

**The (non)-regulation of the health insurance industry and  
its potential impact on the rights to health and life: A  
comparative analysis of Malawi and South Africa**

By

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**A dissertation submitted in partial fulfilment of the requirements of the degree  
LLM (Human Rights and Democratisation in Africa)**

**prepared under the supervision of**

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29 OCTOBER 2010

**DECLARATION**

I, **MANDALA DICK MAMBULASA**, do hereby declare that the work submitted for this dissertation is the result of my own efforts and that where a secondary source has been referred to, cited, or used, the same has been duly acknowledged and further that this work has never been submitted for any academic or the award of any degree in any other university.

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## **DEDICATION**

To my wife Janet and children Davina and David

## **ACKNOWLEDGEMENTS**

I would like to express my gratitude to a number of people whose help shaped this work. First and foremost, I thank Prof. B.K. Twinomugisha for his guidance and suggestions when I was writing this dissertation. Second, I also thank Mr. Redson Kapindu and Dr. Jamil D Mujuzi for their comments in the early stages of this work. Finally, special tribute is paid to the staff of the Centre for Human Rights, University of Pretoria, and the LLM 2010 class for their constructive engagement during the dissertation exercise. I shall forever be grateful.

## **LIST OF STATUTES**

Constitution of Malawi (Amendment) Act 11 of 2010

Constitution of Malawi Act 20 of 1994

Constitution of South Africa Act 108 of 1996

Consumer Protection Act 14 of 2003

Courts (Amendment) Act 2004

Financial Services Act 2009

Insurance Act 31 of 2009

Medical Aid Funds Act 23 of 1995

Medical Schemes Act 131 of 1998

National Health Act 61 of 2003

Refugee Act 3 of 1989

## **LIST OF INTERNATIONAL HUMAN RIGHTS INSTRUMENTS**

African Charter on Human and Peoples' Rights

Convention on the Elimination of All Forms of Discrimination against Women

Convention on the Rights of the Child

Declaration of Almata-Ata of 1978

Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to promote and protect universally recognised Human Rights and Fundamental Freedoms

International Covenant on Civil and Political Rights

International Covenant on Economic, Social and Cultural Rights

Maastricht Guidelines on Violations of Economic, Social and Cultural Rights

Universal Declaration of Human Rights

Vienna Declaration and Programme of Action of the World Conference on Human Rights

World Health Declaration of 1998

## LIST OF CASES

*Chakufwa Tom Chihana v The Republic* MSCA Criminal Appeal No. 9 of 1992 [1993] MWSC 1

*Commission National Des Droits Des L'homme et Des Libertes v Chad* (2000) AHRLR

*Dr Mohiuddin Farooque v Bangladesh & Others (No. 1)* (1996) 48 DLR, HCD 438

*EN and Others v Government of the Republic of South Africa and Others* 2007 1 BCLR 84 (D)

*Evanse Moyo v The Attorney General*, Constitutional Case No. 12 of 2007 (Unreported)

*Francis Coralie Mullin v The Administrator, Union Territory of Delhi & Others* (1981) AIR 746, (1981) SCR (2) 516

*Francis Kafantayeni and Others v The Attorney General*, Constitutional Case No. 12 of 2005 (Unreported)

*Filartiga v Pena Irala* (1980) 19 ILM 966

*Free Legal Assistance Group & Others v Zaire* (2000) AHRLR 74 (ACHPR 1995)

*Government of the Republic of South Africa and Others v Grootboom and Others* 2000 11 BCLR 1169 (CC)

*Guwendi v AON Malawi Ltd*, Miscellaneous Civil Cause No. 25 of 2000 (High Court of Malawi, Principal Registry) (Unreported)

*In the Matter of Presidential Reference of a Dispute of a Constitutional Nature under sec 89(1)(h) of the Constitution and in the Matter of sec 65 of the Constitution and in the Matter of the Question of Crossing the Floor by Members of the National Assembly*, MSCA Presidential Reference Appeal No. 44 of 2006 (Unreported)

*In the Matter of the Adoption of Children Act and in the Matter of Chifundo James (An infant)* MSCA Adoption Appeal No. 28 of 2009

*Khosa v Minister of Social Development* 2004 (6) SA (CC)

*Locker and Woolf Ltd v Western Australian Insurance Co Ltd* [1936] 1 KB 408

*Malawi Telecommunications Ltd v Makande and Omar*, MSCA Civil Appeal No. 2 of 2006  
(Unreported)

*Minister of Health and Others v Treatment Action Campaign and Others* 2002 5 SA 721 (CC)

*Paschim Banga Khet Samity v State of West Bengal & Another* (1996) 4 SCC 37

*President of the Republic of South Africa and Another v Hugo* 1997 6 BCLR 708 (CC)

*Prudential Insurance Co v IRC* [1904] 2 KB 658

*Purohit and Moore v The Gambia*, Communication 241/2001, Sixteenth Annual Activity Report

*Roselodge Ltd (formerly Rose Diamond Products Ltd) v Castle* [1966] 2 Lloyds Rep 113

*S v Makwanyane and Another* 1995 3 SA 391 (CC)

*S. Kalinda v Limbe Leaf Tobacco Ltd*, Civil Cause No. 542 of 1995 (High Court of Malawi,  
Principal Registry) (Unreported)

*Social and Economic Rights Action Centre (SERAC) & Another v Nigeria* (2001) AHRLR 60

*Velásquez Rodríguez v Honduras* (19 July 1988) Ser. C No. 4

*Zimbabwe Human Rights NGO Forum v Zimbabwe*, Communication 245/ 2002, Twenty-First  
Annual Activity Report

## **LIST OF ABBREVIATIONS/ACRONYMS**

ACHPR	African Charter on Human and Peoples' Rights
ACmHPR	African Commission on Human and Peoples' Rights
AIDS	Acquired Immunity Syndrome
CHAM	Christian Health Association of Malawi
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
DPSP	Directive Principles of State Policy
HIV	Human Immuno Deficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
MASM	Medical Aid Society of Malawi
MSCA	Malawi Supreme Court of Appeal
MoH	Ministry of Health
OPD	Out Patient Department
PNP	Principles of National Policy
RBM	Reserve Bank of Malawi
UNGA	United Nations General Assembly
UDHR	Universal Declaration of Human Rights
WHO	World Health Organisation

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# Chapter One

## 1. Introduction

### 1.1 Background of the study

Malawi reverted to multiparty politics in 1993.<sup>1</sup> A new Republican Constitution,<sup>2</sup> (the Constitution) with a Bill of Rights was provisionally adopted on 18 May 1994 and it entered into force on 18 May 1995.<sup>3</sup> Chapter 3 thereof deals with fundamental principles upon which the Constitution is founded and Principles of National Policy (PNP). Section 13(c) of the Constitution which falls under the PNP deals with health. It is to the effect that ‘the State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving adequate healthcare, commensurate with the health needs of Malawian society and international standards of healthcare’. According to section 14 of the Constitution, PNP are only directory in nature. Courts are obliged to have regard to them in the interpretation and application of the Constitution or any other law or in the determination of the validity of executive decisions. In the light of the foregoing, arguably, the right to health is not justiciable under the Constitution.<sup>4</sup>

The Constitution protects and guarantees the right to life of every person under section 16 of the Bill of Rights. Unlike the right to health, the right to life is justiciable. In terms of section 45(2) of the Constitution as amended,<sup>5</sup> there cannot be derogation with regard to this right.<sup>6</sup> Its conceptualisation in this discourse is not the restraining of the State from executing convicts of heinous crimes, or the abolition of the death penalty.<sup>7</sup>

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<sup>1</sup> D Posner ‘Malawi’s new dawn’ (1995) 6(1) *Journal of Democracy* 1.

<sup>2</sup> Act 20 of 1994 [www.sdn.org.mw/constitut/intro.html](http://www.sdn.org.mw/constitut/intro.html) (accessed 5 September 2010).

<sup>3</sup> Constitution of Malawi sec 212(1). See also PA Mutharika ‘The 1995 democratic Constitution of Malawi’ (1996) 40(2) *Journal of African Law* 205.

<sup>4</sup> I shall comprehensively discuss this aspect again in Chapter 2 where I shall demonstrate that in spite of section 14, the right to health could be justiciable and enforceable by using other justiciable rights, especially, the right to life.

<sup>5</sup> Constitution of Malawi (Amendment) Act 11 of 2010. See *The Malawi Gazette Supplement*, 14 January 2010 (No. 2C).

<sup>6</sup> See generally DM Chirwa ‘Upholding the sanctity of rights: A principled approach to limitations and derogations under the Malawi Constitution’ (2007) 1(1) *Malawi Law Journal* 3.

<sup>7</sup> *S v Makwanyane and Another* 1995 3 SA 391 (CC); MJ Nkhata ‘Bidding farewell to mandatory capital punishment: *Francis Kafantayeni and Others v Attorney General*’ (2007) 1(1) *Malawi Law Journal* 103.

Rather, it is how policies, procedures, actions and omissions of the health insurance/medical aid schemes (health insurance) may result in present and potential members of schemes not accessing better healthcare services eventually leading to violations of the right to health and possibly, the right to life.

In 2007 it was observed that Malawi was one of the countries that did not have specific legislation regulating the health insurance.<sup>8</sup> Three years since then, the situation has not significantly changed.<sup>9</sup> This lack of an elaborate and comprehensive regulatory framework and its potential attendant effect on the enjoyment of the right to health and possibly, the right to life of the existing or potential members, is what aroused the interest for this study.

South Africa was chosen for the comparative analysis because out of the nine Southern African countries in which the research was carried out, only two countries, South Africa and Namibia had the relevant legislation. Of these two, South Africa's, is more recent than that of Namibia.<sup>10</sup> In addition, South Africa repealed an earlier one of 1967 which entails that it covers new emerging issues.

The South African Republic Constitution 1996<sup>11</sup> does not provide for the right to health as such. Section 27 stipulates, *inter alia*, that everyone has the right to have access to healthcare services. It is this important component of the right that I equate to the right to health in this study even though the right to health is much broader than access to healthcare services. Unlike Malawi, in South Africa, socio-economic rights and the right to have access to healthcare services in particular, are justiciable and enforceable.<sup>12</sup> The non-justiciability and non-enforceability of socio-economic rights under the Malawian Constitution has led some scholars to argue that such rights are not given the same level of protection as civil and political rights.<sup>13</sup>

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<sup>8</sup> AIDS and Human Rights Research Unit *Human rights protected? Nine Southern African country reports on HIV, AIDS and the law* (2007) 103.

<sup>9</sup> The new Insurance Act 31 of 2009 (Insurance Act 2009) now regulates health insurance organisations as well. As the discussion will later show, the regulation is largely financial in nature and its scheme is not based on a human rights approach.

<sup>10</sup> Namibia's legislation is called the Medical Aid Funds Act 23 of 1995 while the South African legislation is called the Medical Schemes Act 131 of 1998 (Medical Schemes Act 1998).

<sup>11</sup> Act 108 of 1996 [www.constitutionalcourt.org.za](http://www.constitutionalcourt.org.za) (accessed 5 September 2010).

<sup>12</sup> I Currie & J De Waal *The Bill of Rights handbook* (2005) 566-595; C Mbazira *Litigating socio-economic rights in South Africa: A choice between corrective and distributive justice* (2009) 15-51; JC Mashamba 'Are economic, social and cultural rights judicially enforceable?' (2009) 15(2) *East African Journal of Peace & Human Rights* 225.

<sup>13</sup> C Mbazira 'Bolstering the protection of economic, social and cultural rights under the Malawian Constitution' (2007) 1(2) *Malawi Law Journal* 220; DM Chirwa 'A full loaf is better than half: The constitutional protection of economic, social and cultural rights in Malawi' (2005) 49(2) *Journal of African Law* 207.

Similarly, the right to life is also specifically protected and guaranteed under section 11 of the South African Constitution. It is enforceable and has been the subject of extensive litigation.<sup>14</sup>

Malawi has a population of about 13.1 million.<sup>15</sup> Health services are essentially provided to all citizens at the expense of government in all its hospitals and some Christian Health Association of Malawi (CHAM)<sup>16</sup> hospitals with which government has special arrangement and private-for-profit hospitals. CHAM provides 37% of the total healthcare services in Malawi.<sup>17</sup> The government provides 60% of all formal healthcare services.<sup>18</sup> The private-for-profit hospitals provide 3% of the formal healthcare services.<sup>19</sup> However, referral hospitals have paying out patient departments (OPDs) where user fees are charged and paid by able and willing patients. The user fees payable are far much lower than those charged in private-for-profit hospitals. Generally speaking, there is no significant marked difference in the treatment and care that one receives in the non-paying OPDs. The only advantage is that in the event of hospitalisation, admission is in private wards, which are less congested and the food is of better quality. Inevitably, because of the high demand for healthcare services due to among other factors, high population growth<sup>20</sup> and HIV, the quality of the services in public hospitals is generally below standard and the conditions are deplorable. Patients wait for hours on long queues to see clinicians or medical assistants or if the hospital is big, and subject to availability, qualified doctors. Public hospitals frequently have shortages of basic essential drugs.<sup>21</sup> Consequently, the middle to upper class people prefer to go to private hospitals where the quality of services is generally good and patients fewer. However, user fees in private hospitals are prohibitive. This has resulted in an increase in the demand for private health insurance as members only pay for a shortfall, determined based on the type of scheme joined. Private health insurance has therefore become attractive and the industry is likely to boom as the economy grows further.

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<sup>14</sup> Currie & De Waal (n 12 above) 280-290.

<sup>15</sup> The Final Report of the Population and House Census of 2008 [www.nso.mw](http://www.nso.mw) (accessed 16 August 2010).

<sup>16</sup> For more information about CHAM and its activities visit: [www.cham.org.mw](http://www.cham.org.mw) (accessed 26 August 2010).

<sup>17</sup> <http://www.coldfusionwebhostings.be/ICCO/www/index.cfm?type=workprocedure&id=67> (accessed 26 August 2010).

<sup>18</sup> Government of Malawi, *2001b and Government of Malawi/World Bank* 2006 133.

<sup>19</sup> As above.

<sup>20</sup> It is currently 2.8% (n 15 above).

<sup>21</sup> 'Drug shortages persist countrywide' *The Daily Times* 19 August 2010 3.

There are a number of private health insurance providers in Malawi namely, Medical Aid Society of Malawi (MASM),<sup>22</sup> Momentum Africa,<sup>23</sup> Liberty Health,<sup>24</sup> Group Medical Scheme<sup>25</sup> and Oasis Medical Aid. As of August 2010, MASM had 115 000 members.<sup>26</sup> As of July 2010, Momentum Africa had policies with 3 000 companies.<sup>27</sup> Plans were underway to introduce individual membership as well. Even though I was not able to obtain statistics for membership from Liberty Health and Oasis Medical Aid, it is arguable that over time, membership is likely to grow exponentially thereby affecting many people. This calls for strict regulation to monitor the activities of the industry to ensure compliance with human rights obligations of the members. As mentioned above, until recently, there was no legal framework to regulate this industry.<sup>28</sup>

In South Africa, there are numerous providers of health insurance. To ensure protection of human rights and fair business practices, South Africa has in addition to an Insurance Act,<sup>29</sup> a dedicated legislation on this industry the Medical Schemes Act 1998. Among other things, this legislation prohibits unfair discrimination and risk and age rating of members present or prospective.<sup>30</sup> It also establishes a Council for Medical Schemes whose duties and functions include the investigation of complaints and resolution of disputes relating to medical schemes.<sup>31</sup>

The study explores and interrogates the right to health and right to life obligations of the health insurance industry as non-state actors in the management, provision and access to healthcare services. This shift in the provision of such services from the government to private non-state actors is largely due to globalisation as it will become clearer later in the discussion. The study also specifically examines the human rights obligations of Malawi in respect of the two rights in issue, in the context of (non) or little regulation of a third party whose decisions or policies have potential to infringe or violate human rights.<sup>32</sup>

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<sup>22</sup> www.masmw.com (accessed 16 August 2010).

<sup>23</sup> www.momentumafrica.com (accessed 16 August 2010).

<sup>24</sup> www.essentialhealthmalawi.com (accessed 24 August 2010).

<sup>25</sup> This is a very recent health insurance established while this study was already underway. See 'Swift unveils group medical scheme' *The Nation* 31 August 2010 7.

<sup>26</sup> E-mail from Ms A Hara of MASM, 19 August 2010.

<sup>27</sup> n 42 below.

<sup>28</sup> n 9 above.

<sup>29</sup> Act 36 of 1998.

<sup>30</sup> S Khoza (ed) *Socio-economic rights in South Africa* (2007) 295.

<sup>31</sup> Medical Schemes Act 1998 sec 3.

<sup>32</sup> See for instance *Velásquez Rodríguez v Honduras* IACHR (19 July 1988) Ser. C No.4.

## 1.2 Objectives of the study

The primary objective of this study is to demonstrate that in spite of contrary forces of globalisation which are against regulation and seem to be in favour of deregulation, the need for strong regulatory and institutional framework for private health insurance industry in Malawi based on a human rights approach is imperative.

The secondary objective is to critically analyse the current regulatory legal framework in order to determine whether it sufficiently protects human rights and whether it compels health insurance industry to use a human rights-based approach in the design and provision of healthcare services.

The third objective of the study is to consider whether the Medical Scheme Act 1998,<sup>33</sup> and the Regulations made thereunder could be used as a model legislative framework for Malawi and whether it sufficiently addresses human rights issues of existing or potential members of various medical schemes.

## 1.3 Theoretical framework

It is trite that human beings have human rights which need protection against the state and its agencies, non-state entities and other human beings. Human rights are a vehicle through which entitlements are demanded from the state as provided in its Constitution, other laws and in appropriate situations international treaties to which the state is a party.

The primary duty to protect human rights lies with the state. Governments are established to run the affairs of the state so that the interests and human rights of all persons in its territory are guaranteed and protected. Why then should the health insurance industry, being a non-state actor, be required to observe and protect human rights generally and the two rights in issue specifically when states themselves are often accused of failure to adequately protect and observe human rights? What is the theoretical justification for extending the observance of human rights to the health insurance industry? How can that be achieved?

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See also A Chapman 'A "violations approach" for promoting the international covenant on economic, social and cultural rights' (1996) 18 *Human Rights Quarterly* 23.

<sup>33</sup> n 31 above.

The first argument is that the protection of human rights spurs development as businesses flourish in an environment where the rule of law exists. The rule of law, in this regard, is to a greater extent concerned with respect and protection of human rights. It is therefore in the interest of all business organisations, to protect human rights as this ensures the continued enabling environment for business organisations to operate in.<sup>34</sup> The above proposition is not always true all the time. There are few countries whose human rights and democracy record are not so good, and yet development and business organisations are flourishing in those circumstances.<sup>35</sup>

The second argument is that the Constitutions of the two states provide that the Bill of Rights or provisions thereof may, where applicable to them, bind natural and juristic persons taking into account the nature of the right and the duty imposed by the right.<sup>36</sup>

The third argument is that there is a growing realisation that entrenching the culture of human rights cannot only be left to governmental and intergovernmental mechanisms. It also requires private action such as non-state actors.<sup>37</sup> In any case, non-state actors have been known to seriously violate human rights.<sup>38</sup> It is therefore only fair that the protection of human rights should be extended to them.

The fourth argument is that the Universal Declaration of Human Rights (UDHR) (the Universal Declaration), envisages that every individual and 'every organ of society' shall promote the rights enshrined therein.<sup>39</sup> Even though the Universal Declaration is not a legally binding document, it is generally agreed that most, if not all of its provisions have now matured into binding norms of customary international law, *jus cogens*.<sup>40</sup> Given that non-state actors such as businesses are part of 'society' they are bound to promote and protect human rights.

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<sup>34</sup> Human Rights Program Harvard Law School and the Lawyers Committee for Human Rights *Business and Human Rights* (1999) 20.

<sup>35</sup> J. Oloka-Onyango 'The problematique of economic, social and cultural rights in globalised Uganda: A conceptual review' HURIPPEC Working Paper No. 3 2007 4.

<sup>36</sup> n 3 above, sec 15; n 11 above, sec 8(2) (3) and (4).

<sup>37</sup> n 34 above.

<sup>38</sup> See for instance, Amnesty International *Nigeria: Ten years on: injustice and violence haunt the oil Delta* (2005).

<sup>39</sup> Last paragraph of the Preamble to the Universal Declaration.

<sup>40</sup> *Filartiga v Pena Irala* (1980) 19 ILM 966.

In practice however, non-state actors such as business organisations do not consider themselves to be bound by human rights obligations. Usually, they prefer non-binding obligations such as corporate social responsibility. This theoretical framework therefore operates from the premise that health insurance being non-state actors, will not voluntarily observe human rights. They require regulation by some legislation for them to have regard to human rights. Regulation is also important for other reasons such as prevention of unreasonable premiums, excessive earnings and discrimination.<sup>41</sup> Additionally, legislative regulation also ensures that there is a level playing field for competition within the industry.<sup>42</sup>

#### 1.4 Justification of the study

This study can be justified on two fronts. First, it is theoretically relevant in that organisations, governments, businesses themselves and scholars such as Chirwa<sup>43</sup> are still grappling with the issue of whether private commercial entities such as business organisations are duty-bound to protect, promote, respect and fulfill human rights in their business environment and in society, if states themselves hardly comply with their human rights commitments, and if so, to what extent and on what basis. Second, the fact that Malawi does not yet have an adequate regulatory legal and institutional framework for this specialised industry, further justifies the present study as timely. Third, there is also a dearth of literature on the subject both in Malawi and South Africa and therefore it is hoped that this study will stimulate further debate and possibly play a role in spurring the process of law reform in the area.

#### 1.5 Research problem

The study wishes to interrogate how the (non)-regulation of the health insurance industry by the Malawi Government may impact on the enjoyment of existing or potential members of various schemes, of the right to health and, possibly the right to life and what lessons if any, Malawi can learn from South Africa.

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<sup>41</sup> See generally CF Phillips *The economics of regulation: Theory and practice in the transportation and public utility industries* (1965) 126.

<sup>42</sup> E-mail from B Kamanga, General Manager, Momentum Health Malawi, 29 July 2010.

<sup>43</sup> DM Chirwa 'Towards binding economic, social and cultural rights obligations of non-state actors in international and domestic law: A critical survey of emerging norms' unpublished PhD thesis, University of the Western Cape, 2005.

## **1.6 Research questions**

- 1.6.1 What is the extent of the recognition and protection of the right to health and the right to life in the Malawian and South African legal systems?
- 1.6.2 What are the likely implications of the (non)-regulation of the health insurance industry in Malawi on the enjoyment of the above two rights by members of the various medical schemes?
- 1.6.3 Does the health insurance industry have any obligation, legal or otherwise, to protect, promote, respect and fulfill the above two rights? Is it legitimate for the industry to refuse membership or cover based on a member's age, health status or any other ground? Do such refusals amount to discrimination in law and fact? If not, would such refusals pass the limitation test under section 44 of the Constitution?
- 1.6.4 How is the health insurance industry regulated in South Africa?
- 1.6.5 What lessons, if any, can Malawi learn from South Africa?

## **1.7 Research methodology**

The research for this study will be analytical in nature. It will rely heavily on desk-top and library research analysing books, articles, reports, legislation, cases, regulations and international human rights instruments relating to the subject matter.

## **1.8 Limitations of the study**

The study would have benefitted immensely from direct interaction with some health insurance organisations and their members both in South Africa and Malawi, but this was not possible as it was being conducted while in Uganda. However, depending on the goodwill of the people and their ability to provide information in time through questionnaires, an attempt will be made to contact them for some information within the limited time and space allocated for the dissertation.

## 1.9 Literature review

It is now a settled position that the primary duty of promoting and protecting human rights rests with the state.<sup>44</sup> That was particularly true because states were mostly responsible for the provision of basic essential services such as education, security, water and healthcare. However, in a world where such services are now looked upon with the lenses of profit-making and financial interests mostly through privatisation and liberalisation as a result of globalisation,<sup>45</sup> the question that scholars have recently been grappling with is whether in view of such a shift in the provision of services from government to non-state actors, such non-state actors have any human rights binding obligations.<sup>46</sup> A considerable degree of theorisation of the nature of such binding human rights obligations is now emerging.<sup>47</sup> A consensus is now building that private actors too have a duty to respect, promote, and fulfil human rights.<sup>48</sup>

Where a state has allowed certain services to be provided by a non-state actor, it has a continuing obligation to ensure that such services are being provided in a manner that does not violate the human rights of its citizens.<sup>49</sup> This continuing obligation is achieved, among other things, by regulating the activities of the non-state actors. Without such regulation, the non-state actors are bound to violate human rights as they are usually inspired by the quest for profits. Consequently, the failure by the state to put in place such a regulatory and supervisory mechanism which results in violations of human rights, the violations are imputed on the state.<sup>50</sup> The human rights responsibility never shifts from the state.

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<sup>44</sup> GA Res. 53/144 'Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to promote and protect universally recognised Human Rights and Fundamental Freedoms' adopted on 9 December 1998, para 7 of the Preamble; Article 1 of the Vienna Declaration and Programme of Action of the World Conference on Human Rights; W Tarinyeba 'The role of multinational corporations in the protection and promotion of human rights' (2004) 10(1) *East African Journal of Peace & Human Rights* 159.

<sup>45</sup> HS Kanzira-Weltshire 'Globalisation nonsense upon stilts? Reflections on the globalisation and human rights nexus' (2008) 14(1) *East African Journal of Peace & Human Rights* 132.

<sup>46</sup> A Clapham *Human rights obligations of non-state actors* (2006) 195-266.

<sup>47</sup> DM Chirwa 'In search of philosophical justifications and suitable models for the horizontal application of human rights' (2008) 8 *African Human Rights Law Journal* 294.

<sup>48</sup> DM Chirwa 'The right to health in international law: Its implications for the obligations of state and non-state actors in ensuring access to essential medicine' (2003) 19 *South African Journal of Human Rights* 561-565. See generally, GS Kamchedzera 'Child rights, duties and the African Child Charter' in E Verhellen (ed) *Understanding children's rights* (1999) 523.

<sup>49</sup> *Commission National Des Droits Des L'homme et Des Libertes v Chad* (2000) AHRLR .

<sup>50</sup> *Social and Economic Rights Action Centre (SERAC) & Another v Nigeria* (2001) AHRLR 60; *Zimbabwe Human Rights NGO Forum v Zimbabwe* Communication 245/2002- Twenty-first annual activity report paras 142-164.

In this search for binding human rights obligations for non-state actors, little has been written on specific industries and how their operations or manner of delivery of services may impact on the enjoyment of human rights. This dissertation is a modest contribution in this regard, with a specific focus on how (non)-regulation of the health insurance industry in Malawi, can impact on the enjoyment of the right to health, and, possibly the right to life. While this work is country specific, it is argued that it may inform reform in the other countries mentioned in the research from which this study was inspired and even beyond.<sup>51</sup>

Our point of departure is therefore that violations of the right to health and the right to life could result from lack of, or insufficient regulation of the health insurance industry in Malawi.<sup>52</sup> Any such violation would be imputable on Malawi.

Many scholars have written on health especially after the *1987 Health Services Financing in Developing Countries: An Agenda for Reform* by World Bank. This report called for the minimum role of governments in the provision of health services and a reduction of governments' expenditure on social services. It recommended, among other things, that the private sector should be taken on board in the financing and provision of healthcare services in order to improve the efficiency and quality of healthcare services, through the use of existing resources. Three years later, Vogel published his work, *Health Insurance in Sub-Saharan Africa: A Survey and Analysis*. The survey was carried out in twenty-three countries and one of his interests was to find out the type and forms of health insurance existing in those countries. He concluded among other things that health insurance was mostly benefiting the middle class, and that the development of health insurance did not result in the promotion of greater equity of healthcare services to the poor nor did the forms of health insurance adopted in those countries encourage efficiency in the delivery of services. Other works on health insurance have been produced both within African and beyond.<sup>53</sup> For instance, Normand<sup>54</sup> grapples with the question whether private health insurance is a solution to financing the health sector in developing countries. He also aptly explains the other mechanisms for financing healthcare such as government revenue, social insurance which he distinguishes from private health insurance, and direct payments by

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<sup>51</sup> n 8 above.

<sup>52</sup> Chapman (n 32 above).

<sup>53</sup> SE Phalatsi 'Health insurance options for Lesotho' in G Mwabo et al (eds) *Improving health policy in Africa* (2004) 242; A Kennedy 'Private health insurance in Ireland' (1996) 3 *European Journal of Health Law* 345 and R Schneider 'Reform of health insurance in Switzerland' (1996) 3 *European Journal of Health Law* 331.

<sup>54</sup> C Normand 'Health insurance: A solution to the financing gap? In C Colclough (ed) *Marketising education and health in developing countries: Miracle or mirage?* (1997) 205.

the patients. Soberlund and Hansl<sup>55</sup> carried out a study that sought to investigate the pattern of private health insurance coverage in South Africa before and after deregulation. Among other findings, they noted that risk-rating of members was not associated with higher premiums. Makoka *et al*<sup>56</sup> investigated the factors that determine the demand for private health insurance among formal sector employees in Malawi. The study revealed, *inter alia*, that the above category of employees prefers to receive treatment from private owned hospitals where user-fees are charged but health insurance is relevant. The factors that determine the demand include levels of income, age and sizes of families.

None of the works reviewed and cited herein, explored the interplay between the provision of health insurance to members, present or potential, and the human rights obligations of the health insurance organisations as non-state actors in respect of the right to health and the right to life. Furthermore, most of the scholarship on the human rights obligations of non state actors has tended to emphasise on obligations of big multinational corporations. This study is unique in that not only does it locate the interplay between the provision of health insurance to the members stated above and the human rights obligations of these health insurance organisations, but it also demonstrates that beyond big multinational corporations, health insurance organisations, have a similar obligation to observe and uphold human rights in the provision of their services. Such interplay would only be visible where there is a comprehensive and efficient legal regulatory framework to monitor their work and activities for compliance with human rights norms. It is further demonstrated that it is the continuing duty of the state to create such an environment.

## 2.0 Overview of chapters

### Chapter 1

This chapter deals with the background, objectives, theoretical framework and justification of the study. Additionally, it also tackles the research problem, research questions, delineations and limitations of the study, methodology, literature review and the structure of the chapters.

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<sup>55</sup> N Soberlund & B Hansl 'Health insurance in South Africa: An empirical analysis of trends in risk-pooling and efficiency following deregulation' (2000) 15 (4) *Health Policy and Planning* 378.

<sup>56</sup> D Makoka, B Kaluwa & Patrick Kambewa 'The demand for private health insurance in Malawi' (2007) <http://ideas.repec.org/p/pramprapa/4974.html> (accessed 28 August 2010).

## **Chapter 2**

This chapter conceptualises the right to health and the right to life both at the global and African human rights systems. It then investigates the extent to which the Malawian and South African legal systems recognise and protect the two rights. It also discusses strategies that could be employed to enforce the right to health under the Malawian legal system where health is only mentioned in the PNP. Finally, the chapter also discusses potential challenges that may be encountered to litigate the right to health.

## **Chapter 3**

In this chapter, I assess the (non)-regulation of the health insurance industry in the two countries and its potential impact on the enjoyment of the right to health and the right to life. It also discusses how health insurance functions in theory and practice and their importance. The chapter further discusses the concept of 'freedom of contract' as it relates to the members and the health insurance organisations. It shall also advocate for a human rights based approach in the design and provision of health insurance services and any legislation meant to regulate the industry. Finally, the chapter analyses the current regulatory frameworks and highlight their weaknesses and gaps, if any.

## **Chapter 4**

This chapter discusses the comparison between Malawi and South African and draws some lessons from South Africa for Malawi and the nature of the binding obligations of the rights to health and life on Malawi and the health insurance industry.

## **Chapter 5**

This chapter discusses the summary of the findings and the major conclusions drawn from the study. It then makes recommendations on the way forward regarding the need to have a comprehensive legislative or other mechanism to regulate the health insurance industry to ensure compliance with human rights obligations.

## Chapter Two

### 2. Understanding the Right to Health and the Right to Life

#### 2.1 Introduction

There are three main tasks to be accomplished in this chapter. The first is to conceptualise the right to health and the right to life as understood both at international and African regional systems. The second task is to further discuss the extent to which Malawi and South Africa recognise and protect the two rights. The third task in relation to Malawi where the right to health is not expressly provided for in its legal framework is to suggest an appropriate strategy that could be used to protect and enforce the same. Any potential challenges that may be encountered in enforcing the right will be highlighted.

#### 2.2 The right to health in the global arena

Every human being is entitled to the enjoyment of the highest attainable standard of health. Without good health, other human rights cannot be realised. In the global arena, the World Health Organisation (WHO) was the first body to define *health* in its preambular statement to the Constitution in 1946.<sup>57</sup> *Health* was defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. This definition is not without criticisms. They are reflected in other works.<sup>58</sup> At WHO level, discussions have been ongoing to revise the definition.<sup>59</sup> Later on, *health* found expression as a right in various international legal instruments. In 1948, it was included in the Universal Declaration<sup>60</sup> under article 25. The right to health was later concretised in a binding legal instrument, the International Covenant on Economic Social and Cultural Rights (ICESCR)<sup>61</sup> in 1966.

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<sup>57</sup> The Constitution of the WHO was adopted on 22 July 1946 and it entered into force on 7 July 1948.

<sup>58</sup> C Onyemelukwe ‘Access to anti-retroviral drugs as a component of the right to health in international law: Examining the application of the right in Nigeria’ (2007) 7 *African Human Rights Law Journal* 454; VA Leary ‘The right to health in international human rights law’ (1994) 1 *Health and Human Rights* 26.

<sup>59</sup> Executive Board of WHO Res. EB/101.R2 adopted on 22 January 1998. The proposed definition reads: ‘Health is a dynamic state of complete physical, mental, spiritual and social well being and not merely the absence of disease or infirmity’. The new definition does not unfortunately recognise health as a right.

<sup>60</sup> The UDHR was adopted on 10 December 1948 by the United Nations General Assembly (UNGA) under Res.217 A (II) 1948.

<sup>61</sup> The ICESCR was adopted on 16 December 1966 and it entered into force on 3 January 1976.

It has further been replicated in other international instruments including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979<sup>62</sup> and Convention on the Rights of the Child (CRC) of 1989.<sup>63</sup> It has also been affirmed in a number of international conferences such as the Declaration of Almata-Ata of 1978 and the World Health Declaration of 1998.<sup>64</sup> The terminology, 'right to health' is not used in any of the instruments cited above. However, it is widely used in human rights literature. It is a shortened version of the highly packed diction used in the international legal instruments.<sup>65</sup> 'Right to health' therefore, is a misnomer since no state can guarantee health as it is determined by many variables including the environment, nature and personal habits of individuals.<sup>66</sup> Toebes (as quoted in Onyemelukwe)<sup>67</sup> further notes that, 'right to health' is synonymous with the 'enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health'. Interestingly, this conceptualisation is exactly the same as that adopted by ICESCR Committee.<sup>68</sup> The study therefore adopts it as a working definition.

Reverting to ICESCR, article 12(1) provides that 'the states parties to the present covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Article 12(2) then outlines the measures to be undertaken by state parties in order to realise the right. These include, 'prevention, treatment, and control of epidemic, occupational and other diseases'.<sup>69</sup> Article 2 further enjoins each state party to undertake steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, to achieve progressively the full realisation of the rights recognised therein by all appropriate means, including particularly the adoption of legislative measures. The Economic, Social and Cultural Rights Committee (the ESCR Committee), which is responsible for monitoring the rights under ICESCR, clarified in General Comment No 14 (2000) the scope and normative content of the right to health. The interpretation is the most authoritative statement. The ESCR Committee stated that the right to

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<sup>62</sup> Arts 11 & 12, adopted on 18 December 1979 and it entered into force on 3 September 1981.

<sup>63</sup> Art 24, adopted on 20 November 1989 and it entered into force on 2 September 1990.

<sup>64</sup> Uganda Human Rights Commission *10<sup>th</sup> Annual Report (2007)* 51.

<sup>65</sup> JC Mubangizi & BK Twinomugisha 'The right to health care in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?' (2010) 10 *African Human Rights Law Journal* 109.

<sup>66</sup> Chirwa (n 48 above), 545.

<sup>67</sup> Onyemelukwe (n 58 above) 454.

<sup>68</sup> General Comment No 14 para 9.

<sup>69</sup> n 61 above, art 12(2)(c).

health has four elements namely, *availability* of public health and healthcare facilities, goods and services among others; *accessibility* of the services referred above in a non-discriminatory manner to all, especially the most vulnerable or marginalised such as ethnic minorities, women, children, older persons, persons with HIV among others, on any prohibited grounds, affordable to all and access to information relating to health issues; *acceptability* in that the facilities and services must be respectful of medical ethics and culturally appropriate and finally *quality* in that the facilities and services must be scientifically and medically appropriate and of good quality.<sup>70</sup> The right to health also envisages curative and preventive measures.<sup>71</sup> As any other human right, the right generates three levels of duties on the part of the state, namely, respect, protect and fulfil.<sup>72</sup> It is noteworthy that the ESCR Committee treats the duty to promote as being part and parcel of the duty to fulfil. The duty to respect entails refraining from interfering either directly or indirectly with the enjoyment the right. The duty to protect envisages taking of steps to ensure that third parties do not interfere with the right. In this regard, the right can be violated by non-state actors insufficiently regulated by the state.<sup>73</sup> The duty to fulfil encompasses the adopting of appropriate legislative, administrative, judicial and other measures to realise the right. The ESCR Committee went further and reaffirmed the concept of 'minimum core obligations' propounded in General Comment 3 (1990). It is to the effect that while the right to health as a social, economic and cultural right is to be progressively realised subject to the availability of resources, the minimum core obligations enumerated in paragraph 43 thereof, are non-derogable. A state party will not be heard to say that it did not have resources to realise even these minimum core obligations. One such core-obligation is the provision of essential drugs, as defined from time to time by the WHO Action Programme on Essential Drugs. WHO defines essential drugs as 'those considered to be of the utmost importance and hence basic, indispensable, and necessary for the health needs of the population. They should be available at all times, in the proper dosage forms, to all segments of society'.<sup>74</sup> This entails that the right to health is enforceable at international level, through state reporting procedures under the ICESCR.

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<sup>70</sup> n 68 above, para 12.

<sup>71</sup> As above, para 16.

<sup>72</sup> As above, para 33.

<sup>73</sup> As above, para 48.

<sup>74</sup> H Mahler *Report to the 28<sup>th</sup> World Health Assembly*, Official Records of the World Health Organisation, No. 226, Annex 13 (1975).

The ESCR Committee has also opined that states have to provide remedies for violations of economic, social and cultural rights. If a state fails to do so, it carries the burden of justifying the failure. It said:

[A] state party seeking to justify its failure to provide any domestic legal remedies for violations of economic, social and cultural rights would need to show either that such remedies are not 'appropriate means' within the terms of article 2, paragraph 1, of the International Covenant of Economic, Social and Cultural Rights or that, in view of the other means used, they are unnecessary. It will be difficult to show this and the Committee considers that, in many cases, the other means used could be rendered ineffective if they are not reinforced or complemented by judicial remedies.<sup>75</sup>

### 2.3 The right to health in the African human rights system

The African Charter on Human and Peoples' Rights<sup>76</sup> (ACHPR) (the Charter) also provides for the right to health. Article 16(1) states that, 'every individual shall have the right to enjoy the best attainable state of physical and mental health'. Article 16(2) on the other hand, enjoins state parties to take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. It has been argued by other scholars such as Odinkalu (as quoted in Kapindu<sup>77</sup>) and Heyns (as quoted in Kaime<sup>78</sup>) that the formulation of the right to health under article 16 is immediate and not subject to progressive realisation and thus it could undermine its legitimacy. This study agrees with Kaime when he notes that:

[T]his reading of the Charter is not supported by a holistic interpretation of its provisions and the current jurisprudence of the Commission. The Charter clearly allows the Commission to 'draw inspiration from the international law on human and peoples' rights' and 'instruments adopted by the United Nations and by African countries in the field of human and peoples' rights. Principles of 'international law' and provisions of 'instruments adopted by the United Nations and by African countries have firmly entrenched the principle that economic, social and cultural rights must be progressively realised within the maximum available resources.

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<sup>75</sup> General Comment No 9 para 3.

<sup>76</sup> Malawi ratified this instrument on 23 February 1990.

<sup>77</sup> RE Kapindu 'Poverty reduction strategies and the rights to health and housing: The Malawian and Ugandan experiences' (2006) 6 *African Human Rights Law Journal* 506.

<sup>78</sup> T Kaime 'Beyond social programs: The right to health under the African Charter on Human and Peoples' Rights' (2004) 10 (2) *East African Journal of Peace and Human Rights* 202.

The same reasoning could be used to counter any arguments that article 16(2) of the ACHPR only envisages curative healthcare services and not preventive. In fact, that conclusion would not be supported by state practices.

Article 1 of the Charter enjoins state parties to recognise the rights, duties and freedoms and adopt legislative and other measures to give effect to them. The right to health has been interpreted by the African Commission on Human and Peoples Rights (ACmHPR) (the Commission) in a number of cases. In the *SERAC* case,<sup>79</sup> the Commission held that the right to health generates four levels of duties on states, namely, the duty to respect, protect, promote and fulfil. Unlike the ESCR Committee, the Commission treats the duty to promote as a standalone duty. However, in a recent resolution on *Access to Health and needed Medicines in Africa*, the Commission used a triple typology of the levels of duties, namely, the duty to promote, to protect and to fulfil.<sup>80</sup> This does not however mean that under the above resolution, states do not have the duty to respect.

In *Purohit and Moore v. The Gambia*, the Commission had another opportunity to pronounce itself on the connection between the right to life and the right to health. In discussing this relationship, the Commission stated that:

The enjoyment of the human right to health, as it is widely known, is vital to all aspects of a person's life and well-being and is crucial to the realisation of all other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed without discrimination of any kind.<sup>81</sup>

The Commission's position in *Purohit and Moore* aligns with the ICESCR. This communication, while it was a step in the right direction in the African human rights system, has been criticised for not expressly stating in very clear terms the standard to be used for measuring the concreteness of the steps to be taken by member states and whether they are well targeted in the realisation of the right to health.<sup>82</sup> Similarly, stemming from article 1 of the Charter, the Commission has averred that state parties thereto have a duty to ensure the inclusion of the

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<sup>79</sup> *SERAC* Case (n 49 above).

<sup>80</sup> ACHPR Res. 141 (XXXVIII) 08.

<sup>81</sup> Communication 241/2001, Sixteenth Annual Activity Report.

<sup>82</sup> C Mbazira 'The right to health and the nature of socio-economic rights obligations under the African Charter: The Purohit Case' *Economic Social Right Review* 6 (4).

right to health in their constitutions.<sup>83</sup> In addition, state parties are also required to regulate the activities of third parties so that right holders are able to claim and realise their rights. In the *SERAC* case, the Commission said:

[T]o protect right-holders against other subjects by legislation and provision of effective remedies. This obligation requires the state to take measures to protect beneficiaries of the protected rights against political, economic and social interferences. Protection generally entails the creation and maintenance of an atmosphere or framework by an effective interplay of laws and regulations so that individuals will be able to freely realise their rights and freedoms.<sup>84</sup>

## 2.4 The right to life in the global and African system

At the global level, the United Nations Human Rights Committee has given a wide interpretation of the right to life as follows:

The right to life is a fundamental human right and the exercise of this right is essential for the exercise of all other human rights. If it is not respected, all rights lack meaning. Owing to the fundamental nature of the right to life, restrictive approaches to it are inadmissible. In essence, the fundamental right to life includes not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence. States have the obligation to guarantee the creation of the conditions required in order that violations do not occur...

The right to life under the African system has already been discussed under the previous section when dealing with the *Purohit and Moore* case.

## 2.5 Locating the right to health and right to life in the Malawian legal system

As explained in section 1.1 of chapter 1, Malawi does not have a clear and express provision on the right to health other than a statement in the PNP.<sup>85</sup> However, section 32 of the Constitution obliges the state to take all measures to the right to development, which includes equality of

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<sup>83</sup> Kaime (n 77 above).

<sup>84</sup> SERAC Case (n 49 above) para 46.

<sup>85</sup> n 4 above.

opportunity for all in their access to basic resources, education, health services, among others. In view of the foregoing, it would appear that it would be difficult to enforce the right to health in the Malawian legal system. Could it be imported through treaty obligations to which Malawi is a party?

Malawi is a party to various international treaties which have provisions on the right to health. The instruments include the ICESCR,<sup>86</sup> International Covenant on Civil and Political Rights (ICCPR),<sup>87</sup> CRC,<sup>88</sup> ACHPR,<sup>89</sup> to mention but some. Malawi is expected to implement its obligations under these treaties in the domestic arena as it is bound at international level to protect the right to health. Unfortunately, Malawi does not have a tradition of reporting under its treaty obligations, let alone domesticating international instruments.<sup>90</sup> Take for instance the treaties cited above. Of the four, Malawi has only reported once to the CRC Committee. The report was submitted in 2000 when it was due in 1993.<sup>91</sup> This is a very sad state of affairs. In view of the above, international treaties would hardly offer a good alternative to enforce the right to health in Malawian courts because Malawi is essentially a dualist state.<sup>92</sup> So far, other than some few provisions of some treaties that were replicated in the Constitution or some specific legislation such as the Refugee Act,<sup>93</sup> Malawi has not domesticated any human rights treaties. It must be observed that the Malawi Supreme Court of Appeal (MSCA) has rendered rather conflicting decisions on the requirement to domesticate conventions. In *Chakufwa Tom Chihana v The Republic*<sup>94</sup> the appellant was charged with importing and being found in possession of seditious materials. The case was decided under the 1966 Constitution, now repealed. In terms

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<sup>86</sup> Malawi ratified ICESCR on 22 March 1994.

<sup>87</sup> Malawi ratified ICCPR on 22 March 1994.

<sup>88</sup> Malawi acceded to this instrument on 2 January 1991.

<sup>89</sup> Malawi ratified the ACHPR on 23 February 1990.

<sup>90</sup> FE Kanyongolo *Malawi justice sector and the rule of law* (2006) 30-34.

<sup>91</sup> Committee on the Rights of the Child 'Initial report of states parties due in 1993: Malawi' (CRC/C/8/Add.43) (2001).

<sup>92</sup> n 3 above, sec 211 provides as follows:

- 1 Any international agreement entered into after the commencement of this Constitution shall form part of the law of the Republic if so provided by or under an Act of Parliament.
- 2 Binding international agreements entered into before the commencement of this Constitution shall continue to bind the Republic unless otherwise provided by an Act of Parliament
- 3 Customary international law, unless inconsistent with this Constitution or an Act of Parliament, shall form part of the law of the Republic.

<sup>93</sup> Act 3 of 1989.

<sup>94</sup> M.S.C.A. Criminal Appeal No. 9 of 1992, [1993] MWSC 1 (29 March 1993) <http://www.malawilii.org> (accessed 13 September 2010).

of section 2 of the Schedule to the repealed Constitution, Malawi was to continue to recognise the rights and freedoms provided in the UDHR. The court was also referred to the ACHPR. It held that:

This Charter, in our view, must be placed on a different plane from the UNO Universal Declaration of Human Rights. Whereas the latter is part of the law of Malawi, the African Charter is not. Malawi may well be a signatory to the Charter and as such is expected to respect the provisions of the Charter but until Malawi takes legislative measures to adopt it, the Charter is not part of the municipal law of Malawi and we doubt whether in the absence of any local statute incorporating its provisions the Charter would be enforceable in our Courts.

For a long time, the above position represented an authoritative position on the applicability and enforceability of international treaties in the domestic arena. However, the MSCA partly overruled itself on the above position to the extent that it was understood that all international treaties required incorporation/domestication first before they could be relied upon as law in local courts. In *Malawi Telecommunications Limited v Makande and Omar*<sup>95</sup> the court said:

In the circumstances, this Court's decision in *Chakufwa Tom Chihana v The Republic*, MSCA Criminal Appeal No. 9 of 1992 (Unreported) and the High Court decision in *Guwendu v AON Malawi Limited, Miscellaneous Civil Cause No. 25 of 2000* to the extent that they purportedly indicated that the law on the point then was as after the amendment of 2001 to section 211(1) were wrong and should be and are overruled.

The MSCA took the view that in addition to section 211 of the Constitution, one has to consider also the language of the treaty and its provisions to determine whether it requires domestication before it could be relied upon in a domestic court. The Court observed that in some cases, the provisions of treaties would not require domestication because they are self-executing.

The High Court attached a different interpretation to section 211 of the Constitution. In *S. Kalinda v Limbe Leaf Tobacco Ltd*<sup>96</sup> it held among other things, that all international conventions entered into before 1994 and binding on the Republic are part of our law.

However, because of the doctrine of *stare decisis*, the High Court decision cannot be relied upon as law.

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<sup>95</sup> M.S.C.A. Civil Appeal No.2 of 2006 (unreported).

<sup>96</sup> Civil Cause No. 542 of 1995 [http://www.judiciary.mw/judiciary/civil/Kalinda\\_Limbe\\_Leaf\\_Tobacco.htm](http://www.judiciary.mw/judiciary/civil/Kalinda_Limbe_Leaf_Tobacco.htm) (accessed 13 September 2010).

Then in 2009, in, *In the matter of the Adoption of Children Act and In the Matter of Chifundo James (An Infant)*<sup>97</sup> (the *Madonna case*) the MSCA held, *inter alia*, that international treaties become part of the law of Malawi if they have been domesticated. The court rejected a submission by the petitioner that section 211(1) of the Constitution was intended to make international treaties signed by Malawi part of the law of the land. This being a more recent case by the MSCA, it takes precedence over the other two cases discussed above. Specifically, it reaffirms and reinstates the *Chihana* position even though no reference was made to *Chihana* in the judgment. Surprisingly, *the Madonna case* did not also make reference to the *Makande and Omar* case. This does not speak very well of the highest court in the land. At a minimum, it is obliged to make reference to its own jurisprudence and develop it further or change it in a systematic manner. This anomaly could partly be explained by the fact that in its quest to expeditiously dispose of matters, two different sets of three justices of appeal out of the seven are constituted to hear a matter. Even then, the assumption is that the two sets, read each other's judgments. This anomaly could also be because of lack of law reporting in Malawi such that counsel may not be aware of the developments in the law. The *Makande and Omar* position is the more favourable and progressive.

In spite of the above, courts in Malawi do take into account Malawi's international obligations when interpreting the Constitution and other laws.<sup>98</sup> Furthermore, courts are obliged, in terms of section 11(2)(c) of the Constitution, to have regard, where applicable, to current norms of public international law and comparable foreign case law.<sup>99</sup>

### 2.5.1 Enforcing the right to health through the right to life

The right to life is provided for under the Bill of Rights in the Constitution. It is therefore justiciable. However, as we saw earlier, section 14 of the Constitution being part of the PNP,

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<sup>97</sup> MSCA Adoption Appeal No. 28 of 2009. For a critical review of the decision, see D Ngabirano 'A critical appraisal of contemporary adoptions: In the matter of the Adoption of Children Act and in the matter of CJ (An infant), also known as the "Madonna Adoption Case" ' (2009) 15 (2) *East African Journal of Peace & Human Rights* 520.

<sup>98</sup> *Evance Moyo v The Attorney General*, Constitutional Case No. 12 of 2007 5 (unreported).

<sup>99</sup> In *Francis Kafantayeni and Others v The Attorney General*, Constitutional Case No. 12 of 2005 12 & 13 the High Court said, '[u]nder this heading of denial of fair trial, counsel for the plaintiffs have cited in their support the provision in article 14, paragraph 5, of the International Covenant on Civil and Political Rights to which Malawi is a State Party. We accept and recognize that the Covenant forms part of the body of current norms of public international law and in terms of section 11(2) of the Malawi Constitution courts in Malawi are required to have regard to its provisions in interpreting the Constitution...'

provides that government shall implement policies and legislation aimed at achieving adequate healthcare, commensurate with the health needs of Malawian society and international standards of healthcare. It was also noted that PNP are only directory in nature and not justiciable. In spite of this, it is argued that to the extent that the right to health is so intertwined with the right to life, it can be enforced through the right to life. This is because human rights are 'indivisible, interdependent, interrelated and of equal importance for human dignity'.<sup>100</sup> The right to life can be interpreted so broadly to subsume other rights within it. That is how the right to health has been recognised and protected in some jurisdictions. In those jurisdictions, like Malawi, they also just have similar statements on health in the Directive Principles of State Policy (DPSP) which are non-justiciable. A few examples will now be discussed to show the level of judicial engineering other jurisdictions have engaged in.

In *Francis Coralie Mullin v The Administrator, Union Territory of Delhi & Others*<sup>101</sup> the Supreme Court of India took the view that:

While arriving at the proper meaning and content of the right to life the attempt of the court should always be to expand the reach and ambit of the fundamental right rather than to attenuate its meaning and content. A constitutional provision must be construed, not in a narrow and constricted sense, but in a wide and liberal manner so as to anticipate and take account of changing conditions and purposes so that the constitutional provision does not get atrophied or fossilized but remains flexible enough to meet the newly emerging problems and challenges. This principle applies with greater force in relation to a fundamental right enacted by the constitution. The fundamental right to life which is the most precious human right and which forms the ark of all other rights must therefore be interpreted in a broad and expansive spirit so as to invest it with significance and vitality which may endure for years to come and enhance the dignity of the individual and the worth of the human person.<sup>102</sup>

The court also interpreted the right to life to mean much more than just physical survival, adding that it includes the right to basic necessities of life such as water, food and health.

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<sup>100</sup> The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1998) 20 *Human Rights Quarterly*, para 4.

<sup>101</sup> (1981) AIR 746, (1981) SCR (2) 516.

<sup>102</sup> As above (paras 526 C-D, 528 A-C).

The above interpretation is consistent with that given by both the ESCR Committee and the Commission.<sup>103</sup> The services mentioned are the underlying determinants of the right to health.

In Ghana, courts have taken the view that even though DPSP are not enforceable, there are exceptions to this general rule. The exception is where these are read together with the enforceable rights in the Constitution.<sup>104</sup>

In *Dr Mohiuddin Farooque v Bangladesh & Others (No.1)*<sup>105</sup> the government of Bangladesh was sued for failure to halt the importation of powdered milk, which upon being tested, some of it had exhibited high levels of radiation above the recommended limit. The Supreme Court held that the failure by Bangladesh to take measures to send back the consignment to the exporter had violated the right to life of potential consumers. It was further held that the protection of the right to life is not limited to the protection of life and limb, but also the protection of the health and longevity of an ordinary citizen. The Court also noted that where health and longevity were threatened, as in the present case, the state could be compelled by the court to remove the threat in spite of the fact that the primary DPSP duty in terms of article 18 to raise the level of nutrition and improve public health could not be enforced.

In *Paschim Banga Khet Samity v State of West Bengal & Another*<sup>106</sup> the petitioner who had suffered terrible head injuries in an accident was refused medical treatment in eight public hospitals allegedly due to lack of beds or technical capacity. He ended up being admitted to a private hospital where he paid Rs 17,000. He then sued the respondent claiming that his right to life had been violated. The Supreme Court of India held that his right to life had indeed been violated under article 21 of the Constitution. It also held that the right to emergency medical care formed a core component of the right to health, which in turn was an integral part of the right to life. The court also awarded him compensation.

In view of the above examples, it is clear that the right to health may be enforced through the right to life on the basis of indivisibility, interdependence, and interrelatedness and equal importance of all human rights for human dignity. This would require that the court dealing with

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<sup>103</sup> n 67 above, para 9 and *Free Legal Assistance Group & Others v Zaire* (2000) AHRLR 74 (ACHPR 1995).

<sup>104</sup> JC Mubangizi 'The constitutional protection of socio-economic rights in selected African countries: A comparative evaluation' (2006) 1 2 *African Journal of Legal Studies* 17; BK Twinomugisha 'Implications of the TRIPS agreement for the protection of the right of access to medicines in Uganda' (2008) 2 (2) *Malawi Law Journal* 260-261.

<sup>105</sup> (1996) 48 DLR, HCD 438.

<sup>106</sup> (1996) 4 SCC 37.

the issue be creative and interpret the right to life expansively. This would also depend on the judge or judges handling the case. It is submitted that this strategy could also be employed in Malawi, even though other commentators are of the view that the right to health could also be enforced through the right to development under section 30(2) of the Malawi Constitution.<sup>107</sup> However, that debate is beyond the scope of this study. It is further submitted that such a broad interpretation of the right to life to include the right to health would be in line with Malawi's obligation both under ICESCR and the ACHPR which require that states do put in place mechanisms for redress for violations of economic, social and cultural rights including judicial remedies.<sup>108</sup>

It is important to note that the employment of the above strategy could be problematic to implement partly because Malawi does not have a specialised constitutional court. Whenever a matter touching on the interpretation or application of a constitutional provision arises, the Chief Justice is required by the Courts (Amendment) Act, to certify the matter as constitutional.<sup>109</sup> Subsequently, he/she empanels three judges of the High Court, usually one from each administrative region of the country, to hear and dispose of the matter. Even though in ordinary parlance people speak of the court as being a constitutional court, legally and strictly speaking, it is actually a High Court sitting in a constitutional case. Obviously, such a court is not the final arbiter on such matters in terms of the hierarchy of the courts. The MSCA is.<sup>110</sup> This practice of empanelling three judges to sit in a constitutional case deprives the judges of the ability to develop exceptional competence in the handling of constitutional matters. It also has a bearing on the nature and extent of constitutional litigation generally.

On the other hand, it is arguable that there is merit in the current arrangement because not many constitutional cases are litigated in Malawi. This is partly because the MSCA has unduly restricted the scope of *locus standi* under the Constitution.<sup>111</sup> Having a fully-fledged constitutional court would have meant no work for the judges for the most part of the year. In any case, the Constitution does not envisage the establishment of any further courts either at

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<sup>107</sup> Chirwa (n 13 above) 228 & 231.

<sup>108</sup> n 74 above.

<sup>109</sup> Courts (Amendment) Act 2004 sec 9(3).

<sup>110</sup> *In the Matter of Presidential Reference of a Dispute of a Constitutional Nature under sec 89(1)(h) of the Constitution and In the Matter of sec 65 of the Constitution and In the Matter of the Question of Crossing the Floor by Members of the National Assembly*, MSCA, Presidential Reference Appeal No 44 of 2006 (unreported).

<sup>111</sup> MJ Nkhata 'Public interest litigation and *locus standi* in Malawian constitutional law: Have the courts unduly fettered access to justice and legal remedies' (2008) 2 (2) *Malawi Law Journal* 209.

par with the High Court or above it other than the MSCA.<sup>112</sup> Another practical reason is that there are few judges, about twenty five, in Malawi and consigning others to only full time constitutional work would negatively affected access to justice.

In view of the above difficulties that would be faced, the solution seems to lie in amending the Constitution, to guarantee the right to health. Such an amendment would be in line with Malawi's international human rights obligations, both under ICESCR and ACHPR. Such an enforceable provision would assist in ensuring that the government is accountable to the people, otherwise its lack thereof, perpetuates the perception that the provision of healthcare services and goods to the people are gifts or privileges or a favour from the government and not legal entitlements or rights, hence the extreme politicisation of such services in many cases.

## 2.6 The rights to health and life in the South African legal system

As discussed in Chapter 1, South Africa has a clear provision on the right to health in its Constitution. Section 27(1)(a) provides that '[e]veryone has the right to have access to healthcare services, including reproductive healthcare'. While this section would ordinarily include virtually 'everyone',<sup>113</sup> the draftpersons deemed it fit to repeat the above section in respect of the rights of children<sup>114</sup> and in a slightly modified version, with regard to the rights of detainees and prisoners,<sup>115</sup> perhaps because of their vulnerability. South Africa promulgated the called National Health Act,<sup>116</sup> which seeks to realise the right to health as in the Constitution. Unlike Malawi, in South Africa, section 27(1)(a) has been a subject of litigation in a number of cases.<sup>117</sup>

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<sup>112</sup> n 3 above, sec 110.

<sup>113</sup> *Khosa v Minister of Social Development* 2004 (6) SA (CC) paras 46-7 interpreted 'everyone' to include non-citizens living in South Africa.

<sup>114</sup> Constitution of South Africa sec 28(1)(c).

<sup>115</sup> As above, sec 35(2)(3).

<sup>116</sup> Act 61 of 2003.

<sup>117</sup> *Minister of Health and Others v Treatment Action Campaign and Others* 2002 5 SA 721 (CC); *E N and Others v Government of RSA and Others* 2007 1 BCLR 84 (D).

In South Africa, in terms of section 39 of the Constitution, courts and other bodies when interpreting the Bill of Rights, they are required to consider international law.<sup>118</sup>

In this regard, even though the courts have adopted certain standards set by international mechanisms for instance 'available resources', they have also rejected others, such as the concept of 'minimum core obligations'.<sup>119</sup> However, other scholars argue that, in practice, the South African Constitutional Court implicitly accepted the 'minimum core obligations'.<sup>120</sup> The Constitutional Court has opted to maintain the formalistic and linguistic standard of reasonableness used in sections 26 and 27 of the Constitution. Otherwise, in terms of applicability and enforceability of international treaties, the practice between Malawi and South Africa is the same.

## 2.7 Conclusion

In conclusion, there is a need to specifically recognise the right to health in the Malawi Constitution. Such recognition would enhance accountability on the part of government. However, on the international plane, Malawi still remains bound to take measures to realise the right to health. To a limited extent, the right to health can be enforced through a litigation strategy that uses the right to life. In South Africa, the right to health is justiciable because it is within the Bill of Rights.

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<sup>118</sup> For a comprehensive analysis of how the courts have fared in this regard, see RE Kapindu *From the global to the local: The role of international law in the enforcement of socio-economic rights in South Africa* (2009).

<sup>119</sup> *Government of the Republic of South Africa and Others v Grootboom and Others* 2000 11 BCLR 1169 (CC).

<sup>120</sup> Kapindu (n 76 above) 510.

## Chapter Three

### **3. Assessing the (non)-regulation of the health insurance industry and its impact on the two rights**

#### **3.1 Introduction**

This chapter deals with several issues. First, in order to contextualise the study, I briefly discuss how health insurance functions in theory and practice and why they are important. Second, I summarily discuss why in view of the concept of freedom of contract, the state should be involved in regulating the relationship between members and the health insurance organisations. Third, the chapter also advocates for a human rights based approach to the design and implementation of the services offered by the health insurance organisations and any legal framework meant to regulate them. Finally, I shall analyse the existing legal frameworks in the two states and discuss whether health insurance are being adequately and sufficiently regulated to protect the rights to health and life of the existing and potential members. In this regard, I also discuss the potential impact of any weaknesses or gaps in the legal frameworks on the enjoyment of these rights by the members described above.

#### **3.2 Health insurance: How they function and their importance**

Health insurance is a method of financing healthcare systems. They can either be public or private in nature. This study focuses on private health insurance. Health insurance is not the only method of financing healthcare systems. Other methods include user-fees and revenue collected from tax.<sup>121</sup> The main disadvantage of user-fees is that they tend to exclude the poor from primary healthcare services.<sup>122</sup> Yet, the right to health as interpreted by the ESCR Committee envisages that such services must be accessible to all, especially the most vulnerable or marginalised groups such as women, children, older persons and persons with HIV.<sup>123</sup> As for public financing through revenue collected from tax, the position is aptly summarised by the World Health Report that ‘if [healthcare] services are to be provided to all,

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<sup>121</sup> D De Ferranti ‘Paying for health services in developing countries’ quoted in Phalatsi (n 51 above) 241.

<sup>122</sup> Phalatsi (n 53 above) 241.

<sup>123</sup> n 68 above.

then not all services can be provided'.<sup>124</sup> Healthcare services delivery by states especially in developing countries is inadequate and inefficient.<sup>125</sup>

Insurance may be defined as 'a contract whereby one person, called the *insurer* undertakes, in return for the agreed consideration, called a *premium* to pay to another person, called the *assured* a sum of money, or its equivalent, on the happening of a specified event.'<sup>126</sup> In *Prudential Insurance Co v IRC* a case which dealt with life insurance, Channell J said:

...That I think is the first requirement in a contract of insurance. It must be a contract whereby, for some consideration, usually, but not necessarily, for periodical payment called premiums, you secure to yourself some benefit, usually, but not necessarily the payment of a sum of money upon the happening of some event.<sup>127</sup>

Insurance is also a mechanism by 'which risks or uncertain events are shared among many people'.<sup>128</sup> When people join health insurance they pay an agreed premium within an agreed period. Whenever they become ill, the health insurance foots their medical bill either in a larger part or in total depending on the type of scheme or level joined. That is the benefit that accrues to the assured. The premiums paid form a 'pool'. Pooling is therefore the 'accumulation and management of the revenues in such a way as to ensure that the risk of having to pay for healthcare is borne by all the members of the pool and not each contributor individually'.<sup>129</sup> Pooling is also known as the 'insurance function' in a health system.<sup>130</sup> In practice therefore, because members of the pool do not fall ill at the same time, there is equalisation of the contributions among the members regardless of the risk associated with utilisation of medical services by individuals within the pool.<sup>131</sup> Stated differently, all things being equal, health insurance still remains profitable to the insurers because risk pooling has the effect of enabling those who are healthy to subsidise the cost of those who are ill at any point in time, and also those who are rich subsidising those who are poor. It is for this reason that in theory, health insurance can assist in the mobilisation of additional resources for the betterment of the

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<sup>124</sup> WHO *World health report* (2000) IX.

<sup>125</sup> RJ Vogel *Health insurance in sub-Saharan Africa: A survey and analysis* (1990).

<sup>126</sup> ER Hardy Ivamy *General principles of insurance law* (1993) 3.

<sup>127</sup> [1904] 2 KB 658.

<sup>128</sup> Phalatsi (n 53 above).

<sup>129</sup> PJ van Krieken (ed) *Health, migration and return: A handbook for a multidisciplinary approach* (2001).

<sup>130</sup> As above.

<sup>131</sup> As above.

healthcare systems.<sup>132</sup> If governments would have in place good regulatory frameworks for the insurance to level the playing field and also put in place sufficient safeguards for the protection of the interests and human rights of the members, it would stimulate more people to join. When that happens, financial resources under Ministry of Health (MoH) are freed for the poor in public health facilities. Consequently, other than regulation of third parties so that right holders are able to claim and realise their rights being an international human rights obligation placed on the states,<sup>133</sup> in this case, it is also in the interest of the state for the reason explained above. Under international law, states are obliged to ensure that their international obligations are respected in their territory.<sup>134</sup> Legislation therefore becomes handy to ensure the effective implementation of specific obligations under the treaties. It is this point that triggers the issue of freedom of contract, my next issue for consideration.

### 3.3 Where is freedom of contract if regulation by a state is allowed?

States have historically used public policy as the main ground for regulating insurance companies in market economies, notwithstanding the doctrine of free enterprise.<sup>135</sup> Protection of human rights is now another ground. A state has a continuing oversight and regulatory role over private service providers to ensure that rights of consumers are being respected. The doctrine of freedom of contract is intertwined with the doctrine of free enterprise. It is rooted in the belief that parties are free to determine the terms and conditions of their contract.<sup>136</sup> The underlying assumption is that the parties have equal bargaining power. The truth however, is that the parties never have equal bargaining power.<sup>137</sup> Insurance companies have more power than an ordinary individual. This may be one justification for state intervention in private contracts between persons. The main justification, it is submitted, is that any contract entered into by private persons, is subject to the laws of the state. In this regard, the laws of the state are not only domestic legislation. They also include the state's international human rights obligations. Non-state actors have a duty to ensure that their economic, social and cultural activities do not

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<sup>132</sup> Vogel (n 125 above).

<sup>133</sup> SERAC case (n 50 above).

<sup>134</sup> MN Shaw *International law* (2008) 859.

<sup>135</sup> R Kabala 'An overview of the Insurance Act laws of Uganda 2000 (Cap 213) and the Insurance Regulations, 2002 (The Regulations)' (2006) 1 (1) *Makerere Law Journal* 145.

<sup>136</sup> Cheshire, Fifoot & Furmston's *Law of contract* (2001) 1-20

<sup>137</sup> As above, 20-21.

compromise the state's human rights obligations both at domestic and international level. In sum, even in free market economies, freedom of contract must exist within the ambit of the framework of the state's laws and its human rights obligations.<sup>138</sup> This issue takes me to a human rights based approach to service provision and legislating for regulation.

### 3.4 Advocating for a human rights based approach

Health insurance organisations are first and foremost businesses. Their aim is to make profit or surplus regardless of the fact that many are registered either as trusts or companies limited by guarantee as not-for-profit organisations. However, as lawyers, we know that this is a legal fiction. It serves certain business interests better. It is because of this business-mindedness that the services they offer are often packaged to maximise profits/surpluses and not to respect the human rights of the members. This usually manifests itself in the manner in which the terms and conditions of the policies/benefits are drafted. The terms and conditions ought to be drafted in a manner that does not offend or infringe the rights of the members and also a realisation that the services the members receive are also legal entitlements. It is for this reason that when assessing the (non)-regulation of the health insurance the human rights based approach is an appropriate framework that shall be employed, besides, the conceptualisations of the two rights discussed in chapter 2.

Briefly, a human rights based approach means locating the health/medical needs of the members in human rights. It would further mean employing the terminology of rights in the design and implementation of the products offered to the members.<sup>139</sup> This approach facilitates and enhances the testing of services, policies and legislation against human rights where they exist, and where they are non-existent, it uses rights to agitate for their formulation and effective implementation, monitoring and evaluation.<sup>140</sup> This approach was initially adopted by the United Nations in its programmes.<sup>141</sup> It has since been embraced by UN agencies, states and state agencies in their operations across the globe.

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<sup>138</sup> See generally PS Atiyah *The rise and fall of freedom of contract* (1979), 398-404 & 681-693.

<sup>139</sup> C Kisson & et al *Whose right? AIDS review 2002* 14.

<sup>140</sup> As above.

<sup>141</sup> MS Pais *A conceptual framework for human rights for UNICEF* (1999) iv.

### 3.5 Assessing the (non) regulation of the health insurance in Malawi

The interest for this study arose out of an observation that Malawi had no specific legislation regulating health insurance.<sup>142</sup> At the time the observation was made in 2007, Malawi had an Insurance Act,<sup>143</sup> now repealed, that did not regulate the health insurance as they were non-existent in 1957.<sup>144</sup> Consequently, when the industry came up, the Reserve Bank of Malawi (RBM) which was regulating insurance companies had no jurisdiction over them.<sup>145</sup> A new Insurance Act 2009<sup>146</sup> has now been promulgated, which includes ‘a friendly society’ and ‘a medical aid scheme’ in its definition of an insurer.<sup>147</sup> Using two of the areas identified by Phillips<sup>148</sup> which call for regulation namely, prevention of *unreasonable prices* (premiums), and *discrimination* I now analyse the new Insurance Act 2009 to determine the extent to which it achieves this goal.

#### 3.5.1 Equality and non-discrimination (risk and age rating)

Makoka *et al*<sup>149</sup> noted that MASM has an age limit of 54 within which a person may join membership. According to Ms A. Hara of MASM, the reason for having that cut-off point is that after 54, people become risky as they become ill more often.<sup>150</sup> Studies have apparently been conducted elsewhere that have confirmed that position.<sup>151</sup> MASM’s policy was informed by such studies and it may not be the only health insurer with such a policy.

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<sup>142</sup> AIDS and Human Rights Research Unit (n 8 above).

<sup>143</sup> Cap. 47:01 of the Laws of Malawi.

<sup>144</sup> MASM is the oldest and largest health insurance having been established in 1983, *Masm health update* (2008) 6.

<sup>145</sup> E-mail from Dalitso Kafere, Legal Counsel, RBM 19 February 2010.

<sup>146</sup> n 9 above.

<sup>147</sup> ‘Insurer’ is defined as ‘a corporation incorporated under the Companies Act carrying on an insurance business, otherwise than as a broker, an agent for brokers or as an insurance agent and includes a reinsurer, a friendly society and a medical aid scheme unless this Act contains a separate provision specifically applicable to the reinsurer, the friendly society and the medical [aid] scheme in which case that provision shall apply’.

‘Insurer’ is also defined as ‘an insurer licensed under this Act in accordance with the procedures laid down in the Financial Services Act, 2009.

<sup>148</sup> Phillips (n 41 above). 4

<sup>149</sup> n 56 above.

<sup>150</sup> n 26 above.

<sup>151</sup> As above.

Members who reach 54 years their membership is never discontinued because they will have accumulated sufficient premium savings to cover them beyond 54 years.<sup>152</sup> In view of the interpretation of the right to health by the ESCR Committee, especially, the element of *accessibility* that health services and goods must be accessible in a non-discriminatory manner on any prohibited grounds and a similar holding by the Commission in the *Purohit and Moore*, and also the prohibition of discrimination under section 20 of the Constitution, is such a policy not discriminatory? Does the new Insurance Act 2009 address this issue? Are health insurance organisations bound by Malawi's international human rights obligations and also the laws of the country and the Constitution in particular? Can such a policy be justified under section 44(2) of the Constitution as a reasonable limitation of the right to health?

The starting point is the preamble to the new Insurance Act 2009. It provides thus, '[a]n Act to provide for the supervision and regulation of the insurance industry and for matters connected therewith or incidental thereto'. The next is section 3 which stipulates that:

The principal object of this Act is to make provision for the enhancement of the safety, soundness and prudent management of insurers and other persons involved in the insurance industry in Malawi with the aim of protecting the **interests of insurance policyholders** and ensuring the highest standard of conduct of business of insurance companies, brokers and agents [Emphasis supplied].

Clearly, the preamble, section 3 or any other provision in the new Insurance Act 2009 does not mention anything about bringing into effect any of Malawi's international human rights obligations nor are 'interests of insurance policyholders' defined therein. Principally, the legislation regulates the health insurance industry from the perspective of complying with financial procedures rather than the protecting the human rights of the members. This view is further fortified by the manner in which the second definition of an 'insurer' is framed.<sup>153</sup> The right to equality and non-discrimination which has a direct bearing on access to healthcare services is not protected.

### 3.5.2 Unreasonable premiums

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<sup>152</sup> As above.

<sup>153</sup> n147 above.

Health insurance organisations have different types of schemes. Each person joins a scheme type depending on their ability to pay for it. Then, premiums are adjusted upwards annually. The justification is always that the cost of medical treatment is ever increasing both in Malawi and the Southern Africa region. Can the adjustments be explained scientifically to ensure that members are not exploited and the premiums are reasonable? If left unchecked, some members may opt out of the membership of health insurance. If that would happen, it would put pressure on the public facilities that are already struggling to provide healthcare services to the greater majority of the poor people and the most vulnerable. Has this issue been addressed in the new Insurance Act 2009? The answer is in the negative.

An independent body created by legislation would be ideal to vet premiums being levied against the members. Such a body would also deal with complaints by members against their health insurance and the reasonableness of some waiting periods imposed by health insurance organisations before a member can enjoy certain benefits under different schemes. The independent body comprising professionals from insurance, health, law, economics, accounting, administration and actuarial sciences would be most ideal. The body would also have oversight role over health insurance organisations to ensure the realisation of the two rights in issue and other human rights. For instance, in terms of the core minimum obligations of the state under the right to health, both at international (the ESCR Committee) and the African human rights system levels (Commission's resolution), this body would ensure that at a minimum, every type of scheme covers essential medicines. The design of schemes must not hinder access to essential medicines as this is a non-derogable obligation on the part of the state.<sup>154</sup> The non-derogability of access to essential medicines has nothing to do with domestication of ICESCR by Malawi, provided the instrument was either signed or ratified by Malawi. The body would enhance accountability of the health insurance industry in relation to human rights.

### **3.5.3 Strengths of the new Insurance Act 2009**

In spite of the above weaknesses, there are some positive aspects in the legislation. First, unlike in the past when the health insurance organisations were not licensed to operate, now in

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<sup>154</sup> Chirwa (n 48 above).

terms of section 7, no person<sup>155</sup> can carry business of insurance without being licensed by the Registrar of Financial Services Institutions (the Registrar). The section also criminalises the carrying on of business of insurance without a licence punishable by a fine of K10 000 000.00<sup>156</sup> and to imprisonment for four years upon conviction, or if the offender is not a natural person, the provisions of the Financial Services Act shall apply. Second, in terms of section 10, no person will be licensed to carry on business of insurance until it has entered into a reinsurance agreement. Third, in the event that the person wishes to wind-up, the Registrar shall not approve of the same until all policyholders benefits are paid, or all policyholders are transferred to an alternative insurer under a scheme for the transfer or the amalgamation of policyholders in terms of the Financial Services Act 2009. Generally, upon taking effect, all insurers are expected to meet the legislation's requirements, including those in respect of incorporation, capital and margin of solvency.<sup>157</sup> The legislation also makes provision for insurers to make an application to the Registrar 'to allow a transition period to facilitate compliance by him with the Act'.<sup>158</sup>

### **3.6 Assessing the (non) regulation of the health insurance in South Africa**

South Africa has a specific legislation dealing with health insurance the Medical Schemes Act 1998.<sup>159</sup> The legislation was passed in the broader context of reforming the healthcare system in South Africa to address past inequalities brought about by apartheid.<sup>160</sup> The issue here is how well does this legislation regulate the health insurance in South Africa to strike a balance between compliance with financial requirements and compliance with human rights?

#### **3.6.1 Equality and non-discrimination**

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<sup>155</sup> 'Person' is defined in section 2 of the Act as including 'a company, corporate body, association, natural person, partnership and scheme'.

<sup>156</sup> This sum is about \$70 000

<sup>157</sup> n 9 above, sec 79(1).

<sup>158</sup> As above, sec 79(2).

<sup>159</sup> n 10 above.

<sup>160</sup> The Report of the Committee of Inquiry into a National Health Insurance System <http://www.imsa.org.za> (accessed 28 September 2010).

The principle of equality and non-discrimination is entrenched in the South African Constitution under section 9. The Medical Schemes Act 1998 mirrors the constitutional provision in a more specific context. Section 24(2)(e) thereof provides as follows:

No medical scheme shall be registered under this section unless the Council is satisfied that the medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.

Section 29(1) of the same also promotes equality and prohibits discrimination. It provides thus:

The Register 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 dependents 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 [Emphasis supplied].

A person cannot be refused membership of a health insurance on the basis of their age or any other status. The legislation therefore addressed the right to equality and non discrimination which has a direct bearing on access to healthcare services.

Section 67(1)(l) permits the Minister, in consultation with the Council for Medical Schemes,(the Council) to make regulations. Regulation 13 allows medical schemes to charge penalty premiums for late joiners. Consequently, old people or late joiners cannot be excluded from joining a medical scheme provided they are able to pay the penalty premiums. This arrangement treats old people with human dignity, unlike the Malawi position where they are unprotected.

### 3.6.2 Unreasonable premiums

This issue does not seem to have been directly addressed in the legislation. However, medical schemes are required to submit their annual returns to the Registrar of the Council in terms of section 37 thereof. The aim is to assess their financial viability as going concerns. Arguably, since the Medical Schemes Act 1998 has a mechanism for dealing with complaints and appeals under chapter 10, members could lodge a complaint with the Council, if they consider premiums to be unjustifiably too high. It is arguable therefore, that there exists a mechanisms to tackle unreasonable premiums, if at all.

### **3.6.3 General analysis of the Medical Schemes Act 1998**

The legislation by and large, addresses some issues from a human rights based approach. Unsurprisingly, it was drafted at the same time that the approach was being developed and advocated by the United Nations in or about 1999.<sup>161</sup> That would probably explain the inadequate use of the approach in the legislation. For instance, under section 7, the functions of the Council could have been stated in a language of protecting both, the rights and interests of the members, rather than just interests. When settling claims, medical schemes may come into contact with medical records of their members. The legislation obliges them to treat such records with confidentiality concerning the member's state of health. This is also a right to privacy to be enjoyed by the members. The Council also monitors all the activities, financial stability and resolves complaints by members against the medical schemes.

## **3.7 Conclusion**

The chapter has explained how medical schemes function, and how if properly regulated could assist a state to free some resources for MoH which in turn could improve service delivery in public hospitals. It has also provided justification that freedom of contract in market economies is subject to the laws of the state and thus allowing states to regulate the health insurance industry in order to protect the human rights and interests of the members. The chapter has also advocated for a human-right based approach in the provision of services and products by the health insurance and the state in developing policies and legislation. Finally, it has also

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<sup>161</sup> Pais (n 141 above).

analysed the current legal frameworks for regulating medical schemes in the two states and highlighted their strengths, and weaknesses.

## Chapter Four

### 4. Lessons from South Africa for Malawi

#### 4.1 Introduction

The main task in this chapter is to determine the extent to which the Medical Schemes Act 1998 could be used as a model law for regulating the health insurance in Malawi. While the new Insurance Act 1998 is regulating health insurance as well, the regulation is predominantly financial in nature. It does not protect the human rights of the members nor does it make health insurance organisations accountable for human rights of the members. Some of the issues that came up in chapter 3 shall be further pursued to determine possible lessons for Malawi.

#### 4.2 Risk and age rating of potential members

The discussion thus far has shown that some of the health insurance organisations in Malawi, notably MASM, do not insure persons aged 54 and above for being high-risk persons.<sup>162</sup> This practice is called risk and age rating. In some cases, risk rating manifests itself by making some members pay higher premiums for being high risk persons.<sup>163</sup> Their exclusion regardless of their ability to pay the required premiums begs the question whether that practice does not, in law and fact, amount to discrimination. The Constitution clearly outlaws discrimination and promotes equality of all persons. In section 20(1), it prohibits discrimination on 'grounds of race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, disability, property, birth, or other status or condition'.<sup>164</sup> The Constitution does not list age as a ground for non-discrimination. Does that mean that persons could therefore be discriminated against on the basis of age and presumed status? The answer is in the negative. Both age and presumed status of being risky may be considered to be included in the wording 'other status' of the above section. The Constitution binds the executive, legislature and the judiciary and where applicable to them, natural and legal persons. A person according to the new Insurance Act 2009 'includes a company, corporate body, association, natural person, partnership and scheme'.<sup>165</sup> The policy

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<sup>162</sup> n 56 & n 26 above.

<sup>163</sup> Khoza (n 30 above).

<sup>164</sup> n 5 above.

<sup>165</sup> n 9 above, sec 2.

of non-discrimination applies both in public and private sectors. Consequently, health insurance organisations being legal persons are bound by section 20 of the Constitution. On the face of it therefore, the exclusion of persons aged 54 and above from being insured regardless of their ability to pay premiums amounts to discrimination. Their exclusion impairs their fundamental dignity as human beings are equal in dignity and worthiness.<sup>166</sup> The notion of *accessibility* under the right to health is also violated by that exclusion. The doctrine of freedom of contract or free enterprises cannot be invoked in aid of such a practice. Could the exclusion satisfy the limitation test under section 44(2) of the Constitution? The section envisages that any limitation of any right, in this instance, the right to equality and not to be discriminated against, must be prescribed by law, reasonable, recognised by international human rights standards, and necessary in an open and democratic society. There is no law that prescribes that practice of exclusion of the persons under discussion. According to MASM, that policy is based on some studies carried out elsewhere.<sup>167</sup> On this score alone, the policy fails to meet the test under section 44(2). It is not necessary to proceed with the analysis of the other limbs of the test. It offends the Constitution, the supreme law of the land.<sup>168</sup> It cannot even be justified on the basis of being a business practice. It is an illegal policy that perpetuates the vulnerability of old persons in society.

To push the pendulum further in that direction, it is arguable that any age from 15 and above, is a potentially high risk age. This is due to HIV/AIDS, high rate of accidents or likelihood of being involved in one, high consumption of narcotic substances, alcohol, unhealthy foods, the condition of our environment, genetic make-up and a host of other reasons.<sup>169</sup> It is therefore doubtful, whether only a certain category of persons could be labelled high-risk. In any case, even if it was to be conceded that persons aged 54 and above fall ill very often, that too, would be a generalisation. Experience shows that other persons of much older age than 54 do not fall ill very often. This too is also influenced by such factors as diet, personal habits and genetic heritage. Furthermore, the fact that persons who joined schemes and turned 54 while being members are not eventually discontinued from the membership renders the policy discriminatory. In *MASM Health Update*,<sup>170</sup> an 85 year old person said to have a number of

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<sup>166</sup> *President of the Republic of South Africa and Another v Hugo* 1997 (6) BCLR 708 (CC) para 41.

<sup>167</sup> n 26 above.

<sup>168</sup> Constitution of Malawi, sec 199 provides that: 'This Constitution shall have the status as supreme law and there shall be no legal or political authority save as is provided by or under this Constitution'.

<sup>169</sup> J Montgomery *Health care law* (2003).

<sup>170</sup> n 144 above, 17.

health problems associated with his old age was featured and quoted as saying, 'had it not been for MASM, he would have been paying huge bills, or could not even afford the best treatment at all'. In 2008, MASM had been in existence for 24 years. If this policy was in existence from the time MASM became a legal entity, it could mean that the gentleman in the article, joined when he was 61 years. The other explanation could be that the gentleman joined MASM when it was still part of NICO General Insurance Company.<sup>171</sup> If not, the other explanation could be that the exclusion policy was introduced later on. The policy offended the Constitutions of Malawi at any point. If it was introduced after 1995, it offends the new Constitution. If it was introduced before 1995, it also offended the 1966 Constitution. According to *Chihana*<sup>172</sup> the Universal Declaration had a force of law in Malawi.<sup>173</sup> In terms of article 1, all human beings are born free and equal in dignity and rights. Article 2 prohibited discrimination on the grounds stated in the 1995 Constitution. Even though the Universal Declaration did not specifically list age as a ground for discrimination, the argument I made about 'other status' above, would have applied then. It is therefore difficult to see how that policy would have been justified.

The argument that persons who joined MASM before attaining 54 years are not discontinued from membership upon reaching 55 years because they will have accumulated savings is problematic. In a health insurance no member pays from their own specific contributions. The payment is from the pool. None of the existing schemes in Malawi are prepayment programs. In a prepayment program, coverage is for certain future events, while insurance, coverage is for uncertain future events.<sup>174</sup> It is only in a prepayment program that individuals pay a set premium in advance for consumption of a specified quantity of medical or health services in the future. The total treatment expense is known in the event of an illness in the prepayment program, while in insurance, it is not known, although it may be subject to an agreed maximum limit. The argument of accumulated savings would therefore fall away and is consequently unsustainable. Again, the population of Malawi is quite youthful.<sup>175</sup> The median age is 17 years.<sup>176</sup> 7% is less than 1 year old. 22% is under 5 years of age. 46% is 18 years and older. The life expectancy in Malawi currently stands at 53 years.<sup>177</sup> Persons of 54 years and above

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<sup>171</sup> Interview with Lester Chinyang'anya, Assistant General Manager (Operations), on 25 July 2010.

<sup>172</sup> n 94 above.

<sup>173</sup> Chirwa (n 13 above).

<sup>174</sup> Phalatsi (n 53 above).

<sup>175</sup> The 2008 Population and Housing Census Final Report [www.nso.mw](http://www.nso.mw) (accessed 15 October 2010).

<sup>176</sup> As above.

<sup>177</sup> [www.unicef.org/infobycountry/malawi](http://www.unicef.org/infobycountry/malawi) (accessed 15 October 2010).

wishing to join health insurance would therefore be few. This would not significantly affect the overall financial performance of the industry. In addition, health insurance organisations have waiting periods, as one of the safeguards for dealing with moral hazards. In *Locker and Woolf Ltd v Western Australian Insurance Co Ltd* Slesser LJ defined a moral hazard as follows:

It is elementary that one of the matters to be considered by an insurance company is entering into contractual relations with a proposed assured is the question of the moral integrity of the proposer-what has best been called the moral hazard.<sup>178</sup>

In *Roselodge Ltd (formerly Rose Diamond Products Ltd) v Castle McNair* J said:

Each of these witnesses was emphatic in the view that in a jewellery insurance of this kind the moral hazard is important. Mr Archer defined the moral hazard as the risk of honesty and integrity of the assured...<sup>179</sup>

A moral hazard is dishonesty and lack of integrity on the part of the insured in disclosing crucial information. In the context of health insurance, it is ‘the danger that insured persons, having paid their premiums in advance, will demand more services than they would have demanded had they not been covered by insurance’.<sup>180</sup> Health insurance organisations also use coinsurance<sup>181</sup> and deductibles<sup>182</sup> to deal with moral hazards. One of the lessons for Malawi is that risk and age rating must be prohibited to ensure compliance with the non-discrimination and equality clause and other international human rights obligations.<sup>183</sup> South Africa legislation uses community rating whereby the grounds on which premiums may be determined or varied is the size of one’s family or income.<sup>184</sup> Otherwise, any person who is able to pay the community rated premium cannot be excluded on any ground or status.<sup>185</sup> On this aspect, the Medical Schemes Act 1998 provides a good framework for Malawi.

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<sup>178</sup> [1936] 1 KB 408.

<sup>179</sup> [1966] 2 Lloyds Rep 113, 132.

<sup>180</sup> Phalatsi (n 53 above) 246.

<sup>181</sup> Coinsurance is the required contributions from the insured for his or her coverage.

<sup>182</sup> Deductibles are initial amounts per illness episode that must be paid by the insured individual before the insurance covers the remainder of the expenses.

<sup>183</sup> n 31 above, secs 24(2)(e) & 29(1).

<sup>184</sup> As above, sec 29(n).

<sup>185</sup> As above.

### 4.3 Monitoring premiums

Determination of premiums is a scientific process. While some health insurance organisations in Malawi take a decision to increase premiums at their annual general meetings, it is not clear on what basis the figures or percentages for the upward adjustments are arrived at other than that the cost of treatment in the country and the region is also skyrocketing. Before the adoption of the new Insurance Act 2009, there was no legal requirement for a health insurer to appoint an actuary. Now it is. However, the weakness, is that the appointment of an actuary, may only be done 'where the Registrar is of the opinion that actuarial review of an insurer's business is warranted, or that such review is warranted for all companies undertaking a particular class of insurance business...'<sup>186</sup> The way the current provision is drafted, it would mean that if the Registrar is not of the opinion that review of an insurer's business is warranted, or that such review is warranted for all companies undertaking a particular class of insurance business, members may not be protected from high premiums. It is therefore submitted that the provision dealing with appointment of an actuary be fine-tuned so that members are not exploited.

### 4.4 Setting of minimum benefits

It is argued that every scheme of a health insurance should have regulated minimum benefits to ensure that the minimum core obligations under the right to health, especially, access to essential medicines, are complied with by health insurance organisations. The design of schemes and their implementation must take into account Malawi's international human rights obligations. Failure to fulfil the minimum core obligations, by private healthcare systems resulting from health insurance policies can violate the rights to health and life. Unlike the Medical Schemes Act 1998, the new Insurance Act 2009 does not make provision for minimum benefits. In chapter 3 of the Medical Schemes Act Regulations, there are minimum benefits consisting of treatment of all the categories of diagnosis and treatment pairs listed in Annexure A thereto. The minimum benefits, which include essential medicines, are offered by all schemes and yet South Africa is not party to the ICESCR while Malawi ratified it.<sup>187</sup> It is submitted that to the extent that the Medical Schemes Act 1998 minimum benefits, enhance access to essential

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<sup>186</sup> n 9 above, sec 22(1).

<sup>187</sup> n 86 above.

medicines, a component of the right to health, it provides a good lesson for Malawi. The treatment and diagnosis pairs may be modified to suit diseases that are common in Malawi.

#### 4.5 Establishing an oversight independent body

An independent body that has oversight control over health insurance organisations is necessary. Malawi has none. The new Insurance Act 2009 does not create such a body. Even at voluntary level, health insurance organisations are neither members of the Insurance Association of Malawi nor the Insurance Institute of Malawi.<sup>188</sup> Additionally, the legislation does not make any provision for the handling of complaints. The Consumer Protection Council, established by the Consumer Protection Act<sup>189</sup> would not be competent to handle such complaints because of the composition of its membership and in any event the body is still yet to be set up.<sup>190</sup> The Medical Schemes Act 1998 provides a good model for such a body, the Council. In terms of section 4(1), it comprises fifteen members who have expertise in law, accounting, actuarial sciences, medicine, economics and consumer affairs. Among other functions, the Council protects the interests of the members, controls and co-ordinates the functioning of medical schemes in a manner that is complementary with the national health policy and it investigates complaints and resolves disputes in relation to the affairs of medical schemes.<sup>191</sup> Thus, an independent oversight body over health insurance organisations is another lesson that Malawi could learn from South Africa.

#### 4.6 Adopting a human rights policy

In the absence of any comprehensive legislation, health insurance organisations could do better to adopt human rights policies where they make commitment to render their services in a manner that balances business interests and observance of human rights. Not only are they bound by the Constitution, they are also part of the society required to promote human rights, and it is in their interest to do so as we saw.<sup>192</sup>

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<sup>188</sup> n 171 above.

<sup>189</sup> Act 14 of 2003.

<sup>190</sup> 'Govt ignores consumer act' *The Daily Times* 23 July 2010.

<sup>191</sup> n 31 above, sec 7 (a)(b)&(d).

<sup>192</sup> n 34 above.

#### 4.7 **Conclusion**

In conclusion, this chapter has shown that there are a number of weaknesses that the new Insurance Act 2009 has. Its scheme is predominantly financial in nature. It does not adequately address specific issues peculiar to health insurance and the human rights of the members. The chapter has also shown that the Medical Schemes Act 1998, even though it is not entirely drafted from a human rights based approach, it does provide a number of useful lessons for Malawi. A case has also been established that Malawi needs to adopt a framework legislation that addresses all the weaknesses identified. Taking such a legislative measure is one of the primary obligations of Malawi in international human right law both under the ICESCR and ACHPR.

## 5 Conclusions and Recommendations

### 5.1 Conclusions

The study set out to interrogate how the (non) regulation of the health insurance industry may impact on the enjoyment of the rights to health and life of both existing and potential members of health insurance organisations. It sought to compare the (non) regulation in Malawi and South Africa. In line with the research questions posed at the outset and the specific objectives of the study, several conclusions have been reached.

First, members of health insurance organisations have rights to health and life. The rights are protected in various international instruments to which Malawi is a party. Malawi and health insurance organisations have a duty to protect and respect these two rights specifically and other human rights of the members of health insurance organisations. However, save for the right to life, the right to health is not expressly recognised and protected under the Bill of Rights in the Malawi Constitution. It is part of the PNP. In spite of this, in appropriate cases, the right to health could be protected by a litigation strategy that invokes both the PNP and an expanded interpretation of the right to life. For this strategy to work out the courts must be creative and be involved in some degree of judicial activism

Second, the policy by some health insurance organisations in Malawi that excludes persons aged 54 years and above from insurance coverage regardless of their ability to pay premiums on the ground that they are high risk persons is unlawful. It contravenes the equality and non discrimination clause under section 20 of the Malawi Constitution and it does not pass the limitation test set by section 44(2) of the same. The policy also offends Malawi's international human rights obligations under the right to health especially the element of *accessibility*. The policy is unlawful as it perpetuates the vulnerability of old persons in society.

Third, the regulation of the health insurance industry in Malawi is a move in the right direction but it is not sufficient. The new Insurance Act 2009 is not comprehensive in its scheme to ensure compliance with the two rights in particular and other human rights of the members by this industry in the provision of its services. Such insufficient regulation can lead to violations of

human rights. The violations committed are imputable on the state as it has a continuing obligation to ensure that its human rights obligations are being respected in its jurisdiction.

Fourth, the Medical Schemes Act 1998, in spite of some weaknesses, it offers a good framework for reform in Malawi.

## **5.2 Recommendations**

### **5.2.1 The constitutional framework**

In line with Malawi's international human rights obligations, both at global and African systems, there is a need to expressly recognise and protect the right to health in the Malawian Constitution. Taking such a constitutional measure would render the right justiciable and enforceable. This would enhance the accountability of the state to its people. Arguments of non-justiciability of economic, social and cultural rights or the perceived incompetence of the judiciary to deal with such rights or infringement of the doctrine of separation of powers are now giving in to new creative thinking and greater ideals of democratic governance.<sup>193</sup> The judiciary should in the meantime be creative and use the PNP and the right to life to protect the right to health.

### **5.2.2 The legal framework**

There is also a need for Malawi to sufficiently regulate the health insurance industry to ensure protection of the two rights and other human rights of the members of the health insurance industry. This requires the adoption of a distinct legislation as this class of insurance has its own peculiar features that need to be comprehensively addressed. In this regard, the Medical Schemes Act 1998 provides a fairly good framework. Among other things, the distinct legislation should:

- (a) expressly prohibit risk and age rating and discrimination on any ground or status of potential members of health insurance organisations.

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<sup>193</sup> n 75 above & Mbazira (n 13 above).

- (b) make provision for minimum benefits for all types of schemes to ensure that access to essential medicines, a non-derogable obligation under the right to health, is not impeded by the quest for profit or surplus maximisation on the part of health insurance organisations.
- (c) establish an independent body that oversees the activities of health insurance organisations. Its composition should include professionals from law, accounting, economics, actuarial sciences, medicine, administration and consumer affairs. This body should monitor and be consulted on any premium adjustments in order to protect the members and prevent unjust enrichment on the part of the health insurance organisations. The body should also be vested with powers to receive and resolve complaints from the members against their health insurance organisations. It is hoped that such legislation would instil confidence in the public that they would be protected and therefore encourage more people to join health insurance organisations. That would have the effect of freeing resources for the Ministry of Health to provide better services to the poor and the most vulnerable groups.

### **5.2.3 Applying a human rights based approach**

The state must ensure that health insurance organisations should apply a human rights based approach in the design and implementation of their schemes to ensure that human rights of the members are protected. Any legislation that may be adopted should also reflect this approach.

**Word Count (including footnotes): 17 864**

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