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Submission by the Free Market Foundation to the National Treasury

ON

THE SECOND DRAFT REGULATIONS ON THE DEMARCATION BETWEEN HEALTH INSURANCE POLICIES AND MEDICAL SCHEMES

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Demarcation 2nd Draft Regulations

Free Market Foundation Submission

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1. Introduction

The Free Market Foundation (FMF) welcomes this opportunity to comment on the Second Draft Demarcation Regulations made under Section 70 (2b) of Short-Term Insurance Act, No. 53 of 1998 ('draft regulations'). In this matter, as in the FMF's work generally, it espouses a pro-market approach because of the overwhelming evidence from the world's experience that freer markets serve, above all, the interests of middle- and low-income groups.

This submission tackles the issues concerned in a direct, even passionate manner, which we trust will be appreciated as constructive rather than discourteous.

International comparisons show that always and everywhere, people 'at the bottom of the pile' have higher living standards where markets are freer. That is why 'the poor' risk and often lose their lives trying to get from less-free to more-free economies. The poor know something that eludes many elites and intellectuals, that the best place to be poor is where markets are freer, other people are rich, and where the course of events is determined by freely exercised consumer choice instead of one-size-fits-all regulation.

Living standards, especially health care, are higher in relatively free economies than in economies characterised by the kind of interventionism proposed in the draft regulations. That this is true is no longer subject to informed debate. The evidence provided by a substantial body of cross-country research is as conclusive as evidence gets in social science. The FMF will gladly provide literature and sources for anyone interested in or unfamiliar with the data.

This submission does not address the draft regulations from the perspective of medical schemes, insurers or other providers of health care and cover. Instead, it is consumer-centred in that it considers the draft regulations from a consumer perspective. It does so specifically from the perspective of middle- and low-income consumers, and shows that they, in particular, would be adversely impacted if the regulations are implemented in their present form.

The FMF is concerned that draft regulations and accompanying documents (explanatory memoranda and media releases) seek to alleviate real and perceived problems without asking why they exist. This submission shows that problems the government wants to alleviate are caused or exacerbated by pre-existing controls. The solution, as with many problems, is to discontinue causes.

The evidence suggests that the proposed regulations will compound rather than solve problems for consumers, especially those most in need of affordable quality care and insurance protection. Trying to solve regulation-induced problems by further regulations, instead of deregulation, will make things worse. That will, in turn, create the perceived need for yet more regulation in an endless downward spiral, the end result of which will be the destruction of affordable, competitive and innovative health care and cover, especially for middle- and low-income consumers.

Unlike most submissions the government receives, FMF submissions reflect no vested interest. Being an independent think tank, FMF submissions are the considered and informed contribution to government policy formulation of staff, researchers and consultants, and do not purport to be the views of members, friends and supporters.

The FMF is one of the world's oldest and most internationally respected think tanks. It has, for forty years, made influential, sometimes decisive, policy contributions locally and internationally. It has been consistently and unambiguously for personal liberty, equality at law, social justice, democratic values and the rule of law. As such, it was automatically and resolutely opposed to apartheid, and continues espousing the same values in the face of anti-freedom policies.

Since free markets are primarily about the rights of ordinary people, the FMF has always worked with and had close relationships with people in lower income groups, especially the representative bodies of small-scale farmers, SMMEs and consumers. Its work over many years has made it clear that the primary beneficiaries of economic freedom (properly defined) are not the rich, but the poor. Indeed, wealthy vested interests often are the most effective lobbies against freedom and social welfare, devoting considerable resources to securing government intervention that favours them.

As with most proposed controls, the draft regulations are supported by and have been encouraged by vested interests wanting government protection from consumer choice and competition. We urge the government to be ever-mindful of what lies behind lobbies, and to guard against their seductive and selfish anti-market, and thus anti-consumer and anti-poor, vested interests. Because of the highly concentrated benefits regulation confers on the few at the expense of the many, government tends to be subjected overwhelmingly to pro-interest and anti-consumer pressure. Needless to say, vested interests never disclose their real agenda; they never say "We want the government to benefit us at everyone else's expense; we want regulations that give us an unfair advantage". Fake benevolence conceals their unwillingness or inability to compete for consumer support.

The only way for businesses to prosper when markets are free or relatively free of regulation is to offer consumers more innovative and attractive choices.

Consumer interests demand freedom for consumers to choose between options offered to them by freely competing efficient and innovating suppliers, including medical schemes, insurers, traditional healers, complimentary health medicine, faith-based healthcare, self-care and the like.

2. South African context

The draft regulations and this submission exist in a specific historical context. That context demands that we must acknowledge local realities, on one hand, and learn from the world's experience, on the other. The South African context entails the apartheid crime against humanity and more. It includes the origins and evolution of financial and healthcare policy, such as common and insurance law, medical schemes, public healthcare, private healthcare, traditional healing, complimentary medicine and jurisprudence.

For many decades, the ANC struggled so that black South Africans would gain rights previously reserved for whites, including the right to vote and control their own lives. Under apartheid, many black South Africans had little or no healthcare. One of the most important rights apartheid denied blacks was the right to choose between healthcare options, and to decide how to spend their own money. Blacks had single digit participation rates in medical and insurance schemes. Thanks to the abolition of apartheid, blacks have soared ahead, and now account for around half of new medical scheme memberships, insurance policies and other financial products, such as bank accounts, company registrations, share purchases, credit cards, cell phones, house sales and so on in virtually every sector. It is of paramount importance, if the triumph over apartheid is to become economic reality, not to stifle such progress with measures such as the draft regulations.

The escalation of interventionist regulation in recent years, following a post-apartheid decade of liberalisation, runs the real risk of placing blacks back in the world of curtailed choices from which they escaped. Instead of blacks gaining freedoms previously reserved for whites, we run the risk of doing the opposite, of adding whites to the lack of freedom previously reserved for blacks. That would be, for blacks, a tragic hollow victory and reversal of fortunes. We urge the government to reverse post-apartheid interventions, to which the draft regulations would contribute.

An emancipated society in which government respects the rights, dignity and competence of citizens, is one in which citizens enjoy the right to decide for themselves how to allocate their wealth and protect their interests, including being free to choose healthcare options. Personal responsibility for citizens presumed to be capable of voting, marrying, having children, choosing careers, religions and so forth, includes the consumer's right to a range of private healthcare and insurance options. Many options are already banned. The law should respect the consumer's right to choose from a range of competing and evolving schemes, insurance, co-ops, clubs, societies, religious care and traditional healing.

Another context reality is that the parlous state of public healthcare suggests that the government should concentrate on getting its house in order, and, in fairness to its citizens, not subvert private alternatives until it succeeds.

3. Evolution of the status quo

The Medical Schemes Act (MSA) of 1998 made sweeping changes to regulations governing medical schemes and set in motion a process of "crowding-out" what consumers could acquire in the private sector. An ever-tightening regulatory straightjacket made it increasingly difficult for medical schemes to offer consumers realistic choices, or for insurers to provide affordable cover. Paradoxically, the prospect of national health insurance (NHI) has been accompanied by an intensified erosion of consumer freedom. True health insurance would entail the right of consumers to buy health insurance cover, and for government to pay premiums for the indigent. In other words, "NHI" is a misnomer; what most protagonists of the idea seem to have in mind is not insurance at all, but the opposite, namely

nationalisation. National health insurance, properly defined, is the right way to go. By further curtailing health insurance, the draft regulations work against properly defined NHI.

The ideal would be for consumers to be empowered and emancipated to the point where they can buy whatever health insurance they wish and get healthcare from efficient competitive private providers, most of whom would probably be BEE owners of formerly state-owned hospitals and other facilities. The government would then be a true health insurer; it would pay premiums for the poor. Privately delivered NHI has a proven track record in various countries, such as Switzerland, and is, the idea behind "Obama care". Instead of rejecting lessons learned from abroad, we should be embracing them.

Four counter-productive changes introduced in the 1998 MSA, were (1) open enrolment, (2) community rating, (3) statutory solvency requirements, and (4) prescribed minimum benefits (PMBs). Each of these reduced consumer choices and forced consumers to pay more for medical scheme coverage.

Since the marginal value of money is higher for the poor, they were the biggest victims. Such policies are the opposite of 'progressive' income tax, where the rich pay higher rates on the assumption that each rand is worth less 'at the margin'. The MSA changes are regressive discrimination against the poor for whom cost increases are disproportionately prohibitive. That leaves society's most needy people without protection or searching for alternatives, including insurance.

Open enrolment is the practice whereby medical schemes are compelled to accept all individuals, regardless of decisive variables such as age, gender or health status, subject only to number of dependents and income, which makes it another form of taxation rather than community rating. The MSA made it compulsory for every scheme to charge the same premium for members with nothing of relevance in common. That is like compelling supermarkets to charge the same for every trolley regardless of what consumers buy. In order to reduce the inevitability of schemes being overwhelmed by high-risk individuals, schemes were permitted to apply waiting periods and penalties to those members over a certain age joining for the first time.

The MSA also introduced statutory solvency requirements, which stipulate the minimum amount of accumulated funds each scheme had to hold in reserve, which further drove up consumer prices. Given the absence of preceding insolvencies, consumers incurred costs without benefits.

The 1998 Act made it compulsory for every scheme to provide PMBs, which drove consumer costs even higher. South Africans, especially middle- and low-income consumers, were forced by a law intended for their protection to vacate medical schemes and remain unprotected, or to seek whatever paltry surrogates they were allowed by law to get from insurers.

4. Specific issues arising from the draft regulations

a. "Maximum Commission Payable" (Reg. 5.3)

Commission control is, of course, price control. It is anomalous to have price control in the modern world, let alone to intensify it. Price control has been thoroughly discredited worldwide. Most countries have relaxed or abandoned it in most contexts. Perhaps because people with expertise in health are unfamiliar with the consensus amongst experts in economics, they still believe in it. The draft regulations, however, are not proposed by the Health Department, but the Treasury, where there are experts in economics and finance. That makes it particularly difficult to make sense of the proposal.

It will, if implemented, be counter-productive because an artificially low price causes shortages – more demand; less supply – and an artificially high price causes surpluses – more supply; less demand. There is no reason to believe that health care and insurance are any different.

When commissions are capped, all that happens is that consumers, especially the poor, are confronted by a shortage of products, on one hand, and a shortage of brokers and agents offering and explaining what little is available. No coherent reason is given for the arbitrary number of 12.5%, probably because there is none. There is no economic theory by which this can be considered the imaginary correct percentage.

It is easy to see the flaw in the proposal if higher and lower numbers are considered, such as 0.01% or 1000%. If the idea is lower prices for consumers, why 12.5%? Why not 0.01%? If the idea is for consumers to continue having access to products and services, why not 1000%?

The answer is that whoever proposed the number realises intuitively that at 0.01% zero products will be offered, and that 1000% would be meaningless because no consumer would pay that much when quality services are available at a fraction of the price.

Between these extremes, all that changes is degree, not principle. At 1% only very rich people will be offered products and services. At 100% it might be worth serving poor people buying entry-level cover. At 50% things would be better for consumers than at 5%, and so on. There is no coherent logic to the figure proposed except the amorphous feeling of whoever proposed it that at 12.5% enough of a market will survive to prevent the inevitable damage caused by the measure being obvious to everyone.

The world's experience over many centuries is that price controls distort markets, and the biggest, often only, losers, are the poor. Price controls also cause 'black' or 'underground' markets, in which people simply break the law (evasion). People who want to be law-abiding find ingenious ways of bypassing the law (avoidance). Officialdom has less of a vested interest in enforcement than buyers and sellers have in evasion and avoidance. For that reason alone, private people will always be more creative – always one step ahead – with regulators trying belatedly to 'plug loopholes'.

That is precisely what informs the draft regulations: officialdom trying to remedy the counter-productive effects of earlier regulations, which sought to remedy still earlier regulations, back to the point where markets were free of regulation-induced distortions. The way forward, if these regulations are adopted, will be identical; new distortions will lead to the perceived need for more new regulations in the futile pursuit of suppressing negative effects.

There is a contradiction in the draft regulations, namely that their purpose is to reduce consumer access to both choice and cover, which would be the inevitable effect of, for instance 'social solidarity' pricing (see below), on one hand, commission control, which is supposed to lower prices and consumer costs. Were commission control to succeed, it would have the opposite effect.

One of the great myths of price control is the belief that it actually regulates prices. A maximum price simply excludes all consumers who would be provided with products and services only at higher prices, and does little or nothing for consumers who qualify for lower prices – they tend to pay the same lower price they would have without the control. The limited extent that there appears to be a clustering at a regulated price, is an illusion created by suppliers seeking ways to lower the value of what consumers get to below the threshold. Consumers thus penalised, would be free without price control to settle for less, but would prefer what they get at higher prices.

What qualifies some consumers for lower and others for higher prices is often overlooked by regulators, although it should be obvious. A common basket of products, such as groceries,

illustrates the point. It is cheaper per consumer and per product to serve consumers from a high-turnover office in Sandton selling expensive products, perhaps electronically, than it is for a door-to-door broker to sell cheap products to poor peasant farmers in remote tribal villages. Commission control has the inevitable effect of denying products and services to consumers below some unknowable threshold, which is unique for each context and each consumer in that context.

Price control diverts the efforts of suppliers from the poor to the rich, where they enjoy economies of scale. This benefits the rich at the expense of the poor, which, in South Africa, means urban elites, many of whom are white, at the expense of low-income people, most of whom are black.

An interesting feature of interventionism of the kind proposed is that inevitable and predictable negative effects are said to be 'unforeseen'. Regulators routinely excuse government failure by calling it an 'unforeseen (or unintended) consequence', despite the fact that the consequences concerned are completely foreseeable and usually predicted, as we do here.

Despite it being obvious that victims of compulsory discrimination against healthy people in medical schemes would be driven to the bosom of insurers, it was supposedly unforeseen, which is hard to believe. Maybe it was foreseen, but ignored. That too is hard to believe. How could anyone applying their mind to the matter not have foreseen what transpired?

Since there does seem to be some kind of blind faith – regulatory fundamentalism – not just in South Africa, but worldwide, we explain in this submission what the counter-productive effects of the draft regulations will be. Commission control will:

1. reduce products and services offered to middle- and low-income consumers, most of whom happen to be black;
2. reduce opportunities, especially for small and aspirant brokers and agents, most of whom happen to be black, and
3. inhibit growth in the short-term insurance market, and thus prosperity generally.

Since those proposing commission control seem to be unaware of the consensus of experts regarding the counter-productivity and futility of price control, we provide a few representative links:

a. The Economist Intelligence Unit (EIU): http://catalog.flatworldknowledge.com/bookhub/reader/13001?e=e1003.rittenberg-ch04_s03
b. 40 Centuries of Price and Wage Controls: http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=7563644
c. Multiple Sources: http://freedomkeys.com/pricecontrols.htm
d. Reference to polls of economists: https://mises.org/etexts/Modig.pdf
e. Survey of Price Controls in the USA: http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1862&context=lcp
f. Concise Encyclopaedia of Economics: http://www.econlib.org/library/Enc/PriceControls.html

To summarise and elucidate:

1. Commission control is price control.
2. There is near unanimity amongst economists that price control is counter-productive.
3. It distorts supply and demand, and reduces overall prosperity.

4. A minimum price increases supply relative to demand and causes a surplus.
5. Enduring surpluses or shortages are almost always due to price controls.
6. Prices are signals that tell economically active people what to buy and supply.
7. Free competition is the only feasible means of establishing the supposedly 'right' price or commission for anything.
8. Since virtually everything supplied has shared costs with other goods and services, it is usually impossible to calculate the actual cost of any given product or service.
9. This is equally true of financial products and services such as insurance.
10. To fix commissions at all presupposes a regulator knowing something no person can possibly know, namely everyone's circumstances.
11. A one-size-fits-all commission cannot possibly be right, except for people at the margin.

b. Misconceptions about 'community rating', 'social solidarity', 'discrimination' and 'health spend' (Reg. 7.2)

There appears to be confusion regarding the meaning and implications of draft regulation 7.2 (2) (a). Media comments and some submissions that we have seen reflect the belief that the medical scheme principle of charging all people (regardless of risk and value enjoyed) the same, is to be extended to health insurance. The non-discrimination provision is curious in various ways.

Firstly, it resembles section 9 of the Constitution, but is altered in ways that are hard to understand. Like the Constitution, it says that there must be no 'unfair' discrimination, which means that fair discrimination will be permitted. This means that, unlike medical schemes, discrimination on all or any of the grounds specified is allowed if it is fair.

Secondly, since unfair discrimination on the grounds specified in the Constitution is already prohibited, it is unclear what the purpose of 7.2 (2) (a) might be. The laws of interpretation mean that the provision must be presumed to have a purpose, and that what it is might be apparent from its departure from the Constitution.

Normally, excluding grounds would mean that those grounds are no longer covered, but this would not be the case as far as the Constitution is concerned. The draft regulations cannot legalise what the Constitution forbids.

So what then is its purpose? Here are the two provisions:

Constitution:

[No person may] *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.*

Draft regulations:

[No contract may] *unfairly discriminate directly or indirectly against any person on any of the following or similar grounds: race, age, gender, marital status, sexual orientation, pregnancy, disability and state of health.*

This is how they differ:

… unfairly discriminate directly or indirectly against ~~anyone~~ any person on ~~one or more~~ any of the following or similar grounds: ~~including~~ race, age, gender, ~~sex, pregnancy~~, marital status, ~~ethnic or social origin, colour~~, sexual orientation, ~~age~~, pregnancy, disability, ~~religion, conscience, belief, culture, language~~ and ~~birth~~ state of health.

Is there significance to the reordering of some criteria? If not, why is there reordering? If so, what might it be? The same questions arises regarding what has been added and omitted. Is it intended that unfair discrimination be permitted on omitted grounds? As stated above, the draft regulations cannot do so.

In the absence of good undisclosed reasons to the contrary, and to avoid legal uncertainty, it is suggested that what is already forbidden by the Constitution be omitted, and only what is additional be included.

If we are wrong about draft regulation 7.2 (2) (a), and it is intended to extend the medical schemes principle to insurance, we suggest that it would fly in the face of the very essence of the draft regulations, which is to clarify demarcation. For fear that it might be intended either in the draft regulations, or at some future date, we provide the case against the principle.

An idea of 'social solidarity' and 'community rating' would be manifestly absurd in other contexts, such as requiring supermarkets to charge the same price per trolley regardless of what consumers buy, or car dealers to charge the same price regardless of which car is sold. The predictable and predicted negative effects of the profoundly flawed medical scheme principle include:

1. Discrimination against healthy people, especially younger people. The ratio of young to old people is greater amongst blacks than other groups, and by far most young people are blacks. Furthermore, for various reasons, lower-income people have lower medical claims, even when they have cover, than wealthier people. Accordingly, the mirage of equality is in fact extreme discrimination, on average, against black youth. The degree of discrimination is greater than most people realise. Care for 80-84 year olds costs about nine times that of 45-49 year olds. Care for 5-9 year olds costs about 3 per cent of a 45-49 year old.
2. The medical scheme principles also discriminate unfairly against people who live healthy lifestyles; people who do not drink or smoke, do not eat junk food, exercise regularly, avoid unsafe sex, do not have dangerous recreations or jobs etc.
3. Charging people different prices for different products is not discrimination. On the contrary, charging the same for different products discriminates against people who get less. That people get the same cover in medical schemes is obviously untrue. Higher risk people get more at the expense of the cross-subsidisation mentioned in Box 1 and surrounding text in the Explanatory Memorandum. We have no formal legal opinion on the matter, but it could be argued that 'community rating' is unfair and thus unconstitutional discrimination against low-risk people forced to subsidise high-risk people.

Stated differently, the notion that charging different people different prices is 'discriminatory' either attaches an erroneous and thus misleading meaning to the word, or reflects misconceptions about the price mechanism, or both.

Supermarkets do not, as stated above, 'discriminate' when they charge customers different prices for different trolleys. Were they to do so, they would be discriminating against people who buy less, which, on average, means poor blacks. Car dealers do not discriminate when they charge different

prices for different cars. They would be discriminating against the low-income buyer of an old bakkie if they charge him/her the same price as the buyer of a new Rolls Royce.

That health 'benefits', especially 'minimum benefits', might be nominally identical, creates a superficial illusion that consumers of 'minimum benefits' who pay the same price, regardless of individual differences, get identical value for money. This illusion is due to a failure to understand what cover is. Cover is protection against risk. The product sold varies according to risk, just as supermarket trolleys vary according to what is in them. A given person's risk is a statistical, not a policy, question. Some people are more risky than others. Reasons vary enormously. People are more risky for such reasons of choice and chance as genetics, diet, obesity, unsafe sex, occupation, culture, smoking, sport or neighbourhood.

The self-interest of insurers, including medical aids, is to price risk accurately and objectively. Their self-interest is, contrary to popular myth, the opposite of discrimination. Maximal efficiency and profitability for them is zero discrimination. Discrimination means distinguishing between people for reasons of prejudice instead of differentiation according to objective criteria. That is why our constitution outlaws 'unfair' discrimination and allows both fair discrimination and differentiation. It is not unfair, for example, to have separate male and female toilets, to sell bigger clothes to bigger people, or to charge different prices for what people order in restaurants. To charge the same price would be to discriminate unfairly against someone who orders salad instead of lobster.

If insurers do not price efficiently, i.e. objectively, they will be out-competed by insurers who get it right. To force insurers, including medical aids, to charge the same for people with different risk profiles is to force them to discriminate against low-risk consumers, especially young healthy people with safe virtuous lifestyles. To charge low-risk people as much as high-risk people, is discrimination. It is so self-evidently unfair that it might well be unconstitutional. The reason medical schemes and insurers do not challenge such laws is simply that it is not in their interests to do so. Firstly, provided all competitors are subjected to the same rules of the game there is little or no relative prejudice. That is as true for the price of electricity and computers, as it is for health cover. Secondly, the powers of various regulators have become so extreme and arbitrary, that financial sector enterprises are too terrified of victimisation to do anything that might upset regulators. Thirdly, the cost of a constitutional challenge is, in most instances, prohibitive.

Seductive terminology, like 'social solidarity', conceals more than it defines. It means in effect that consumers are forced to purchase and pay for full expensive medical cover or have no medical cover at all. It necessarily discriminates against people, especially poor people, who want lesser cover because it is more affordable. As such, it discriminates directly against middle- and lower-incomes people, which in South Africa, means mainly black people, in favour of higher income people who are mainly black elites and whites. The reasons are not germane to the draft regulations, but they are worth noting because of the extent to which they illustrate how easily well-intentioned polices can be counter-productive.

Labour market regulation has the effect that white incomes have been rising faster than black incomes. The main reason is probably labour law which has led to virtually full employment for whites and the world's highest enduring unemployment for blacks. This is not difficult to explain or understand. If employers must pay higher than market-clearing incomes, they obviously employ preferred workers, that is people with skills, experience and expertise, which, given our apartheid history, combined with the ghastly quality of most largely black schools, means mostly whites.

For this reason alone – there are many others – 'social solidarity' amounts to an unconscionable form of anti-black discrimination. The other reason stated above is that the average age of blacks is

much lower than the average age of whites. Since younger people are less risky for insurers, uniform contributions discriminate disproportionately against not just youth, but specifically black youth. The degree of discrimination is compounded when discounts for other low-risk factors is banned.

These are practical real world flaws in the 'social solidarity' myth. There are more profound jurisprudential, ideological and philosophical reasons for rejecting the idea. The anti-apartheid struggle was, if anything, a struggle not just against discrimination, but for freedom, specifically the freedoms whites retained for themselves and denied blacks. It would be a tragic irony were blacks in the new South Africa to find that all that changed was for whites to be subjected to the lack of freedom blacks endured instead of blacks celebrating true individual liberation. Personal liberty means freedom to choose.

Allowing people to decide for themselves what cover, or anything else for that matter, they buy should be regarded as an essential hard-won liberty. All citizens should be accorded the dignity and respect entailed in emancipating them from pretentious regulation. Paying for what you want is called "discrimination" if you do not subsidise the sick, lame and lazy. You may not, for instance, pay lower premiums justified by your healthy lifestyle; medical schemes and insurers may not charge you accordingly. You must subsidise strangers with self-inflicted problems. Health cover 'solidarity', as it is called, is as irrational as 'supermarket solidarity'.

c. Demarcation

'Demarcation' tries to delineate medical insurance and medical schemes, which is ultimately impossible since both are forms of insurance. They are and should be accepted as alternative and competing sources of health cover. There should be a level playing field. We realise how far we are from that ideal, but caution against making things worse.

Consumers, it is suggested, should be emancipated and empowered. They should be free to choose health cover options. Unfortunately, insurers may not offer health cover, but they may offer insurance for certain risks, such as expenses exceeding what medical schemes cover, and loss of income. The problem is not inadequate regulation of insurance, but over-regulation of medical schemes that renders them uncompetitive. That they are uncompetitive should be acknowledged as being to the obvious detriment of consumers. They are being forced to pay much more than they would were medical schemes free to provide tailored cover.

Regardless of whether insurers may compete with medical schemes, it should be clear in the demarcation draft regulation (7.2 (1)) that insurers may offer 'shortfall' or 'gap' cover specified in category 1, and they should, under draft regulation 7.2 (2) (e) be free to advertise and market accordingly.

Since many consumers, especially middle- and lower-income consumers, may not want to buy and/or cannot afford medical scheme cover at inflated minimum benefits rates, they should be free to buy a wider range of insurance options. They should, for instance, be free to use public health for normal purposes, and buy insurance cover for abnormal health events. The degree to which existing laws, confounded by the draft regulations, inhibit consumer rights is most unfortunate.

d. 90-day notice of termination (Reg, 7.2 (3) (a) and (b))

This proposal denies consumers the right to get enduring security and cover at lower prices. Such provisions are mistakenly believed to be controls of suppliers, whereas they are really limitations of consumer rights. We respectfully submit that this proposal would, if implemented, unduly prejudice consumers.

Insurance policies are the equivalent of property owned by consumers. That insurers must retain the right to cancel them and that the registrar can ban them (Reg. 7.6) violates an important consumer right, the right to contractual benefits that endure for whatever period the parties agree.

If insurers want the right to terminate, they are free to insert it. They do not in response to consumer demand and in the face of competition. Why, since insurers are free to insert such provisions, would the law force them onto freely contracting parties? There is no clear justification other than the possibility that the government might want to cancel policies against the wishes of consumers.

e. Maximum cover allowed (Reg. 7.2 (4))

That it is proposed to deny consumers the right to buy more cover in accordance with their needs as they see them, is most unfortunate. The proposals should, we submit, be scrapped.

That a growing number of South Africans, especially black South Africans, earn more than R3000 per day, or R50,000 per month, should be celebrated and acknowledged in the draft regulations. Many are managers and many are self-employed. The present writer happens to have engaged the services of a young dynamic black entrepreneur recently to clean carpets. He is willing to testify if it would help. He earns well in excess of the amounts concerned. He, his family and his growing number of employees would be devastated were he to be prevented by ill-health from working and be unable to secure adequate cover. He has been buying equipment and vehicles for which he has to maintain instalments.

There is no sound reason why consumers should be told how much cover they may purchase. They and only they have the slightest idea what would be appropriate in their unique circumstance.

Although this submission concentrates on consumer rights, it is also of grave concern that the draft regulations reflect hostility towards insurers. Their ability to innovate and grow is being needlessly inhibited. They should have the right to gauge and respond to consumer demand and consumers deserve the right to determine what they buy.

f. Reporting and product information (Reg. 7.5 and 7.6)

The proposals regarding submission of existing and future polices for screening are, with respect, bizarre. There is no other context of which we are aware in which lawful contracts have to be submitted for bureaucratic approval. In rare cases, contracts are lodged for record purposes, such as deeds of land sale, and credit agreements, but never for arbitrary screening.

This draft regulation would add extremely wasteful red tape, all of which would be pure economic waste. The draft regulation, like others, purports to bind insurers, but the real victim will, as always,

be consumers. They will pay the price (through taxes, higher premiums and fewer products) for wasted costs, delays, enforcement, evaluation, submissions and documentation.

The only requirement, as in law generally, should be that everything is lawful. When drivers embark on journeys, they have to drive lawfully in roadworthy vehicles. They do not have to apply for permission to someone with the arbitrary power to forbid their journey. Likewise people entering into any other contracts. The law specifies, for instance, what must and may not be in credit agreements. It is a complaints-based system, not, as proposed, a compliance-based approach. It is particularly anomalous that the proposed policy information must be submitted to a registrar other than the one under which insurers fall.

The most serious aspect of 7.5 and 7.6 is their discretionary and arbitrary nature. They purport to confer powers that blatantly violate the rule of law, which requires legal certainty. Where there is discretionary power, the rule of law requires clear objectives for the power, and objective criteria according to which it must be exercised. The rule of law is a foundational and justiciable provision of our Constitution. According to the opening section, South Africa is founded on the "supremacy of the constitution and the rule of law". The rule of law enjoys equal status with the Constitution, unlike other provisions which are subservient to it, or the Bill of Rights, which is subject to the limitation clause (§36). As such, the rule of law is absolute.

Draft regulations 7.5 and 7.6 provide no objective criteria for evaluating policies and related materials, or grounds for prohibition. If there is to be submission at all, it could be with a view to establishing illegality. The Registrar's opinion should be subject to appeal to the judiciary as the only means of ensuring impartiality.

7.5 (2) and 7.6 (2) refer to the "opinion" of the Registrar regarding the "objectives and purposes" of the Medical Schemes Act. The insurance Registrar may then under 7.5 (3) and 7.6 (3) arbitrarily issue banning orders, which is ominously reminiscent of the way in which apartheid-era banning orders were issued. He/she is not required to act according to objective law, is given no purpose for which the power is conferred and to which end it must be exercised, is not required to give reasons (except indirectly under §33 (2) of the Constitution), and there is no right of judicial appeal or independent arbitration on the merits.

Since there is, we respectfully submit, no basis in logic or law for this proposal, it should be scrapped *in toto.*

If, for some abnormal reason, it or something like it is to be introduced, the draft regulations should, at the very least, include the following:

1. Screening will be strictly for objective legality. The act and regulations specify objective criteria with legal certainty, and that is all that should be under consideration.
2. Instead of needless and wasteful bureaucratic duplication, the insurance Registrar should have the right to consult the medical schemes Registrar.
3. An automatic right of appeal on the merits to the high court, or to arbitration by the Arbitration Foundation (AFSA).
4. A default assumption of legality, with the onus being on the Registrar to prove otherwise.
5. No right for the Registrar to reconsider a policy already examined – once passed, that should be the end of the matter.

We repeat, however, and emphasise, that this is a most extraordinary concept that should be no part of our law.

We wonder to what extent consideration is given to the risks incurred by government when it descends into the private sector arena, not as a referee blowing the whistle for infringements, but as both a referee and player. There might well be claims against the government and officials personally if there are damages actions flowing from policies they have approved. It is one thing for the government to make laws, but quite another to be a role-player in implementation and interpretation. The FSB declared Fidentia, Tannenbaum and other scams to be 'fit and proper'. Curiously, their misrepresentations have not produced damages actions. It might be a matter of time until victims realise that they might be able to sue the government, as might be the case for approved insurance contracts and polices.

5. **Conclusions and Recommendations**

We repeat our appreciation for the opportunity to comment. We believe that the tone of the Explanatory Memorandum reflects an unduly hostile view of consumers. It is characterised by such wording as "prohibiting", "removing", "limiting", "requiring" and "prescribing". All are presumed to govern insurers, but actually apply to consumers. A limit is a limit on cover consumers may purchase.

We urge the government to have greater respect for consumers, to stop eroding consumer rights, freedom and dignity, to let consumers decide which insurance products and services they want and what they are willing to pay. In particular, we urge consideration and respect for middle- and low-income consumers. They will be the principal victims of commission control, of prohibited cover and being forced to buy medical cover only from medical schemes.