

# Free Market Foundation Submission

## National Department of Health Medical Schemes Amendment Bill, 2018

20 September 2018

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## About the Free Market Foundation

The Free Market Foundation is an independent public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships.

## Introduction

The National Department of Health (NDOH) published the Medical Scheme Amendment (MSA) Bill on 21 June 2018 and has invited interested persons to submit comments on the MSA Bill. The Free Market Foundation (FMF) welcomes the opportunity to participate and provide input in this critical debate.

The FMF is dedicated to promoting a sound economic policy approach to the provision and funding of health care. The FMF maintains that the private supply of competitive health care services and the incremental extension of private funding is the most effective method of supplying high quality health care to the entire South African population.

The FMF urges government to devote its limited health budget to the supply of services to the poor, to purchase an increasing percentage of those services from private providers, and to allow and encourage the rapid growth of the private healthcare sector, thus enabling it to provide services to an increasing percentage of the population.

Government works hard. Most of what it does seems to be to keep up the unceasing struggle to circumvent the bad things caused by other things they already do. Consider for example that South Africans have many different forms of insurance options available: car insurance, home insurance, life insurance, even pet insurance. Most of these insurance policies work well and are fairly priced. But there is one glaring exception: South Africans do not have access to a properly functioning health insurance market.

The obvious question is: Why? To answer this question, we must start at the beginning. What is insurance? It's straightforward. You pay a monthly fee which provides financial protection against unforeseen, sometimes catastrophic events. People buy homeowners insurance, for example, to protect themselves from the financial loss incurred in the event of a fire, a flood, or theft. Because millions of people are paying into the insurance pool, the pool has enough money to cover, for instance, the unlucky person whose house burns down. Since insurance is meant to share risk, it only stands to reason that higher risk individuals must pay more to be insured.

Someone who has had two accidents is going to pay more for car insurance than someone who has never had an accident because their track record indicates they are more likely to have another accident. While insurance provides a bulwark against unforeseen loss, it does not protect against routine expenses. Car insurance protects you if you wind up in a car accident or if your vehicle is stolen. But it does not cover routine maintenance like oil changes, replacing brake pads, or tyre erosion because everyone needs routine oil changes, new brake pads, and new tires. So, there is no risk to protect against.

Similarly, for health coverage arrangements to perform well, the risk pooling should result in expected costs for the pool being reasonably predictable for the insurer and relatively stable over time. The average level of health risk in the pool should therefore not vary significantly over time. To accomplish

a predictable and stable pool of beneficiaries over time, health insurers and more specifically medical schemes, should be able to offer sticks and carrots that penalise and reward people for behaviour and actions that affect their health negatively or positively. For instance, in a well-functioning market, medical schemes can create positive incentives (carrots) such as reduced premiums or special discounts for members and policyholders who do not smoke, exercise regularly, drink in moderation etc. Similarly, they can create disincentives (sticks) by charging higher premiums to customers who smoke, drink excessively and are obese.

When medical scheme actuaries are prevented from creating carrots and sticks and pooling members on a logical actuarial basis into their relevant risk categories, it becomes difficult to predict the average cost of the pool and premiums will rise to reflect this unpredictability. As the number of unhealthy people in the pool increases relative to the number of healthy people, the average costs rise, causing each healthy individual at the margin to drop out until eventually the group consists only of unhealthy individuals.

In South Africa, a properly functioning health insurance market is simply not available. Approximately, 8.9 million lives are covered by private medical schemes, but this is not health insurance. They are pre-paid healthcare plans. They cover routine check-ups, less serious illnesses, and, depending on the benefit option, recurring expenses like prescription and chronic medications in addition to protecting you from a health disaster.

## The Role of the MSA in Driving Up the Price of Contributions

The fundamental problem yet to be openly identified, let alone resolved, is the principle of so-called “social solidarity” contained in the Medical Schemes Act of 1998 (MSA). The MSA ushered in four main amendments: open enrolment, community rating, statutory solvency requirements, and a comprehensive package of hospital and outpatient services that all schemes are compelled to provide regardless of the individual’s age, sex or health status. This minimum package of benefits is commonly referred to as prescribed minimum benefits (PMBs). Each of these amendments resulted in an increase in the cost of providing medical scheme coverage, which invariably needed to be borne by the consumer. The MSA made it compulsory for every scheme to charge the same premium to every member within an option, despite their age or state of health, a practice commonly referred to as community rating.

The MSA also introduced statutory solvency requirements, which stipulate the minimum amount of accumulated funds that each scheme should hold as a reserve. Regulation 29 of the Act prescribes that the minimum accumulated funds of the medical schemes should be at least 25 per cent of gross annual contributions. This legislation was enacted to prevent a scheme from going insolvent should it experience an unusually high number of claims and record an operating loss in a particular period. But the formula for calculating the current solvency ratio was arbitrarily decided with no regard to the implications for the functioning of medical schemes. The solvency requirements were set at a level of 10 per cent when they were introduced in 2000 and have since been increased by incremental amounts to the current level of 25 per cent, which has been effective since 2004.

According to the Actuarial Society of South Africa, solvency is an asymptotic function of contribution increase. In other words, the higher the solvency requirement, the greater the increase required to improve solvency by 1 per cent. For example, increasing the solvency requirement from 10 per cent to 11 per cent requires a contribution increase of 1.39 per cent. However, increasing the solvency requirement from 24 per cent to 25 per cent requires an increase of 2.07 per cent in contributions.

Increasing the solvency requirement drives up membership contributions disproportionately and this negatively affects the rate of increase in the number of members entering a scheme.

A scheme that has reserves below the legislated 25 per cent minimum requirement will have trouble 'catching up' because new members will be in the invidious position of having to contribute not only towards their own portion of the required reserves, but also towards making up past shortfalls, a cost for which they will receive no benefit. Despite the intentions of the SA government to prevent schemes from failing, the solvency requirements increase contributions, which, in turn have adversely affected the number of individuals covered by schemes by artificially raising the costs of private medical scheme cover.

Under the community rating system, schemes need to attract new young members constantly to cross-subsidise the older members in the scheme. If this is not done, the average age in the pool will increase and the average premium will have to rise commensurately. The solvency ratios of schemes that are growing are placed under pressure because if a scheme's membership increases rapidly, its contribution income must rise steeply.

As noted previously, a scheme's solvency ratio is determined from the reserves as a percentage of the contributions. If the contributions increase without a similar increase in the reserves, the solvency ratio will decrease. Solvency requirements are a barrier to entry for new medical schemes trying to enter the private medical schemes market. It is unreasonable to expect potential entrants to raise enough capital, not only to fund their daily activities, but also to meet the statutory solvency requirements. Considering South Africa's aging population and the barriers to entry in the market, the effect of introducing unrealistic statutory solvency requirements were entirely predictable – substantial consolidation of existing medical schemes. Since 2000, the number of schemes operating in the medical schemes market has dropped by over 40% from 144 in 2000, to 82 in 2016 – an average rate of decline of almost four medical schemes per year over the period.

Statutory solvency requirements introduce a considerable regulatory bias in favour of some medical schemes and against others. A scheme that has accumulated reserves that exceed the required minimum is in a better position to attract new members than one that has a shortfall. It will be particularly difficult for new medical schemes to enter the market and rapidly growing schemes will be at a disadvantage relative to slowly growing ones. This is not a desirable situation given the substantial expected future demand for health care in the country.

The MSA also introduced open enrolment which is the practice whereby medical schemes are compelled to accept all individuals, regardless of age, sex or health status (subject only to their income and number of dependents or both). To reduce the probability of selecting high-risk individuals, schemes were permitted to apply waiting periods and penalties to those members over a certain age joining a scheme for the first time. But this was a mere band-aid to the regulatory problem created by community rating. Finally, the MSA made it compulsory for every scheme to provide PMBs which at an average cost of R680 per beneficiary per month excludes a large proportion of the South African population.

The so-called act of 'social solidarity' contained in the MSA has had the effect of driving lower-income and healthy people out of the market or preventing them from even entering the market. The consequence is that the risk pool of insured people has become progressively smaller and less healthy, driving up contribution levels and making medical scheme cover unaffordable.

In contrast, when schemes are permitted to “risk rate” individual’s health coverage, providers typically vary premiums based on factors associated with differences in expected health care costs, such as age, gender, health status, occupation, and geographic location. In cases where the individual is paying the full premium for coverage, health coverage providers will charge a higher premium to people who are older to recognise the higher expected costs. People seeking health insurance therefore pay premiums commensurate with their expected health risks.

With risk rating, the responsibility for an individual’s health is placed directly in their own hands, whereas the theory of social solidarity, in practice, is neither efficient nor effective. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older people with higher expected costs, raising the average cost and making coverage in the pool less attractive to younger and healthier people. This practise of selecting high-risk individuals is commonly referred to as adverse selection.

For obvious reasons, people who know that they are in poor health are more likely to seek health insurance than people in good health. A pool subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to rise continually until the scheme becomes unviable and everyone in the scheme loses out – a process commonly referred to as the ‘death spiral’.

To the extent that medical schemes are compelled to move away from economic and actuarial realities, they will be creating a situation that will be unsustainable. People, to the greatest degree possible, should be allowed to make their own decisions about their own lives and not be required to bear the costs of errors made by others. Government should not lock people into a preconceived notion of what is currently regarded as ideal. Changes will occur over time and, as the population ages, premiums will be forced to rise.

Regulatory add-ons have made healthcare much more expensive and complex than any other form of insurance. Social solidarity has caused the price of medical scheme cover and, more recently, gap cover to rise dramatically. Instead of heaping on more regulation, the obvious answer to increase the affordability and number of people covered by private medical financing arrangements would be to deregulate the market by making health “insurance” like other types of insurance.

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*“The curious task of economics is to demonstrate to men how little they really know about what they imagine the can design”*

*F. A. Hayek, The Fatal Conceit: The Errors of Socialism*

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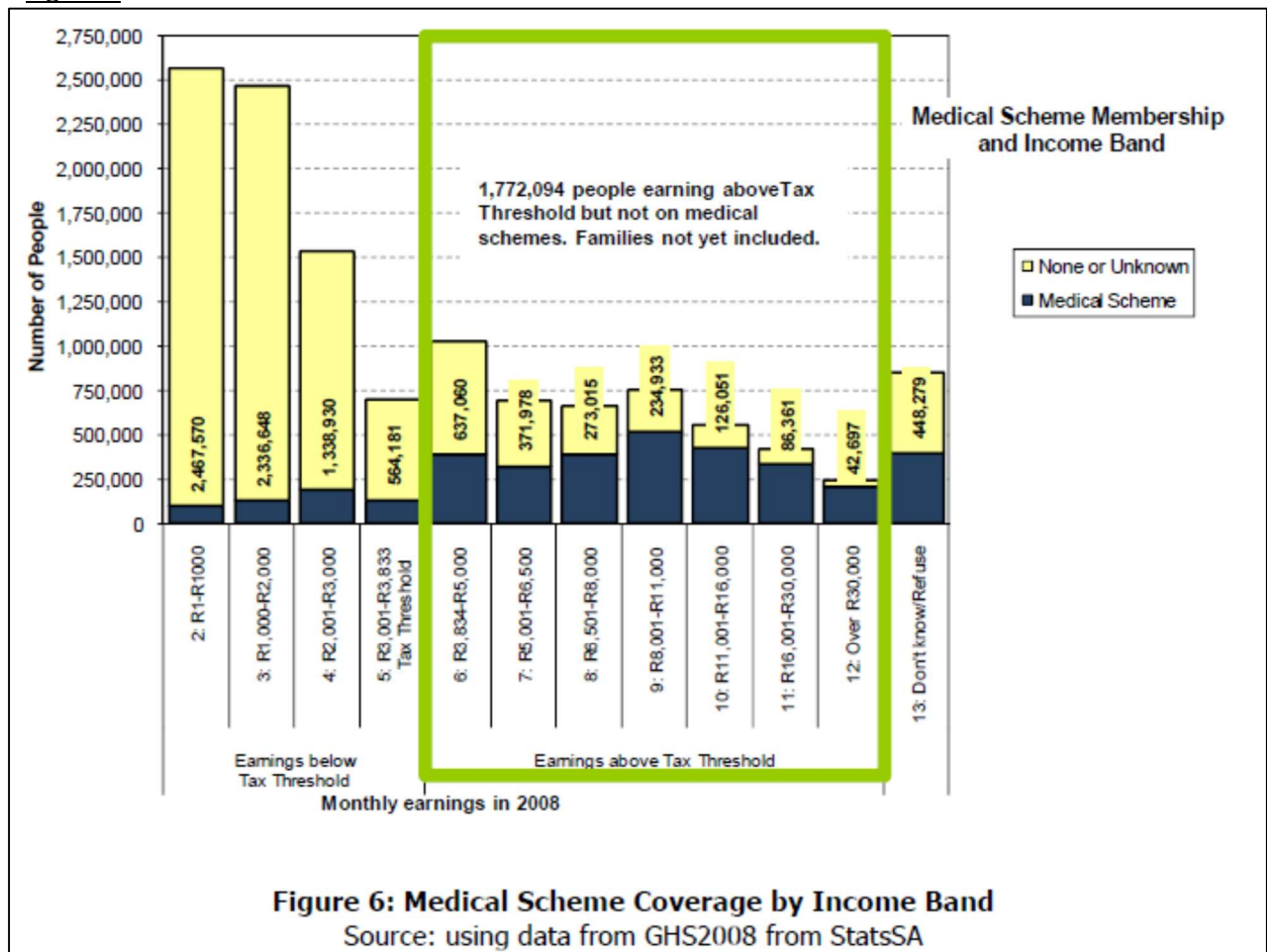
## The Cost Impact of Medical Scheme Legislation

The graph below is drawn from a study undertaken by Innovative Medicine SA (Brief 9 of 2010). It shows that there are almost 1.8 million taxpayers earning above the tax threshold who do not belong to a medical scheme.

These members are fully entitled to belong to a medical scheme and have the financial means to do so, especially the higher income bands. Considering that this graph is measuring tax payers (i.e. adults of working age), who would be supporting other dependents (minors and/or spouses), the potential membership that arguably should be in the medical scheme net, but are not, is around 4 million beneficiaries.

The current medical scheme membership is approximately 8.9 million beneficiaries, so the potential membership that are not participating, represent approximately 45% of the current medical scheme membership base.

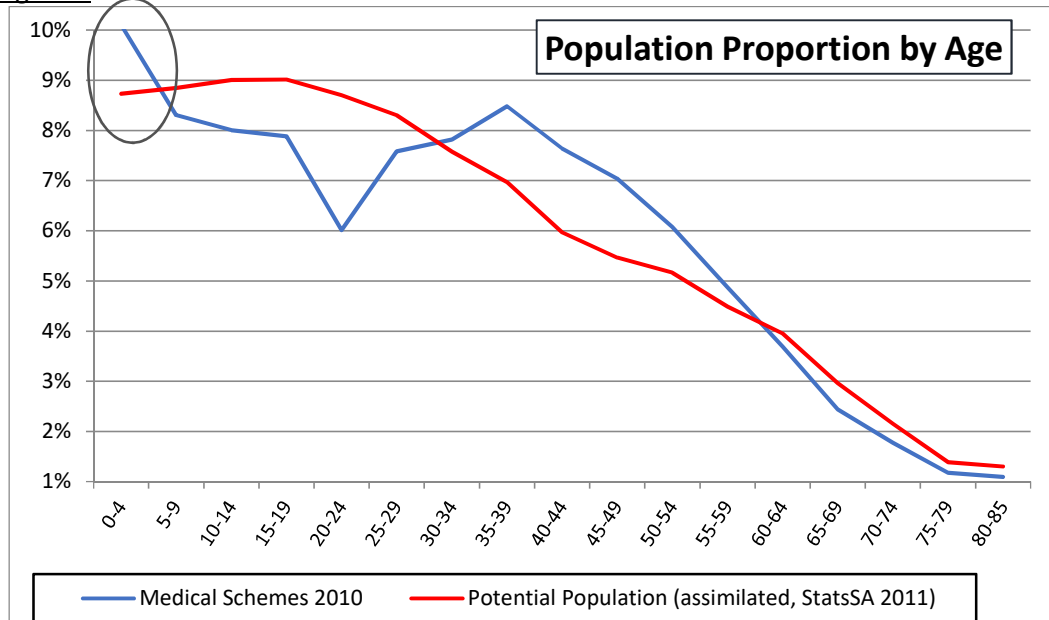
Figure 1



It is correctly assumed that members who have the financial means to belong to a medical scheme, but elect not to, are younger and/or healthier than the existing medical scheme population.

The graph below corroborates this – it compares the **potential population** age distribution by age band with that of the **existing medical scheme members**.

Figure 2



Source: CMS Annual Report 2010 (adj to Stats SA Format); Stats SA Mid-Year Population Est (2011)

It is evident from the above graph that the existing medical membership is underrepresented in the age categories below 35 years and conversely over represented in those above 35 years.

It is also well known that age is the **most significant driver** of health costs, especially in tertiary services such as specialist and hospital costs.

Clearly, as costs accelerate with age, it becomes too risky to remain uninsured and therefore we witness the higher than normal representation in the 35+ year age groups of medical scheme beneficiaries.

The only exception is the high risk and cost often associated with childbirth – and hence again we witness an over representation of young infants in the medical scheme population<sup>1</sup> in the above graph (circled in green). Young couples intending to start a family join a medical scheme knowing that they will be entitled to full benefits within 12 months.

Families also become selective in terms of which family members they decide to add to their medical scheme cover. There is no legal prescription to have all dependents in a family on cover. Families can leave off their younger healthier children or choose only to cover the member with a serious health condition.

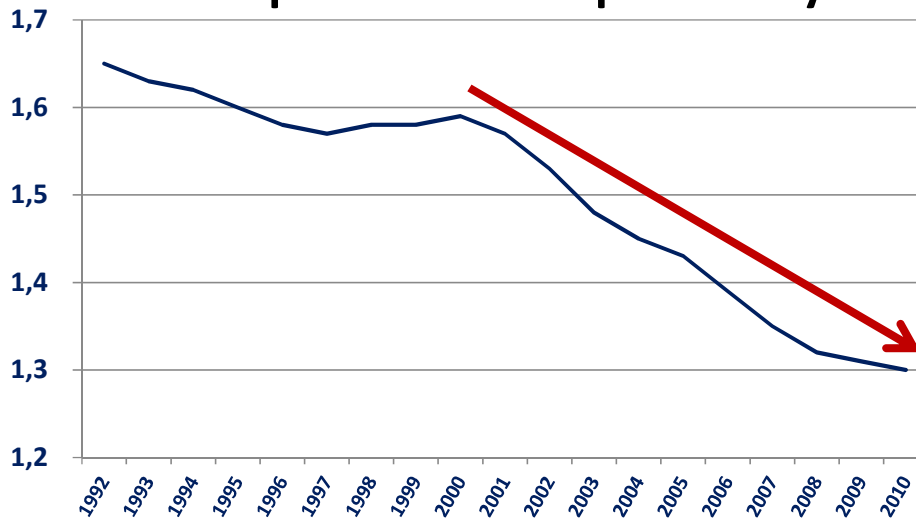
It is very apparent to see the substantial reduction in family size since introduction of the MSA in 2000.

<sup>1</sup> CMS data shows age categories of younger than 1 year and then from 1 to 4 years. However, StatsSA data only provides a category from 0 – 4 years so no direct comparison is possible for infants younger than 1 year.



Figure 3

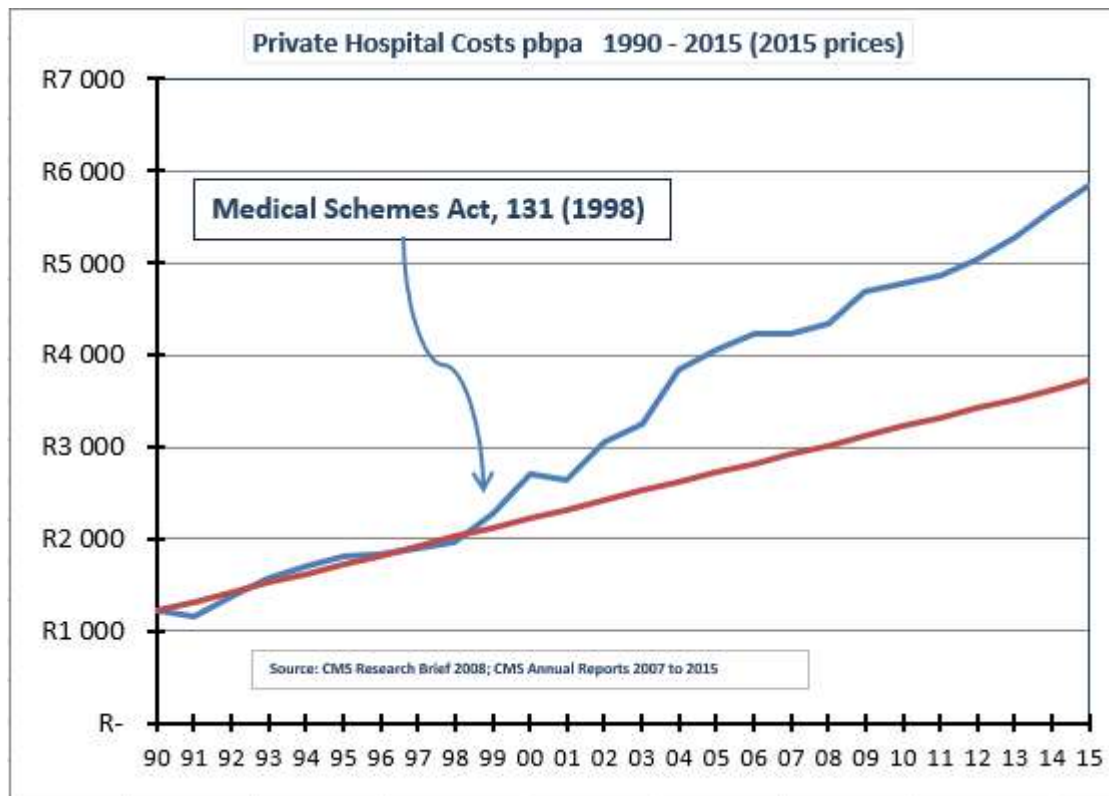
## Dependent Ratio per Family



This type of human behaviour represents classic examples of the opportunistic behaviour by consumers ('anti-selection'). Anti-selection has become widespread in the industry and is given legitimacy by the unfortunately skewed policy framework that underpins the MSA.

The graph below reflects the average cost of hospital services per beneficiary per annum for the period 1990 to 2015. The graph is shown in 2015 values.

Figure 4



The red trend line shows the rate of increase in hospital costs in the 1990's (i.e. prior to the implementation of the current Medical Schemes Act 131. The current Act's provisions came into effect in 2000 and it is clearly evident from the above graph that hospital costs increased at a level well above the trend line of the 1990's since the advent of the current Medical Schemes Act.

This has forced medical schemes to increase contributions substantially above CPI levels and simultaneously decrease or strip out benefits over the same period (i.e. 2000 to 2015).

An actuarial study conducted by experienced healthcare actuary, Barry Childs (Lighthouse Actuarial, 2013), estimated that the impact of maintaining open enrolment and community rating without a concomitant balancing of these risks with mandatory participation, has raised claims costs in the private sector between 30 and 35% higher than they would have been without these onerous provisions.

We submit that the regulatory framework that government has created for medical schemes to operate in for the past 18 years, is the primary reason that private healthcare costs have risen so significantly in South Africa. We do not see that any of these problems are being addressed within this bill. The lack of appropriate regulation of the private sector has also been raised in the findings of the Competition Commission's Health Market Inquiry.<sup>2</sup>

## Risk Concerns on the Medical Schemes Amendment Bill

The following points are raised with regards to areas of risk within the bill:

- Sec 1 (d) - The definition of broker allows for an employer, employer representative or trade union to undertake advisory services as contemplated in the FAIS Act. This is contradictory to the intent of the FAIS Act that any person/s providing advice is appropriately qualified to do so.
- Sec 2 – We question why it is proposed that the Act be exempted from the provisions of the Consumer Protection Act.
- Sec 5 – We question how it can be asked of the Council to support the objectives of the NHI Fund and simultaneously regulate medical schemes in an objective, fair and transparent manner. It cannot be assumed that the objectives of the NHI Fund will always align with or be of benefit to the objectives of schemes, which need to be safeguarded by the Council.
- Sec 13 – It states in 32B (2) that medical schemes may not impose waiting periods in respect of a child and that the scheme must enrol such child upon application. It is contended that this clause enables anti-selection since parents planning on or who are already pregnant can join the scheme just prior to the child's birth and enjoy unlimited and immediate benefits. We contend that should the parents, or more specifically the mother, be in a waiting period at the time of birth, that such waiting periods should apply equally to the new born child. There is substantial empirical evidence that anti-selection exists around this matter and that the ability to do so should in fact be removed from the Bill, not enhanced as is being proposed currently.

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<sup>2</sup> Justice Sandile Ngcobo. Presentation of the HMI Provisional Report. Accessed 20-09-2018. Available at: <http://www.compcom.co.za/wp-content/uploads/2018/07/Panel-Chair-Former-Chief-Justice-Sandile-Ngcobo.pdf>

- It is also not clear if the intention of this clause is to allow enrolment at any stage in the child's life or if the intention is that the child must be enrolled immediately upon birth. If it is the former, then this clause will permit even further anti-selective behaviour against schemes.
- New Section 32F (2) – by specifying contribution maximums of the categories of child and young adult beneficiaries (as a % of adult contributions) will create a perverse incentive to maximise the adult contribution. This may result in schemes setting adult contributions at higher rates than even the principal member rate. As is evidenced by the change in dependent ratios since 2000 (see Figure 3 above), this anti-selective behaviour may worsen with this provision. In any event, the percentages shown give the opposite effect to the social solidarity principle of the old being subsidised by the young, since the contributions of members over the age of 30 will need to be raised to compensate for the lost income in providing a subsidy for members below 30. We propose that this clause be excised and allow schemes the right to set their own contributions and maximums according to their actuarially calculated risks.

## The Constitution

The Constitution contains various provisions, especially in the Bill of Rights, that protect the freedom of South Africans to determine their own destinies. This can be summed up in the notion of freedom of choice, or freedom of enterprise.

The most important provision underlying all of the other provisions is found in section 1 of the Constitution – the Founding Provisions. Section 1(a) provides that South Africa is founded on “[h]uman dignity, the achievement of equality and the advancement of human rights **and freedoms**” (our emphasis). This provision permeates all the provisions of the Bill of Rights by virtue of being a founding value.

Other provisions relevant to freedom of choice include the following:

- Section 7(1) provides that the Bill of Rights “enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and **freedom**” (our emphasis). Section 9(2) provides that the right to equality “includes the full and equal enjoyment of **all rights and freedoms**” (our emphasis).
- Section 10 provides that “[e]veryone has inherent dignity and the right to have their dignity respected and protected”. According to the Department of Justice and Correctional Services, this means that “[n]o person should be perceived or treated merely as instruments or objects of the will of others. Every person is entitled to equal concern and to equal respect”.<sup>3</sup>
- Section 12(1)(a) provides that everyone has the right “not to be deprived of freedom arbitrarily or without **just** cause” and section 12(1)(c) guarantees the right of everyone “to be free from all forms of violence from **either public or private sources**” (our emphasis).
- Section 13 prohibits “slavery, servitude or forced labour”, the converse of which will also be true: forced unemployment or labour disassociation.

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<sup>3</sup> [http://www.justice.gov.za/brochure/2014\\_ConstitutionRights.pdf/](http://www.justice.gov.za/brochure/2014_ConstitutionRights.pdf/).

- Section 14 guarantees the right to privacy, meaning private affairs should not be interfered with or monitored without consent.
- Section 18 provides that “[e]veryone has the right to freedom of association”. This right means that natural or juristic persons may associate or disassociate with whomever they wish and cannot be forced by law or other coercive means to associate or disassociate.
- Section 22 provides that all citizens have “the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law”. The language of the provision is clear, in that the *practice*, but not the *choice*, of profession may be *regulated*, but not *prohibited*. To read prohibition into regulation would make the entirety of the provision and the ‘right’ redundant. No provision in the Constitution may be construed as being redundant or inconsequential.

With reference to healthcare specifically, section 27(a) of the Constitution provides that, “Everyone has the right to have access to health care services, including reproductive health care”. This, read with the above, clearly implies that South Africans have the right to freely choose their healthcare service providers and services. While the State is obliged in section 27(2) to “take reasonable legislative and other measures ... to achieve the progressive realisation of [this right]”, this provision cannot be read to mean the State may in the process violate the freedom of South Africans to exercise, on their own, their right to access to healthcare.

Chapter 2 of the Constitution – the Bill of Rights – does not ‘create’ rights, but merely protects pre-existing rights from infringement. Section 7(1) states that the Bill of Rights “enshrines” the rights, not creates them. Enshrining something, in the constitutional sense, means to place that thing somewhere where it is protected, in this case, in a constitution.<sup>4</sup> South Africans have rights outside of the Constitution, and if a provision in the Bill of Rights is repealed, that does not mean South Africans ‘lose’ that right. If this were the case, there would be little use in referring to rights as ‘human’ rights, as section 1 and the Preamble of the Constitution do. South Africans are all rights-bearing entities because we are humans with dignity and individuality, not because government has ‘given’ us those rights.

The rights in the Bill of Rights can be limited by operation of section 36, but the basic essence of the right in question must remain. Indeed, if protection for human rights is removed from the Constitution or otherwise perverted through legislative ‘limitation’, South Africa’s constitutional project will be severely undermined in that the highest law will continue to recognise the rights in question, but will not adequately protect them. This is not a situation South Africans would want to find themselves in. By implying that government can extinguish rights simply by enacting legislation dressed in the garb of ‘protecting’ the people while undermining their freedom, the impression is created that rights are an idea owned by the State, and not the people. This would be faulty both according to human rights theory, but also according to the logic of the Constitution itself.

<sup>4</sup>

<https://dictionary.cambridge.org/dictionary/english/enshrine>.

## The Rule of Law

Section 1(c) of the Constitution provides that South Africa is founded upon the supremacy of the Constitution and the Rule of Law. Section 2 provides that any law or conduct that does not accord with this reality is invalid. This co-equal supremacy between the text of the Constitution and the doctrine of the Rule of Law remains underemphasised in South African jurisprudence, but it is important to note for the purposes of this submission.

The FMF's Rule of Law Project's Board of Advisors formulated the following ten Imperatives of the Rule of Law:

**1st Imperative:** All law must be clear, predictable, accessible, not contradictory, and shall not have retrospective effect.

**2nd Imperative:** All legislation that makes provision for discretionary powers, must also incorporate the objective criteria by which those powers are to be exercised. The enabling legislation must, in addition, stipulate the purpose or purposes for which the powers may be exercised.

**3rd Imperative:** All law must apply the principle of equality before the law.

**4th Imperative:** All law must be applied fairly, impartially, and without fear, favour or prejudice.

**5th Imperative:** The sole legitimate authority for making substantive law rests with the legislature, which authority shall not be delegated to any other entity.

**6th Imperative:** No law shall have the aim or the effect of circumventing the final authority of the courts.

**7th Imperative:** No one may be deprived of or have their property expropriated, except if done with due process for the public interest, and in exchange for compensation that is just and market-related.

**8th Imperative:** The law shall afford adequate protection of classical individual rights.

**9th Imperative:** All law must comply with the overriding principle of reasonableness, which comprehends rationality, proportionality, and effectiveness.

**10th Imperative:** The legislature and organs of state shall observe due process in the rational exercise of their authority.

One of the Constitutional Court's most comprehensive descriptions of what the Rule of Law means was in the case of *Van der Walt v Metcash Trading Ltd*. In that case, Madala J said the following:

"[65] The doctrine of the rule of law is a fundamental postulate of our constitutional structure. This is not only explicitly stated in section 1 of the Constitution but it permeates the entire Constitution. The rule of law has as some of its basic tenets:

1. the absence of arbitrary power – which encompasses the view that no person in authority enjoys wide unlimited discretionary or arbitrary powers;

2. equality before the law – which means that every person, whatever his/her station in life is subject to the ordinary law and jurisdiction of the ordinary courts.
3. the legal protection of certain basic human rights.

[66] The concept of the rule of law has no fixed connotation but its broad sweep and emphasis is on the absence of arbitrary power. In the Indian context Justice Bhagwati stated that:

‘the rule of law excludes arbitrariness and unreasonableness.’

We would also add that it excludes unpredictability. In the present case that unpredictability shows clearly in the fact that different outcomes resulted from an equal application of the law.”<sup>5</sup>

The Rule of Law thus:

- Permeates the entire Constitution.
- Prohibits unlimited arbitrary or discretionary powers.
- Requires equality before the law.
- Excludes arbitrariness and unreasonableness.
- Excludes unpredictability.

The Good Law Project’s *Principles of Good Law* report largely echoed this, saying:

“The rule of law requires that laws should be certain, ascertainable in advance, predictable, unambiguous, not retrospective, not subject to constant change, and applied equally without unjustified differentiation.”<sup>6</sup>

The report also identifies four threats to the Rule of Law,<sup>7</sup> the most relevant of which, for purposes of this submission, is the following:

“[The Rule of Law is threatened] when laws are such that it is impossible to comply with them, and so are applied by **arbitrary discretion** [...]”

Friedrich Hayek wrote:

“The ultimate legislator can never limit his own powers by law, because he can always abrogate any law he has made. The rule of law is therefore not a rule of the law, but a rule concerning what the law ought to be, a meta-legal doctrine or a political ideal.”<sup>8</sup>

What is profound in Von Hayek’s quote is that he points out that *the* Rule of Law is not the same as *a* rule of *the* law. Indeed, any new Act of Parliament or municipal by-law creates and repeals multiple ‘rules of law’ on a regular basis – expropriation without compensation would be an example of ‘a’ rule of ‘the’ law. The Rule of Law is a doctrine, which, as the Constitutional Court implied in *Van der Walt*, permeates all law, including the Constitution itself.

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<sup>5</sup> *Van der Walt v Metcash Trading Ltd* 2002 (4) SA 317 (CC) at paras 65-66. Citations omitted.

<sup>6</sup> Good Law Project. *Principles of Good Law*. (2015). 14.

<sup>7</sup> Good Law Project 29.

<sup>8</sup> Von Hayek FA. *The Constitution of Liberty*. (1960). 206.

Albert Venn Dicey, known for his *Introduction to the Study of the Law of the Constitution*, and considered a father of the concept of the Rule of Law, wrote that the Rule of Law is “the absolute supremacy or predominance of regular law as opposed to the influence of arbitrary power, and excludes the existence of arbitrariness, of prerogative, or even wide discretionary authority on the part of the government”.<sup>9</sup>

Dicey writes “the rule of law is contrasted with every system of government based on the exercise by persons in authority of wide, arbitrary, or discretionary powers of constraint”.<sup>10</sup> He continues, saying the Rule of Law means “the absolute supremacy or predominance of regular law as opposed to the influence of arbitrary power, and excludes the existence of arbitrariness, of prerogative, or even of wide discretionary authority on the part of the government”.<sup>11</sup>

The opposition to arbitrary power should not be construed as opposition to discretion in and of itself. Officials use discretion to determine which rules to apply to which situation, and thus some discretionary power is a natural consequence of any system of legal rules. However, the discretion must be exercised per criteria which accord with the principles of the Rule of Law, and the decision itself must also accord with those principles.

A common example of arbitrary discretion is when a statute or regulation empowers an official to make a decision “in the public interest”. What is and what is not “in the public interest” is a topic of much debate, and empowering officials to apply the force of law in such a manner bestows upon them near-absolute room for arbitrariness. The “public interest”, however, can be one criterion among other, more specific and unambiguous criteria.

The fact that some discretion should be allowed is a truism; however, the principle that officials may not make decisions of a substantive nature still applies. Any decision by an official must be of an enforcement nature, i.e. they must do what the legislation *substantively* requires. For instance, an official cannot impose a sectoral minimum wage. The determination of a minimum wage is properly a legislative responsibility because it is of a substantive nature rather than mere enforcement. Unfortunately, the Basic Conditions of Employment Act gives the Minister of Labour the authority to make “sectoral determinations” – which includes determining a minimum wage – which is a clear violation of the Rule of Law and the separation of powers.<sup>12</sup>

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<sup>9</sup> Dicey AV. *Introduction to the Study of the Law of the Constitution*. (1959, 10<sup>th</sup> edition). 202-203.

<sup>10</sup> Dicey 184.

<sup>11</sup> Dicey 198.

<sup>12</sup> Section 51 of the Basic Conditions of Employment Act (75 of 1997).



## Legal Matters Relating to the Medical Schemes Amendment Bill

Clause 4(a), which amends section 7(e), provides that one of the functions of the Council for Medical Schemes is to collect and disseminate information about “any aspect” of private healthcare, “including information about the prices, utilisation and costs of relevant health services”.

Clause 6, which inserts a section 8A, provides that the Council may require medical schemes to furnish it with any information it wants in relation to services rendered by healthcare providers. This provision violates the Rule of Law imperative that no law shall have the aim or effect of circumventing the final authority of the courts. This information is the proprietary information of the providers and they should have the authority to determine whether third parties may have access. Failing their consent, a court would ordinarily be empowered to hear the regulator’s case on why the information, as a matter of public interest, must be made available to it, and that court may then approve a warrant. Clause 6 circumvents this process entirely. We submit that this provision be excised from the Bill unless it explicitly states that it must be done by way of an ordinary warrant.

Clause 15, which inserts a section 32I, provides that the Council shall “determine comprehensive service benefits and specify relevant health services in relation to [the] comprehensive service benefits”. This provision contains no criteria, meaning the Council’s determination is unconstrained and its power unlimited. This violates the Rule of Law imperative that when legislation assigns discretionary power, criteria must be incorporated, and the purposes for which that power may be exercised must be spelled out. We submit that this provision be excised from the Bill unless objective criteria is incorporated into it.

Clause 16, which inserts a new section 33(1), provides that a medical scheme may not offer any benefit unless that benefit has been approved by the Registrar.

Clause 16, which inserts a new section 33(2), provides the Registrar with the power to not approve the offering of a benefit if “in his or her opinion” it will “run at a loss”, unless the Registrar “is satisfied that” *inter alia* “it will be in the best interests of the beneficiaries”. This power is unlimited and unconstrained and can yield absurd results. The NHI Bill provides that NHI Fund cover for treatment may be refused to users if a health practitioner believes the treatment is not “cost-effective”, meaning the user only has recourse to private schemes. Read with this provision, it might come to pass that the NHI Fund refuses to cover necessary treatment while the Registrar also refuses to allow a scheme to offer a benefit, meaning some will have no recourse to have their treatment covered unless they pay out of pocket. The refusal to approve a benefit also does not require justification or an explanation, since only the Registrar’s “opinion” is required to refuse. This provision, thus, does not only fall foul of the Rule of Law for not specifying criteria for when the Registrar may or may not refuse a benefit, but is also a direct attack on South Africans’ section 27 constitutional right to access to healthcare. We submit that this provision be excised from the Bill.

Clause 17, which amends section 34, provides that the Registrar may “restrict the extent of benefits offered by medical schemes” if those benefits and services are covered under the NHI Fund, “thereby eliminating duplicative costs for the same benefit”. This provision is extremely problematic. Like the above: The NHI Bill provides that NHI Fund cover for treatment may be refused to users if a health practitioner believes the treatment is not “cost-effective”, meaning the user only has recourse to private schemes. Read with this provision, it might come to pass that the NHI Fund refuses to cover necessary treatment while the Registrar also restricts medical schemes from covering that treatment, meaning some will have no recourse to have their treatment covered unless they pay out of pocket. This provision does not only fall foul of the Rule of Law for not specifying criteria for when the Registrar



may or may not restrict benefits and services but is also a direct attack on South Africans' section 27 constitutional right to access to healthcare. We submit that this provision be excised from the Bill.

Clause 18, which amends section 44(8), provides that the Registrar may restrict medical schemes' non-healthcare expenditure. No purpose for this power is stated, meaning that this provision does not only assign an unrestrained discretionary power, but the power itself is unjustified. The Registrar will be empowered to arbitrarily tell medical schemes how much money they may spend on, for example, office furniture or catering, which is a clear impairment of South Africans' constitutional right to freedom. We submit that this provision be excised from the Bill, unless criteria and justification can be incorporated.

Clause 26, which inserts a section 56E, provides for the power of the Registrar to determine the maximum remuneration for trustees, chief executive and financial officers of medical schemes. This provision contains no criteria, meaning the Registrar can arbitrarily determine ceilings without any regard to market realities. This power can be abused for personal or political gain. We submit that this provision *in toto* be excised from the Bill.

Clause 26, which inserts a section 56O(c), provides that the Registrar may direct a medical scheme "where, in the opinion of the Registrar, the medical scheme or any of its officers are acting ... contrary to the best interests of the members of the medical scheme, to cease so acting or to remedy the adverse consequences of having so acted". This provision contains no criteria and thus amounts to an unlimited discretionary power, which falls foul of the Rule of Law. The Registrar need simply be of the opinion that some conduct is detrimental to the members of the scheme, which is an extremely low threshold which jurisprudentially requires no explanation or justification. We submit that this provision be excised from the Bill, and if necessary, be replaced with a provision with objective legal criteria.

## Summary and Conclusion

As a result of government regulations and legislation, South Africa simply does not have a properly functioning private health insurance market. This must be corrected as a matter of urgency. People must not be prevented from entering into mutually beneficial contracts that will minimise their risk of financial catastrophe when tragedy strikes.

The published Bill is an extension of, maintenance of or strengthening of the provisions of the current Medical Schemes Act (131 of 1998). The evidence provided in our submission clearly demonstrates that this regulatory framework is largely responsible for the significant cost increases that have been seen since the advent of the provisions of this Act in 2000.

The provisions contained within this Bill are by and large not addressing the core issues that are negatively affecting the private healthcare market. It is pushing the cost of private care beyond the reach of more and more citizens as each year passes. This exacerbates the government's responsibility in terms of providing healthcare to citizens. It is our view that it is wholly unsustainable to maintain a voluntary market with the provisions of open enrolment and community rating and the evidence is clear to see.

The only two methods available to fix this are to either introduce mandatory membership to avert the anti-selection that is effectively mandated under the current Act, or to scrap the social solidarity principles and allow a risk-rated, voluntary environment.

Moreover, the MSA Bill proposes to vest unrestrained and unlimited discretionary and law-making powers in the hands of officials, which is a direct breach of government's obligation under section 1(c) of the Constitution to respect the supremacy of the Rule of Law. The Rule of Law excludes the rule of man – unlimited power in the hands of functionaries – and demands that South Africans only be bound by the law, not the transient whims of politicians or officials. In some cases, these unrestrained powers will yield absurd, if not oppressive, consequences, which might see South Africans also deprived of their section 27 right to have access to healthcare. This makes the constitutionality of the MSA Bill highly suspect.

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