

## NOTES / AANTEKENINGE

### CURE OR CURSE? REGULATIONS ON THE DEMARCATION BETWEEN HEALTH-INSURANCE POLICIES AND MEDICAL SCHEMES

#### 1 Introduction

In South Africa, private insurance policies are regulated by the Long-term Insurance Act (52 of 1998, hereinafter “LTIA”) and the Short-term Insurance Act (53 of 1998, hereinafter “STIA”). Medical schemes fall under the Medical Schemes Act (131 of 1998) and yet, despite the fact that there are three dedicated statutes that deal with the risks relating to ill health, it seems that the distinction between insurance products and medical-scheme benefits is not so clear. On 2 March 2012 National Treasury published the proposed amendment of regulations made under section 72 of the LTIA and under section 70 of the STIA (“Long-term Insurance Act, 1998: Publication of Proposed Amendment of Regulations made under Section 72 for Public Comment” GG 35114 of 2 March 2012; and “Short-term Insurance Act, 1998: Publication of Proposed Amendment of Regulations made under Section 72 for Public Comment” GG 35114 of 2 March 2012). These are jointly referred to as the “Demarcation Regulations”. This note provides an overview of these proposals against the background of the difference between insurance business and medical-schemes business. In addition, it investigates the policy principles that informed the Demarcation Regulations and comments on the impact of those on the insurance industry and on medical schemes.

#### 2 Insurance business and medical schemes

As indicated, it is often difficult to determine the exact nature of a particular product and the legislation applicable thereto. Reinecke, Van der Merwe, Van Niekerk and Havenga (*General Principles of Insurance Law* 3ed (2002) 5–6) argue that a distinction between short-term and long-term insurance is embodied in the respective statutory definitions. Accordingly, “short-term insurance business” means the business of providing policy benefits under defined short-term policies, which include engineering policies, guarantee policies, liability policies, miscellaneous policies, motor policies, accident and health policies, property policies or transportation policies or even a contract which combines any of those policies (s 1(1) of the STIA). Long-term insurance on the other hand refers to assistance policies, disability policies, fund policies, life policies or sinking-fund policies or any contract which combines any of these policies (s 1(1) of the LTIA). Upon analysis, it

becomes evident that the policies provided for by the STIA are mostly indemnity insurance (Reinecke *et al General Principles of Insurance Law 6*). However, accident and health policies under the current STIA are forms of capital insurance, with the result that the distinction between short-term and long-term insurance is not exactly clear at the moment (Reinecke *et al General Principles of Insurance Law 6*). One may very well ask whether it is really all that important to have a strict separation of the different types of insurance. It helps to recall the fundamental distinction between capital and indemnity insurance: A contract for capital insurance aims to provide an insured with a specified amount or periodical amounts on the happening of the event insured against and the object of a capital insurance contract is non-patrimonial (Reinecke *et al General Principles of Insurance Law 5*). Therefore, the insured will for example insure his life and upon his death, the insurance company is obliged to pay out the amount agreed upon. With an indemnity-insurance contract on the other hand the interest insured must be of a patrimonial nature, such as an asset (Reinecke *et al General Principles of Insurance Law 5*).

There are also those eventualities that cannot form the object of an insurance contract under short-term or long-term insurance because it is covered elsewhere. An example is compulsory third-party insurance in terms of the Road Accident Fund Act (56 of 1996). Should a road user cause death or injuries to others because of his negligent driving, those victims have claims against the Road Accident Fund and not against the perpetrator or his insurer (Klopper *The Law of Third Party Compensation* (2008) 20; and *Aetna Insurance v Minister of Justice* 1960 (3) SA 273 (A)). It is therefore possible for the legislator to formulate policies pertaining to certain risks and to prescribe how these risks should be dealt with.

Medical costs associated with illness can be provided for by medical schemes. These schemes assist their members with expenses associated with ill health. Currently, section 1 of the MSA defines a medical scheme as any scheme registered under section 24(1) of the Act, and the "business of a medical scheme" is defined as:

- "the business of undertaking liability in return for a premium or contribution
- (a) to make provision for the obtaining of any relevant health service;
  - (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
  - (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme."

Evidently there is not only an overlap between short-term and long-term insurance products but which deal with ill health but there is also no clear distinction between the business of a medical scheme and certain insurance products. National Treasury explains the fundamental difference between health policies and medical-scheme benefits by stating that a health-insurance policy is a binding contract between an insurance company and an individual (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za>

accessed 2012-03-30). This contract or policy can be sold by an insurance company in terms of the LTIA or the STIA (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za> accessed 2012-03-30). In addition, it is subject to regulatory oversight by the Financial Services Board ("FSB"). Any such policy undertakes to pay for certain agreed benefits when the individual is ill or injured (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za> accessed 2012-03-30). The insured pays a certain premium which is directly related to his age, health status or income. Often, specific exclusions are built into a policy, which can have the effect of determining to whom the policy may be sold (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za> accessed 2012-03-30).

In contrast, National Treasury describes medical schemes as non-profit organizations that belong to their members (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za> accessed 2012-03-30). A medical scheme collectively pools good and bad risks (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za> accessed 2012-03-30). This means that a scheme may not discriminate between individuals based on age or health status. Determined contributions apply universally to all members of the scheme and these may only vary in respect of the cover provided, hence the different benefits options (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za> accessed 2012-03-30). These are priced differently depending on the level of cover afforded, and the rules of the scheme determine that cover and its price. National Treasury states that: "[T]he effect is that there are equal premium contributions for high- and low-risk members, which promote greater equity in the scheme." In addition, medical schemes are regulated in terms of the Medical Schemes Act by the Council of Medical Schemes ("CMS") (*Frequently Asked Questions: Demarcation Between Health Insurance Policies And Medical Schemes 1* ("FAQ'S") <http://www.fsb.co.za> accessed 2012-03-30).

There seems to be a good case for the demarcation of insurance products and medical-schemes products. New regulations should ideally be based on sound principles which support the intended separation. The next paragraph sketches these principles.

### **3 Underlying policy principles**

The policy principles that informed the Demarcation Regulations may be described as open enrolment and community rating. Open enrolment refers to the social-security principle that ensures "non-discriminatory access to private healthcare financing" (10). This means that every person who applies for membership is guaranteed membership of an open medical scheme, regardless of their age and health status.

In turn, community rating refers to the payment of the same contribution by all those who belong to a specific benefit. This is the opposite of individual risk-rating, which entails the individual assessment of an individual and the charging of a corresponding premium (10). Community rating is said to have a number of benefits, which include considerable cross-subsidization between members in a particular benefit option, providing the most vulnerable members with affordable access to healthcare and preventing price discrimination against those who pose a high risk (10).

The Demarcation Regulations point out that it is necessary to change the existing legislation in order to achieve these policy principles and accordingly, there are seven initiatives which achieve these aims. First, the draft regulations identify those categories of accident and health policies which may be interpreted as doing the business of a medical scheme, but does not undermine the principles of open enrolment, community rating and cross-subsidization (10). Second, the policy benefits which may be provided under these categories are now prescribed to ensure that it is in fact insurance, thus further protecting the business of a medical scheme. In addition, clear criteria is being prescribed for contracts under these categories in order to ensure that these contracts clearly set out which policy benefits are paid for (10). Furthermore, the draft regulations also prescribe matters relating to the marketing of these categories of accident and health policies and, importantly, matters pertaining to disclosures that must be made by insurers and intermediaries (Demarcation Regulations 11). The final two initiatives involve the prescription of requirements for reporting product details of these categories of accident and health policies and the transitional arrangements for regularizing existing accident and health policies which do not comply with the draft regulations (Demarcation Regulations 11).

## **4 Summary of Draft Regulations**

### **4.1 *Short-term insurance***

For purposes of paragraph (b) of the definition of “accident and health policy” in the Short-Term Insurance Act, there are seven new categories of accident and health policies and a contract will only be an accident and health policy if that contract matches any of these categories of contracts (regulation 7.2 (1) of the Demarcation Regulations (STIA)). Accordingly, category 1 includes lump-sum or income-replacement policy benefits payable on a health event. These contracts may not provide policy benefits relating to medical expenses (regulation 7.2 (1) of the Demarcation Regulations (STIA)). Although category 1 policies are not easily confused with the business of a medical scheme, category one is specifically provided for in the Demarcation Regulations in order to avoid interpretational difficulties (par 7 of Schedule B to the Demarcation Regulations). Categories 2, 3, 4, 5, 6 and 7 deal with contracts that provide policy benefits relating to actual medical expenses associated with health events. Although these policies in fact constitute the business of a medical scheme, they are excluded from the business of a medical scheme as defined in the Medical Schemes Act because it is

alleged not to be harmful to the medical-schemes business (par 7 of Schedule B to the Demarcation Regulations). The remaining categories are the following, namely: Category 2, Motor: Third Party Liability; Category 3, Property: Third Party Liability; Category 4: HIV and Aids; Category 5: International Travel Insurance; Category 6: Domestic Travel Insurance; and Category 7: Emergency Evacuation or Transport (par 7 of Schedule B to the Demarcation Regulations).

It seems contradictory to say that categories two to seven do provide policy benefits relating to medical expenses but that these are not the business of a medical scheme. However, if one looks at the types of policies, it becomes clearer. Take for instance international travel insurance. A South African tourist who already belongs to a medical scheme may purchase travel insurance with his air ticket. Should this tourist require treatment whilst outside the borders of the Republic, the medical scheme will probably not cover the treatment, hence the need for travel insurance. Travel-insurance policies clearly do not compete with medical schemes. The same applies to categories two and three. If the roof of an insured home owner's house collapses on a guest and that guest requires medical treatment, the home owner's liability insurance covers his liability to make good his guest's damage which may include medical expenses, and this liability exists regardless of whether the injured guest is a member of a medical scheme or not. A motor-vehicle owner is in the same position where his passenger is injured in a hijacking.

The legislator evidently decides how risks should be dealt with. However, it is not always sure whether the legislator possesses Solomon's wisdom. It does seem strange that the legislator had opted to include HIV and Aids cover to be sold to the public, even though these products are directly related to the cost of medical care. In an attempt at an explanation for this decision, National Treasury is of the opinion that the "current social pressures in the public and private health-care sectors" have prompted the inclusion of voluntary health-insurance products that pertain specifically to HIV and AIDS (FAQ's 3).

In addition to the new categories of insurance, the Demarcation Regulations also include specific criteria for each category. Regulation 7.2(1) of the Demarcation Regulations sets out the policy benefits and specific criteria as follows:

CATEGORY	POLICY BENEFITS	CRITERIA
Category 1: Lump sum or income-replacement policy benefits payable on a health event.	Covers loss of income and contingency expenses associated with an insured person experiencing a specified health event.	<ul style="list-style-type: none"> <li>• Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract.</li> <li>• Policy benefits are limited to 70% of the policyholder's net income per day.</li> <li>• Policy benefits may be differentiated for different health events.</li> <li>• Policy benefits may be differentiated in accordance with the severity of different health events and expressed as a percentage of the sum assured, up to the maximum of 10 severity levels.</li> </ul>

CATEGORY	POLICY BENEFITS	CRITERIA
		<ul style="list-style-type: none"> <li>An elimination or deferred period may apply before policy benefits are paid.</li> </ul>
Category 2: Motor: Third Party Liability	Covers policyholders and insured persons for the costs associated with damages incurred during a theft or accident of a vehicle, including the costs of a relevant health service following the injury to occupants of the vehicle or a third party as a result of an accident	<ul style="list-style-type: none"> <li>Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> </ul>
Category 3: Property: Third Party Liability	Covers policyholders and insured persons for all damages or theft from property, including any costs of a relevant health service following the injury of third parties while on that property and/or compensation for bodily injury of the policyholder or insured person as a result of violent and external means.	<ul style="list-style-type: none"> <li>Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> </ul>
Category 4: HIV and AIDS	Covers expenses for HIV-related testing and HIV and AIDS treatment on an employee group basis.	<ul style="list-style-type: none"> <li>Cover offered to employers in respect of employees.</li> <li>Policy benefits may be paid in kind or to a provider of a relevant health service.</li> <li>Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> <li>Cover may be offered on a pre-funded or immediate needs basis.</li> </ul>
Category 5: International travel insurance	Covers costs associated with a relevant health service incurred while travelling outside South Africa, as a result of a health, disability or death event that occurs while not in the Republic.	<ul style="list-style-type: none"> <li>Policy benefits may be payable in kind or to a provider of a relevant health service.</li> <li>Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> <li>Cover may be offered on a pre-funded or immediate needs basis.</li> </ul>
Category 6: Domestic travel insurance	Covers costs associated with a relevant health service incurred while travelling inside South Africa, as a result of a health, disability or death event that occurs while in the Republic.	<ul style="list-style-type: none"> <li>Policy benefits may be payable in kind or to a provider of a relevant health service.</li> <li>Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> <li>Cover may be offered on a pre-funded or immediate-needs basis.</li> </ul>
Category 7: Emergency Evacuation or Transport	Covers guaranteed access to and utilization of specialized medical transportation and/or guaranteed hospital admission to ensure that the policyholder or insured	<ul style="list-style-type: none"> <li>Policy benefits are ancillary to the main policy benefits provided under the policy.</li> <li>Policy benefits may be payable in kind or to a provider of a relevant health service.</li> <li>Policy benefits may be linked to actual</li> </ul>

CATEGORY	POLICY BENEFITS	CRITERIA
	persons are admitted to an emergency treatment facility and stabilized.	costs or expenses of a relevant health service.

The Demarcation Regulations are very specific about the products that may be sold. In addition, regulation 7.2(2) specifies that any contract referred to in regulation 7.2(1) is prohibited from containing certain provisions, namely:

- that the policyholder or insured person must be a member of a medical scheme (reg 7.2(2)(a));
- a provision which entitles the insurer to refuse policy benefits because a policyholder had experienced a health event prior to obtaining cover, unless there was material misrepresentation or non-disclosure by the insured (reg 7.2(2)(b));
- a provision which entitles a policyholder to cancel, vary or refuse to renew a contract as a result of the health or claims experience of a policyholder or insured person, unless there was material misrepresentation or non-disclosure by the insured (reg 7.2(2)(c));
- a provision in terms of which policy benefits may be provided which are “fully or partially related to indemnifying the policyholder against medical expenses incurred in respect of a relevant health service” (reg 7.2(2)(d); and
- a provision that allows for the cession or payment of any policy benefits to a health services provider (reg 7.2(2)(e)).

It is submitted that these prohibited contract terms serve an important purpose. By preventing insurers from excluding those who do not belong to medical schemes, the legislator ensures that insurers do not market to and insure only those who already have access to some form of safety net. In addition, by stipulating that insurers can only repudiate claims or cancel, vary or refuse to renew policies when material facts were misrepresented or not disclosed, the legislator forces insurance companies to be more transparent and to provide cover to a larger number of the population.

Category 1 benefits are supposed to provide lump-sum or income-replacement benefits to an insured person who experiences a health event. The purpose of such a policy is clearly to enable an insured to replace or supplement his income. Such a payment may also enable the insured to cope with other day-to-day expenses, such as hiring an assistant to run a business in his absence. Furthermore, insurers should provide clients with proper advice in order to make sure that they purchase a suitable product which is in fact utilized for a particular risk that individual may run. Category 2 and 3 benefits cover individuals against two major risks, namely road accidents and crime. The prohibition against the cession of categories 1, 2 and 3 policy benefits to services providers is a good innovation. Often, private health-care providers refuse to treat patients who do not have a medical aid. Where a patient offers to cede his benefits, it may be indicative of the fact that the policy was inappropriate for that individual's needs and

that money that should have served as income replacement is now used to defray medical costs.

## 4.2 Long-term insurance

The Demarcation Regulations effectively propose to change the definition of “accident and health policy” in the Long-Term Insurance Act by introducing four new categories of accident and health policies. A contract will only be a health policy if that contract matches any of these categories of contracts (reg 7.2 (1) of the Demarcation Regulations). The new categories include the following, namely: Category 1: Lump Sum or Income Replacement Policy Benefits Payable on a health event; Category 2: Frail Care; Category 3: HIV and AIDS and Category 4: Emergency Evacuation or Transport (reg 7.2 (1) of the Demarcation Regulations).

Category 1 in terms of Regulation 7.2(1) of the Demarcation Regulations for Long-term insurance specifies policy benefits and criteria which are almost identical to Category 1 for short-term insurance which was discussed under 4.1 above. The only difference is that the proposed policy benefits in terms of the STIA refer to “insured person”, whereas the proposed policy benefits in terms of the LTIA refer to “life insured”. The criteria for Category 1 under both acts are also identical, with the proposed criteria in terms of the Long-term Insurance Act adding that “Cover may be offered on a whole of life or defined term basis.” This is highlighted in the table below. Another almost identical category is HIV and AIDS. The proposed Category 4 for the Short-term Insurance Act is identical to Category 3 for the Long-term Insurance Act as far as policy benefits and criteria are concerned, with an additional requirement for long-term insurance policies which allows for policy benefits to be “one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract.” This is also highlighted in the table below:

CATEGORY	POLICY BENEFITS	CRITERIA
1. Lump sum or income replacement policy benefits payable on a health event.	Covers loss of income and contingency expenses associated with an insured person experiencing a specified health event.	<ul style="list-style-type: none"> <li>• Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract.</li> <li>• Policy benefits are limited to 70% of the policyholder’s net income per day.</li> <li>• Policy benefits may be differentiated for different health events.</li> <li>• Policy benefits may be differentiated in accordance with the severity of different health events and expressed as a percentage of the sum assured, up to the maximum of 10 severity levels.</li> <li>• An elimination or deferred period may apply before policy benefits are paid.</li> <li>• <b>Cover may be offered on a whole of life or defined term basis.</b></li> </ul>
2. Frail care	Covers custodial care (assistance with activities of daily living) for policyholders.	<ul style="list-style-type: none"> <li>• Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract.</li> </ul>



CATEGORY	POLICY BENEFITS	CRITERIA
		<ul style="list-style-type: none"> <li>• Policy benefits may be paid in kind or to a provider of a relevant health service.</li> <li>• Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> <li>• Policy benefits may be paid on a pre-funded or immediate needs basis.</li> </ul>
3. HIV and AIDS	Covers expenses for HIV-related testing and HIV and AIDS treatment on an employee-group basis.	<ul style="list-style-type: none"> <li>• Cover offered to employers in respect of employees.</li> <li>• <b>Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract.</b></li> <li>• Policy benefits may be paid in kind or to a provider of a relevant health service.</li> <li>• Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> <li>• Cover may be offered on a pre-funded or immediate needs basis.</li> </ul>
4. Emergency evacuation or transport	Covers guaranteed access to and utilization of specialized medical transportation and/or guaranteed hospital admission to ensure that the life insured is admitted to an emergency treatment facility and stabilized.	<ul style="list-style-type: none"> <li>• Policy benefits are ancillary to the main policy benefits provided under the policy.</li> <li>• Policy benefits may be payable in kind or to a provider of a relevant health service.</li> <li>• Policy benefits may be linked to actual costs or expenses of a relevant health service.</li> </ul>

In addition to the above, regulation 7.2(2) of the Demarcation Regulations specifies that any contract referred to in regulation 7.2(1) is prohibited from containing certain provisions, namely:

- That the policyholder or insured person must be a member of a medical scheme (reg 7.2(2)(a));
- that the insurer may refuse policy benefits because a policyholder had experienced a health event prior to obtaining cover, unless there was material misrepresentation or non-disclosure by the insured (reg 7.2(2)(b); and
- that a policyholder may cancel, vary or refuse to renew a contract as a result of the health or claims experience of a policyholder or insured person, unless there was material misrepresentation or non-disclosure by the insured (reg 7.2(2)(c)).

Furthermore, no category 1 contract may provide policy benefits that are fully or partially linked to indemnifying the policyholder against medical expenses and it may also not allow for the session of any policy benefits to a health-services provider (reg 7.2(2)(d)(i) and (ii)). The same comment as was made in 4 2 above on cession of benefits to service providers, applies here.

### 4.3 *Marketing and disclosures and reporting of product information*

The Demarcation Regulations in terms of both the STIA and the LTIA set out the requirements for any marketing activities. These rule primarily that marketing material may not use the words “medical” or “hospital” (reg 7.3(a) of the Demarcation Regulations). Importantly, it may not create the perception that the contract “indemnifies a policyholder against medical expenses incurred as a result of a relevant health service” or “is a substitute for medical-scheme membership” (reg 7.3(b)(i) and (ii)). For contracts under both the STIA and the LTIA Regulation 7.3(c) of the Demarcation Regulations dictate that marketing material or activities must display in clear, legible print in a prominent position the following words: “This is not a medical scheme and the cover is not equivalent to that of a medical scheme. This policy is not a substitute for medical-scheme membership.”

In addition to this statement, policies under category 1 of the LTIA must also show the following statement: “The intention of this policy is to cover contingencies other than medical expenses. This policy may not be ceded and no benefit payments are allowed to be paid to a provider of a relevant health service through cessions or similar means” (reg 7.3(d)). In addition, such material must disclose and explain in easily understood language the matters referred to in section 48 of the Act, and that the contract is not a medical scheme and the cover is not a substitute for or equivalent to a medical scheme (reg 7.3(e)(i) and (ii)). Marketing material for policies under the categories proposed for short-term insurance must “clearly disclose and explain in easily understood language the matters referred to in Regulation 7.2(3)(b)” (reg 7.3(d)).

In addition, insurers should submit a summary of benefits, terms and conditions of a new accident and health policy they wish to launch to the Registrar of Long-term Insurance or the Registrar of Short-term Insurance, depending on the applicable statute and to the registrar of Medical Schemes (reg 7.4(1)). It is then within their discretion to suggest amendments to the product or to prohibit the marketing of the product (reg 7.4(3)).

### 4.4 *Transitional arrangements*

This new dispensation will require insurers to review existing policies. Regulation 7.5(1) also requires insurers to provide the registrars of long-term and short-term insurance and medical schemes with a summary of “the benefits, terms and conditions and marketing material of all existing accident and health policies introduced or launched on or after 15 December 2008. This will enable the respective registrars to evaluate these policies for non-compliance with the Demarcation Regulations.

## 5 **Comment**

It is clear that the intention of the *Demarcation Regulations* is not so much to differentiate between short-term and long-term insurance but rather to

---

identify those risks which may be associated with health events, to group these together under either long-term or short-term insurance and to distinguish further the benefits payable in terms of insurance policies from benefits provided by medical schemes.

One of the benefits of so grouping together different policies and products is that insurance companies are forced to sell only products they are licensed to sell. Employees of these companies or independent advisors or intermediaries are also clear on the nature of the benefits available under these statutorily defined policies and it may just be that it will in future be easier to provide a prospective client with correct and appropriate advice, thus enabling him to purchase a product that meets his needs. In addition, by prescribing the criteria for insurance products, the legislature ensures that purely risk-based products remain under the umbrella of true insurance, whereas products which guarantee membership to an applicant regardless of his/her age and health status, as well as payment of the same contribution by all those who belong to a specific benefit-option resort under the Medical Schemes Act. By making this clear to consumers, a scheme ensures that the benefits of considerable cross-subsidization between members in a particular benefit option of a medical scheme become evident. By effectively protecting the business of medical schemes, it is perhaps possible to increase the scope medical schemes, thereby providing vulnerable members of society with affordable access to healthcare.

It is not clear what the role of medical aids will be in Government's proposed national-health system. At this stage one can only speculate on the future of medical aid schemes. However, what is clear is that the Demarcation Regulations seek to differentiate between risk-based and other products. Perhaps this distinction will make it easier for consumers to make the right decision in procuring products aimed at providing assistance for health-related expenses and pave the way for a fairer dispensation for consumers. Only time will tell whether this innovation will indeed serve Government's aims.

Daleen Millard  
*University of Johannesburg*