

**AIDS AND INSURANCE LAW:**  
**POSSIBLE SOCIAL POLICY SOLUTIONS FOR LIFE INSURANCE**  
**APPLICANTS EXCLUDED DUE TO HIV SEROPOSITIVITY**

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"Research dissertation presented for the approval of Senate in fulfillment of part of the requirements for the degree of Master of Laws in approved courses and a minor dissertation. The other part of the requirement for this degree was the completion of a programme of courses."

**OCTOBER 1994**

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## **DEDICATION**

This study is dedicated to persons with AIDS, in the hope that a truly humanitarian solution comes to your rescue, soon.

## ACKNOWLEDGEMENTS

The author hereby wishes to acknowledge his sincere appreciation for the valuable assistance in the preparation of this study offered by the following people;

Graham Bradfield of the Department of Commercial Law, University of Cape Town, for agreeing to act as my supervisor, his willingness work to tight deadlines and his flexible and helpful supervision.

My wife, Cheryl Potgieter, for your constant encouragement in the face of my procrastination, your continuing support and motivation and for just being there when needed.

**TABLE OF CONTENTS**

	<b>Page</b>
Dedication	i
Acknowledgements	ii
Table of Contents	iii
Abstract	vi

**CHAPTER ONE: AN OVERVIEW**

1.1 The Extent of the Problem	1
1.2 South Africa - A Developing Country	2

**CHAPTER TWO: AIDS - ITS EPIDEMIOLOGY**

2.1 Introduction	5
2.2 Etiology	5
2.3 Diagnosis	6
2.4 Treatment and Prognosis	7
2.5 Conclusion	9

**CHAPTER THREE: LIFE INSURANCE**

3.1 Introduction	11
3.2 How does Life Insurance Work?	11
3.3 Why is Insurance Necessary?	13
3.4 The Significance of Aids to the Insurance Industry	14

**CHAPTER FOUR: STRATEGIES DESIGNED TO PROTECT THE INDUSTRY**

4.1 Introduction	16
4.2 The Arguments in favour of Testing	17
4.3 The Arguments against Testing	18
4.4 Conclusion	20
4.5 The Vexed Exclusion Clause	21
4.6 Conclusion	23
4.7 Exclusive Life	23
4.8 Conclusion	24

**CHAPTER FIVE: THE INTERNATIONAL RESPONSE**

5.1 Introduction	26
5.2 The American Experience	26
5.3 The American Solutions	29
5.3.1 High Risk Pools	29
5.3.2 Open Enrolment Periods	30

5.3.3 Specialised Underwriting	31
5.4 Netherlands and the European Experience	31
5.5 The African Experience	32
5.6 Similarities in Strategies - South Africa and the USA	34
5.7 Conclusion	35

## **CHAPTER SIX: POSSIBLE SOLUTIONS**

6.1 Introduction	37
6.2 The Broker Solution	37
6.3 High Risk Pools	39
6.4 Open Enrolment Periods	40
6.5 The Public Solution	42
6.6 The Combined/Mixed Solution	43
6.7 Conclusion	46

## **CHAPTER SEVEN: THE CONSTITUTION AND FUNDAMENTAL RIGHTS**

7.1 Introduction	47
7.2 The Principle of Equality	47
7.3 The Operation of the Constitution	48
7.4 The Constitutional Solution?	48
7.5 Possible Solutions and Possible Discrimination	51

## **CHAPTER EIGHT: CONCLUDING REMARKS**

8 Concluding Remarks	54
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## ABSTRACT

The broad aim of this study is to investigate and recommend a model which would contribute to finding a solution to the AIDS pandemic facing the insurance industry. At present HIV positive persons are excluded from obtaining life insurance, and as a result of this they are excluded from obtaining access to finance as a life insurance policy is a vital financial instrument when attempting to access finance.

The insurance industry has decided to protect itself and its response to the pandemic smacks of crisis intervention rather than an attempt to find a solution acceptable to all parties. The intention is to investigate the role that all stakeholders, the public sector, the state and the industry can play in contributing to an imaginative response posed by this challenge.

This study explores the causes and prognosis of AIDS, how the life insurance industry operates, how necessary life insurance is, strategies adopted by the industry in the face of this challenge, the experience of international insurers, as well as suggesting possible solutions and examining their mechanics.

The study also investigates the impact of the Constitution and the Fundamental Rights on the suggested solutions. It recommends a particular solution as a workable model within a social policy perspective. It concludes with a request that all stakeholders participate in this solution for and to the benefit of everyone, as AIDS is not the problem of medical practitioners, or attorneys, or the insurance industry, but a societal problem.

## CHAPTER ONE AN OVERVIEW

### 1.1 THE EXTENT OF THE PROBLEM

The South African Insurance Industry continues to sketch a dismal picture regarding the issue of AIDS, and specifically how the industry has and intends to deal with the AIDS challenge facing it. Whilst this picture is bleaker than that of overseas companies, who are now questioning their doomsday predictions, the statistics on AIDS in South Africa can help us understand the concerns within the industry.

According to statistics released by the Department of National Health and Population Development (DNHPD), an estimated 566 000 South Africans were HIV positive at the end of 1993.<sup>1</sup> This means that 47 out of every 1 000 sexually active persons are HIV positive. It is estimated that by the year 2000 South Africa will have between 3,7 million and 4,1 million HIV positive persons, and that this will have increased to between 18% and 30% of the population by the year 2005. The number of deaths due to AIDS will have reached 2,3 million, and approximately 500 000 children will be orphaned due to AIDS.<sup>2</sup>

In an address to the Senate, the Minister of Health, Dr Nkosazana Zuma, stated the following:

*'Aids is the major threat, not only to our health services but to our economy and our country as a whole.'*<sup>3</sup>

The above statement is echoed by an insurance industry spokesperson who warns that:

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<sup>1</sup>Argus March 30, 1994 at 1

<sup>2</sup>Finansies en Tegniek May 7, 1994

<sup>3</sup>Argus September 2, 1994 at 1

*'The AIDS epidemic in Africa and the Third World is still spreading relentlessly.'*<sup>4</sup>

In order to combat this threat, the Ministry of Health has adopted a R257 million, two year national plan to fight AIDS. The plan has three broad goals, namely (1) to prevent the spread of AIDS; (2) to reduce the impact of the disease; and (3) to mobilise local, national and international resources to combat AIDS.<sup>5</sup> However, as a result of the various competing interests for a slice of the national budget, the Department of Health would only be able to contribute R120 million of the required R257 million, and the government would look to big business, private funders and agencies such as the World Health Organisation to make up the shortfall.

## 1.2 SOUTH AFRICA - A DEVELOPING COUNTRY

South Africa is a diverse country in a range of aspects. In terms of development there are stark contrasts. The majority of the population live in dire poverty, which exists in tandem with modern cities and an advanced technological and commercial framework. Thus, synonymous with South African society is the vast discrepancy between rich and poor.

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<sup>4</sup>Sanlam warns: Don't underestimate the HIV risk' in *African Insurance and Finance Record* May/June 1994 at 12

<sup>5</sup>Argus July 22, 1994 at 6

It almost goes without saying that the segregation in all areas of society has had dire consequences. South Africans have now to find creative ways to solve problems in the economic, social, political, moral, cultural and environmental spheres of society.<sup>6</sup>

It has been well documented that AIDS and poverty, and obviously apartheid are closely linked.<sup>7</sup> Structures such as the migrant labour system, overcrowded single-sex hostels and other such structures which were necessary to entrench the apartheid policies of the National Party have left us with malnourished children, a low level of literacy and poor primary health care services. All these factors contribute to the spread of HIV and AIDS.<sup>8</sup>

The economically disadvantaged are, therefore, the people most affected and afflicted by HIV and AIDS. In South Africa black rural women are the most oppressed sector of the community.<sup>9</sup> It is therefore clear that in South Africa the people who, are and most likely will be, the victims of AIDS will be the black population in general and black women in particular.<sup>10</sup>

The black population will be the sector most affected by policies relating to AIDS. It could be argued that there is a link between persons seeking life insurance and rising standards of living and education. The five key policy programmes contained in the RDP are, namely, meeting basic needs; developing human resources; building the economy; democratising

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<sup>6</sup> Ibid at 1-13

<sup>7</sup>C Evian 'The socio-economic determinants of the AIDS epidemic in South Africa - a cycle of poverty' in (83) *South African Medical Journal* Sept 1993 p635 at p 635

<sup>8</sup>I Toms 'The Medical Nature of AIDS - A Developing Country's Experience of Ill Health Patterns Affecting Employment' a paper presented at the *AIDS in the Workplace Conference* on 27-28 June 1994 at UWC

<sup>9</sup>D Budlender 'RURAL WOMEN: The 'also-rans' in the development stakes' (1992) 12 *Agenda* at 27

<sup>10</sup>A Strebel 'Women and AIDS: A Study of issues in the Prevention of HIV Infection' Dissertation for D.Phil in Psychology at UCT September 1993 at 27-29 (unpublished)

the state and society; and implementing the RDP. All these programmes will inherently contribute to the upliftment of those previously discriminated against.

The above detour was necessary in order to illustrate that if the insurance industry introduces discriminatory practices in respect of AIDS, they would be discriminating against those who have suffered the brunt of apartheid, but more importantly, they would be excluding potentially their most important and largest client base.

This overview of the AIDS crisis paints a bleak picture of the South African situation, a view which is further re-inforced by the doomsday predictions of the insurance industry. These predictions appear to be predicated on the assumption that AIDS is a unique medical problem, and that established insurance practices should not be applied. But is this disease unique?

## CHAPTER TWO

### AIDS - ITS EPIDEMIOLOGY

#### 2.1 INTRODUCTION

The Acquired Immune Deficiency Syndrome, or AIDS as it is more commonly known, is a syndrome (i.e. a set of symptoms which occur together), though most laypersons refer to it as a disease. The terms Gay Related Immune Deficiency (GRID) and even Gay cancer were initially used to characterise a syndrome that was first reported among young gay men in the United States of America. However, once the syndrome's epidemiological pattern emerged and cases of the same syndrome were reported among blood transfusion recipients, intravenous drug users and heterosexuals in different continents, the term Acquired Immune Deficiency Syndrome (AIDS) was introduced and accepted, since it was clear that no one group of people was exclusively affected by this new disease.<sup>11</sup>

In South Africa, the first case of AIDS was identified in 1982. Initially the virus spread among white male homosexuals. However, this rate of infection has now begun to level off. In 1987 AIDS was first diagnosed in the black population, and since then a major expansion amongst black heterosexuals has taken place.<sup>12</sup>

#### 2.2 ETIOLOGY

AIDS is a communicable disease caused by a viral organism that is usually referred to as the Human Immunodeficiency Virus (HIV). The virus, which resides in many types of cells, can be transmitted to an individual in several ways, including by various types of

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<sup>11</sup>R Bor, J Elford, G Hart & L Sher 'AIDS-care - into the 90's' (1990) 2 *AIDS care* no 1 at 3

<sup>12</sup>Cape Times March 18, 1991

sexual acts in which the virus in infected blood or semen either enters or is absorbed into the bloodstream of another person, through the use of needles or syringes carrying small amounts of infected blood, from exposure to or receiving a transfusion of contaminated blood or blood products, as a result of being the recipient of a transplanted body organ from someone whose infection was not detected, and in some instances from an infected mother to a fetus during pregnancy.<sup>13</sup> Whilst no other disease is transmitted in all these ways, for example, acute viral hepatitis is transmitted by human blood and urine, the viruses that cause gonorrhoea and syphilis are transmitted via the delicate membranes of the genital tract and the virus which causes German measles can be transmitted through the mother's placenta to the fetus, the methods of transmission of AIDS are not particularly distinctive.<sup>14</sup> Thus, in respect of its etiology, AIDS is no different from a number of other diseases and is not unique.

### 2.3 DIAGNOSIS

When first confronted with the disease the medical profession had difficulty in diagnosing AIDS and the virus that caused it. However, this difficulty was soon overcome, and reliable test protocols were established and approved.<sup>15</sup> The test protocols used by the South African insurance industry, which closely follows those set up by American insurers, is a set of three tests. Firstly, a blood sample is taken from the applicant and subjected to an enzyme-linked immunosorbent assay (ELISA) test. If this test returns a positive result, a second ELISA test is done. If this second test also returns a positive result, the applicant is called in for a fresh blood sample, and this sample is then subjected to another test, this

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<sup>13</sup>A Widiss 'To Insure or Not to Insure Persons infected with the Virus that Causes AIDS' (1992) 77 *Iowa Law Review* 1617 at 1628-1630

<sup>14</sup>*Ibid* at 1630

<sup>15</sup>*Ibid* at 1633

time the WESTERN BLOT test, which is a confirmatory test. If the latter test also returns a positive result, the applicant is classified HIV positive. In this event the laboratory which performed the confirmatory test informs the insurer's chief medical officer. The latter thereafter informs the applicant's designated medical practitioner, who then informs the applicant of the outcome of the test.<sup>16</sup> The method of communicating a positive result to an applicant is, according to the industry, done in this manner to ensure the confidentiality of the test. It, however, leads to "buck-passing" by the industry, as the applicant is saddled with knowledge that he or she did not want in the first place, and on top of this the applicant has now to arrange his or her own post-test counselling. Whilst the industry does arrange pre-test counselling, it does no post-test counselling.

When the above test protocols are followed, the number of instances in which there is an incorrect diagnosis of an infection is less than one half of one percent (0.5%).<sup>17</sup> There are various other diseases for which blood tests are used to test for the presence of disease. Therefore, in respect of the diagnosis of AIDS, there is nothing unique.

#### 2.4 TREATMENT AND PROGNOSIS

With the many advancements in the medical field, there exists effective therapy for the treatment of bacterial infections. The same, however, cannot be said for viral infections, including HIV infections. Statistical analysis of the population infected with the AIDS virus indicates that at least fifty percent (50%) - and maybe as many as eighty-five percent (85%) - will develop full-blown AIDS within ten years of contracting the virus.<sup>18</sup> In a

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<sup>16</sup>Life Offices Associatio of South Africa (LOA) Draft HIV Testing Protocol dated 30 July 1993 at 3-5 (adopted on 4 November 1993)

<sup>17</sup>Widiss (n 13 at 1638)

<sup>18</sup>Ibid at 1635

developing country such as South Africa, the period from contracting the virus to death due to AIDS is estimated at five years.<sup>19</sup> Whilst progress has been made with antiretroviral drugs such as dideoxyinosine (DDI) and zidovudine (AZT), these have only managed to impede the progression of the disease, not to cure it.<sup>20</sup> In fact, two medical researchers have indicated that a powerful vaccine alone will not cure AIDS, and may even make the epidemic worse.<sup>21</sup>

Originally the disease was divided into three distinct phases. As more information about the disease became available, this was revised and the disease is now seen as falling into four distinct phases. These are:

(1) Acute initial HIV infection: Up to three weeks after first infection about seventy percent (70%) of people experience an acute viral illness with fever. During this 'window' period, antibody tests will usually be negative. The subject will appear to recover.

(2) Asymptomatic infection: Most people then follow a number of years when they are infected and antibody positive (seropositive) but have no apparent illness. This interval usually lasts from eight to 11 years but in some cases it may last indefinitely.

(3) Persistent Generalised Lymphadenopathy: Then, following a trigger, the cause of which is not fully understood, a number of

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<sup>19</sup>Toms (n 8 at 4)

<sup>20</sup>Widiss (n 13 at 1635, notes 64 & 66)

<sup>21</sup>Argus September 2, 1994 at 6

patients will begin suffering from enlarged lymph nodes. Illness, night sweats and weight loss will typically follow.

(4) AIDS and Related Conditions: The final stage on this journey is AIDS. The immune system has so deteriorated that serious illnesses occur with increasing frequency. Most typical of these are the constitutional disease of weight loss, diarrhoea and persistent cough known as AIDS Related Complex (ARC). But there are also neurological diseases including dementia, opportunistic infections such as pneumonia and the appearance of strange and previously rare cancers such as Kaposi's Sarcoma.<sup>22</sup>

The fact that an HIV infection is frequently a fatal disease does not make the virus unique in any way, as viral infections such as yellow fever, smallpox and influenza have killed millions of people. Further, illnesses such as lung cancer, pancreatic cancer and cerebrovascular accidents (strokes) are incurable conditions that almost always result in death.<sup>23</sup>

## 9 (2.5) CONCLUSION

When AIDS is analysed as a disease in terms of its etiology, diagnosis, treatment and prognosis, there is virtually no reason to view it as a medical problem whose uniqueness means that it should be treated differently when the insurability of a person who may be infected is at issue. After the condition has been diagnosed, there is no greater justification for categorising AIDS as a unique disease than there is for so classifying illnesses such as

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<sup>22</sup>M Kirby 'AIDS and the LAW' (1993) 9 *South African Journal of Human Rights* 1 at 9

<sup>23</sup>Widiss (n 13 at 1637)

cancer or heart disease.<sup>24</sup> If AIDS is not a unique disease, why is it that the insurance industry is so fearful of it? What is insurance all about, and why do we need it?

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<sup>24</sup>Ibid at 1639

## CHAPTER THREE

### LIFE INSURANCE

#### 3.1 INTRODUCTION

Life insurance is about peace of mind.<sup>25</sup> It provides financial security to the dependants of policyholders or may protect the business assets of partners when one partner dies. By investing in life insurance we are also investing in psychological well-being, as well as investing in economic well-being, as we are protecting ourselves from the negative financial consequences that may result from an uncertain future event, such as death or disease.

#### 3.2 HOW DOES LIFE INSURANCE WORK?

Life insurance companies 'share' losses by redistributing the cost of these losses among all its policyholders. Those fortunate enough to survive for a long time are willing to pay for those who suffer ill-health or an early death. The fortunate thus subsidise the unfortunate.<sup>26</sup> This takes the form of a regular premium payment by the individual (insured) to the company. Payment of the premium usually guarantees that the insured's claim will be paid out on the happening of the event insured against.

Thus, insurance is about the transfer and distribution of risk from the insured to the company. For this reason, it has been correctly defined as *'an arrangement under which*

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<sup>25</sup>C Visser 'AIDS and Insurance Law: A preliminary laundry list of issues' (1993) 9 *South African Journal of Human Rights* 130 at 131

<sup>26</sup>T Hartwig 'Update on current trends regarding AIDS and the Insurance Industry' a paper presented at the *AIDS in the Workplace Conference* on 27-28 June 1994 at UWC at 1

*an insurer contracts to do something that is of value to an insured upon the occurrence of a specified harmful contingent'.<sup>27</sup> This definition clearly indicates that the transfer and distribution takes place by means of a contract. Insurance law is mainly concerned with the principles of contract.<sup>28</sup>*

Fundamental to the business of insurance is the process of underwriting. This is the process by which *'an insurer determines whether or not and on what basis it will accept an application for insurance. The primary goal of underwriting is the accurate prediction of future mortality and morbidity costs.<sup>29</sup> Insurers use the process of underwriting to determine the kind of risk an applicant for insurance will bring to the insurance pool. Characteristics which are taken into account and which will affect the risk are the age of the applicant, health status, gender, occupation and whether the applicant uses alcohol or tobacco. These characteristics will be analysed by the company to enable it to understand how these will influence mortality, and to further enable the company to classify the risk into classes or categories to charge the appropriate premium.<sup>30</sup>*

Integrally linked to the process of underwriting is the concept of risk classification. In essence risk classification involves the development of a number of different categories, called "classes", to accommodate the varying degrees of risk of loss which individual applicants represent to the insurer.<sup>31</sup> Risk classification recognises that, for example, a 70 year old has a much higher chance of claiming under a life insurance policy than a 30 year

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<sup>27</sup>M Scherzer 'Insurance' in H L Dalton, S Burris & the Yale AIDS Law Project (Eds) *AIDS and the Law: A Guide for the Public* (1987) Yale University Press at p 187

<sup>28</sup>Ibid at 187

<sup>29</sup>K A Clifford & R P Iuculano 'Aids and Insurance: The Rationale for AIDS-Related Testing' (1987) 100 *Harvard Law Review* 1806 at 1807-1808

<sup>30</sup>Ibid at 1808

<sup>31</sup>J N Hoffman & E Z Kincaid 'AIDS: The Challenge to Life and Health Insurers' Freedom of Contract' (1986-87) 35 *Drake Law Review* 709 at 715-716

old, that women have greater longevity than men, that someone with heart disease is likely to die before someone with a healthy cardiovascular system.<sup>32</sup> By assigning applicants to an appropriate class, the insurer can make a reasonable estimate of the risk of loss presented in a given case.<sup>33</sup>

Coupled with risk classification is the concept of risk pooling. By pooling risks the insurer reduces risk variance in order to offer more attractive policies to potential insureds and thereby increase the availability of insurance. The insurer, therefore, needs certain information from the applicant to effectively classify the applicant according to the risk such an applicant brings to the pool.<sup>34</sup>

As stated earlier, insurance falls within the principles of the law of contract. South African law of contract recognises freedom of contract, i.e. the right of the parties to the contract to agree to anything provided this agreement does not contain any illegal clauses or clauses contrary to public policy. Individual life insurance, therefore, is voluntary, i.e. each person decides when, whether and for how much he or she will insure or contract for. Given the power relationship between the parties and the position from which each party is negotiating from, it is usually the insurer who can dictate the terms upon which it will accept the risk. The question which now arises is if the applicant is negotiating from a position of weakness, why is insurance so necessary?

### 3.3 WHY IS INSURANCE NECESSARY?

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<sup>32</sup>D Keir 'Submission by the Life Offices Association of South Africa to the South African Law Commission on matters regarding AIDS and Insurance Law' dated February 11, 1993 at 3

<sup>33</sup>Hoffman & Kincaid (n 31 at 716)

<sup>34</sup>L Bergkamp 'Life Insurance and HIV Testing: Insurance Theory, Discrimination and Solutions' (1989) 8 *Medicine and Law* 567 at 568

Life insurance serves a useful public function in maintaining the financial security of people who depend upon the applicant/insured for support or fulfilment of mutual financial or business obligations. Those whose assets are severely depleted by caring for a terminally ill person may be made whole to a degree through the proceeds of such insurance.<sup>35</sup> Also, financial institutions often require the cession of a life insurance policy in their favour as collateral security to cover a mortgage bond, short-term loan or overdraft facility. Life insurance is more than about peace of mind - *'it is an indispensable instrument of finance'*.<sup>36</sup>

### 3.4 THE SIGNIFICANCE OF AIDS TO THE INSURANCE INDUSTRY

The previous overview of concepts central to insurance enables me to address the pertinent question "Why is AIDS so important to the life insurance industry?" This question is especially pertinent if one considers that more persons are killed in road traffic accidents over a single Easter weekend than the total number of persons to have died from AIDS in this country to date.

The life insurance industry bases the premiums it charges on mortality statistics. Due to advances in the medical field, as well as improvements in living conditions, mortality statistics have steadily improved over the years, and purchasers of insurance have reaped the benefit of this improvement in the form of reduced premiums for given amounts of life cover.<sup>37</sup> As a result of the AIDS pandemic, the industry expects these mortality statistics to decline.

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<sup>35</sup>Scherzer (n 27 at 187)

<sup>36</sup>Visser (n 25 at 131)

<sup>37</sup>C Booth 'The Insurance Industry and AIDS - An insider's perspective' (1993) 9 *South*

The industry has advanced four reasons as to why it regards AIDS as being significant. These are (1) that unlike other fatal diseases, the future progression of the disease is still unknown, and consequently the industry is having difficulty in predicting its long-term effect on mortality rates; (2) that the expected mortality rate of an HIV-infected person is up to 50 times greater than that of a non-infected persons of the same age; (3) that due to the relatively long period of time during which an HIV-infected person is asymptomatic, there is a strong possibility that the person may be aware of his or her condition without the insurer knowing about this condition; and (4) social problems come to the fore when an attempt is made to deal with AIDS, mainly because of the method by which most people become infected.<sup>38</sup>

In the final analysis, however, life insurance companies are '*creations of capitalism*'<sup>39</sup>, and are driven, like most businesses, by a profit motive. AIDS is perceived as a threat to their profitability, and remedial steps must therefore be taken to counter this threat. How do insurers respond to this threat?

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*African Journal of Human Rights* 151 at 151

<sup>38</sup>Visser (n 25 at 132)

<sup>39</sup>C Visser 'Foundering in the Seas of Human Unconcern: AIDS its metaphors and Legal Axiology' (1991) 108 *South African Law Journal* 619 at 636

CHAPTER FOUR  
STRATEGIES DESIGNED TO PROTECT THE INDUSTRY

4.1 INTRODUCTION

In an effort to protect itself against the perceived threat posed by HIV-infected persons, and to keep, as far as possible, its insurance pools free of AIDS, the industry has adopted four strategies. These are:

- (1) the exclusion of AIDS as a covered condition;
- (2) the refusal to insure persons with AIDS;
- (3) the refusal to insure high-risk groups without regard to their health status; and
- (4) requiring the applicant to undergo an HIV antibody test as a condition of coverage.<sup>40</sup>

With regard to the above strategies, the first and fourth strategies appear to be the most popular with South African insurers. Stone says the following of HIV testing:

*'HIV testing, after all, is only a very small part of underwriting in health and life insurance.'*<sup>41</sup>

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<sup>40</sup>Bergkamp (n 34 at 569)

<sup>41</sup>D A Stone 'The Rhetoric of Insurance Law: The Debate over AIDS Testing' (1990) 15

Though HIV testing may only be a small part of underwriting, the issue of testing is one of the most debated issues within the industry.

#### 4.2 THE ARGUMENTS IN FAVOUR OF TESTING

The proponents of mandatory HIV antibody testing advance the following arguments (these contain a strong financial appeal) for the continued use of the test to determine insurability.

1. The insurance industry will not be able to function adequately (on a financially sound basis) without HIV testing because of the spiral of adverse selection.<sup>42</sup> Adverse selection affects life insurance in one of three ways, namely: (a) individuals who know they are at risk buy abnormally large amounts of life insurance; (b) HIV positive individuals buy normal amounts of insurance they would not otherwise have bought; and (c) HIV negative individuals switch to self-insurance.<sup>43</sup> Each of these three mechanisms will inevitably lead to an increase in premium rates. This in turn will lead to low risk members withdrawing from the pool, further increasing premium rates which will in its turn lead to more low risk members leaving the pool and this cycle will continue until the pool finally collapses.
2. HIV testing is in line with underwriting practices, and HIV positive people have to be singled out in order to protect (not to discriminate against) other policyholders who are not as high a risk as an HIV positive person.<sup>44</sup> It has been suggested that the true motivation for the industry's '*no special treatment*' argument is not a desire to avoid unfair

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*Law and Social Inquiry* 385 at 388

<sup>42</sup>Visser (n 39 at 635)

<sup>43</sup>Bergkamp (n 34 at 574)

<sup>44</sup>Visser (n 39 at 635)

discrimination against people who are rejected because of other health risks, but rather a desire to test without regard to social costs.<sup>45</sup> Also, if AIDS is not excluded, applicants who have other uninsurable illnesses will lobby to have their illnesses covered.

3. The prospect of HIV testing will encourage persons not to engage in behaviour which increases the risk of infection.<sup>46</sup> This 'incentive' to minimise the risk to oneself by altering high risk behaviour has not been successful. Motor vehicle drivers are constantly warned of the dangers of reckless or negligent driving, but still persist with such behaviour, and the proof of this failure can be found in road accidents statistics. Bergkamp is also of the opinion that the scope of this argument (risk minimisation) is limited as it does not apply to those who are already HIV positive and can do nothing to change that fact.<sup>47</sup>

#### 4.3 THE ARGUMENTS AGAINST TESTING

The proponents of a ban on HIV testing draw on social and humanitarian concerns when advancing their arguments. They counter the arguments for testing as follows:

1. The test may have actuarial significance but it cannot predict who will definitely develop 'full-blown' AIDS, it merely indicates a higher probability of contracting it.<sup>48</sup>

Whilst this point is true, it misses the point in that only 100 percent specific and sensitive tests should be allowed in underwriting.<sup>49</sup> The current tests, while highly specific, still

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<sup>45</sup>B Schatz 'The AIDS insurance crisis: underwriting or overreaching?' (1987) 100 *Harvard Law Review* 1782 at 1798

<sup>46</sup>Visser (n 39 at 635)

<sup>47</sup>Bergkamp (n 34 at 576)

<sup>48</sup>Visser (n 39 at 635-636)

<sup>49</sup>Bergkamp (n 34 at 572)

have a 0.05% margin of error. These tests are still fallible during the window period, i.e. the period between initial infection and the first signs of viral fever.

2. HIV testing should be one of the well recognised exceptions to the general rule of rate setting on an actuarial basis.<sup>50</sup> However, exceptions have also been made on the basis of race and national origin, as well as other diseases. Why should AIDS, and not lung cancer or pancreatic cancer, enjoy the same exception? Insurers have pointed out that those exceptions that have been allowed have not posed the same threat to them as the threat posed by AIDS.

3. HIV positive test results will burden applicants with information they have not requested or desired.<sup>51</sup> This argument presupposes that insurers will not be able to provide adequate counselling services or arrange for adequate referrals. As pointed out earlier, insurers do arrange for pre-test counselling, and the applicant is referred to his or her medical practitioner to facilitate post-test counselling. It would probably be advisable for an applicant to be made aware of his or her infection at the earliest stage possible so as to prevent the infection of such applicant's partner(s).

4. HIV testing may raise ethical issues around confidentiality and privacy.<sup>52</sup> Insurers have ensured that test protocols are firmly adhered to, and have been dealing with confidential information without any problems. However, this has not prevented confidential information in respect of HIV positive applicants from leaking out, but fortunately for the industry no litigation has arisen from these leaks to date. If testing were prohibited, an applicant will not be exposed to the risk of a possible leak of confidential information.

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<sup>50</sup>Visser (n 39 at 636)

<sup>51</sup>Ibid at 636

<sup>52</sup>Ibid at 636

The above are but a few of the many arguments for and against HIV testing. The arguments in favour of testing have been advanced by the industry. The main thrust of these arguments seems to be that it cannot operate efficiently, i.e. on the basis of actuarial soundness, and perhaps at all, if it is burdened <sup>up</sup> will all kinds of social objectives. However, actuarial soundness means nothing more than business soundness, which translates into the basic fact that an insurer should take in at least as much money in premiums and investment income as it expects to spend in claim payments, operating expenses and income tax. Stone suggests that there are many ways to manipulate this formula, including the changing of premium rates, operating expenses and investment strategies.<sup>53</sup>

The arguments in favour of a ban on HIV testing have been advanced mainly by AIDS activists. They argue that HIV testing discriminates against an already overly discriminated minority, namely homosexual men. Initially this may have been correct when the first AIDS cases were diagnosed in South Africa, but the incidence of AIDS in the gay communities has tapered off, and instead the disease has now become a major threat to the black heterosexual population.<sup>54</sup> AIDS activists have also called for insurers to take a more distributive role, but have made discrimination, not need, the basis for this distribution. They want the State to intervene to prevent insurers from excluding groups who have historically been the victims of discrimination, but this line of argument ignores those people who are needy but who do not fit into one of the social groups recognised as victims of discrimination.<sup>55</sup>

#### 4.4 CONCLUSION

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<sup>53</sup>Stone (n 41 at 406)

<sup>54</sup>See note 12 supra

<sup>55</sup>Stone (n 41 at 407)

I am in agreement with Stone when she points out that '*in their struggle to control the representation of the issue, the two sides are so concerned with making their preferred policy seem necessary and obvious that they ignore broader societal issues.*<sup>56</sup> The debates/discourses around the issue of HIV testing seem to be more in the line of a crisis response to the problem than an effort to find a long-term solution to the problem presented by AIDS. However, testing is not the only popular response by the industry.

#### 4.5 THE VEXED EXCLUSION CLAUSE

In October 1988 the Life Offices Association of South Africa (LOA), a body representing the majority of life insurers, adopted an entrenched agreement relating to the imposition of an AIDS exclusion clause. In terms of this agreement members of the LOA may not issue a life policy of R200 000 or more, a disability policy of R2 000 per month or more, or a business overhead/expense disability income policy of R8 000 per month or more without the applicant supplying a negative HIV antibody test result. Where an applicant declines to undergo an HIV test, the member office may, at the request of the applicant, issue a policy with an AIDS exclusion clause.<sup>57</sup> The clause reads as follows:

*'In the event of there being a claim under this policy following the life assured's death, illness, disorder, disability or inability to carry out a remunerative occupation which is due to or arising directly or indirectly, entirely or partially from the Acquired Immunodeficiency Syndrome (AIDS) or infection from any Human Immunodeficiency Virus (HIV), this policy shall*

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<sup>56</sup>Ibid at 404

<sup>57</sup>AIDS: The LOA Acts' (1988) 1 Cover 29-31

*immediately terminate and the proceeds thereof be restricted to the surrender value or refund of premiums, whichever is the greater.*<sup>58</sup>

Individuals who become infected through blood transfusions or in the execution of their duties in the medical or emergency services are exempted from this exclusion. These exemptions are clearly discriminatory, as they intend to separate the "innocent" victims of AIDS from the ones who are "guilty" (and who should be punished for their guilt). Professor Coenraad Visser correctly analyses these exemptions as reiterating *'corporate homophobia and racism.*<sup>59</sup>

Another problem with the AIDS exclusion clause, and one that is particularly offensive, is the wide discretion accorded to the person or persons who have to exercise the discretion (usually the claims manager of the insurer), resulting in most cases in the insurer escaping liability. Death need not be the direct result of AIDS or HIV - it is sufficient if it arose directly or indirectly, entirely or partially from AIDS or HIV. The causal link does not require any objective, logical or rational criteria - all that is required for the coming into effect of the clause is the subjective opinion of the authorised representative of the insurer. In practice, the company can deny liability if in its opinion, however unreasonable and unsubstantiated by medical facts, death can be attributed indirectly and partly to AIDS or HIV.<sup>60</sup>

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<sup>58</sup>LOA AIDS Agreement dated 1 November 1988, updated 19 February 1993

<sup>59</sup>Visser (n 25 at 139)

<sup>60</sup>Ibid at 139

#### 4.6 CONCLUSION

It is probably for the above reasons that certain insurance companies are not totally comfortable with exclusion clauses. If called upon the company will have to prove that the policyholder died of AIDS related causes, and it may not be able to do so, especially in the case where the body has been cremated. Clem Booth, the chief executive of Munich Reinsurance Company of South Africa, finds the exclusion of AIDS as a covered condition '*most controversial*', as the selection of AIDS as an exception will be seen as inappropriate by the public, who do not have much faith in the industry. He further states that in his opinion, and that of his group, AIDS exclusions are not the way to go, as this merely postpones the problem and does not assist the industry in finding a solution.<sup>61</sup>

#### 4.7 EXCLUSIVE LIFE

During April 1993 a member office of the LOA introduced a new life product called '*Exclusive Life*', which the company claimed to be a world first. The conditions attached to the product are that the potential applicant would have to undergo an HIV test prior to the policy being issued, and repeat HIV testing at five yearly intervals until the applicant reaches the age of forty-five years, whereupon the life cover vests. If the applicant fails or neglects to undergo the repeat HIV testing, his or her life cover will be reduced to ten percent (10%) of the original life cover.<sup>62</sup> The company's motivation and justification for this new product and its related conditions was that it sought to introduce an AIDS-free pool of policyholders to prevent healthy policyholders in the pool from subsidising HIV-infected policyholders. This justification seems to be contrary to its primary business, as

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<sup>61</sup>C Booth (n 37 at 154-155)

<sup>62</sup>Cape Times April 30, 1993; Daily News April 30, 1993

all life insurance contains elements of cross-subsidisation.<sup>63</sup> The introduction of the Exclusive Life product initially created a furore (both the concept and its advertising campaign<sup>64</sup>), but this soon died down. In and during June 1994, the chief actuary of another life office commented on the fact that in the face of the AIDS pandemic, repeat testing of applicants may be the way to go, and that this type of product was becoming more popular among applicants for insurance.<sup>65</sup> Three months later this life office launched a product similar to the Exclusive Life product, save that with the new product if the applicant fails or neglects to undergo the repeat HIV test, the life cover reduces to thirty percent (30%) of the original life cover.

#### 4.8 CONCLUSION

Professor Edwin Cameron has the following to say about the insurance industry's response to the AIDS crisis:

*'Insurance companies, who control a substantial portion of our national wealth, have chosen to try and opt out of the crisis facing our country. They ask intrusive questions about HIV of all insurance applicants, insist on pre-insurance HIV testing in many cases and waive coverage for HIV-related eventualities. They use the common law rules of contract to exempt themselves from any burden in dealing with AIDS and to repudiate liability in the case of non-disclosure even where the insured's death is unrelated to*

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<sup>63</sup>See note 26

<sup>64</sup>See 83 *South African Medical Journal* September 1993 at 690

<sup>65</sup>Hartwig (n 26 at 4)

*HIV. They, alone, it seems, propose to survive South Africa's  
AIDS epidemic unscathed.*<sup>66</sup>

How have international insurers responded to the perceived AIDS threat facing them?

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<sup>66</sup>E. Cameron 'Human Rights, Racism and AIDS: The New Discrimination' (1993) 9 *South African Journal of Human Rights* 22 at 25

## CHAPTER FIVE

### THE INTERNATIONAL RESPONSE

#### 5.1 INTRODUCTION

It is generally accepted that American and European insurers are more experienced than their South African counterparts in that they were confronted by the AIDS crisis before the South African insurers. This is especially true in the case of American insurers, as they also sell health insurance (medical aids), and whilst Americans do not have a right to life insurance, the right to health is regarded as a fundamental right. Allied to this right is the fact that health care should be affordable, so the AIDS threat directly affects insurers. How have American insurers responded?

#### 5.2 THE AMERICAN EXPERIENCE

At the outset of the AIDS crisis, testing for medical conditions including blood tests were generally accepted.<sup>67</sup> However, with the spread of AIDS this general acceptance was challenged. Several states in America then proposed legislation to prevent insurers from using HIV tests and the results of those tests for insurability purposes. Clifford and Iuculano argue that this move was based on a misunderstanding of insurance principles and a desire to prevent discrimination against homosexuals.<sup>68</sup> Schatz, however, argues that the reason for this move was to prevent insurers from discriminating against gay and bisexual men, as an August 1985 report of the chair of the American Council of Life Insurers (ACLI) and the Health Insurance Association of America (HIAA) states that the major

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<sup>67</sup>R P Iuculano 'Life Insurance: Legislative and Regulatory Restrictions on AIDS-Related Testing' in W H L Dornette (Ed) *AIDS and the Law* (1992) Wiley Law Publications at 214

<sup>68</sup>Clifford & Iuculano (n 29 at 1814-1815)

threat to insurers is posed by the homosexual population, and that antibody testing should be aimed at this population.<sup>69</sup>

In April 1985, the Californian legislature introduced a law prohibiting, for insurability purposes, the use of blood tests to detect antibodies in respect of AIDS, as the use of these tests was seen as discriminating against a particular minority, namely homosexual men.<sup>70</sup> The next state to follow California was Wisconsin, which in July 1985 introduced a law similar to that of California, but more restrictive in that insurers were also prohibited from enquiring whether an applicant had previously taken an HIV antibody test.<sup>71</sup> The third state to follow suit was Florida, which enacted a law prohibiting the use of serological tests to determine insurability once the Secretary of the Department of Health declares a threat to public health because of the existence of an infectious disease. However, this law only related to the tests conducted under the Secretary's declaration, and did not expressly prohibit an insurer from ordering its own HIV antibody tests.<sup>72</sup> Meanwhile, in Wisconsin in November 1985 remedial law was introduced which allowed insurers to test for HIV antibodies in respect of individual life and health insurance, but only once the state epidemiologist and the insurance commissioner had made a finding in respect of the reliability of the tests. This finding was finally made on 29 August 1986.<sup>73</sup> Following closely on the above the state of Maine initially introduced legislation prohibiting the use, not only of HIV antibody testing, but also tests to measure the virus as well as a test to

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<sup>69</sup>Schatz (n 45 at 1799)

<sup>70</sup>California Health and Safety Code quoted in Clifford & Iuculano (n 29 at p 1815 note 48)

<sup>71</sup>Ibid at 1815 note 49

<sup>72</sup>Iuculano (n 67 at 214)

<sup>73</sup>Ibid at 215

measure the immune system. However, this was not enacted and instead a law barring insurers from enquiring about the results of a previous test was passed.<sup>74</sup>

The most serious "threat" to insurers came from legislation enacted in the District of Columbia by that district's City Council. This legislation prohibited the use of all AIDS-related tests for a period of five years, including tests for HIV antibodies, tests for the condition of the immune system and tests to identify the AIDS virus itself. It also prohibited insurers from using factors such as age, marital status, geographic area of residence, occupation, sex or sexual orientation for the purpose of seeking to predict which individual would in future develop AIDS or AIDS Related Complex.<sup>75</sup>

On 5 August 1986 the ACLI and HIAA filed a suit against the District of Columbia, on the grounds that the statute enacted violated both the Fifth Amendment of the Constitution and the extra-territoriality prohibition of the District of Columbia Self-Government and Government Reorganization Act.<sup>76</sup> The court held in favour of the District, claiming that whilst the District may have acted too hastily in imposing the five year moratorium, it had not acted arbitrarily or irrationally. The District had also acted constitutionally in that it had attempted to regulate, by statute, companies within the district only and not those outside the district. The result of this decision was that most commercial insurers ceased selling individual health and life insurance in the District of Columbia whilst the ban was in place.<sup>77</sup>

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<sup>74</sup>Ibid at 215

<sup>75</sup>Ibid at 215

<sup>76</sup>ACLI v District of Columbia 645 F Supp 84 (DDC 1986) (Civil Action No 86-2131) quoted Ibid at 328-333

<sup>77</sup>R R Bovbjerg 'AIDS and Insurance: How Private Health Coverage Relates to HIV/AIDS Infection and to Public Programs' (1992) 77 *Iowa Law Review* 1561 at 1591

By 1988, however, almost all the states in the USA had removed any prohibition on the use of HIV antibody testing for insurability purposes, and instead substituted a requirement that there should be pre-and post-test counselling.<sup>78</sup>

### 5.3 THE AMERICAN SOLUTIONS

As a result of being confronted with the problem at an earlier stage, and also because American insurers are involved in the provision of health insurance, they and their state insurance regulators have attempted to find a solution to the problems of applicants excluded from insurance due to HIV seropositivity. These solutions are mainly in the area of health insurance, but would have application to the South African life insurance context.

#### 5.3.1 HIGH RISK POOLS

The first of these solutions, what Stone calls '*the industry's preferred solution*',<sup>79</sup> works on the basis of spreading the costs of insuring high risk applicants among all the insurers. This calls for mandatory high risk pools, where each health insurer in a given state is compelled to accept a share of previously rejected applicants. Its share is calculated in relation to its market share in that particular state.<sup>80</sup> The pool is usually administered by one insurer, who has been appointed by the others operating in the state. Eligibility for these high risk pools is limited to residence in the state for a minimum period, usually twelve months. Cover is limited to those of major medical policies (the policy only covers major expenses), and is often subject to limitations for certain treatments. Pre-existing conditions, i.e. a condition which existed prior to the entry into the pool, or a sickness

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<sup>78</sup>Iuculano (n 67 - 1992 update at 91-96)

<sup>79</sup>Stone (n 41 at 407)

<sup>80</sup>Schatz (n 45 at 1796)

which manifests itself within six months of entry, are not covered until twelve months from entry into the pool has elapsed. The policy may be renewed, unless the maximum lifetime benefits have been reached.<sup>81</sup>

\* Premiums for these policies are usually higher than for healthy insureds, and benefits are generally less comprehensive. Schatz gives the figure for premiums as statutorily limited to 150% to 200% higher than that of the average premium for healthy insureds.<sup>82</sup> Though the premiums are higher and the benefits are less, the cost of these pools usually exceeds the income generated from premiums and investment income. Subsidisation is therefore necessary, and these deficits are covered by imposing assessments on the insurers operating in that state.<sup>83</sup> These assessments are eventually passed onto other policyholders.<sup>84</sup>

Therefore, if more applicants join these pools, the assessments on insurers would be higher, which in turn would mean that either the premiums for healthy insureds are increased or a state subsidy would be necessary. Schatz views these high risk pools as vitally important, as it makes health insurance available to those who otherwise would not be covered.<sup>85</sup>

### 5.3.2 OPEN ENROLMENT PERIODS

The second solution to the problem of insurability is that of open enrolment in the state-controlled Blue Shield and Blue Cross Plans. These plans would declare open enrolment periods when all applicants who have been rejected by private insurers could become members. As with the mandatory high risk pools, this type of coverage usually offers

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<sup>81</sup>Widiss (n 13 at 1723-1728)

<sup>82</sup>Schatz (n 45 at 1796)

<sup>83</sup>Widiss (n 13 at 1727)

<sup>84</sup>Schatz (n 45 at 1796)

<sup>85</sup>Ibid at 1797

lower benefits, longer waiting periods before benefits become effective, pre-existing conditions are excluded for longer periods, and cost more than similar coverage at standard rates.<sup>86</sup> Again, as with the mandatory high risk pools, these open enrolment periods allow applicants who would not have qualified to obtain cover, albeit on a limited basis.

### 5.3.3 SPECIALISED UNDERWRITING

The last solution is not really a solution in the true sense of the word, but makes cover available in very limited circumstances. Certain companies specialise in underwriting persons who suffer from serious medical conditions, and therefore a person suffering from, for instance, cancer may still be able to obtain insurance. This is possible when the cost of cover is not an object. When it becomes evident, as in certain cases in the USA, that HIV positive persons may remain asymptomatic for ten to fifteen years, life insurance may become more available to persons who are HIV positive.<sup>87</sup>

### 5.4 NETHERLANDS AND THE EUROPEAN EXPERIENCE

The position in the Netherlands is similar to that of South Africa in that should a potential applicant for insurance require life cover above a certain amount, he or she has to submit to an HIV antibody test. A similar situation also exists in respect of how insurers obtain information about prospective applicants, namely requiring applicants to answer questions posed in the application form. One question, known as the '*blood question*', is posed very widely, and reads as follows:

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<sup>86</sup>Bovbjerg (n 77 at 1594-5 note 177)

<sup>87</sup>Widiss (n 13 at 1721-2)

*'Has your blood ever been examined for blood disease, diabetes, kidney disease, amount of fat (for instance cholesterol), hepatitis (A or B), sexually transmitted diseases such as syphilis or AIDS? If so, why, when, for what reasons and with which result?'*<sup>88</sup>

The National Committee on AIDS Control is of the opinion that the above question is too wide and invasive, given the individual's right to privacy. It feels that because of this question the balance between the contracting parties (i.e. the applicant and the insurer) has shifted in favour of the insurer. Accordingly, the Committee has proposed that the use of the HIV antibody test be limited to those special cases where the applicant applies to be insured for a sum greater than he or she needs to cover real risks, taking into account the applicant's social position and personal situation. HIV antibody testing as part of an insurance application should also be forbidden, except as set out above. Further, the blood question on the application form should be amended to read *'Do you have AIDS?'* and *'Are you HIV-seropositive?'*. These recommendations have been accepted by the Dutch Health Council and the matter has been forwarded to parliament.<sup>89</sup>

It would appear that other European countries such as the United Kingdom, France, Germany and Spain also require an HIV antibody test when an applicant applies for life cover above a certain amount.<sup>90</sup>

## 5.5 THE AFRICAN EXPERIENCE

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<sup>88</sup>E T M Olsthoorn-Heim 'HIV Testing and Private Insurance' (1993) 12 *Medicine and Law* p11 at 12

<sup>89</sup>*Ibid* at 13-14

<sup>90</sup>*Ibid* at 11

In Kenya, many companies had what was called a free cover limit (FCL). This was fixed at the equivalent of R50 000. An applicant could, therefore, apply for life cover and be insured for up to this free cover limit without having to submit to an HIV antibody test. However, as a result of pressure from overseas reinsurers and the poor views on the AIDS projections, this free cover limit has been dropped to R25 000. As these AIDS projections become a reality, the free cover limit is being looked at again with the view to reducing the amount further.

In Zimbabwe the government initially opted to ban all HIV antibody testing for insurance purposes. Insurers and the government then entered into a period of negotiation, whereafter a protocol was agreed upon and the ban on HIV antibody testing was lifted, but only if the life cover applied for exceeded Z\$100 000. Where the life cover required is less than this amount, insurers cannot insist on a test.<sup>91</sup>

In Malawi, as a result of the high incidence of AIDS, insurers introduced HIV antibody testing. The government responded by withdrawing the insurers' right to insist on a test as a condition of coverage. Insurers responded to this ban by raising premium rates, in some cases by as much as 500%, and even this was not sufficient to cover the negative claims experience of insurers. As in the case of the situation in the District of Columbia, Malawi insurers withdrew individual life products from the market. Shortly thereafter the ban on HIV antibody testing was lifted. Insurers may now suggest that a prospective applicant undergo an HIV antibody test. Failure to take the test results in the applicant being declined for life insurance.<sup>92</sup>

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<sup>91</sup>Booth (n 37 at 153)

<sup>92</sup>Ibid at 153

For some African based life insurance companies the potential effect of AIDS is catastrophic. At the thirteenth conference of the International Association of Consulting Actuaries, M J Bell explored a number of ways in which African life insurers could reduce or limit their exposure to AIDS. These include the removal of all mortality options from contracts (e.g., guaranteed renewability without medical evidence); reducing terms to 20 years; withdrawal of all term assurance; the strengthening of underwriting standards including HIV antibody tests; increasing premium rates; changing policy design to remove the mortality risk taken and the inclusion of a clause empowering the company to vary benefits or increase premiums.<sup>93</sup>

#### 5.6 SIMILARITY IN STRATEGIES - SOUTH AFRICA AND THE USA

It is interesting to note how closely the South African insurance industry follows in the footsteps of the American insurance industry. In an effort to place a cap on its costs, the American insurance industry adopted four strategies, and South African insurers have adopted these same strategies. American insurers follow a specific HIV test protocol, which has also been adopted by South African insurers. In an effort to ease the cares of health workers, specifically nurses, an American based insurer has entered into an agreement with the Ontario Nurses Association to offer a special policy to their members. A member who has purchased this policy will be paid a cash lump sum on contracting the HIV infection, with no questions being asked as to how the member contracted the virus.<sup>94</sup> In September 1994 the South African Nursing Association advised its members of

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<sup>93</sup>M J de H Bell 'The impact of AIDS on the actuarial management of an African Life Office' at the *13th International Association of Consulting Actuaries Conference* May 1992

<sup>94</sup>As Demand for HIV Insurance grows, Insurers Move to Market New Policies' *American Journal of Nursing* May 1992 at 93&96

insurance it had negotiated with a local broker and which is being underwritten by Lloyd's of London. Whilst the cover is short-term, it makes provision for a cash payment should the member test positive for the AIDS virus, regardless of how the virus was contracted.<sup>95</sup> Where the South African insurance industry has overtaken its American counterparts is in the area of repeat testing. It remains to be seen if South Africa can claim a world first by introducing a lasting solution to the problem of life insurance for HIV seropositive persons.

### 5.7 CONCLUSION

From this short overview of the international experience and response it can be clearly seen that insurers are preparing themselves to survive (and overcome) the AIDS crisis. One point which is conspicuous is that HIV antibody testing has become accepted internationally. But what happens to persons who are not aware that they are infected, and only find out once having undergone an HIV antibody test? Or the individual who tests positive after paying for life cover for five years, only to find his or her life cover has been reduced to 10% of the original amount? Clearly these people suffer psychological, social and financial disadvantages, and probably discrimination too. For example, you would most likely not be granted a mortgage bond, overdraft or other financial assistance if you are HIV positive, as you will not be able to furnish the necessary collateral security (in the form of a life insurance policy) required by deposit-taking institutions.

The above illustrates that the response to the AIDS crisis by insurers has been anything but creative. In the scramble to protect their "solvency" and profitability, insurers have lost sight of the fact they also fulfil a social function. What insurers, AIDS activists, government, employers and the public should focus on is not whether there is a need for

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<sup>95</sup>Sunday Times September 11, 1994 at 15

HIV antibody testing, but what can be done to assist those persons who are or who will become HIV seropositive and who will then be uninsurable.

## CHAPTER SIX

### POSSIBLE SOLUTIONS

#### 6.1 INTRODUCTION

The National AIDS Plan for South Africa 1994-1995 under the section dealing with Insurance Law, has as its priority the following:

*'To negotiate a basis upon which the life and health insurance needs of persons with HIV/AIDS can be fairly accommodated.'*<sup>96</sup>

South Africa has entered a new era in its history, and its people are attempting to put the past behind it and grapple with the issues facing it. One of the most important problems it has is to find an equitable solution to the AIDS crisis, and more specifically the problem of its citizens who are HIV seropositive and therefore uninsurable. This solution must be acceptable to all parties, without favouring one party above another, and must be what alternative dispute resolution calls a "win-win" solution. Are there any solutions to this problem?

#### 6.2 THE BROKER SOLUTION

Insurance brokers, in an attempt to be of assistance to their clients who have serious medical conditions, have devised various schemes and products to circumvent their clients'

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<sup>96</sup>NACOSA : 'A National AIDS Plan for South Africa 1994-1995' July 1994 at p 47

uninsurability. One such plan, called the Medsave Plan, and negotiated by brokers O'Hanrahan and Associates and two leading underwriters merits some attention.<sup>97</sup>

The plan consists of three products, namely, a pure endowment policy, unit trusts and a retirement annuity policy (without life cover). The applicant contributes R300 per month to the plan, and for the purposes of this example is a male aged 28 years next birthday, who will develop full-blown AIDS at 35 years of age. The term for all these contracts will therefore be seven years. From the sum of R300, R75 is paid as a premium to the pure endowment, R125 is paid to the unit trusts and the balance of R100, escalating at 15% per annum, is contributed toward the retirement annuity. The latter contribution is deductible for income tax purposes.<sup>98</sup>

The benefits emerging at age 35 would be R29 000 (assuming a growth rate of 15%) to pay for medical expenses, and a monthly annuity of R250. In terms of the Income Tax Act, a member may not access his or her retirement annuity before reaching the age of 55 years, unless the Commissioner is satisfied that the member has become permanently incapable of carrying on his or her occupation.<sup>99</sup> Full-blown AIDS qualifies as permanently incapable in this case. Further, it has been negotiated with the underwriters that the person will be treated as if he has reached the age of 65 (because of the reduced life expectancy) and the annuity will carry a nil guarantee (cease on death). As a result of these concessions the monthly annuity payment is higher. In addition to this a back-to-back scheme (an annuity funding an endowment) has been arranged which will return the

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<sup>97</sup>A Duigan 'Uninsurables can provide' *Vitae* May/June 1993 at 59

<sup>98</sup>Section 11(n)(aa) *Income Tax Act 58 of 1962*

<sup>99</sup>Definition of 'retirement annuity fund', subsection (v) thereof contained in section 1 of the *Income Tax Act 58 of 1962*

capital used to purchase the monthly annuity. This ensures that the applicant's dependants receive approximately R25 000 on his death.

This plan is flexible as there is no life cover attached to the products, and therefore the applicant's age does not matter. It is innovative in that it utilises existing products, and no new products and systems have to be developed. Its major drawback lies in the fact that it is expensive and is only affordable at the top end of the market.

### 6.3 HIGH RISK POOLS

Whilst South Africa should develop its own solutions for its problems, it is sometimes better not to re-invent the wheel, but to adapt the existing wheel to suit the conditions in South Africa. With this in mind, the High Risk Pools preferred by the American Health Insurers could be adapted to the South African life insurers' needs. This would entail the insurers accepting their "share" of rejected applicants in relation to their share of the market. For example, if Old Mutual has 40% of the life insurance market, it would accept 40% of the rejected applicants. Currently 10% of its applicants in the KwaZulu/Natal area are rejected due to HIV seropositivity.<sup>100</sup> One life office would have to be appointed to administer the pool. There would have to be a lien period of two to three years in favour of the insurer who issued the policy (i.e. the claim would not be paid if the applicant died within this lien period). Premiums would be high, as at present insurers estimate that an HIV positive person represents a risk 50 times higher than that of a standard risk.

Benefits/coverage would have to be limited in line with the applicant's real risks to be covered, income, number of dependants and reasons for insuring. Even then, as more and more HIV positive persons join this pool, the income received in premiums and investment

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<sup>100</sup>Hartwig (n 26 at 3)

would probably not be sufficient to cover claims. The pool can be expected to sustain substantial losses.<sup>101</sup> These losses would then have to be made good by the life offices participating in the pool. This would, in effect constitute an extra tax on insurers, and would be contrary to the four fund approach negotiated between insurers and Inland Revenue, as well as the trend of the last four years which has seen company rates drop from 50% to 35%. However, I am aware of one life office who is investigating the possibility of setting up such a high risk pool, but for group schemes rather than for individual life insurance.

#### 6.4 OPEN ENROLMENT PERIODS

Another possible solution that can be borrowed from the Americans and adapted to suit South African needs is that of open enrolment periods. This would entail an insurer advertising that during a certain period, for example, within 30 days of the advert, it would accept all applicants regardless to health or HIV status.

Once again this would mean that premiums would be higher than those charged for standard risks, and the benefits/coverage would be limited to real risks to be covered, income, number of dependants and reasons for insuring. There would also have to be a lien period during which the benefits would not be paid.

A system similar to this has been attempted by certain life offices in South Africa, not as an attempt to provide cover for uninsurable applicants but as an attempt to gain market share, with not altogether successful results. The life office in question marketed the scheme as endowment assurance with minimum life cover, with no medical being

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<sup>101</sup>Clifford & Iuculano (n 29 at 1822)

questions asked. The case eventually came before the Appellate Division as A A MUTUAL LIFE ASSOCIATION LIMITED v SINGH.<sup>102</sup> The facts of the case are as follows:

On 3 February 1986 Singh's wife completed a proposal form as proposer and life assured for a 10 year endowment policy with minimum life cover. Singh was named as beneficiary. On 23 March 1986 the proposer died - she was suffering from cervical cancer - and the insurer repudiated liability under the policy. Singh approached the Provincial Division for relief and his claim was upheld. The insurer elected to take the matter on appeal to the Appellate Division.

The policy was marketed as an investment policy, with minimum life cover included to comply with the Sixth Schedule (now repealed) to the Income Tax Act. The marketing notes which accompanied the application form and issued by the insurer stated '*Free cover...up to R30 000 sum assured...free of medical evidence.*' In explaining the policy to the broker, the agent of the insurer stated that applicants fit to lead normal lives and who were employed in their normal occupations would qualify as potential purchasers.

Whilst neither the proposer, nor the broker who completed the proposal form filled in the medical questions, the proposer signed and warranted that all statements and answers given in connection with the policy were true and correct. Counsel for the insurer argued that the manner in which the warranty question had been drafted required the proposer to disclose any facts which were material to the risk the insurer was to undertake. There was, therefore, an obligation on the proposer to disclose that she was suffering from cancer. As the proposer had failed to do so, the insurer was entitled to repudiate liability.

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<sup>102</sup>1991 (3) SA 514 AD

The court held that the warranty section could not be regarded in isolation, but had to be read in the light of the questions that preceded it. As the insurer was not interested in the proposer's medical history, she was not required to disclose this. The warranty section dealt with whether the proposer was actively employed in her usual occupation, which she had answered truthfully. The court further held that as the proposer was not required to answer any medical questions, the insurer must be taken to have waived its right to require information as to the proposer's state of health. The appeal was dismissed.

If one accepts that this type of insurance will in all probability be used for mortgage protection or to make provision for dependants, having an insurer repudiate liability under the policy will cause serious financial hardship. The initial reason for entering into the policy would then have been defeated.

These solutions have one common thread permeating them, namely, the solution is private and the total cost will be borne by insurers. AIDS is a societal problem, and accordingly the whole of society must be involved in the solution. Insurers will have to contribute to the cost of the solution, but they cannot be expected to bear all the costs. For these reasons the solution should not be private. Should the cost be transferred to the public?

## 6.5 THE PUBLIC SOLUTION

A further solution, and an alternative to the exclusively private solution, is to allow HIV antibody testing, and to accommodate all those applicants rejected by the private insurers into a public insurance scheme.<sup>103</sup> Setting up such a scheme should not involve too many complexities as various public insurance schemes already exist in South Africa (e.g..

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<sup>103</sup>Bergkamp (n 34 at 578); Visser (n 25 at 141) and Visser (n 39 at 637)

Workmen's Compensation, Unemployment Insurance Fund and the Multilateral Motor Vehicle Fund). This would be a truly public solution.

However, this scheme suffers from three major drawbacks. Firstly, adverse selection will be at its greatest as only HIV positive persons will join the scheme. These persons may, because such a scheme exists, decide to purchase insurance which they would otherwise not have purchased, or purchase abnormally large amounts of insurance. Secondly, how would the premium be calculated? Should it be a fixed cost, such as a percentage of all claim payments, or related to the applicant's circumstances? A policy with a sum assured of R100 000 would require a premium of R4 633 per annum for someone newly HIV positive, R10 928 for someone who has been HIV positive for five years and R17 975 for someone who has been HIV positive for ten years.<sup>104</sup> Based on the above, the public scheme would have to be heavily subsidised in order to make it accessible to everyone. Lastly, the scheme would retain all the negative consequences associated with HIV antibody testing by insurers.<sup>105</sup>

## 6.6 THE COMBINED/MIXED SOLUTION

The solution that has to be preferred is the one which combines both the private and the public. Coenraad Visser states that what is needed is *'to involve both the insurance industry and the public sector.'*<sup>106</sup> This solution would have the private insurers and the public insurance scheme operating in tandem, with the public scheme compensating the private insurers for the losses occasioned by the ban on testing. However, only those claims that can be ascribed to the ban on testing will be covered by the public scheme. All

<sup>104</sup>J Slawski - Actuary - Southern Life Association Limited 6 May 1994

<sup>105</sup>Bergkamp (n 34 at 578)

<sup>106</sup>Visser (n 25 at 141)

other claims will still have to be met by private insurers. The public scheme would thus reimburse private insurers for their losses arising out of adverse selection due to the ban on testing.<sup>107</sup> Whilst this solution is not perfect, it is reasonable and should be acceptable to all parties.

Various conditions would have to be attached to this solution to make it a workable model. Firstly, there must be a limit to the sum assured obtainable from the public scheme. This will be determined in accordance with each applicant's income, family structure and dependants, reasons for insuring and real risks to be covered (e.g. mortgage bond protection or overdraft facility protection or both). Should the applicant require more insurance than he or she qualifies for in terms of the criteria, he or she will have to submit to an HIV antibody test.<sup>108</sup> Placing caps on the limits covered by the public scheme will also counter the effects of adverse selection on the scheme.

Secondly, as with current life cover in respect of suicide, if the applicant dies within two years of the date of issue of the policy, he or she is presumed to have misrepresented his or her health status to the insurer. In this case, the life cover will not be paid. However this presumption is rebuttable if the family members, dependants or executor can provide evidence that the policyholder had not misrepresented information.<sup>109</sup>

Lastly, if the policyholder dies of AIDS or AIDS related causes after ten years of the date of issue of the policy, he or she will not be covered by the public scheme, but this will be for the private insurer's cost. The reason for this is that the claim could hardly be related to

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<sup>107</sup>Bergkamp (n 34 at 578-9)

<sup>108</sup>Ibid at 578

<sup>109</sup>Ibid at 578

the prohibition on HIV testing. However, the insurer may present evidence of the bad faith of the policyholder.<sup>110</sup>

A further argument favouring this solution, and one which should appeal to the industry, is the legitimacy of the LOA Life Register. The LOA keeps a central life register in which it records the medical history and general medical condition of the proposed life assured. This information is stored and controlled by the LOA, and only made available to members of the LOA. The ostensible reason for maintaining this register is to combat the lack of information on the part of the insurer (and thereby enforce the duty of disclosure). One way of obtaining the information necessary to assess the risk is for the proposed life assured to sign a waiver clause, which is contained in all proposal forms.

Schulze, however, argues that this waiver clause is invalid. Collecting and storing confidential information about another person's health constitutes a wrongful invasion of privacy. Also, the disclosure of this information to other members of the LOA is a further wrongful invasion of privacy.<sup>111</sup> He contends that the waiver clause is invalid, firstly, because it is framed too wide. To be valid the consent given by an applicant must be given with the applicant's full knowledge and appreciation. This is not the case with the waiver clause. Secondly, the consent is given to a specific life insurance company and authorises the latter to collect information. It does not authorise the insurer to store the said information, or to make this information available to other insurers.<sup>112</sup> The industry could be exposed to numerous delictual claims for wrongful invasion of privacy.<sup>113</sup> To date no

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<sup>110</sup>Ibid at 579

<sup>111</sup>W Schulze 'The LOA Life Register - a snap survey of possible legal pitfalls' (1994) 57 *THRHR* 75 at 80-81

<sup>112</sup>Ibid at 81

<sup>113</sup>Ibid at 82

litigation has arisen from this register, but this does not rule out the possibility of such litigation.

However, should the combined solution be agreed upon and implemented by all the parties, such a register will be a necessity in order to prevent adverse selection, and more specifically to prevent applicants from attempting to obtain more life insurance than they would be entitled to without an HIV antibody test. Accepting this solution would give the register the legitimacy it now lacks and prevent the industry from being exposed to a rash of lawsuits. This solution, therefore, has benefits for all parties to the solution.

## 6.7 CONCLUSION

As stated earlier, this latter solution is not perfect, but presents a reasonable and workable model (the so-called win-win solution). The costs are distributed more evenly across the whole of society. The funding for the public insurance scheme could be raised by an across the board levy, such as the current transitional levy. This model is also aligned to the National AIDS Plan, which proposes the following:

*'An investigation should be made into whether a central fund can be established for reinsuring insurance and other claims paid out in respect of HIV-related illness and deaths. Insurance actuaries should be approached to devise a reinsurance fund and to calculate the appropriate costs and levies.'*<sup>114</sup>

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<sup>114</sup>NACOSA (n 96 at 47)

## CHAPTER SEVEN

### THE CONSTITUTION AND FUNDAMENTAL RIGHTS

#### 7.1 INTRODUCTION

On 27 April 1994 the Interim Constitution, Act 200 of 1993, came into operation. In terms of s 7(1), the Constitution binds both the legislative and executive organs of the state at all levels. This means that parliament, provincial government and local government is bound by the Constitution and must abide by it. However, s 33(4) also makes provision for persons or bodies other than those mentioned above to be prohibited from practising unfair discrimination. To give effect to this the Constitution also introduces so-called '*class actions*' [s 7(4)(b)(iv)], and also recognises the right of a person or persons to act in the public interest [s 7(4)(b)(v)].

#### 7.2 THE PRINCIPLE OF EQUALITY

Given South Africa's history and its glaring lack of a human rights culture, it is not surprising that the first fundamental right introduced by the Constitution is the right of equality. The Constitution contains both a preamble and a so-called after-amble, and calls for and makes provision for equality. The preamble calls for a '*democratic constitutional state in which there is equality between men and women and people of all races*'.

Schedule 4, which in terms of section 232(4) is given the same status as the Constitution, once again re-iterates the principle of equality between men and women, people of all races, and also of racial and gender equality. Chapter 3 of the Constitution deals with Fundamental Rights (the so-called Bill of Rights). Section 8(1) once again confirms the principle of equality and reads as follows:

*'Every person shall have the right to equality before the law and equal protection of the law.'*

The principle of equality is enshrined in the Constitution. Section 8(2) further confirms that no person shall be unfairly discriminated against, whether directly or indirectly, and then lists fourteen categories or classes which are protected against discrimination. This list is by no means exhaustive, but it does seem to imply that only those categories or classes that may be added in future will only apply to human traits, as the original fourteen categories only deal with human traits. But no rights are absolute, and s 33 limits the rights contained in chapter 3. What happens when a fundamental right is infringed?

### 7.3 THE OPERATION OF THE CONSTITUTION

If an aggrieved person or persons approaches the Constitutional Court for relief, the court will institute a two-pronged investigation. The first part of the investigation will be to establish if the party against whom the relief is being sought has violated or breached the complaining party's rights. If the court answers this in the affirmative, the second part of the investigation then begins, namely, to determine if the breach complained of falls within the limitations allowed by s 33. To fall within this limitation the breach must be reasonable, justifiable, not negate the essential content of the right, and in certain instances it must be necessary. If the breach satisfies all these requirements, the party who sought relief will not have been successful. However, if the breach fails on any one of the above grounds, the complaining party will be entitled to relief. Given the scope of the Constitution, does it provide any relief for persons who are HIV positive and therefore excluded from obtaining life insurance?

### 7.4 THE CONSTITUTIONAL SOLUTION?

It would be obvious for the HIV positive person or persons excluded from obtaining life insurance to approach the court in terms of s 8(2), which deals with the various categories of unfair discrimination. The most important category for the purposes of this dissertation is that of 'disability.' Thus, no person may be unfairly discriminated against on the basis of such person's disability. A person who has full-blown AIDS can clearly be said to be suffering from a disability, and therefore may not be discriminated against. Can a person who is HIV positive call on the same protection on the basis that he or she has a disability? If one takes into account the fact that HIV positive persons are asymptomatic for long periods of time, and are able to function in the same way as healthy persons, a court may have difficulty coming to the conclusion that such a person is a person with a disability. The disability, however, could be found in the fact that an HIV positive person has an immune system which is deficient (suppressed), and would be more susceptible to infections than a healthy person. Thus, to be successful the plaintiff would have to lead the necessary medical evidence, and this could only be done on an individual basis.

Professor Edwin Cameron is of the opinion that the Constitution will come to the assistance of the person referred to above.<sup>115</sup> He appears to base his opinion on the Americans with Disabilities Act of 1990, and more specifically the definition of *'disabled person'* in this Act. This definition was modelled on s504 of the Rehabilitation Act of 1973, and this latter Act supports the view that an HIV infection will be classified as a disability by the American courts.<sup>116</sup> Further, a report prepared for members of the American Congress by the House Judiciary Committee on the Americans with Disabilities

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<sup>115</sup>E Cameron 'AIDS and the South African Legal System: Human Rights and Employment Law' a paper presented at the *AIDS in the Workplace Conference* on 27-28 June 1994 at UWC and at 3

<sup>116</sup>Widiss (n 13 at 1690)

Act specifically mentions an HIV infection to be a disability.<sup>117</sup> In interpreting our Constitution the Constitutional Court may be guided by the above reasoning as South Africa lacks a human rights culture, and our courts will be guided by the decisions of countries having similar constitutions.

Section 28 of the Constitution grants every person the right to acquire and hold rights in property. The word 'property' is used in its wider sense, and would include the right to acquire immovable property. All financial institutions require the cession of a life policy on the life of the mortgagor in their (the institution's) favour as a requirement for the granting of the mortgage bond. An HIV positive applicant will not be able to fulfil this condition, and will therefore be deprived of his or her right to acquire property. Such a person may approach the court for relief on the basis that the requirement of a life policy indirectly discriminates against him or her.

Whilst the above would appear to offer possible solutions to the problem, these solutions would have to clear two further hurdles. Firstly, in terms of s33(1)(a)(i) and (ii), these Fundamental Rights may be limited *'to the extent that such limitation is reasonable and justifiable in an open and democratic society based on freedom and equality.'* A convincing argument by the insurance industry that a prohibition on the testing and exclusion of HIV positive applicants is in breach of their right to freely engage in economic activity (business/financial necessity), could find favour with a court. Secondly, Act 200 of 1993 is an interim Act, designed to cover the period until the Constitutional Assembly drafts and ratifies a final Constitution. In the final Constitution the reference to *'disability'*

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<sup>117</sup>Ibid at 1689

could very well be left out, and Professor Cameron mentions that it was surprising that it was included in the interim Constitution in the first place.<sup>118</sup>

## 7.5 POSSIBLE SOLUTIONS AND POSSIBLE DISCRIMINATION

How would the solutions suggested in chapter 6 fare when measured against the Constitution? The Broker solution utilises existing products which do not require life cover and therefore would not require HIV testing. As such it would not fall foul of the Constitution.

High risk pools are mandatory, and the state compels insurers to institute them. They would, therefore, be compelled to undertake a burden not shared to any great extent by any other sector of the population. Would this entitle them to relief under the Constitution? Section 7(3) entitles juristic persons to the rights contained in chapter 3, but only where the extent and nature of the rights so permit. A juristic person would probably be entitled to the rights of economic activity, labour relations, assembly, association, access to court, access to information, property and administrative justice, but not to political rights, citizens' rights and probably not to the right to equality. This is because under the equality clause the categories mentioned pertain to human traits or conditions. So whilst an insurer may not seek relief under s 8, it could argue that being compelled to institute a high risk pool infringes its right to freely engage in economic activity[s26(1)]. The state, on the other hand, can assert that by limiting an insurer's right to free economic activity it is promoting the protection and improvement of the quality of life (of dependants of persons with AIDS), or equal opportunity for all (equal access to life insurance)[s 26(2)]. A shareholder or policyholder may, however, also approach the court for relief on the basis

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<sup>118</sup>Cameron (n 115 at 2)

that the state, by compelling insurers to institute high risk pools, indirectly discriminates against shareholders or policyholders[s 8(2)]. This solution, therefore, is not free from discrimination.

Open enrolment periods work best with state or public insurers. However, if the insurance industry were compelled to institute these open enrolment periods, the same arguments used for high risk pools would be applicable here. A shareholder or policyholder could also obtain relief by first asking the court to hold that s 33(4) be applicable to the insurer, and once this is successful, use s 8(2) and assert that the insurer indirectly discriminates against shareholder(s) or policyholder(s).

The public solution would be imposed by the state. The public insurance scheme would discriminate on the basis that it would only accept applicants who were rejected by private insurers. Can an aggrieved citizen claim that this discrimination is unfair, and ask the court for appropriate relief? I am of the opinion that such a citizen will not be successful, as the state is required to treat equals as equals and unequals as unequal. The state makes available and funds various public schemes, but limits these to particular sections or sectors of the public, such as unemployment insurance, a public scheme to which a large number of people contribute but only certain people obtain benefits from.

The combined/mixed solution combines both the insurance industry and the public sector. No one party is overly burdened in terms of costs, there is no HIV testing and everyone is accepted into the scheme subject to certain benefit limitations. As there would be no testing, there cannot be said to be any discrimination against any particular minority or sector of the population. Whilst the insurance industry will initially carry the cost, the public scheme will re-imburse the industry for any deaths relating to the ban on testing, so shareholders and policyholders will have no reason to claim discrimination. The state will

also ensure equal opportunity for all as well as be seen to be promoting the protection and improvement of the quality of life. The life cover/ benefit limitation will not be discriminatory as it will be tailored to each individual applicant's need. Those applicants seeking cover above their limit will have to undergo an HIV test, and as this will exceed the norm, it will not be discriminatory. This solution, therefore, has the added advantage of not being discriminatory.

CHAPTER EIGHT  
CONCLUDING REMARKS

AIDS is an equal opportunity disease. It does not distinguish between male or female, rich or poor, black or white, nor does it stop to enquire about a victim's sexual orientation before it infects him or her. Instead of competing parties attempting to gain the advantage for their particular position, it would be advisable for these competing parties to sit down and negotiate an imaginative response/solution to the problem. The combined solution is not perfect, but it goes a long way in addressing the concerns and fears of the parties. It will also ensure that the cost of the AIDS insurance is spread evenly among all parties, instead of being placed on a particular segment of society. There is no right to life insurance in the present Constitution, but given the fact that a life insurance policy is a financial necessity,<sup>119</sup> the final Constitution may well make provision for a right.

Life insurance by its nature is a long-term business. Insurers should start planning now for the future. It would be a double tragedy if the black population, who bore the brunt of discrimination under apartheid and who are the most affected by AIDS, find themselves further discriminated against when they require life insurance for mortgage protection and are unable to obtain insurance.

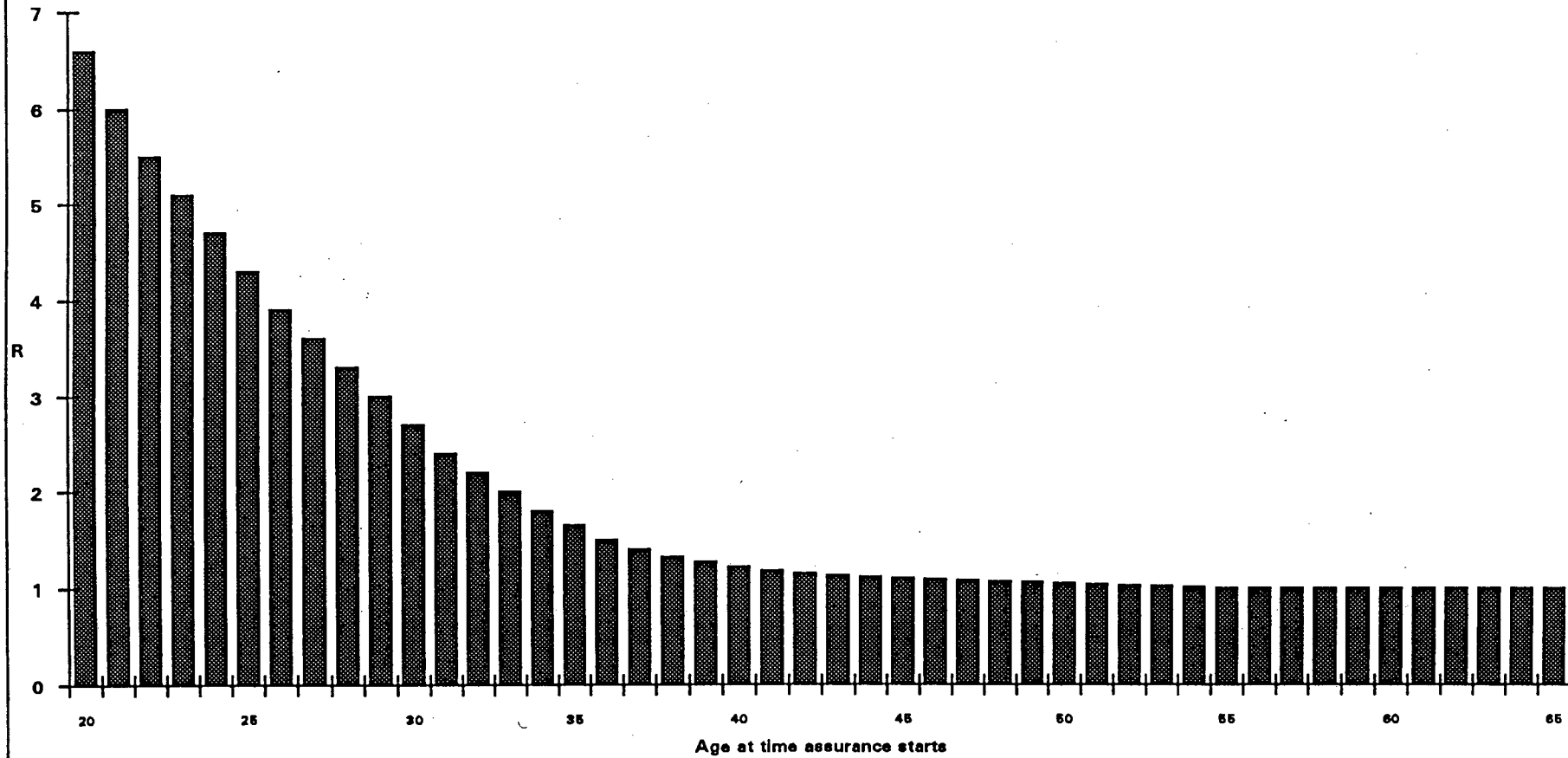
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<sup>119</sup>Schulze (n 111 at 81-82)

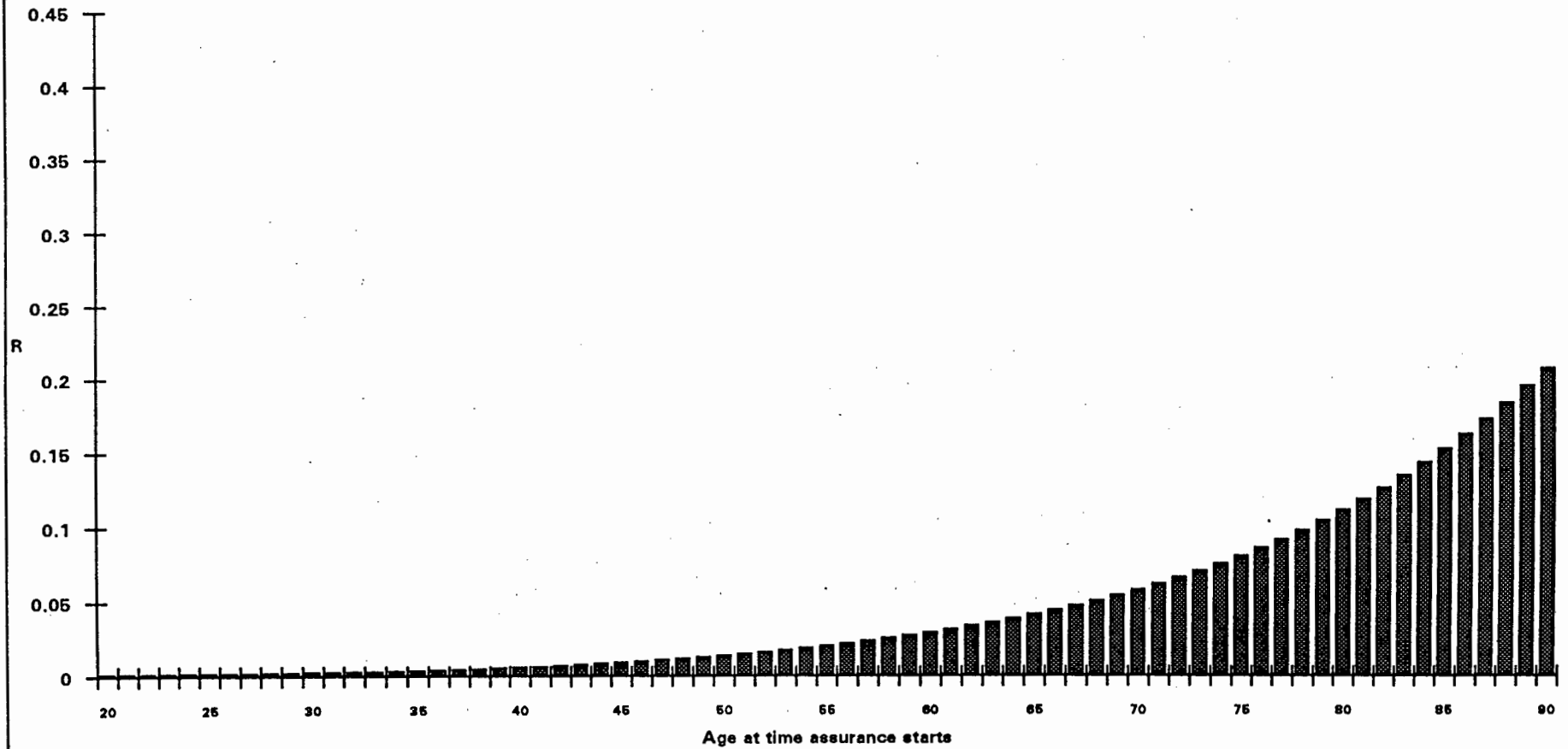
# RELATIVE MORTALITY OF 1000 LIVES AGED 35

	Average Life Expectancy	Annual Number of Deaths	Mortality Relative to Standard Life
* Standard Life	37	2	x 1
* Smoker	29	4	x 2
* Diabetic	23	8	x 4
* Coronary	20	10	x 5
* Quadraplegic	16	15	x 8
* HIV infected 2 years ago	8	15	x 8
* HIV infected 5 years ago	5	80	x 40
* HIV infected 8 years ago	3	135	x 68
* HIV infected 10 years ago	2	174	x 87
* Person with AIDS	1	500	x 250

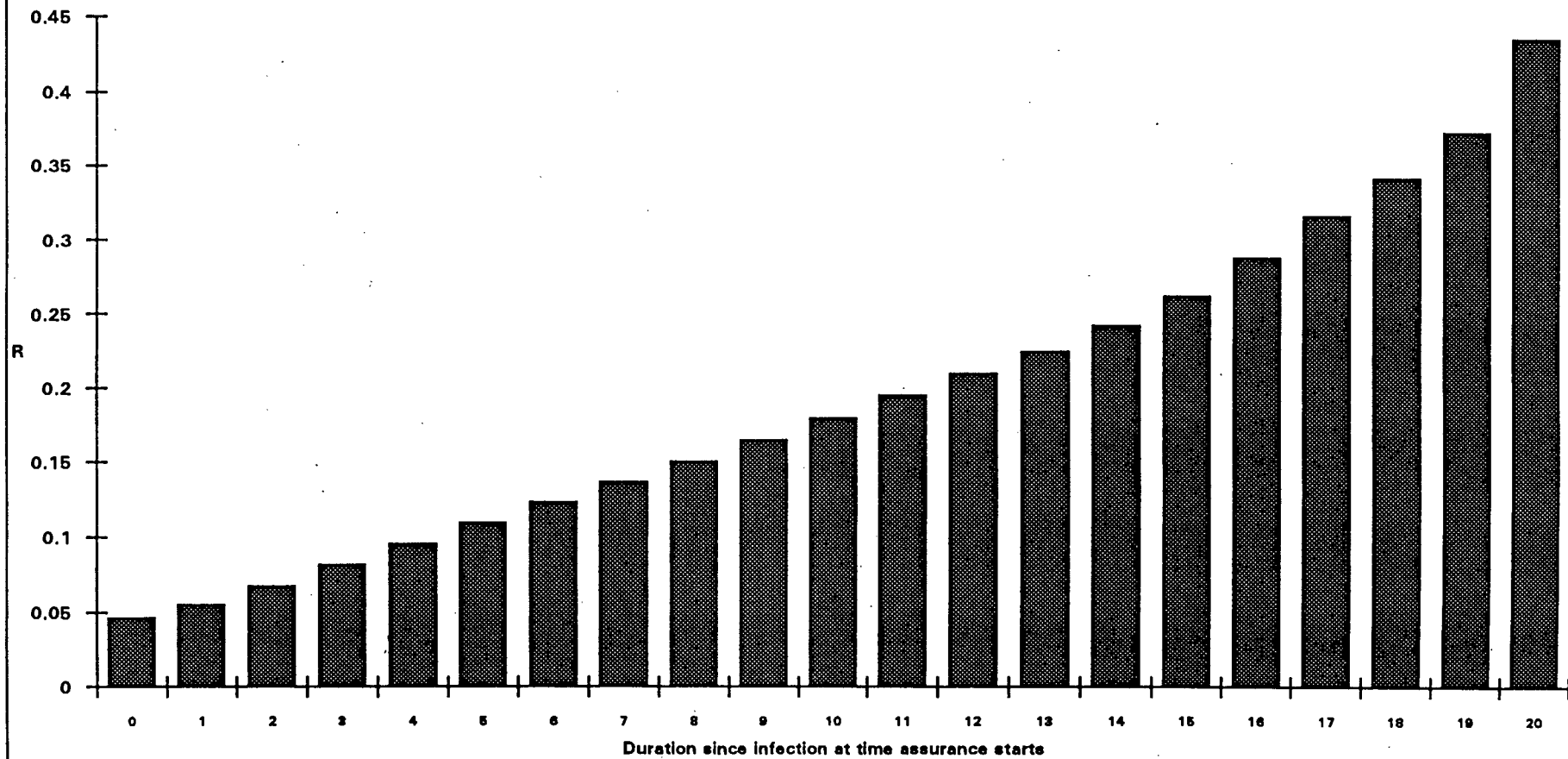
Ratio of Level Whole Life Premium Rates for HIV Tested Lives to Premium rates in an AIDS-free Environment



Level Whole Life Premium Rates per R1 Sum Assured in the Absence of AIDS



Level Whole Life Premium Rates per R1 Sum Assured for an HIV Positive Person



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