

2 South African Health System: a review

2.1 Overview

This section reviews the evolution of the South African health system, both public and private. This review provides a backdrop against which certain strategic challenges are identified in **section 14**, and provides the basis for recommended strategic reforms identified in later sections.

2.2 Public sector

2.2.1 Historical overview

One of the first pieces of legislation enacted of a purely medical nature was the “Contagious Disease Act” (No. 1 of 1856). This was to deal with regular outbreaks of measles and smallpox. In 1867 an epidemic struck Cape Town with a high mortality rate. This resulted in the enactment of the Contagious Diseases Act No. 25 of 1868. In Kimberly the government passed the Medical Tax Act in 1874 as a means of financing the provincial hospital. In terms of this legislation a fee of one shilling was levied upon each “native” worker for medical services on the diamond diggings. The diggers, however, opposed the Act and enforcement was deferred until 1882 when the various companies paid the levy for their “native” employees directly to the Cape government. (Ginwala, 1981).

The first Public Health Act was promulgated in South Africa in 1833 following a smallpox epidemic in Kimberly. For the first time vaccination and notification of infectious diseases was made compulsory in the Cape Colony. Extensive emergency powers were delegated to local authorities by the governor to permit officials to enter premises, and draw up and enforce quarantine regulations. Local authorities were given the power to establish hospitals and departments while the government advanced 50 percent of the costs of expenses and maintenance. (Ginwala, 1981).

The South Africa Act resulted from the National Convention of 1909 which created the Union of the four colonies, Cape of Good Hope, Natal, Transvaal, and the Orange River Colony. The Act made limited references to health care. The four Provincial Councils were endowed with various health and local government laws inherited from the Colonies. Local Authorities, by virtue of previous Colonial legislation and subsequent ordinances and under their local by-laws were responsible for environmental hygiene and measures to deal with outbreaks of infectious disease. There were however overlapping responsibilities and confusion with respect to public health. The influenza epidemic of 1919 exposed serious inadequacies in the existing responsibilities,

safeguards and procedures. This resulted in the Public Health Act No. 36 of 1919. (Ginwala, 1981).

In terms of the Public Health Act provincial administrations retained their responsibility of administration of local government and the establishment, maintenance and management of general hospitals and matters relating to charitable institutions and for pauper medical relief. The Act established the Department of Health with executive responsibility. The intention of the Act was to decentralise. The Department of Health was given powers to advise, assist and if necessary coerce the local authorities and provincial administration in fulfilling their public health responsibilities. (Ginwala, 1981).

Local authorities had as their primary role the control of infectious diseases and environmental sanitation. These functions were facilitated by the statutory provision for refunds in respect of certain staff and certain services for infectious diseases. The Act made a distinction between communicable and non-communicable disease. The State took responsibility for persons with a communicable disease through isolation and prevention of spread of infection. Responsibility of a person with non-communicable disease was accepted as part of pauper medical relief at provincial hospitals and district surgeons. For the majority of people provision of health care was an individual responsibility. (Ginwala, 1981).

Private hospitals were subdivided into those that existed for gain and those that did not. The non-profit hospitals were divided into those established for philanthropic reasons and those established to fulfil statutory requirements. Into the latter category fell the Mine and Indian Immigration Bureau hospitals that were developed in response to peculiarly South African arrangements of labour supply. The pre-Union Natal government levied a special tax upon employers of Indians, the proceeds of which were paid into a fund administered by the Indian Immigration Bureau and utilised to establish special hospitals under its control, and relieving the tax-payer of this particular burden. (Ginwala, 1981).

The Union Legislature in 1911 passed the Native Labour Regulation Act which imposed on the gold and other mining industries the duty of providing hygienic housing, adequate diet and hospitals for Native labourers employed by them. Tax was not imposed on the employers but in accordance with the regulations and its specifications, the employers provided hospitals. Equivalent legislation did not emerge in the instances of secondary industry. (Ginwala, 1981).

Mission hospitals were established in rural areas where no local authority capable of making a financial contribution. (Ginwala, 1981).

The Public Health Amendment Act of 1946 demarcated the functions of the Central Government and the Provinces. The provinces were responsible for general hospital services and outpatient services connected with their institutions while the government was to proceed with extra institutional services by the development of a system of health centres. The Act made provision for refunds to both provincial administrations and local authorities in respect of any outpatient services independent of general hospitals which either would institute. Difficulties in implementing services and funding however arose. (Ginwala, 1981).

In the period after 1948 health policy and planning became more determined by political rather than health criteria. The focus was essentially that of satisfying the needs of the white population. The Tomlinson Report of 1954 for instance recommended a separate "Bantu Health Service" which ended the moves of the Department of Health of the time to create a unitary system. The subsequent development of a homeland system in South Africa further fragmented service delivery and policy through the extension of numerous first tier government structures. In an attempt to co-ordinate the functions of the numerous health departments the Regional Health organisation of Southern Africa (RHOSA) was established in 1979. (van Rensburg et al, 1995, p.57).

The Health Act of 1977 for the first time included Provincial Administrations in the same way that local authorities were involved since the first Public health Act of 1883. Under this Act the Department of Health had the functions of co-ordinating health services rendered by Provincial Administrations and Local Authorities as well as to provide such additional services as may be necessary to establish a comprehensive health service for the population of the Republic of South Africa. (Ginwala, 1981).

According to Van Rensburg *et al* (1995) despite the fact that the Health Act 63 of 1977 intended to rationalise health care organisations by means of clearer definitions of the duties, powers and responsibilities of the respective authorities; to effect greater co-ordination between the various tiers of authority and to move to a nationally co-ordinated health policy, the Act had no real effect on the fragmentation embodied in the three tiers of authority and services. The provinces remained responsible for hospital services, local authorities were responsible for preventive and promotive care, and the central department was responsible for overall co-ordination. Two new bodies were created to achieve greater overall co-ordination: the Health Matters Advisory Committee and the National Health Policy Council.

The period from 1980 onward continued to be characterised by a high degree of fragmentation in the health services and policy co-ordination. The implementation of the homeland policy and the Tricameral system (in 1983) led to the breaking up of administrations into seventeen different political entities many of which had little political legitimacy. Although the four provincial administrations effectively covered the vast majority of the population, great disparities existed in resource allocations within and between provinces and between the provinces and homeland administrations. Public facilities were also segregated with separate services for the non-white population. In many instances this separation extended to entire facilities with separate white and non-white hospitals.

The Browne Commission, appointed in 1980 concluded in 1986 that there was excessive fragmentation of control over health services and a lack of policy direction, resulting in a misallocation of resources, duplication of services and poor communication between the various tiers.

The National Policy for Health Act 116 of 1990 repealed the sections of the Health Act related to policy-making structures. It made provision for the Minister of National Health and Population Development to determine policy. Three new bodies were established to assist in this, the Health Policy Council, and the Health Matters Committee. The Act attempted to co-ordinate health services and to diminish the role of provincial authorities. (Van Rensburg *et al*, 1995, p.59).

During 1989 to 1990 the public health system was officially desegregated technically generating a dual system based on income differentials. However, the former structure of the public sector system and its target population resulted in informal barriers to access that have survived the legal barriers. These barriers relate to **location**, i.e. many public facilities are situated in areas that make services inaccessible to the population now legally entitled to use them, and to the **appropriateness** of the service, i.e. many of the services and personnel are inappropriate for low-income and socio-economically deprived communities.

In the late 1980s and early 1990s the desegregation of public hospitals resulted in a dramatic growth in private hospitals. This growth in public hospital utilisation was mirrored by dramatic cost increases in medical aid costs experienced in these years.

2.2.2 Reforms from 1994

Subsequent to 1994 the public health system was reformed administratively along the lines of the new Constitution. Nine provincial health administrations were created responsible for the delivery of both hospital and primary health care. The provincial administrations transfer a portion of their

budgets to local authorities who also render primary health care services. Overall responsibility for health policy resides with the national Minister of Health supported by the national Department of Health.

Since 1994 a number of significant changes have occurred in the financial arrangements of government in general with major implications for the rendering of health services. These have included the introduction of a fiscal federal system affecting the financing and budgeting of virtually all significant social services, including health, social development and education.

These financial changes have impacted in a number of ways that have relevance to the overall principles and objectives of the health system based on a large number of reports. These include:

- (a) Budget levels;
- (b) Inter-provincial equity;
- (c) Revenue raised from medical schemes and other user charges; and
- (d) Staff retention within the public sector.

The central issue is whether the changes occurring within the public health system reflect explicit policy decisions, or are merely a consequence of structural difficulties in co-ordination and implementation to achieve centrally determined policy objectives. A key issue in this discussion is the role and extent of provincial discretion relative to national policy requirements and whether a proper balance is currently maintained.

For the 1995/96 and 1997/98 financial years the health budget for the country was determined centrally based on recommendations by the Health Function Committee. In the 1997/98 financial year the public sector officially switched over to a fiscal federal system whereby budgets for health were determined by provincial legislatures and not advised by national policy. The funds made available to provinces were allocated through an unconditional (equitable share) grant allocated from the national budget.

According to the recent National Health Accounts review (NHA Review) there has been a systematic overall and per capita decline in public health expenditure since 1996/97. According to the NHA Review this expenditure decline is in part attributable to the peculiarities of the fiscal federal system rather than to any explicit national policy decisions. Various studies as well as the NHA review have pointed out the inability of the health system to achieve national policy objectives with respect to equity as a consequence of the fiscal federal environment. Initial progress toward equity, prior to the introduction of the fiscal federal environment, appears to have reversed in the years since 1996/97. However, a significant contributor to the decline in health

budgets appears due to the decline in the overall allocations to provinces. (Thomas S. *et al*, 2000).

Table 2.1: Sources of Comprehensive Public Health Sector Financing, 1996/97-1998/99 (R million, real 1999/00 prices)

| Sources of Finance | 1996/97 | 1997/98 | 1998/99 |
|-----------------------------------|---------------|---------------|---------------|
| Local authority revenue | 845 | 963 | 996 |
| User fees from households | 499 | 418 | 340 |
| Provincial Government own revenue | 334 | 578 | 384 |
| Donors | 18 | 33 | 68 |
| Total | 30,941 | 32,963 | 32,695 |

Source: Thomas S. *et al*, 2000, p.133

Various problems relating to the budget system for health care were brought to light by the Committee reviews. The problems appear pervasive and impact significantly on the performance of the health delivery system. These are listed below:

- o Policy decisions concerning health care at a national level cannot be backed by resource flows as the provincial governments are responsible for budget setting for health services. As a consequence a fundamental public health principle, that of equity, is potentially undermined. There is also significant potential for policy fragmentation.
- o Budget allocations for health departments are declining in real terms in all provinces despite substantial emerging needs. No specific measures have been undertaken to deal with the service-related impact of HIV/AIDS.
- o The conditional grants allocated for teaching and research and supra-regional services (highly specialised services that are only available in a few provinces) are not linked to any specific services, and are apparently being reduced in real terms without any clearly defined policy framework.
- o Conditional grant allocations to provinces are undermined by provincial treasuries who dominate resource allocation decisions. As such the primary motivation for a "conditional" grant is substantially undermined. This appears to occur for all grants including the capital funds made available as conditional grants.

- o As yet no specific norms and standards that can be used for budget motivation and resource allocation have been satisfactorily developed. As such, the basis for resource allocation decisions cannot be defined.
- o The allocation of capital budgets for the health system is inefficient and in a number of provinces is still highly centralised, particularly where Public Works departments are used. The use of a dedicated Public Works department results in inefficiencies as the hospital or facility is several steps removed from the process of determining capital allocations and the procurement process. A large portion of the capital backlog in state hospitals can probably be attributed to the over-centralised budget process for capital allocations. In recent years this appears exacerbated by the centralisation at national level of hospital rehabilitation funds.
- o In recent years there has been a tendency for an increased level of funding for normal capital expenditure to be made available at a national level. Access to these funds is uncertain, difficult and bureaucratic. As a result, time periods between application, approval, draw-down and utilisation are so long that they exceed the financial year in which the funds were made available. The funding of capital backlogs in such a centralised manner is inefficient and probably leads to poor prioritisation. It also does not address the primary reason for the emergence of capital backlogs in the first place, i.e. the centralised and bureaucratic budgeting process for capital.
- o All funds raised in additional revenue from medical scheme and other private patients is not retained by the relevant cost-centre (i.e. the hospital). As such hospitals lose out financially when they treat private patients. The uncertainty associated with the return of funds is a fundamental factor undermining the ability of public hospitals to access non-tax revenue.
- o The Treasury Department is not applying a consistent approach with respect to mixed financing options within the public sector generally. This has particular relevance for the Health system, as a degree of flexibility between alternative revenue sources for public health institutions is a characteristic of all successful health systems. Such a framework generally regards additional revenue collected from user charges or pre-paid (capitation) user charges as *additional* to general revenues and hence not part of the tax system. This principle is not being applied in respect of public hospitals where such charges are effectively regarded as part of general tax revenue.

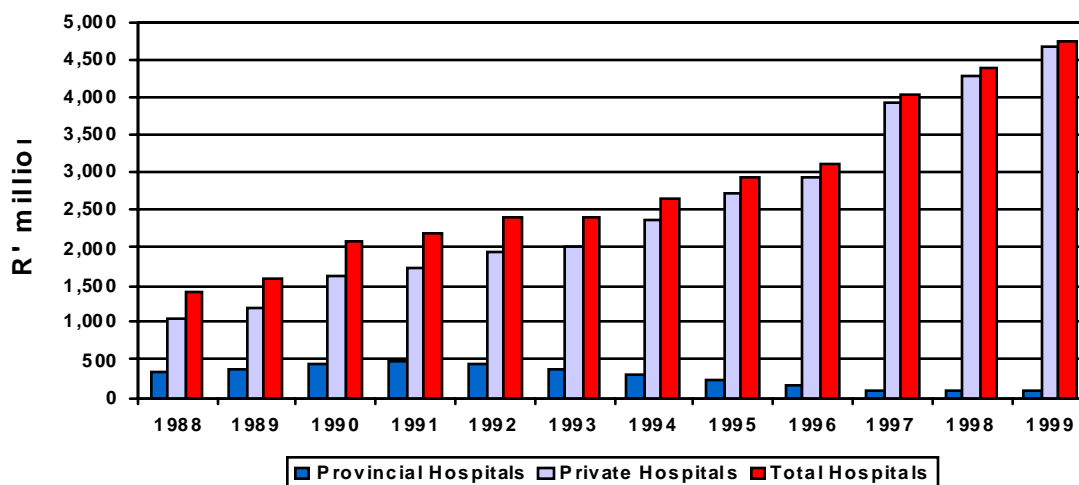
- o The current system of public finance for the health system is inflexible and inefficient. Institutions are generally uncertain about future budget allocations, despite the Medium-Term Expenditure Framework (MTEF). Additional allocations such as conditional grants or fees generated from private patients are undermined by budget cuts or not returned to the institution.
- o Hospital managers are disempowered in their ability to manage large and complex institutions. This is primarily a consequence of poor governance structures for hospitals rather than the quality of hospital managers. Despite the very large amounts of money they spend, the head of a hospital is not the accounting officer. They have little control over the appointment of staff, particularly their own support staff. Hospital boards do not have fiduciary responsibility for the hospitals they oversee, as a consequence the oversight value of the boards are minimal.
- o Hospital managers have little control over minor and major works budgets, expenditure and procurement. This, as much as tight financial conditions, plays a significant role in generating capital backlogs in institutions.
- o The budgeting system appears to involve an inconsistent mix of centralisation and decentralisation with respect to the public health. Firstly, budget allocations are decentralised to provinces resulting in a weakening of equity and other national policy objectives. Secondly, key aspects of the budget which are more appropriately managed with a high degree of decentralisation are at a national or provincial level. Thirdly, hospital managers have insufficient control over operational matters.
- o The system of user fees, charged at point of service, used by public hospitals relies on the application of a means test. This system is both dysfunctional and inequitable (as it is not evenly and consistently applied). This is discussed further below in **section 2.2.3**.

2.2.3 Private revenue sources

The public hospital sector currently charges fees for hospital services to higher income earners. Indigent patients receive free services. The fees charged are highly subsidized and invoiced at point-of-service. Invoices are also submitted to medical schemes. This system is highly inefficient as a source of revenue for public hospitals and needs to be substantially revised. The problems run fairly deep and cannot be resolved merely through improvements to the billing system or the setting of higher fees:

- (a) *The system of billing patients at point of service is complex*, especially where an assessment of the income status of the patient must be performed on the spot. Given the inability of the hospital to turn patients away, this assessment is not practical.
- (b) *Claims from non-medical scheme members*: Where patients are not members of a medical scheme, following up many small or even large unpaid accounts is costly and impossible to administer. Collections are only cost-effective where unpaid accounts are for greater amounts and smaller in volume. The majority of unpaid accounts from non-medical scheme members are however small and numerous (low-cost - high-volume). Given the enormous volume of activities occurring within health systems, the most efficient forms of funding involve bulk payments and billing.
- (c) *Retention of revenue*: As hospitals do not retain revenue, they have a reduced incentive to claim user fees or funds owed from medical schemes or related funds. However, the problem runs deeper than this. Retention of revenue would not materially alter the funding position of public hospitals if budgets are reduced to such an extent that they offset the additional revenue. Problems are:
- o *New patients*: Where additional revenue comes from patients formerly seen in private hospitals, the full cost of the services provided must be recovered. Where budgets are cut to offset new revenue from fees, public hospitals will be in a worse funding situation than before. New patients must be funded at full cost, and a net increase in the funding of the hospital by this amount should occur.
 - o *Previously non-paying patients*: Where patients are made to pay where formerly they used the service free of charge, a reduction in budget reduces the hospital to the position it was in when patients were not compelled to pay. Budget reductions in these instances will result in a reduced incentive to recover fees, and a consequent drop in services and service quality.

Figure 2.1: Real Total Medical Scheme Expenditure on Public and Private Hospitals (1995 prices) 1988 to 1999



Source: Council for Medical Schemes Statutory Returns 1988 to 1999

2.2.4 Compatibility with a contributory system

The existing financial management system of government is not compatible with any form of contributory system, whether fee-for-service or pre-paid in one form or another. It is more compatible with a tax funded free service. If it is a policy decision to include a contributory component to the public system, as is apparently the case at present, then the appropriate technical reforms are needed.

2.2.5 Health Care Personnel

There has been a substantial shift of key healthcare professionals out of the public sector. Only 45.5 percent of all professional nurses work in the public sector (based on the 1999 estimates). Over the past 10 years general practitioners have also moved out of the public system with a shift from 38.3 percent in 1989 to 22.5 percent in 1999.

At present only 37 percent of all surgery related specialists function within the public sector. Seventy five percent of all anesthetists work exclusively in the private sector.

Table 2.2: Distribution of healthcare professionals between the public and private sectors

| Staff | Total SA | Public** | | Private* | |
|-------------------------|----------|-----------|-------|-----------|-------|
| | | Total no. | % | Total no. | % |
| Period: 1989/90 | | | | | |
| Medical officer (GP) | 12,889 | 4,936 | 38.3% | 7,953 | 61.7% |
| Specialist | 5,595 | 1,891 | 33.8% | 3,704 | 66.2% |
| Pharmacist | 8,262 | 909 | 11.0% | 7,353 | 89.0% |
| Dentist | 3,111 | 218 | 7.0% | 2,893 | 93.0% |
| Period: 1998/99 | | | | | |
| Professional nurse*** | 90,923 | 41,401 | 45.5% | 49,522 | 54.5% |
| Staff nurse | 33,039 | 21,008 | 63.6% | 12,031 | 36.4% |
| Nursing assistant | 51,583 | 22,550 | 43.7% | 29,033 | 56.3% |
| Total nursing | 175,545 | 84,959 | 48.4% | 90,586 | 51.6% |
| Medical officer (GP)*** | 15,376 | 3,458 | 22.5% | 11,918 | 77.5% |
| Specialist*** | 6,136 | 1,741 | 28.4% | 4,395 | 71.6% |
| Pharmacist | 9,599 | 1,210 | 12.6% | 8,389 | 87.4% |
| Dentist | 3,482 | 471 | 13.5% | 3,011 | 86.5% |

Sources: *Sodelund *et al*, 1998, and **PERSAL 1999.

***These data were adjusted to full-time equivalents according to average salary costs and total expenditure for these personnel categories in 1998/99. Many doctors and some nurses only work part-time and therefore the PERSAL information used without adjustment distorts the actual number employed.

2.3 Private sector

2.3.1 Overview

No regulatory supervision of the private health system existed prior to 1956 after which schemes became regulated as Friendly Societies. From 1967 to 1975 medical schemes were regulated in terms of the Medical Schemes Act by both the Department of Health and the Registrar of Financial Institutions. From 1975 onward, medical schemes were regulated exclusively by the Department of Health. The policy underlying medical scheme regulation shifted considerably over time. A review is provided below of the historical evolution of the private health system in South Africa, drawing on a paper produced for the Melamet Commission (1994).

2.3.2 Prior to Supervision: 1889 to 1955

The first “medical scheme” in South Africa was the De Beers Consolidated Mines Ltd. Benefit Society, established in 1889. By 1910 seven such schemes were in existence.

At the creation of the Union of South Africa in 1909, no co-ordinated health system existed in the country. A centralised authority for co-ordinating health activities was only created ten years later in response to the influenza epidemic of 1919. This was incorporated in the Public Health Act, No. 36 of 1919, and resulted in a three tier public sector structure of central government, provincial administrators and local authorities. A system of private practitioners developed outside of the public system but there was no regulation of private sector schemes.

By the beginning of the Second World War in 1940 there were 48 medical schemes. After the War the significant increase in the number of schemes generated a need for some regulation. Consequently in 1950 the *Advisory Council for Medical Fund Societies* was formed. Its role was to act as a representative for the affiliated schemes in negotiations with the Medical Association of South Africa. Before 1956, however, there was no regulation of the behaviour of medical schemes.

2.3.3 Supervision as Friendly Societies

On 31 December 1956 the **Friendly Societies Act, No. 25 of 1956**, came into effect. All schemes (with a few exceptions) were required to register as Friendly Societies before they could operate. The controls applied by this Act were primarily financial in nature.

The feeling of the **Reinach Committee** (1962) was that although the registration of schemes would lead to greater stability, more comprehensive legislation would be required to control all other aspects of medical insurance. A consequence of the lack of legislation was that until the late 1960s no uniformity would exist within private sector healthcare. Schemes varied significantly in the coverage they offered.

Requests were made to the House of Assembly to set up a countrywide medical scheme in the 1950s to ensure coverage for the entire white population. In 1959 the private sector took the initiative and started the **“Plan for Medical Services”**. The scheme was initiated, administered and controlled by doctors, and used its own schedule of tariffs which were higher than the preferential tariffs applied to other schemes. The plan offered 100 percent benefits for services offered by medical practitioners and hospitals, but excluded dentistry and medicines. Members had no say in the administration or determination of membership fees or benefits.

Some employee organisations advocated a National Health Scheme while others supported a comprehensive state-supported “existence-protection” scheme which included schemes. However, most were not in favour of amalgamation.

By 1960 there were 169 schemes providing cover for 368,890 members and 588,997 dependants. These schemes served the needs of the white middle class, especially those in urban areas. The importance of this type of scheme can be seen in the rapid growth in coverage that this form of scheme provided for the predominantly middle class white population. For whites over a period of 15 years from 1945 to 1960, coverage grew from 48 percent to 80 percent of the eligible population.

By 1960 virtually all whites in South Africa had shifted away from the free services provided by government. On the other hand, 95 percent of non-whites were reliant on public sector services which were largely free. By this time membership of medical schemes had effectively become mandatory for whites due to it being a condition of employment and given that virtually all whites were formally employed. Pensioner members of many schemes received the same medical benefits as ordinary members, but **free of costs**.

In 1960 three types of scheme existed:

- a) *Sick Funds*: This was the oldest type of scheme (and still the largest in 1960). Members paid fees or premiums in return for comprehensive cover for medical services and medicines. The member's choice was limited to a panel of permanent and/or temporary medical practitioners who were remunerated on a capitation basis. Sick funds were crude fore-runners of pre-paid plans equivalent to health maintenance organisations (HMOs) and independent practitioner associations (IPAs).
- b) *Benefit Funds*: (Not to be confused with benefit funds registered under either the old Friendly Societies Act or the Income Tax Act). Benefit funds evolved from sick funds which was how many had begun. Members paid a premium which permitted a free choice of practitioners who were reimbursed on the basis of a preferential tariff per service. The member had to pay a percentage of the bill with percentages varying according to membership fees and benefits. Funds were organised by groups of professions or medical practitioners. No clear distinction existed between sick funds and benefit funds with differences depending upon benefits and reimbursement methods.

- c) *Assurance Schemes*: Assurance schemes originated as a means of supplementing the benefits of benefit funds. These schemes functioned on the basis of a third party taking the initiative to provide medical cover for profit.

Many medical practitioners shifted into sick and benefit funds due to the large number of patients they were able to access in this way. However, a significant number of medical practitioners also provided full-time and/or part-time health services according to Government or provincial tariffs.

The Advisory Council for Medical Schemes, and virtually all schemes, were of the view that there should be *mandatory membership* of medical schemes. The basis of the view was that this would ensure the effective spread of risk by admitting the ill and old, as well as the young and healthy, which would result in schemes becoming increasingly viable.

The *Reinach Committee*, however, did not recommend mandatory insurance on the basis that "mandatory membership by means of legislation was not necessary because most existing schemes had, on their own initiative, moved to mandatory membership." Although it was noted by the Reinach Committee that 55 schemes offered additional benefits such as sick leave payments, mortality benefits, funeral costs and disability insurance, it was felt that medical cover should be dealt with separately.

The *Snyman Commission*, which incorporated the recommendations of the Reinach Committee, reported in 1962. Some of the important comments and recommendations were:

- o There should be fixed tariffs for medical services for all groups of patients. A number of benefits were expected: This would have the positive effect that households could, to a greater extent, budget timeously for medical expenses. With fixed tariffs, expenses to suppliers would be stabilised and the spread of cost maximised. This system would also limit the State's need to further enter the field of medical services. It would preserve the patient-doctor relationship and trust.
- o With the imposition of fixed tariffs, high income patients should pay higher premiums to cross-subsidise low-income patients.
- o To preserve personal initiative, own choice and variety, and to prevent possible disruption of the present system, the institution of a single (national) scheme should be avoided. The development and stabilising of present institutions and the founding of new benefit funds was preferred.
- o A Central Fund should be instituted to which each scheme should contribute in order to make provision for extraordinary expenses not covered by the schemes.

- At least half the managing bodies of schemes should consist of members of the scheme which were elected by the scheme.
- No scheme must be allowed to offer additional benefits that are not of a medical nature.
- No scheme must be registered if it does not make provision for dependants of members.
- Pensioners and widows of deceased members with their dependants must be allowed to continue their membership against premiums that are the same as other members' premiums in the same group.
- If a person was a member of a scheme and has changed job, they must be allowed as a member by the scheme of the new employer without preconditions such as waiting periods, age restrictions or medical reports.
- There is a need for cover for smaller groups or individuals who are not in a position to make arrangements for medical insurance.
- If an assurance company undertakes medical insurance, it must be subjected to the same legislation as other independent schemes.
- New legislation must be created in which the relevant financial and other provisions of the **Friendly Societies' Act, No. 25 of 1956**, are to be absorbed. Such legislation must also make provision for the establishment of a central council for schemes and the necessary machinery to give effect to the legislation under the authority of the Department of Health.
- The reasons for the rising cost of medical expenses are so inherently connected with the quality and quantity of service that they will, to a great extent, prevail in the future. The final conclusion is that global medical expenses will remain high and might even rise further.

These recommendations, and subsequent debate, resulted in the **Medical Schemes Act, No. 72 of 1967**.

2.3.4 Supervision under the first Medical Schemes Act: 1967

The intentions of the **Medical Schemes Act, No. 72 of 1967** ("the 1967 Act") were (Hansard, 1967):

- To invent an insurance type of scheme to distribute the costs of medical expenses over a period of years;
- To retain the costs of medical expenses at a low level; and
- To co-ordinate and control the functioning of medical benefit and medical aid funds and to develop and propagate these schemes.

The initial Medical Schemes Act resulted in the creation of two important bodies. The first was the *Central Council for Medical Schemes*, the functions of which were to:

- Control, promote, encourage and co-ordinate the establishment, development and functioning of medical schemes;
- Investigate complaints and settle disputes in relation to the affairs of registered medical schemes; and
- Perform such other functions as may be prescribed.

In addition the Act allowed for the appointment, by the Minister of Health, of a *Registrar of Medical Schemes* who would perform the duties assigned to the position by the Minister or the Secretary for Health. (Original Medical Schemes Act, No. 72 of 1967).

2.3.5 The Regulation of Tariffs and Payments: 1968 to 1986

Until this time, much emphasis had been placed on the regulation of tariffs set with the medical profession. The setting of medical fees between medical schemes and the medical profession was always a problem and a source of conflict. The Medical Association often objected to the fees that were set and the arbitration mechanism. This resulted in many doctors choosing to opt out of the tariff of fees system. If a medical practitioner was contracted in, then payment of the account was guaranteed by law. This provided an incentive for doctors to remain contracted in.

In order to resolve this conflict, a Remuneration Committee was set up in terms of the **Amendment Act, No. 95 of 1969**, to investigate the tariff of fees at least every two years. The objective of this amendment was to improve the arbitration mechanism such that disputes would not result in further doctors choosing to opt out of the tariff of fees system which was regarded as damaging to doctor/patient relationships.

However, the medical profession eventually regarded the Remuneration Committee in a negative light. Allegations were made that the Act was being used to control the medical profession and that the inflexible provisions relating to the Remuneration Committee were financially prejudicial to medical practitioners and dentists. By 1978 the Dental Society and the Medical Association indicated that they were no longer prepared to participate in the activities of the Remuneration Committee. Consideration had been given to regulating against the free choice of doctors to contract out. However, publication of draft legislation to this effect resulted in a further 1,600 medical practitioners deciding to contract out. By this time 3,941 out of a total of around 14,000 medical practitioners had already contracted out.

As a consequence of these conflicts, the **Amendment Act, No. 51 of 1978**, abolished the Remuneration Committee and the Commission that made recommendations to the Council on fees. Provision was made for the Medical and Dental Council to determine fees. This was allowed

on condition that it prevent further contracting out. If not successful the Minister would step in to regulate the ability of the medical profession to contract out.

The **Amendment Act, No. 42 of 1980**, made provision for contracted in doctors to send accounts *directly* to medical schemes. This issue had been a constant source of conflict between medical practitioners and government. The previous dispensation only allowed accounts to be sent to patients who had to pass them on to the medical scheme. Medical practitioners argued that this caused extensive delays and reduced the benefit for contracted-in doctors of guaranteed payment.

However, the *Browne Commission* (1986) recommended very strongly in its interim report that the provision allowing direct payment be scrapped and that the doctor send the first and second account to the patient and only the third directly to the medical scheme. Upon receipt of the account, the scheme was required by law to pay within six weeks.

The **Amendment Act, No. 59 of 1984**, effectively eliminated the principle of contracting in and contracting-out. Any profession or supplier of a service was allowed to determine its own tariffs through their respective statutory control bodies. The *Representative Association of Medical Schemes* (RAMS) was allowed to determine a scale of fees after consultation with representatives of suppliers of services. If a service supplier were to charge fees equal to or less than the fees indicated on the scale of benefits, the medical scheme was required to pay the supplier of the service directly, provided the scheme offered that benefit.

2.3.6 The “Free Market” Reforms: 1984 to 1988

By 1980 it began to be recognised that there were too many medical schemes with a consequent inadequate spread of risk.

The amendments to the Medical Schemes Act in the **Amendment Act, No. 59 of 1984**, had the following objectives:

- a) To have a health service which the ordinary person will be able to afford;
- b) To achieve optimal security of cover by medical schemes to save their members from a financial catastrophe in times of serious or lengthy illness;
- c) To create and maintain, in the interest of medical care, the best possible doctor/patient relationship; and
- d) To prevent the socialisation of health services.

The prevention of a “socialised health system” became a recurrent theme in many parliamentary debates over amendments to the Act toward the end of the 1970s and for most of the 1980s. The extension of the private sector was seen as an important mechanism for preventing the government from having to take on any direct additional burdens with respect to healthcare. By this stage government still regulated the *minimum benefits* which all schemes were required to provide.

The *Browne Commission*, which reported in 1986, developed a free-market theme where it saw the public interest served through the gradual privatisation of the public health service. This was followed by a White Paper on the Commission which largely accepted its recommendations and set the scene for the **Amendment Act of 1988**.

The key recommendations accepted by the government were:

- Benefit Schemes should not be compelled to become aid schemes (7.1.1.(2)).
- In-house schemes should not be compelled to dissolve or to join other or larger schemes (7.1.1.(3)).
- Schemes exempted in terms of the provisions of section 3 of the Medical Schemes Act should not be compelled to register under the Medical Schemes Act (7.1.1.(4)).
- The operation of the free market should determine the number of schemes (7.1.1.(5)).
- That 25 percent of contributions may be an excessive level of reserve to cater for increase in tariffs, but that it should be maintained as a guide for the time being: Provided that the Central Council for Medical Schemes consider this matter. Additional reserves for pensioners should, however, be established according to the circumstances of the scheme (7.3.1 (1)).
- Medical schemes should consider expanding their range of services by running their own private hospitals and dispensaries (7.5.1. (2)).
- The establishment of an additional type of medical cover for insurance for members who exceeded the annual maximum benefit be considered. (7.6.1).
- All employers who have not yet made provision for their employees to join some registered medical scheme should now seriously consider doing so. (7.9.1 (3)).
- A major effort should be made to make suppliers of services aware of the fact that they can play an important role in curbing over-utilisation of services and have a great responsibility in this regard (7.12.1(2)).
- The market for medical coverage should attempt to devise a voluntary insurance system with a view to covering additional medical costs. If a satisfactory system can be devised the necessary statutory amendments should be made to make the establishment of such a system possible. (7.15.1(2) and (3)).

Key recommendations not accepted by government were:

- The government rejected proposals that compulsory minimum benefits be removed on the grounds that “otherwise those members who do not have minimum cover would simply turn to the State for assistance.” (7.6.2)
- The Government rejected the idea of a scheme being set up purely to cater for the aged on the grounds that “there is already sufficient provision for medical services for such aged persons. Owing to the high claims experienced in the case of aged persons and the fact that no employer’s contributions will be payable in respect of them, the Government believes that the proposed scheme would result in an escalation rather than a saving in costs.”

The *Browne Commission* made various suggestions supporting the application of *risk-rating* and *experience-rating* within the Medical Schemes Act :

“Greater flexibility in contribution rate determination should be allowed, enabling schemes to charge different contribution rates for different classes of risk. Provision could also be made for allowing different levels of benefit to be chosen by groups or individuals to satisfy their needs. This will encourage merging of small schemes with larger ones, resulting in increased administrative efficiency. In some cases significant cost savings could be achieved if the member paid small claims himself and was only allowed to claim from the scheme after a specific amount had been paid by himself.”

The *Browne Commission* supported a “free-market” approach to health service provision in South Africa, with the public sector only taking responsibility for indigent patients. It supported the development of health insurance as a complementary form of private health cover, as well as the development of group-related underwriting, i.e. risk-rating. However, it also supported the extension of compulsory medical aid cover through employers although no concrete recommendations were made in this regard.

Measures to curb provider induced cost/expenditure increases were very soft with no concrete measures recommended. Recommendations concerning the introduction of risk-rating were seen as a measure to encourage the merging of smaller into larger schemes.

The Commission regarded risk-rating as having the potential to achieve significant cost saving through making the consumer bear the cost of low-cost high-frequency claims (general

practitioner visits). Although these recommendations were apparently not accepted in the White Paper, they were nevertheless introduced in 1989 amendments to regulation.

2.3.7 The “Freedom” to Risk Rate: 1989 to 1994

Prior to 1989, a medical scheme registered under the Act was *only* entitled to vary the rate of members' contributions based on their income and their number of dependants. In 1989 a significant modification to the environment was introduced in the form of a change to Regulation 8 of the Medical Schemes Act.

According to the modified regulation, a member's contributions could be based on: number of dependants; income level; age; geographic area; actual claims experience; extent of cover provided; period of membership; and size of group to which member belongs.

This regulation allowed medical schemes to introduce *risk-rating* into the management of medical schemes, i.e. schemes were free to eliminate existing cross-subsidies within schemes. Although this was of little immediate significance to employer-based medical schemes, open schemes were affected.

The rationale for the change in direction in thinking was clear : the authorities regarded moral hazard on the part of the consumer as the most important variable in achieving cost-containment. In addition the insurance industry was beginning to perpetuate the view that cross-subsidies within health insurance are unfair.

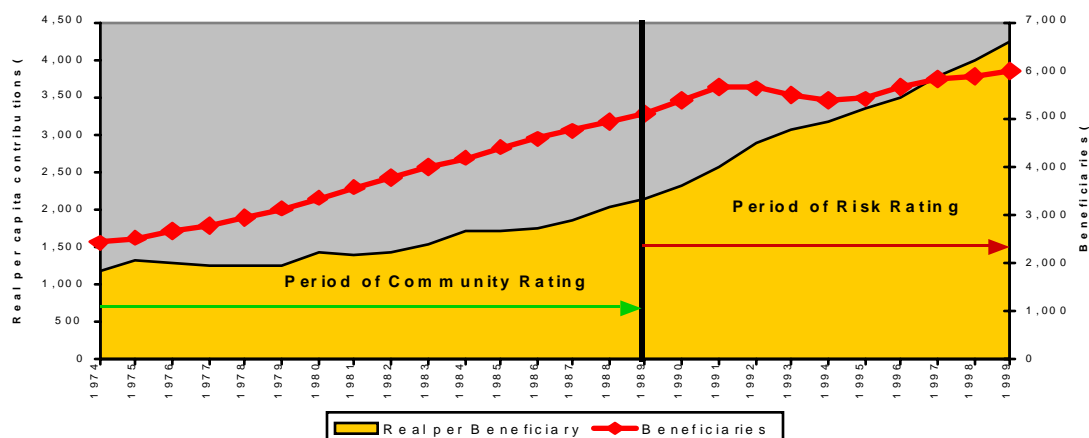
The **Amendment Act, No. 23 of 1993. No Act in 1994** to the **Medical Schemes Act** introduced further far-reaching changes in legislation. Statutory guaranteed *minimum benefits* and *guaranteed payment* for claims were removed from the Act. Schemes would be able to exclude or limit cover for procedures, and risk-rate to a greater extent. However, the Act also gave medical schemes the ability to directly supply healthcare services for members. In essence medical schemes were allowed to own and run clinics and hospitals, employ doctors, nurses, physiotherapists and pharmacists.

Two alternative tendencies were being permitted by the regulatory structure. The first offered medical schemes, through their administrators, the opportunity to compete with insurance products on the basis of risk-rating. Here cost containment occurs through attempting to control consumer behaviour. The second allowed schemes the opportunity to contain costs in the longer term through gaining greater control over the supply of medical services.

An amendment was also introduced allowing schemes to “provide additional cover for members by way of insurance, reinsurance or in any other manner whatsoever or, subject to the provisions of any law relating to insurance, underwrite or provide for such cover”. (20B(5)(d)). The consequence of this amendment may have been that insurance products got channelled through medical schemes acting as fronts for insurance companies and removing their reserves as profits.

The history of the medical schemes movement and its regulation, shows a drift from solidarity principles which defined the original schemes, to individualising health cover. To some extent this drift was slowed due to the predominance of employer-based schemes which indirectly provided compulsory membership on all employees above a particular income level. Where schemes were able to protect their membership base in this way, insurance products lacked influence. However, at no stage in this development had expenditure trends shown any abatement. From 1989 real per capita expenditure grows more steeply than during the community rated period, while beneficiary increases slow down. The slow-down in beneficiary growth is related to contributions growing faster than real incomes. (Figure 2.2).

Figure 2.2: Registered medical schemes: Per capita real expenditure and changes in beneficiaries



Source: **Council for Medical Schemes**, Compiled by the Centre for Actuarial Research, UCT

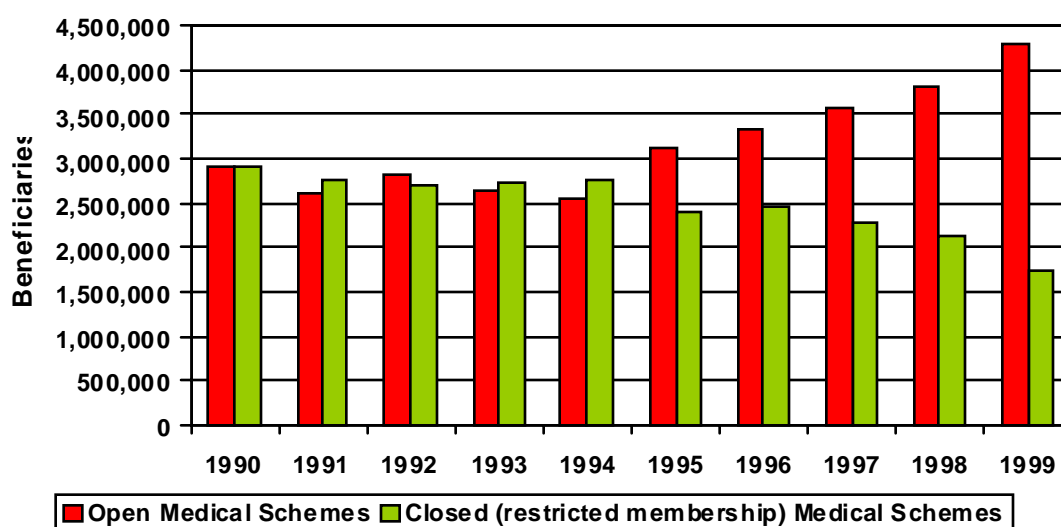
In 1994 the *Melamet Commission* reported and recommended further deregulation on the basis that insurance products represented the best way of providing health cover. It also recommended that all health cover be governed by a single Act, and that the remaining legislation preventing

insurance products from being registered as medical schemes be removed. These recommendations, if implemented, would represent the final stage of a shift from medical schemes to insurance as a way of providing health cover within the private sector.

The philosophy supporting this trend suggested that there was no market failure within the healthcare market, except that resulting from moral hazard on the part of the consumer of healthcare. It recognised no strong requirement for an agency function on the part of the third-party payer, and regarded market forces as the primary factor that would achieve a socially desirable outcome.

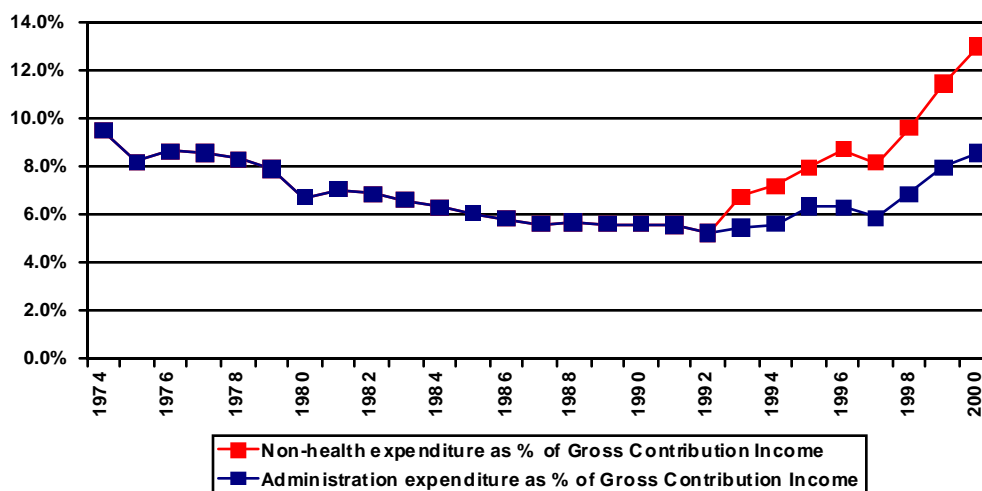
The trends that emerged from the 1993 deregulation, however, do not support these views. After 1993 a significant shift occurred within the medical schemes environment, with de-facto for-profit open schemes (medical schemes operating as conduits for insurance companies) strongly incentivising broker organisations to cannibalise restricted membership schemes. From 1993 to 1999 the percentage of people covered in open schemes changed from 49 percent to 71 percent. (Figure 2.3). At the same time substantial increases in administration and other non-medical expenditure begin to occur. Whereas in 1992 non-medical expenditure averaged less than 6 percent of scheme Gross Contribution Income (GCI), by 2000 it grew to more than 13 percent of GCI. (See figure 2.4). From 1992 to 1999 (8 years) there was a 243.5 percent real increase in non-health expenditure with only a 6.5 percent increase in beneficiaries.

Figure 2.3: Medical Scheme Beneficiary Changes for Open and Closed Medical Schemes, 1990 to 1999



Source: Council for Medical Schemes

Figure 2.4: Medical Scheme Beneficiary Changes for Open and Closed Medical Schemes, 1990 to 1999

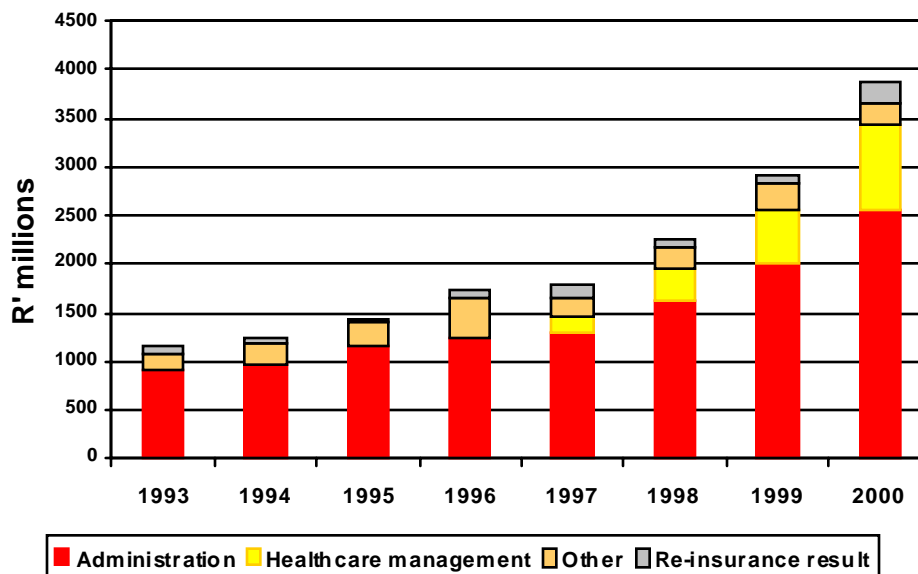


Source: Council for Medical Schemes

The additional non-medical expenditure emerging within the medical schemes environment apparently reflect profit-taking from schemes (via reinsurance and higher administration fees) and very high and hidden commissions paid by administrators to broker organisations. Whereas in the past higher medical costs caused the increasing costs for schemes, from 1993 the ability of “commercial” open schemes to charge higher tariffs within what appears to be a largely *price inflexible* environment resulted in an additional layer of cost added to scheme contributions.

Overall, however, during this period benefits declined and the older and sicker membership were excluded from cover to a greater extent. By 1999 no open scheme was permitting anyone over the age of 55 to join as an individual member. Virtually all open schemes applied life-time exclusions for pre-existing conditions, and age-rated and/or experience rated their membership without restriction. As such, by 1999 the majority of medical scheme membership were in an environment which excluded vulnerable groups from cover (e.g. the old and those with chronic conditions), where medical costs continued to rise (due to the retention of fee-for-service reimbursement) and where non-medical costs were driven up (through profit taking and hidden commission costs).

Figure 2.5: Non-medical Cost Trends from 1993 to 2000 (Rands)



Source: Council for Medical Schemes

The net result of the 1989 and 1993 deregulation was a significant increase in cost, a general reduction in benefits within schemes, and the virtual elimination of cover for vulnerable groups within the open scheme environment. These trends are consistent with international experience with voluntary health insurance markets.

2.3.8 Returning to Social Solidarity: 1994 to 1999

The direction recommended by the Melamet Commission was rejected by the new Government and replaced by a strategic direction which emerged from the 1995 National Health Insurance Committee of Inquiry. Although the focus of this report was on a system of National Health Insurance, medical scheme reform featured prominently.

Policy directions that were supported by the analysis adhered to the following four objectives

- The regulatory structure should reinforce the *agency function* of the third-party payer. This was seen as a fundamental requirement for empowering the consumer of health insurance and healthcare.
- In order to limit confusion in the market, the regulatory structure should reinforce *uniformity* in the benefit structure of medical schemes. This would enable people to make effective decisions in their own favour.

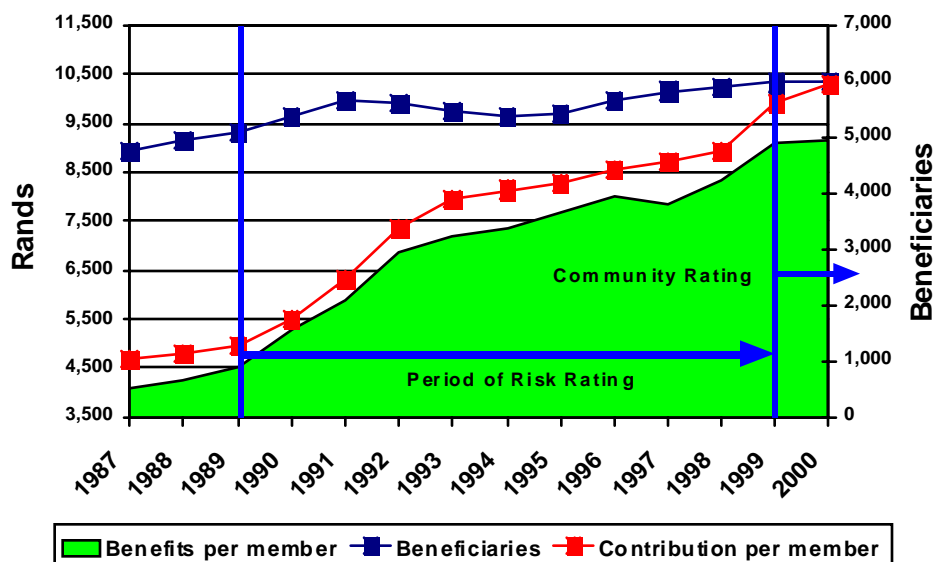
- Schemes should operate on the basis of *solidarity*, i.e. that groups do not get treated differently within a scheme. This remains a structurally rational manner in which to provide coverage.

The overall system should create a rational system of risk-sharing between as large a group as possible and, in the longer-term, ensure the availability of a *minimum level of cover* for all within the public and private sectors.

The recommendations flowing from the analysis of industry issues were largely incorporated in the **Medical Schemes Act, No. 131 of 1998**. The 1998 Act came into effect on February 1999 and key Regulations under the Act came into effect on 1 January 2000.

One year after the introduction of the reforms real per capita medical costs showed virtually no real increase (0.5 percent), while non-medical costs increased by more than inflation (4 percent). Thus the trend in increased non-medical costs continued as before. The effect of the new reforms on medical cost increases therefore appears to be deflationary. However, savings on medical costs were not passed on to members. Increased profit taking, through administration fees and quota share reinsurance (used to move the underwriting surplus of a scheme to the administrator as profit), saw virtually all the improvements from cost-containment disappear as gains to intermediaries (administrators, brokers, managed care companies). (See **figure 2.6**).

Figure 2.6: Medical Scheme Real Cost per Beneficiary and Benefit Trends, 1993 to 2000



Source: Council for Medical Schemes

(Note: During 2000 certain previously exempted schemes were required to register as medical schemes. This amounted to an additional 500,000 beneficiaries becoming part of the reporting system affecting medical schemes. These were mostly closed schemes covering certain public sector groups or large parastatals, e.g. Transmed, Medcor, etc.. The analysis in this section excluded these new groups to allow comparison of comparable data through time.)

2.4 Concluding Remarks

Until 1994 the health system was splitting markedly into a public sector focused exclusively on the indigent or those without medical scheme cover and private sector focused on the young and healthy employed population. The trends were well established by 1994 with a need for substantial intervention to change direction.

The period of medical scheme risk-rating indicates suggests that underlying medical cost increases were not affected by cost-shifting onto individuals. In fact the reverse is true. Increased underwriting and risk-rating increased the growth in private expenditure, slowing down the growth in medical scheme membership.