THE SUPREME COURT OF APPEAL
REPUBLIC OF SOUTH AFRICA

JUDGMENT

Case No: 168/07
REPORTABLE

In the matter between:

GUARDRISK INSURANCE COMPANY LIMITED Appellant

and

REGISTRAR OF MEDICAL SCHEMES First Respondent

COUNCIL FOR MEDICAL SCHEMES Second Respondent

Coram: HOWIE P, HEHER, PONNAN JJA, SNYDERS AND KGOMO AJJA
Heard: 19 FEBRUARY 2008
Delivered: 28 MARCH 2008

Summary: Interpretation of 'business of a medical scheme' in the Medical Schemes Act 131 of 1998 and 'accident and health policy' in the Short Term Insurance Act 53 of 1998 – ascertainment of whether selling certain policies constitutes the business of a medical scheme.

Neutral Cititation: This judgment may be referred to as *Guardrisk Insurance Company Ltd v Registrar of Medical Schemes* (168/07) [2008] ZASCA 39 (28 MARCH 2008)

SNYDERS AJA/

SNYDERS AJA:

[1] The appellant is a registered short term insurer in terms of the Short Term Insurance Act 53 of 1998 (the STI Act). The respondents are respectively the Registrar and Council for Medical Schemes duly established and appointed in terms of the Medical Schemes Act 131 of 1998 (the MS Act).

[2] In the Johannesburg High Court the respondents sought and obtained an interdict before Goldblatt J against the appellant who now appeals that order with the leave of the court a quo.

[3] The interdict prohibits the appellant from marketing and selling two of its policies named AdmedGap and AdmedPulse. The interdict was obtained on the basis that the sale of these policies constituted the 'business of a medical scheme'[1] and as the appellant is not registered[2] in terms of the MS Act, should be prohibited from marketing and selling same.

[4] The 'defined events' insured against by both policies are the necessity for an insured to be confined to hospital and having to undergo medical, surgical or treatment procedures whilst in hospital, chemotherapy, radiotherapy or kidney dialysis on an out-patient basis or any other out-patient treatment as agreed to by the insurer. The benefits in terms of the policies are the cost of the service for a registered medical practitioner less the rate for that service as listed by the National Health Reference Price List (NHRPL), limited to three and a half times the NHRPL rates and an annual maximum specified in the policy. The differences between the cost of the medical service and the NHRPL are likely to be significant because of the nature of the defined events. The benefits are paid to the insured with no prescription as to how they are to be utilised.

[5] In the court a quo the case was argued and decided on the interpretation of the definition of 'business of a medical scheme' in s 1 of the

[1] See the definition of 'business of a medical scheme' in s1 of the MS Act quoted in para 6.
[2] Section 20(1) of the MS Act: 'No person shall carry on the business of a medical scheme unless that person is registered as a medical scheme under section 24.'

MS Act and the definition of 'accident and health policy' in the STI Act. That is also the case on appeal. The respondents contended that the appellant's activities fell within the ambit of the 'business of a medical scheme', whereas the appellant contended that its activities fell within the scope of an 'accident and health policy' but did not constitute the 'business of a medical scheme' in contravention of the MS Act.

[6] In terms of the MS Act '"business of a medical scheme" means 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'.

[7] An 'accident and health policy' is included in the definition of 'short-term policy' in the STI Act and the first is defined as 'a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if a –

(a) disability event;

(b) health event; or

(c) death event,

contemplated in the contract as a risk, occurs, but excluding any contract –

(d) of which the contemplated policy benefits –

(i) are something other than a stated sum of money;

(ii) are to be provided upon a person having incurred, and to defray, expenditure in respect of any health service obtained as a result of the health event concerned; and

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

(e) (i) of which the policyholder is a medical scheme registered under the Medical Schemes Act, 1967 (Act 72 of 1967);

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

(iii) which is entered into by the scheme to fund in whole or in part its liability to such member or beneficiaries in terms of its rules; and includes a reinsurance policy in respect of such a policy'.

[8] The court below decided that:

'[15] If (a), (b) and (c) in the definition of a medical scheme are to be read conjunctively, it would, in my view, lead to results which clearly could not have been the intention of the Legislature. If a person made provision for the obtaining of a relevant health service then such person would not have to grant assistance in defraying expenditure incurred in connection with the rendering of such health service as no expenditure would be incurred. Thus (a) and (b) of the definition would be in conflict with each other if they were to be read conjunctively. However, if (a) and (b) were separated by "and/or" it would make sense and would give effect and meaning to the definition. Similar meaning must be given to the word "and" between (b) and (c) to make sense of the definition. If the scheme itself rendered health services or got a supplier or group of suppliers to render health services then similarly it would not need to grant assistance in defraying expenditure incurred in the rendering of such health service.

[16] I am strengthened in my view of a consideration of exclusion (d) in the definition of an "accident and health policy" in the STI Act. If (d)(i), (ii) and (iii) are to be read conjunctively they make no sense as (ii) and (iii) are in conflict and cannot be read together unless the word "and" is read as "and/or". . . . .

[17] If the exclusions are to be read disjunctively i.e. separated by "and/or" then if an insurer provides any of the benefits the exclusion is operative and it would preclude an insurer from providing benefits which constitute the carrying on of the business of a medical scheme in terms of the MS Act. This would have the intended effect of rendering the MS Act and the STI Act compatible.

[18] I am accordingly satisfied that (a), (b) and (c) in the definition of the business of a medical scheme in the MS Act are to be read as separate and distinct activities any of which will result in the undertaker of the business carrying on the business of a medical scheme if the activity is in return for "a premium or contribution". The word "premium" is clearly used to cover an insurance policy providing one or all of the listed activities.'

[9] The legal principle[3] that has evolved regarding the interpretation of the words 'and' and 'or' in statutes is clear. In *Ngcobo v Salimba CC; Ngcobo v Van Rensburg* 1999 (2) SA 1057 (SCA) at 1067J-1068B Olivier JA stated:

'It is unfortunately true that the words "and" and "or" are sometimes inaccurately used by the Legislature and there are many cases in which one of them has been held to be the equivalent of the other. . . Although much depends on the context and the subject-matter. . . it

[3] The authorities relied upon in the court below are *R v La Joyce (Pty) Ltd* 1957 (2) SA 113 (T) at 116A; *Federated Timbers Ltd v Bosman* 1990 (3) SA 149 (W) at 151F-G and *Binda v Binda* 1993 (2) SA 123 (W) at 125B-126G.

seems to me that there must be compelling reasons why the words used by the Legislature should be replaced; . . . The words should be given their ordinary meaning ". . . unless the context shows or furnishes very strong grounds for presuming that the Legislature really intended" that the word not used is the correct one. . . .'

[10] The definition of 'accident and health policy' lists some exclusions in subsecs (d) and (e). The word 'or' used between subsecs (d) and (e) indicates that the Legislature was conscious of the difference between the words 'and' and 'or' by specifically using 'or' as a link in the one instance and 'and' as a connector of the subparagraphs in subsecs (d) and (e). Hence a contract that falls within the ambit of subsec (d) or within the ambit of subsec (e) would fall within the exclusion provided for. Between subsecs (d)(ii) and (d)(iii) the word 'and' is used. This differentiation in the use of 'and' and 'or' within the same definition suggests the ordinary, literal meaning of the words and therefore that the subsections should be interpreted conjunctively. That usage has the effect that only a contract which contains all the elements in subparagraphs (i), (ii) and (iii) of subsec (d) will be excluded from the ambit of a 'short term policy'.

[11] Such an interpretation does not create any conflicts within subsec (d), as the subsection lists different aspects of benefits of a policy that falls within the exception. First, the nature of the benefit is dealt with, namely that it is to be 'something other than a stated sum of money'. Second, the event which triggers the benefit, namely the insured having incurred the expenditure, and the purpose of the benefit, namely the defraying of expenditure consequent upon the event are both identified. Third, the entity to whom the benefits are to be paid is dealt with, ie the service provider. When these three aspects are all included in a contract which would otherwise fall within the definition of an 'accident and health policy' that policy is excluded from the operation of the STI Act.

[12] It therefore appears that the Legislature indeed intended the three subparagraphs of subsec (d) to be read conjunctively and for the word 'and' to be given its ordinary, literal meaning in order to fully describe the policy

benefit that falls within the exclusion. There are no compelling reasons to deviate from the literal meaning of the words used.

[13] The AdmedGap and AdmedPulse policies do not provide benefits which fall within subparagraphs (i) and (iii) of subsec (d) of the definition. They are consequently not excluded from it.

[14] Section 2(1) of the MS Act provides that 'if any conflict, relating to the matters dealt with in this Act, arises between this Act and the provisions of any other law save the Constitution or any Act expressly amending this Act, the provisions of this Act shall prevail.'

[15] The wording of the definition of 'business of a medical scheme' in the MS Act is cumbersome. If the word 'and' is given its ordinary, literal meaning, it suggests that subsecs (a) and (b) are to be read conjunctively, and with subsec (c), unless subsec (c) is not applicable as it is introduced by the words 'where applicable'. The use of the words 'where applicable' suggests that what precedes it is to be read conjunctively, otherwise those words would have been superfluous. The result of a conjunctive interpretation is that any business which undertakes liability in return for a premium or contribution for all the elements of (a) and (b), and (c) where applicable, carries on the 'business of a medical scheme' and is subject to all the provisions of the MS Act.

[16] This interpretation does not give rise to a conflict between the provisions of subsecs (a) and (b). To make provision for obtaining a medical service is not the same as defraying expenses incurred in respect of the rendering of a medical service. Conceivably, 'to make provision for the obtaining of any relevant health service' could mean undertaking to the service provider to make payment for all or part of such health service before it is undertaken, which is quite different to actually assisting in defraying the expenditure incurred in connection with the rendering of a health service.

[17] In the predecessor to the MS Act[4] the Legislature used the word 'or' in the corresponding definition of 'medical scheme', which read:

'. . . . a scheme established with the object of making provision for –

(a) the obtaining by members thereof and by dependants of such members, of any service;

(b) the granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of any service; or

(c) the rendering of a service to members thereof or to dependants of such members, either by the scheme itself or by any supplier of a service or group of suppliers of a service in association with or in terms of an agreement with the scheme'.

Replacing 'or' in the old Act with 'and' in the MS Act, together with the use of the introductory words 'where applicable' in subsec (c) indicate that the Legislature was mindful of the different meanings of 'and' and 'or'.

[18] When the relevant definitions in the STI Act and the MS Act are read conjunctively in terms of the ordinary, literal sense of the words 'and' and 'or', there is no conflict between them. To interpret the two definitions in this way honours the 'well recognised rule of statutory construction' which was formulated in *Chotabhai v Union Government (Minister of Justice) and Registrar of Asiatics*[5] and relied upon in *Shaik v Minister of Justice and Constitutional Development* 2004 (3) SA 599 (CC) at 609 fn14:

'(E)very part of a statute should be so construed as to be consistent, so far as possible, with every part of that statute, and with every other unrepealed statute enacted by the same Legislature.'

[19] The respondents advanced the argument that the purpose and aim of the MS Act will be undermined in the event of a literal interpretation of the two relevant definitions. In support of this contention the respondents suggested in the founding affidavit that the appellant's policies would encourage younger and healthier members of a medical scheme to choose to subscribe only to

[4]The Medical Schemes Act 72 of 1967 as amended by Act 59 of 1984 and Act 23 of 1993.
[5] 1911 AD 13 at 24.

minimum benefits of the scheme and supplement their benefits by subscribing to the appellant's cheaper policy. As such the viability of a medical scheme could be reduced.

[20] This contention loses sight of several aspects. First, there is no evidence of an analysis of cost in relation to benefits of the appellant's products compared to cost of membership and benefits from a medical scheme. Second, the suggestion is vehemently challenged by the appellant on the ground of absence of factual support and relevance. Third, although the STI Act does not contain a provision similar to s 29(1)(n)[6] of the MS Act, the appellant is obliged not to 'unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth"[7].

[21] Although the provisions of the MS Act fundamentally changed the operation of medical schemes in that membership of a medical scheme and, through that, access to core health and medical services[8] were made accessible to a broader spectrum of people, as discriminatory considerations based on age, sex and health status are no longer permissible and differentiation between members may only occur on the basis of income and

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[6] Section 29(1)(n): 'The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters:…(n) The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed.' This section is to be compared with the previous MS Act 72 of 1967, particularly s 20 thereof which contained no similar exclusion of these discriminatory grounds.

[7] Sections 9(3) and (4) of the Constitution of the Republic of South Africa 108 of 1996.

[8] Section 29(1)(o) and (p): 'The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters:…(o) The scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed. (p) No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient.' Section 20 of Act 72 of 1967, the predecessor to the current MS Act, did not contain similar provisions.

number of dependants[9], there is no factual indication before us that the policies of the appellant are undermining or would undermine the MS Act, or would in any way affect the viability of medical schemes in general.

[22] Practical reality has shown that there exists a need for this type of insurance and there seems to be no reason why it should not be permitted.

[23] The appeal must succeed. The parties were agreed that the costs of two counsel were appropriately incurred in both courts. Consequently the following order is made:

(1) The appeal is upheld with costs, including the costs of two counsel;
(2) The order of the court below is replaced with the following:
'The application is dismissed with costs, including the costs of two counsel.'

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S SNYDERS
ACTING JUDGE OF APPEAL

AGREE:

HOWIE P
HEHER JA
PONNAN JA
KGOMO AJA

[9] Section 29(1)(n).