

National Health Insurance: a future for medical schemes? Possibly.

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Millions of South Africans derive a certain peace of mind that their healthcare needs will be covered by the provision of medical scheme insurance.

Medical schemes, therefore, in various forms, provide benefits that are designed to assist beneficiaries to defray healthcare expenditure, especially in circumstances where that expenditure is unforeseen in time of an emergency or a diagnosis of a dreaded disease.

Whether or not one is a supporter of medical schemes and the role that they play in the delivery of and access to healthcare services, it is incontrovertible that medical schemes play a role in both the delivery of and access to healthcare services.

Taking into account the proposals that are being made about re-engineering the delivery of and access to healthcare services in South Africa in terms of the provisions of the National Health Insurance Bill ("the Bill"),^[1] as it currently stands, the question arises as to the position that medical schemes and their beneficiaries will find themselves in under a national health insurance or NHI regime: a vexed question indeed.

As the Bill currently stands, two provisions appear to endeavour to define the role of medical schemes under NHI in the Bill. The first of those provisions is clause 33.

Clause 33 states that "[o]nce National Health Insurance has been fully implemented as determined by the Minister [of Health] in the *Gazette*, medical schemes may only offer complementary cover to services not reimbursable by the Fund."

Very little is given away about the scope and ambit of clause 33 in so far as the particular language that is used in that clause is concerned.

However, the term "complementary cover" is defined in clause 1 of Bill as "third party payment for personal health care service benefits not reimbursed by the Fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund."

The second of the clauses in issue is clause 6(o), which provides that users, as that term is defined in the Bill, of the Fund have a right to "purchase health care services that are not covered by the Fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act...".

On the face of the two clauses referred to above, medical schemes are to be limited to providing benefits that are not otherwise provided by the Fund. The reasons for such a limitation are not apparent from the Bill but the question as to why medical schemes should be limited in such a manner deserves an answer.

The two clauses, referred to above, employ different language to arguably the same end: a limitation on medical schemes to provide certain benefits. In clause 33, medical schemes may not provide benefits otherwise "reimbursable by the Fund".

The meaning of reimbursable is not clear from the Bill. However, taken at its ordinary meaning, and within the context of the scheme of the Bill, that term must mean a liability to be discharged by the Fund, on behalf of a user of the Fund, in respect of the costs of the provision of a healthcare service by an accredited healthcare provider to the user concerned.

Such a position is supported by the overall intention of the Bill in clause 2(a):

"The purpose of this Act is to establish and maintain a National Health Insurance Fund in the Republic funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services by –

- serving as a single purchaser and single payer of health care services in order to ensure the equitable and fair distribution and use of health care services".

Therefore, the Bill intends for the Fund to do the heavy lifting: identify the healthcare providers to provide the needed services and then pay those providers for the services ultimately rendered to users. Such a scheme appears to be a straightforward tripartite relationship amongst the Fund, its users and healthcare providers.

However, the Bill, whilst defining what a mandatory prepayment is,[2] is silent on any legal obligation for a person to register as a user of the Fund. In order to become eligible to receive healthcare services paid for by the Fund, one is required to register as a user of the Fund.[3]

Such a dynamic makes sense as the Fund will want to know for whom it is liable for purposes of reimbursing the costs of healthcare services obtained. Such a relationship is one where a user is entitled to accept that he/she is not liable for the costs of the healthcare that he/she receives as that liability, through a user's registration, now lies with the Fund.

On that basis, the Fund will define the benefits for which it is liable and the costs for which the Fund will reimburse healthcare providers.

But, what of those persons, otherwise eligible to register as users of the Fund, who choose not to do so? Such so-called non-users would still be entitled to access healthcare services in accordance with their rights under section 27 of the Constitution of the Republic of South Africa, 1996.

In so far as non-users are concerned, where a non-user seeks a healthcare service, the costs of that healthcare service are not, in the hands of that non-user, reimbursable by the Fund – the Fund has no liability to that non-user as he/she has not registered to qualify for the liability and subsequent reimbursement for the costs on his/her behalf.

Accordingly, in the hands of a non-user, the costs of a healthcare service that may otherwise be reimbursable by the Fund, are not. If one accepts that position, then there can be no logical (or legal) bar to a non-user seeking liability for the payment of his/her healthcare costs from another source, including a medical scheme.

On that basis, the Bill contemplates two categories of persons, for purposes of a revised or rejigged healthcare delivery and access system, users and non-users.

Users understand that they are entitled to expect the Fund to fulfil the liability for the costs of the healthcare services that such users consume and, equally, non-users understand their disqualification from such an expectation.

Why then, if one accepts the position above, with reference to the ordinary principles of contractual liabilities, would a non-user not be able to access benefits, of whatsoever nature, from a medical scheme, more particularly, where, as a result of he/she being a non-user, the healthcare services that he/she seeks and obtains are not reimbursable by the Fund?

The answer must be that a non-user is entitled to obtain access to healthcare services by any lawful and reasonable source available to him/her including via a medical scheme.

What then of clause 6(o)? Clause 6(o) does not use the word "reimbursable" but rather "not *covered* by the Fund" (our emphasis). If one accepts that the overall scheme of the Fund, as is stated above, is one accepting the liability for the costs of healthcare services provided by accredited healthcare providers to registered users, then one must accept that "covered" means the benefits for which the Fund accepts liability to users.

Therefore, clause 6(o) cannot be interpreted as being broader than what is intended by the scheme of the intended NHI with reference to the principles of how liability is intended to operate under that scheme.

One must accept that the State cannot force a person to register as a user of the Fund.

To do so, would arguably expose such an obligation to constitutional challenge on the basis of a right to freedom of association but, equally, the State cannot enact legislation that unfairly or unreasonably limits a person's rights to access healthcare services where there is a viable and available alternative to do so.

Such a situation would, no doubt, bring the Bill and eventual NHI scheme into a collision course with the Constitution.

Certainly, where a user is registered for purposes of receiving healthcare benefits from the Fund, one must accept that duplicating that cover by allowing a user to seek benefits from a medical scheme is illogical and largely impractical.

A non-user is not faced with such a situation. A non-user has no expectation that the Fund will defray his/her healthcare-related liabilities.

Accordingly, a non-user should be entitled to seek an alternative source for that liability and where better than a medical scheme.

The position that is posited above is, however, premised on, at least, three potential assumptions –

1. non-users are prepared to pay for medical scheme premiums notwithstanding a statutory requirement for a mandatory prepayment to the Fund;
2. medical schemes are able to enhance their value proposition to beneficiaries by, potentially, making benefits more attractive, more accessible and understandable *and* offering products that are cost-effective but relevant to the consumers who use and need them, for example, a low-cost benefit option or a similarly novel product and/or service; and
3. there is a willingness amongst the population not to abandon medical scheme membership and not, *en masse*, emigrate to the Fund to the financial detriment of medical schemes who are left with a scarcity of members and thus compromised financial viability.

Whilst the Bill's overall intentions with regard to medical schemes and their future under a NHI is unclear,[4] there may still be a role for medical schemes under a NHI regime if one accepts that there may be a cohort of non-users of the Fund who choose to seek assistance for defraying liability in respect of the costs of healthcare services from a person other than the Fund.

Footnotes

[1] B 11B-2019

[2] A "compulsory payment for health care services before they are needed in accordance with income levels".

[3] Clause 5(1) of the Bill

[4] Paragraph 6.33 of the Memorandum on the Objects of the National Health Insurance Bill, 2019 merely explains clause 33 as follows: "Clause 33 deals with the role of medical schemes. In terms of this clause, medical schemes will be restricted to providing complementary cover for health care service benefits that are not purchased by the Fund *on behalf of users*." (our emphasis)



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