backwards in that they attach new consequences for the future to an event that took place *before* the statute was enacted. A retrospective statute changes the law from what it otherwise would be with respect to a prior event.[29]

39.5. Regulation 7.5 does all of this. Contracts of insurance entered into on or after 15 December 2008 and until now lawful, are now vulnerable to being summarily terminated by the Registrar.

39.6. It is for this reason unconstitutional in that it offends against the rule of law.

39.7. It also offends against section 25 of the Constitution in terms of which "no law may permit arbitrary deprivation of property". In terms of section 25 of the Constitution "property" comprises land and other corporeals.[30] A policy is a corporeal item in the favour of the policyholder.

39.8. Legislative measures are arbitrary when they bear no rational relationship to the legislative goal they are intended to achieve.

39.9. The legislative goal sought to be achieved is the protection of medical schemes (see above).

39.10. It is not clear why outlawing contracts launched or introduced after 15 December 2008 and which have been lawful until now, bears any rational relationship to either this legislative goal or to any other

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28 Veldman v DPP (WLD) 2007 (9) BCLR 929 (CC) at pars 26-27
29 National Director of Public Prosecutions v Carolus 2000 (1) SA 1127 (SCA) par 34
30 Lebowa Mineral Trust Beneficiaries Forum v President of the RSA 2002 1 BCLR 23 (T) at 31

legislative goal sought to be achieved.

40. SIXTH GROUND OF UNLAWFULNESS – THE REGULATIONS OFFEND AGAINST THE CONSTITUTION ACT 108 of 1996

40.1. The exercise of all legislative power is subject to at least two constitutional constraints. The first is that there must be a rational connection between the legislation and the achievement of a legitimate government purpose.[31]

40.2. The question whether legislation is rationally connected to the government purpose calls for an objective enquiry. Otherwise a decision that, viewed objectively, is in fact irrational, might pass muster simply because the person who took it mistakenly and in good faith believed it to be rational. Such a conclusion would place form above substance and undermine an important constitutional principle.[32]

40.3. The other constitutional constraint is the Bill of Rights. Legislation must not infringe any of the fundamental rights enshrined in the Bill of Rights.[33] The rights however may be limited by a law of general application. Such a limitation is limited by the limitations contained in section 36(1) of the Constitution or "elsewhere in the Bill of Rights". A limitation that does not

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31 The idea of a constitutional state presupposes a system whose operation can be rationally tested. Thus when Parliament enacts legislation that differentiates between groups and individuals, it is required to act in a rational manner. In New National Party v Government of the RSA &ors 1999 (3) SA 191 (CC) the Court held that the rational connection test is the standard for reviewing legislation holding that "the first of the constitutional constraints placed upon Parliament is that there must be a rational connection between the scheme it adopts and the achievement of a legitimate government purpose. Parliament cannot act capriciously or arbitrarily. The absence of such a rational connection will result in the measure being unconstitutional. (see Affordable Medicines Trust &ors v Minister of Health RSA & another 2005 (6) BCLR 529 (CC) at par [74])

32 Affordable Medicines Trust &ors v Minister of Health RSA & another (supra) at par [75]

33 Affordable Medicines Trust &ors v Minister of Health RSA & another (supra) at par [76]

comply with such limitations, infringes the right in question.[34]

40.4. It is submitted the demarcation regulations fails both tests.

41. **DEMARCATION REGULATIONS NOT RATIONALLY CONNECTED TO A LEGITIMATE GOVERNMENT PURPOSE**

41.1. The assumptions of the demarcation campaign are set out in the Explanatory Memorandum to the Demarcation Regulations which suggests that accident and health policies and health insurance policies (providing similar benefits to medical schemes) may result in: –

41.1.1. younger and healthier members terminating, limiting or reducing their medical scheme cover;

41.1.2. a negative impact on the life-cycle protection offered by medical schemes; and

41.1.3. medical schemes reducing benefits.[35]

42. FIRST BASIS OF IRRATIONALITY – SUSPICIONS OF MEDICAL SCHEMES THAT THEY ARE BEING UNDERMINED UNPROVEN AND UNFOUNDED

42.1. Until now health insurance products have been lawfully marketed to the public under the STIA and the LTIA.

42.2. The legislature's intentions until now are perhaps best summed up by the words of the Court in Guardrisk, namely that ***"practical reality has shown that there exists a need for this type of insurance and there seems to be no reason why it should not be permitted."***[36]

42.3. The intentions of Parliament, which amount to no more than a recitation

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34 Affordable Medicines Trust &ors v Minister of Health RSA & another (supra) at par [77]
35 R9706, GG 2 March 2002, no 35114, p. 9
36 Guardrisk at par 22

of the paramount rule of statutory interpretation,[37] must not, however, be confused with the intentions of the Council for Medical Schemes ("the CMS").

42.4. While the legislature has always until now permitted the marketing of health insurance products, this marketing for a long time has taken place against the background of a *"battle for turf"* launched by the CMS. For want of a better word this may be the so-called "**demarcation campaign**".

42.5. The CMS is a statutory body established in terms of section 3 of the MSA and was originally constituted under the now repealed Medical Schemes Act no 72 of 1967.

42.6. The functions of the CMS are *inter alia* to control and co-ordinate the functioning of medical schemes; to advise the Minister on any matter concerning Medical Schemes and to collect and disseminate information about private health care.[38]

42.7. On a reading of the MSA and section 7 thereof in particular, it is not difficult to understand that the primary function of the CMS is to protect the interests of medical schemes registered under section 24 (1) of the MSA.

42.8. The CMS has a vested interest in protecting what it perceives to be the best interests of medical schemes. It is submitted that its vested interest has served to fundamentally compromise its impartiality.[39]

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37 See LAWSA, Statute Law & Interpretation, Vol 25(1), 2nd ed, par 315

38 See section 7 of Act 131 of 1998

39 The extent to which a vested interest may distort the evaluation of what is fair and just has been noted by the Courts.That fairness and justice are underlying aims of our constitutional order is uncontroversial. Most legal systems would subscribe to these values. Central to the idea of fairness, writes Amartya Sen, is: '(A) demand to avoid bias in our evaluations, taking note of the interests and concerns of others as well, and in particular the need to avoid being influenced by our respective vested interests, ... It can broadly be seen as a demand for impartiality.' See Law Society of the Northern Provinces v Mahon 2011 (2) SA 441 (SCA) at par [31]

42.9. The CMS's vested interest requires assessment from a constitutional perspective. Given that the Constitution is both the supreme law of the Republic (section 2 of Act 108 of 1996) and that the Constitution provides that everyone has the right to have access to health care services and the state must take reasonable measures, within its available resources to achieve the progressive realisation of this right, the question is whether the state in the context of the present regulations, and guided by the vested interests of the CMS with respect to its "demarcation campaign", has achieved what public policy and the Constitution demands"?

42.10. It is submitted that the answer to this question is "no".

42.11. The reasons therefor are set out below.

42.12. The premise behind the regulations is that accident and health policies and health policies that provide similar benefits to medical schemes serve to undermine medical schemes in that the sale of these products may result in –

- Younger and healthier members terminating, limiting or reducing their medical scheme cover;
- A negative impact on the life-cycle protection offered by medical schemes; and
- Medical schemes reducing benefits.[40]

42.13. The accompanying media statement clarifies what the regulations are designed to achieve – namely to outlaw most, if not all, health insurance products on the grounds that these products pose a threat to medical schemes.

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40 R 9706, GG 2 March 2002, no 35114, p. 9

42.14. The explanatory memorandum holds that a clear demarcation between accident and health policies and medical schemes is necessary to support and enhance the objectives and purpose of Medical Schemes Act no 131 of 1998, which entrenches the principles of community rating, open enrolment and cross-subsidisation, within medical schemes.[41] The critical statement contained in the Media Statement accompanying the Regulations is the following: *In determining whether a health insurance product should be allowed to be sold, consideration will be given to its impact on medical schemes.* In determining whether health insurance products will or will not be sold to the public, regard was given to the objectives of the MS Act and the current and potential harm that a health insurance policy may cause to medical schemes environment. *Health insurance products which will be allowed to be sold to the public in terms of the Regulations will fall outside the scope of the MS Act* and will be subject to regulatory oversight by the FSB.[42]

42.15. The alleged adverse impact of health insurance products on medical schemes is both the impetus for and trigger of these regulations.

42.16. It should be noted that the fear of Medical Schemes that they are allegedly undermined by insurance companies is an old one and antedates the Constitution of the RSA no 106 of 1996.

42.17. Thus in the Health Finance Committee Report submitted to the Department of Health in 1994 (this is before the Medical Schemes Act 1998 came into effect) the report concluded "insurance companies do not fall under the Medical Schemes Act and now attract particularly the young and healthy into short-term insurance schemes which are very close to medical schemes. This is a threat to the viability of medical

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41 R 9706, GG 2 March 2002, no 35114, p. 9

42 Media Statement pars 5 and 6

aids which rely on cross-subsidies."[43]

42.18. Despite these fears, the number of beneficiaries in registered medical schemes in the decade 1999 to 2009 increased from 5.975 million in 1999 to 8.1 million in 2009, this is an increase of 35.5 %.[44]

42.19. There does not moreover, appear to have been a significant increase in the average age of beneficiaries in medical schemes. In fact the average age of beneficiaries in medical schemes has declined in the recent past. In 2006 the average age of beneficiaries was 32.0 years and this reduced to 29.3 in 2010.

42.20. In decrying health insurance products the Minister overlooks conclusions that have been long accepted within the industry. Thus for example the 1994 *Melamet Commission*[45] which was charged with enquiring into the manner of providing for medical expenses, whilst suggesting that both long and short term insurance show health as an entirely different class of business, nonetheless recommended that these insurers should be allowed to continue to sell these products.[46]

The suspicion that Medical Schemes are allegedly being undermined by insurance companies is not valid.

42.21. The central premises of the regulations and indeed the proposed amendment to the definition of business of medical scheme - namely that health insurance products serve to undermine medical schemes and that young and healthier members are terminating, limiting or reducing their medical scheme cover - are contentions which are unproven.

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43 See LAWSA, Vol 13(2), Olivier & Smit, Social Security Law, par 224

44 Council for Medical Schemes, Year Report 2000, read with Annual Report Council for Medical Schemes 2009, figure 14

45 This Commission reported on 14 April 1994

46 Speaker notes for Melamet Commission Presentation

42.22. The argument is presented as a proposition, the truth of which is self-evident.

42.23. Yet this proof does not in fact exist.

42.24. It is true that certain studies produced by the Council for Medical Schemes contain figures which suggest that membership of medical schemes declines in the age group 25-29.[47]

42.25. There is however, no indication that this represents a permanent loss in membership to the schemes.

42.26. The very same graphs that show a decline in membership for the ages 25-30, show that membership increases in the ages 30-34 and 35-39 and this pattern continues over time suggesting that whereas persons aged 25–30 might temporarily not join medical schemes, they do so later in life.

42.27. Compounding all of the above it is understood that Treasury have been requested to provide proof that gap cover undermines medical schemes and that Treasury has conceded that there is no evidence that gap cover undermines the risk pool of medical schemes.

43. SECOND GROUND OF IRRATIONALITY – DENYING THE CONSUMER OF BOTH A CHOICE AND THE OPTION OF INSURING FOR THE EXTENT OF MEDICAL COSTS NOT COVERED BY MEDICAL SCHEMES

43.1. While the clear primary object of the regulations is to protect medical schemes, the explanatory memorandum also claims that a clear demarcation between accident and health policies (providing benefits that appear similar to that of medical schemes) and medical schemes

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47 See Council for Medical Schemes Annual Report 2009, p. 160, age and gender distribution of beneficiaries

is necessary to protect consumers/policyholders.[48]

43.2. The Minister claims that the absence of a clear demarcation may result in consumers believing: –

- That accident and health policies offer the same protection as a medical scheme, when in fact the protection is partial and conditional; and/or
- The accident and health policies are medical schemes.

43.3. If the Minister seeks to suggest that medical schemes offer full and unconditional protection he respectfully misleads the public.

43.4. It is notorious that medical scheme cover is both partial and capped (a fact proved by the existence of the "gap-cover industry" which the Minister now proposes to outlaw). It is a known fact that certain medical specialists charge on average between 350% and 440% of a scheme's tariff. The highest benefit option on most medical schemes is not greater than 300% of the scheme's tariff. Specialists have even adopted a two-tier billing system where a scheme is billed and the rate above scheme tariff billed to the individual consumer.

43.5. Furthermore many benefits under a medical scheme are conditional. It not unknown for example for medical schemes to require the member to give the scheme prior written notice before the acceptance by the scheme of liability for the cover of a relevant medical procedure.

43.6. As to bullet two referred in paragraph 43.2 above, as long as accident and health policies are marketed in "plain language", which explain that they are not medical schemes, a proposal with which Day 1 has

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[48] R 9706, GG 2 March 2002, no 35114, p. 9

no quarrel, there should be no danger of consumers being confused.

43.7. Not only is it strongly denied that the regulations are required to protect consumers, but the reverse is in fact true - consumer choice will be massively limited by the regulations and the patronizing claim of the Explanatory Memorandum of consumer protection is hollow and false.

43.8. The regulations by effectively outlawing health insurance products will deny the consumer a choice and the opportunity to insure for medical costs not covered by medical schemes and is unreasonable and irrational for this reason.

43.9. In this regard the demarcation argument which focuses only on the alleged and unproven negative impact of health insurance products on medical schemes, loses sight of the fact there is a significant and legitimate demand for health insurance products.

43.10. This demand arises firstly because medical schemes do not cover the full extent of medical costs.

43.11. Without an affordable alternative to the gap cover consumers are being denied this essential cover.

43.12. Secondly this demand caters for a different market to the medical scheme market.

43.13. There are a roughly a million families covered by the health insurance market versus a medical scheme market of some 7.8 million active members.

43.14. This is a market which includes many of the old and pensioned who both purchase and are permitted to health insurance products, including so-called gap cover products.

43.15. Contrary to an assumption that underlies this amendment, namely that only medical schemes provide for open enrolment, all persons are permitted to purchase health insurance cover. Indeed any discriminatory limitation on membership is constitutionally impermissible.[49]

43.16. These persons will be denied this option should the regulations be enacted.

43.17. South Africa places a premium on protecting the interests of all consumers and promoting an economic environment that supports and strengthens a culture of consumer rights (see preamble to Consumer Protection Act no 68 of 2008).

43.18. The regulations contradict these objectives.

43.19. They are for this reason not rationally connected to a legitimate government purpose.

44. THIRD GROUND OF IRRATIONALITY – NO CERTAINTY THAT FORMER CONSUMERS OF HEALTH INSURANCE PRODUCTS WILL TRANSFER TO MEDICAL SCHEMES AS OPPOSED TO BECOMING AN INCREASED BURDEN ON FISCUS

44.1. **There is no guarantee that the persons who are currently covered by the health insurance market will transfer to medical schemes should health insurance products be outlawed or effectively outlawed.**

44.2. **While the regulations are an overtly protectionist step aimed at buttressing and shoring up medical schemes - a demarcation necessary to support and enhance the objectives of the Medical Schemes Act no 131 of 1998 - there is no proof that this demarcation will necessarily strengthen medical schemes or make**

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49 Section 9(3) and 9(4) of the Constitution; see also Guardrisk at par [20]

them a more sustainable and desirable product in the market.

44.3. **On the contrary, there is a reasonable possibility that were this market denied the option of health insurance, it may turn to the public health care system and thereby increase the burden on the already stretched public health care sector.**

44.4. Until now, individuals who could afford private health care had the option of either insuring against the risk of ill-health insurance through private insurance products registered under STIA or LTIA, or through becoming members of medical schemes.[50]

44.5. That option will no longer exist if the regulations are promulgated.

44.6. A significant segment of society which hitherto has been able to protect itself from escalating health costs will be denied this protection.

44.7. The regulations are thus likely to deny access to health care services under section 27 of the Constitution to a significant segment of society.

44.8. **It is therefore altogether possible that the regulations may not only fail to achieve their stated objective, but that they may instead deny reasonable access to health care services to a significant segment of society. They are thus not rationally connected to a legitimate government purpose.**

44.9. The SCA was faced with the same arguments in Guardrisk and noted in a passage which remains relevant to this day: -

> *"The respondents advanced the argument that the purpose and aim of the MS Act will be undermined in the event of a literal interpretation of the two relevant definitions. In support of this contention the respondents suggested in the*

founding affidavit that the appellant's policies would encourage younger and healthier members of a medical scheme to choose to subscribe only to minimum benefits of the scheme and supplement their benefits by subscribing to the appellant's cheaper policy. As such the viability of the scheme could be reduced. This contention loses sight of several aspects. First there is no evidence of an analysis of the cost in relation to benefits of the appellant's products compared to cost of membership of a medical aid scheme. Second the suggestion is vehemently challenged by the appellant on the ground of absence of factual support and relevance. Third although the STI Act does not contain a provision similar to section 29(1)(n) of the MS Act, the appellant is obliged not to unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. Although the provisions of the MS Act fundamentally changed the operation of medical schemes in that membership of a medical scheme and through that, access to core health and medical services were made accessible to a broader spectrum of people..... there is no factual indication before us that the policies of the appellant are undermining or would undermine the MS Act, or would in any way affect medical schemes in general."[51] [emphasis added]

45. FOURTH GROUND OF IRRATIONALITY – AMENDMENT ANTI-COMPETITIVE

45.1. South Africa places a premium on creating an efficient, competitive economic environment balancing the interests of workers, owners and consumers, and focused on development that will benefit all South Africans (witness preamble to Competition Act no 89 of 1998).

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50 See LAWSA, Vol 13(2) Social Security Law, par 224

51 Guardrisk at pars [19], [20], [21]

45.2. The regulations serve to counter competition within the health care sector by effectively destroying the health insurance industry.

45.3. Should the regulations become law only medical schemes will operate in this space.

45.4. There is a general consensus that medical care costs are already very high.

45.5. Logically the more competition there is within the medical health care space, the greater is the prospect of prices being contained.

45.6. The publication of the proposed amendment in the FSLGA Bill 2012 coincides with a time when Medical Schemes stand accused of fuelling inflation by the South African Medical Association, which has accused schemes of driving medical inflation by overspending on administration and broker fees.[52]

45.7. By effectively outlawing health insurance products, the regulations serve to strengthen monopolistic tendencies in the provision of private health care.

45.8. Media reports indicate that the Competition Commission is considering initiating a market enquiry into the private health care industry.[53] The deputy commissioner of the Competition Commission is reported as saying that "the commission was likely to commence with an enquiry because of growing concern about the high cost of private healthcare and the effect this had on the public healthcare system."

45.9. Day 1 would welcome such an enquiry.

45.10. The monopolistic effects of the regulations are further reason why it is unreasonable, irrational and unconstitutional.

46. FIFTH GROUND OF IRRATIONALITY – REGULATIONS CONTRADICT PROPOSALS IN RESPECT OF NHI

46.1. The irrational nature of the regulations is aggravated by the extent to which it contradicts the Government's plans for National Health Insurance (NHI).

46.2. The Government has been speaking about introducing NHI for some time.

46.3. The Department of Health issued a green paper on NHI on 12 August 2011.

46.4. The Green Paper states that NHI will ensure that everyone has access to appropriate, efficient and quality health services. It will be phased in over a period of 14 years.[54]

46.5. The Green Paper states that the South African health care system is inequitable with the privileged few having disproportionate access to health services. NHI is intended to ensure that all South Africans will benefit from health care financing on an equitable and sustainable basis.

46.6. The Green Paper specifically states that while membership to the NHI will be mandatory for all South Africans, nevertheless it will be up to the general public to continue with voluntary private medical scheme membership if they choose to do so. Accordingly medical schemes will continue to exist alongside NHI.....The exact form of services that

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52 Business Day 17 April 2012, Medical Aid Schemes "fuelling inflation"
53 Business Day 30 December 2011, Competition Commission may probe healthcare
54 Department of Health, National Health Insurance in South Africa, Policy Paper, 12 August 2011

medical schemes may offer may evolve to include top-up insurance.[55]

46.7. Thus top-up or gap cover insurance is contemplated by the NHI.

46.8. Yet the regulations will effectively outlaw this form of insurance.

46.9. Clearly for this reason alone the regulations are capricious, arbitrary and irrational.

46.10. The regulations are thus not rationally connected to a legitimate government purpose.

47. SIXTH GROUND OF IRRATIONALITY – REGULATIONS EFFECTIVELY TERMINATE HEALTH INSURANCE INDUSTRY

47.1. The regulations irrationally prevent sellers of health insurance from operating.

47.2. This irrationality is compounded when it is understood that there is no guarantee that the stated purpose of the regulations, namely to "support and enhance the objectives and purpose of the Medical Schemes Act no 131 of 1998", will be achieved by the promulgation of the regulations. (see above).

47.3. The regulations thus contradict section 22 of the Constitution which provides that every citizen has the right to choose their trade, occupation or profession freely.

47.4. While it is so that the practice of a trade, occupation or profession may be regulated by law (section 22 of Act 108 of 1996), the Constitution does not permit the regulation of trade or occupation such as that

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55 Department of Health, National Health Insurance in South Africa, Policy Paper, 12 August 2011, p. 43

contemplated by the demarcation regulations which is both irrational and unjustifiable.

48. **THE REGULATIONS CONTRADICT THE BILL OF RIGHTS – IN PARTICULAR THE DUTY TO TAKE REASONABLE LEGISLATIVE MEASURES TO ACHIEVE PROGRESSIVE REALISATION OF THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES**

48.1. According to the Constitutional Court the key to the justiciability of socio-economic rights in the Constitution is the standard of reasonableness.[56]

48.2. Section 27(1) of the Constitution provides that "everyone has the right to have access to (a) health care services, including reproductive health care".

48.3. Section 27(2) of the Constitution provides that "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights".

48.4. Section 27(2) reads precisely the same way as does section 26(2) of the Constitution which relates to housing.

48.5. Thus in terms of section 26(2) it is provided that "the state must take reasonable legislative and other measures, to achieve the progressive realisation of this right."

48.6. In Government of the Republic of South Africa v Grootboom 2000(1) SA 46 (CC) the CC found that measures of the government to provide housing to be unreasonable since no provision was made for temporary shelter for homeless people. This omission was unreasonable since it

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56 LAWSA, vol 5(3), Constitutional Law, 2nd ed, 2004, par 131

ignored those most in need.[57]

48.7. While the precise content of the measures to be adopted is primarily a matter for the legislature and the executive, the legislature and the executive must ensure that the measures they adopt are reasonable. The CC held: "Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The state is obliged to achieve the intended result and the legislative measures will have to be supported by appropriate well directed policies and programs implemented by the Executive. The policies and programs must be reasonable in their conception and implementation. The formulation of the program is only the first stage in the meeting of the State's obligations. The program must also be reasonably implemented. An otherwise unreasonable program that is not implemented reasonably will not constitute compliance with the state's obligations."[58]

48.8. In Grootboom the CC further held that when state policy does not give sufficient weight to the needs of a "significant segment of society" then it may fall short of its obligations and therefore cannot be said to be reasonable.[59]

48.9. In Grootboom the CC further held "Where state policy is challenged as being inconsistent with the Constitution, courts have to consider whether in formulating such policy the state has given effect to its Constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to say so. In so far as that constitutes an intrusion into the domain of the executive that is an

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57 At par [44]
58 Grootboom at par [42]
59 LAWSA, vol 5(3), Constitutional Law, 2nd ed, 2004, par 132

intrusion mandated by the Constitution."[60]

48.10. The Grootboom decision was applied in Treatment Action Campaign v Minister of Health 2002(4) SA 356 (T) which decision was in turn upheld by the Constitutional Court,[61] which decision held that for a legislative programme to move progressively there has to be "a balance between goals and means."

48.11. The regulations need to be assessed within this Constitutional context.

48.12. The questions to be asked of the regulations are: -

48.12.1. Do the regulations give effect to the state's Constitutional obligations?

48.12.2. Do the regulations assist in providing everyone with access to health care services?;

48.12.3. Are the regulations in conception or in their implementation directed at achieving the progressive realisation of the right to access to health care services?; and

48.12.4. Do the regulations constitute a reasonable legislative measure, within the available resources of the State that assist to achieve this goal?

48.13. The questions have merely to be posed for it to become apparent that the answer to all of these questions is "no".

48.14. The regulations do not give effect to any Constitutional obligation and certainly not to any Constitutional obligation pertaining to the provision of health care services.

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60 Grootboom at par 99

61 LAWSA, vol 5(3), Constitutional Law, 2nd ed, 2004, par 132

48.15. The purpose of the regulations is not directed at achieving any Constitutional goal.

48.16. Instead the stated purpose of the regulations read with the proposed amendment to the definition of business of a medical scheme in the FSLGA Bill 2012 is "to support and enhance the objectives of the Medical Schemes Act, 131 of 1998".[62]

48.17. The purpose of the Medical Schemes Act, 131 of 1998 as set out in the title to that Act is to consolidate the law relating to medical schemes and: to provide for the establishment of the Council for Medical Schemes as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the co-ordination of medical schemes; and to provide for incidental matters.[63]

48.18. The Medical Schemes Act, 131 of 1998, when viewed within the context of the provision of health care services for the South African population, is a law in terms of which a selected and privileged part of the population are enabled to make provision for their health care.[64]

48.19. Medical scheme premiums are paid for either by the members of the scheme or by their employers or both[65] and the State has no role in the subsidy of these schemes.

48.20. In a nation in which there is a large disadvantaged and unemployed section of the population, medical schemes are for the employed and

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62 R 9706, GG 2 March 2002, no 35114, p. 9
63 See Act 131 of 1998
64 See LAWSA, Vol 13(2), Olivier &Smit, Social Security Law, par 143
65 Section 26(6) of the MS Act no 131 of 1998

privileged. Membership is often a condition of employment.[66]

48.21. Medical Schemes are neither sourced in the Constitution, nor do they enjoy any particular claims to Constitutional fortification.

48.22. In fact medical schemes are an instrument of private health created by the Medical Schemes Act no 72 of 1967 an Act which long ante-dates both the Constitution and a democratic South Africa.

48.23. In contradistinction to medical schemes, health care for the bulk of the population is provided by the limited public measures in this area as well as free hospital care for women with young children and the aged.[67]

48.24. The state of our public hospitals is notoriously poor. To quote "just landed", an internet facility catering for foreign tourists, "generally public [healthcare] facilities tend to be underfunded, bureaucratic, inefficient and hopelessly oversubscribed."[68]

48.25. The pressures on these thinly spread resources are only likely to increase should the regulations be enacted. Instead the needs of a "significant segment of society" – some one million persons - are going to be overlooked should the regulations be promulgated.

48.26. The central basis on which Medical Schemes seek to justify their products vis-à-vis those of the insurance industry are on four grounds: -

48.26.1. Open enrolment;[69]

48.26.2. Community rating; [70]and

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66 See LAWSA, Vol 13(2), Olivier &Smit, Social Security Law, par 224

67 See LAWSA, Vol 13(2), Olivier &Smit, Social Security Law, par 143

68 www.justlanded.com "Public healthcare South Africa's health system"

69 Open enrolment is a social security principle that requires every open medical scheme registered in South Africa to accept as a member or dependant any and every person who wishes to join that medical scheme. Applicants must be accepted into the scheme regardless of factors such as their age or past and present medical history.

48.26.3. Cross-subsidization.[71]

48.26.4. The payment of prescribed minimum benefits.[72]

48.27. As noted already, open enrolment is not a characteristic that is exclusive to medical schemes. Health insurance products are prohibited by the Constitution from practicing any form of unfair discrimination.[73]

48.28. The remaining statutory provisions of community rating and cross-subsidisation involve low risk individuals subsidizing high risk individuals and the guaranteed payment of certain minimum benefits.

48.29. It bears repetition that the benefits of medical scheme membership are afforded only to a very exclusive market within the context of South African society as a whole. Bearing this in mind, to defend the abolition of health insurance on the basis that medical schemes are required to practice community rating and cross-subsidisation is akin to defending an otherwise regressive tax regime on the basis that only at the very top of the pyramid, the very privileged elite are required to subsidize the slightly less privileged.[74] This is unreasonable and irrelevant.

48.30. The regulations do not constitute a reasonable legislative measure, (as contemplated by section 27(2) of the Constitution), within the available resources of the State that will serve to assist to achieve providing everyone with access to health care services.

48.31. The reverse is true.

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70 Community rating refers to the practice of charging all members on a particular option the same contribution, regardless of their age or health status or any other arbitrary ground.

71 Cross-subsidization flows from community rating between low-risk and high-risk individuals. All members on a specific medical scheme benefit option pay the same benefits based on what they need. (see R 9706, GG 2 March 2002, no 35114, p. 10)

72 See section 29(o) of Act 131 of 1998

73 See Guardrisk at par [20]

74 A regressive tax is a tax where the relative tax burden increases as the individual's ability to pay it decreases

48.32. Moreover no limitation clause qualifies the highly unreasonable nature of this subordinate legislation.

48.33. The regulations must not be enacted into law.

DAY 1 HEALTH (PTY) LTD

7 MAY 2012