SOCIAL SECURITY – MEDICARE

1993

JAN. ___ JUNE

Rescue team for Africa

(299)

STAR 8/1/93.

Pretoria Correspondent

One of the largest international medical rescue services has relocated its operations centre to Grand Central Airport, midway between Pretoria and Johannesburg, and claims to have the edge in rescuing travellers north of the border.

With African countries attracting a large number of South African travellers, the incidence of people becoming ill or being injured and requiring repatriation is on the increase, said Munro Deysel, managing director of Europ Assistance SA.

Last year the company handled 1 000 air evacuations of travellers from African countries, transporting them back to South Africa where the medical care is more sophisticated and reliable.

Deysel said they expected the number of evacuations to rise substantially this year.

The company has its own R4,5 million Bell Long Range Helicopter and a road ambulance based at the airport.

Ready to be loaded at any time is R2,5 million worth of miniaturised aviation medical equipment, kept in a hangar at the airport. This includes an incubator, ventilators, basic life monitors and pulse oximeters.

A locality sketch of the area affected by the proposed jetty lies for inspection at the office of the Chief Director: Nature and Environmental Conservation, Provincial Administration of the Cape of Good Hope, Room 302, Utilitas Building, Dorp Street, Cape Town.

Objections to the proposed lease must be lodged with the Chief Director: Nature and Environmental Conservation, Private Bag X9086, Cape Town, 8000, on or before 8 February 1993.

(8 January 1993)

'n Liggingsplan van die gebied wat deur die voorgestelde aanlegsteier geraak word, lê ter insae by die kantoor van die Hoofdirekteur: Natuur- en Omgewingsbewaring, Provinsiale Administrasie van die Kaap die Goeie Hoop, Kamer 302, Utilitasgebou, Dorpstraat, Kaapstad.

Besware teen die voorgestelde verhuring moet by die Hoofdirekteur: Natuur- en Omgewingsbewaring, Privaatsak X9086, Kaapstad, 8000, ingedien word voor of op 8 Februarie 1993.

(8 Januarie 1993)

NOTICE 10 OF 1993

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES: SCALE OF BENEFITS IN RESPECT OF SERVICES RENDERED BY MEDICAL PRACTITIONERS

The following pages must be substituted in General Notice 1086 of 1992, published in *Government Gazette* No. 14433 dated 4 December 1992.

S. J. ROODT,

Chairman: Representative Association
of Medical Schemes.

(8 January 1993)

KENNISGEWING 10 VAN 1993

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING

VERTEENWOORDIGENDE VERENIGING VAN MEDIESE SKEMAS: VOORDELESKAAL TEN OPSIGTE VAN DIENSTE GELEWER DEUR GENEESHERE

Die volgende bladsye moet vervang word in Algemene Kennisgewing 1086 van 1992, gepubliseer in *Staatskoerant* 14433 gedateer 4 Desember 1992.

S. J. ROODT,

Voorsitter: Verteenwoordigende Vereniging
van Mediese Skemas.

(8 Januarie 1993)

LEGEND/BESKRYWING

10	Anaesthetics/Narkose	24	Neurosurgery/Neurochirurgie	38	Radiology/Radiologie
12	Dermatology/Dermatologie	26	Ophthalmology/Oftalmologie	40	Radiotherapy/Radioterapie
14/15	General Practitioner/Huisarts	28	Orthopaedics/Ortopedie	42	Surgery/Chirurgie
16	Gynaecology/Ginekologie	30	Otorhinolaryngology/Oor, Neus en Keel	44	Thoracic Surgery/Torakale Chirurgie
18	Physicians/Interniste	32	Paediatrics/Pediatrie	46	Urology/Urologie
20	Neurology/Neurologie	34	Physical Medicine/Fisiese Geneeskunde	52	Clinical Pathology/Kliniese Patologie
22	Psychiatry/Psigiatrie	36	Plastic Surgery/Plastiese Chirurgie	53	Anatomical Pathology/Anatomiese Patologie

CONSULTATIVE SERVICES (Continued)/**KONSULTATIEWE DIENSTE** (Vervolg)

0107 Exclusive attendance to baby at caesarean section, normal delivery or visit in the ward / Uitsluitlike bystand aan baba by keisersnee, normale bevalling of besoek in saal:

	10	12	14/15	16	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	52	53
U/E	-	-	22,00	-	-	-	-	-	-	-	-	33,00	-	-	-	-	-	-	-	-	-
R	-	-	62,50	-	-	-	-	-	-	-	-	93,70	-	-	-	-	-	-	-	-	-

SUBSEQUENT CONSULTATIONS OR VISITS within 4 months for the same condition (See Rule A)/**OPVOLG KONSULTASIES OF BESOEKE** binne 4 maande vir dieselfde toestand (Sien Reël A)

0108 At rooms/By spreekkamers:

	10	12	14/15	16	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	52	53
U/E	12,00	12,00	12,00	12,00	18,00	18,00	18,00	18,00	12,00	12,00	12,00	18,00	18,00	12,00	12,00	12,00	12,00	17,00	12,00	12,00	12,00
R	34,10	34,10	34,10	34,10	51,10	51,10	51,10	51,10	34,10	34,10	34,10	51,10	51,10	34,10	34,10	34,10	34,10	48,30	34,10	34,10	34,10

0109 At hospital or nursing home: All hours/By hospitaal of verpleeginrigting: Alle ure:

	10	12	14/15	16	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	52	53
U/E	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00	10,00
R	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40	28,40

0110 Weekly maximum for 0109 for first 2 weeks/Weeklikse maksimum vir 0109 vir eerste 2 weke:

	10	12	14/15	16	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	52	53
U/E	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00	70,00
R	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80	198,80

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		Radiologist Radioloog		Other Specialist and General Practitioner Ander Spesialis en Huisarts		Anaesthetic Narkose	
		Units Eenhede	R	Units Eenhede	R	Units Eenhede	R
3585	Head, single examination, full series/Kop, enkel ondersoek, volle reeks	160,00	441,60	-	-	5+T	68,10+T
3587	Head, repeat examination at the same visit, after contrast, full series/Kop, herondersoek by dieselfde besoek, na kontras, volle reeks	55,00	151,80	-	-	5+T	68,10+T
3589	Chest/Borskas	185,00	510,60	-	-	5+T	68,10+T
3591	Abdomen (including base of chest and / or pelvis)/Buik (longbasis en/of bekken ingesluit)	215,00	593,40	-	-	5+T	68,10+T
3593	Multiple examinations: For an additional part, the lesser fee shall be reduced to/ Veelvuldige ondersoek: Vir 'n bykomstige liggaamsdeel word die geld vir die kleiner item verminder na	50,00	138,00	-	-	5+T	68,10+T
3595	Limbs and other limited examinations/Ledemate en ander beperkte ondersoeke	50,00	138,00	-	-	5+T	68,10+T
3597	Contrast media: General Rule Y applies/ Kontrasmiddels: Algemene Reël Y geld.						
19.10	**MISCELLANEOUS/DIVERSE**						
	RULES/REëLS						
Y.	Except where otherwise indicated, radiologists are entitled to claim for the cost of contrast material used/Behalwe waar anders aangedui, mag radioloë eis vir die koste van kontrasmateriaal wat gebruik is.						
Z.	No fee to be subject to more than one reduction/Geen gelde onderworpe aan meer as een vermindering nie.						
3601	Fluoroscopy: Per half hour: Add (not applicable to items 3445 and 3447)/Fluoroskopie: Per halfuur: Voeg by (nie van toepassing op items 3445 en 3447)	+11,60	+36,00	+7,80	+24,20	-	-
3602	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add/ Waar 'n C-arm mobiele röntgeneenheid in die hospitaal of teater gebruik word: Per halfuur: Voeg by	16,00	49,60	10,70	33,20	-	-
3603	Sinography/Sinografie	27,70	85,90	18,50	57,40	-	-
3604	Bone densitometry/Beendigtheidsmeting	100,00	310,00	67,00	207,70	-	-
3605	Mammography: Unilateral or bilateral/Mammografie: Unilateraal of bilateraal	32,00	99,20	21,00	65,10	-	-

Insurers' doctors set up new body

DOCTORS in the insurance industry have formed a new body to cut back on medical insurance fraud.

The Association of Insurance Medical Officers of SA (AIMOSA) will train doctors to assess patients for insurance purposes.

AIMOSA is the brainchild of Southern Life chief medical officer Len Myers, and it aims to lift standards in the industry.

Southern Life medical consultant Jack van Niftrik says this is particularly necessary as the number of fraudulent claims has increased as the economy puts pressure on companies as well as household budgets.

Dr van Niftrik gives the example that certain companies have been persuading employees that they should go on a disability pension rather than retrench them. In this way the insurance companies and pension funds bear the cost of dismmissing the employee.

He says it is a mindset among many people that after they have put in 20 to 30 years of hard work it is their due to cash in, and then carry on with other, easier work.

For people financially stressed a disability grant can give a quick cash injection into the monthly budget.

Dr van Niftrik says it does not help that

299 By TERRY BETTY

many doctors tend to exaggerate the degree of a patient's disability. "This is more often the result of excessive compassion on the part of the doctor than attempts at fraud.

"Nonetheless, large sums of money are being paid to skilled people who are capable of contributing to the country's workforce, which further weakens an already crippled economy. It will also lead to an increase in premiums and an added burden on healthy insurance consumers." ST Times C B455

Insurance medicine is a specialised field in the US and Britain, where doctors have to pass a post-graduate course. 10/11/93

Dr van Niftrik describes it as sleuthing as opposed to the normal curative or preventative medicine. "The doctor has to look for all the possible long-term problems that will shorten a person's life.

"Depending on what is picked up the insurance premiums will be loaded, or if curable, the person's doctor will be informed and once the person is better he can take out the insurance policy."

Transnet puts rural eye care clinics on track

A PROJECT to bring primary eye care to rural communities throughout the country by using converted railway coaches as mobile clinics had been launched, Transnet spokesman Wilma de Bruin said at the weekend.

The project had been initiated by the Transnet department of community involvement, the Lions Sight Foundation of Southern Africa, the SA Optometric Association (SAOA) and the optometry department at the Rand Afrikaans University (RAU), De Bruin said.

She said Transnet had donated the three coaches which had been converted into clinics and an accommodation coach. The Lions foundation had funded equipment on the train and a portion of the initial operating expenses, totalling R1m, a spokesman said.

STEPHEN COPLAN

De Bruin said the scheme planned to visit 65 destinations during the first half of the year.

The trains will be staffed by 80 RAU fourth-year optometry students working in relay under the supervision of members of the SAOA, which will administer the project and finance a full-time community clinic director.

Prof Jannie Ferreira, head of the department at RAU, said the project was aimed at raising awareness of eye diseases and methods to prevent them, in line with the approach of the World Health Organisation. He added that according to recent statistics there were at least 218 000 blind people in SA's rural communities.

It was hoped to extend the service beyond SA's borders.

Your blood can be a gift of life

(299) Star 12/1/93.

Every time you donate blood, you could save the life of a cancer patient on chemotherapy, a bleeding haemophiliac, a burn victim, an accident case or someone needing emergency surgery . . . it could even be yourself, reports PAULA FRAY.

IN JOHANNESBURG and Pretoria alone, at least 600 units of blood are needed each day for people undergoing operations. There is often no alternative but to give the patient donated blood.

This week — National Donor Week — the SA Blood Transfusion Service (SABTS) aims to create awareness of regular donations and honour regular donors countrywide.

"If you have never donated blood, now is the time to overcome your fear, says the SABTS. If you have previously given, it's time to consider becoming a regular donor.

The SABTS, which has 16 branches in the southern Transvaal, Free State and northern Cape, has about 270 000 donors — less than one percent of the total population. Each year about 485 000 units of blood are given.

"Our keyword is that it is safe blood that saves lives," says SABTS deputy director Dr Robert Crookes. "It is the donor giving blood regularly — up to six times a year — who is the safe donor."

People who have a lifestyle that exposes them to Aids should not donate blood, says Crookes — nor should those seeking a free Aids test.

Because there is a "window period" in which the HIV antibody is not detected, it is possible for contaminated blood to slip through, but any sample positive for HIV, Hepatitis B and C and venereal disease is quickly destroyed.

"Anyone over the age of 16, in good health, can become a donor," he says. "We need new donors, but there are people who haven't donated for a long time and we are appealing to them to return."

At the SABTS Hillbrow centre, volunteers trickle up to the sixth floor to give blood. At least 50 units of "emergency blood" — Group O — are needed each day, as well as about 250 units of platelets.

"The need is continuous," says corporate PR Diane de Coning.

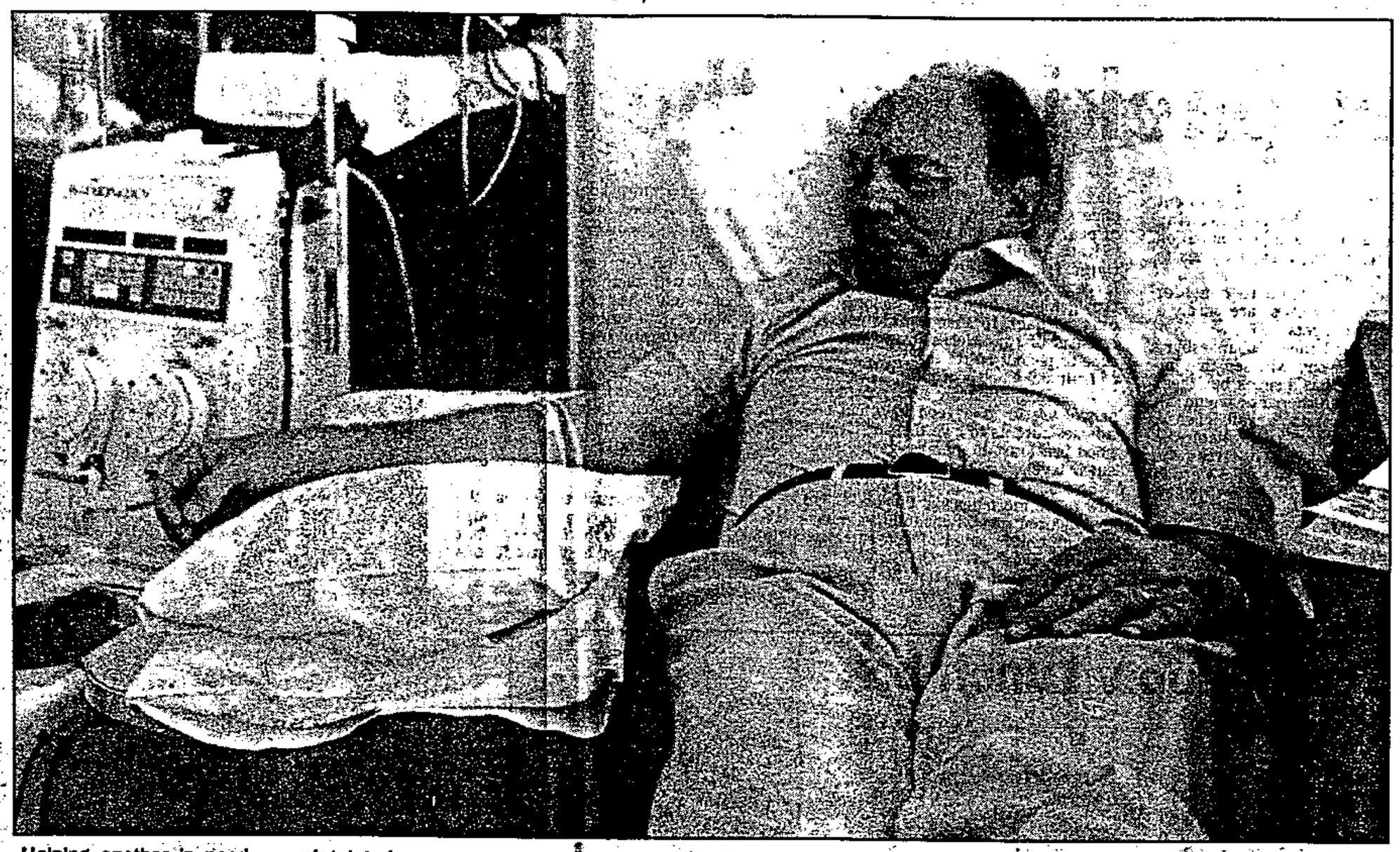
Each donor is asked to fill in a form on his or her recent activities and illnesses. Some volunteers are asked not to donate — for health or other reasons — and some blood might be marked for separation.

A finger prick and a splotch of blood into an iron-determining solution decide whether the prospective donor can, in fact, give blood.

Finally, blood pressure is checked and then the donor is ready for 10 minutes of blood-giving. There is little other discomfort after the initial prick.

"Whole" blood is quickly becoming a thing of the past. Blood is now broken up into components and patients are given the constituent they specifically need.

Plasma is separated, frozen and later divided into albumen and Factor 8. Albumen is given to burn victims and people who have gone into shock following a big loss in blood volume.



Helping another in need . . . platelet donors at the South African Blood Transfusion Services offices in Hillbrow give 2½ hours of their time and their precious blood to help cancer patients undergoing unpleasant chemotherapy. Picture: Gary Bernard

Factor 8 is given to haemophiliacs to help the blood coagulate: "Every month we save the lives of at least 1 000 haemophiliacs on the Reef," says De Coning.

Platelets are also drawn from the blood for cancer patients undergoing chemotherapy, to replenish loss during treatment. If the patient's platelet count drops too low, they could, literally, bleed to death.

While platelets can be separated from normal donations, some donors specifically provide platelets. They must sit for 2½ hours while a machine draws out the blood, separates the platelets and then returns the red blood cells.

Most platelet donors began by helping a friend with cancer with many of them continuing their generosity after the patient went into remission.

Peter and Kathleen Thomas of Kempton Park are two such donors. Every six weeks they make an appointment for the long stint on the separation machine.

"We started when a friend of ours, Timothy Pike, had leukaemia. That was two years ago, and he is now in remission," says Peter.

"I come here for a break," jokes Kathleen. "I don't feel uncomfortable. You feel that you are helping someone . . . I would advise people to do the same."

In the cell separation division — also known as apheresis — four donors, including a man giving plasma for anti-rabies serum, sit patiently.

Thanks to the Lions Club, they have a television set and headphones to keep them entertained.

Cell separation unit head Diane Sawyer says the department cannot get enough donors or machines to meet the demand. Prospective platelet or antibody donors undergo pretesting before they are taken for their first session.

SABTS medical director Professor Anthon Heyns has the last word: "Blood is a cornerstone of medical treatment that we will always need. Our mission is to procure sufficient safe blood from the community to supply sufficient safe blood to the best of our ability." □

Check medical cover before travelling

(299)

STAR - 16/11/93

FINANCE STAFF

TRAVELLERS, particularly those going abroad, should be aware of exclusions that might apply to insurance policies regarding medical expenses incurred while travelling, says a leading insurance broker.

Travel cover, often taken out when a booking is made through a travel agent, is necessary to protect the traveller against unforeseen problems including baggage loss, accidents and medical expenses.

"Travellers need to find out exactly which medical expenses are covered, since most travel policies exclude costs arising from pre-existing medical conditions for which travellers have to receive medical attention while overseas," says Wally Thom, a director of PFV Group Broking Services.

"Medical costs are astronomical, as the following examples of actual claims paid by insurers show:

- R86 000 — stroke in Hong Kong involving 13 days in hospital.
- R100 000 — heart bypass in Holland, with 21 days in hospital.
- R170 000 — peritonitis in Switzerland.

"Some policies exclude existing heart conditions, even if such conditions have not required treatment for several years. For other chronic illnesses, such as diabetes and kidney problems, full information should be disclosed when taking out the policy, since the exclusions in policies can differ in their requirements regarding the predetermined period of good health."

For instance, some insurers will provide cover for a person who has had treatment for such an illness if it happened more than six months before the trip, while others require a longer period of good health.

Thom advises travellers to consult their brokers or other insurance advisers before embarking on a trip to ensure they are aware of the specific exclusions applying to medical costs and continuation of treatment.

Fraud maims health funds

ST Times (Buss) 17/1/93. (299)

By CHERILYN IRETON

A QUARTER of all payments made by Medical Aid schemes this year — around R2,5-billion — will be for fraudulent or false claims.

A growing proportion of these claims will be submitted by suppliers — including doctors, pharmacists, dentists and physiotherapists — fund administrators warn.

Administrators estimate that up to 25% of all claims submitted are inaccurate or fraudulent. The industry is expected to pay out R10-billion to suppliers this year.

Crimes

At present hundreds of suppliers are under investigation by the administrators' various in-house investigation units. A single case under investigation is understood to run to several hundred million rand.

A medical aid adiministrator, who is also a doctor and therefore cannot be named for professional reasons, estimates that increases in medical costs could have been contained to the level of inflation over the past few years if fraud and abuse had been stamped out.

Many medical schemes have been raising their tariffs by more than 20% a year over the past few years.

Crimes range from charging out medicines or services not supplied to dispensing cheaper generic drugs than the ones charged for.

Most cases under investigation will never be tried in court or publicised because of the manner in which the industry choses to deal with offenders.

Only extreme cases ever make it to court or to the disciplinary committee of the SA Medical and Dental Council.

Even then the offenders can continue practising for months or years before they are sentenced.

The rest are confronted directly by the scheme or face a "peer review" under the auspices of the Medical Association of SA.

At October's biannual meeting of the SA Medical and Dental Council eight practitioners were censured for various actions ranging from rendering excessive or false accounts to billing for services that were never provided.

Their names and penalties are published in a recent government gazette. Examples of penalties imposed by the council are removal from the register and a reprimand.

At April's meeting five doctors were found guilty of offences.

SAMDC Registrar Nico Prinsloo says that of the thousands of complaints received by the council only about 100 proceed to the disciplinary committee.

Fraud cases include an incident where a medical doctor got hold of the personnel records of a company, giving him records of staff names and details, including medical aid numbers.

He submitted accounts for all these "patients" — many of whom he claimed to have seen twice a day.

Another practitioner was lending money to patients, and getting them to sign blank statements in return. These were then all submitted by him to medical aid for payment.

Medscheme director Les Hollis cautions that it is difficult to determine the extent of fraud and abuse. "We spend a great deal of time and money checking on trends in an attempt to identify abuse."

But he says if three cases investigated by his funds were handed over to the police for further investigation and prosecution last year, it was a lot.

Medical schemes often prefer to use the "peer review" system of the Medical Association of SA to deal with suspected fraud or misconduct by its members.

There are currently 200 medical aids in SA, administered by five or six large administrators.

Loopholes

The Medical Schemes Amendment Bill, which will go before Parliament in the next session, is expected to eliminate some of the fraud loopholes.

Essentially it will remove the minimum and maximum accounts any scheme is obliged to pay for services. It will also do away with guaranteed payment of accounts.

Observers say the laws will eliminate overservicing and over-prescribing.

They say the current system whereby doctors get a fee for their service has been a major reason behind rising medical costs.

Appeal to the community for donations

299

Sometan 19/1/93.

By Joe Mdhlela

■ **AT STAKE** *Survival of Ikemeleng Remedial Education Centre:*

Factfile

Name of School: Ikemeleng Remedial Education Centre.
Established: 1984
Population: 125 pupils.
Waiting list: 103 pupils.
Who goes to this centre? Children with learning disabilities.
Situated at: Orlando East.
Education officer: Carol Tshoaedi.
The school requires R500 000 to establish its own centre.

ALTHOUGH companies and individuals have already made cash contributions, the survival of Ikemeleng Remedial Education Centre will depend on the donations made by the community.

By the time you read this article, the hat will be out begging for at least R500 000 which will make the construction of new premises in Meredale, south of Johannesburg, possible.

The acquisition of funds will make it possible for children with learning disabilities to get attention.

The minimum donation the centre is asking from the community is R1 a person.

Education officer of the centre Mrs Carol Tshoaedi this week made an appeal to the community to donate generously to the project.

To make sure that every parent has a say about the wellbeing of their children, the centre has called a meeting on January 23.

"During this meeting we expect parents to bombard us with ideas on how to raise funds," said Tshoaedi.

'Dig deeper'

She urged the corporate world to "dig deeper into their pockets" for donations.

"We are not asking for too much from the community of Soweto and other adjacent areas. What we are asking for is small if one considers that the donations will go a long away in enriching our community as a result of the knowledge and skills their children will acquire.

"We alone know what is good for our society, and can therefore pull ourselves up by our own bootstraps to achieve what we have to achieve," she said.

She is asking businessmen to contribute at least R100 each.

Extra cash

"We cannot dictate to the business world how they should spend their money but we think contributing to this project will alleviate the plight of children with learning disabilities," said Tshoaedi.

The extra cash would ensure that language laboratories, audio-perception equipment and other facilities to help overcome defects experienced by children are installed.

"I am confident the black community will help us raise the required R500 000 to build a centre to benefit children with learning defects," she said.

Tshoaedi said the centre would house 125 pupils but did not know what to do with a waiting list of 103 children who have acute learning disabilities.

"By having our centre we hope to phase out the waiting list," she said.

"The more we have a backlog of children on the waiting list, the higher the level of illiteracy will increase among the black community.

"We are not asking for too much from the community of Soweto and other adjacent areas. What we are asking for is small if one considers that the donations will go a long away in enriching our community as a result of the knowledge and skills their children will acquire. We alone know what is good for our society, and can therefore pull ourselves up by our own bootstraps to achieve what we have to achieve"

"The aim of the new project is to help alleviate the problem of illiteracy," Tshoaedi said.

The Ikemeleng Remedial Education Centre was adopted by *Sowetan* in 1989.

It moved from Youth Alive Ministries in Dube to the Baptist Church in Orlando East in 1991.

"We have outgrown the premises we are renting at the Baptist Church. Besides, we need to have our own premises if the centre is to grow to its full potential."

Tshoaedi said donations they had received from from various sources had dried up.

This was due to the fact that a big portion of the budget went on salaries.

The Department of Training and Education did not subsidise their wage bill, she said.

A big slice of their income went to running costs, the payment of teachers' salaries and other costs.

"We believe that once we acquire our own premises we will be more efficient with the resources we have, and will generate funds from the projects which we hope to run," she said.

Among the fund-raising projects the school hopes to stage are the mini-Olympic school games.

"We will be asking sporting organisations to participate in our mini-Olympic games to cater for various sporting codes.

"We are hoping the project will enable us to raise substantial funds to make the centre realise some of the objectives we have set to achieve," she said.

The date for the games will be made known in due course, she sad.

"We will be asking sporting organisations to participate in our mini-Olympic games to cater for various sporting codes. We are hoping the project will enable us to raise substantial funds to make the centre realise some of the objectives we have set out to achieve"

Waiting for a miracle . . . still dependent on a back brace to help ease the pain, Ingrid Zohar is hoping someone will help put a new "miracle" drug within her reach. Picture: Joao Silva

Ingrid could miss out on 'miracle' drug

299

STAR 20/11/93.

By Paula Fray
Medical Reporter

About 140 South Africans suffering from a rare debilitating and crippling disease have been offered a "miracle" drug, but the prohibitive costs have put it well out of the reach of most of the patients.

Vivacious Ingrid Zohar was eight years old when a persistent nose-bleed and her swollen stomach alerted her parents that something was wrong. Ingrid, now 25, has Gaucher's disease.

According to medical science, Gaucher's disease is a progressively incapacitating disorder caused by the lack of an enzyme called Glucocerebrosidase.

But Ingrid knows the real disease: painful crumbling of bones, pain so intense it seems "my whole body is sore", the removal of her spleen because of progressive accumulation of glucocerebroside in her bone marrow and at least two hip replacements.

She has had an operation on her knee, visits to doctors too numerous to mention and is constantly uncomfortable because of her enlarged abdomen and a spinal brace she wears because of the collapse of her lumbar vertebrae.

Her parents, Ann and Sonny Zohar of Bramley, would give anything to take away their daughter's pain.

Now the family has been offered a "miracle" ... but unless they receive some help the miracle will be snatched away. A new drug, Ceredase, which has therapeutic effects described as nothing short of miraculous, is now available for compassionate use with permission from the Medicines Control Council. It is the only proven therapeutically effective drug for use in patients with Gaucher's disease.

However, the cost of the treatment — between R10 000 and R12 000 a month — is prohibitive.

"If I don't have Ceredase I will definitely have to have another hip replacement. It is literally the only thing that will help," said Ingrid.

● Anyone who can help should contact the Zohars at Box 9033, Johannesburg 2000.

Train clinic brings eye-care to bundu

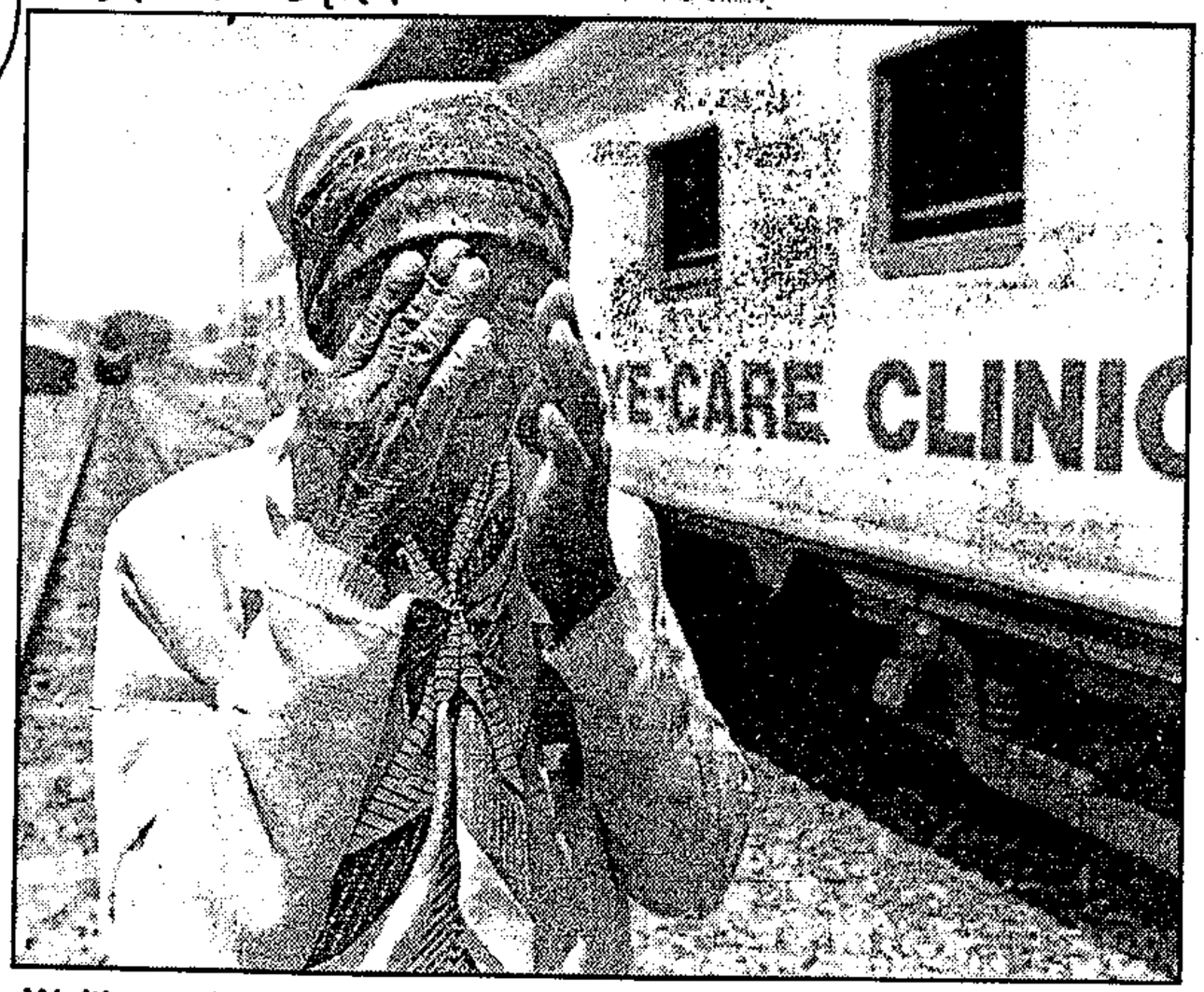
STAR 20/11/93.

By Paula Fray
Medical Reporter

299

More than 1 000 rural dwellers have been given a new view of life since modern technology took to the train tracks last week to bring primary eye-care within the reach of all people.

Volunteer optometrists and 12 final-year students have seen about 200 people a day since the innovative eye clinic train first pulled into Thabazimbi last week, according to Rand Afrikaans University Department of Optometry head Professor Jannie Ferreira.



Waiting . . . Helena Radisi joined about 200 Brits residents at the mobile eye clinic at Brits Station this week. Picture: Joao Silva

Carried

Among the first 200 patients was a woman who had given birth barely hours earlier: "Her relatives, who carried her to the station, said this was the only chance she would get to have her eyes tested."

The overwhelming response has been encouraging for a project which has been in the pipeline for barely six months.

"There is a need for primary health care facilities for those who cannot afford to go into private clinics. We looked at putting up clinics but these were static and we need to expand our services."

At first they considered renovating a truck but there was still the problem of inaccessible roads in the rural areas.

A staffer mentioned a similar train project in India and the rest, as they say, is history.

"That set the whole thing in motion. Here we are, six months later.

Token

"This is no token gesture. We decided that if we did do it, we would have to do it properly," says Ferreira, taking a break in the kitchen area of the "living quarters" coach where four first class compartments house the 14 students who will work with the train for a three-week stretch.

During the next six months, the train will travel to 43 towns.

On Monday it chugged into Brits as the temperature soared into the high '30s. Down at the station queues of people began forming as early as 8 am.

For 78-year-old Helena Radisi it was a matter of the mountain coming to Mohammed.

- Three years ago her eyesight began to dim. It's been two full years now that cataracts have taken away the eyesight in her left eye ... and there is a start of a cataract formation in her right eye.

Cataracts

After thorough eye tests, a pair of black-rimmed "John Lennon-type" glasses later and Radisi will probably still be referred to an opthamologist in town to have her cataracts removed. In the meantime, a pair of glasses will greatly increase her vision.

"I was at the clinic when they told me the eye doctor was here. I've been waiting since early morning ... it's been a bit long," she said.

At No 107, she had numerous other people ahead and behind her.

It is estimated that eye-care services are inaccessible to about 80 percent of South Africa's estimated 37 million population.

Recent statistics show that there are at least 218 000 blind people in rural communities — most of whose blindness could have been prevented if diagnosed at an early stage.

The three coaches were refurbished by Transnet; Lion's International assists in streamlining the waiting procedure and appointment schedule, while the South African Optometric Association members are giving of their time and money.

The project is unique in South Africa as it takes eye-care to the doorstep of those who need it but who do not have the necessary financial means.

During the second phase, the service will be extended to include other services to provide comprehensive primary health care. Then, the final vision is to take the project north to provide a service outside South Africa's borders.

At present, final-year optometry students provide the backbone of the project.

"We start now and don't stop until this evening when everyone is completed. There is no lunch hour," explains Ferreira.

The students work hard: "During third year we did treatments at the RAU clinics and went to Alexandra township and Coronation. But I haven't seen patients at the pace we've seen here," says final-year student Aadil Sujee.

At the end of the day, when the equipment is packed away and the train moves off to the next station, hundreds of more hopeful patients will prepare for their treatment.

"The patients are there, the need is there," says Ferreira.

Cuba's way could transform our health

STAR 21/11/93.

299

CHANGE OF TACTICS

The fight for health for all in South Africa cannot be fought on the medical front alone . . . the battle needs to be taken into the community and its surroundings, say Cuban experts. PAULA FRAY reports.

WHEN Cuba emerged from its revolution more than three decades ago, it made health a right for all. Now, not only are medical services free, but the infrastructure has been improved to facilitate the move to better health.

"Today, that health service is one of the most important social achievements of the revolution in Cuba. Health, like education, is a priority," says Cuban epidemiologist Dr Felipe Delgado Bustillo.

Bustillo and Ministry of Health colleague Dr Carlos Mas Zabala have been in South Africa as guests of the African National Congress for the past six months — during which they visited 76 health institutions including 20 hospitals.

"The first task of our health service is prevention," says Zabala. "Then, we have an epidemiological approach to health problems. We see the disease in its context, its enviroment."

An example of this is TB: once someone has tested positive, the surrounding community is tested and the socio-economic conditions checked.

Bustillo emphasises that this is as important as prevention. To improve a community's health, it is important to look at nutrition, water supply education, social services, sanitation, recreation and employment.

"Health is not just the medicine, the nurse, the doctor ... health is also the socio-economic condition of the community," says Zabala. So, immunisation in Cuba went hand in hand with upgrading facilities.

In 1955, about 30 percent of the Cuban population had waste disposal; 30 years later this had increased to 80 percent. An excellent vaccination programme means that the last polio case was reported in 1962.

German measles, measles and mumps have been eliminated in five of the 14 provinces through immunisation — the country aims to eliminate it completely by 1995.

The island has 814 HIV cases — an incidence of 0,006 percent — and about 100 cases of full-blown Aids. Virtually everyone in the 10,8 million population has been tested — there have been more than 13 million tests.

A widespread education campaign has been well-received by the population which has a 98 percent literacy rate and a high average education.

Cuba boasts 50 000 doctors and 80 000 qualified nurses — a ratio of one doctor for every 250 people and one nurse for every 150 people. A "Family Doctor Programme" — in which a doctor is placed to live within the community he or she serves — has helped cope with demand.

THESE doctors and health workers, says Bustillo, now concentrate on eliminating the chronic illnesses — such as hypertension and cancer — from the society by the year 2000.

"We were fifth place in Barcelona ... we are healthy people," he jokes.

But South Africa has a long way to go.

Reluctant to appear to be prescriptive, Zabala describes South African as two countries: "One in the First World and one in the Fifth World ... not even in the Third World. We think the deprivation — it's not a shortage — of health services to most of the people in a very big problem in South Africa. More than that, the majority of people have been deprived of life.

"It is very sad to see how many people are dying here every day ... in a very rich country ... of preventable diseases and malnourishment."

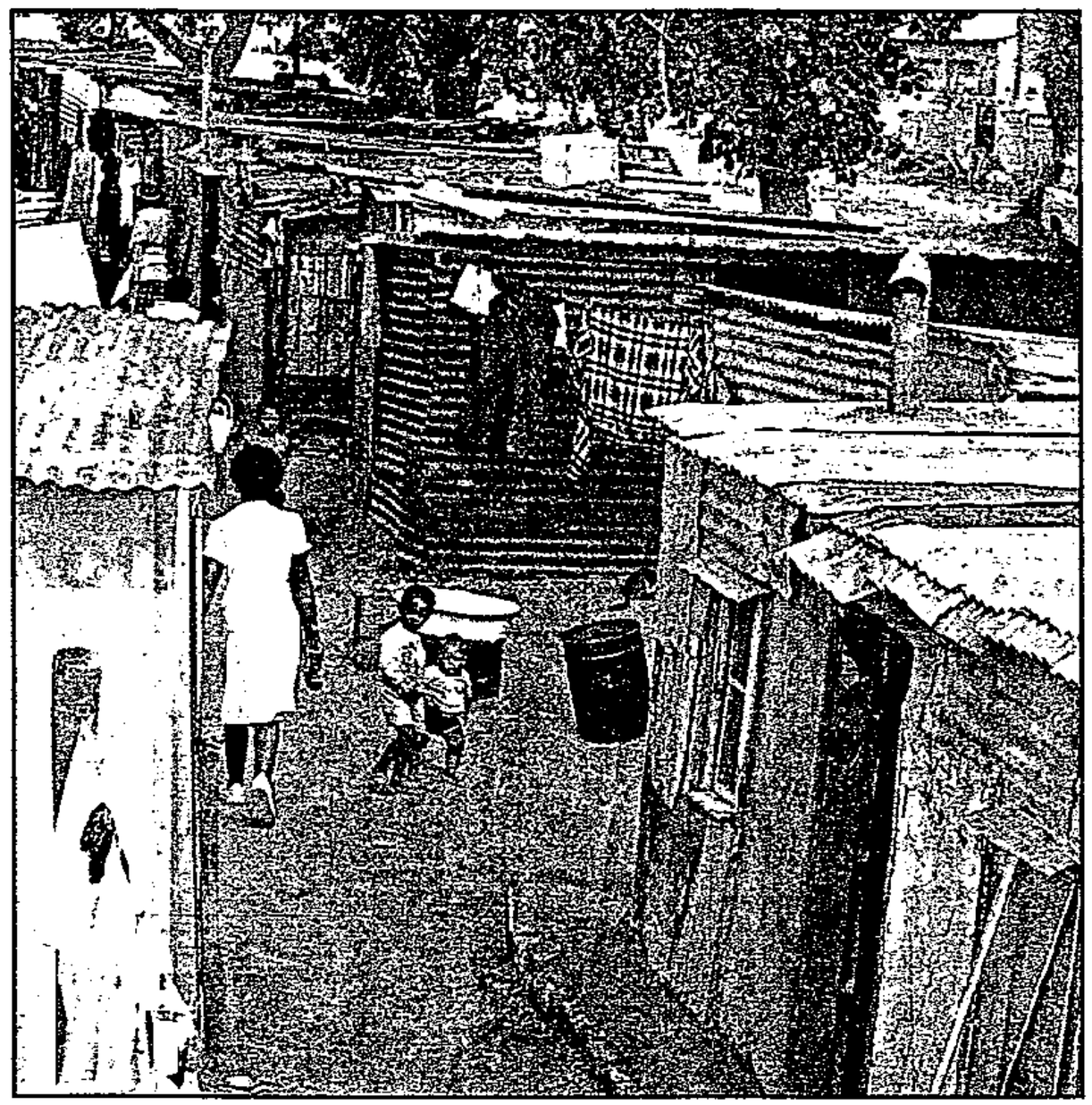
Primary health care (PHC), adds Zabala, is very weak for all races.

"There is a shortage of personnel, particularly in the rural areas. There is also an unequal distribution of facilities. For example, in the Transkei, 25 percent of the doctors are in Umtata. Hospitals don't have enough qualified personnel. And, because of the lack of PHC, hospitals' outpatients are crowded."

Bustillo sees several problems: fragmentation of services, a shortage of facilities and a real shortage of community, epidemiological and preventative approaches: "People here think mainly in a curative way."

Ironically, Zabala sees another major factor: "Wastage. There is a waste of resources. Some hospitals have expensive technology which is underused."

Cuba spends 8 percent of its budget on health; South Africa allocates 6 percent: "This is not a big difference. The problem is where you spend that 6 percent. If South Africa prioritises primary health care, prevention and some problem diseases, then the results will be evident in a few years."



In need of help . . . a squatter camp near Johannesburg. Visiting experts say health care here is so uneven that it divides between a First World and a Fifth World.

TOMORROW

Top Kenyan basketball player takes a turn on the silver screen.

Go generic, save on health costs

Doctor, chemist and patient need to liaise

STAR 23/1/93. (299)

FINANCE STAFF

SOUTH African health care costs, generally regarded as being among the highest in the world, could be reduced significantly through the wider use of generic medicines and the trend would be accelerated considerably by the expected partial deregulation of the health care system.

This is the view of Dave Stubbins, chief executive of Lennon Generics, who maintains that such deregulation would give the pharmacist, as well as the patient, a greater say in the choice of medicines.

More pragmatic

Lennon is reputed to be the biggest manufacturer and marketer of generic medicines in the southern hemisphere.

Stubbins says: "There could well be a more pragmatic dispensation in which doctor, pharmacist and patient will consult with each other on treatment costs."

Generic medicines are typically up to 60 percent cheaper than the original branded products, of which they are the therapeutic equivalents.

While they are already widely used in the public health care sector, there is considerable scope for their increased application in the private sector.

This can be deduced from the fact that whereas generics currently account for some 25 percent of all medicines dispensed in South Africa, the comparable figure in the US is 60 percent.

Stubbins continues: "Since 1983, the annual increase in medical scheme contributions has been 10 percent ahead of the inflation rate, primarily due to the rise in medicine prices. Earlier this year, Dr Coen Slabber, Director-General of National Health, noted that South African medicine prices were now higher than those of virtually all Western countries.

The cost burden has become severe.

"It's now generally accepted that some deregulation of our health care system is essential if its spiralling costs are to be contained. This is likely to include the descheduling of some medicines, a greater measure of pharmacist-initiated therapy and the reintroduction of generic substitution — the pharmacist's right to supply a generic equivalent to the branded original prescribed by the doctor, should the patient want it."

A commonplace practice elsewhere in the world, substitution was briefly permitted in 1985 until pressure from the multinational manufacturers forced the Pharmacy Council to ban it again.

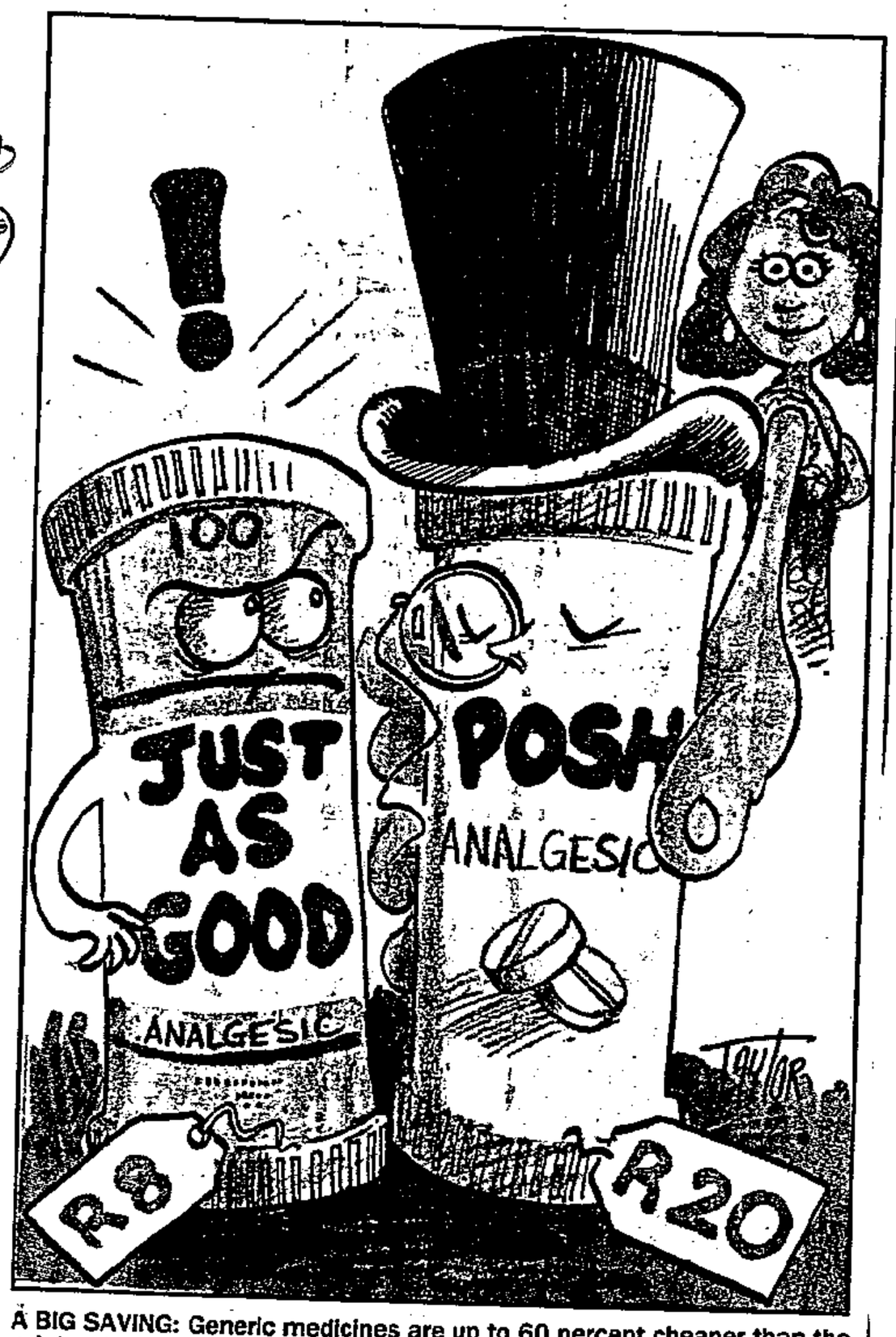
Stubbins predicts that strong advocacy by the medical aid schemes would also be a major contributing factor to the wider use of generics in South Africa.

"They are advising members to ask their doctors to prescribe generic medicines in order to contain their medicine costs," he says.

Stringent standards

"In addition, many of the schemes are moving towards what is known as the MMAP (maximum medical aid price) system, which is based on the cost of generics. This means that if a branded original is dispensed when a generic equivalent is available, the member has to pay the difference," Stubbins says.

"Generics have to meet the same stringent quality and efficacy standards the SA Medicines Control Council sets for all the pharmaceuticals dispensed in this country and can, therefore, be used with complete confidence by the consumer as an affordable equivalent to more expensive branded products."



A BIG SAVING: Generic medicines are up to 60 percent cheaper than the original branded products, of which they are the therapeutic equivalents.

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Creativity needed to solve medical aid crisis

STAR 23/11/93 (299)

MAGNUS HEYSTEK

THE traditional medical aid scheme will not survive in its current form, says Andre Fick, head of the health care division at actuaries Alexander Forbes Shepley & Fitchett.

Writing in the latest edition of the Alexander Forbes quarterly survey, he says: "The health care system is in turmoil. There are numerous questions all along the same line: *What is going on?*"

The one consolation — if it is a consolation — is that everyone has the same question, the same problem.

The perception that medical aid is a rip-off is false.

Medical aid administrators are possibly the only part of the health care chain who are *not* abusing the system. The structure is wrong. Guaranteed payments entice abuse, and abuse is rampant.

The catch is that, as a medical aid fund in effect belongs to its members, it is the members who have to pay for all abuse and over-use by way of contribution increases.

As health care costs rise, a number of insurance arrangements have been created. However, many of these new products will not solve the long-term problem. Elaborate short-term solutions will be temporary stop-gaps.

All-inclusive health care packages are required, tailored to meet the needs of particular groups.

The market is evolving and will continue to evolve. The only certainty is more change.

Issues which will have to be addressed, as unpalatable as they may appear, are excess or co-payment schemes.

The days of the traditional 100 percent cover scheme are numbered. Members and the system have priced it out of the market.

The problems facing employers are many and varied. Aids and pensioners' pre-funding are two of the more pressing problems. Intensive education of members is required. The traditional stand-alone medical aid scheme will not survive the end of the decade.

It is essential that employers act now, involving their employees in any aspects that directly affect not only companies and their staff but also members' families. Is is an issue that has to be addressed with vision and creativity.

DEMANDING . . . Strikers at the Sizwile School for the Deaf have a list of demands.

Pupils strike in solidarity

By JOHANNES NGCOBO

HANDICAPPED pupils at Sizwile School for the Deaf in Dobsonville this week protested in solidarity with their teachers who are demanding permanent status at the school.

Among the strikers are domestic workers who downed tools alleging that they have been employed as temporary workers since 1986.

The protesters included deaf security guard Fanie Mvulane.

Speaking through a sign interpreter, he said: "I was informed that I was going to be retrenched and I am against it."

Protesters staged a sit-in at the administration offices of the school, waving placards and making it impossible for staff to carry on with their normal duties.

Other demands include a pay increase and that school management withdraw the letters threatening retrenchment of staff.

Placards reading: "No to unilateral restructuring of the school" and "we cannot be temporary workers forever" were held high above the heads of protesters.

The school principal, France Walker, said he had nothing to say about the demonstration.

...ter of time before aluminium ...
HORST PESCHKES ... industrial councils are a vestige of apartheid

Forum for health market

(287)

(299) By CHERILYN IRETON

REPRESENTATIVES of the fragmented health care market will meet in Johannesburg in March to discuss plans for a new national health policy. ST Times (B455)

Invitations for the national Health Forum — to be held from March 24 to March 26 — are being sent out to all players in health services, confirms the Department of National Health and Population Development.

This follows a meeting earlier this month of a steering committee to draw the groundrules for the forum. 24/1/93

The meeting comes amid continued arguments about who is to blame for the high cost of health care and the massive abuse taking place in the private health care market.

Preliminary figures from the Registrar of Medical Schemes suggest that the high cost of medicines is one of the main reasons why medical inflation remains stubbornly above a rate of 30%.

His annual report to be released in April will show that medicine costs rose a rate of 40,4% in 1991 (the latest figures available), followed closely by a 40% increase in funds to specialists.

The increase in medicine costs follows a rise of 41,5% in 1990 and 29,5% in 1989. Other increases recorded by medical aids were:

- General practitioners: 25,6% (1990: 22,6%)
- Specialists: 39,9% (27,6%)
- Dentists: 29,8% (27,1%)
- Private hospitals: 21,7% (55%)
- Provincial hospitals: 16,8% (35,9%)
- Hospitalisation (total): 20,7% (50,4%)

The Registrar says 7,3-million South Africans enjoyed health care cover at the end of 1990.

Delegates from ... Moosbagel says although ...

Jonty now a role model for epileptic children

STAR 28/1/93

(299)

SUFFERERS GIVEN HOPE
When Jonty Rhodes went out to bat for people with epilepsy he helped create a new perspective, reports **PAULA FRAY.**

TO RUN out Pakistan batsman Inzaman-ul-Haq with a flying dive, in front of millions of spectators and television viewers during a crucial World Cup cricket match, takes about as much courage as standing up and telling that same audience that you have epilepsy.

Jonty Rhodes has done both.

In a national advertising campaign, the popular cricketer urges the public to give people with epilepsy a chance.

And, says the South African National Epilepsy League (Sanel), the response has been overwhelmingly positive. Sanel national director Kathy Pahl says the advertisement campaign has had "a tremendous response from the public".

"We have managed at least to get people to start thinking and looking at epilepsy from a different perspective," says Pahl.

"People with epilepsy, especially children, say they feel more confident. We have always needed a role model for our children and Jonty is that."

One focus of attention now is the critical shortage of facilities for people with epilepsy in greater Soweto and the West Rand.

Sanel southern Transvaal estimates that there are about 50 000 people with epilepsy — most of them unemployed — living in the area.

According to Sanel, social and psychological problems of people with epilepsy stem mainly from misconceptions of those around them.

If these misconceptions are replaced by sound information, the problems would be reduced.

"Epilepsy is not a disease," said a Sanel spokesman.

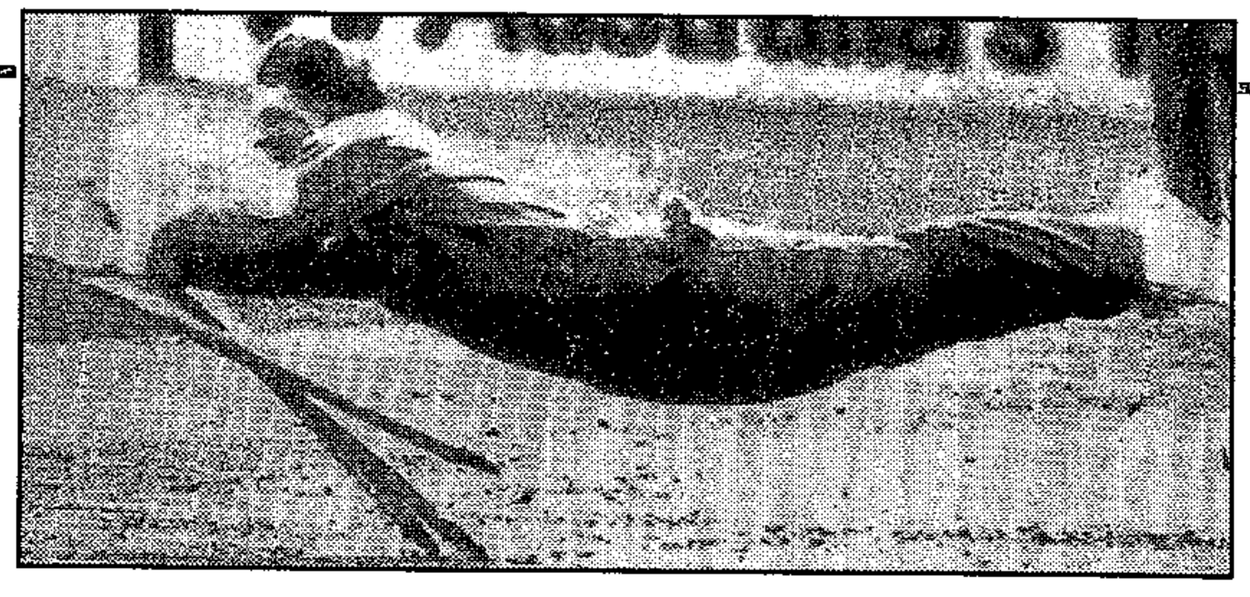
"It is a physical condition of the brain, predisposing individuals to recurrent seizures which may take many forms and vary considerably."

An estimated 350 000 South Africans have epilepsy.

Of these, many are unaware they have epilepsy.

As many people associate this neurological disorder with dramatic convulsive seizures it is difficult to understand how anyone could not notice it.

The answer, according to Sanel, lies in the special nature of epilepsy and the different types of seizures that may be involved.



That dive . . . Jonty Rhodes leaps to world fame during the World Cup.

EPILEPSY, derived from a Greek word meaning "seizures", is the medical term given to a sudden, temporary malfunction in the brain's electrical system.

This system consists of billions of nerve cells which, when working properly, send messages to one another by making tiny electrical currents. When these controlled bursts of energy pass between cells, communication and all the other elaborate functions of the brain become possible.

However, when someone has epilepsy, there are a number of brain cells which periodically discharge a larger electrical current. A chain reaction follows involving that part of the brain or even the whole brain.

All this, of course, is invisible to the onlooker since it takes place in the infinitely small structures of the brain. However, the effects of this cerebral overload may become dramatically obvious if the result is a convulsive seizure — perhaps the best-known manifestation of epilepsy. There are many other manifestations — often dismissed as being just "funny spells".

INTERNATIONALLY it is accepted that neither the diagnosis of epilepsy nor the actual occurrence of seizures should disqualify a person from paid employment, reports Sanel.

"All people with epilepsy should have equal opportunities in gaining access to available health care, rehabilitation and vocational programmes and social support services to gain maximum control over their disorder," says a Sanel spokesman.

Medical aid blow to retired teachers

(299) CT 28/1/93

By DAN SIMON

TEACHERS who volunteered for early retirement last year had a rude awakening this week when they learnt that one of their conditions of retrenchment — which qualifies them for free medical aid at the age of 60 — has been withheld.

It was learnt yesterday from a former school headmaster that a condition of the voluntary retrenchment package offered by the Department of Education and Culture in the House of Assembly in its rationalisation programme was that teachers would retain their membership of the Medihelp medical aid scheme once they retired.

However, teachers would be liable for the full monthly medical aid subscriptions ranging between R345 to R563 until the age of 60, whereupon they automatically qualified for free medical aid.

Medihelp was formerly a state institution known as the Public Service Medical Aid Association before it was privatised in July last year.

Former Eversdal Primary School headmaster Mr Jack van Renen said teachers who accepted the package were only "now discovering" that they were no longer members of Medihelp and would have to "re-apply" for reinstatement.

If accepted they would no longer be eligible for free medical aid once they turned 60.

He said thousands of teachers would now be affected and made "much the poorer" by a decision which was an "unscrupulous action" on the part of the department.

Teachers can, however, apply to the department for a "six-month subsidy", Mr Van Renen said.

Cape Education Department spokesman Dr Orland Firmani said the department "understood the response" of teachers but said the department was simply "a go-between" between the teachers and Medihelp, which had instituted the change.

SA donates mobile hospital

A MOBILE hospital is to be sent to war-ravaged Bosnia-Herzegovina in the third South African consignment of humanitarian aid. (299)

Negotiations on how to transport the hospital and two ambulances had not yet been concluded but a commercial ship seemed to be the answer, Bosnia Relief Fund spokesman Dr Imtiaz Sooliman said yesterday. Other countries had contributed medical supplies and equipment, but the hospital would be "the first of its kind in the world to go in," he said. — *Sowetan Correspondent and Sapa.*

Sowetan 28/1/93

Air medical firm grows

KATHRYN STRACHAN

WITH Africa becoming an increasingly popular tourist and business destination, an air medical rescue service has boosted its operation to cope with the hazards of the continent.

Last year more than 1 000 people in need of medical care were evacuated by air charter from many African countries to SA by Europ Assistance SA, part of the world's largest insurance-linked travel assistance chain.

Europ Assistance SA assistant GM Raymond Uren said with the poor medical standards in African countries and the dangers of diseases such as malaria, it was best to bring critically ill or injured travellers to SA for expert treatment as quickly as possible.

He said the company expected the number of evacuations to rise substantially this year.

In a bid to make its air medical rescue faster, the organisation yesterday relocated its Johannesburg Operations Centre from the CBD to Grand Central Airport at a cost of R500 000.

At present, R2,5m worth of medical equipment is stored at the hangar and a shock, trauma and resuscitation centre has been set up.

Poor living conditions a health issue

SOWETAN 30/1 – 3/2/93.

By Justin Pearce

BAD SANITATION, air pollution and similar unhealthy conditions must be addressed by health planners if a primary health programme is to be at all effective.

This was the conclusion drawn by Mr Chris Derry of the Cape Technikon at a conference on primary health care convened by the Medical Research Council.

In the past environmental considerations had been put outside of public health in South Africa, Derry said, and this was a problem that now had to be redressed.

"People in public health can no longer say issues like housing and air pollution are outside their portfolio."

Ms Angela Mathee, a researcher with the Johannesburg City Council, reported on conditions at the Imizamo Yethu squatter settlement in Hout Bay, which have been linked to incidents of diseases there.

Over a third of residents in the settlement cook in rooms in which they also sleep. Most cook over coal or wood fires in rooms without proper ventilation.

This means people breathe highly polluted air at night, a fact Mathee linked to the high incidence of respiratory problems in the settlement.

Gastro-intestinal problems are another common health hazard in the camp. This seems to be related to inadequate sanitation services.

Most surveyed complained of the large numbers of flies in the settlement, which contribute to spreading disease. Flies are encouraged by the use of pit latrines and a communal rubbish disposal system. Households dump refuse in open containers which often overflow.

Water storage also creates health risks. People in Imizamo Yethu collect their water from communal taps and store it in buckets or drums. In many cases these are left uncovered, leaving water open to contamination.

Derry reported a case in another squatter camp where a cholera epidemic broke out in spite of the presence of communal taps.

The epidemic had been traced to a water storage drum used by a number of households. A contaminated cup had been used to scoop up water and had consequently infected the whole supply.

Derry recommended that stored water be changed every day to prevent spreading diseases, even though this could be difficult for squatters who had to walk long distances to fetch water.

A "north European concept of water supply" had hindered the efforts of people trying to organise satisfactory water for South African squatter settlements, Derry said.

According to this European concept, chlorinated water necessarily meant good water. But for chlorine to be effective, one first needed a supply of clear water, which was unobtainable in many parts of South Africa. Amino acids and other substances present in the water could neutralise the sanitising properties of chlorine.

Bad lighting also contributed to food contamination and disease, Derry said.

"In bad light it is impossible to see what you're cooking or eating."

HEALTH HAZARD: Contamination is a danger in squatter areas when water has to be fetched and stored in buckets Photo: Yunus Mohamed

'Feminisation' of poverty, illness

299 SOUTH 30/1 – 3/2/93.

By Justin Pearce

WOMEN'S health cannot be addressed without addressing women's empowerment, agreed speakers at the women's health session of a recent primary health care conference in Cape Town.

Dr William Pick of UCT's Department of Community Health reported on progress made by the Women's Wellness Initiative (WWI), a project set up to address health needs of women in the Griffiths Mxenge area of Khayelitsha.

The project takes what Pick described as a "developmental approach to health", involving not only addressing illness from a medical perspective, but also the social and economic conditions at the root of physical and mental ill health.

The WWI was established after a survey examined the economic and social oppression of women in Khayelitsha.

Nearly all women said they would like to work outside the home and earn money. But of those who earned money, only a third had sole control over how their earnings were spent.

Women's lack of control over their own lives could be one reason for the ignorance surrounding specifically female health problems.

For example, more women knew about Aids prevention than about pap smear tests, which are essential to the prevention of cervical cancer.

The survey found gynaecological illness and especially infections were rife.

Pick noted a particular need for a women's health focus, otherwise female health would be ignored amid issues affecting women — such as the provision of child care.

He argued that women in recently-settled areas such as Khayelitsha endured not only race, class and gender oppression, but also "urban alienation", the upheaval in changing from a rural to an urban lifestyle.

A consequence of urbanisation was a change in the composition of family units, away from traditional father-centred units. About 40 percent of Khayelitsha households were headed by women.

Anthropologist Dr Mamphela Ramphele suggested that many women opted for single parenthood since it gave them more control over their lives than if they lived with men.

But households led by women tended to be economically disadvantaged in comparison to male-headed households, in line with an international trend that Pick described as "the feminisation of poverty".

As poverty was an indirect cause of ill health, a developmentally-based primary health care programme had to work towards increasing women's earning power.

The WWI has therefore made links with other organisations working to foster income generation in Khayelitsha. In this way women learn skills they can put to use in the township's informal business sector.

Ms Cheryl Carolus, head of the ANC's Department of Health and Social Welfare, linked women's education levels and their ability as caregivers.

With women almost totally responsible for child care, women's health awareness has implications for whole communities.

"Black women get the worst slice of the pie when it comes to education, and this has implications for the health of a community."

Carolus referred to research done in Alexandra township, which found children's health was closely related to their mothers' level of education.

Pension funds should allow for increases

(299) S/Times (B955) 31/1/93

Business Times Reporter

CONTRIBUTIONS to medical aid schemes during the early '80s used to be about 20% of the amount going into pension funds. But by 1991, the medical aid take was more than 60% of the amount going into retirement provision.

Old Mutual estimates the total medical and retirement savings market at R20-billion a year. Both issues are of increasing concern to employee and employer.

At a seminar in Johannesburg this week, Garth Griffin, general manager of employee benefits, also discussed the plight of the SA pensioner and contrasted the findings of the Mouton commission — that inadequate increases are provided to counter the effects of inflation — with the 1990 Social Security Act passed in Britain, where all defined benefit pensions must be granted increases in line with inflation.

Britain also prioritises the use of fund surplusses for the purpose of increasing pensions. As a result, 99% of British pension schemes make some provision for pension increases.

In SA, there are no legal parameters binding funds to pay higher pensions and while 90% of funds do provide for some kind of increase, there is a growing realisation of the need to link rises with the consumer price index to ensure maintained purchasing power.

At an inflation rate of 15%, an SA pensioner's income halves in terms of purchasing power in only five years.

Mr Griffin says it is important for pensioners' interests to be represented on the board of trustees of the fund. He recommends that fund members take up certain issues, such as the level of increases in pension on retirement; who benefits from scheme profits, whether increases are targeted, ad hoc or promised, and on what basis are increases decided on.

As a yardstick, a member retiring on a pension of R1 000 a month in 1983 with Old Mutual's Pension Plus, will now be receiving R4 091.

The average level of pensions paid out is between R500 and R600 a month to 530 000 private sector pensioners. A quarter of these pensions are below R150 a month and only 27% are more than R800 a month. There are 1,1-million State pensioners.

Old Mutual made the presentation as part of a drive to increase employee and employer awareness about the issues facing workers and pensioners.

(45), was shot and killed at his cafe about 7.45 on Friday. He was hit by a bullet after an unknown black man allegedly fired a shot through the window.

Elderly blind get the boot

Sowetan 1/2/93

■ Workers given small retirement package:

By Alinah Dube

THE Itireleng Institute for the Blind in GaRankuwa has laid off 50 blind workers because of "old age".

The workers, aged between 60 and 85 years, said they were not compensated for loss of work.

One of the workers acting as spokesman, Mr Phillip Mokgoloboto (71), said he had worked for the company for 54 years. Now he had been left in the cold and did not even know where his next meal would come from.

"We are all destitute people not knowing who to turn to. While we did not expect to work here forever, one would expect some form of consideration and a fair settlement," Mokgoloboto said.

The institution's manager, Mrs Pauline Roos, said the workers were each paid R50 for each year of unbroken service as a "thank-you package".

The 50 were too old and had to be laid off as a result. She said their retirement dates were long overdue.

Potential cancer victims

ONE out of every four South Africans is a potential cancer victim, according to statistics released by the National Cancer Association of South Africa (NCA)

Sowetan 4/2/93

The NCA said yesterday 90 percent of cancers were linked to dietary factors and certain living habits. A healthy, balanced diet with low fat, a moderate intake of alcohol and no smoking were indispensable in the fight against cancer. - *Sapa*

(299)

urged to keep a lid on medical costs ● Herpes may block arteries

Illness cuts pensions

Soweten 5/2/93

By Mokgadi Pela

HOSTILE RELATIONS Co-operation needed between doctors and medical financiers: (299)

EVER-RISING medical costs could soon consume the entire income of pensioners, an official of Old Mutual warned this week.

And as a result pensioners have to rely on active working family members to finance them with regard to other necessities of life.

Mr Henk Beets was speaking at a media seminar organised by Old Mutual in Johannesburg.

Monthly pensions paid by retirement funds show that 25 percent receive less than R500; 16 percent receive between R150 and R299.

He also called for a better working relationship between doctors and financiers of health care, adding that in South Africa "these two parties are hostile to each other".

South Africa needed to place a lid on medical expenditure. US evidence showed a third of all medical procedures were unnecessary.

peak hours was conducive to acts of terror, for political reasons,

Govt strategy for health care

BIDAY 5/2/93. (299)

KATHRYN STRACHAN

GOVERNMENT has enlisted the services of advertising agency Saatchi & Saatchi Worldwide to promote its new plan to revamp health care services.

The Health Department has stressed that the state cannot afford to spend a greater percentage of its GNP on health, and the only way it can hope to resuscitate the health system is by radically shifting its focus and resources from sophisticated curative care to primary preventative strategies.

Saatchi & Saatchi Klerck and Barrett director Kgomotso Modise said advertising in social marketing had proved itself capable of soliciting participation and response cost-effectively by focusing on a single-minded proposition.

It also provided a tangible benefit in solving a problem in a community, he said.

In his presentation at the launch, Modise said rapidly escalating costs and the growing need in providing health services to all had affected future plans for health care.

Health care had also been affected by economic and social pressures which had resulted in a tendency for people to be more concerned about their own interests than those of others, he said.

"There is an immediate need in SA today to restructure and launch a supportive community programme in order to redirect attitudes and perceptions regarding the health care system."

He said the primary health care programme hoped to strengthen health services particularly in rural and squatter areas, and the advertising campaign intended to focus on issues such as nutrition, hygiene and immunisation.

As well as educating people to take responsibility for their own health and advertising the services of clinics, one of the principal objectives of the campaign was to promote the concept of primary health care to the business sector and to gain business and community leaders' support for the new strategy.

To boost the strategy, a public relations campaign had been formulated with the aim of creating a partnership between government and the private sector.

cinema manager Pierre Joubert last year was yesterday sentenced in the Rand Supreme Court to life imprisonment.

Moses Dabula, 24, was also sentenced to 15 years' imprisonment for robbery with aggravating circumstances. His co-accused, David Makena, who was 17 at the time of the killing, was sentenced to 25 years' imprisonment for murder and robbery.

The pair, who were both employed at the cinema, attacked Joubert while he was cashing up. Joubert was stabbed 101 times.

A third man, Percy Tshabalala, who also took part in the robbery, escaped from the scene and did not stand trial.

Judge M J Stegmann, sitting with two assessors, found the fact that the robbery and murder were planned weeks prior to the incident was an aggravating feature of the crime.

Peace accord officer to look into Bopape case

B/DAY 5/2/93

DIRK HARTFORD

THE case of political detainee Stanza Bopape — who police allege escaped from custody in 1988 and who friends and family believe has been murdered — will be investigated by the newly appointed police reporting officer under the peace accord, Jan Munnik.

And Bopape's father Junius will today brief ANC leaders Nelson Mandela and Walter Sisulu on the circumstances surrounding his son's disappearance. Mandela has taken a personal interest in Bopape's case and is said to be determined to make sure the mystery of his disappearance is solved.

Munnik said yesterday he would be approaching the special police unit — set up in terms of the peace accord — to investigate Bopape's disappearance. He would then report back to Bopape's family who requested the investigation.

Bopape's family has also demanded a public inquiry.

Meanwhile, lawyers acting on behalf of the Bopape family claim to have established that two constables at John Vorster Square — Engelbrecht and Mostert — took Bopape out "for the purposes of investigation" on the day he allegedly escaped.

Mostert, together with a Maj van Niekerk, had interrogated Bopape in detention two days before he disappeared, said the lawyers.

They said yesterday it was not clear if these three policemen were the "major who was the authorised appointed investigating officer and two colleagues" said by Lt-Gen Johan van der Merwe to have been with Bopape when he disappeared.

The SAP and Law and Order Minister Adriaan Vlok have so far refused to name the men who were with Bopape when he allegedly escaped.

Star 9/2/93

Firms 'in for med-aid shock'

By Paula Fray
Medical Reporter

299

Companies countrywide are in for a shock when they review their medical aid policy for pensioners and discover the true extent of their obligations, a leading executive in the field has warned.

Financing health care costs for pensioners was becoming a critical issue, said Medicaid Administrators managing director Jeff Slome at the weekend.

"Medical aid schemes have traditionally charged pensioners 50 percent of the rate paid by active employees," he said.

"However, health care needs and costs increase significantly with age, and the average claims experience of pensioners is about twice as high as the general rate."

As companies usually paid a percentage of the medical aid contributions for pensioners, pensioners' medical aid contributions would become a "weighty burden" which companies would have to finance from the economic activities of current employees as the number of pensioners and health costs increase.

See

In the longer term, said Slome, companies would have to decide whether it was economically viable to retain relatively low-income pensioners on a medical aid scheme.

id and they decided to meet for three days mentation.

Heated debate likely on medical aid Bill

ANDREW KRUMM

TODAY's parliamentary debate over the Medical Schemes Amendment Bill is expected to be acrimonious as parties air their feelings about the provision and cost of health care.

However parliamentary sources expect the Bill to be passed largely unscathed — and with the support of those who regard it with distaste. (299)

DP health spokesman Mike Ellis said yesterday that although his party would prefer to see a revision of the entire health care system, it would support the Bill. B/OAm

"On its own the Amendment Bill does not solve a thing in the long run." However the medical schemes were in "a mess" and the Bill would ease some problems in the short term.

Ellis said the Bill was crisis management on government's part, in an area which required the attentions of a full commission of inquiry. 9/2/93.

The Bill has been opposed by doctors and medical aid societies.

Doctors, worried that they would not be paid for services, initiallly objected to the Bill's proposed removal of automatic payment guarantees by medical aids. The Medical Association of SA called for the resignation of Health Minister Rina Venter.

However, a recent concession ended the stand-off when Venter agreed to write the Representative Association of Medical Aid Schemes (Rams) out of the Bill, effectively ending Rams' statutory powers. Its powers curtailed, Rams remains dissatisfied.

Other commentators say the Bill is ineffective if not accompanied by other legislative changes, such as an altered Medical and Dental Act to allqw for group practices and the inclusion of pharmacists and nurses.

They say this would complete the levelling of the medical playing fields.

Media 'has important role'

CAPE TOWN — Except for one case, the Registration of Newspapers Act had never been used, Home Affairs Minister Louis Pienaar said yesterday. (463)

Introducing the second reading debate on the Registration of Newspapers Amendment Bill, he said the repeal of the Act was now being proposed, except for one provision relating to films. B/OAm 9/2/93

The media would play an important role in the establishment of a democracy. (327)

Jan van Eck (Ind Claremont) said Press freedom not only meant the right of the Press to publish what it wanted, but also the right of individuals and organisations to establish their own newspapers without being regulated by government.

Van Eck said one of the greatest threats to Press freedom was the lack of political diversity in the media. Eighty percent of existing newspapers supported the NP and, with few exceptions, most were anti-ANC and did everything possible to place it in a bad light. — Sapa.

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Crackdown

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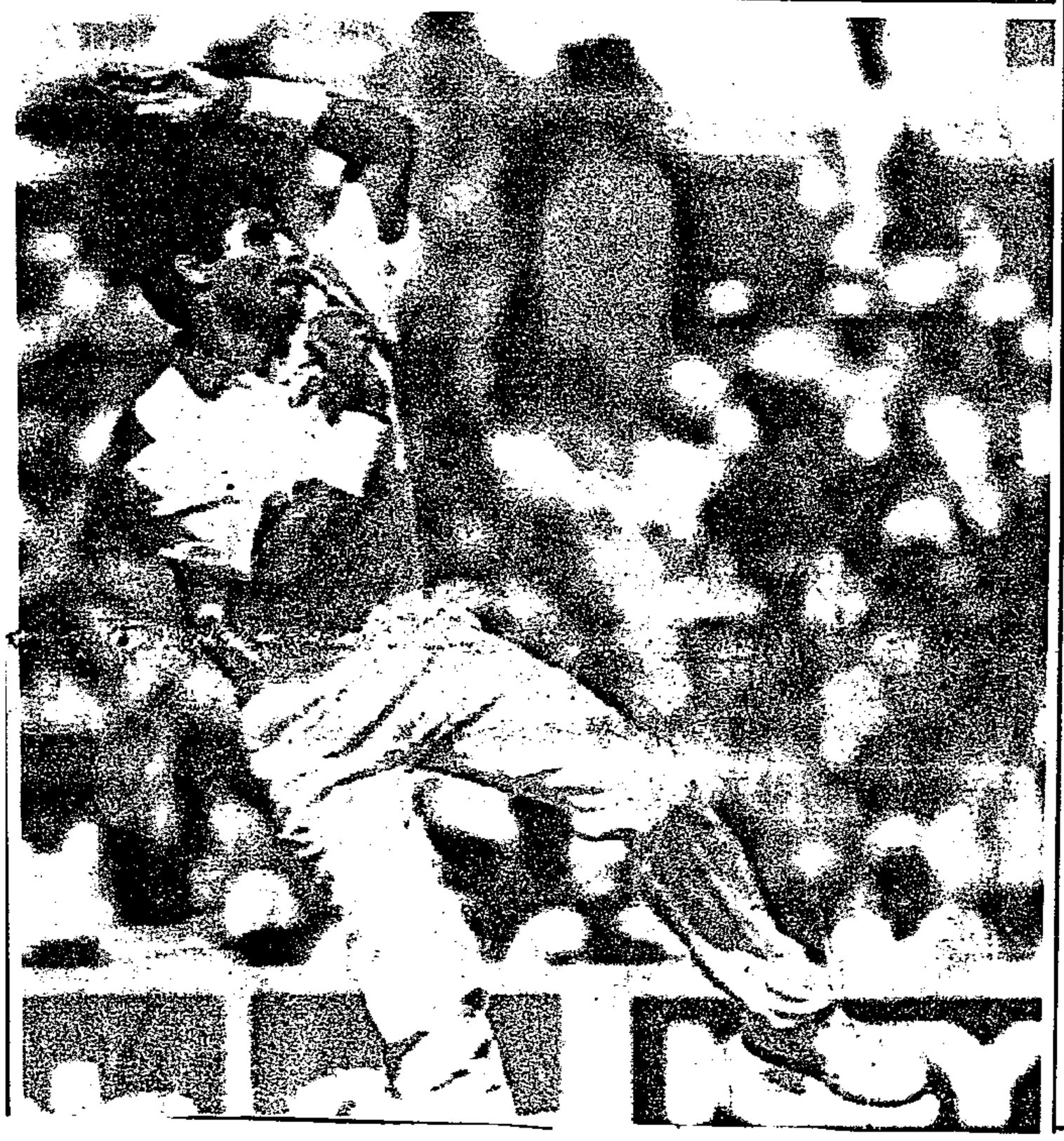


CT 10/2/93 (299)

Disaster plan for medical aid

Political Staff

THE government launched two separate actions yesterday to sterilise private sector medicine after widespread allegations of fraud and overuse of medical aid.

Measures were initiated to investigate medical aid schemes and to introduce a bill to deregulate the medical aid industry.

National Health Minister Dr Rina Venter said in Parliament a commission of inquiry would investigate the funding of the schemes, which opposition spokesmen claimed had paid inflated or fraudulent claims running into billions of rands.

The commission of inquiry would not look into the possibility that fraudulent claims were submitted but would focus rather on questions surrounding the future of the funds.

These included:

● Whether schemes were adequately funded and whether their funding could be controlled;

● What role the insurance industry could play in providing medical cover, and

● What role institutions such as benefit funds and mutual aid societies could play in enabling individuals to provide for future medical expenses.

Debate also began in Parliament yesterday on the Medical Schemes Draft Bill, which would scrap a provision in the existing act guaranteeing that the suppliers of medical services be paid.

This provision, unique to this country, forced schemes to make payments even if the services proffered were more expensive than required. This had driven the schemes to the brink of financial disaster, Dr Venter said.

DP health spokesman Mr Mike Ellis said his party would be supporting the bill, with certain reservations. Scheme administrators estimated that fraudulent and false claims had amounted to a quarter of the claims paid out, he said.

● Medical Association of South Africa (Masa) federal council chairman Dr Bernard Mandell said certain shortcomings in the new bill would have serious implications for future financing, delivery and standards of health care.

● Masa president Dr Norman Levy cautioned that the scrapping of the present compulsion of schemes to pay fees direct to suppliers could disadvantage lower income groups.

● The Representative Association for Medical Schemes endorsed the draft bill which their executive director Mr Rob Speedy said would free doctors and the public from previous constraints that had prevented competitive rates.

● 'White' hospitals little used

DP urges medaid fraud probe

Star 10/2/93 (299)

Political Staff

Multibillion-rand fraud in the medical aid industry should be investigated by a commission of inquiry, the Democratic Party has urged.

Speaking in the second reading debate on the Medical Schemes Amendment Bill, DP health spokesman Mike Ellis said patients and medical aid schemes could not afford to continue losing such huge sums of money.

He cited reports that a quarter of all payments made by medical aid schemes this year would be against fraudulent or false claims.

"This reflects a figure of R2,5 billion out of a total of R10 billion.

"Something needs to be done to protect the patient against the rackets."

Serious consideration should be given to setting up a commission of inquiry to investigate the allegations of fraud.

Dr Johannes Vilonel (NP Langlaagte) said life-saving measures were needed to counter financial pressures on medical aid schemes.

Government moves on fraud, crippling costs

Star 10/2/93

Bid to save sick

(299)

By Peter Fabricius
Political Correspondent

CAPE TOWN — The ailing medical aid industry, staggering under annual cost increases of 38 percent and massive fraud, is to undergo fundamental deregulation to rescue it from collapse.

The changes will mean patients paying more for low-cost treatment and having to shop around for the cheapest treatment available.

New legislation was introduced in Parliament yesterday to counter spiralling costs caused by widespread rip-offs by some doctors and abuse by patients.

The Medical Schemes Amendment Bill will try to put the brakes on medical aid claims by scrapping minimum benefits and ending the system of guaranteed payment of fees to doctors.

Rina Venter . . . rip-offs by some doctors and abuse by patients.

National Health Minister Dr Rina Venter said yesterday that the main effect of the legislation on the public would be that it might have to pay more for low-cost treatment.

This was because medical aid societies would now be free to introduce new schemes to make beneficiaries pay "the first rand" for treatment.

They would also be able to offer a range of benefits to fit the pocket of their clients.

The way would be open for patients to insure themselves for lower-cost treatment and rely on lower-cost medical aid only for severe illness or surgery. Financiers and suppliers of services would be able to negotiate benefits according to business principles.

Doctors would also lose their privileged position of being the only supplier of medical services who were guaranteed payment from medical schemes. This had contributed to gross abuses.

Venter said she was reporting the names of about 200 doctors who had claimed excessively. One had claimed just less than R1 million in 1991.

She said the unnamed doctor had claimed R997 685 from medical aid schemes in 1991 — 30 percent of it for doctor's fees and 68 percent for medicines.

"This is a trading doctor. He is making money from medicine," she said.

Venter gave the assurance that under the new system, there would still be ample provision for serious treatment.

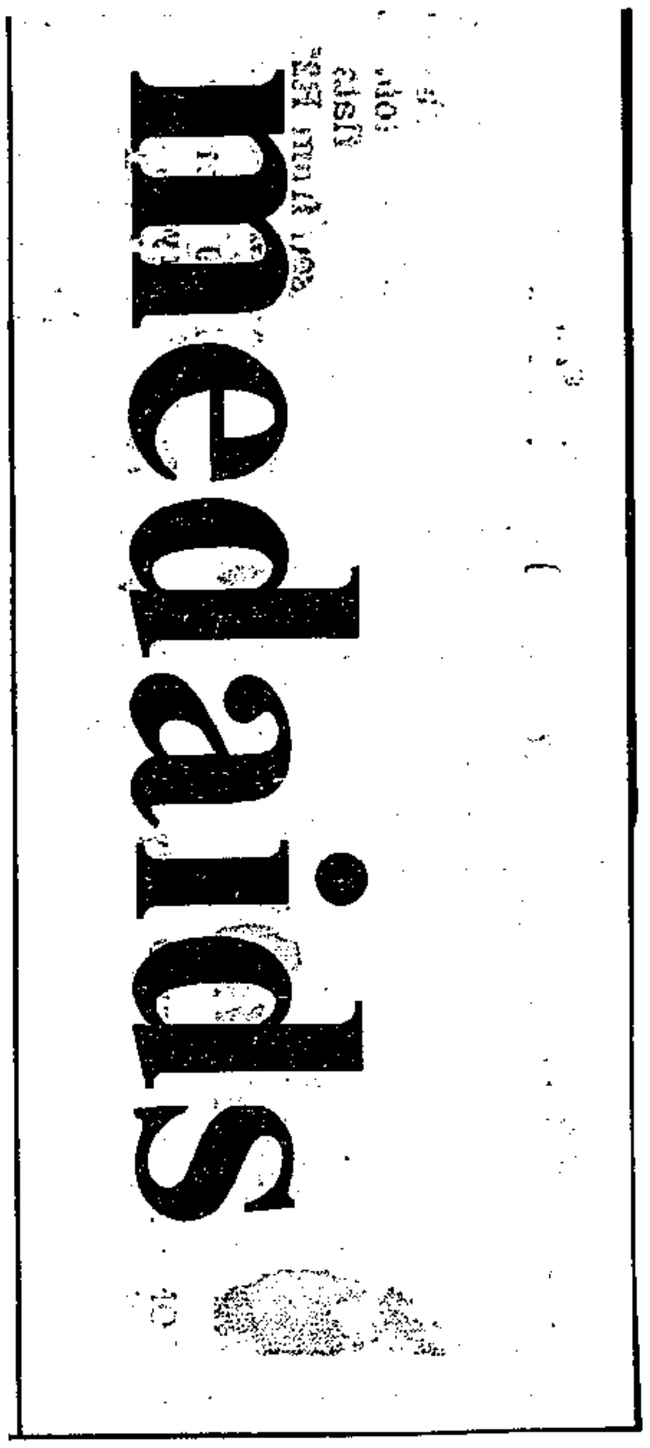
She said the attitude of patients that medical costs were "free" if they were on medical aid would have to change.

Venter also announced that the Cabinet had just approved an investigation into the long-term financial viability of medical aid schemes.

Among the aims of the investigation would be to consider whether schemes should be subject to compulsory actuarial audits.

The Minister said the Government had a duty to protect the interests of contributors to medical aid schemes, who were now paying R7 billion a year.

● DP urges medaid fraud probe — Page 3



Inquiry into medical aid fraud urged

299

ARG 10/2/93

Political Correspondent

MULTI-BILLION rand fraud in the medical aid industry should be investigated by a commission of inquiry, the Democratic Party has urged.

Patients and medical aid schemes "cannot afford to continue with the loss of such huge sums of money", DP health spokesman Mr Mike Ellis told parliament.

He added: "Something needs to be done to protect the patient against the rackets that are apparent in the medical industry at present."

Speaking in the debate on the Medical Schemes Amendment Bill, Mr Ellis cited reports that a quarter of all payments made by medical aid schemes this year "will be against fraudulent or false claims.

"This is an estimation made apparently by several administrators of medical aid schemes themselves and reflects a figure of R2,5 billion out of a total of R10 billion that medical aids expect to pay out this year.

"This is cause for major concern."

Mr Ellis said that while he recognised that the Bill would provide some measure of control to prevent "this appalling waste of money", the overall effects of the Bill "may be negligible, particularly as far as this fraud is concerned".

"I believe that serious consideration should be given to setting up a commission of inquiry to investigate these allegations of fraud.

"Such a commission, I believe, could be of equal importance to the patient and to the medical aid schemes, both of whom cannot afford to continue with the loss of such huge amounts of money."

The DP believed an important element of the Bill would be "the entire process of deregulation of the health care system which will now get under way by the passing of this legislation".

While the DP supported the legislation, it still believed it reflected "a measure of crisis management".

"What is really required ... is a complete review of the entire health care delivery system."

NEWS Government tables legislation to privatise medical aid schemes

Medical aid reviewed

■ Benefits paid out increased by 28 percent a year over five years

By Ismail Lagardien
Political Correspondent

THE Government yesterday tabled legislation in Parliament which proposes that medical aid schemes be deregulated and thrown open to the dictates of the free market. The Medical Schemes Amendment Bill also proposes that the automatic guarantee of payment by medical schemes to doctors be dropped.

This means that any patient who is a member of a medical aid scheme will no longer have the assurance that his or her scheme will pay for medical services.

Explaining the Bill yesterday, the Minister of National Health and of Health Services and Welfare, Dr Rina Venter, said in the past medical aid schemes prescribed (through legislation) minimum benefits for members.

This did not leave "much room to medical schemes to introduce flexible and innovative measures which may induce members to use their benefits sparingly".

Introducing the Bill in Parliament later in the day, Venter said that over the past five years benefits paid out by the various schemes had increased by an average of 28 percent a year while the increase in membership rose at an average of 3,3 percent a year.

The new law would prevent doctors from claiming excessively and would give patients the right to question them on their prices and charges.

Giving an example, Venter said a doctor had claimed about R1 million in one year, 68 percent of which was for medicines for which medical aid funds had to pay. "He is making money from the dispensing of medicine," Venter said. "The Bill aims to deregulate medical schemes in order for free market principles to operate."

'Fat cat' doctors face the music for medical aid abuses

ARG 10/2/93 (299)

Political Staff

ABOUT 200 doctors who have been enriching themselves at the expense of medical aid patients have been identified by the government and reported to the Medical Council.

The government is now waiting to see what the Medical Council does about these doctors.

Dr Rina Venter, Minister of National Health, said a commission of inquiry would investigate the funding of the medical aid schemes. She has introduced measures to deregulate the medical aids schemes which she said would guard against greedy doctors, and protect those who were acting in the interests of the patients.

The Democratic Party has called for an investigation into the multi-billion rand fraud in the medical aid industry.

DP health spokesman Mr Mike Ellis said patients and medical aid schemes "cannot afford to continue with the loss of such huge sums of money".

"Something needs to be done to protect the patient against the rackets that are apparent in the medical industry at present."

Mr Ellis cited reports that a quarter of all payments made by medical aid schemes this year "will be against fraudulent or false claims".

"This is an estimation made apparently by several administrators of medical aid schemes themselves and reflects a figure of R2,5 billion out of a total of R10 billion that medical aids expect to pay out this year.

Dr Venter said the 200 doctors, who she described as a small group, were abusing the medical aid system. "You will find that they were using the health delivery system for their own financial benefit."

Dr Venter did not release names.

The doctors identified had each claimed between R500 000 and R997 685 in fees from medical aids for a year, of which just 30 percent was for diagnosis, and the rest for medicines they dispensed themselves.

"I am not saying that all dispensing doctors are doing this," she said.

"It is in the public interest that this information should be investigated."

Dr Venter said the Cabinet had approved of an investigation into the financial state of medical aid societies.

● See page 6

Probe into schemes' funding

Govt plans shake-up for medical aid

B/DM 10/2/93. (299)

CAPE TOWN — Government initiated steps yesterday to investigate medical aid schemes and to deregulate the medical aid industry.

National Health Minister Rina Venter said in Parliament a commission of inquiry would investigate the funding of the schemes, which opposition spokesmen claimed had paid inflated or fraudulent claims running into billions of rands.

The inquiry would not investigate the possibility that fraudulent claims were submitted but would focus rather on questions surrounding the future of the funds. These included:

☐ Whether schemes were adequately funded and whether their funding could be controlled;

☐ What role the insurance industry could play in providing medical cover;

☐ Whether intermediaries, such as recruiting agents, should be allowed to market membership of schemes; and

☐ What role institutions such as benefit funds and mutual aid societies could play in enabling individuals to provide for their future medical expenses.

Debate also began in Parliament yesterday on the Medical Schemes Draft Bill, which would scrap a provision in the existing Act guaranteeing that the suppliers of medical services be paid. This provision, unique to SA, forced schemes to make payments even if the services proffered

TIM COHEN

were more expensive than required. This had driven the schemes to the brink of financial disaster, Venter said.

The benefits paid out by medical schemes increased over the past five years by an average of 28% a year, while the number of beneficiaries increased on average by only 3,3%.

"Medical schemes are unfortunately exploited in SA. Overutilisation and fraud perpetrated against medical schemes is rife," Venter said.

Health department officials felt the guaranteed payment of accounts had created the impression among medical scheme members that health care was free. Members were therefore often not aware of the costs involved and this gave rise to excessive demands. The mandatory direct payment of accounts, criticised by the Competition Board, could therefore no longer be justified, she said.

The other major amendment to the Act would be the scrapping of the requirement that a scheme must afford members certain minimum and maximum benefits, Venter said. This had prevented medical schemes from introducing flexible and innovative measures which could induce members to use their benefits sparingly.

This new market-orientated approach

☐ To Page 2

Medical aid

B/DM 10/2/93. (299)

☐ From Page 1

would place the responsibility on the individual to provide for his and his family's health care and related costs.

Venter said the importance of the industry could be illustrated by the fact that the 187 registered schemes provided health care cover to more than 6-million beneficiaries and paid almost R7bn in benefits during the 1991 financial year.

DP health spokesman Mike Ellis said his party would support the Bill, with certain reservations. Scheme administrators estimated that fraudulent and false claims had amounted to a quarter of the claims paid out. About R10bn was expected to be paid out this year, he said.

Ellis said serious consideration should be given to setting up a judicial inquiry to investigate fraud allegations.

He welcomed the process of deregulation and the decision that the Representative Association of Medical Schemes would no longer be afforded statutory recognition. According to department officials, there was dissatisfaction among suppliers of services that membership of Rams was compulsory, which was considered to be unjustly favoured.

MARIANNE MERTEN reports that Medical Association of SA federal council chairman Dr Bernard Mandell said certain shortcomings in the new Bill would have serious implications for future financing, delivery and standards of health care.

Masa had requested the appointment of a commission of inquiry into the matter. Negotiations with minimum state interference were the best vehicle to bring about stable and effective methods of financing health care, he said.

SA Health and Social Services Organisation national publicity secretary Aslam Dasoo condemned the Bill and asked for it to be withdrawn.

Registrar of Medical Schemes Danie Kolver said once the Bill was passed there would be no statutory prescription on benefits or prices. It would compel medical aid schemes to give their members, and the Registrar, detailed information on the scheme's performance.

Star 11/2/93

Call for big overhaul of medical aid

(299)

While some leading players yesterday lauded the Government's deregulation prescription for the medical aid industry, others called for a complete overhaul.

Health Minister Dr Rina Venter this week proposed the Medical Schemes Amendment Bill to minimise claims — by scrapping minimum benefits and ending guaranteed payment of doctors' fees.

The National Progressive Primary Health Care Network said: "We believe that tinkering with current medical aid legislation will not solve the crisis in the private and public sector, and that a major overhaul of the whole system is necessary."

Dr Bernard Mandell of the Medical Association of SA warned of serious implications for the future financing, delivery and standards of health care.

However, the SA Nursing Association said private nurses would finally be recognised. — Medical Reporter.

Govt 'blind to' medical aid conmen

299
CT 11/2/93

Staff Reporter

THE government yesterday turned a blind eye to more than 200 doctors guilty of enriching themselves through medical aid scams.

On Tuesday Health Minister Dr Rina Venter was announcing changes to laws controlling the country's 187 medical aid schemes when she said the names of about 200 hundred doctors guilty of abusing the system were known to her.

However, a spokesman for her office said yesterday that the list of guilty doctors would not be presented to the medical council and it had merely served as "an illustration" of abuse of the current system.

Changes to the act have been justified by Dr Venter because loopholes in the previous act have led to abuse of the system by doctors and patients.

The Democratic Party said they too had evidence detailing the medical schemes "rip-off" which was "vast and horrific" — but the DP did not call for guilty parties to be prosecuted.

DP health spokesman Mr Mike Ellis said doctors were not the only professionals guilty of abuse, alleging that some pharmacists, dentists and physiotherapists had also been involved.

Mr Ellis charged that some members of the medical profession had been found to be working in collusion with patients.

In one case, a patient had visited his doctor 40 times in one month and had colluded with the doctor in making fraudulent claims, he said.

Mr Ellis added that it was believed that the patient shared the profits from this medical aid scam with the doctor.

He estimated that the increased output by medical aid schemes under the current system would mean a tarrif increase for the patient of as much as 25%.

The registrar of medical aid schemes, Mr Danie Kolver, said changes to the act would force patients to cut out "unnecessary visits" to the doctor as they would be liable to pay a higher proportion of their medical bills once the medical aid industry was deregulated.

Mr Kolver said it was hoped that "ongoing consultations and prescriptions" would fade away with the introduction of a range of competitive medical aid packages with restricted cover.

Patients would have to "think twice" if they had to pick up the bill, he said.

Medical aid scheme administrators estimate that a quarter of all medical aid payments this year will be made against fraudulent or false claims.

'SA's health system collapsing' — ANC

JOHANNESBURG. — The ANC yesterday accused National Health Minister Dr Rina Venter of ignoring a national health care crisis while tackling only aspects of the crisis that affect whites.

The organisation rejected Dr Venter's "piecemeal" approach and called for a swift restructuring of the entire health care system.

On Tuesday Dr Venter announced new legislation to stifle rising medical costs she said were due to fraud and overuse of medical schemes.

An ANC statement charged that Dr Venter was focusing on the medical aid issue — which affected mainly whites — while sidelining problems suffered by most South Africans.

"The big academic hospitals, the medical schools, the nursing profession, provincial hospitals, private hospitals, rural health services, labour relations, private practice and standards of health care throughout the country are collapsing," the ANC said. — Sapa

Overcharging: 'No action'

299
CT 11/2/93

THE government yesterday turned a blind eye to over 200 doctors guilty of enriching themselves through medical aid scams.

A spokesman for health minister Dr Rina Venter said yesterday the list of guilty doctors would not be presented to the medical council, and it had merely served as "an illustration" of abuse of the current system.

● Full report — Page 7

focus on medical aid

THE MEDICAL SCHEMES AMENDMENT BILL tabled in Parliament is an indication of how big business is trying to take over health care and turn it into a profitable concern.

And as the Government goes ahead with the discussions of the Bill in Parliament, opposition is growing in medical sectors, trade unions and political organisations, who see the measure as an abrogation of responsibility by the State.

At the centre of the debate is the state of the country's public health care system, which is in shambles, with overcrowded wards, overworked doctors and a lack of basic facilities in many hospitals.

South Africa, with no definable public health system, has found it necessary to intervene in a scheme dealing with seven million people out of a population of about 35 million.

The motivation, as defined by Health Minister Dr Rina Venter, is to curb abuses that have led to medical schemes paying R7 billion a year in benefits.

Doctors and other sectors in the chain have been accused of abusing the medical aid schemes, with one doctor allegedly claiming almost R1 million in one year.

But the amendments go further than just dealing with measures to curb abuses. The sum total of the amendments are that medical aid groups will now:

- Be able to form Health Management Organisations (HMO) with groups of doctors who will be hired by them and who will treat their members. In such a case, according to various players in the medical field, a medical aid member's right to choose a doctor of his-her choice is eliminated.
- Be empowered to set their own tarrifs and will, therefore, be able to reject claims by doctors who may have charged what that medical aid group will have set as its own tariff. In such a case, the doctor will revert back to a member for the balance of his costs.

Also:

- The forum for discussing tariffs between the state, medical practitioners and medical aid schemes in the form of the Representative Association of Medical Schemes (RAMS), will no lnger be statutory, thereby leaving the issue of tariffs to each scheme operator.

The South African Medical and Dental Practitioners (SADMP), Community Health Awareness Programme (CHAP), South African Health and Social Services Organisation (SAHSSO) all agree that the measures are intended to bolster the profitability of medical aid schemes.

All, in conjunction with the ANC, Azapo, PAC, Cosatu, Nactu, VAT Co-ordinating Committee, South African Consumer Union, South African Council of Churches, accuse the Government of acting unilaterally and at the behest of big capital.

The new Medical Schemes Amendment Bill is intended to curb fraud and save Medaid from bankruptcy. Its opponents say it will provide poor health services and take from the poor to subsidise the rich, write **Mokgadi Pela** and **Mathatha Tsedu**:

Sowetan 12/2/93 (299)

Health, they insist, is under the present scheme being turned into a profit commodity for the benefit of the scheme operators.

They feel that the Government is abrogating its responsibilities to provide adequate basic health care for the citizens and is instead propping up big capital in the private sector that serves mainly white people to the detriment of the more than 80 percent black population who are not on medical aid.

Patients, they insist, will suffer in the end as the new scheme provides for stratified benefits "with second class contributions for second class treatment".

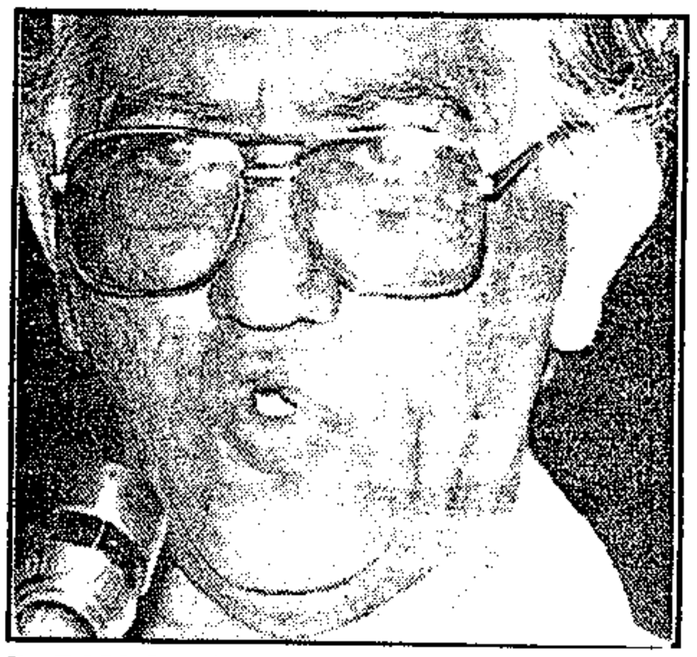
"Can health be quantified in those terms, like a fridge or house furniture, where one is able to say I do not need a double door fridge?" Dr RAM Salojee of the SAMDP asked. "We reject this entrenchment of classes in medical provisions.

"What happens when a patient who is supposed to be in second class benefits needs a serious operation? Who will pay for this?"

Cosatu and Nactu both said the inferior schemes would be shifted to workers who will in the end actually subsidise the rich.

They all felt that private medical schemes should not be used as a replacement for a public health policy which would have a health insurance scheme that guaranteed everyone in the country free basic health care.

"Can health be quantified in those terms, like a fridge or house furniture, where one can say I do not need a double door fridge?"



Dr RAM Salojee

But a spokesperson for Medscheme, which administers 47 schemes in the country, Mrs Laetitia Mouton, said the Bill was a positive development that would curb abuses.

She said of the R7 billion paid out in benefits each year, it was calculated that 25 percent was fraudulent. This meant R1,72 billion was paid out fraudulently.

She said if a member did not like an HMO, she could challenge this "at the annual general meeting of the scheme and have this amended".

Mouton said members would benefit because lesser use would eliminate the need for annual increments of contributions.

Health Minister Venter said the bill would also allow a wife of a contributor to belong to another scheme or make her husband a dependant. Dependants of a deceased contributor would also be able to continue to be members, she said.

She said if the amendments were not implemented, the private medical aid industry would fold up. Hence the rescue.

But those opposing the move say what is needed is immediate attention to the collapsing public health sector which serviced more millions of people.

(Monday: the growing opposition and what the organisations say about the amendments.)

Importers to oppose medical supply duties

LINDA ENSOR

CAPE TOWN — Importers of medical supplies have formed a lobby group to fight imposition of import tariffs which they say will squeeze them out of the market and give big manufacturers a monopoly.

The lobby group — consisting of Macmed, RM Salters, Medical Textiles, Vitamed, Paperback SA and General Medical — would meet the Board on Tariffs & Trade (BTT) and Health Minister Rina Venter to discuss the matter, Macmed MD Don McArthur said yesterday.

"Companies are using the BTT to eliminate competition at the expense of healthcare costs in SA," McArthur said. The group, with the support of private hospital groups and Macmed's US principals, has also taken its case up with the Competition Board.

There were two issues of complaint, McArthur said. First, the BTT had acceded to an application by Promex for import protection of the R25m-a-year syringe market. McArthur said "punitive duties" of 70% were imposed compared with the previous 35%, despite the opposition of syringe importers.

Promex replied to the allegations, saying it had sought protection against dumping, a request granted by the BTT after extensive investigation.

The second cause of complaint related to the application by Smith & Nephew, which McArthur estimated to have 85% of the R50m-a-year gauze market, for tariff protection against the import of finished and raw material gauze products.

Smith & Nephew GM Neil Wallace said the company had numerous sources of supply for low-cost medical fabrics, but believed it would be opportunistic and short term to switch its sourcing. "Given a level playing field on cotton and labour costs, high import duties would not be necessary. But until this happens we have some 800 jobs to protect."

Mixed reaction to medical aids Bill

THIS week's introduction in Parliament of legislation to amend the Medical Schemes Bill was met with reservation by doctors but applauded by medical aid schemes.

Medical Association of SA (Masa) spokesman Hendrik Hanekom said the new legislation addressed the problems of medical aid schemes, but ignored the interests of doctors and patients.

Masa believed that scrapping the direct guaranteed payment of doctors could compromise patient care. Many patients did not have the financial means to make copayments or settle accounts, pending refunds from their medical schemes.

But Hanekom welcomed Cabinet's approval of an inquiry into the health insurance industry.

Masa was concerned that the proposed changes would not meet the criteria of making health care more accessible, affordable and efficient.

Much of the controversy surrounding the Bill centres on the provision it makes for "managed health care". Under the new legislation, medical aid schemes would be allowed to, for instance, set up a clinic and employ a range of health professionals to give a more comprehensive service.

Representative Association of Medical Aids (Rams) executive director Rob Speedie said managed health would eliminate wastage and cut down on overservicing by doctors, but it would not lead to substandard care.

KATHRYN STRACHAN

Masa was concerned that the changes allowing the scrapping of minimum and maximum benefits would enable medical aids to "risk rate" members, favouring the young and healthy. The organisation favoured more flexible benefit packages tailored according to individual needs, but medical schemes should provide essential benefits.

It was also concerned about the power given to Rams and that it could wield too much control over the use and provision of services. The amendments would legally entrench Rams as the single spokesman of medical schemes.

AN ANC health spokesman said the collapse of medical aids was part of a much greater crisis affecting the entire health care system. He said the new legislation was aimed at resolving a crisis which affected mainly whites who were employed and ignored all aspects that affected the vast majority of South Africans such as the underfunding of public facilities.

Sapa reports that the South African Nursing Association said it was delighted that the amendments had been approved.

Apple juice scare evaporates

could cause cancer and oth-

Old Mutual in R272m legal battle

By JEREMY WOODS

THE Supreme Court in Cape Town is set to host a R272-million David and Goliath battle between Old Mutual and a close corporation, Profcare.

Profcare alleges that Old Mutual pulled out of an underwriting arrangement for a health care insurance product and later used the product in one of its own health care schemes.

In a statement of claim lodged at the Supreme Court this week, it is alleged that a medical care package developed by Deon Scheepers for Profcare was to be underwritten by Old Mutual and Old Mutual Health Care Insurance.

The papers say that, despite an agreement, Old Mutual pulled out of the underwriting deal days before the project was to be launched.

Furthermore, when the Old Mutual's health insurance business launched its Flexicare product some momths later, it is alleged that one of the components of the scheme was the policy developed by Mr Scheepers for Profcare.

Dr Thys Oosthuizen, senior legal adviser for Old Mutual, says: "The summons was served on the Old Mutual and referred to the society's legal advisers with the instructions to defend.

"The necessary steps are being taken. Inasmuch as the matter is now before the court, it would be inappropriate for Old Mutual to comment any further."

'Shop around for most economical treatment'

Political Staff (299)

HEALTH Minister Dr Rina Venter has given some free advice to hard-pressed medical patients: turn the tables on doctors and shop around for the most economical treatment.

She wants to introduce a new culture in medical care.

The first question almost all doctors ask their patients is "how will you pay?" Most patients do not dream of asking the doctor what the charges are. They just hold thumbs and hope for the least until the bill comes.

But Dr Venter wants to change this and create a new culture between patients and doctors. She is making changes to the laws controlling the country's 187 medical aid schemes through the Medical Schemes Amendment Bill that was tabled in parliament yesterday.

This will deregulate the schemes to allow free market principles to operate.

At a Press briefing, Dr Venter said the minimum and maximum benefits that a medical aid scheme could pay would no longer be set by law. Dr Venter wants patients to discuss the costs of treatment with their doctors at the outset and to go to another doctor for a second opinion and a better price if there is a chance their medical aid is being exploited.

"In the beginning patients and doctors will feel very uncomfortable, but it is a culture we have to bring into the health delivery system," Dr Venter said.

Also, patients going to hospital should look for the best price as the cost of private hospitals for medical aid schemes jumped by 55 percent in 1991.

Among the changes coming to medical aid, schemes will be able to offer different packages to their members — allowing some members to pay higher premiums for more sevices, and some to pay lesser premiums for less services.

A married woman can become a member of a medical aid scheme in her own right, irrespective of her husband's membership of another scheme.

The dependants of members will be entitled to continue with their medical aid membership after the member has died.

Behind the changes made in the 43-page Bill is the government's fear that if medical aid schemes start to tumble, it will have an even bigger medical budget bill itself.

Benefits paid out by medical schemes increased over the past five years by an average of 28 percent a year, while the number of beneficiaries increased on average by only 3,3 percent over the same period.

Medical aid schemes cover six million people and were responsible for 45 percent of total health care expenditure by paying out almost R7 billion in benefits in the 1991 financial year.

NEWS FEATURE Amendment Bill should go back to drawing board say various spokesmen

Medical Aid Bill widely rejected

Sowetan 15/2/93

299

By Mokgadi Pela and Mathatha Tsedu

■ THUMBS DOWN Health and political groups say patients will be the losers:

Mokoape

Marcus

Randera

VARIOUS ORGANISATIONS HAVE rejected the changes to the Medical Schemes Amendment Bill which were announced by Health Minister Dr Rina Venter in Parliament last week.

The changes will mean patients paying more for less quality treatment. The Bill will also stop minimum benefits and end the system of guaranteed payment of fees to doctors.

The South African Health and Social Services Organisation said the Bill would ensure the continued profitability of medical aid schemes, pharmaceutical companies and organised medical practitioners. The subsidisation of private medical practice at the expense of public health care had to stop, it said.

"We were not consulted in the drafting of these amendments. Despite repeated calls for talks to the Government and other people, nothing has been done. The Central Council for Medical Schemes is an organisation that has no credibility in the eyes of the people. It represents the interests of big capital.

"The total effect of the amendments is that medical aid schemes are now going to set their own tarrifs, and doctors will move from public practice into private practice.

"There is no denying that abuse was and still is rife and we condemn this as unethical. But the use of this excuse to push a secret agenda to privatise health care services is equally repugnant.

"We will oppose this with mass action and meetings countrywide to have the restructuring stopped."

Attempt to shift blame

The Community Health Awareness Project [Chap] said:

"To illustrate this myopic superficial analysis by the powers that be, one needs to read the clause that refers to guaranteed direct payments by medical schemes to suppliers of services.

"To isolate direct payment as a cause for serious malpractices is obviously a naked attempt to shift the blame from incompetent and inadequate administration procedures of the medical schemes to suppliers of services, most of whom have proved to be fair and honest in their practices.

"It is our view in Chap that the whole business of medical schemes should be scrapped and that a new system that will arrest and improve the deteriorating health care management be devised.

"We believe that a national scheme to which all workers contribute could go a long way towards alleviating this problem."

Chap said the Government had destroyed the public health sector and it was clear that it could not give direction to the private sector as well.

"The amendments proposed by the Minister of Health are just a manifestation of the inability of the Minister and the central council for medical schemes to diagnose and treat the primary cause of the debilitating disease that is destroying the medical schemes.

The National Council of Trade Unions said: "One identifiable feature is the privatisation of the health care which will be disastrous for the majority of our people.

"We have always been left behind in receiving qualitative health care and it is therefore unacceptable for Dr Rina Venter to suggest that minimum and maximum benefits are done away."

Industry was collapsing

The ANC said Venter had created another crisis and proved yet another failure of National Party policies in the health sector. Announcing the Medical Aid Amendment Bill she admitted that the Medical Aid industry was collapsing.

"Many other people, including the ANC, have known this for years.

"A system of third party payments with no controls and no incentives for anybody to contain costs is doomed to failure. Under National Party rule greedy businessmen have been encouraged to milk South Africans of millions of rands through the Medical Aid schemes.

"But the Medical Aid crisis is only part of the much greater crisis affecting the whole health care system. The big academic hospitals, the medical schools, the nursing profession, provincial hospitals, private hospitals, rural health services, labour relations, private practice and the standards of health care throughout the country are all collapsing."

"Azapo readily acknowledges that abuse of medical aid does contribute to the high cost of medical care, but then none of the different health teams possesses monopoly on such abuse.

"It is the responsibility of any medical system to police and catch such abuses of the system and the proposed Bill is a tacit acknowledgement of failure by the system''.

the triangular one-day series. Picture: BRIAN HENDLER

Correctional Services spokesman ... are in a critical condition before they start talking to us."

... protest, he said.

Police arrest 498 people for drug trafficking over a week

BIDAY 16/2/93

RAY HARTLEY

POLICE arrested 498 people in connection with drug trafficking during the week ended February 1 this year.

SA Narcotics Bureau police confiscated 15 950 mandrax tablets, 1 810kg of dagga, 250g of cocaine and 40 units of LSD during the clampdown, a police statement said.

Vehicles worth R29,2m were confiscated by police between January 28 and February 4 this year. Of 346 vehicles seized, 238 were identified as stolen.

Police spokesman Capt Nina Barkhuizen said the figure of 498 arrests for drug related crimes was "higher than normal", but vehicle confiscations were "normal".

Twenty-nine people were arrested and R53 000 worth of diamonds, gold and precious metals seized.

A special operation in Katlehong and Tembisa netted 13 stolen vehicles and led to four arrests.

Meanwhile police said they confiscated three assault weapons and a significant quantity of ammunition from a hostel and private residences in Tembisa.

Police spokesman Capt Ida van Zweel said an AK-47, a Makarov pistol and home-made shotgun linked to criminal activity in the area were seized from Vusimusi hostel and houses in its vicinity.

Four men were arrested in connection with the April 1992 murder of a Tembisa resident, she said.

Meanwhile, Sapa reports a man was shot through his car window and robbed of his firearm as he arrived at his work at Marlboro, Sandton, yesterday. His attackers ran away.

Spokesman W/O Andy Pieke said Dirk Otto, 46, was dead on arrival at hospital.

Late on Sunday night three men held up Marius Mulana, 59, with a pistol while he was counting money at Branigans Restaurant, Bedfordview, and forced him to open a safe. They escaped with R12 000.

On Monday four men attacked J M Booysen, 53, at his business, Rapid Scrap Metals, Brakpan. One man hit Booysen with an iron rod and tied him up before the gang made off with R17 000 cash, a camera and a tape recorder. Booysen received head wounds.

New system hopes to cut medical costs

299

A HIGH-tech system designed to cut medical health care costs to patients and medical aid societies, and to guarantee payments to medical practitioners, is about to be launched by a Johannesburg company.

Entitled Prodoc, the computerised system, designed by HMS Health Services Management, proposes to achieve this by ensuring swift payment to the medical profession, cutting medical aid societies' administration costs and by keeping in check doctors who abuse medical aid systems.

BIDAY 16/2/93

One of the medical profession's major costs is credit which has to be extended to cover delayed payments due to slow medical aid response.

The system hopes to eliminate this problem by cutting the processing time for claims by medical aid societies. This will be done by linking various medical and paramedical practices with Prodoc through a computer network.

The system will transmit information directly to the medical aids daily.

Implats

BIDAY 16/2/93

From Page 1

Pre-tax income dropped to R158m (R248m) and after lease, tax, royalty payments and tax provisions, after-tax profit stood at R83,3m (R97m).

Income from the company's 27% stake in Eastern Platinum and Western Platinum fell to R10,5m (R29,8m), resulting in a 25% drop in attributable income to R93,6m (R125m).

In the year ended June 1992, turnover stood at R2,26bn against cost of sales of R1,67bn. Pre-tax profit was R511m and after-tax profit was R233m.

Borrowings increased by 69% to R210m.

McMahon said industrial relations had ... industry standards. Retrenchment costs of R370/kg were included in the figure.

The company was still toll-refining some of its material overseas, including in Russia, and would continue to do so while it was commercially viable.

McMahon reiterated that Implats was interested in increasing its stake in Lonrho's Western Platinum and Eastern Platinum as it had pre-emptive rights, but he said no new approaches had been made.

Prices were the only bad news, he said. "The passage of time has made fools of us all," he said, referring to expected increases in prices by the industry. Average

Group condemns Venter's health Bill

Sowetan 16/2/93

■ **New health scheme discredited in US:**

By Mokgadi Pela

THE South African Medical and Dental Practitioners has added its voice to the round condemnation of Dr Rina Venter for the amendments to the Medical Schemes Act.

The changes will mean patients paying more for less quality treatment. The Bill will compromise the patient's right to consult the doctor of his choice.

Spokesman for SAMDP Dr Joe Maelane said his organisation would liaise with other organisations to frustrate the implementation of the bill. He listed the loopholes in the Bill as:

- Privatisation and uncontrolled profitability for the medical schemes to the detriment of the patient;
- Doctors will be appointed by medical schemes resulting in business doctors serving the community. "We suspect that their aim may be to please their employers at the patient's expense,";
- This is a blatant attempt to establish a system of health already discredited in the United States;
- The blame for the high cost of health must be put squarely on the State;
- The lack of reciprocal responsibility between private and public health is a curse for the lower wage earner. This locks him into a medical aid system with only basic benefits; and
- Doubts if the negotiation process can be complete when health remains outside the discussions.

Organisations that have already condemned the changes include the South African Health and Social Services Organisation, the Community Health Awareness Project, Azapo and the ANC.

Venter is criticised

THE SA Medical and Dental Practitioners' organisation has joined a host of other bodies in criticising National Health Minister Dr Rina Venter's proposed adjustments to medical aid schemes.

(299)

Last Tuesday Venter announced new legislation to counter increased medical costs, which she said was caused by overuse and fraudulent use of medical schemes by medical practitioners. "To suggest that mainly doctors, because of a few transgressors, are responsible for the medical aid crisis is deplorable," the SAMDP said. - *Sowetan Reporters and Sapa.*

Sowetan 16/2/93

Medical aid law criticised

THE SA Medical and Dental Practitioners organisation has joined in the criticism of National Health Minister Rina Venter's proposed adjustments to medical aid schemes.

In Parliament last week Venter announced new legislation to counter increased costs. (299)

"To suggest that mainly doctors, because of a few transgressors, are responsible for the medical aid crisis is deplorable," the organisation said yesterday.

Spokeman Dr Joe Maelane said a meeting of medical practitioners, medical aid administrators and representatives of patients and employers could solve the crisis. — Sapa.

12/2/93
Business Day

Medi-Clinic wants hike in ICU tariff

ARG 17/2/93 (299)

STEPHEN CRANSTON

JOHANNESBURG. — Medical aid tariffs for intensive care units should be increased by 50 percent to provide private hospitals with adequate returns, according to Medi-Clinic managing director Louis Alberts.

Mr Alberts said in a presentation to the Investment Analysts Society the tariff for an ICU was R1 026 a day, but the cost of nursing alone was R890 a bed and the capital cost of a unit was R284 000 a bed. The ICU tariff should be closer to R1 500 to give an adequate return, he said.

Mr Alberts said hospitals within the Medi-Clinic group were paid R18,78 a minute by medical aids, yet a three-hour heart operation, which required considerably more sophisticated equipment and more skilled personnel warrented only R10,95 a minute.

In effect, the basic cases were cross-subsidising more complex procedures.

Medi-Clinic chairman Dr Edwin Hertzog said that in terms of the proposed amendments to the Medical Schemes Act, these tariffs would no longer be compulsory and medical aids would be allowed to reimburse private hospitals better if the members were prepared to pay for the cover.

Hospitals would also be able to contract with medical aids as preferred providers.

Medical ombudsman urged

~~290~~ (299) STAR 18/2/93.

By Paula Fray
Medical Reporter

The South African National Consumer Union (SANCU) has called for an independent ombudsman to vet accounts of private patients in view of the proposed Medical Schemes Amendment Bill.

SANCU president Lillibeth Moolman was speaking at the launch on Tuesday night of the Care Smart Card Network — which allows members to manage their own benefit funds and pay immediately for medical services and medicines by the Botshelo Health Care Systems.

Moolman said only 15 percent of the population had consistent access to private health care while 80 percent of the population was being taken care of by the State under an ever-diminishing budget.

"A cause for concern in the medical aid system is that premiums keep going up and benefits keep going down. We are aware that many medical aid schemes are in deep financial trouble," said Moolman.

Running

Amendments to the Act could lead to medical schemes running their own hospitals and pharmacies: "This will have to be watched carefully to ensure that this does not have the effect of making health care even more expensive instead of less so," she added.

The union felt strongly that certain rights had to be guaranteed to the patient. "We would very much like to have an independent ombudsman who could be asked to vet an account," said Moolman, who added that the union would also press for a statutory body for private hospitals.

And, she said, the time was past when all decisions as to the patient's financial treatment could be made without discussions with the people concerned — consumers of health services.

The Medical Schemes Amendment Bill, under debate in Parliament, would give medical aids some leeway in rearranging their mechanisms and structures to curtail rampant cost escalation and make affordable health-care cover available to a broad spectrum of the community, said Medical Schemes' Registrar Danie Kolver.

Kolver said there would always be three major players: the medical scheme, the patient and the providers of services. And, as medical services and health-care costs escalated, new and innovative structures would be brought into play.

The Botshelo Health Care Smart Card operates through a special savings account into which the member's monthly benefit fund contributions are placed. The member is issued with a card to pay directly for his medical expenses.

Tax-free interest is paid on the savings and, if members manage their funds, they can build up substantial amounts in their savings accounts to provide for major medical expenses later in their lives.

R2bn paid out in medicine benefits

BIDAY 18/2/93 (299)

GERALD REILLY

MEDICINE benefits totalling almost R2bn accounted for the lion's share of medical aid organisations' payouts during 1991, the latest Registrar of Medical Aid Schemes figures show.

The income of the 176 medical aid schemes, 20 medical benefits schemes and 40 exempted schemes in 1991 amounted to R7,8bn.

Membership fees totalled R6,63bn for medical aid schemes and R805,5m for medical benefit schemes. Exempted schemes' income totalled R288,4m. Total benefits during the year amounted to R6,892bn.

DP health spokesman Mike Ellis estimates this figure will escalate to almost R10bn during 1993.

Administration costs of schemes totalled R420,7m — 5,71% of membership fees.

Medicine payouts totalled R1,998bn — 29% of total benefits.

The second biggest payout item was R1,542bn to hospitals (22,4% of benefits) of which R1,194bn went to private hospitals.

During the year R967,3m was paid to general practitioners (14%), R1,197bn (17,4%) to specialists and R688,4m (10%) to dentists. "Other" benefits came to R478m.

Meanwhile, last week National Health Minister Rina Venter told Parliament there would be an investigation into the funding of medical schemes which opposition spokesmen claimed had paid inflated prices for services or fraudulent claims "running into billions of rands".

A Medical Aid Schemes Bill now before Parliament aims to scrap the existing Act which guarantees payment to suppliers of services.

Total membership of aid, benefit and exempted schemes at the end of 1991 was nearly 2,378-million and, with dependents, 3,913-million.

This means just over 20% of the population is covered to some extent by medical aid organisations.

The 1992 figures would be available at mid-year, a spokesman said.

MEDICAL SCHEMES (299)

Discovering a cure

Health Minister Rina Venter this week scored her first major victory in reforming SA's ailing health care services when parliament passed the Medical Schemes Amendment Bill. FM 19/2/93.

The Bill, first tabled in parliament early last year and fiercely opposed by doctors because of what it might do to private practices, amounts to an extensive deregulation of private-sector health care.

"I knew we had a strong but difficult case, but I never hesitated that we were on the right track," Venter says. But she warns that this won't automatically cut costs. "We need to change the health care culture. Doctors, patients, all health care providers and the media need to evaluate health care in terms of cost — it's also a commodity."

In brief, the Bill gives medical schemes the clout to question claims and keep costs in check by ending guaranteed payments and minimum rates. It also opens the sector to competition by allowing schemes to run hospitals and clinics, and employ doctors.

Doctors have argued that as schemes acquire greater powers of discretion over the use and provision of services, doctors could find their professional and clinical judgment compromised in favour of cost considerations. They also fear that the schemes could put the private doctor out of business by limiting the patient's choice.

But Venter says the aim is not to punish doctors. "The Act is designed to save the whole private-sector health-care system from collapse." She says benefits paid by schemes have increased 28% a year over the past five years while the number of beneficiaries increased by an average of only 3,3% a year.

The Medical Association of SA wants doctors who contract with schemes to ask their professional councils to intervene when a contractual obligation interferes with their ethical responsibilities to the patient. But executive director Rob Speedie of the Representative Association of Medical Schemes points out that doctors should be aware of their ethical responsibilities when they enter into a contract. → Continued

FM 19/2/93. (299)

Another association demand is that the law should provide for dispute resolution between the "collective health service professions" and the medical scheme industry — similar to trade union-type negotiations.

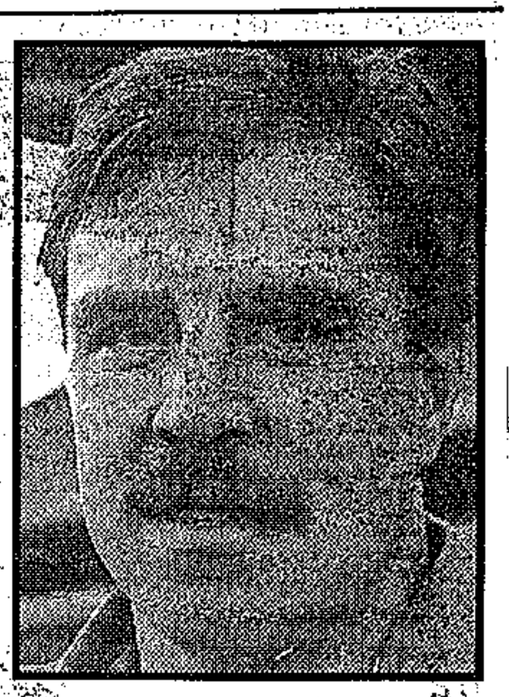
Says Speedie: "I can't see why the contractual relationship between the provider and financer of health care should be any different to parties contracting in, for example, an engineering contract. What's wrong with our legal system? Why do they need all this legislative protection?

"Just because doctors are venturing into the commercial arena for the first time doesn't mean they can exclude all risks through legislation." ■

Kickback row: Medical council sends letters to 22 doctors

(299)

ARG 19/2/93



Dr Uli Schmidt

The Argus Correspondent

JOHANNESBURG. — Twenty-two doctors, believed to be directors in a pharmaceutical company embroiled in a row over alleged kickbacks to doctors prescribing its medicines, have been asked to explain their positions to the South African Medical and Dental Council.

However, Pharmaceutical Trade Mark Company chairman Mr Gabe Simaan said yesterday the company had been formed within the ethical boundaries of the medical profession and was now being targeted because of its success in the market by lowering the prices of certain medicines.

This follows widespread reports that doctors who are shareholders in the company were offered incentives to prescribe its products. About 200 doctors are believed to be shareholders in the company.

The row centres on whether or not the shareholder doctors have contravened any ethical rules which prohibit them from engaging in or advocating "the preferential use or prescription of any medicine" for any gain.

Doctors may, however, own shares in a company.

According to the council, the matter is being given its "urgent attention".

Council spokeswoman Thelma Winterbach said letters had been written to 22 doctors to inform them of the complaints made about the company. All the doctors have, apparently, not yet received the letters.

She confirmed that the National Association of Pharmaceutical Manufacturers had laid a complaint with the council on February 2.

According to Mr Simaan, many pharmaceutical companies have doctors as shareholders and it was not only doctors who owned shares in his company. All shareholders received the same dividends.

He said the company's products, some of them known brands under different names, sold between 10 and 60 percent lower than alternatives.

"Because of our success in the market place, we've become a major threat to some pharmaceutical companies.

"We believe our competitors leaked information to the Press to basically discredit and stop us," he said.

However, medical council president Dr Len Becker said the council was investigating in terms of the disciplinary regulations.

Uli: 'My conscience is clear'

The Argus Correspondent

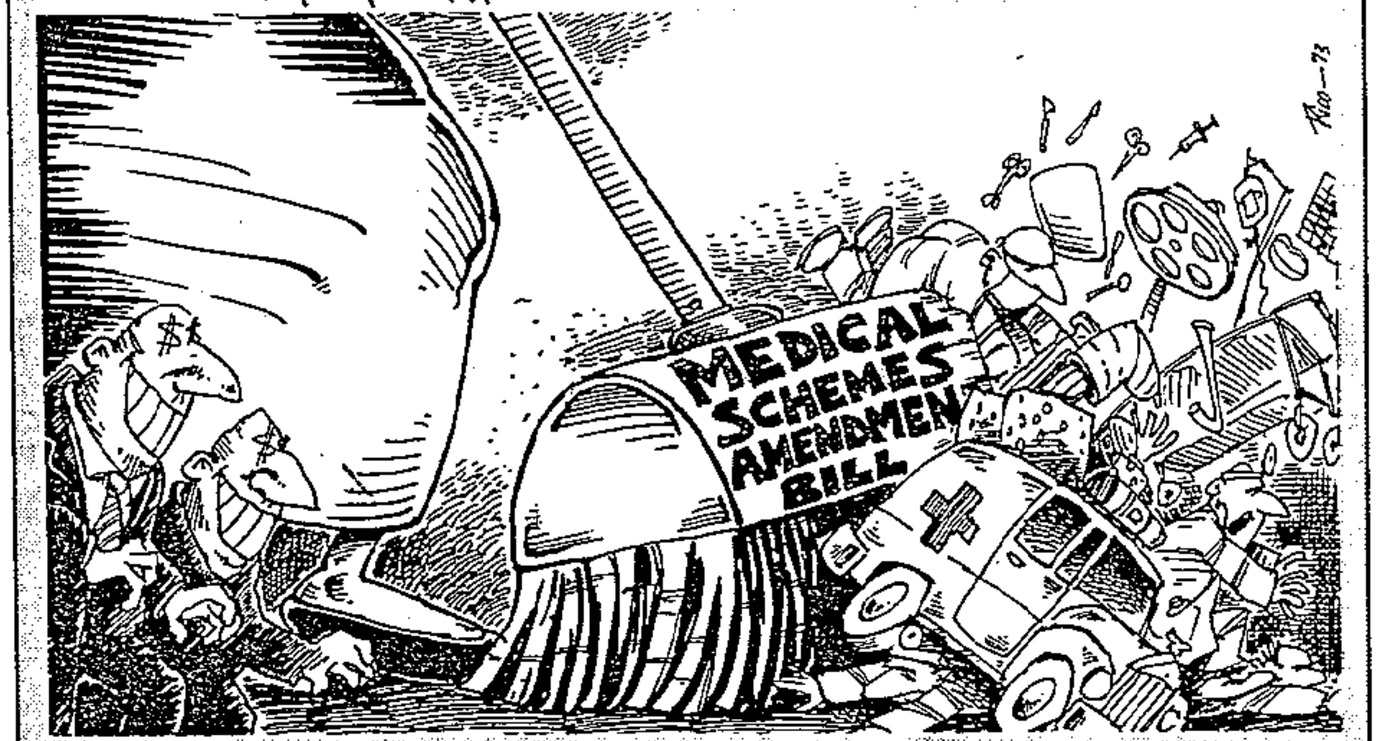
PRETORIA. — Former Springbok rugby hooker Uli Schmidt — one of the doctors implicated in the pill-prescribing business — said his conscience was clear.

"I bought shares in a company — just as anyone else can buy shares in a business. As far as I am concerned it is not unethical and doesn't contravene section 28 of the South African Medical and Dental Council rules."

Dr Schmidt said he provided the best possible care for his patients and this included getting them the cheapest possible medicines.

As the row over doctors being shareholders in the Pharmaceutical Trade Mark Company (PTMC) deepens, the Pharmaceutical Manufacturers' Association said doctors should not benefit from prescribing medicines supplied by companies of which they were shareholders.

Is there pain or gain in Venter's Bill?



Rina Venter's new medical aid Bill seeks to bring health services in line with the American system by putting a stop to overservicing and defrauding of medical aids. But unless it is carefully controlled, it could hurt those who most need health services

By **Dr BRIAN RUFF**

THE public is blissfully ignorant of the implications of Health Minister Rina Venter's Medical Schemes Amendment Bill, tabled in parliament last week. The Bill will have a profound direct effect on some six million medical aid members, and indirectly touch many millions more.

Doctors affected by it are increasingly terrified and hysterical about their future, while business, in the form of medical aid administrations, the insurance industry and private hospitals, are gearing up to grab as large a share of this lucrative market as they can.

In essence, Venter is moving South Africa towards the "managed health care (MHC)" system emerging in the United States, which cuts costs at the expense of patient choice. Initially this could benefit the 25 percent of the population, such as trade union members, who could afford some private health care if it were cheaper. But it could worsen the crisis in the public health sector, on which more than 55 percent of South Africans will always depend.

In terms of MHC, medical aids negotiate lower costs with multidisciplinary groups of doctors in return for predetermined payments, a guaranteed patient load and structured working hours.

It also permits shared facilities, central buying of equipment and medicines. The general practitioner becomes the central figure in the MHC team, controlling patient access to specialists and other services.

Venter's Bill facilitates this by abolishing the traditional system of guaranteed direct payments from the medical aid to the doctor at schedule of benefit rates. It also repeals the statutory powers of the Representative Association of Medical Schemes (Rams) — the statutory body representing medical aid schemes — and does away with maximum and minimum benefits offered by schemes.

It must be read in tandem with two other bits of legislation: a 1989 Act which allowed the "risk-rating" of individuals — contributions were previously determined only by earnings and the number of dependants — and a Bill, soon to be tabled, allowing multidisciplinary group practices and doctors to work on a salaried basis in the private sector.

Drastic changes in health sector funding were undoubtedly needed. Costs in the private sector — which serves 20 percent of the population, employs 12 000 of South Africa's 20 000 practising doctors and absorbs half the R15-billion spent annually on health — have risen at nearly double the inflation rate in recent years.

The result has been higher fees to medical aid members, fewer services and fewer people able to afford medical aid, adding to the load on the already crisis-stricken public sector.

Underlying rampant medical inflation is a culture of overservicing by doctors to boost their earnings, encouraged by business, in the shape of owners of clinics using expensive equipment, theatres and dispensaries. Also a factor is fraud by patients claiming for services never rendered, or sharing benefits with friends and family by assuming false identities — estimated at 25 percent of spending in the private sector — and the dispensing of medicines by doctors from their own rooms.

What are the advantages of the MHC system? The packages it affords will cut the cost of comprehensive health care. And through market forces, it will theoretically keep services up to scratch by enabling patients to change organisations if they are dissatisfied.

Under the present system, doctors are encouraged to overservice, as they receive guaranteed third party payments for every service they perform. The costs of this are hidden from the patient, who therefore colludes in this practice.

For the patient, MHC will mean loss of choice of doctor and service. The American experience has shown that there is a risk of "fly-by-night" organisations, and of the loss of medical excellence when organisations become large and monopolistic.

Doctors also have much to fear, primarily a loss of autonomy and even a threat to their professional judgment — under the MHC system, the practitioner's freedom to treat may be circumscribed by the need for cost containment. They also stand to lose money if the negotiated payments are too low.

Medical aid schemes are by statute non-profit organisations, but the administrators are allowed to make up to 10 percent profits and expect the new system to print money. Between them and dispensing doctors who are dead against the new approach, there is a third group which accepts the need for cost control but is not happy about the way it is being achieved. It includes the African National Congress, the Medical Association of South Africa, the Centre for Health Policy and some medical aid societies.

They are concerned that the government's approach involves a loss of the "generational contract", in terms of which the young and healthy subsidise the old and infirm. Risk rating will force increasing numbers of elderly people into the public sector, worsening the crisis there.

ANC health spokesman Tim Wilson also criticises the government's piecemeal approach to national health, which ignores South Africa's macro-economic realities. Other problems glossed over are the underfunding of the public sector, the academic hospital crisis and the shortage of drugs at clinics.

There is a perception that the new system will simply increase the profits of business while transferring risk and bad debts to doctors, since guaranteed payments will disappear.

Venter is trying to mop up 40 years of National Party misrule, and doing it without adequate consultation with political organisations which will have to inherit her policies. Managed care is better than unmanaged care, but the temptation to risk rate and the absence of proper safeguards could fatally undermine the MHC initiative.

●Dr Ruff is a physician practising in an academic hospital in Johannesburg

Ailing professor fights for payout

By GLENDA NEVILL

A MAN with a serious heart condition has initiated legal proceedings against insurance giant Sanlam because the company has refused to pay him a R100 000 disability claim.

Professor W T Barham, 56, an associate professor of zoology at the University of Zululand for 14 years, had double-bypass heart surgery in January last year and was declared medically unfit to return to work by four specialists and a cardiologist.

Staff members of the University of Zululand are obliged to contribute to its Group Life and Disability Scheme, which is underwritten by Sanlam.

The University of Zululand "boarded" Professor Barham in May last year, following which he lodged a claim for a "lump sum payment" with Sanlam.

The case has raised questions about the definition of "disabled".

It has also caused controversy at the university because its Board of Trustees is obliged to act as claimants on behalf of a staff member and has not done so yet.

Acuze News, an internal University of Zululand newsletter, noted that although the rules of the Group Life Assurance Scheme made it clear that "the university's obligation (is) to act as claimant on behalf of members of the scheme, it has chosen not to do so".

There was no one available at the University of Zululand for comment.

Professor Barham's son, Mr Dave Barham of Cape Town, said this week his father had issued summons against the Group Assurance Scheme.

A spokesman for Sanlam said one of the company's doctors had discussed the case in detail with one of Professor Barham's cardiologists.

"They concluded that Professor Barham was not fit to continue with the job at the univeristy, but they also agreed that on cardiac grounds, there was not enough reason to find him disabled for another, less stressful occupation.

"Both doctors were worried about the possibility of Alzheimer's disease. Sanlam suggested that Professor Barham visit a psychiatrist for an evaluation, to enable us to reconsider the claim."

Professor Barham said this week he was willing to have these tests but had asked that Sanlam pay his transport costs from Ladismith. He also wanted a written promise that this action would not be prejudicial to his legal rights.

"I wrote to Sanlam through the university in December and still haven't had a reply."

Professor Barham said he had been hospitalised with angina three weeks ago and doctors had discovered a leaking valve.

PROVINCE	(A)	(B)
Cape Province	Kempdorp) Kwanonguaba (Mossel Bay) Gompo Town (East London) E'Thembeni (Prieska) Motswedimosa (Ritchie) Ikhutseng (Warrenton) Sweletemba (Worcester) Mbekweni (Paarl) KatiKati (Cathcart) Luxolweni (Hofmeyr) Kuyasa (Colesberg)	
Transvaal	Alexandra, Diepmeadow, Bekkersdal, Khutsong, Evaton, Dobsonville, Sebokeng, Soweto, Daveyton, Duduza, Katlehong, KwaThema, Ratanda, Tembisa, Tokoza, Tsakane, Vosloorus, Wattville, Tswelang, Kgakala, Reagile, Ipelegeng, Lebaleng, Tigane, Ikageng, Khuma, Borolelo, Utlwanang, Bethal, KwaDela, Lebohang, Wesselton.	Alexandra, Diepmeadow, Bekkersdal, Khutsong, Evaton, Dobsonville, Mohlakeng, Soweto, Daveyton, Duduza, Katlehong, KwaThema, Ratanda, Tembisa, Tsakane, Vosloorus, Wattville, Ikageng, Kanana.
TOTAL	57 Black Local Authorities	19 Black Local Authorities

(3) No.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Medihelp: benefits of breadwinners

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*10. Mr A S BEYERS asked the Minister of National Education:†

(1) Whether he has received any representations from the organized education profession on the medical benefits of breadwinners who retired on accelerated pension after their posts in education had been abolished; if so, what (a) was the nature of these representations and (b) was the effect of such accelerated retirement on their membership of and contributions to Medihelp;

(2) whether the persons who so retired had been informed of the implications their retirement would have regarding their membership of Medihelp; if not, why not; if so, what are the relevant details;

(3) whether he intends taking steps to place these persons' membership of Medihelp on an equal footing with that of persons retiring at the usual age; if not, why not; if so, what steps;

(4) whether he will make a statement on the matter? B163E

The MINISTER OF NATIONAL EDUCATION:

(1) (a) No representations relating specifically to the medical benefits of breadwinners have been received from the organised education profession. However, during a meeting with part of the organised teaching profession, discussion took place concerning general lack of clarity about the medical benefits of teachers who have retired early.

(b) Early retirement has the effect that Medihelp reconsiders the continued membership of each individual member involved. If continued membership is allowed, the member is responsible for the payment of the full subscription levied by Medihelp on private members until the member has reached the age of 60 after which he will receive the same benefits as a person who has retired on the usual grounds of age.

(2) The Office of the Commission for Administration have indicated that they informed all departments in writing concerning the changes in the management and benefits in regard to Medihelp. Medihelp itself has indicated that the alterations to the rules were provided to all members. The details of the changes to the rules are:

(i) Medihelp was deregulated on 1 July 1992, but this deregulation in itself had no impact on the continued membership of members, and

(ii) the subscriptions payable by members leaving service on reaching their retirement age were altered. Previously, these people conributed nil Rand, while from 1 October 1992 this was altered to 50% of the usual tariff paid by serving members

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i.e. one sixth of the full tariff. The State continues to pay the other five sixths.

(3) No. Deregulation resulted in Medihelp determining its own rules and the State cannot prescribe to Medihelp in this regard.

(4) No.

Ambassador: donation to USA organization

*11. Adv T LANGLEY asked the Minister of Foreign Affairs:†

(1) Whether, with reference to certain details that have been furnished to the Minister's Department for the purpose of his reply, a certain South African ambassador made a financial donation to an American organization; if so, (a) what ambassador and organization were involved, (b) what was the amount of the donation and (c) (i) when and (ii) for what purpose was the donation made;

(2) whether he will make a statement on this specific case in particular and on the question of donations by ambassadors to foreign organizations in general? B166E

The MINISTER OF FOREIGN AFFAIRS:

(1) (a) Yes. Dr P G J Koornhof, who was during this period the South African Ambassador in Washington, made a contribution to the Safari Club International of the United States of America;

(b) $100,000 (approximately R250,000);

(c) (i) 31st March 1989;

(ii) The contribution was made to enable the Safari Club International to promote tourism from the United States of America to South Africa and to counter trade sanctions.

(2) The contribution occurred during a period when American sanctions at Federal, State and Local level were most severe. The Safari Club International is one of the most important and influential big-game hunters' associations in the United States of America with an af-

cont →

Row erupts over cheaper spectacles

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KELVIN BROWN

A ROW has broken out between Frames Unlimited, which is selling spectacle lenses at a 25% discount against the lowest medical aid tariffs and registered optometrists.

Frames Unlimited faces criminal charges on April 15 in the Cape Town regional court for selling lenses directly to the public. The charges were laid by the SA Optometric Association (SAOA) which said only a person registered with SA Medical and Dental Council could sell lenses to the public.

Frames Unlimited has 30 branches which sell spectacles and lenses, but do not test eyes. It started selling lenses a year ago, charging no dispensing fees. About 25% of Frames Unlimited's income was derived from lenses. Orders were made up from prescriptions or old lenses.

Frames Unlimited MD Irwin Schaffer said his organisation and optometrists used the same laboratories to produce their lenses.

In a similar but unrelated dispute, the Cape Town Supreme Court granted a temporary interdict on February 5, preventing Spectacle Warehouse from advertising its prices.

The outlet is run by five registered optometrists in Cape Town. The action was brought by optometrists saying advertising was in breach of professional rules and by-laws.

Spectacle Warehouse director Chris Faul said it was proved possible to provide cheaper care without "compromising on standards".

Last year the Professional Board of Optometrists asked the SAOA to lift the ban, but it had not changed the rules. "The SAOA is supposed to be the public watchdog and is not there to protect the profession," Faul said.

SAOA president Loock van Zyl refused to comment, saying the matter was sub judice.

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whole page

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Business Day SURVEY

While proposed amendments to legislation are expected to give medical aid schemes more flexibility in financing health care, individuals must expect to fund their needs in terms of the level of care desired. However, health insurance should be seen as supplementary and not a substitute for medical aid. ***LYNN CARLISLE*** *reports.*

Clinisure to offer enhanced benefits

PRIVATE hospital groups are starting to provide health care products and Clinic Holdings (CHL) is refining its first medical scheme.

After establishing subsidiary Medafford last year, CHL has added certain benefits to that company's medical scheme, CliniSure, in response to its market of individuals and employers.

Medafford also plans to introduce smartcard technology later this year so members need only present their card to health service providers, who will then debit their CliniSure savings account.

Medafford MD Grant Campbell says the latest refinements include linking CliniSure to its Medico benefit fund and increasing the specialist practitioner's benefit from R125 to R1 200 a year.

Abbreviated

Although predominantly a hospital protection plan from day one of admission and payment of the first contribution, in essence it works as an abbreviated medical aid plan.

Initially, CliniSure covered full hospitalisation for members until retirement or death and also offered limited benefits for more routine medical care.

Now, by linking it to the Medico medical savings account, the member can draw funds to pay certain medical expenses provided the limited benefits offered by CliniSure have been exhausted for that year.

Campbell says this discourages over-use of medication.

In addition to meeting the full cost of hospitalisation and all related costs for surgery, doctors, medicines, X-rays at any CHL or associated hospital, cover also includes no deposit on admission, no account on discharge and no shortfalls.

Health insurance should be seen as supplementary

HEALTH insurance should not be regarded as an attempt to take over from medical aid schemes but rather a top-up benefit to cover major costs, assurers say.

Standard General (life division) national legal and marketing manager Dick Broeke believes insurers and assurers should stick to top-up cover for major medical expenses arising from hospitalisation and surgery.

This is because the packages can create the impression that conventional medaids are no longer required, leading to a higher incidence of claims.

"Insurance rates then have to be adjusted upwards in line with claims history. This could affect the cover limitations of medical insurance."

He says the Medical Schemes Act prevents insurers becoming involved in linking payment of benefits to patients' accounts.

'My observation of certain medical cover products offered by insurers and assurers suggests they have tried to create packages to replace the need for medical aid.

"However, membership of a sound medical aid scheme is still vital — particularly for those with families — to meet most of the high-frequency, low-cost expenses."

DICK BROEKE

No guarantee

There is no guarantee that the average breadwinner who opts out of a medaid scheme and into medical insurance can calculate reasonably accurately how much self-insurance funding will be required to cover routine medical expenses.

Fedlife individual life deputy GM Andrew McGinn says even though the spiralling cost of medaid funds is cause for concern, the average person still needs them.

"But, with the gap widening between the amount reimbursed by medical aid funds, insurers have adequately filled this niche in the market by introducing health cover."

McGinn says top-up health insurance products provide one or more of the following:

☐ Benefits payable as a result of hospitalisation for a period usually exceeding three days;

☐ Benefits payable as a result of major medical procedures — either surgical or non-surgical;

☐ Convalescence benefits payable after long periods of hospitalisation and which provide clients with a certain amount of cash on hand while they recuperate from a major illness.

Economic growth 'the only answer'

REAL economic per capita growth is the only way to real improvement in SA health care, says Sanlam chief medical officer Dr Altus van der Merwe.

The Medical Schemes Amendment Bill will address mainly the micro-economic inefficiencies of medical schemes, but will not do much to improve macro-economic structural problems, he says.

"Deregulation and supply side restructuring will not, however, solve all our health care problems. Real GDP growth per capita is the only way to provide sustainable health care improvement."

But with such growth at minus 3,3% for the past three years, each year there will be less funds available for health care.

Compounded

This problem has been compounded since 1986 by an average annual increase in health care inflation of 24,5% compared with a CPI inflation average of 13,7%.

Government's health budget and private sector funding through medaid schemes have reached a financial ceiling, he says. Medaid contributions by employers are close to pension contributions in some cases.

"Alternative ways to improve the efficient utilisation of available limited resources are the only solution."

With traditional comprehensive cover having become a luxury few can afford, people will have to look diligently to alternative health care financing and delivery plans.

Onerous

"Consumers now have the onerous task of choosing the right cover, selecting responsible and cost-efficient insurers and accepting personal responsibility for areas not covered."

He cautions that while a "proliferation" of new health insurance products can be expected, insurance health cover should still be seen as a supplement to medical aid.

Proposed changes are geared to flexibility

EMPLOYERS and individuals should take another look at their medical cover amid the upheaval in SA's general health care environment, say consultants.

In Parliament this month Health Minister Rina Venter called for changes aimed at rescuing the ailing R10bn-a-year medical aid (medaid) industry and curbing patient and medical services supplier abuse.

While proposed amendments to legislation are expected to give medaid schemes more flexibility in financing health care, individuals must expect to fund their needs in terms of the level of care desired.

Crusader Life director Dr Marius Barnard sees a more open, cost-effective medical benefits market unfolding with the introduction of the Medical Schemes Amendment Act.

MARIUS BARNARD

Specifies

SA's almost 240 registered medaid societies — which cover almost 20% of the population — have always been governed by legislation which specifies minimum or maximum payments relative to an official scale of benefits.

He says the new proposals aim to create greater freedom in the industry which is preparing for:

☐ Medical schemes no longer having to pay a minimum fee for each unit of treatment (as currently prescribed and rated);

☐ Schemes and private hospitals/clinics being able to employ their own pharmacists and doctors, on a fixed salary basis, who will assist in provision of more cost-effective treatment and controlled prescription of medicines;

☐ Insurers and assurers becoming more involved in medaid as such;

☐ Medaid rates being set more in favour of younger members who traditionally have had to subsidise the older and more sickly.

Medicaid Administrators MD Jeff Slome says along with abolition of the compulsory guarantee of payment to doctors, the main thrust of the amendments is a more flexible, market-orientated approach to medaid schemes.

"Members will have a choice of insuring at three levels — scale of benefits, less or more than the scale and they will also be able to select tailor-made health care products.

Guardian National marketing manager Roy Natheson says with legislative changes expected to give schemes greater scope to check costs, future health care will place greater emphasis on self-care and preventative care.

"Price transparency will disappear and the health consumer will have to contribute a greater proportion of co-payment upfront, at the time of service."

Dewar Rand employee benefits division MD Murray Tonathy says medaid members who have become accustomed to monthly claims will have to prepare for a new self-managed style of health cover.

"Consumers and employers should shop around for the package most suited to their needs. Whether from an insurance house or investment scheme, the package must allow for cover after retirement."

Encourage

Barnard says the amendments should encourage the private health sector to get its house in order, better positioning it to counter the call for all health care to be nationalised.

People and employers are also being given notice to start planning to pay more for the higher medical costs that result later in everyone's lives, he says.

Kessel Feinstein Consulting CE Graeme Victor says despite the impending amendment, much is going on behind the scenes. Some medical cover products are being developed but purposely held back until the deregulation of medaids.

"Although people and employers will need to reconsider their medical care, right now they should not swap to different schemes as there could be other interesting developments afoot."

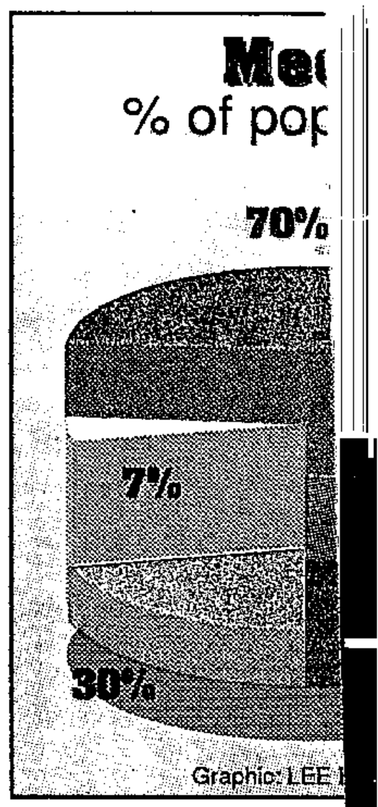
Price war

Don't rule out a price war, says Victor, as this is the first time that medical schemes will be fundamentally commercialised and made more competitive.

"There should be room for negotiation with medical schemes of all varieties once the employer or individual has studied their pamphlets."

"With the insurance industry having entered the market, it seems insurers have an outlet in a package deal which combine the variety of products offered by insurers with medical aid schemes," says Tonathy.

An example of what is being done to plug the holes associated with traditional medical cover is Dewar Rand's latest development — Plan 101, which rewards non-claimers, provides some cover for day-to-day medical costs and full cover in the event of a major medical expense.



Few positi lower inco

THE parlous state of many m cal aid schemes will for the f seeable future prevent more ple from lower income gro obtaining health cover.

With the situation having w ened in recent years, it is not pected to be remedied by impe ing improvements to the indus contained in the Medical Schen Amendment Bill.

Guardian National marketing rector Roy Natheson says t since the Health Department ported 88 of SA's more than registered medaid schemes fered losses in December 1991, n have gone insolvent.

Fedlife industrial benefits technical services GM Dick C says the financially strain medaid schemes have tended to duce benefits and increase pre ums to offset spiralling costs.

Popularity

This accounts for the increas popularity of the group health c schemes.

"A contradiction is arising in provision of underwritten hea benefits — by assurers f medaids, industrial council a company medical schemes — the lower income groups.

"The up-front excess payable the member or his medical scheme plays a major role in det mining rates. However, the low income groups cannot afford hi premiums or large excesses."

Similarly, a low excess is no s lution as it tends to encoura

Medical schemes and insurers should present a united front

AS FUNDERS of the inflationary health triangle, health insurers and medical aid schemes should join forces to create better managed and more cost-effective cover.

Guardian National marketing manager Roy Natheson says there is a case to be made for a greater degree of co-operation and co-ordination between the parties which have been competing against each other.

Natheson says the elderly typically fill up to half the available hospital beds.

Their care absorbs five times as much as the rest of the population.

However, a likely scenario for health consumers is one in which medical schemes and health carry a proportion of the risk at

system or force them to seek alternative cover — notably health insurance," says Natheson.

Already the shift is to insurance by the young and other low risk groups.

medical catastrophes that befall some people.

Until now, consumers have exercised free choice as to where they wished to go for medical attention, and the medicines they wanted to buy.

Levels

While free choice will not be eradicated, consumers will be offered different packages of benefits that include various levels of health care and how they intend financing the costs.

As a leadin corporate

With an annual medaid subscription increase of almost twice the rate of inflation, the limits of what individuals and businesses can accept has been reached.

"Considering the high levels of formal unemployment and the many business failures, further contribution increases will drive members out of the

Medical schemes may only cover costs and provide benefits from above a certain minimum threshold level.

This will be negotiated with consumers or their employers.

Supplementing this package of benefits will be a health insurance package to provide cover for major

has developed products after working in tandem with medical schemes.

"These are designed firstly to contain the cost of healthcare to the private consumer or employee," says Natheson.

It also asks them to shoulder some of the responsibility for their own costs, he says.

funds costs i

CLAIMING an industry fir Southern Life and a leading me cal aid administrator have dev oped a group health product to fu medical costs in retirement.

Southern Life employee-benef GM Roy Lennox says Group M Help is a revolutionary long-te plan that includes tax-deducti

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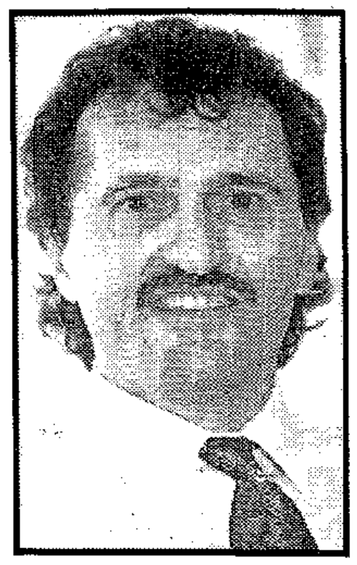
Party is over for abusers as groups begin clampdown


MURRAY TONATHY

ABUSE of medical aid schemes (medaids) is bound to decrease now that members, insurers and regulators are taking steps to discourage guilty parties.

Medaid scheme members are unfortunately often behind the abuse of funds, says Dewar Rand employee benefits division MD Murray Tonathy.

Crusader Life marketing director Brian Peters says scheme members and suppliers of medical care have created a major problem for medaids, the insurance industry and the public.

"As a result, other members are no longer prepared to subsidise abusers, while assurers like ourselves and insurers have designed products for the benefit of genuine claimants and prescribers."

Botshelo MD Douglas Kalkwarf says medical aid figures estimate that R1,3bn of all medical aid payouts annually are fraudulent. The DP puts the figure at R2,5bn a year.

Norwich Life assistant actuary (product development) Nicholas Gubbay says although medaid schemes are not to blame for the underlying increases in medical costs, their inflexibility has worsened the situation.

"For example, the cross-subsidisation between young and old, and healthy and sick, inherent in these schemes and the system of guaranteed payments to health-care providers have led to overuse of medical services, often encouraged by providers.

"Fraudulent claims by members and their relatives have added to the costs, all of which must be spread across the entire group of members."

Gubbay says dissatisfaction among medaid members is largely the result of:
☐ High increases in medical costs;
☐ The widening gap between the official (Rams) scale of benefits and that of the Medical Association of SA (Masa).

Tonathy cites several problems with medaids:
☐ Unequal return on contribution arising from some members claiming more than the value of their contribution while others claim almost nothing after years of contribution;
☐ Inflexibility as most schemes carry one package for all and members are forced to tailor themselves to the medical aid, instead of vice versa;
☐ Limitation of benefit as cover is extended according to tariff (medical rates). Should this be higher in cases such as hospitalisation, the member has to settle the balance of the expense;
☐ Increases in fees to recover losses because of vast claims, but without reward for non-claimants.

Kessel Feinstein Consulting CE Graeme Victor says the medaid abuse party is over.

"This seems imminent now that government is to introduce new legislation to clamp down on patient overmedication and investigate 'tariffmanship' by doctors."

More cost-effective programmes needed

TO SURVIVE, medical aid schemes must change from conventional systems and institute more cost-effective programmes which ensure employers and employees get better value for contributions.

Pro Regno Financial and Economic Services CE Dr Lawrence McCrystal says despite medical aid member costs rising faster than medical expenses, medaids are running increasingly at a deficit.

"There will have to be major changes in the way medical aid schemes are structured if they are to survive," he says.

Pro Regno and Botshelo Health Care Systems have jointly designed a system to reduce escalating medical care costs. Unlike conventional medical aid schemes, the new solution allows members to regulate their own contributions and exercise full control over their benefit funds.

Botshelo MD Douglas Kalkwarf says the Managed Health Care System places control of medical expenses in the hands of the member, as an incentive to handle it in a responsible manner to his own benefit.

The package includes a savings account into which two-thirds of the monthly contribution is paid. Tax-free interest calculated on a daily basis is paid.

Kalkwarf says the remaining third covers insurance against hospitalisation, underwritten by a major international health care insurer.

Each member receives a smart card, to pay immediately for routine medical services and medicines, thereby controlling his own medical benefit fund.

Because cash cards are an effective tool with which to negotiate payment discounts, any savings accrue to the member.

McCrystal says payouts are calculated at Medical Association of SA rates, while medical aid schemes are using Representative Association of Medical Schemes rates, which are almost 50% lower.

Prepare now for old age, warn specialists

PLAN on needing more medical attention and cover as you get older.

This is the advice of medical cover specialists who warn that everyone should make far greater provision for medical ex-

No longer are state and provincial hospitals as accommodating or affordable, nursing home fees and medicine costs have rocketed and other negatives, some political, loom.

And living longer is of en

hese are set to take an increasing portion of one's pension.

Such provision, they say, arises not only because advances in medical technology have resulted in people living longer, but because medical costs will spiral while traditional cover is reduced.

Especially affected are retired people.

Long-term planning necessary

MORE attention must be paid to planning the long-term provision of high medical benefits at stable premium rates.

Fedlife industrial benefits deputy GM Vivian Cohen says this falls in the field of actuarial science, which specialises in the long-term funding of benefits based on life contingencies, such as mortality and serious illness.

Unless medical schemes carry out scientific long-term planning they are likely to continue reducing cover for the growing range of expensive claims.

To place health care financing on a sound footing, schemes must clearly identify and properly manage the phenomena that have led to their present crises.

Most SA medical schemes operate on a "pay-as-you-go" basis without adequate long-term planning. This subjects them to disruptive ad hoc adjustments and they generally cannot guarantee payment of very high claims.

In addition, Cohen says schemes are often reluctant to include large groups of lower-salaried employees, partly because of uncertainty regarding the level of expected claims.

"Due to such inadequacies of conventional medical schemes, medical insurance is increasingly viewed as a necessary supplement or alternative.

"However, due to the volatility of the levels and volumes of smaller claims (which are often incurred at the sole discretion of members), actuarial methods and long-term insurance generally do not suit smaller claims covered by medical schemes.

"A confluence of traditional 'pay-as-you-go' and long-term actuarial methods thus seem inevitable," he says.

mental problems or frailty.

Norwich Life GM Robin Sharp says this makes sufferers a burden on their loved ones and reliant on long-term nurse-aid care.

Norwich has thus created its Frail Care Benefit, which guarantees its policyholders regular personal assistance for life.

Top-up health insurance products that provide frail care benefits have become essential for certain people, says Fedlife deputy GM Andrew McGinn.

Such contracts are designed to assist the elderly once they cannot, for example, bath, feed or clothe themselves.

But he says the benefits are not yet appreciated by most people.

"This is due to the young market not realising the implications of the cost of frail care," he says.

However, by the time they become aware of tte possibility of needing it tte costs of adequate provisin will be out of reach, says McGinn.

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HEALTH

The medicine goes down

Rina Venter has given more clout to medical aids

Three years after being made Health Minister, Rina Venter appears to be well on her way to making health care in SA more affordable and accessible.

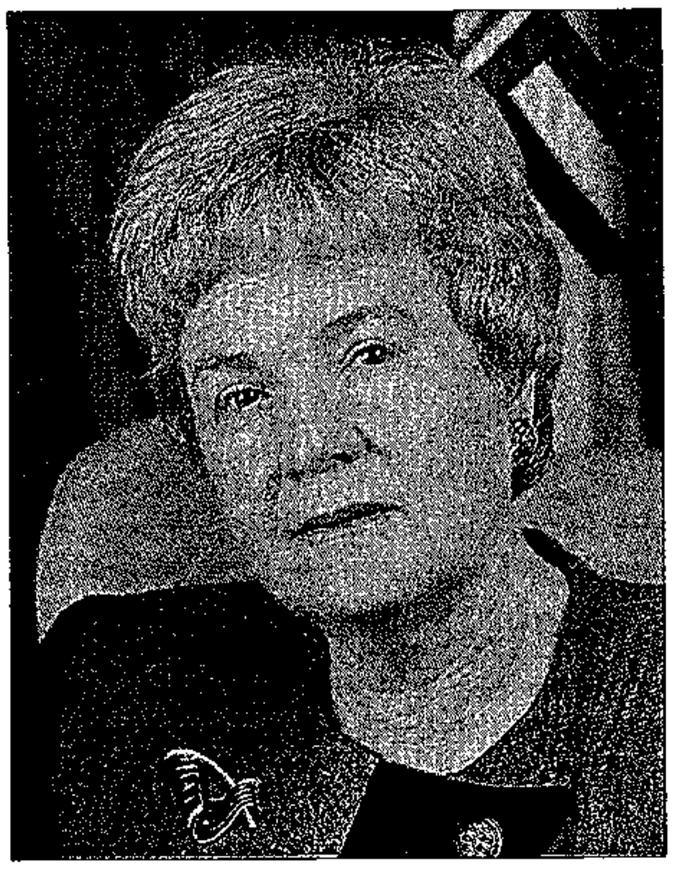
Parliament's approval last week of the controversial Medical Schemes Amendment Act certainly promises to cure many of the ills plaguing the private sector. The Act — first tabled in parliament early last year — amounts to extensive deregulation of the sector. It offers sound, well-tested mechanisms for cutting costs, introducing competition and improving standards.

The Act's provisions also drive home that health care, like any other commodity, is a service which needs to be evaluated on cost and quality.

Says Venter: "If costs are to be controlled, we need to engender a consumer culture for health care among doctors, patients, health care providers and the media."

This thinking has often incensed an industry — doctors, drug manufacturers, private hospitals and other service providers — which has been accused by the Competition Board of operating "restrictive practices that don't serve the public interest."

In a nutshell, the Act gives schemes the clout to keep costs in check and question claims. This will be done by ending compulsory minimum benefits and the guaranteed



Venter ... *there will always be a risk*

payments that medical schemes automatically make to beneficiaries and health-care providers when they receive a claim.

The law also opens the sector to competition by paving the way for medical aid schemes to run hospitals and clinics and employ doctors and other health-care providers. Known as "managed health care", this practice has cut costs by as much as 40% in some countries.

But these moves challenge the doctors' discretion in dispensing health-care services to the patient, so they've fought Venter almost to the end. They argue that, as the schemes acquire greater powers over the use

Speedie ... *sincere negotiation ahead*

and provision of services, doctors could find their professional and clinical judgment compromised in favour of cost considerations. They also fear that schemes could put the private doctor out of business by limiting the patient's choice.

The doctors' scenario is indeed a gloomy one. But Venter and the Act's supporters say that the changes are essential to ensure that schemes survive as viable organisations. Says Venter: "The current fee-for-service system is characterised by unchecked use and fraud, bringing about spiralling costs which consistently exceed the inflation rate." Put differently, the fee-for-service system offers doctors and patients no incentive to be cost-effective because it is taken for granted that some faceless medical scheme will pay the bill.

By contrast, the new Act could see the formation of managed health-care packages, run by schemes or independent practitioner associations, that would remove the incentive to over- or under-supply services. A scheme could, for example, provide members with a full spectrum of health-care services at a hospital staffed by GPs, specialists, nurses, paramedics, radiologists and so on — at ordinary contribution rates. In such a model, costs would be kept low largely through economies of scale — treating 100 people instead of 10 gives the scheme greater buying power and allows for savings on overheads, better use of equipment and expertise. Much would be saved by paying doctors fixed salaries instead of applying the fee-for-service system.

Another option could be the US-style "preferred provider" organisation. Such a model would see a group of medical practitioners join forces to meet the needs of a community for a fixed period — usually a year.

They would usually contract their services out to a scheme but payment would be based on the number of patients they see, not on fees for service.

There are many possibilities. While managed health care offers the lower income worker — as opposed to those without income — affordable health care, it isn't likely to be welcomed by everyone. More affluent people who want to retain their choice of practitioner will probably stay on conventional medical schemes and insurance policies while they can still afford them.

Whatever the options, Venter stresses the gravity of the present situation. She says that benefits paid out by medical aid schemes increased over the past five years by an average of 28% a year, while the number of beneficiaries increased by an average of 3,3% a year over the same period. "This is perhaps why the claims experience of South Africans rank among the highest in the world. This escalation can no longer be tolerated," says Venter.

Since the 187 registered schemes provide health-care cover to more than 6m beneficiaries and are responsible for about 45% of all health expenditure in SA, she is adamant that her intervention is needed.

Says Venter: "If drastic action is not taken, this already high percentage will increase dramatically and the State's responsibility for providing health care will become unbearable."

But she has gone a long way towards easing doctors' fears of the new dispensation. She has agreed to end the statutory power enjoyed by the Representative Association of Medical Schemes (Rams). It's a compromise that was made after a bitter two-year fight which saw the doctors, represented by the Medical Association of SA (Masa), call for the Minister's resignation.

Venter initially wrote Rams into the new Act because she felt that a body dealing with so much public money needed statutory powers to mediate between schemes and doctors. The doctors argued with some force that if schemes were to compete with doctors in providing services, they shouldn't enjoy statutory protection.

There's no doubt that the compromise will benefit the deregulatory climate. Says Rams executive director Rob Speedie: "Sincere negotiation, rather than edict, will permeate

→ Continued

Albinism is often seen as a curse

STAR 27/2/93

299

ALBINOS have started an organisation to fight their cause, reports JOE LOUW.

JEFF was 11 when he first thought about killing himself because of the relentless teasing he suffered from other children and the shame his parents seemed to feel every time they looked at him.

His problem was that he was white in a black world.

Jeff, now a fully grown man with a family of his own, was born with a hereditary genetic condition known as albinism. He is pure white with deep red patches scattered about his face, his hair is yellowish and since boyhood he has worn a deeply furrowed brow — developed from constant squinting to protect his weak and sensitive eyes.

Insulting names

He walks with a stoop, wears a big floppy hat, his teeth are bad and he is deeply shy.

As a child, he played a lot by himself. The children in his neighbourhood called him all kinds of insulting names — from "white man" to "amper baas" (almost "baas") to unprintable ones.

Even his parents seemed to be deeply disappointed and puzzled by his condition. "I used to run crying home to my mother and would ask her why I wasn't like other children, and she would say she didn't know and would tell me to go out and play. When I was a kid I always thought about killing myself. I still don't know why I didn't do it."

His neighbours in the township had a simple explanation. It was a curse, they said.

Most albinos have heart-rending stories to tell, and the theme that runs through them is of deep prejudice and suspicion, even of wanton cruelty, in a society scarred by an over-sensitivity to skin colour.

Now these abused people have formed an organisation to protect and promote themselves. More than 250 albinos from all walks of life — teachers, housewives, professionals, labourers — met in Soweto to form the Soweto Albino Society with Sonti Mazibuko as chief executive.

"We launched our society to alleviate the trauma suffered by people with the condition of albinism, to combat the prejudices faced by them and to educate the public to the idea that albinism is not a curse but a genetic disorder," Mazibuko says.

"People with the condition are shy, withdrawn, angry and bitter. Many albino children are abandoned at birth because the mothers may not be able to deal with the so-called shame. Families are torn apart as couples blame each other for the 'curse' or 'affliction', and society blames their parents, other races and even almighty God himself."

She says albinos are doubly discriminated against: they are not integrated socially or in work situations.

Research has shown that one person in 17 000 has some type of albinism and that it is caused by genes that do not make the usual amounts of a pigment called melanin. Most albinos suffer serious eye problems because of a lack of pigment in the retina.

Mazibuko herself was one of 10 children — five were born albino and five were normally pigmented — yet four of her five own children are normally pigmented.

"There is an appalling amount of cruelty against people with albinism — especially children," she says.

Mazibuko, a strong, proud woman who has overcome her shyness, is determined to make a success of the albino society. She wants the organisation eventually to cover most of South Africa and to help carry out research on ways of alleviating the condition.

Help needed

"Like many other groups in this country who are fighting this kind of prejudice we need help — help with setting up an office, help to educate the public through the media and through public awareness programmes. But most of all we need help to restore the self-esteem of our people and to help them confront and overcome the afflictions society heaps on them daily."

(a) The Performing Arts Council of the Transvaal was not represented at the first meeting which took place on 1992-12-08, and which was attended by the Transvaal Provincial Administration and the ANC, although Pact was fully informed about the decisions taken at the meeting.

(b) The first meeting which took place on 1992-12-08 was essentially of an exploratory nature, although the following decisions were taken:

(i) The 12 point plan titled "Basic points of understanding between the parties" was accepted by both parties.

(ii) It was emphasised that both parties should refrain from making public statements unilaterally.

(iii) A joint working committee should be established consisting of an independent chairperson and approximately six persons (maximum) from each of the parties.

(iv) The working committee will be an advisory committee to the Administrator.

(v) Decision-making of the working committee will be on a consensus basis.

(vi) That a time schedule be drawn up for the establishment of the working committee.

(2) Yes, similar talks have taken place since then.

(a) A meeting was held on 1993-01-11 which was attended by representatives of Pact, the TPA and the ANC.

(b) The meeting mainly centred around the establishment of the joint working committee, the appointment of an independent chairperson and the nomination of each party's six members. Additionally, administrative issues like the working committee's budget and the time schedule were discussed, although no final decisions were taken in this regard.

(3) No. A joint statement was issued after the conclusion of the first meeting on 1992-12-13.

†Mr A GERBER: Mr Chairman, arising out of the reply of the hon the Minister, we should like to know whether the future of Pact is now being determined by the TPA in co-operation with the ANC, and whether there are also other parties which have been approached to make a suggestion in this regard. Is it these two parties only which are involved in the decision on the future of Pact?

†The MINISTER: Mr Chairman, as I in fact stated, according to the reply that was obtained, both the Administrator . . . [Interjections.] . . . and from my own knowledge I know . . . [Interjections.]

†The CHAIRMAN OF THE HOUSE: Order! The hon member for East London North was not called upon to speak.

†The MINISTER: I know from my own experience and knowledge that the Administrator and Pact are consulting more widely than only with the parties I mentioned here. [Interjections.]

†The CHAIRMAN OF THE HOUSE: Order! As the time for replying to questions on general affairs has expired, we go on to own affairs. [Interjections.] Order! Hon members must really not take this amiss, but I am certainly not prepared to carry on struggling to bring about order in this House.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Core syllabuses in schools: revision

*6. Mr R M BURROWS asked the Minister of National Education:

(1) Whether, with reference to his reply to Question No 64 on 19 March 1992, the Committee of Heads of Education Departments has finalized the revision of core syllabuses; if not, (a) why not and (b) when is it anticipated that the matter will be finalized; if so, with what result;

(2) whether he will make a statement on the matter? B246E

The MINISTER OF NATIONAL EDUCATION:

(1) No. Core syllabuses currently in use are assessed on a continuous basis with the view to adapting them if necessary in the interim period until a revised curriculum is implemented.

(a) The comments received on the curriculum model released in November 1991 as a discussion document have been incorporated in the document where possible. In respect of certain facets of the model, research is still being conducted.

(b) It is envisaged that, if the viewpoints of all interest groups can be successfully accommodated in the model, new syllabuses will be phased in from 1996.

(2) No.

*7. Mr L Fuchs—Justice. [Question standing over.]

Disability pensions: payment date changed

*8. Mr B B GOODALL asked the Minister of National Health:

(1) Whether the date or dates on which disability pensioners of all race groups receive their pension were changed in 1992; if so, why;

(2) whether the pensioners concerned were given any notice of this change; if not, why not; of so, what notice? B251E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, the dates of payments are determined annually according to week-ends, public holidays and in respect of Whites, Coloureds and Asians also to fit in with the other duties of the Post Office;

(2) yes, beneficiaries are informed in writing at the beginning of the year of the dates of payments for the year concerned.

Prisoners: accidental injuries

*9. Mr A J LEON asked the Minister of Correctional Services:

How many persons serving terms of imprisonment were injured accidentally in 1992? B252E

The MINISTER OF CORRECTIONAL SERVICES:

During 1992, 5 458 prisoners sustained injuries. This represents approximately 1,35% of the total number of prisoners admitted to South African prisons from police custody and courts during the 1992 calendar year. These statistics include, *inter alia*, injuries sustained in work situations and during participation in sport.

The Department of Correctional Services does everything possible to prevent accidents and injuries to prisoners. The safe custody of prisoners implies, *inter alia*, the prevention of accidents and injuries. With due consideration of safety measures comprehensive instructions and precautions exist to ensure that prisoners do not injure themselves or other prisoners during work, recreation or otherwise. Where appropriate, the stipulations of the Machinery and Occupational Safety Act, 1983 (Act 6 of 1983) are complied with.

When prisoners participate in organized sport it is done under supervision and preventative measures are also taken to prevent prisoners from being injured.

Every injury sustained by a prisoner is properly recorded and should the circumstances under which it was sustained or the nature of the injury necessitate it, a comprehensive enquiry is held into the incident. If necessary remedial/preventive steps are instituted.

It is standing practice that every prisoner who sustains an injury is seen by a doctor in order that he may receive the necessary medical treatment.

Should a prisoner sustain an injury during the performance of his work or during participation in organized sport the stipulations of Correctional Services Regulation 107 may become applicable.

Views are changing on the patient's right to die

STAR 3/3/93

As the Dutch parliament passed a law recently permitting mercy killing under strict guidelines, South African doctors were taking a closer look at patients' rights to refuse treatment . . . even if it leads to death, reports PAULA FRAY.

EUTHANASIA came back into focus in South Africa last year during the trial of a Cape nurse who administered a lethal injection of insulin to two elderly, infirm patients.

Then, later in the year, protracted legal proceedings eventually resulted in former Natal MEC Dr Fred Clarke being allowed to die in a Durban hospital. Dr Clarke, who had left a "living will" or advance directive, was in a persistent vegetative state from which there was "no prospect of any improvement in his condition, and no possibility of recovery".

According to Natal University dean of law Professor David McQuoid-Mason, the court did not decide on the legality of the living will, but appointed Clarke's wife as curatrix and gave her power to withhold agreement to treatment, including nasogastric treatment. If she did authorise the withholding of treatment, this would not be unlawful.

It has only been in recent years that our right to die has been debated.

In fact, the whole question of euthanasia has grown considerably more complex in the light of modern hi-tech medicine — particularly as the term is often used indiscriminately to describe both "active" euthanasia, which involves deliberate killing, and "passive" euthanasia, which implies the withholding of life-support systems or life-sustaining treatment, according to Dr S R Benatar, who wrote on the subject in the July edition of the South African Medical Journal.

"Medical progress, secularisation of life, growing acceptance of individual human rights (including the right to refuse medical treatment) and of shared decision-making in medicine have focused public attention on the ways in which life may, and perhaps even ought to, be allowed to end in our complex modern era," he writes. However, the concepts of assisted suicide and active euthanasia are generally still considered "unacceptable perversions" of medical practice, he adds.

Given medicine's ability to sustain life for prolonged periods, the unrealistic expectations of some medical personnel and the lay public, the severe constraints on health-care facilities, and the totally inadequate allocation of resources for highly effective medical treatments, the time was right to debate the limits of "striving officiously to keep alive", and on the distinction between "allowing to die" and "killing", he adds.

It is this debate which is taken further in the latest edition of "Continuing Medical Education" in which Dr Bruce Buchan and McQuoid-Mason present the medical and legal ethics of the living will.

Any patient has the right to refuse treatment, says Buchan, "but the moment the patient becomes unconscious, he amazingly loses all his rights", including the right to determine what is done with his own body.

"In order to overcome this problem — which is becoming more acute because of advancing technology — the living will/advance directive has come into being," he says. Common law in South Africa gives patients the right to refuse specific medical treatments: "A treatment given by a doctor or nurse against their wishes constitutes a common law assault."

McQuoid-Mason concurs: It is generally accepted in South African law that patients have the right to refuse treatment even if it may cause them injury or death.

"Furthermore, a physician may not treat a patient without his or her consent, except if there is a statutory duty to do so or there is an emergency, and then only if it is not done against the wishes of the patient," he adds.

In 1986, the American Medical Association's council on ethical and judicial affairs stated it was not unethical to discontinue life-prolonging treatment for patients in irreversible coma, reports Buchan.

In short, when a patient is in a persistent vegetative state, the stress on both the patient and the family must be taken into consideration.

Nasogastric feeding should be administered according to the patient's wishes; a hospital policy needs to be developed for the use of nasogatric tubes and other forms of alimentation.

When treating terminally ill patients, minimisation of pain is paramount, even if it has the potential to hasten death: "To allow a patient to experience unbearable pain or suffering is medically unethical," says Buchan.

Finally, he adds, medical training should emphasise the need for humanity, warmth and touch at the time of approaching death. □

CORPORATE HEALTH

FM 5/3/93.

Health Minister Rina Venter will deliver the keynote address at the Financial Mail Corporate Health Care conference in Johannesburg this month. (299)

The one-day conference, to be held at the Carlton Hotel on Tuesday, March 16, will deal extensively with the implications of the recently approved Medical Schemes Amendment Act.

In particular, speakers will discuss the various options available to corporate health care purchasers — medical aid schemes, managed health care and the insurance route — and offer delegates some valuable insights.

Speakers include Reg Magennis of the Medical Association of SA, Representative Association of Medical Schemes executive director Rob Speedie, Alexander Forbes's Leon Lewis and Izak Fourie of the SA Chamber of Mines. More than 300 delegates are expected to attend.

For further information contact (021) 683-3265 or fax (021) 683-4086.

Hearing the deaf — through theatre

Sowetan 6/3-10/3/93. (299)

THEATRE is where people stand on a stage and talk, right?

Wrong.

Deaf people can't be included in anything that involves a lot of talking, right?

Wrong again.

South Africa's deaf communities are slowly discovering that theatre is more entertainment.

"Acting has enabled me to break through that barrier. When you are acting, your whole body is the means of communication," says Manfred Mouers, one of Theatre of the Deaf's actors.

Theatre is also a creative outlet for deaf people who are often sidelined into mundane jobs.

At a workshop last Saturday, deaf actors were working together with professional, hearing actors, overcoming many of the fears that the deaf have about contact with hearing people, and vice versa.

Mouers feels it is the physical nature of acting that makes that contact possible.

But that's not to say deaf people's theatrical experience must be confined to mime.

"I don't like using the word 'mime'," says the group's co-ordinator Cara Loening. "The general public tend to assume that the deaf won't talk — it's like assuming that blind people can only do basketwork."

The group's immediate plans include productions of Dario Fo's "Can't pay won't pay," and "The Three Sisters" by the famously wordy Anton Chekov. The cast will include deaf and hearing actors. Deaf actors will "speak" their lines by means of sign language, while a hearing actor who is on stage will switch to the character of the deaf actor and translate the line into speech.

It is significant that the concept promoted by the group is called theatre of the deaf rather than theatre for the deaf.

The idea is not to present deaf people with specially made ghetto-theatre, but rather to provide opportunities for deaf people to become involved in the theatre as initiators and not only as consumers.

The result is ideally a theatre that may be enjoyed equally by hearing and deaf people.

Theatre of the Deaf is new in South Africa — Loening believes that we are decades behind the countries that pioneered the concept.

Mouers, who works in a bakery, longs to become a professional actor. But while deaf actors may find paid employment in the US, there are no such positions in South Africa.

As with so many innovative artistic ventures, money is the problem. Capab paid for Theatre of the Deaf to put on a show at last year's Grahamstown Festival, but so far no sponsor has shown any ongoing interest in funding the group.

As SA Theatre for the Deaf grows, they hope to expand beyond their Cape Town base and go national. Mouers' words sum up what this could mean to deaf people nationwide: "Theatre has given me something I can be interested in, something I can grow into."

● SA Theatre of the Deaf can be contacted at (021) 462-4470/1/2.

JUSTIN PEARCE

Viva helps care centre

ST Times (Metro) 7/3/93

THE Sunrise Special Care Centre for profoundly mentally handicapped children in Cape Town has used a R10 000 donation from the Viva Trust as part payment for a new minibus. (£1K)

The centre is one of the latest Western Cape recipients of donations from Viva. (299)

Viva distributes all money it raises in a region to charities it supports in the area.

The Sunrise Centre, which is using a house in Heathfield until it has raised sufficient money to build premises in Lavender Hill, cares for 16 children every day.

Doctors 'push tariffs up'

ADRIAN HADLAND

PRETORIA — Excessive claims for over-the-counter medicines were forcing medical aid schemes to raise tariffs, Consumer Council executive director Jan Cronje said at the weekend.

Unnecessary claims by consumers for non-prescribed medicines had placed a significant burden on medical aid schemes, forcing them to increase tariffs on a regular basis, he said in a statement.

The council's finding was the result of a comprehensive survey on prescribed medicine prices completed last week. Cronje said doctors who prescribed medicine which was available "over the counter" had contributed to rising medical aid costs.

The survey report also suggested consumers should negotiate with chemists and doctors for more favourable cash prices. The survey showed many chemists and dispensing doctors gave generous discounts for cash when asked. Many medical aid schemes also negotiated discounts with dispensers on behalf of their members.

The survey indicated that the difference in the prices of prescribed medicines, whether from dispensing doctors or from chemists, was negligible.

also as far as Black local authorities are concerned.

I further stated that an inclusive package approach will be followed and that I do not intend to deal with the matter of representation of areas of jurisdiction of management and Local Affairs Committees in City Councils in isolation, but as part of a comprehensive process. The package that I envisage will include the present black local authority areas.

Medical aid schemes: false claims

*18. Mr M J ELLIS asked the Minister of National Health:†

(1) Whether, with reference to certain information that has been furnished to the Minister's Department for the purpose of her reply, her Department has investigated a claim that approximately R2,5 billion or 25 per cent of payments made by medical aid schemes are in respect of fraudulent or false claims; if not, why not; if so,

(2) whether any substantiation has been received of such payments; if so, what are the relevant details;

(3) whether she will consider recommending the appointment of a commission of inquiry and/or appointing a departmental committee of inquiry to investigate the payments allegedly made in respect of such fraudulent or false claims; if not, why not; if so, what steps is it envisaged will be taken in this regard? B329E

The MINISTER OF NATIONAL HEALTH:

(1) No, there is no substantiation or scientific grounds on which the estimated figure is based;

(2) no;

(3) no, since medical schemes apply controlling measures and take action against such parties. This action includes:

— the termination of such members' membership of the scheme and the collection of amounts due; and

— litigation and/or reporting unethical behaviour by suppliers of services to statutory bodies.

Cost of medicine: forum

*19. Mr M J ELLIS asked the Minister of National Health:†

(1) Whether a forum entitled "Curtailing the Cost of Medicine" was held on or about 28 February 1992; if so, what are the names of the members of the working group appointed to investigate the recommendations of the forum;

(2) whether this working group has completed the investigation; if not, why not; if so,

(3) whether she will release the recommendations referred to above; if not, why not; if so, in what manner;

(4) whether this working group consulted with interested parties in the private sector; if not, why not; if so, with whom;

(5) whether she will make a statement on the matter? B330E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, a working group has not yet been constituted. Some of the proposals were referred to the statutory councils—the South African Medical and Dental Council, the Medicines Control Council and the Pharmacy Council. Even before the forum they were attending to these proposals. They have already implemented some of these proposals. The amendments to the Medical Schemes Act also make it possible to implement some of these proposals. The only proposal which cannot be implemented at present is generic replacement. A working group will be constituted should it become clear that the implementation of the other proposals do not have a meaningful influence on the cost of medicines.

(2), (3) and (4) fall away;

(5) No.

Armscor: LM4s/LM5s sold to Transkei

*20. Mr L FUCHS asked the Minister of Defence:

(1) Whether Armscor or any of its affiliates have sold and/or are selling LM4s and LM5s to (a) the Government of and/or (b) any private institutions in Transkei;

(2) whether he will make a statement on the matter? B333E

The MINISTER OF DEFENCE:

(1) and (2) The disclosure of details regarding the sale of armaments by Armscor is prohibited by Sec 11 A of the Act on Armaments, Development and Production, Act No 57 of 1968, as amended, unless so authorised by the Minister.

I am, however, prepared to make a once-only exception to the rule and announce that some 5 years ago, in July 1988, a single consignment of 15 LM5s was sold to the Transkei Development Corporation. In passing it should also be mentioned that since 1 April 1992, Armscor no longer has any affiliates which produce armaments and Armscor itself is in no way directly involved with the manufacture of armaments anymore.

Hijacking of motor vehicles: Johannesburg

*21. Mr D H M GIBSON asked the Minister of Law and Order:

(1) Whether there has been an increase in hijackings of motor vehicles in the north-eastern suburbs of Johannesburg during the past year; if so, to what extent;

(2) whether any steps are contemplated in this regard; if not, why not; if so, what steps? B334E

The MINISTER OF LAW AND ORDER:

(1) No.

(2) The steps which have already been taken and which are being taken on a continuous basis are:

— Increased police patrols;

— Quicker reaction to cases which are reported; and

— A special unit has been established in order to deal with the hijacking of vehicles.

*22. Mr J A Jordaan—National Health.† [Question standing over.]

Ballito: electricity supply

*23. Mr J A JORDAAN asked the Minister of Mineral and Energy Affairs:

(1) Whether any communities in the vicinity of the municipal area of Ballito have made direct or indirect representations the Electricity Control Board for the supply of electricity to them to be taken over by an institution other than that municipality; if so, what are the relevant details;

(2) whether he will make a statement on the matter? B339E

The MINISTER OF MINERAL AND ENERGY AFFAIRS:

(1) Yes, the relevant details are as follows:

(a) The Borough of Ballito supplies electricity to extra-municipal consumers in the vicinity of its municipal area under the authority of a licence which was issued by the Electricity Control Board (ECB) on 1 April 1987.

(b) From the outset the Borough of Ballito experienced problems with the poor electricity supply network which had been taken over from a previous operator and which had to be upgraded at a considerable cost. This expenditure had to be recovered in the form of increased tariffs to the consumers.

(c) The Durban City Council applied in a letter dated 10 December 1992 for the transfer of the right of supply in Ballito's extra-municipal supply area to that council. The ECB considered this application together with the Borough of Ballito's objection on 12 February 1993 and has called for the Durban City Council's explanation of how it intends supplying the consumers in the Borough of Ballito's extra-municipal supply area, ie whether it intends using Ballito's existing facilities such as its substation and/or transformers or whether it intends obtaining a direct supply from Eskom. The said council was also requested to inform the ECB of whether there would be separation costs and if so, what this would amount to. Ballito was also requested by the ECB to furnish its comments on these matters.

REGION H: EASTERN TRANSVAAL

Prison	*% over-populated*
Barberton Maximum	36,0
Barberton Medium A	56,2
Barberton Medium B	35,5
Bethal Male	7,7
Ermelo	0,8
Lydenburg	27,2
Middelburg (Tvl)	38,6
Nelspruit	[illegible]
Newcastle	23,2
Standerton Medium A	13,0
Standerton Medium B	8,6
Utrecht	17,1
Vryheid	12,7
Waterval Medium A	49,6
Waterval Medium B	50,3
Witbank Male	37,2

REGION I: NATAL

Prison	*% over-populated*
Bergville	43,8
Bulwer	34,9
Dundee	29,4
Durban Medium B	63,9
Durban Medium C	32,4
Durban Medium D	5,8
Empangeni	101,6
Eshowe	39,6
Estcourt	20,9
Glencoe	10,3
Greytown	11,8
Ixopo	30,4
Kokstad	83,1
Kranskop	78,1
Ladysmith (Natal)	35,9
Matatiële	14,3
Melmoth	18,2
Pietermaritzburg	51,3
Port Shepstone	57,9
Sevontein	37,8
Stanger	32,2

A new prison for 350 prisoners is planned at Umzinto.

The Department of Correctional Services annually provides a priority list of identified building projects to the Department of Public Works with a view to incorporating them in the Department of Public Works's five year building programme according to which building work is programmed for a term of five (5) years.

This programme is revised annually according to the availability of funds. The fact that a specific project appears on the major works services programme does not imply that it will be executed within five (5) years.

The average rate of over-population in South African prisons on 31 December 1992 was 28,2% in comparison with 15,67% on 31 December 1991.

ANNEXURE A

ANALYSIS OF THE PRISON POPULATION AS ON 31 DECEMBER 1992

Sentenced	
Up to and including 6 months	6 973
More than 6 months to under 2 years	11 316
2 years to 5 years	33 698
Longer than 5 years to 10 years	22 746
Longer than 10 years to 20 years	7 626
Longer than 20 years and imprisoned for life	1 761
Indeterminate sentences	3 886
Unsentenced	20 408
Other categories	284
TOTAL	*108 698

*Not daily average as mentioned in (1) (b) above.

Self-governing territories/TBVC countries: land purchased

97. Mr P G SOAL asked the Minister of Regional and Land Affairs:

(a) What was the total accumulated amount spent on purchasing land for the purpose of consolidation in respect of the (i) self-governing territories and (ii) independent Black states as at 31 December 1992 and (b) how much land was added to each such territory or state in 1992? B232E

The MINISTER OF REGIONAL AND LAND AFFAIRS:

(a) In terms of the White Paper on Land Reform it is no longer the policy of the Government to acquire large extents of land for addition to the TBVC States and Self-governing Territories. The acquisition of land can, however, not be summarily terminated and the Government is therefore, prepared to adopt a flexible approach to this matter. Land

will, however, no longer be incorporated into the TBVC States and the Self-governing Territories for the purpose of state forming as in the past.

(i) and (ii) Separate statistics are not available. The total accumulative amount spent from 31 August 1936 until 31 March 1992 in respect of the acquisition of land amounted to R1 403 373 297. The South African Development Trust has been abolished on 31 March 1992.

(b) Former SA Development Trust properties which had already been included in the areas of jurisdiction of the various self-governing territories on 31 March 1992, have been transferred in ownership to the said authorities on 1 April 1992 by Proclamation R28/1992 on the understanding that, where practically feasible, it will be transferred to tribes/communities.

No land, being the property of the former South African Development Trust, situated outside the areas of jurisdiction of the self-governing territories, has however, been incorporated into the areas of jurisdiction of the said authorities during 1992, or transported to the Self-governing territories.

The extent of the land transferred to the various self-governing territories on 1 April 1992 by Proclamation R28/1992, is as follows:

KwaZulu	1 013 487 hectares
Lebowa	506 325 hectares
Gazankulu	304 086 hectares
KaNgwane	146 821 hectares
KwaNdebele	16 738 hectares
Qwaqwa	46 499 hectares
TOTAL	2 033 956 hectares

Prisons: provision for disabled persons

127. Mr A J LEON asked the Minister of Correctional Services:

(1) (a) How many members of the current prison population are (i) physically, (ii) visually and/or (iii) auditorily disabled and (b) in respect of what date is this information furnished;

(2) whether any prisons make special provision for disabled persons; if not, why not; if so, (a) which prisons and (b) for what categories of disablement in each case? B297E

The MINISTER OF CORRECTIONAL SERVICES:

(1) (a) (i) 67 (of which two are dependent on wheelchairs)

(ii) 61 (only one eye in all cases)

(iii) 14 (partially in all cases)

(b) 2 March 1993.

(2) No. Structurally prisons do not cater specially for disabled persons except for those prison hospitals which are designed in such a way that a wheelchair can be accommodated in passages and bathrooms. However, provision for disabled persons is made in the sense that such persons are accommodated where it is convenient for them with due consideration of the nature of their disability. This sometimes necessitates a transfer to a large prison where a 24 hour nursing service is available.

(a) and (b) Fall away.

Own Affairs:

Teachers: retirement on accelerated pension

6. Mr A GERBER asked the Minister of Education and Culture:

(1) How many teachers in his Department retired from service on accelerated pension in 1992;

(2) whether any of these teachers have since been re-employed as teachers by his Department; if so (a) how many as at the latest specified date for which information is available and (b) why? B92E

The MINISTER OF EDUCATION AND CULTURE:

(1) 5 492 (early retirement 234; medical grounds 74; retrenched 5 045; prior to 1–4–1992 converted to state-aided school 139) in the two main categories which are considered for accelerated pension, namely:

P TO P

also as far as Black local authorities are concerned.

I further stated that an inclusive package approach will be followed and that I do not intend to deal with the matter of representation of areas of jurisdiction of management and Local Affairs Committees in City Councils in isolation, but as part of a comprehensive process. The package that I envisage will include the present black local authority areas.

Medical aid schemes: false claims

*18. Mr M J ELLIS asked the Minister of National Health:† (299)

(1) Whether, with reference to certain information that has been furnished to the Minister's Department for the purpose of her reply, her Department has investigated a claim that approximately R2,5 billion or 25 per cent of payments made by medical aid schemes are in respect of fraudulent or false claims; if not, why not; if so,

(2) whether any substantiation has been received of such payments; if so, what are the relevant details;

(3) whether she will consider recommending the appointment of a commission of inquiry and/or appointing a departmental committee of inquiry to investigate the payments allegedly made in respect of such fraudulent or false claims; if not, why not; if so, what steps is it envisaged will be taken in this regard? B329E

The MINISTER OF NATIONAL HEALTH:

(1) No, there is no substantiation or scientific grounds on which the estimated figure is based;

(2) no;

(3) no, since medical schemes apply controlling measures and take action against such parties. This action includes:

— the termination of such members' membership of the scheme and the collection of amounts due; and

— litigation and/or reporting unethical behaviour by suppliers of services to statutory bodies.

Cost of medicine: forum

*19. Mr M J ELLIS asked the Minister of National Health:† (299)

(1) Whether a forum entitled "Curtailing the Cost of Medicine" was held on or about 28 February 1992; if so, what are the names of the members of the working group appointed to investigate the recommendations of the forum;

(2) whether this working group has completed the investigation; if not, why not; if so,

(3) whether she will release the recommendations referred to above; if not, why not; if so, in what manner;

(4) whether this working group consulted with interested parties in the private sector; if not, why not; if so, with whom;

(5) whether she will make a statement on the matter? B330E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, a working group has not yet been constituted. Some of the proposals were referred to the statutory councils—the South African Medical and Dental Council, the Medicines Control Council and the Pharmacy Council. Even before the forum they were attending to these proposals. They have already implemented some of these proposals. The amendments to the Medical Schemes Act also make it possible to implement some of these proposals. The only proposal which cannot be implemented at present is generic replacement. A working group will be constituted should it become clear that the implementation of the other proposals do not have a meaningful influence on the cost of medicines.

(2), (3) and (4) fall away;

(5) No.

Armscor: LM4s/LM5s sold to Transkei

*20. Mr L FUCHS asked the Minister of Defence: (103)

(1) Whether Armscor or any of its affiliates have sold and/or are selling LM4s and LM5s to (a) the Government of and/or (b) any private institutions in Transkei;

(2) whether he will make a statement on the matter? B333E

The MINISTER OF DEFENCE:

(1) and (2) The disclosure of details regarding the sale of armaments by Armscor is prohibited by Sec 11 A of the Act on Armaments, Development and Production, Act No 57 of 1968, as amended, unless so authorised by the Minister.

I am, however, prepared to make a once-only exception to the rule and announce that some 5 years ago, in July 1988, a single consignment of 15 LM5s was sold to the Transkei Development Corporation. In passing it should also be mentioned that since 1 April 1992, Armscor no longer has any affiliates which produce armaments and Armscor itself is in no way directly involved with the manufacture of armaments anymore.

Hijacking of motor vehicles: Johannesburg

*21. Mr D H M GIBSON asked the Minister of Law and Order:

(1) Whether there has been an increase in hijackings of motor vehicles in the north-eastern suburbs of Johannesburg during the past year; if so, to what extent;

(2) whether any steps are contemplated in this regard; if not, why not; if so, what steps? B334E

The MINISTER OF LAW AND ORDER:

(1) No.

(2) The steps which have already been taken and which are being taken on a continuous basis are:

— Increased police patrols;

— Quicker reaction to cases which are reported; and

— A special unit has been established in order to deal with the hijacking of vehicles.

*22. Mr J A Jordaan—National Health.† [Question standing over.]

Ballito: electricity supply

*23. Mr J A JORDAAN asked the Minister of Mineral and Energy Affairs:

(1) Whether any communities in the vicinity of the municipal area of Ballito have made direct or indirect representations to the Electricity Control Board for the supply of electricity to them to be taken over by an institution other than that municipality; if so, what are the relevant details;

(2) whether he will make a statement on the matter? B339E

The MINISTER OF MINERAL AND ENERGY AFFAIRS:

(1) Yes, the relevant details are as follows:

(a) The Borough of Ballito supplies electricity to extra-municipal consumers in the vicinity of its municipal area under the authority of a licence which was issued by the Electricity Control Board (ECB) on 1 April 1987.

(b) From the outset the Borough of Ballito experienced problems with the poor electricity supply network which had been taken over from a previous operator and which had to be upgraded at a considerable cost. This expenditure had to be recovered in the form of increased tariffs to the consumers.

(c) The Durban City Council applied in a letter dated 10 December 1992 for the transfer of the right of supply in Ballito's extra-municipal supply area to that council. The ECB considered this application together with the Borough of Ballito's objection on 12 February 1993 and has called for the Durban City Council's explanation of how it intends supplying the consumers in the Borough of Ballito's extra-municipal supply area, ie whether it intends using Ballito's existing facilities such as its substation and/or transformers or whether it intends obtaining a direct supply from Eskom. The said council was also requested to inform the ECB of whether there would be separation costs and if so, what this would amount to. Ballito was also requested by the ECB to furnish its comments on these matters.

P70 P

HOUSE OF DELEGATES

INTERPELLATION

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

General Affairs:

Doctors: fraud iro medical aid schemes

1. Mr M RAJAB asked the Minister of National Health:

(1) Whether she made a statement to the effect that approximately 200 doctors had allegedly defrauded medical aid schemes in the recent past; if not, what is the position in this regard; if so,

(2) whether she intends revealing their names or reporting them to the South African Medical and Dental Council; if not, why not; if so, what are the relevant details?

D90E.INT

The MINISTER OF NATIONAL HEALTH: Mr Chairman, my reply is no. I wish to quote from my Hansard of 9 February 1993, col 851:

> As an example of this I should like to refer to a survey of the approximately 200 doctors who claim the highest income from medical schemes.

I mentioned this to demonstrate claim tendencies and made the point that the information in respect of claims paid to medical practitioners during 1990 was submitted to me by five administrators of medical schemes.

I wish to make it quite clear that the medical profession, like all other professions, has successful members who, through hard work and honest business, make a substantial income. These practitioners were obviously included in the survey. It is also quite clear from what I said in Parliament that I was only referring to dispensing practitioners whose income for that year was almost R1 million. Like certain others, almost 70 % of the payments made by these medical schemes were in respect of medicine dispensed to their patients by these practitioners. That unequivocally indicates that such doctors are doing business in medicine.

As it is not appropriate, I am not prepared to discuss ethical matters across the floor. I have asked the SA Medical and Dental Council for advice on whether it is in the interests of the public for 70 % of a doctor's gross income to be made from the sale of medicine. I am, however, prepared to discuss the matter with the hon member in private and on a confidential basis.

Mr M RAJAB: Mr Chairman, I thank the hon the Minister for that very kind invitation and I will certainly take her up on it.
It is now common cause that the hon the Minister in fact mentioned a survey of some 200 doctors whose names are known to her and who are quite clearly guilty of abusing medical aid schemes by, to quote the hon the Minister, "doing business in medicine". I am sure the hon the Minister never intended it, but by not naming the individuals concerned she regrettably and unjustifiably tainted the reputation of the entire medical profession by her statement. If one considers that these 200 doctors amount to some 1,25 % of the practising doctors in this country, is it any wonder that there has been such an outcry and such resentment within the profession as a result of that unfortunate statement?

We accept that there will always be a handful of professionals who behave unprofessionally and unethically. It is precisely by publicly exposing those who are guilty of improper conduct that we can protect the reputation, the standing and the respect of the innocent ones. In these circumstances I therefore find the actions of the hon the Minister to be unacceptable and urge her, even at this time, to make public the names of the 200 on that particular list. In fact, I would argue that our sense of justice and equity demands it.

I have already indicated to the hon the Minister that I will take up her invitation to visit her in her office and, I trust, have a cup of tea with her. Nevertheless, I believe it is in the public interest to, in fact, name those particular doctors. I again urge the hon the Minister to do just that.

The CHAIRMAN OF THE HOUSE: Order! On the list I have before me the hon member for Montford is due to speak next, but the hon member for Malabar may proceed.

Mr K PADAYACHY: Mr Chairman, firstly I wish to congratulate the hon the Minister of National Health on her courageous action in

exposing these 200 doctors whom I label mercenary, merciless doctors. These doctors who are enriching themselves at the expense of medical aid schemes and their patients are a disgrace to their profession and an insult to the Hippocratic oath they have sworn to uphold. However, I believe that those 200 doctors are only the tip of the iceberg and that many more doctors are guilty of this scandalous practice. I personally know of a doctor who, after being in private practice for just six months, bought himself a house valued at R300 000, a brand-new Mercedes Benz and a BMW car. I do not deny the right of somebody who has studied for seven years to enjoy the fruits of his labour, but I feel that it is high time that unscrupulous doctors were rooted out and struck off the list of medical practitioners.

The MINISTER OF NATIONAL HEALTH: Mr Chairman, I am not prepared to name the 200 doctors for the simple reason that when I mentioned them I did so in order to demonstrate the claim tendencies, which was the essence of the debate. What was happening, and it is still happening, is perfectly legal. There is nothing wrong with what these doctors are doing. This was one of the reasons I put forward to demonstrate the need for the introduction of the Medical Schemes Amendment Bill. I think we should focus on that fact.

I would welcome the support of the National Association of Medical Aid Schemes. They should come forward and say that this is unacceptable and that they would like to address the problem of trading in medicine, which is the main problem. The question that should be asked is whether or not this is acceptable and in the interests of the public. I want the debate to focus on these aspects and the public should support me in this. Furthermore, I believe it is the duty of the medical profession to do likewise.

Mr A RAJBANSI: Mr Chairman, there is no doubt about the fact that, on behalf of the public, we shall support the hon the Minister of National Health if she should want to take action by exposing anyone who abuses medical aid schemes in this country. We shall fully support her in such action against those who want to destroy the goose which lays the golden eggs.

There is no doubt about the fact that medical aid schemes are experiencing a very torrid time as a result of abuses, and not only doctors but also pharmacists are guilty. There have been cases in my area in which the SA Pharmacy Council took action against pharmacists who had been giving cosmetics in return for prescriptions.

If the hon the Minister is not supported and medical aid schemes die a natural death in this country, the entire infrastructure of our future health care system will be destroyed. The very fact that the hon the Minister made this statement means that the guilty ones should be identified in order to ensure that such malpractices are discontinued.

Mr M RAJAB: Mr Chairman, lest there be a misunderstanding, I do not hold a brief for any particular medical practitioner, nor for any person who is guilty of any kind of improper conduct. In fact, we are saying that the guilty ones should be publicly charged and tried. I trust that due process will take place in this regard.

The hon the Minister indicated that this matter had been referred to the SA Medical and Dental Council.

The MINISTER OF NATIONAL HEALTH: The principle, not the names!

Mr M RAJAB: I see, it was the principle. I am pleased that the hon the Minister has rectified this, because I understand that the president of the SA Medical and Dental Council, Dr Backer, in fact denied that the hon the Minister had referred this matter to him.

The MINISTER OF NATIONAL HEALTH: That is correct as far as the 200 names are concerned. However, I have mentioned the principle.

Mr M RAJAB: I see. I just want to make the following point, and I trust that the hon the Minister will take it with all the seriousness with which I am making it.

The CHAIRMAN OF THE HOUSE: Order! I regret that in terms of time the opportunity for making the point has elapsed.

The MINISTER OF NATIONAL HEALTH: Mr Chairman, I shall carry a torch for the doctors, because they work hard, and I think we can trust the majority of them. I think it is necessary for us to say this.

I raised the point in order to demonstrate the overutilisation of the system and why it was imperative to amend the Medical Schemes Act.

I think in this debate we should not focus on who those 200 doctors are, because they were acting within the terms of the present Act. What they did, was quite legal. I should like to repeat myself.

Mr M RAJAB: Mr Chairman, may I ask the hon the Minister a question?

The MINISTER: Mr Chairman, the hon member had his opportunity. [Interjections.]

The point he raised was that not mentioning these names gave the impression that all doctors were guilty of this. This is not what I implied.

Mr M RAJAB: The hon the Minister could then be guilty of being an accessory after the fact.

The MINISTER: Yes, and this is not what I implied. That is why I am saying that if doctors themselves would come forward and say that this is unacceptable, and would themselves defend the principle and investigate its soundness, it would be to their own benefit.

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

Prison at Umzinto: tenders

*1. Mr M RAJAB asked the Minister of Correctional Services:

Whether, with reference to the reply to question No 1 on 29 April 1992, tenders for the building of the prison at Umzinto have been accepted; if not, why not; if so, (a) to whom was the tender awarded, (b) what is the cost involved and (c) when is it anticipated that the work on this prison will be completed? D49E

The MINISTER OF CORRECTIONAL SERVICES:

Mr Chairman, at the outset I should like to say that I received certain requests in this regard from *inter alia* the hon member for Umzinto, and I hereby reply to the question as follows:

No, an invitation for tenders was published in the Government Tender Bulletin of 5 March 1993. It is expected that the duration of the contract should not exceed 32 months and that construction should be completed during the 1996/7 financial year.

(a), (b) and (c) Fall away.

Mr N SINGH: Mr Chairman, arising out of the hon the Minister's reply, do I then take it that the planning phase has been completed? Secondly, previous plans included the construction of tennis courts, squash courts, a bowling green and other sporting facilities on this site. Are these facilities also included in the present tenders which have been called for?

The MINISTER: Mr Chairman, as far as the second part of the hon member's question is concerned, unfortunately I do not have those specific particulars with me. I invite him to come and have a cup of tea with me and I shall give him that information. [Interjections.]

As far as the first part of his question is concerned, I should like to say that last year I replied to this question as:

According to present planning the tender date is set for February 1993 and it is expected that the project will be completed by 1996, provided that sufficient funds are available.

The present tender date is 5 March.

†We are as near as possible.

It will be completed by 1996–97.

Mr M RAJAB: Mr Chairman, further arising out of the hon the Minister's reply, for which I thank him, may I ask him whether, given the fact that so much time has elapsed since this particular prison was planned, and given the fact that our jails are overflowing, that particular jail would not be too small by the time it is fully operational?

The MINISTER: Mr Chairman, this is a possibility, but this is unfortunately the situation that we are in. It takes quite a long time to do the planning and we have to wait for funds to become available. The possibility exists that the jail will be too small by the time it is completed.

SAA: flights to/from India

*2. Mr A RAJBANSI asked the Minister for Public Enterprises:

Whether the South African Airways have applied or intend applying for permission to introduce flights to and from India; if not, why not; if so, what are the relevant details? D52E

The MINISTER FOR PUBLIC ENTERPRISES:

The Managing Director of Transnet Limited replied as follows to the hon member's question:

No, the South African Airways does not intend introducing flights to India, as another South African airline has already been granted permission to operate services between the two countries.

Braemar: death in prison cell

*3. Mr M RAJAB asked the Minister of Law and Order:

(1) Whether a certain person of Braemer in Natal, particulars of whom have been furnished to the South African Police for the purpose of the Minister's reply, was at any stage detained in a police cell during February 1993; if so, what is this person's name;

(2) whether this person was found dead in a cell one morning; if so, (a) in which police cell and (b) when was he (i) arrested and (ii) found dead;

(3) whether a pathologist's report has been received in regard to his death; if not, why not; if so, what were the findings? D73E

The DEPUTY MINISTER OF LAW AND ORDER:

(1) Yes.

Kader Shaik.

(2) Yes.

(a) Sowati.

(b) (i) At 15:40 on 15 February 1993.

(ii) At 05:15 on 16 February 1993.

(3) Yes, the finding of the state pathologist was that the cause of death of Mr Shaik was consistent with that of a heart attack. The histological report is still outstanding.

Mr M RAJAB: Mr Chairman, arising out of the hon the Minister's reply, could he please tell us whether the pathologist's report was, in fact, communicated to the family of the deceased?

The DEPUTY MINISTER: Mr Chairman, to my knowledge this has not yet been done, because we are still awaiting the histological report as well.

Islamic/Hindu marriages: legislation

*4. Rev C PILLAY asked the Minister of Justice:

(1) Whether he will consider introducing legislation to recognize Islamic and Hindu religious marriages; if not, why not; if so, when;

(2) whether he will make a statement on the matter? D76E

The DEPUTY MINISTER OF JUSTICE:

(1) and (2)

A project dealing with Islamic marriages and related matters was placed on the programme of the South African Law Commission during July 1986. The project committee appointed for the purpose of the investigation considered a working paper. A copy will be handed to the hon member immediately after the question period. A study of comparative law is presently being conducted. All interested parties are welcome to submit proposals in this regard to the Secretariat of the Law Commission.

Mr A RAJBANSI: Mr Chairman, arising out of the hon the Deputy Minister's reply, is he prepared to tell us why the Government is dragging its feet on this, while the ANC and the IFP have officially announced that they will recognise these marriages, and while the NP recognises that there is freedom of religion in this country?

The DEPUTY MINISTER: Mr Chairman, there is no doubt as far as the commitment of the Government is concerned. The fact is that this project has been launched and is being conducted. [Interjections.]

PTO →

Public service pay increases

CAPE TOWN — Thousands of public servants and teachers will receive salary increases this year way above the 5% across-the-board rises to be granted to all public servants on July 1.

About 40% of ordinary public servants and about 60% of teachers will also receive notch increases of between 4% and 7%. Only those at the top of their scale and those on fixed salaries will receive only 5% increases.

These increases will be higher than the average paid in the private sector.

The Afrikaanse Handelsinstituut has estimated average increases in the private sector at between 6% and 8%.

President F W de Klerk said this week he was prepared to meet teacher organisations, but was not prepared to discuss representations on the 5% issue.

The National Education Department said yesterday that some teachers had not yet reached the maximum of the scale on which they were appointed.

"Where the services of these teachers have been satisfactory over the past year, they will receive the normal increase of a notch on their respective incremental dates," it said in response to a question.

Political Staff

"This increase will be in addition to the 5% salary increase that every educationist will receive on July 1 1993."

It is understood that about 60% of teachers will receive increases and that these will range between 6% and 7%.

Fewer ordinary civil servants will benefit from notch increases.

Commission of Administration spokesman Corrie Smit said the average notch increase this year would be 4,2%.

About 40% of Public Service Act public servants qualified for these increases.

Apart from those at the top of their scale, people on fixed salaries would not receive notch increases.

In the case of teachers, the top scale for people such as rectors of colleges of education, principals of large schools and superintendents is at present R94 692 a year, and they will receive increases of about R4 700, as they will not be eligible for notch increases.

These salaries exclude housing subsidies and retirement benefits, including gratuities.

Venter quizzed on medical aid fraud

CAPE TOWN — National Health Minister Rina Venter acknowledged yesterday that the extent of "overutilisation" and fraud against medical aid schemes was unknown.

However, during an interpellation in the House of Delegates Venter refused to name the 200 doctors who were part of a survey. It was disclosed that one practitioner had made R1m — 70% of it from dispensing medicines.

She said she had asked the SA Medical and Dental Council for advice as what was happening was "perfectly legal".

Political Staff

Malabar MP Kasoo Padayachy said that there were "mercenary, merciless" doctors who were growing rich at patients' expense. Many were guilty of "scandalous behaviour". He knew of one who after just six months could afford a R300 000 house, a Mercedes-Benz and a BMW.

Such people, he said, should be rooted out.

Springfield MP Mahmoud Rajab said the Minister should name the 200 doctors, as the reputation of the whole profession was being tainted. It was accepted that there would always be a handful of people in every profession who would "behave unprofessionally". By exposing those who did, the reputation and standing of the others could be protected.

CORPORATE HEALTH CARE CONFERENCE

FM 12/3/93.

Private-sector health care is set to undergo radical change with the recent passage of the Medical Schemes Amendment Act.

As the Act sweeps away guaranteed minimum payments and set tariffs for medical procedures, employers and employees will be swamped with health care cover options from the insurance industry, medical schemes, private hospitals, doctors and others — all bidding for business.

The *FM*'s one-day conference on Corporate Health Care next Tuesday at Johannesburg's Carlton Hotel will deal with the implications of the new legislation and highlight the benefits and pitfalls of the different policies on offer.

The keynote address will be delivered by Health Minister Rina Venter. Other speakers include Rob Speedie, executive director of the Representative Association of Medical Schemes; Reg Magennis of the Medical Association of SA; Alexander Forbes's Leon Lewis; and Izak Fourie of the SA Chamber of Mines.

About 400 delegates are expected to attend. For further information contact Global Conferences at (021) 683-3265 or fax (021) 683-4086.

Medical aid: No action?

ARG 13/3/93

THE Minister of Health, Dr Rina Venter, has made no formal request for action by the South African Medical and Dental Council (SAMDC) against the 200 doctors who were allegedly abusing medical aids. (299)

There was an outcry earlier this year when Dr Venter claimed in parliament she had a list of 200 doctors "abusing" the system.

A number of medical aid societies claimed she should submit the list of "crooked" doctors to the SAMDC.

A SAMDC spokesman said the ethical principle involved was "informally discussed" with Dr Venter.

Education is the key

299

Sowetan 16/3/93.

■ **Albinos to start campaign:**

By Pearl Majola

IT WAS about time albinos launched a campaign to educate the public and do away with the myths surrounding their condition once and for all.

This is the message from clinical psychologist Ms Anne-Gloria Masetle. She was speaking at a workshop on albinism at the Careers Centre in Diepkloof, Soweto, at the weekend.

The workshop, organised by the Soweto Albinism Society, was attended by about a hundred albinos, their families and concerned members of the community.

"The first step is to accept your condition and build up your confidence," said Masetle. "Then strengthen this organisation (SAS)-and provide for yourselves a strong support group so that you are able to deal with the attitudes of ignorant people."

Medical aid hikes outstrip pay rises

KATHRYN STRACHAN 299

MEDICAL scheme costs had risen 33% faster than company salaries, and unemployment and high taxes had put pressure on individuals' and companies' ability to afford health care, Medical Association of SA (Masa) health policy director Reg Magennis said yesterday. BIDAY 17/3/93

He told a Financial Mail Corporate Health conference in Johannesburg that in recent years medical inflation was significantly higher than the CPI. Analyses of the years 1985 to 1990 showed about R1,3bn more was paid to medical schemes by companies and employees — representing an increase of 34% in monthly premiums.

Health was critical to economic development, said Magennis, and the health sector should be regarded as an economically productive sector able to compete for domestic resources in its own right.

He added that the business sector was under pressure to alleviate social problems and it would be forced to make health care a priority if it was to survive prevailing economic conditions.

The AIDS epidemic, which threatened to consume half the country's health expenditure by the year 2000, presented the business community with a major social and economic problem and required immediate attention, he said.

Dr Izak Fourie of the Chamber of Mines said corporate health care costs were out of control and employee health benefits had become a major cost of doing business.

To Page 2

Medical aid BIDAY 17/3/93 (299)

From Page 1

The current medical aid system was fast becoming unaffordable to its traditional customers, and it would be impossible for employers, employees and the economy as a whole to try to extend the current system to cover the entire workforce.

Although during the past few years most companies had opened their medical aid schemes to all employees, or created a separate scheme for lower categories, Fourie said that because of the high contributions, many of the lower-income employees had elected not to join.

Every company would have to invest the necessary resources to develop a comprehensive organisational health plan, with the emphasis on preventative care, rather than attempting to solve the problem in a piecemeal manner.

In her opening address, National Health Minister Rina Venter said private health care was becoming increasingly unaffordable. There was an urgent need to restructure private health to enable the sector to function according to market-related principles.

"It is for this reason that tough decisions have to be taken to improve the health status of the population as a whole and to ensure that a cost-effective private health care system remains in place," she said.

A strong private health sector meant government could get on with providing for the indigent, particularly through boosting primary health care.

Warning on private health care

17/3/93

299

Own Correspondent

JOHANNESBURG. — Medical scheme costs have risen 33% faster than company salaries, and the national health minister warned that private health care was becoming increasingly unaffordable.

In her opening address at a Financial Mail Corporate Health conference here, Health Minister Dr Rina Venter stressed that there was an urgent need to restructure private health to enable the sector to function according to market-related principles.

"It is for this reason that tough decisions had to be taken to improve the health status of the population as a whole and to ensure that a cost-effective private health care system remains in place," she said.

Unemployment and high taxes have placed considerable pressure on the ability of individuals and companies to afford health care, Medical Association of SA (Masa) health policy director Mr Reg Magennis said yesterday.

Mr Magennis said that in recent years medical inflation was significantly higher than the CPI. Analyses of the years 1985 to 1990 showed that about R1,3 billion more was paid to medical schemes by companies and employees — which represented an increase of 34% in monthly premiums.

He added that the business sector was under pressure to alleviate social problems and it would be forced to prioritise health care if it was to survive in the prevailing harsh economic conditions. The Aids epidemic required immediate attention, he said.

Speaking at the same conference, Dr Izak Fourie of the Chamber of Mines said corporate health care costs were out of control and employee health benefits had become a major cost of doing business.

Govt restructuring prompts mass action

JOHANNESBURG. — A mass action campaign to oppose the government's restructuring of health services is to be launched next Saturday, the South African Health and Social Services Organisation (Sahsso) announced yesterday.

In a statement, Sahsso said the effects of restructuring were already being felt, with "massive retrenchments of health workers, cutbacks in services and the closure of hospitals at a time when people, especially the poor, need these services more than ever before".

"The actions by this government are, at best, heartless and cynical," the statement said.

As a result of the government's actions, "Sahsso and the South African National Civics Association are embarking on a mass action campaign to render all these proposed changes unworkable".

No details on what form the campaign, to begin on March 27, would take were available. — Sapa

'Extra burden for private patients'

Medical Reporter

The increase in VAT would burden private patients with an extra R350 million in health care costs this year, Representative Association of Medical Schemes (RAMS) executive director Rob Speedie warned yesterday.

Speedie said the VAT increase came at a time when health care was already under extreme pressure and people were suffering economically. "This could result in added pressure on public sector health care services."

RAMS would meet other concerned parties this month to discuss the VAT increase before a full meeting of RAMS on March 31 to discuss possible adjustments to the scales of benefits.

The Medical Association of South African (Masa) said it had hoped medical services and medicines would be zero-rated to provide more affordable health care.

Masa also expressed concern that the VAT increase would mean that tax concessions on basic foodstuffs announced last week would not filter into households.

Masa federal council chairman Dr Bernard Mandell, however, welcomed the proposed 16,7 percent increase in spending on primary health care and the increase in the Protein Energy Malnutrition allocation from R400-000 to R40 million.

The Baragwanath Hospital Doctors' Association responded with "deep disappointment" at the way the Government "continues its policy of exploitation and neglect of State-employed" doctors. Association chairman Dr Ron Kemper said a mass exodus of doctors from State hospitals could be expected.

Rob Speedie . . . VAT to add extra R350 million.

FM 19/3/93 299

spectrum of the public." This will in turn minimise State control over business without sacrificing the public interest or jeopardising public health.

She stresses, however, that the consumer must accept more reponsibility to contain costs by using benefits sparingly and negotiating fees with health-care suppliers. The Act offers other innovations. A married woman now qualifies for membership of a scheme in her own right. The new law also continues to allow widows and minors to retain membership after the death of the subscriber.

Members will be further protected by measures geared towards securing the financial security of the scheme. These will include extensive measures regarding disclosure of performance, action by the Registrar when the scheme does not perform in its members' best interests, and actuarial valuations.

The Act won't adversely affect doctors and other practitioners, Venter says. "It's no longer justified to protect private practice artificially.

"Rather, practitioners must exploit the challenges of the free market. In this regard, the new law will set a stable stage for suppliers to market their services."

She points out that a number of independent private practice associations have already been established." ■

FM HEALTH CONFERENCE 299

FM 19/3/93

Rina Venter's Rx

Parliament passed the Medical Schemes Amendment Act last month to give Health Minister Rina Venter the green light to reform the crisis-ridden private health-care sector. The Act gives medical schemes greater scope to keep costs in check and query claims by ending compulsory minimum benefits and guaranteed payments that schemes were legally obliged to make on receipt of a claim.

The legislation will also encourage greater competition in the sector by allowing schemes to own hospitals and clinics and employ doctors and other health care practitioners under managed health care models — practices that have cut costs by as much as 40% elsewhere.

The extensive deregulation redefines the basis for negotiations among the supplier, financier and consumer of services, leaving players wondering just how much will change in the months to come.

Tough decisions

Venter told the *FM* Corporate Health Care Conference this week that health care has become increasingly unaffordable to most of the population. "Benefits paid out by schemes in 1991 increased by 30% over the previous year while the membership numbers increased by only 0,1% and beneficiaries by 2,6%.

"This is why tough decisions had to be taken to ensure that a cost-effective private health care system remains in place."

Venter believes the new legislation will allow consumers to choose affordable cover that will suit their needs. "A deregulated environment will no doubt bring private health-care cover within the reach of a wider

Grants to be increased from July 1

Old age and disability grants are to be increased to R370 for whites, R343 for coloureds and Asians, and R318 for blacks from July 1, National Health Minister Dr Rina Venter said in a statement yesterday.

This follows the announcement by Minister of Finance Derek Keys in his Budget speech on Wednesday of increased social grants for all population groups.

Venter said war veterans and the blind in all three groups would receive R370. A supplementary grant of R18 applied.

She said parity between all population groups would be reached from September 1, when a grant of R370 would be paid in cases of old age, disability, war veterans, the blind, single care and parents.

The children's grant had been increased to R115 and the foster child grant to R260. — Sapa.

Star 22/3/93

Medaid absorbs VAT increase

Tafelberg Medical Aid Society has announced it will absorb the effects of the 4 percent increase in VAT on April 7.

A spokesman said the society was able to save employer groups and members any increases in contributions for the balance of the 1993 calender year due to good controls implemented earlier and good claims behaviour. — Medical Reporter. (299)

Life industry 'wasting R1,5bn a year'

B1DAY 23/3/93

SA's life assurance industry was grossly inefficient and wasted about R1,5bn of policyholders' money every year through lapses and surrenders of policies, Pretoria University Department of Insurance and Actuarial Science Professor George Marx said at the Ilpa congress yesterday.

He said such wastage could not be afforded in health care and called for the life assurance and medical aid scheme industries to combine forces to create a safe and sound form of financing for private health care.

Neither of the two industries were able to provide such a system on their own.

Marx calculated the R1,5bn wastage of policyholders' money through lapses and surrenders by assuming that, on average, two-and-a-half years' premiums were lost when policies were terminated.

He challenged the life industry to conduct an independent investigation to verify this figure.

"These terminations mean premiums which were contributed did not end up being used for the purpose for which the policies were taken out, namely death and disability protection and for long-term savings," Marx said.

Whereas in 1991, the expenses of life assurers (excluding claims) represented 18% of their total premium income, the figure for medical schemes was 5,7%.

The disparity was largely the result of commissions paid to intermediaries, which Marx said did not benefit the policyholder.

In the same year life assurers paid out R9,4bn in benefits (excluding surrenders) and medical aid schemes R6,9bn.

In favour of life assurers was they possessed skills of risk, financial and actuarial management — skills profoundly lacking in the medical schemes industry.

Right

"When it comes to the medical schemes industry, it is clear it has been doing things right in terms of administering claims efficiently."

But it had not been exercising proper risk, financial and actuarial management principles and as punishment for this, members were subject to runaway inflation.

The over-utilisation of medical aid scheme benefits, overservicing and fraud had resulted in medical aid scheme contribution rates increasing at 25% a year over the last decade.

Marx suspected that, considering general practitioners control approximately 85% of all health care costs, the major culprit in this was overservicing.

He said there was an urgent need for the life assurance and medical aid scheme industries to combine to provide efficient finance for the public's private health care and for the elimination of their respective weaknesses.

The health financing scheme had to get actively involved in medical care and could not continue merely processing pieces of paper.

"The days are past where the financier of health care can sit on the sideline and merely pay claims. He has to dirty his hands and also move towards managing the care, be it by way of utilisation reviews, bulk purchasing of medicines, by initiating Preferred Provider Organisations or whatever," Marx said.

He suggested the use of seven criteria for evaluating health financing schemes.

The scheme should distinguish between less and more serious conditions; encourage self-discipline and cost-consciousness; move towards managed care; provide for long-term funding of pensioners' costs; provide for emergency treatment in private hospitals; provide for a convenient payment system; and disclose all cost elements.

Strong economic growth forecast

B1DAY 23/3/93

SA WAS "over the hump" politically and economically and could look to a period of strong economic growth from next year, according to Syfrets Managed Assets MD Leon Campher.

Negotiations were back on track, the drought was broken and propects for the international economy were better.

The one negative threat was the probability of a correction of the US stock market. This usually occurred within 12 months of a US presidential election. As the JSE historically had a 96% correlation with the US market, it was likely the SA market would also suffer a correction.

"Investors should not rush into the stock market at this stage but bide their time and take advantage of the buying opportunities that will emerge later."

Campher said the US economy had emerged from recession in terms of retail sales and manufacturing production. Japan was still in a downturn but hopefully the cut in interest rates there and in Germany would contribute to the achievement of world economic growth next year. This would stimulate the export of SA commodities.

Star 25/3/93

Disability benefit claims up sharply

(299)

CAPE TOWN — Assurers have expressed concern over the sharp rise in claims for disability benefits — which have almost doubled in the past five years.

Senior actuary Wouter Thom says in Sanlam's latest group benefits survey that the weak economy is one of the main reasons for this increase.

There is a tendency worldwide for disability claims to rise sharply during a recession.

"Jobs are scarce and employment prospects poor, while employees are expected to be productive.

"Some workers cannot handle the pressure and see the disability benefits offered by their employer as a way out.

"There are even employers who purposely go about using disability benefits to reduce on their employees and therefore save on salaries."

The high disability benefits offered by some employers contributes to a higher claims propensity.

"The greater the benefit, the lower the motivation for someone already receiving a disability benefit to return to work.

"The type of benefit also plays a role — for example, a disability benefit available as a lump sum is more attractive and usually results in more claims."

According to Thom, the increase in disability claims eventually leads to higher premiums for the employer.

Disability benefits used to be a relatively cheap benefit for the employer to offer.

However, they are becoming more and more expensive, and will remain expensive — even if there is an improvement in the economy and a decline in the level of claims.

Thom also believes that since occupational disability is more socially acceptable these days, employees make use of such benefits more quickly and easily.

He says assurers in South Africa have come across cases where the cause of occupational disability has been Aids.

Although this is not seen as an important cause of the increase in claims at this stage, Aids is expected to become more and more significant in future.

Thom suggests that employers should reconsider the nature and size of disability benefits and, for example, reduce benefit levels, limit the income benefit to at most 75 percent of salary and rather pay lump sum benefits in instalments.

In addition, new applicants could have to undergo a medical examination to prevent potential claims.

He also proposes a rehabilitation programme for persons who already receive disability benefits to encourage them to return to the labour force faster. — Sapa.

Opening the doors to competition

FM 26/3/93
299

As the Medical Schemes Amendment Act throws open the private health-care sector to competition, the medical schemes industry will undergo radical surgery to keep ahead of its nearest competitor — the insurance sector.

Rob Speedie, executive director of the Representative Association of Medical Schemes, told the *FM* Corporate Health Care Conference last week that the legislation — which ends compulsory minimum benefits and guaranteed payments by schemes — would usher in a new era of competition.

"And, I am using the term 'competition' in the sense understood by business people — whatever a businessman has to do to get business away from his rivals and whatever they do to take business away from him. This covers such issues as price rivalry for products that can be substituted one for another, product and service differentiation."

Speedie points out that of the 236 medical schemes registered at the end of 1991, 77% had a membership of fewer than 10 000 while 21% had fewer than 1 000 members. He predicts that increased competition will result in a greater concentration in the market. "A smaller number of larger players will tend to dominate the market. This has been true in the building-society and banking-and-insurance sectors." But he stresses that this doesn't mean competition will be inhibited.

Until September 1989, schemes were prohibited from offering different types of products. Speedie says the first concessions allowed schemes to base subscriptions on factors such as age, area of residence, individual claim patterns and group claim patterns. Schemes, however, still had to provide cover across the board for medical, surgical, dental and physiotherapy services. Hospitalisation and medicines have also been covered.

But, under the new law, Speedie says, schemes can limit or exclude certain types of cover and market these different products in the same way that insurance companies push their hospital plans.

Alexander Forbes joint MD Leon Lewis says health insurers will also offer a greater variety of products, making comparative pricing more difficult. He predicts that patients paying for routine procedures out of their own pocket will become the norm, while cost controls — such as having members pay deductions and placing limits on how much of a bill is covered — will also be implemented.

Speedie ... *look for greater concentration in the market*

"Promotional activities — especially advertising — will be intensified and pricing policies reviewed as the pencils are sharpened," Speedie says. He concedes that advertising will add to costs but this should be offset in the long term by savings resulting from a more cost-effective health-care system. The new legislation scraps the ethical rules that prohibit schemes from paying brokers commissions for introducing new business. Whether this will become an industry practice, however, is uncertain.

Managing a greater number of products will require more sophisticated information systems, a trend that will generally favour larger schemes and keep the riff-raff out of the trade, Speedie says. The well-established principle of the customers who make few claims subsidising the customers who make many also will favour a more concentrated industry, he adds, because lots of different products will make cross-subsidisation more difficult for all but the biggest schemes.

In a far-reaching innovation, the Act allows schemes to supply services — employ doctors, pharmacists, nurses and others and run hospitals and clinics. This paves the way for managed health care, a practice that has cut costs by as much as 40% elsewhere. Speedie says: "The new legislation will bring managed care to the fore, thus enabling schemes to bargain with suppliers of services to obtain cost-effective care on behalf of their members. I have little doubt that the overall cost of health care in the private sector will be contained for the first time in many years."

But Speedie says it's unlikely that schemes will move towards owning and operating their own facilities on a large scale, given the existing oversupply of beds in the private sector. "When implementing managed health care, schemes will probably focus more on preferred provider organisations — where a group of doctors join forces and contract their services out to a scheme for a specific period."

He is adamant that schemes will be able to offer a full spectrum of cover from the fully comprehensive type through to tailored packages. "Schemes will be able to compete effectively with insurance companies offering various innovative products."

Lewis says: "The critical issues will be packaging, marketing, administration and client service." But while he believes that the track record of some major insurers will see them claim a large slice of the market, he predicts that the likely health-care scenarios on offer will combine medical aid with insurance as well as personal savings. ■

Project for disabled runs official gauntlet

S/Times 28/3/93

A SCHEME to divide shares in a bushveld farm between 150 disabled and desperately poor black workers faces collapse because of secret objections by top officials.

Originally welcomed by the Department of National Health in 1991, the Agriset project was soon afterwards referred to the Office for Serious Economic Offences and budgeted funds dried up.

As a result, cash crops to the potential value of R4,5-million weren't planted last year, few disabled workers were hired and the project on the 1 100-hectare farm Roodewal on the banks of the Olifants River is teetering.

Last year's probe failed to uncover irregularities,

By BILL KRIGE

but officials have referred it back to the investigators, keeping the grounds for the inquiry secret.

In response to queries, the Department of National Health said the hiring of able-bodied workers to assist the disabled workers meant that funds were being misapplied.

Fee

"Agriset has given the department enough reason to suspend funding pending the outcome of the investigation by the Office for Serious Economic Offences into the matter," the statement said.

But project manager Dewald Pretorius said he had been questioned largely about a 10 percent management fee which had been written into the contract.

The Department of National Health budgeted R7,3-million for Agriset as part of its nutritional development programme at the end of 1991.

But when Agriset received the first instalment early last year, they were told the Office for Serious Economic Offences had begun an investigation.

Further instalments, due quarterly, were stopped.

Mr Pretorius's plans are modelled on schemes he studied in the United States, seasoned with his experiences as a manager of self-help schemes for the blind in the Transvaal.

"What I wanted to achieve — and, in fact, still do — is to change the basis of welfare from one of charitable handouts to something which is financially viable," he said.

It involves the formation of a Section 21 non-profit company, Agrilima, to channel State funds to an operating company, Agriset. Agriset would hire 150 disabled workers and pay them wages to farm intensively.

Collapse

A total of 49 percent of the shareholding in Agriset is earmarked, at a nominal R100 each, for disabled workers. Agriset would gradually withdraw from the entire operation as it consolidated.

Now, 18 months down the line, Mr Pretorius is staring collapse in the face.

"We can't use the State houses which have been standing empty on Roodewal for years and have been unable to conclude a lease agreement for the land and therefore can't irrigate as we would like.

"We farm intensively with chickens and dairy but we can't build permanent structures.

"In the meantime, we can't hire the people we want. We have only nine handicapped people working here from seven families instead of 150 families," he said.

Schemes to foot VAT hike

KATHRYN STRACHAN

THE Representative Association of Medical Schemes (Rams) announced yesterday it would carry the costs incurred through the increase in VAT — even though it would cost schemes an extra R300m.

Rams executive director Rob Speedie said the association had put up its scale of benefits by 3,64% — which would compensate providers of services for the full effect of the VAT increase.

He said the increase in the scale of benefits and recommended schedules of benefits would apply to services offered by the health care professions, private hospitals and day clinics, following the "most unwelcome" hike in the VAT rate.

Speedie said the move followed a meeting with the Medical Association of SA, the Dental Association of SA and representatives of private hospitals and clinics.

"All parties expressed their dismay that government hadn't seen its way clear to affording VAT relief in respect of health care services — in spite of numerous requests to do so.

"The decision to hike VAT on health care services will add R300m this year alone to claims paid by medical schemes," he said.

Rams would publish its increases in the Government Gazette as soon as possible, but would in the meantime urge medical schemes to apply the higher rates from April 7, when the VAT change came into effect, said Speedie.

Aids cuts a path through SA

Sowth 3/4-7/4 193.

By Wilson Carswell, WorldAids

AIDS in South Africa is set to follow the devastating path taken by the disease in the rest of the continent.

As in other parts of the world, the Aids pandemic is made up of several small epidemics. The first was as early as 1982 and affected white men who had sex with men. The number of reported Aids cases among gay men has now reached an all-time low, suggesting the number of new HIV infections is dropping, probably in response to community-generated Aids education.

But the heterosexually-acquired Aids epidemic is increasing.

There is little evidence that HIV was present among heterosexuals before 1987. Since then it has spread at a rate similar to that in other eastern and central African countries.

South Africa shares some of the conditions which have led to the explosive spread of Aids in the continent, such as a high prevalence of sexually-transmitted diseases (three million cases a year) which facilitate HIV transmission.

Because of the time lapse between HIV infection and Aids, the current number of Aids cases (1 295) only represents the epidemic's past.

The present is determined by extensive surveys from a number of groups — from blood donors to pregnant women — and the results are sobering. By the end of 1991, about 180 000 people were infected with HIV, increasing by about 400 people a day.

There are wide variations, depending on gender, ethnic group and geographical location.

In Natal, over 2,8 percent of young adults had HIV infection in 1991, while in the Cape Province the corresponding rate was under 0,4 percent.

Among women attending municipal clinics in Johannesburg, more than one in seven have HIV. One in eight newly-diagnosed female tuberculosis patients are HIV-infected.

Generally, as in other African countries, women are infected more readily and at an earlier age than men. Among prospective blood donors in 1991, 1,06 percent of black women had HIV against 0,71 percent of black men.

By contrast, only two out of 22 400 prospective white female blood donors had evidence of HIV infection. This ethnic disparity is also visible in the results of a 1991 survey of 17 000 pregnant women attending antenatal clinics. Overall HIV prevalence was 1,49 percent, but among African women the rate was 1,84 percent and among white women nil.

Short-term projections suggest that the number of HIV-infected people is doubling every 14 months: the figure of 250 000 will have risen to nearly 750 000 by mid-1994. After that, the rate of increase will depend on behaviour, chance and other interventions.

Initial scepticism was followed by a programme to monitor the epidemic and to ensure the safety of donated blood. Since 1985 over five million potential donors have been screened. But these early responses have had no significant effect on the pandemic.

People at all levels have difficulty accepting the enormity of the Aids pandemic hanging over the country.

Time is running out — the short time gap still available for effective interventions is shrinking. If it is ignored, the reality of the pandemic will eventually catch up with society. But by then it will be too late for the new generation of adults.

Health Day to focus on violence

299

Sowth 3/4-7/4193.

"HANDLE life with care — prevent violence and negligence" is the theme for World Health Day next Wednesday, April 7.

The World Health Organisation issued the slogan to raise public awareness of the impact accidents and violence have on health.

Throughout the world, health organisations will be looking at how people can make their lives healthier simply by taking more care.

Preventative health measures, such as immunisations, are part of the initiative. But lifestyles are equally important: Driving carefully, eating sensibly, and cutting down on smoking, drinking and drugs are contributions we can all make to our own well-being.

Star 5/4/93

Is Bill the right remedy?

(299)

Everyone agrees the prognosis for private health care is grim. But not everyone agrees the Medical Schemes Amendment Bill is the right prescription for the ailing industry, reports PAULA FRAY.

THE SYMPTOMS were clear to all: spiralling medical aid costs and increasing bankruptcies as schemes paid out more than they were receiving from subscribers.

That action had to be taken was agreed.

It was the nature of the action proposed by Minister of National Health and Welfare Dr Rina Venter through the Medical Schemes Amendment Bill that set off the debate.

Essentially, says the Centre for Health Policy (CHP) at Wits University's Community Health Department, the proposed changes will:

- Abolish the guarantee of direct payment by medical schemes to providers of services who charge within the scale of benefits".
- Do away with prescribed minimum and maximum benefits that schemes are required to provide for their members.
- Repeal the status of Representative Association of Medical Schemes (RAMS) as a statutory body and thus reduce its scale of benefits to guidelines.

At the same time, says the CHP, the new Act will have the effect of facilitating the development of managed health-care options such as health maintenance organisations (HMOs) and preferred provider organisations (PPOs).

The centre says proponents of the new system, including Venter, argue that the guarantee of direct payment and legislated minimum benefits do not provide any cost-saving incentives and that changes will allow schemes to negotiate payments with providers such as PPOs in return for concessions.

Those in favour also argue that the changes will strengthen the public service by making private care cheaper and removing from the public sector those people who can be part of managed care options.

On the other hand, says the Centre for Health Policy, those against the changes — including a number of general practitioners — argue that the new amendments will:

- Reduce the patient's choice of providers as schemes will require members to go to those providers offering discounted fees or who are part of managed care.
- Increase providers' exposure to bad debts.
- Escalate administrative costs as schemes enter into separate contracts with a large number of providers.

Most beleaguered medical aids have, however, welcomed the Bill.

"The crisis in terms of the depletion of medical aid schemes' reserves as a result of unmanaged health-care costs, fraudulent practices, abuse and restrictive legislation has reached epidemic proportions," says Affiliated Medical Administrators (AMA) chief executive officer Timothy Gelman.

He says events have already overtaken changes to the Act as major players in private health care have already researched other viable options.

Abuse of medical schemes, he says, is a result of the present system "which forces medical aids to guarantee direct payment to the health-care provider and offers no incentive to him to contain costs".

AMA says the amendments mean:

- Much of the fraud could be avoided instead of being addressed after the event.
- A joint working relationship with medical providers to manage health-care costs and the utilisation of services would be established.
- Guaranteed payment with medical providers based on agreed criteria of servicing and price, either as a group or individually, would be negotiated.

Gelman says: "We also believe the proposed amendments will remove the bias which currently prevails in South Africa of the man of the family being regarded as the breadwinner and having to have his family on his group medical aid scheme."

The changes would not, however, mean individual consumers could "shop around" for the best service.

But SA Medical and Dental Practitioners (SAMDP) joined a host of other bodies in criticising the adjustments to medical aid schemes, describing them as "half-baked and piecemeal".

The SAMDP further criticises the HMOs, saying: "With the appointment of doctors to HMOs ... mediocrity will replace quality and effectivity."

The Society of Dispensing Family Practitioners has launched a major advertising campaign to tell consumers of the changes and promises to "monitor the activities and business practices of all schemes and other health organisations and draw up a list of "recognised" medical aids".

But, the changes will not affect only the private sector, says the National Progressive Primary Healthcare Network (NPPHCN), which rejects the Bill.

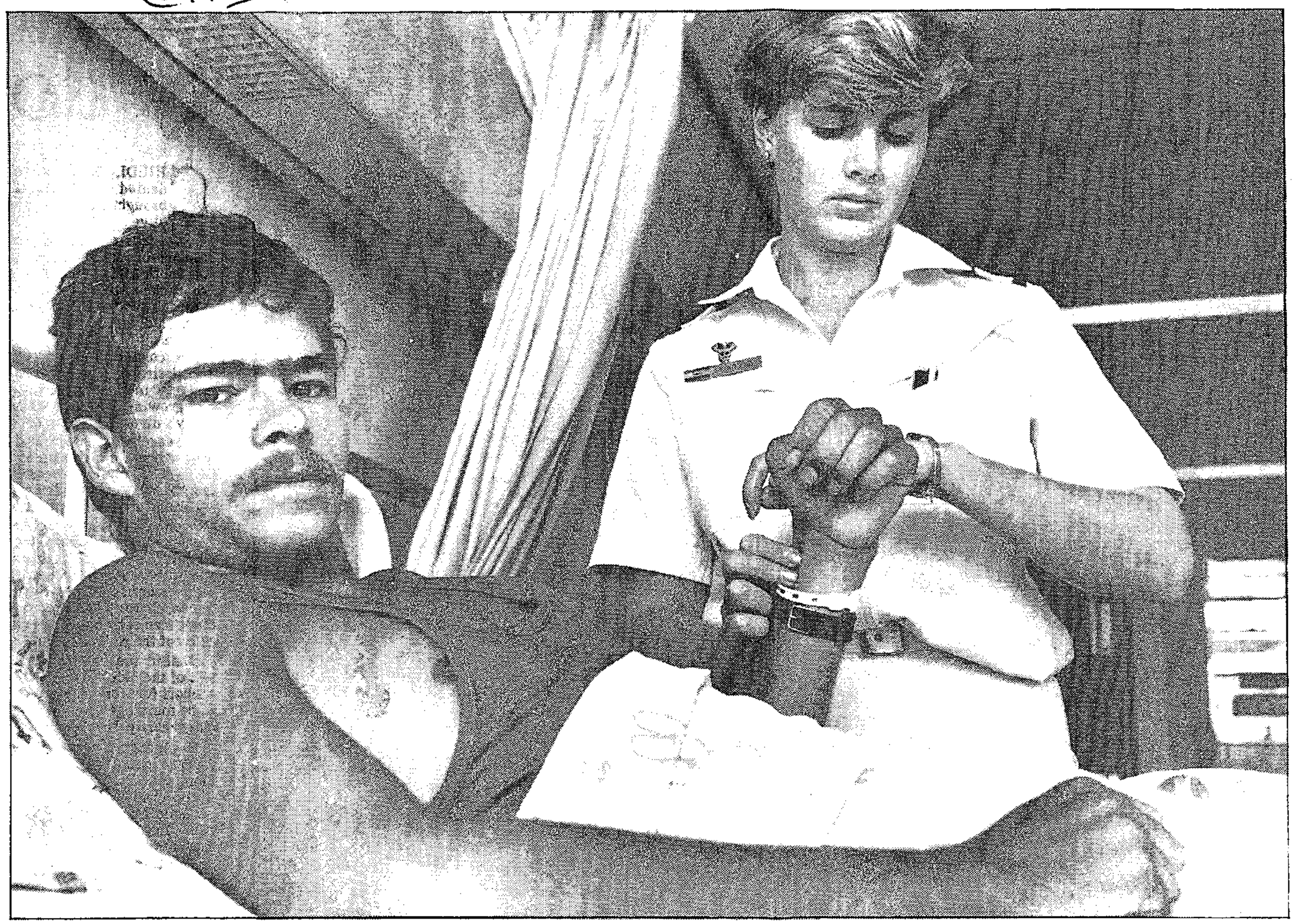
"While the Bill appears to deal with private sector medical care, it will clearly have an impact on the public sector," says the NPPHCN, adding that the amendments give medical insurers the opportunity to package health care.

"This means they have the freedom to cover only certain people and illnesses and inevitably the elderly and chronically ill will be disadvantaged and in the longer term will have to rely on the public sector which is already overburdened and underfunded," says the network. "We believe that tinkering with current medical aid legislation will not solve the crisis in the private and public sector and that a major overhaul of the whole system is necessary. Furthermore, these changes need to be negotiated with all concerned groups in the context of the whole national health system."

The Centre for Health Policy says the proposed changes will leave large numbers of medical scheme members without the ability to meet the substantial out-of-pocket expenses they will face, and thus without adequate cover.

"At the same time the introduction of flexible packages will fracture the cross-subsidisation that is a feature of the current system. Those people faced with expensive packages (the old and sick) are unlikely to afford them. Such patients will inevitably have to be cared for by a public sector already struggling to provide adequate care to almost 80 percent of the population."

The centre proposes that new legislation should retain the minimum benefits that schemes are required to offer members and that forward funding of medical schemes — whereby funds are held in reserve — be required so that the future care of present contributors is adequately provided for. □



Taking the pulse . . . dramatic changes await the private health care sector. Picture: Ken Oosterbroek

New terminology involved

Along with the changes in the Medical Schemes Amendment Bill come several new terms. They include:

- **Preferred Provider Organisations (PPOs).** These allow the providers of health care to give a discount on their services to the scheme which refers its members to them.
- **Health Maintenance Organisations (HMOs).** Formal structures which provide a comprehensive health-care service. HMOs can take various forms, including:

— **Staff Model HMO**, where the medical scheme owns the facility and employs medical practitioners who work on the premises and are paid a salary.

— **Group Model HMOs**, where a group of providers forms an independent entity.

— **Independent Practitioner Association**, where a group of providers forms an association and negotiates contracts with a managed health-care organisation, with each practitioner continuing to practise from his or her own premises.

— **Network Model**, where the managed health-care organisation contracts with more than one group of providers so that it offers a network of primary care physicians and specialists to its members.

PRIMARY HEALTH CARE

WORLD HEALTH DAY
7 APRIL 1993

SPECIAL SOWETAN FEATURE

Handle life with care
Prevent violence and negligence

R9774

Handle life with care

Sowetan 7/4/93 (299)

By Musa Zondi
Health Reporter

■ WORLD HEALTH DAY Preventing careless deaths through violence, negligence and lack of health facilities:

TODAY IS WORLD HEALTH DAY and the theme this year is *Handle life with care — prevent violence and negligence.*

An estimated 3,5 million people die each year throughout the world — with about one million deaths caused unintentionally, says the World Health Organisation.

"These deaths are not caused by disease but by injuries that are sustained through accidents and violence. These statistics do not include the many that are totally disabled and as many as ten times more partially disabled through loss of limb or eyesight," says the Department of National Health and Population Development.

In this country, the day comes against the backdrop of violence and turmoil. It comes against the backdrop of escalating crime which has claimed many lives. It also comes against the backdrop of an ailing health system where to be sick is a grave mistake.

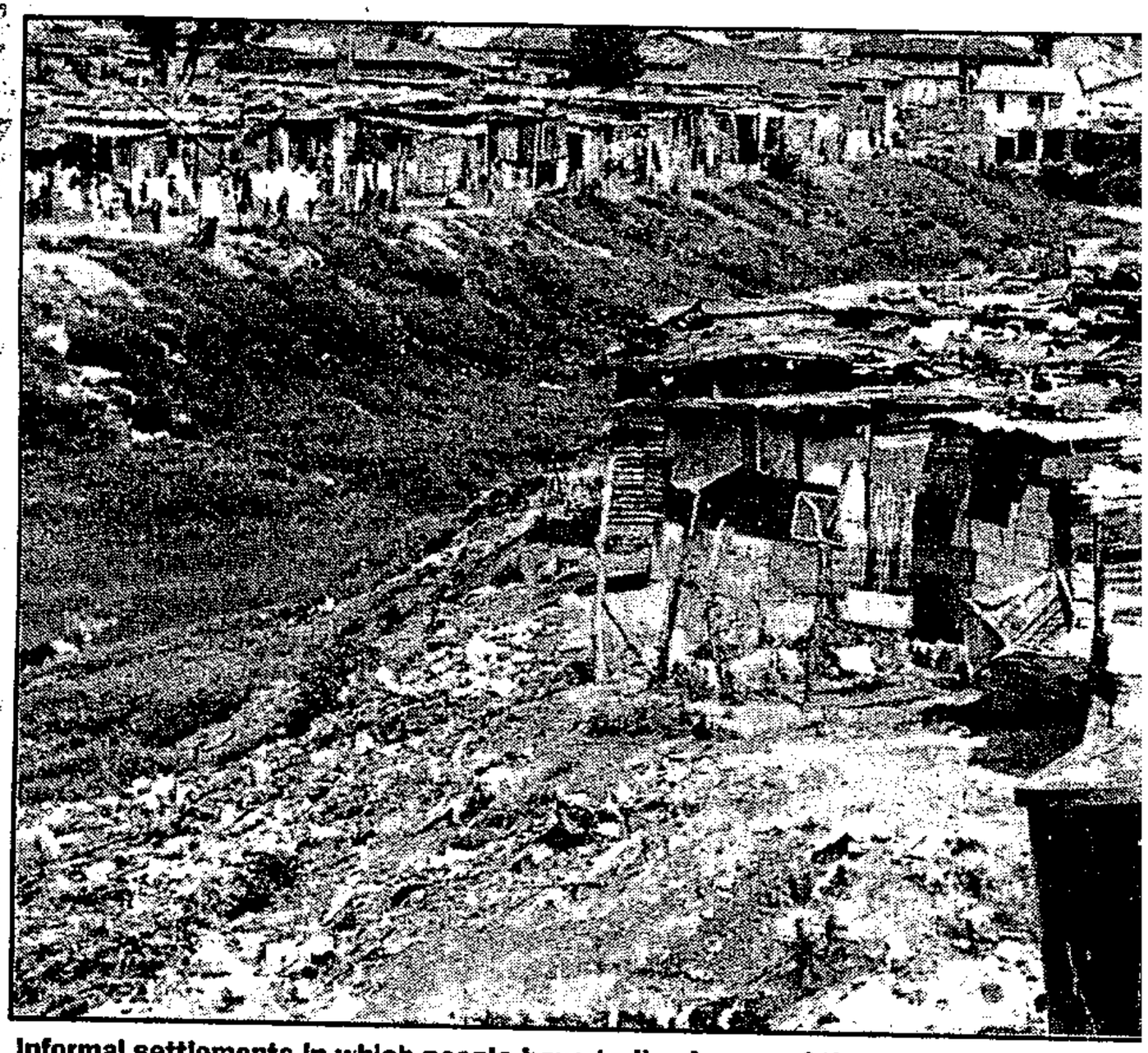
For many of our people in the rural areas, health care is still unattainable. This is no better for people who stay in the informal settlements, who have no jobs, no money or food. These people, who live in squalor and suffer from various diseases, do not have much hope in life.

According to the Central Statistics Service, "the total number of registered deaths in South Africa and self-governing territories for 1991 were 176 475. Nineteen percent of the total number of death registrations can be attributed to accidents, poisoning and violence," says the department.

"In this country, this day comes against the backdrop of violence and turmoil"

A lot still needs to be done to make health care more accessible to many South Africans. The posturing our politicians are engaged in at the moment will not help. We need to have a workable dispensation soon to address the imbalances, eradicate crime and the causes of ill-health. South Africans cannot wait.

Let us handle life with care.



Informal settlements in which people have to live is one of the greatest causes of these problems are tackled.

We can beat high medicine costs

Sowetan 7/4/93. 299

By Musa Zondi
Health Reporter

■ ACTIVE CHEMICAL Generic drugs have same effect as original brands and are a solution to the health crisis:

THE HEALTH CRISIS in this country is, to a large extent, caused by the rocketing costs of medicines.

The rising inflation rate and the weak Rand against other international currencies also contribute to the costs.

But there are ways curtail the escalating costs. One of these is the use of generic drugs as an alternative to other expensive brand names.

According to Lennon Generics, these are "bioequivalent versions of original branded products which are produced by various companies once the patent protection of the original brand has lapsed.

"This means that the active chemical components, strength and dosage forms of the generic are the same as the original brand," the company says.

A doctor prescribes the medicine and writes the brand name of the product.

The pharmacist would then know if there is an alternative drug, which does exactly the same thing but is less expensive.

"Original branded products are more expensive for two reasons:

"The first is that there has usually been substantial outlay in research and development of a branded original which has to be recovered once the product is launched on the market.

"The second is that branded originals have up to 20 years of patent protection. This means there are no competing equivalent products and this allows the innovator company to price its product at a higher level," says Lennon.

Generic products have, on the other hand, far smaller research and development going into making them.

These products contain the same amount of the active ingredients and have been tested thoroughly to ensure that.

They are also put under severe quality control tests against the original product.

But in this country, substitution is regarded as unethical practice and could render pharmacists liable to disciplinary action.

In 1985, it was legal to substitute the medicine but the Pharmacy Council revoked the ban after opposition from the pharmaceutical industry concerned at the profitability of their industry.

But with the pressure to try to curtail the rising costs in the health sector, chances are that substitution will be reintroduced again.

In the United States, 60 percent of the medicines dispensed are generics.

Hi-tech to nail med-aid abuse

CT 7/4/93

(299)

Computer will spot suspicious claims

By MAGGIE ROWLEY
Deputy Business Editor

MEDICAL aid societies are turning to hi-tech surveillance to stamp out the multi-million rand abuse of schemes by doctors and members.

Measures being instituted include jacked-up surveillance panels of professional assessors and sophisticated computer systems capable of identifying suspicious claims and networks of service providers and members.

Abuse of medical aid schemes has been guestimated to be as high as 25% of all claims and the new measures are expected to save societies millions of rands a year.

At least one major medical aid scheme, Bankmed, has embarked on a pilot study of a computer programme that has been used by, among others, Scotland Yard's National Criminal Intelligence office, to detect cases of fraud.

Known as Netmap, this system can graphically link providers of services with certain members and each other.

It will be possible, for example, to map a doctor's connections with certain other service providers as well as map certain members' links with the medical profession.

The system can also pick up a member who might have a drug dependence and submits small but regular claims from many different doctors and pharmacists.

Where previously these amounts might not have raised suspicions, the mapping system will pick up the trend.

Bankmed recently also established a new Clinical Audit Department (CAD) to counter abuse.

Mr Ian van den Berg, who heads the department, said preliminary investigations had identified fraud, abuse of benefits and overservicing by doctors as being of major concern.

Also on the CAD panel are five full-time staff, a medical practioner, a dentist, a pathologist and an optometrist.

"We are not conducting a witchhunt but believe the greatest spin-off lies in the deterrent factor of people knowing they are being monitored."

Professionals on the panel were able to identify areas of abuse that would not be obvious to a lay person.

"Recently we had a case where a private hospital charged for five special respiratory catheters costing thousands of rands each, when in fact two at most can be used in a single operation.

"When the professional assessor queried the account, the hospital said they were aware of it but three of the five had been faulty and they could not credit the medical aid until they had had a refund from the US manufacturers."

Mr Brian Wynter, deputy general manager at Bankmed, said 95% of hospital accounts scrutinised by the panel either had mistakes or non-chargeable items to be rejected.

Since August they had rejected more than 5 000 items at a saving of R220 000.

Of 88 general practitioners with excessive after-hour consultations confronted by Bankmed's consultant GP, 57 had reduced these to normal consultations.

The panel's dental practitioner, he said, had spent the past three months setting up practice profiles and training assessors. To date 500 dentists had been queried on their claims profiles or specific claims or both.

The new surveillance procedures were expected to save Bankmed R2 million on dental claims alone this year.

Stressing that it was a minority of members who were abusing medical aid schemes, Mr Phillip Wessels, a partner of Deloitte & Touche, which has three medical aid schemes as clients, said abuse was nevertheless widespread.

Hospitals may be shut to curb costs

Drastic cuts in health care services

B1DM 7/4/93. 299

ADRIAN HADLAND

PRETORIA — Dramatic cuts in health services announced by cash-strapped provincial administrations yesterday point to the depth of SA's health crisis.

Tabling their 1993/94 budgets, the provincial administrations of the Transvaal, Natal and the Cape warned that hospitals would be closed and a broad range of services limited or terminated in a bid to absorb rising health costs.

Maternity and non-emergency hospital admissions, care for the chronically ill, oncological services for most cancer sufferers, neurosurgical and heart bypass operations and AIDS testing were among the areas most severely affected.

Transvaal Administrator Danie Hough, tabling a R6,7bn budget, told the extended public committee on provincial affairs in Pretoria yesterday that the province expected a budgetary shortfall of more than R300m for the provision of health services in 1993/94.

The loss had been aggravated by unprecedented industrial action during 1992, rapidly growing demand for health services from the newly urbanised, plans to equalise pensions and new provincial responsibilities for own affairs hospitals.

In an effort to cope with the deficit, Hough said all hospitals in the region had been asked to introduce economising measures aimed at saving an estimated R91m.

A further R48m would be recouped following the closure or alteration of hospitals, Hough said.

It was necessary, however, to spend up to R70m on the purchase of new medical equipment, which would offset savings in other areas, he added.

Even with the implementation of the cuts and the "maximum delegation of power" to regional hospitals, the province still expected to lose about R245m this year, he said. This would be requested from central government.

Cape Administrator Kobus Meiring, tabling a R4,7bn budget, said unless additional funds were forthcoming, dramatic cutbacks in health services were also expected in the Cape, LINDA ENSOR reports from Cape Town.

Resources had been stretched by burgeoning demands for aged and disabled care, child and family provisions and welfare subsidy equalisations.

Due to an increasing demand for hospital and health services, the Cape Provincial Administration was "already experiencing difficulties retaining the full spectrum of services", Meiring said.

In Natal, Administrator Con Botha, tabling a R2,7bn budget, said the province expected a 1993/94 shortfall of R263m for health service provision, Sapa reports.

Plans to turn away most maternity cases, discharge chronically ill patients and cut back on services for cancer patients were among measures which could become necessary, Botha said.

Additional cutbacks in Natal could include stricter admission controls for non-emergency patients, a 33% reduction

☐ To Page 2

Health cuts

B1DM 7/4/93. 299

☐ From Page 1

in all neurosurgical and heart bypass operations at Wentworth Hospital and a reduction in already inadequate AIDS testing in the region.

Botha said the anticipated cuts would reduce available beds in the province to 1 342 and would allow for the relocation of a "large number" of health workers.

Hough said academic hospitals in the Transvaal would not be included in the cutback policy as they were destined for "autonomous status" under the control of supervisory boards.

Legislation to that effect would be introduced during the present parliamentary session, he said.

All provinces also reported difficulties in providing new road infrastructure.

The deteriorating condition of Transvaal roads was the result of "other more urgent priorities", Hough said.

The accent would be shifted in 1993/94 from the construction of new roads to the maintenance of the existing network.

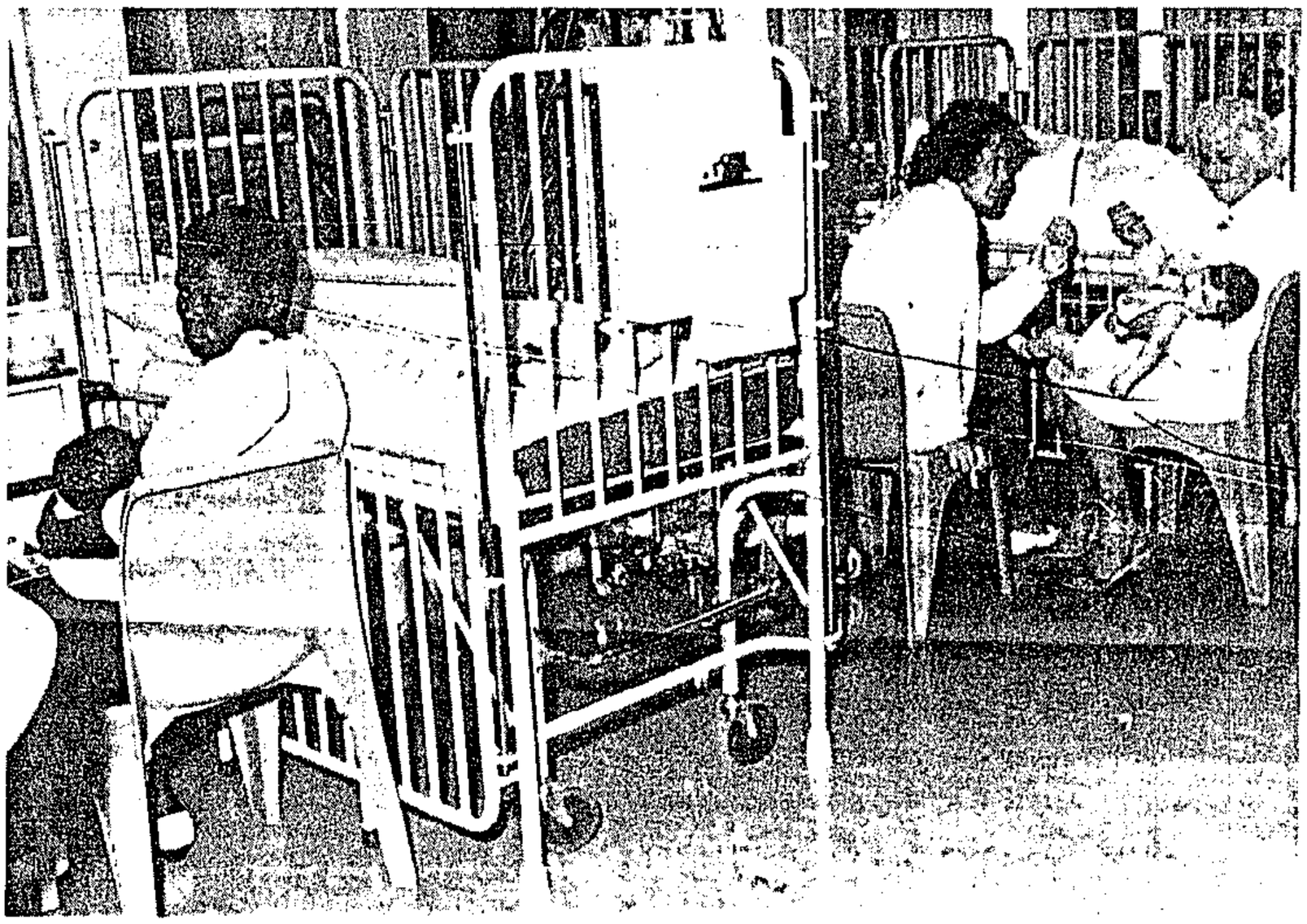
Natal and the Cape adopted similar policy decisions.

Natal MEC in charge of roads Peter Miller said it was cheaper to rip up a deteriorating tar road and turn it into a quality gravel road then to rehabilitate it. This, he said, had been done on a very limited scale since 1991. With the backlog in funding for road maintenance and building, the process could accelerate.

● See Page 3

Not what the doctor ordered

The South African Health and Social Services Organisation (Sahsso) explains why it is opposed to the state's attempts to the restructure the health services:



'Secret committees have made recommendations on matters affecting the health care of all South Africans'

FOR three decades, South Africa's health services have been fragmented because of the apartheid policies of the government, with disastrous consequences for health care in this country.

South Africa has had 14 "national health departments", a large provincial bureaucracy and multiple local authorities involved in providing health care, leading to enormous duplication and inefficiency.

There has been a bias towards curative services with, until recently, only five percent of state spending directed towards preventative health care.

Inequity has flourished under the present government's health policies, with 80 percent of the country's health expenditure going to the private sector which services only 20 percent of the population.

Rural and peri-urban health services have been neglected. For many years community participation has been a non-issue for central government which has been more concerned with providing resources for its electoral support base.

Recently, a number of significant changes have been taking place in the health sector. In the late eighties, the government committed itself to privatisation of health care.

It also introduced far-reaching, but flawed, legislation to rescue the ailing medical schemes industry. And teaching hospitals will soon become autonomous (from state control) and be forced to compete for their income.

At the same time, the quality of state health care has declined. Ordinary people are forced to use private health care which is largely beyond their means. The conditions and morale of public sector health workers has never been poorer, as a result of autocratic management.

The government has sought to absolve itself of responsibility for health care for the majority of South Africans. It has failed to develop a comprehensive approach for the provision of health care.

The health sector as structured cannot continue in its current crisis-ridden state. People's struggles for decent health care have forced the government to realise that it has to respond to the contradictions caused by its own policies.

We now see what we would never have expected years ago: the Department of National Health and Population Development is about to dissolve the tricameral health system.

It appears to be going to great lengths to initiate consultative forums on health care with a wide range of interest groups. In articulating the rhetoric of Primary Health Care (PHC), the government has indicated its intent to build clinics and to promote "community participation" in health care.

However, if we look more closely at the state's actions in this context, we identify many inconsistencies.

- It is clear that restructuring is not going to reincorporate the homelands health departments which carry the burden of illness in our country. A single health department in South Africa should be able to provide comprehensive and equitable health care to all South Africans at all levels. The recent health budget cut the allocation to homeland health departments.

Given the government's stated intention to reduce the wastage of multiple health departments, it is difficult to understand why the 1993 budget still includes the same allocation for staff salaries in the tricameral health departments.

- The process by which restructuring is to be effected illustrates the unaccountable style characteristic of government bureaucrats. There has been no consultation with any of the interested parties affected.

Secret committees have made recommendations on matters affecting the health care of all South Africans. The public has been denied the chance to contribute to or even scrutinise the process.

- The vision of real primary health care is comprehensive and seeks to empower people to achieve improved health status. The government is obviously out of touch with these principles.

"Community participation" has often meant that communities must pay for their health care, or must rubber-stamp the plans produced by the government.

The Department of National Health exhibits a handful of PHC projects for show, but resources for PHC remain scanty. It is also unacceptable that most South Africans still have no access to clean water and sanitation — basic requirements for health.

- Demands for the restructuring of the health services have been articulated by communities and progressive health organisations for many years, but the government remained indifferent.

Suddenly, the same government has expressed a need to restructure the health service. Why is this happening now?

It appears that this is part of an election strategy for the National Party, which has now appropriated many of the ideas emanating from groups opposed to apartheid health care.

Current moves to abolish racial and departmental fragmentation in health care are not sufficient to rectify the appalling state health services are in, particularly those in the public sector.

Viewed in the context of the government's arrogant commitment to restructuring, these moves were little more than a sop to the health care needs of our country.

To meet South Africa's health care needs, we require a fundamental reorientation in the process by which health policy is decided and implemented.

A future national health service must be founded on the PHC principles of equity and social justice and be structured to embrace meaningful consultation with communities and other parties over the nature of health care for South Africa.

Cripple is now 'Shap'

(299) Cipher 11/4/93.

By JUSTICE MOHALE

A GRAAFF-REINET paraplegic had the interests of his own community at heart when he made the long trip to Soweto to study at Mofolo's Self Help Association of Paraplegics (Shap).

David Malgas, 45, says he can now help the 69 paraplegics in his eastern Cape home town who are badly in need of help.

He made the decision to spend "his last cent" to get to Johannesburg soon after he was snubbed by a Labour Party MP whom he asked for help.

"He chased me away," said Malgas, "and told me to ask my communist leaders for help."

In Johannesburg he was welcomed by Shap chairman Friday Mavusa who organised a three-day crash course.

He is now confident he will now be able to persuade people at home to get involved.

"He was really stimulated by the manual work being done by the disabled people in Soweto," said Mavuso, and was inspired by our motto 'Support us so we can feed ourselves'."

Health care critically ill

ST Times 11/4/93

299

MIKE ELLIS says a new approach is needed if South Africa's ailing health-care system is to be rescued

HEALTH services in South Africa — public and private — are in a critical situation.

The fundamental facts are:

The public health system has been extraordinarily badly planned, is grossly under-funded and is in urgent need of restructuring.

The private system, which has developed alongside it, caters for the elite, is expensive and is regulated to the point of self-destruction.

The background is largely historical. The elite — originally the white population — had money and could afford its own health care through a system of medical schemes and health insurance.

Consequently, expensive private hospitals mushroomed during the apartheid years. Along with private pharmacies, and general and specialist practices, they catered for the elite 20 percent of South Africans who could afford them.

This system has now become severely strained. Many of the more than 200 medical-aid schemes in the country are in financial difficulties. They have stated that they expect to pay out more than R10-billion this year on claims, of which 25 percent will be fraudulent.

Add to this the problems of over-servicing and over-prescribing of expensive medicines by some professionals and the reasons for self-destruction become more apparent.

Measures of redress have been taken, but it is obvious that much more has to be done. The point is that health costs are spiralling in the private sector, pushing the service out of reach of a growing number of people.

But the real problems lie in the public sector, which caters for 80 percent of the population who cannot afford their own health care.

The lopsided provision of health care in this sector has its roots in history. By far the majority of people it serves are black, living in rural or peri-urban areas. Yet most state hospitals were built in predominantly white residential urban areas.

As a result, millions of black people have to travel hundreds of kilometres to receive medical treatment — whether for minor ailments or serious illness.

Another major flaw is that the system is based on cure rather than prevention. The rapid rise in the number of TB cases in recent months bears testimony. Curative health is expensive. It is doctor-based and relies heavily on costly medicines and hospital treatment. Add to this the cost of administering 14 departments of health and it becomes obvious that we have allowed the growth of a totally inadequate yet prohibitively expensive monster.

The problem does not end there. A system of unequal funding of the provincial health services has developed over the years to the extent that in 1992/93 the per capita allocation for each province was: Cape, R395; Free State R277; Transvaal, R250; Natal, R223.

This under-funding has left Natal in a parlous position. Major cuts have been made to the extent that hospital beds are being closed, 5 000 jobs are in jeopardy, vitally important AIDS services may have to be stopped — and that is just the tip of an already intolerable situation.

Last year, in spite of its greater per capita allocation, the Cape overspent its budget by R100-million while Natal balanced its books.

But the problems facing health care in South Africa are not insurmountable. The solutions do not lie in the short term in the development of a national health service. The country simply cannot afford it.

Spiralling costs in the private health sector must be controlled and the free-market system encouraged through greater deregulation.

But there is no doubt that public health needs the greater attention. It needs far more, and far more equitable, funding. A geographical per capita allowance patently does not work. Of even more importance is the need for restructuring, based on preventative health care.

There is a crying need to move away from the doctor-based hospital system as the first call for patients to a nurse-based, clinic system.

The proliferation of fixed and mobile clinics must be encouraged. Greater emphasis must be placed on health education.

In short, we need to take health care to the people. To make it available and accessible to everyone at a cost that the people and the country can afford.

□ *MIKE ELLIS is MP for Durban North and the Democratic Party spokesman on health.*

Pharmacists set to provide broader health care service

KATHRYN STRACHAN

PHARMACY was on the threshold of great opportunities, with planned new legislation enabling the industry to convert its focused role to a far broader health care service, SA Pharmacy Council chairman Johan van der Walt said yesterday.

Addressing the national conference of the Pharmaceutical Society of SA, Van der Walt said changes envisaged in the amended Pharmacy Act provided pharmacists with greater discretionary powers in dispensing prescription medicines.

Amendments to the Act would also stimulate better geographical distribution of pharmacies, he said. High profit margins gained from serving an affluent section of the population would be replaced with the provision of affordable medicine to the entire population.

The planned amendments brought pharmacists out of their legislated isolation, enabling them to work as part of a health team with other professions, he said.

Van der Walt challenged the National Health Department to utilise the infrastructure of pharmacy, and to accept the council's recommendations, which would reduce the price of medicines.

A system of generic substitution should be introduced where the pharmacist could provide cheaper, but equally effective medication. It had been proved that medicine costs could be reduced by up to 75%.

SA would have a shortfall of between 2 300 and 4 400 pharmacists by the year 2010 at current rates of growth, Prof Rob Summers of the School of Pharmacy at the Medical University of SA told the national conference. BDAY 12/5/93.

Sapa reports he said there was a gross geographical maldistribution of public sector hospital pharmacists, ranked by the ratio of beds per pharmacist.

Taken with the data for age group and race distribution, figures showed a policy of deliberate neglect and mismanagement was applied to areas populated largely by black people.

While the number of community pharmacies per 10 000 people had remained fairly constant since 1946 at 0,8, the number of pharmacists employed per community pharmacy had climbed from 1,8 to 2,2 between 1982 and 1991.

"Pharmacy student numbers peaked in 1986 (at 1 559). By 1992, the number had fallen to 1 039, a 33,3% drop," he said.

"The number of pharmacist interns has declined continuously since 1986, so that the number in 1992 was only 58,1% of that in 1986 — a drop of more than 40%."

Warning on low-cost medical schemes

BDAY 12/5/93.

KATHRYN STRACHAN

MEDICAL aid administrators have warned consumers to be wary of low-cost medical benefit schemes flooding the market.

Medicaid Administrators CE Jeff Sloame said packages offered by some new budget schemes could be misleading and, in the interests of preventing another "Masterbond-type débâcle", consumers should tread warily.

Low-cost schemes put together by financial services brokers often did not fall under the protection of either the Pension Funds Act, the Assurance Act or the Medical Schemes Act, he said.

"As such they are not required to put up guarantees or meet the requirements of legislation enacted to protect the rights of consumers," he said.

Under the Medical Schemes Act, new schemes were required to have 2 500 members, a cash deposit of R1m and guarantees amounting to a further R1m had to be in place, Sloame said. (299)

However, he said, other schemes were offered in the guise of medical benefit funds. "These funds effectively act as bankers, accepting contributions and paying claims on presentation of accounts."

Sloame said that as the funds did not comply with stipulations aimed at protecting consumers, the benefits of cross-subsidisation were lost.

Star 15/4/93

Concern over test costs

Concern was expressed yesterday over the reluctance of major medical aid schemes to pass on to the public the benefits of lower rates for laboratory tests now available in many areas. A council of the Society of Medical Laboratory Technologists of SA also questioned the motivation of large life assurance groups resisting services offered by medical technologists. (299)

MEDICINE (299) FM 16/4/93

Pathology of protection

Laboratory tests often make up the most expensive part of a medical bill. A batch of tests can easily exceed the surgeon's fee.

The reason was simple — under the law, pathologists held a monopoly on the lab-test business. Finally last year, their grip was broken when medical technologists won the right to set up labs and do most of the tests. The sudden competition has cut prices quickly — the standard tariff for technologists is 17% below the pathologists' rate, according to the scale of benefits recommended by medical schemes.

But the victory for technologists — and patients — may be short-lived. The pathologists are lobbying hard to protect their turf.

Their focus is the medical schemes and life assurers that foot the bills.

Last month, Medihelp, which covers government workers and is one of the largest medical schemes, re-affirmed its decision to pay only 43% of a technologist's bill. In contrast, Medihelp will pay a pathologist's bill in full — a bill that's higher than the technologist's.

The SA Medical & Dental Council — whose decisions have the force of law — finally allowed the country's 3 500 technologists into the business after deliberating for two years. Until then technologists, who do the actual testing, were restricted to working under a pathologist.

In practice, this meant that only pathologists could own the labs while technologists did most of the testing in them. The council's decision now allows technologists to own labs. Five already do, with the council granting permission to another 13. But the council did leave the pathologists with protection in one area — technologists are still not allowed to interpret test results.

More qualified

The struggle between the two groups is similar to the contests in other professions both in SA and abroad. Nurses and paramedics can do much of the work of doctors, but laws often prohibit them. Paralegals and legal secretaries can do much of the work of attorneys, but attorneys work to minimise that possibility.

The argument is always the same: the doctor or attorney, or architect or conveyancer, has more training and therefore must be more qualified.

Tjaart Erasmus, chairman of the Medical Association of SA's National Pathology Group, says a medical technologist spends 18 months at a technikon and two-and-a-half years in a lab before qualifying while a pathologist must study for 12 years.

Technologists argue that advanced medical technology often no longer needs any imput from pathologists.

The Society of Medical Laboratory Technologists of SA's John McGregor says: "In most cases, results are transmitted from the lab instrument to the computer, while lab reports, with or without computer-generated comments, are dispatched via fax, telephones or post — all with little professional interaction."

So far, the life-assurance industry is siding with the pathologists, particularly in the burgeoning and lucrative HIV-testing market. Last year, the Life Offices Association issued a circular cautioning the industry about dealing with the new technologist-run labs.

This year Sanlam chairman Pierre Steyn left no doubt about Sanlam's policy on the HIV-testing issue. In a letter to a technologist, Steyn said that because of the large medical and legal risks involved in doing HIV tests, Sanlam would rely only on the testimony of the pathologist who had signed the HIV lab test, not on the technologist who performed it.

He points out that the same principle applies in other areas of medicine. "Though general practitioners can perform electrocardiograms, insurance companies insist on ECGs and opinions from specialist physicians or cardiologists for high-risk cases. This is because, in a legal dispute, the interpretation of a GP could be overruled by the opinion of a cardiologist."

Hearsay evidence

McGregor disagrees. He says comparing technologists and pathologists with GPs and cardiologists is wrong because cardiologists actually do the ECG and therefore can comment on the result. He's particularly concerned that a pathologist who did not conduct a test could be called in court to give expert testimony on a test result.

"Would this not amount to hearsay evidence?" he asks.

Health Minister Rina Venter cleared the way for the approval of technologist-run labs, but her Aids Advisory Committee now recommends that HIV-testing be left to pathologist-run labs. Nevertheless, Venter stresses that the sector must determine how best to use the independent technologists without increasing risks in HIV cases. She says more sophisticated HIV testing could resolve the issue. ■

NOTICE 334 OF 1993

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES: SCALE OF BENEFITS IN RESPECT OF SERVICES RENDERED BY MEDICAL PRACTITIONERS, DENTAL PRACTITIONERS, PHYSIOTHERAPISTS AND PRIVATE HOSPITALS AND UNATTACHED OPERATING THEATRE UNITS

As a result of the increase of Value-Added Tax, the Representative Association of Medical Schemes, in terms of section 29 of the Medical Schemes Act (Act No. 72 of 1967), as amended, has reviewed the above-mentioned Scales of Benefits and has determined to adjust the same as hereinafter specified.

All amounts should be rounded off to the nearest one cent, downwards for 0,1 to 0,4 cents and upwards for 0,5 to 0,9 cents.

Attention is drawn to the fact that the benefits as adjusted will be inclusive of Value-Added Tax and any charges levied in excess of the relevant adjusted amount will, as a consequence, be in excess of the relevant Scale of Benefits.

The adjusted benefits shall take effect from **7 April 1993.**

KENNISGEWING 334 VAN 1993

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING

VERTEENWOORDIGENDE VERENIGING VAN MEDIESE SKEMAS: VOORDELESKAAL TEN OPSIGTE VAN DIENSTE GELEWER DEUR GENEESHERE, TANDARTSE, FISIOTERAPEUTE EN PRIVATE HOSPITALE EN LOSSTAANDE TEATEREENHEDE

As gevolg van die verhoging van Belasting op Toegevoegde Waarde, het die Verteenwoordigende Vereniging van Mediese Skemas, kragtens artikel 29 van die Wet op Mediese Skemas (Wet No. 72 van 1967), soos gewysig, die bogenoemde Voordeleskale hersien en besluit om dié, soos hieronder aangedui, te wysig.

Alle bedrae moet afgerond word na die naaste een sent, afwaarts vir 0,1 tot 0,4 sent en opwaarts vir 0,5 tot 0,9 sent.

Neem kennis dat die voordele soos gewysig Belasting op Toegevoegde Waarde insluit en enige gelde wat gehef word, wat hoër is as die betrokke gewysigde bedrag, sal gevolglik hoër as die betrokke Voordeleskaal wees.

Die gewysigde voordele sal op **7 April 1993** in werking tree.

discuss this tomorrow. We can consider the balance to which I have referred, viz a balance between two worlds which we have shared separately for such a long time. We have to ensure that there is also political and economic balance in this process, of course. The sooner we are able to achieve this balance, the sooner change and reform can take place.

Debate concluded.

Cost of optical dispensing/frames/lenses: steps

2. Mr R V CARLISLE asked the Minister for National Health and Welfare:

> Whether she or her Department has taken or intends taking any steps in regard to the alleged (a) exorbitant cost of optical dispensing, frames and lenses and (b) unacceptable practices in this field apparently condoned by professional bodies; if not, why not; if so, what steps?

B653E.INT

The MINISTER FOR NATIONAL HEALTH AND WELFARE: Mr Chairman, the hon member for Wynberg raised a very important topic today.

One of the major problems of present-day health care services is the fact that the man in the street can no longer afford them.

I would like to emphasise one point. Neither the Minister nor the department has any direct input into costs in professional practices. Fees are determined by medical schemes. Professional practices are controlled by the SA Medical and Dental Council. The council recently had an in-depth discussion on their ethical rules. The report by the Competition Board on the deregulation of the professions was an important stimulus for these discussions.

It was obvious that some of the ethical rules were there for the protection of the professions and not for the protection of the public. The council therefore amended the rules. The recommendations of the Competition Board can be summarised as follows: There should be no maximum or minimum price-fixing, a greater degree of advertising should be allowed, and professionals should be allowed to work with and be employed by non-members of the profession. The council accepted the first two of these recommendations.

As regards price-fixing, I am aware that the SA Optometric Association recommends a minimum fee for the professional service. This is a practice that is common among associations of health professionals. I feel this is against the spirit of the recommendation of the Competition Board, because a recommended fee often becomes the actual fee.

As regards advertising, the council has accepted that the price of frames may be advertised. Optometrists and optical dispensers may not advertise their professional fee. This is in accordance with the ruling of all professions registered with the council. Although I feel that the rules are too restrictive, they are at least an improvement on the rules of the past. In my discussions with the council I will certainly urge them to relax the rule on advertising even more in the future.

In the third place, as regards the employment of professionals by non-professionals, this recommendation was not accepted by the council. This is a major problem in the health care field. We have exactly the same problem with the ownership of pharmacies. I believe that professionals must have a choice. If they choose to work for nonprofessionals, it is their choice, and professional councils should not prohibit it. [Time expired.]

Mr M J ELLIS: Mr Chairman, I begin by offering the apologies of my colleague the hon member for Wynberg, in whose name this interpellation appears. This matter is one which is very close to his heart, and I speak on his behalf.

The hon the Minister has made some very important statements today, and I am encouraged by what she has had to say. However, she will be aware, of course, that the costs of private health care are escalating at an unprecedented rate in South Africa, and one of the causes for this is in fact that the entire health care service is heavily overregulated and protected by various Acts of Parliament. [Interjections.]

The deregulation of private health care services is generally regarded as an important step in cutting costs—a step recognised by the hon the Minister herself during the debate on the Medical Schemes Amendment Bill this year, when she referred to that Bill as being aimed at deregulating the medical schemes, and I quote from her Hansard (1993, col 855):

> . . . so that free-market principles can operate . . .

The CHAIRMAN OF THE HOUSE: Order! I can hardly hear the hon member for Durban North. Hon members must lower their voices. [Interjections.] Order! The hon member for Durban North may proceed.

Mr M J ELLIS: Mr Chairman, much of the noise is coming from the hon members wearing flowers to commemorate, I believe, their first year as members of the ANC in the House of Assembly. [Interjections.]

We in the DP are not wearing flowers, but perhaps we should be to commemorate the one year since they left us. [Interjections.]

Let me come back to what I was saying. The hon the Minister, in the debate on the Medical Schemes Amendment Bill, said that the whole aim of that particular Bill was to deregulate medical schemes, and I quote from her speech:

> . . . so that free-market principles can operate . . . to offer health care cover suited to the real needs and financial means of . . . members.

The DP fully accepts this principle.

However, what we are calling for today is the further deregulation of all private health services, including the fields of optometry and optical dispensing. By all accounts these fields have become completely monopolised with serious effects on the costs of the services offered by the professions involved, and ultimately on the cost of spectacles. Consequently, there are probably millions of people in this country who should be wearing spectacles, but who are not. In many cases this is simply because people cannot afford them.

In an article in *Fair Lady* dated February 1990 the SA Optometric Association themselves acknowledged the seriousness of the situation when they said, and I quote:

> Two million South Africans wear visual aids and up to six million more should be wearing them.

These two professions, registered by the SAMDC—as the hon the Minister quite rightly said—and controlled through their respective associations and presumably the professional board for optometry have, by all accounts, restricted entry to their profession and have effectively excluded competition in any real sense. [Time expired.]

*Dr F H PAUW: Mr Chairman, I should like to add a few words about the cost of spectacles. I, too, am sorry that the hon member for Wynberg is not present.

Because a person's ability to see and to read is so fundamental to the quality of his life, the services relating to this issue require special attention from the department and the hon the Minister. We cannot simply allow the ordinary market forces to operate and determine the prices of materials and services in this regard. In situations where exploitation is possible, it is not only right that the hon the Minister should intervene, it could also be regarded as her duty to take action in order to protect the public.

The situation regarding equipment and aids over the entire spectrum of the delivery of health services lends itself to abuses. Materials, especially imported materials, are becoming more expensive due to the continued weakening of the rand. The consumer is not always in a position to judge whether the article that he is paying for is being offered at a reasonable price.

As is the case with other health service professionals, the weakening economy is putting practitioners in this field under increasing financial pressure. As is the case with other health service professionals, the cost of running a practice—costs relating to staff, rooms and equipment—is escalating. This probably explains the attitude of the professional bodies.

A person such as the hon member for Wynberg, who is inclined to be impetuous and to make hasty judgements about issues that are not clear at first sight, must be very careful when accusing professional bodies of condoning unacceptable practices.

*The MINISTER FOR NATIONAL HEALTH AND WELFARE: Mr Chairman, I am on record as having said in various debates and on various occasions that market forces alone cannot be allowed to impact upon health services. I concede this to the hon member. The reason for this is that the doctor's decision determines 80 % of the supply and demand in health services. That is one of the problems we need to look into.

The fact that professional associations deter-

mine the minimum price is the very issue that I wish to refer to here. The hon member said we should not interfere with the rules of the professional councils or associations he referred to. I think we should emphasise that the professional councils are there to supervise the standard of services and that the standard of services should at all times serve the public's interests. However, these councils should not get involved in the creation of measures for the protection of the professions that are prejudicial to the public.

It has been brought to my attention that the Optometric Association has approved an increase of between 50 % and 60 % in the price of contact lens material. We shall have to take a serious look at this kind of practice. I think it is important to accept the principle that the interests of the man in the street should come first, but that the supplier of the professional service should also be in a strong position so that he can receive proper compensation for his professional services.

What I object to is the fact that he makes money out of the material that he supplies, not the professional function that he performs. Here I also refer to certain dispensing doctors. The emphasis should always be on the professional function and not on the materials used to provide specific services.

Mr R M BURROWS: Mr Chairman, it is perhaps appropriate that you, and all the participants in this interpellation, have to use spectacles. It does raise the question, raised in the minds of the public outside: Is the cost all of us have incurred, in terms of having the medical scheme supply those spectacles, in accordance with a set minimum tariff? That is why I think we were pleased to hear the hon the Minister say that it is against the spirit of the Competition Board's report that a minimum is being set.

It is also appropriate to refer to last year's twelfth annual report of the Competition Board, in which reference is made to optometrical services and, in particular, the *Van der Westhuizen v Scholtz and others* case concerning pharmacies is cited as follows:

> Apart from restrictions on advertising and price competition, the extent of certain types of work reservation is allegedly not in accordance with modern circumstances and technology. Optometrical services are in various respects analogous with those of a pharmacist and the court decision . . . could perhaps also act as an impetus for more deregulation . . .

Essentially that is the point we want to make. This hon Minister, together with the appropriate Minister or with the Competition Board, has to look at the totality of health service supply professionals, whether they are pharmacists, or in health services occupations, optometry or medical schemes, to ensure that their policy meshes with the Competition Board policy, so that there are no monopolistic conditions, so that restrictive practices are abolished and so that deregulation is occurring. Then the people out there, we who require the services of opticians, will be getting the best services at the best price.

Mr M J ELLIS: Mr Chairman, the points made by my colleague the hon member for Pinetown with regard to the Competition Board are extremely important. The hon the Minister herself has referred to this board, but they apply to many areas within the health care services.

The retail pharmacists, as the hon the Minister herself has said, are having to address very similar matters to the ones that the optometrists are having to address with regard to advertising, the ownership of pharmacies, etc. They are under pressure to sell medicines at a cheaper price, in the same way that optometrists must now start to address the high cost of their services.

However, I want to emphasise what my colleague has said, namely that the hon the Minister has got to play her role in this particular area as well. She has got to play her role in bringing down the cost of health care and cannot put the blame squarely on the shoulders of the SAMDC or the South African Pharmacy Council alone. She has got to play her role as well.

I want to emphasise that the deregulation of the health care industry is essential if it is true that certain optometrists and opticians are blatantly ripping off the public. The deregulation of the health care industry is absolutely essential in order to stop that practice. [Time expired.]

The MINISTER FOR NATIONAL HEALTH AND WELFARE: Mr Chairman, I am tempted to tell hon members to look at my track record. [Interjections.] I support the approach, and it is clear that we are busy deregulating the whole health delivery system. We are in the process of looking at all the professions and negotiating

with all the professional boards to see to it that we do not resort to protective measures in order to protect the various professions.

*It is important that we compel the professional councils to deliver services of a certain standard and that we heed the recommendations of the Competition Board. We are doing that. Therefore, what the hon DP members had so say was not news to us. It was not new either. We have been engaged in this process for the past year. In each discussion that I have had with the various councils, we looked into this matter in order to ensure that any restrictive or protective measures are eliminated as far as possible.

Hon members can rest assured that the Government accepts its responsibility in this regard. One of the principles that we announced two years ago was to make services affordable for the public.

This includes all these extensive steps, for example the deregulation of various laws and quite a number of functions that are being carried out by the professional councils at present.

I am absolutely convinced that, in the first place, we have the interests of the man in the street at heart.

*Mr J H HOON: What about the woman in the street?

*The MINISTER: The woman in the street is included in "the man in the street"!

I think we should bear in mind that the persons we are referring to are people who underwent advanced technical training. Therefore, we should maintain the necessary balance when looking at these matters. The professional fees that they are entitled to should also be worthy of their profession. [Time expired.]

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

State President:

Question standing over from Wednesday, 31 March 1993, when it was put to the then Minister of the National Intelligence Service as Question No 2 (Ministers):

Goniwe: reports of State Security Council

*1. Mr E W TRENT asked the State President:†

Whether, in view of the disclosure of certain secret minutes during the judicial inquiry into the alleged murders of Messrs Matthew Goniwe, Fort Calata and others, he will disclose information in respect of the deceased as contained in (a) all internal reports and inputs of certain persons and organizations, particulars of which have been furnished to the Office of the State President for the purpose of his reply, to all sections of the Secretariat of the State Security Council and (b) reports and inputs of that Secretariat to the former National Joint Management System (NJMS) and the State Security Council; if not, why not; if so, what are the relevant details?

B512E

The MINISTER OF JUSTICE (for the State President):

(a) and (b) The Government is prepared in principle to co-operate with the Acting Attorney-General of the Eastern Cape, who is investigating the matter, and to furnish him with any relevant documents in its possession. In this connection, the Government has already made minutes of the State Security Council available to him.

Mr E W TRENT: Mr Chairman, arising out of the hon the Minister's reply, may I ask him whether the letter written by Col Van der Westhuizen to the then head of the Defence Force regarding a certain Operation Katzen was received by the former head of Defence Force, and if so, whether he replied to it. If he did, what was his reply? These are documents which were made available by Gen Holomisa and which appear to be genuine.

The MINISTER: Mr Chairman, let me make it clear that we cannot have an inquest or inquiry alongside the inquest which is being conducted by Judge President Zietsman at the moment and which has been postponed until 17 May. We cannot have a parallel inquest or inquiry, or for that matter cross-examination as we are now having.

cont'd

Medical scheme body to stay

JOHANNESBURG. — The Representative Association of Medical Schemes (Rams) is to remain a voluntary organisation after it is dissolved as a statutory body in terms of amendments to the Medical Schemes Act.

This was decided at a summit meeting here of the three umbrella bodies in Rams: The Southern African Association of Medical Schemes, the Advisory Association of Medical Schemes and the National Federation of Medical Schemes.

Rams said in a statement yesterday the three organisations represented all registered medical schemes and disbursed about R10bn in claims annually. (299)

The decision to retain Rams as a voluntary representative body was taken in the interests of continuity and unity in the medical schemes movement at a time when it faced "almost unprecedented uncertainty", said Mr Keith Hollis, chairman of the SA Association of Medical Schemes.

"This uncertainty has come on the back of deregulation, the entry into the health-care arena of the insurance sector and the threat of national health," he said. — Sapa CT 22/4/93

Rams to remain as voluntary body

THE Representative Association of Medical Schemes (Rams) will remain in operation as a voluntary organisation after it is dissolved as a statutory body in terms of the amendments to the Medical Schemes Act.

This was decided at a meeting in Johannesburg of the three umbrella organisations in the medical schemes movement. B1DAY 22/4/93

SA Association of Medical Schemes chairman Keith Hollis said the decision to retain Rams as a voluntary representative body was taken in the interests of continuity and unity in the medical schemes movement at a time when it faced almost unprecedented uncertainty. 299

KATHRYN STRACHAN

"This uncertainty has come on the back of deregulation, the entry of the insurance sector into the health care arena," he said.

"It is essential that the medical schemes movement continues to address these and other issues as a single unified body under the banner of Rams — thus helping to ensure the future stability in both funding and the supply of medical services."

'Public abuses medical aid'

CT 27/4/93

299

Staff Reporter

THE Consumer Council was aware that medical schemes had been abused by various parties, including consumers, Professor Deon Rousseau of the South African Co-Ordinating Consumer's Council said yesterday.

Speaking at the conference of the newly-formed National Federation of Medical Schemes in Somerset West, he said the council was concerned by the amount of over-the-counter medicines prescribed by doctors and claimed from medical aid schemes.

Prof Rousseau said employees saw salary deductions for the scheme and felt entitled to medical aid, care and treatment, even for minor ailments.

Proposed amendments to the Medical Schemes Act, would deregulate the movement to make the system more affordable, the director-general of the Department of National Health, Dr Coen Slabber, said at the conference.

5% pay offer 'a threat to health care'

299

The Argus Correspondent ARG 29/4/93

PRETORIA. — The Medical Association of South Africa has warned that medical care could be severely jeopardised by the government's non-negotiable five percent salary increase.

Professor Ralph Kirsch, chairman of Masa's full time practice committee, said yesterday that the impasse between the government and the Public Service Caucus — which has declared a dispute — would be detrimental to health services.

"Every possible effort should be made to create a working enviroment which will retain health professionals," said Professor Kirsch.

"Masa is most perturbed by the government's rejection of the Public Service Caucus's demand that the five percent increase should be applicable to allowances as well as basic salaries.

"To ignore these perfectly reasonable demands is unfairly discriminatory against certain categories of employees," said Professor Kirsch.

As these allowances formed a significant part of doctor's salaries, they would receive an increase of between only 3,7 percent and 4,2 percent.

Professor Kirsch suggested that taxes on products which result in disease, such as tobacco and alcohol, should be increased and this income be dedicated to improving health care.

He said a state health lottery should be introduced urgently.

GENERAL NOTICES

NOTICE 353 OF 1993

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES: SCALE OF BENEFITS IN RESPECT OF SERVICES RENDERED BY PRIVATE HOSPITALS AND UNATTACHED OPERATING THEATRE UNITS

The following corrections should be made to General Notice 1096 of 1992, published in *Government Gazette* No. 14448 dated 4 December 1992.

S. J. ROODT,
Chairman: Representative Association of Medical Schemes.

ALGEMENE KENNISGEWINGS

KENNISGEWING 353 VAN 1993

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING

VERTEENWOORDIGENDE VERENIGING VAN MEDIESE SKEMAS: VOORDELESKAAL TEN OPSIGTE VAN DIENSTE GELEWER DEUR PRIVATE HOSPITALE EN LOSSTAANDE TEATEREENHEDE

Die volgende verbetering moet aangebring word aan Algemene Kennisgewing 1096 van 1992, gepubliseer in *Staatskoerant* No. 14448 gedateer 4 Desember 1992.

S. J. ROODT,
Voorsitter: Verteenwoordigende Vereniging van Mediese Skemas.

Page/Bladsy 71 — Please add/Voeg asseblief by:

..182 Non chargeable items in Wards, High Care wards and all Intensive Care Units/Gratis items in Sale, Hoësorgsale en alle Intensiewe Sorgeenhede

Disposable Patient Controlled Analgesia Pumps **NOT** conforming with the requirements of item ..230 / Wegdoenbare Pasiënt Beheerde Analgesië Pompe wat **NIE** aan die bepalings van item ..230 voldoen nie

Page/Bladsy 75 — Please add/Voeg asseblief by:

..181 Non chargeable theatre items (which would always include the equivalent to the items named)/Gratis teateritems (wat altyd die gelykwaardige van die genoemde item sal insluit.

Disposal Patient Controlled Analgesia Pumps **NOT** conforming with the requirements of item ..230 / Wegdoenbare Pasiënt Beheerde Analgesië Pompe wat **NIE** aan die bepalings van item ..230 voldoen nie

NOTICE 354 OF 1993

SOUTH AFRICAN LAW COMMISSION

The South African Law Commission hereby releases its working paper entitled "Jurisdictional Lacuna in the Supreme Court Act 59 of 1959". The working paper deals with the question whether a jurisdictional lacuna exists in the Supreme Court Act. In this working paper the Commission concluded that a jurisdictional lacuna does exist in the positive law and that it should be remedied by an appropriate statutory amendment.

The Supreme Court should be empowered to authorise an attachment or arrest to—

(i) confirm jurisdiction where the cause of action arose in one division and the property which can be attached or person to be arrested is in another division;

(ii) found jurisdiction where the cause of action arose neither in the division in which the *incola* plaintiff is resident or domiciled nor in the division in which the property or person to be attached or arrested is to be found.

The Commission invites all interested persons and bodies to comment on the working paper in question or to make suggestions for the development, improvement, modernisation or reform of this aspect of the law.

KENNISGEWING 354 VAN 1993

SUID-AFRIKAANSE REGSKOMMISSIE

Die Suid-Afrikaanse Regskommissie stel hiermee sy werkstuk getitel "Jurisdiksionele leemte in die Wet op die Hooggeregshof 59 van 1959" vry. Die werkstuk handel oor die vraag of daar 'n jurisdiksionele leemte in die Wet op die Hooggeregshof bestaan. Die Kommissie het in hierdie werkstuk tot die gevolgtrekking gekom dat daar wel 'n jurisdiksionele leemte in die positiewe reg bestaan en dat die leemte uit die weg geruim moet word deur 'n gepaste wetswysiging. Die Hooggeregshof behoort die bevoegdheid te verkry om 'n beslaglegging of inhegtenisname te magtig om—

(i) jurisdiksie te bevestig waar die eisoorsaak in een afdeling ontstaan het en die eiendom waarop beslag gelê kan word of die persoon wat in hegtenis geneem word, in 'n ander afdeling is;

(ii) jurisdiksie te vestig waar die eisoorsaak nóg ontstaan het in die afdeling waarin die *incola*-eiser woonagtig of gedomisilieer is, nóg in die afdeling waarin die eiendom is waarop beslag gelê word, of die persoon is wat in hegtenis geneem word.

Die Kommissie nooi alle belanghebbende persone en instansies uit om kommentaar te lewer op die onderhawige werkstuk of om voorstelle te doen vir die ontwikkeling, verbetering, modernisering of hervorming van hierdie faset van die reg.

Star 30/4/93

PresMed lifts earnings

By Stephen Cranston

PresMed has reported a 19 percent increase in earnings per share to 23c in the year to February.

The dividend has been increased by 25 percent to 5,25c. (299)

Turnover increased by 19 percent to R95,8 million, but a slight reduction in margins led to a 17 percent rise in operating profit to R13,8 million.

MD Carl Grillenberger says the improvements can be attributed to group expertise at curtailing costs, although several facilities are not operating at peak. (598)

He says that after revised medical aid legislation is implemented, those suppliers who can keep costs down will be favoured by medical schemes.

PresMed is the only hospital group which charges medical aid tariffs in all its facilities.

"Our philosophy is to work in partnership with all market players.

"Making doctors at our facilities an integral part of our team should prove a decisive factor in the implementation of health care in which cost and quality are of equal importance," he says.

2704052

58

(3) whether any corrective steps have been taken in respect of pupils promoted in this manner; if not, why not; if so, what steps;

(4) whether he will make a statement on the matter? B433E

The MINISTER OF EDUCATION AND TRAINING:

(1) No.

(a) to (d); (2) and (3) fall away.

(4) Reports have been received of attempts to intimidate teachers into promoting pupils who did not pass the examinations required for promotion to a following standard. At the beginning of the 1993 school year, such attempts were made at the following schools.

Sharpeville:
— Isizwe Setjhaba Secondary School
— Mohloli Secondary School

Sebokeng/Evaton:
— Tshepo Themba Secondary School
— Esokwazi Secondary School

Imbali:
— Mehlokazulu Secondary School

With the support of the circuit inspectors, assisted by parents and community leaders, these attempts have been successfully neutralised.

Soweto: disruption at schools/involvement of teachers

221. Mr J M BEYERS asked the Minister of Education and Training:†

(1) Whether there were any incidents of disruption at schools in Soweto recently; if so, (a) when, (b) at which schools, (c) why and (d) how many (i) school days were lost as a result of this disruption and (ii) pupils were affected by it;

(2) whether his Department has taken or is contemplating taking any action in this connection; if not, why not; if so, what action;

(3) whether any teachers employed by his Department are involved in this disruption; if so, how many;

(4) whether action has been or is being taken against these teachers; if not, why not; if so, what is the nature of this action;

(5) whether these teachers are still receiving salaries; if not, why not; if so, for what reasons? B478E

The MINISTER OF EDUCATION AND TRAINING:

(1) Yes.

(a) When	(b) At which school	(c) Why	(d) (i) School days lost	(d) (ii) Pupils affected by this
12 February 1993	Selelekela Secondary School	Teachers objected to deductions from their salaries due to absence from work without having applied for leave.	1	1 010
15 February —19 March 1993	All Soweto schools = 360	Members of COSAS forced pupils to attend school between 09:00 and 11:00 only, in protest against the payment of examination fees by Std 10 candidates. On 17 March 1993 teachers participated in a march organised		

(a) When	(b) At which school	(c) Why	(d) (i) School days lost	(d) (ii) Pupils affected by this
		by SADTU protesting against the 5% salary hike. Between 25 February and 3 March teachers at 60 schools in Dobsonville refrained from teaching in solidarity with teachers in temporary employ who insisted on permanent appointments.	25	230 274

(2) Yes.

Where evidence is obtained in respect of individuals who refused to teach, leave without pay is granted in accordance with the principle of no work, no pay.

(3) Yes.

On 17 March 1993, teachers (the number of which cannot be ascertained) were involved with the disruption. The majority of these teachers were allegedly intimidated to join the protest march.

(4) Yes.

All teachers who can be identified will be granted leave without pay.

(5) Yes.

It is only possible to grant leave without pay once irrefutable proof exists that teachers absented themselves from work unlawfully.

Schools: class size/additional teachers

230. Mr R M BURROWS asked the Minister of Education and Training:

(1) What is the average class size in (a) primary and (b) secondary schools in each specified region of his Department;

(2) what is the class size required by his Department for supplying a class teacher in (a) primary and (b) secondary schools;

(3) what is his Department's policy in regard to the supply of additional teachers to schools? B526E

The MINISTER OF EDUCATION AND TRAINING:

		(a)	(b)
(1)	Diamond Fields	41,77	36,81
	Orange-Vaal	38,47	36,11
	Orange Free State ..	41,28	36,04
	Cape	41,31	39,82
	Natal	41,68	33,75
	Northern Transvaal .	41,31	34,83
	Johannesburg	34,88	29,02
	Highveld	41,07	34,97

(2) (a) 1 teacher per 40 pupils

(b) 1 teacher per 35 pupils

(3) Within the limits of the budget of the Department and in accordance with a personnel provisioning formula per school, a number of educators' posts are annually created at various post levels. In accordance with the needs as reflected by the ratios in question 1, the posts are divided between the regions where the Regional Chief Directors are responsible for assigning the posts to ordinary schools.

Blind persons: adaptation of telephone switchboards

234. Mr C W EGLIN asked the State President:

(1) Whether any Government Departments are making use of telephone switch-

boards that have been adapted for use by blind persons; if not, why not; if so, (a) which Departments (i) make and (ii) do not make use of such switchboards, (b) how many such switchboards are being used by each of the Departments concerned and (c) in respect of what date is this information furnished;

(2) whether it is the intention to adapt for use by blind persons any switchboards currently in use in any Government Departments; if not, why not; if so, (a) which switchboards and (b) when;

(3) whether any blind persons are employed by any Government Departments; if not, why not; if so, (a) how many, (b) by which Departments and (c) in what capacities;

(4) whether any Government Departments intend creating posts for blind persons; if not, why not; if so, (a) which Departments, (b) what posts and (c) when?

B535E

The STATE PRESIDENT:

(Reply bound in Annexures of House, see M/335—1993.)

Provincial health clinics for Blacks

241. Mr E W TRENT asked the Minister for National Health and Welfare:

(1) (a) (i) How many provincial health clinics for Blacks were there in the Port Elizabeth/Uitenhage/Ibhayi metropole as at 31 December 1992 and (ii) what are their names, (b) what are the functions of these clinics and (c) (i) what was the staff complement as at the above date and (ii) in what categories were these staff members employed;

(2) (a) what was the expenditure budget of each of these clinics, and (b) how many patients did each of them attend to, in 1992 or the latest specified 12-month period for which information is available?

B547E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) (a) (i) 15—accessible to all population groups, and

(ii) *Port Elizabeth, Dora Nginza Hospital:*
Kwazakhele Day Hospital
Motherwell Community Health Centre (no 2)
Motherwell Community Health Centre (no 8)
Motherwell Community Health Centre (no 4)

Port Elizabeth, Provincial Hospital
Adcockvale Old Age Home
Louis Dubb Old Age Home
Sidwell Clinic
Algoa Park Clinic
Walmer Community Health Centre

Uitenhage Hospital
Laetitia Bam Day Hospital
Paterson Clinic
Kwa Nobuhle Community Health Centres (no's 1–4)
Middle Street Clinic,

(b) the function of the above-mentioned clinics are the rendering of a primary health care service and

(c) (i)

Port Elizabeth, Dora Nginza Hospital	
Kwazakhele Day Hospital	56
Motherwell Community Health Centre (no 2)	3
Motherwell Community Health Centre (no 8)	6
Motherwell Community Health Centre (no 4)	91
Port Elizabeth, Provincial Hospital	
Adcockvale Old Age Home	None
Louis Dubb Old Age Home	None
Sidwell Clinic	None
Algoa Park Clinic	6
Walmer Community Health Centre	25
Uitenhage Hospital	
Laetitia Bam Day Hospital	11
Paterson Clinic	5
Kwa Nobuhle Community Health Centre (no's 1–4)	26
Middle Street Clinic	12

NB: The Adcockvale- and Louis Dubb Old Age Home have no CPA personnel. These old age homes have three professional nurses on the establishment of the Provincial Hospital, Port Elizabeth.

Sidwell Clinic has no CPA personnel—it is a satellite of the Algoa Park Clinic and is served by personnel from the Algoa Park Clinic and

(ii) *Port Elizabeth, Dora Nginza Hospital*

Kwazakhele Day Hospital	
Administrative	5
Medical	1
Pharmacy	1
Nursing	31
General	8
General Assistant	10
Motherwell Community Health Centre (no 2)	
Administrative	1
Nursing	2
Motherwell Community Health Centre (no 8)	
Administrative	1
Nursing	4
General Assistant	1
Motherwell Community Health Centre (no 4)	
Administrative	15
Nursing	61
General	3
General Assistant	12
Port Elizabeth, Provincial Hospital	
Algoa Park Clinic	
Administrative	1
Nursing	3
General Assistant	2
Walmer Community Health Centre	
Administrative	4
Medical	1
Pharmacy	2
Nursing	10
General	2
General Assistant	6
Uitenhage Hospital	
Laetitia Bam Day Hospital	
Administrative	2
Nursing	6
General Assistant	3
Paterson Clinic	
Nursing	3
General	2
Kwa Nobuhle Community Health Centres (4 Satellite clinics of Laetitia Bam)	
Administrative	5
Nursing	15
General Assistant	6
Middle Street Clinic	
Administrative	2
Nursing	7
General Assistant	3

(2) (a) Kwazakhele Day Hospital R2 153 800,00
Motherwell Community Health Centre (no 2)
Motherwell Community Health Centre (no 8)
Motherwell Community Health Centre (no 4)
= R4 711 604,00
* Adcockvale Old Age Home; Louis Dubb Old Age Home; Sidwell Clinic; Algoa Park Clinic.
* No budget allocated as expenditure budget is included in mother hospital's budget.

Walmer Community Health Centre R960 100,00
Laetitia Bam Day Hospital R185 350,00
Paterson Clinic R239 900,00
Kwa Nobuhle Community Health Centre (no's 1–4) R1 082 500,00
Middle Street Clinic R144 500,00

(b) *Port Elizabeth, Dora Nginza Hospital*

Kwazakhele Day Hospital	44 778
Motherwell Community Health Centre (no 2)	3 568
Motherwell Community Health Centre (no 8)	8 145
Motherwell Community Health Centre (no 4)	43 813

cont'd

Medics call for revised fee structure

KATHRYN STRACHAN

ALLEGATIONS of overcharging and abuse under the private hospital tariff structure had damaged the credibility of the entire health care industry, a range of health organisations said yesterday.

After a two-day meeting, the Representative Association of Medical Schemes, the National Association of Private Hospitals and the Day Clinic Association concluded that the current structure of fee-for-service needed to be reviewed because it failed to address the issue of mismanagement.

To contain costs, the parties agreed on the flexibility of introducing a new reimbursement model including fixed fees and per diem rates for selected procedures, they said in a statement.

The statement said the amendment to the Medical Schemes Act and the development of managed healthcare demanded that new tariff structures be developed to keep pace with changes.

"The affordability of health care in SA has been under pressure for some time.

"The phenomenon of many people opting out of medical schemes due to unaffordability on the one hand, and the recognition that more people are demanding health care cover on the other, is being vigorously addressed in the debate on future realistic tariff structures," the statement said.

Star 6/5/93

Health groups call for new tariff structures

New tariff structures must be developed to keep pace with changes in the health care industry, according to representatives of three health care bodies that yesterday concluded a two-day meeting on the future of hospital tariffs.

The Representative Association of Medical Schemes, the National Association of Private Hospitals and the Day Clinic Association said in a joint statement that allegations of overcharging, overservicing and abuse of the present structure had damaged the credibility of the entire health care industry.

"It is necessary to introduce a new reimbursement model to include fixed fees and daily rates for selected procedures," they said.

"The amendment to the Medical Schemes Act, and the development of managed health care, together with more involvement by insurers in the provision of medical care, requires that new tariff structures must be developed to keep pace with changes in the industry.

"Awareness and concern about the cost to the patient is not apparent to the whole of the industry," the statement said.

— Sapa.

DRUG PRICES FM 7/5/93

A bitter pill to swallow

Last week, Finance Minister Derek Keys read the pharmaceutical industry the Riot Act. With drug prices soaring, Keys told the industry to get its act together or face government intervention that he admitted might not be "intelligent."

Keys, who called the closed-door meeting on Friday in Pretoria, says the industry has placed itself in a "provocative position" with price increases that exceed the consumer price index. And while Keys stresses that he doesn't have any specific action in mind right now, he's thrown the industry into a panic. "The industry clearly feels threatened by the warning," says Jan de Kock of the National Association of Pharmaceutical Manufacturers.

"Everyone had a go at one another," says another delegate at the meeting. "The Pharmacy Council blamed medical schemes. Schemes retorted that the council needed to allow greater competition."

Of course, the threat of price controls is the biggest stick Keys can wield. Though they exist in some form or another in most parts of the world — SA and the US are two exceptions — Health Minister Rina Venter has repeatedly stressed that price controls are against government's market-orientated policy. The Cabinet also dismissed the controversial Wim de Villiers report because it proposed such controls.

In any case, industry experts warn that price controls in any form would produce only further distortions in the market. They would also probably chase away foreign drug manufacturers, already nervous over the political and economic uncertainty.

A better solution would be to increase competition and streamline the distribution chain by ending many of the apparently fixed profit margins and mark-ups. A number of far-reaching reforms — geared to cut costs — have already been implemented. For one, the Medical Schemes Amendment Act, passed this year, paves the way for medical schemes to employ pharmacists and run their own pharmacies.

Says Pharmacy Council registrar Chris Van Niekerk: "Four recent and separate studies have shown that medicine costs can be reduced by up to 75% by using, for example, limited medicine lists and generics, and curtailing the prescription habits of doctors — telling them what drugs should be used for certain ailments."

In another far-reaching move, the Medicines Control Council — despite vociferous opposition from drug manufacturers — recently amended its rules to allow imports of medicines already available locally. The decision, however, has yet to take effect.

There's more to come. Venter is scheduled

to table the Pharmaceutical Amendment Bill in parliament this session. The Bill's most controversial proposal would end the ban on non-pharmacists employing pharmacists and owning pharmacies. This move, which is the norm in the US, would allow retailers such as Clicks and Pick 'n Pay to run their own discount dispensaries, using their clout to bargain with drug manufacturers.

Says Pharmaceutical Society of SA president Gary Köhn: "Pharmacists are deeply concerned about what are seen as sinister moves to wrest ownership of pharmacies away from them. Permitting non-pharmacist ownership could not be justified in most circumstances because this threatened professional control of standards."

Venter stresses that medical professionals should be free to choose for whom they work. "I don't believe standards will be compromised since professionals are still obliged to adhere to the standards set by their respective councils."

The Pharmacy Council's Van Niekerk, who was largely responsible for drafting the legislation, concedes that competition could well put many smaller pharmacies out of business. "Pharmacists need to provide affordable services to the community. If they can't succeed, let non-pharmacists who can discount services apply to the Pharmacy Council to do so."

The council has in recent years also lifted all bars on advertising, allowed pharmacists to enter into contracts with medical schemes and scrapped the compulsory 50% mark-up that has traditionally translated into a 100% retail mark-up. In recent years pharmacists have, however, given discounts of up to 40%. But a *FM* survey, conducted last year, revealed that some of the most commonly used drugs cost an average of 130% more in SA than in the US.

One reform that hasn't, however, made it to the statute books is the proposal to allow pharmacists to substitute cheaper generic equivalents for prescribed medicines. While generics have safely been used in State hospitals for more than 30 years, manufacturers and doctors continue to argue their efficacy and safety. Van Niekerk says the patient, like any other consumer, should be given a choice. He stresses that generics, like all drugs in SA, have to meet stringent quality standards. Venter is said to be determined to enact this particular reform.

Certainly, the pharmaceutical distribution chain is a complex one. Most players argue that private-sector prices are severely distorted by the State tender system. They argue that roughly 70% of all medicine is sold on tender to the State for, at most, a third of the price paid by the private sector for the same product. Manufacturers, they say, make up the difference by boosting charges to the private sector.

Van Niekerk suggests this problem could be overcome. "The State needs to contract with the private sector to provide services rather than force them into the inefficient State tender system."

Mirryéna Deeb

MAIZE PRICES FM 7/5/93

Revolt of the poultry men

If both producers and consumers are upset about the latest yellow maize price hike of "only" 2%, then Agriculture Minister Kraai van Niekerk's compromise can't be all bad. Right? Sounds hard to fault this argument by Deputy Director-General of Agriculture Chris Blignaut — until you start analysing industry figures. Then it becomes clear that fixing maize prices is easy if you use mirrors.

National Maize Producers' Organisation CE Giel van Zyl says that with average production costs of R970/ha over more than 3,6m ha — with 1 ha producing about 2 t — maize farmers need higher prices to earn a decent profit.

But Van Niekerk refused farmers' requests to increase yellow maize prices to R516/t, settling for R505/t instead. Nevertheless, farmers will gross about R4,2bn this season from a projected 8Mt crop, compared with last year's R1,5bn from a 2,9Mt crop.

Poultry men and animal feed manufacturers, the biggest buyers of maize, are crying foul. They say the 2% figure used by Van Niekerk distorts the real picture. "The announcement says the new yellow maize price represents a 2% increase over last year's consumer price of R495/t," says the SA Poultry Association's Zac Coetzee. "But the landed price of 4Mt of imported yellow maize last year was R475/t and only a small amount of locally produced yellow maize was priced (and sold) at R495/t. cont

NEWS 100 percent hike in hospital tariffs ● Man arrested over Slovo assasination plot

Sowetan 7/5/93

Hospital fees up

By Josias Charle

HOSPITAL fees are to go up by more than 100 percent from 7,7 to 22 percent, the Transvaal Provincial Administration has announced.

The TPA's member of the executive committee in charge of health services, Mr Fanie Ferreira, said the new fees would be retrospective to May 1 "in synchronisation with other provinces".

Ferreira said the principle followed in the fixing of the new fees was that those who could afford services rendered should pay for them.

"Less privileged members of our community are assisted to a level at which health services become financially accessible to all people in the province," he said.

Income ceilings have also been raised

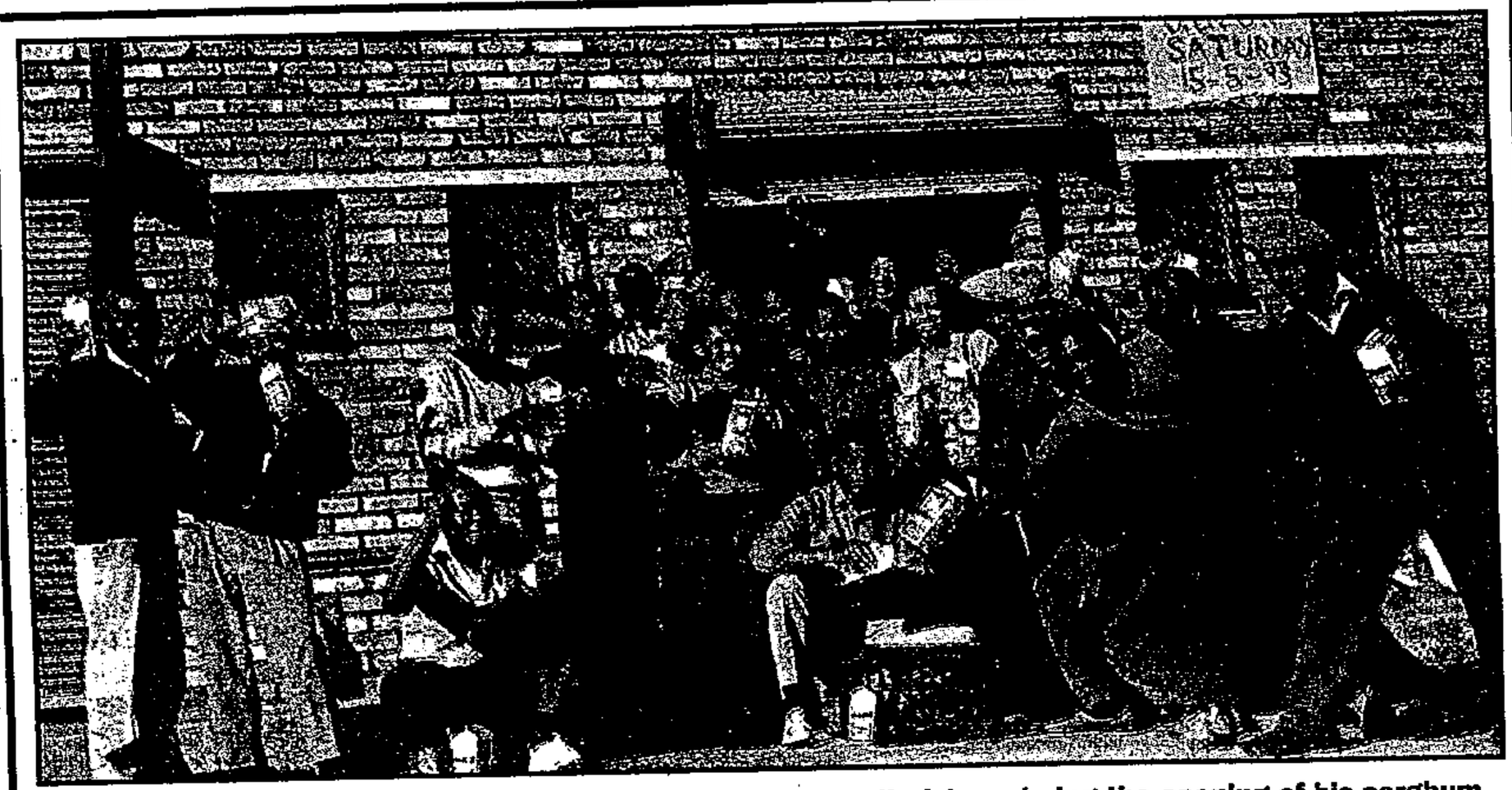
■ Those who can afford to will pay the higher price:

and this has led to more patients being classified in the hospital category, making medical care more accessible to more residents in the province.

The new categories are: H1 — income of less than R10 000 a year; H2 — income of up to R14 000 a year; H3 — income of up R21 000 and; private patients — income of more than R21 000.

Theatre fees have gone up by 9,9 percent while intensive care fees for private patients have been increased from R511 to R613 in community hospitals and R639 to R766 a day in academic and regional hospitals.

High care fees for private patients have been increased from R270 to R326 a day in community hospitals.



Soweto businessman Mr Shezam Setoaba surrounded by well-wishers during the opening of his sorghum beer outlet in Midway, Soweto, at the weekend. PIC: MBUZENI ZULU

WHAT IS MEDICAL AID? – Some facts and hints

Suppl to CIPress

WHEN most South Africans get sick they have to pay. Very few people are able to get help to pay the fees at state hospitals.

Medical aid is a type of insurance. If you are a member of a medical aid scheme, a certain amount is taken from your pay each month. Most employers put in an amount equal to the amount you pay. For example if you pay R30 then your employer will pay R30 as well. Then the money is sent to the medical aid company.

The medical aid company keeps the money it gets from its members. If you get sick or have an accident, the medical aid will pay for most or all of your medical bills.

If you do not get sick, you will not get your money back. Your money pays the medical bills of other members of the medical aid who are sick. The money also helps pay for the company to run the fund.

HOW DOES IT WORK?

There are about 200 different medical aid companies in South Africa. They have different rules. For example, some may pay only a percentage of your bill. Others may pay the full amount.

Medical care is very expensive.

If you have medical aid, it usually helps pay for your dependants as well.

If you get sick and go to the doctor or clinic, you have to fill in forms on your first visit. You must give your medical aid number, the name of your company or employer, and all your personal details. The clinic or doctor will keep the form.

(299)

Sometimes you have to pay cash first, and then send the receipt to the medical aid company. You can get the special forms for this from your employer. Then the medical aid will refund you part of the money.

But usually you do not pay money first. The doctor or clinic sends the bill to the medical aid, which pays the bill. Then they send your employer a statement that says how much of the bill you must pay. This money is taken from your next salary.

The law says medical aids must pay all or most of these costs:

- hospital bills
- visits to the doctor and dentist
- prescription medicines
- other medical services such as spectacles.

Before joining a medical aid make sure that you know and understand the rules. Ask the follo[illegible] questions: How much w[illegible]t me? How much will the employer pay? What portion of the medical costs will the scheme pay? Are there limits to how much the scheme will pay? What medical services are covered? Will all my dependants be covered?

DICTIONARY

Dependants: people who you support with money, food and clothing such as your children.

Prescription: medicine a doctor has told to you to take.

From Learn & Teach magazine. Available at cafés, CNA's and street corners at R4.95.

Change likely on tariff consultations

GERALD REILLY

PRETORIA — Providers of health care and medical schemes will no longer have to consult each other on tariffs and scale of benefits before annual revisions, in terms of new legislation expected to come into effect later this year.

This was said in a joint Medical Association of SA (Masa) and Representative Association of Medical Schemes (Rams) statement yesterday.

Members of medical schemes and doctors have expressed concern about the level of benefits for services and the method of payment.

This could be allayed with the prospect of a formal negotiation agreement between Masa and Rams.

At a meeting last week the two bodies agreed that a formal agreement would be entered into to address issues which had not been addressed or had been regulated by legislation.

Details of the agreement would be determined at a meeting to be held soon.

Issues likely to be built into the agreement were the accessibility of health care; quality improvement and cost containment programmes and appropriate health care cover.

Rams spokesman John Ernstzen said the proposed agreement would be a step forward in ensuring an affordable system of quality health care in SA.

Pressure on medical schemes

KATHRYN STRACHAN

MEDICAL aid schemes face mounting financial difficulties as more companies abandon costly compulsory medical insurance for employees and turn to alternative forms of health cover.

Medicaid Administrators CE Jeff Sloame said that as salaries failed to keep pace with escalating premiums, companies found it increasingly difficult to make their contributions and were choosing to abandon medical aid schemes altogether or to allow individual employees to opt out.

He said it was particularly younger healthier members who opted for the cheaper, less comprehensive products offered mainly by life assurers and short-term insurers, leaving medical aids with a pool of older members more prone to illness who made heavier claims.

Medical aid schemes were dependent on the principle of younger healthier members cross-subsidising older members.

The trend of declining membership, especially of the lower risk group, resulted in a worsening claims experience and inevitably lead to an adjustment in claims contributions. Many schemes had also chosen the option of reducing their benefits.

In the past financial year, the majority of schemes administered by Medicaid made underwriting losses, said Sloame, and profits had been derived only from their investment incomes. Once the investment income had been used to cover underwriting losses, a small profit was shown, but not enough to build up reserves.

The introduction of VAT had also been a hard blow for medical aid schemes, with one scheme reporting an additional R8m paid out since its implementation. As schemes lacked the funds and reserves to carry the cost themselves, they had no alternative but to pass the burden on to their members, he said.

Police held after raid

STEPHANE BOTHMA

TWENTY-two people, including five policemen and two traffic officers, have been arrested for their alleged involvement in an international car smuggling racket involving millions of rand.

Pretoria police had already confiscated 36 expensive vehicles and were investigating the smuggling of more cars across SA's borders, Col Johan Mostert confirmed yesterday.

He said it was likely that more property would be confiscated as investigations continued.

The names of those arrested, including well-known Mamelodi and Eersterus businessmen, would be released when they appeared in court later this week.

Mostert said three pistols had also been seized and police were investigating the link to several car hijackings.

It is believed the cars were exchanged for drugs, gold and diamonds which were sold and profits split among members of the syndicate, but Mostert could not confirm this.

It is further believed that several well-known sports personalities were involved in the syndicate.

Medicine prices are 'far too high'

KATHRYN STRACHAN

THE price of medicines in SA was inordinately high, but very little had been done to rectify the situation in recent years, ANC health spokesman Manoranjenni Chetty said yesterday.

Addressing the Pharmaceutical Society of SA's national conference in Durban, Chetty said pharmacists were currently entangled in a system which included discounts to third party funders, wholesalers, pharmaceutical houses and levies on prescriptions. All these factors contributed to artificial pricing structures and needed to be corrected.

SA's poor synthesising capability had resulted in the majority of medicines or raw materials having to be imported at great cost, she added.

The development of a strong local manufacturing industry, as well as the use of cost-effective high-quality generic medicines, would be encouraged to reduce the exhorbitant costs.

The high cost of medicines, coupled with the concentration of pharmacies in urban areas, meant pharmacists had failed to provide accessible and affordable health care, she said.

National Health director-general Dr Coen Slabber said that of the almost 9 000 pharmacists in SA, 82,5% were in private practice. There were only 36 pharmacists in the six self-governing territories.

The figures dispelled the myth of the dispensing doctor intruding on the role of pharmacists, Slabber said, adding it was the unwillingness of pharmacists to work in the public sector and in deprived areas that had precipitated their problems.

Our Durban correspondent reports that SA Association of Hospital and Institutional Pharmacists president Sue Putter said there were numerous reasons why pharmacists chose not to work in the public sector. Remuneration and lack of career prospects featured prominently.

Putter suggested greater management autonomy for hospital pharmacists as well as improved systems of stock control and computerisation of dispensaries.

Putter also told the conference that recommendations contained in the Du Toit report commissioned by National Health Minister Rina Venter in 1990 should be instituted and not sink into oblivion as other reports had.

The Du Toit report highlighted severe shortcomings in the provision of cost-effective pharmaceutical services in the public sector and recommended their restructuring.

Putter said that in one week alone, five wards at Baragwanath Hospital were unable to account for nearly R5 000 worth of injectable drugs because of outdated stock control systems. Extrapolated over a year the loss would amount to R250 000.

Putter attributed massive financial losses such as these to inadequate stock control — based on the old ward stock system.

She pointed out that only 20% of all hospitals in SA made use of computerised stock control in spite of the proven benefits of such a system.

people murder and maim their victims, as they did yesterday in Breyten. He suggested that the people who should have joint control over the police, should be those who are represented at grass-roots level by those who were responsible for the murders in King William's Town, Queenstown, Ficksburg, Alberton and many other places. [Interjections.]

The DP's disdain for the competent authority the SA Police—to maintain law and order in this country, stretches so far that they want to place terrorists in joint control of that authority. [Interjections.] In essence our proposal is the one we made at the multi-party negotiation process. [Time expired.]

*The MINISTER OF LAW AND ORDER: Mr Chairman, at the outset I want to thank the hon member for Potgietersrus for his standpoint that the Government, and hence the NP, should control the forces. I want to thank him sincerely for that confidence, because it is clear that the CP has so much confidence in this side of the House that they do not want us to relinquish control of the security forces. [Interjections.]

As far as the hon member for Durban Central is concerned, I believe we should take a look at what is meant by "joint supervision" and "joint control". If I get an opportunity to do so, I shall return to this later.

The hon member said it was linked to joint responsibility. However this is not true. At this stage there cannot be joint responsibility. As I have already indicated to the hon member, one of the primary functions of a government is to maintain law and order. In other words, in the final instance the hon member is asking for joint control in a situation in which we would always have to accept the responsibility.

Let us take a look at what the ANC has to say in regard to this joint control. I quote:

> Yesterday senior ANC negotiator, Mac Maharaj, told the *Weekly Mail* that the ANC would not insist on being represented in the command structures of the South African Defence Force. It would accept that the powers of the subcouncil, that we are talking about now, for defence and for law and order would be limited to a supervisory role.

This is the standpoint of the ANC. The AVU also supports our standpoint. Inkatha also supports our standpoint that the government of the day should control the security forces until they have been properly assimilated. [Time expired.]

Mr P H P GASTROW: Mr Chairman, this hon Minister is playing straight into the hands of the ANC, because until now the ANC has said that they want joint control. From their position they have now realised that joint control means joint responsibility. During the elections they want to be in a position in which they do not have to be responsible for the acts of the police.

They want to be able to shift the burden onto the Government so that they can get votes: I want to suggest that it is unhealthy that the ANC is now moving towards the idea of joint supervision for electioneering and partisan party purposes. It is not in the interests of a peaceful election campaign. The Government's insistence on sole control is also unhealthy. It, too, is not in the interests of a peaceful, free and fair election campaign. [Interjections.]

This is precisely the issue. They should decide what is in the interests of the country and of a free, fair and relatively violence-free election campaign. It should, in the first instance, be joint control and not the interests of their own party or their own sectarian group. How can one have a level playing field during an election period if the Police Force of this Government, which is one of the contenders for power, is under its sole control? One cannot have a level playing field as far as law, order and security are concerned. One can only have it when there is joint responsibility and accountability. Whether the ANC is moving away from joint control or whether the Government is clinging to sole control is not the issue. The issue is that if we want a successful election, others need to be brought in.

The Police Force is trying to improve its relationship with the community, and it has made progress. However, this determination to cling to sole control will destroy much of that. The Police Force will be painted as a partisan group during the elections by all political opponents of the Government. This will undermine the standing of the Police Force and undermine its ability to maintain law and order during this highly sensitive period during the election campaign.

I think it is time we looked at the interests of the country as a whole by seeing how we can level the playing field and empower the Police Force to actually do its job properly, with the full backing of the other parties. If there is only joint supervision the Police Force will not be doing its job with the full backing of the other parties, because they will be watching like hawks from the outside to see what the Police Force is doing. If things go wrong, they will wash their hands of the matter, say that they are not responsible and that the blame rests with the Government, because it is the Government's Police Force. We want to avoid that. The Government should not throw power out of the window. They should share it for the purposes of the election campaign by having joint control over the Police Force during that period.

*The MINISTER OF LAW AND ORDER: Mr Chairman, I should like to thank the hon member. He seems to be very concerned that the Government might have to bear the blame in the future. [Interjections.]

However, the hon member accused me of playing into the hands of the ANC. Let us examine what he said. The ANC has been saying that the Police and the Defence Force are the private armies of the NP for a long time. This is exactly what that hon member also said a moment ago. He talks about the Police Force of this Government. In so doing he is playing directly into the hands of the ANC. [Interjections.] The SA Police are not the Police Force of the Government. The Police Force is the Police Force of the Republic of South Africa. [Interjections.]

Neither I nor my predecessor have ever made the Police Force into a political issue. The SA Police is an impartial force, and that hon member had the audacity to talk here about the Police Force of this Government. [Interjections.] I think it is a disgrace. That hon member is a member of the SA Police Board and ought to know better. He is aware of the changes we have introduced in the Police Force recently in order to make them independent and impartial, yet he referred to the police force of the Government. I think it is a disgrace.

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

Question standing over from Wednesday, 5 May 1993:

Medihelp: retired teachers

*2. Mr A GERBER asked the Minister of National Education:†

(1) Whether, since he furnished replies to Question No 5, standing over, on 17 February 1993 and Question No 10 on 24 February 1993, he has taken steps, or is at present envisaging taking steps, to equalize the membership fee contributions to Medihelp of persons who have been retired on accelerated pension with those of retired teachers who retired at the usual age; if not, why not; if so, what steps;

(2) whether these persons who have been retired on accelerated pension were informed beforehand of the implications that their early retirement would have in respect of the payment of membership fees to Medihelp; if not, why not; if so,

(3) whether the State will accept responsibility for financial losses suffered by these persons; if not, why not; if so, to what extent;

(4) whether he will make a statement on the matter? B725E

†The CHAIRMAN OF THE HOUSE: Order! I repeat the invitation I extended at a previous occasion to hon members who are not interested in the replies to the questions to leave the Chamber. There are hon members here who are, in fact, interested in the replies furnished and who would like to hear them. The hon the Minister may proceed.

†The MINISTER OF NATIONAL EDUCATION:

(1) According to information which I have received from the Commission for Administration, the position with regard to medical benefits of teachers who have

been retired on accelerated pension has at no stage changed. These teachers have themselves always been responsible for their medical cover after termination of service. These arrangements appear to be in line with general practice in the private sector. In the light of the sensitivity which has developed concerning this matter, and also because I am very sensitive about it myself, I decided to submit the matter to Cabinet for its consideration. I further decided that all educators who had accepted early retirement since 1 August 1992, owing to rationalization, should receive an amount not exceeding the State's contribution to the medical scheme to which they belonged on the last day of service for a period not exceeding 6 months after retirement.

(2) No, because according to my information no change in respecct of the payment of membership fees to Medihelp had taken place in the case of people who were retired on accelerated pension.

(3) No. Educators who have accepted early retirement are already receiving the assistance referred to in paragraph (1).

(4) No.

Mr R M BURROWS: Mr Chairman, arising from the reply of the hon the Minister, could he inform us whether teachers, particularly those falling under the Administration: House of Representatives who are being offered early retirement at this stage, are being informed about the financial position in regard to their medical scheme?

The MINISTER: Mr Chairman, I am not responsible for the management of the education department of the House of Representatives, so unfortunately I am not in a position to answer the hon member's question.

New questions:

Press freedom

*1. Mr P G SOAL asked the Minister of Mineral and Energy Affairs:

Whether, with reference to the reply by the then Minister of Home Affairs to Question No 7 on 18 March 1992 regarding legislation allegedly detracting from the free flow of information and restricting the Press from reporting, any steps have been taken or are being contemplated in respect of the repeal of the Petroleum Products Act, 1977 (Act No 120 of 1977); if not, why not; if so, (a) what steps and (b) when? B734E

The MINISTER OF MINERAL AND ENERGY AFFAIRS:

A comprehensive investigation into Government's involvement in the petroleum fuel industry is in the process of being finalised at present. One of the aspects which is being addressed in the investigation, is to what extent the need for secrecy regarding specific petroleum matters has reduced under the present circumstances. The repeal of the Petroleum Products Act, 1977 (Act No 120 of 1977) is, however, not envisaged, but only certain regulations promulgated in terms of the Act. It is the intention to consider the amendment of those Regulations which prohibit the publication of information in respect of petroleum products as soon as possible.

Mr R R HULLEY: Mr Chairman, arising from the reply of the hon the Minister, could he tell us whether the question of the deregulation of the petrol price is part of the inquiry he has just referred to?

The MINISTER: Mr Chairman, the reply to that question is "yes". The whole matter of the regulation of the petroleum industry has been looked into and the report will cover that as well.

Capital punishment

*2. Mr J H MOMBERG asked the Minister of Justice:†

(1) Whether he will consider recommending that all persons sentenced to death be reprieved before Parliament takes a decision on the question of capital punishment; if not, why not; if so, what are the relevant details;

(2) whether he will make a statement on the matter? B737E

†The MINISTER OF JUSTICE:

(1) and (2) All persons sentenced to death are from time to time considered for reprieve.

On 29 January 1993 during his Opening Address the State President indicated that the Government was reconsidering its position on the carrying out of the death penalty and that Parliament would be consulted in the process of reconsideration.

On 24 March 1993 the State President therefore indicated further that the Government has decided to approach Parliament on an appropriate occasion, on the basis of a motion, to give all hon members the opportunity to indicate their viewpoints regarding the carrying out of the death penalty in a vote at the end of the debate.

The State President will proceed with the consideration of possible reprieves.

†Mr J H MOMBERG: Mr Chairman, arising out of the hon the Minister's reply, the question was specifically aimed at the situation of persons who have been condemned to death. In the light of the almost inhuman situation existing at present, namely that some persons have been in death row for almost seven years, does the hon the Minister not feel that these persons can be reprieved before the debate on the death penalty begins?

†The MINISTER: Mr Chairman, I have already indicated that at a certain stage the State President considers the granting of a reprieve in the case of all persons who have been condemned to death. We must remember that this institution of the death penalty was amended hardly two years ago to make an appeal to the Appeal Court possible in all cases. It is therefore an automatic appeal. When cases are turned down by the Appeal Court, the question of reprieve remains. In this context we are therefore referring to those cases already considered by the State President, but in which a reprieve was not granted. As far as those persons are concerned, the carrying out of the death sentence has therefore been suspended temporarily. It is the intention, in the light of the hon the State President's motivation on these two occasions to which I have referred, to ask Parliament for its view on the continuation of the carrying out of the death sentence.

†Mr J H MOMBERG: Mr Chairman, further arising out of the hon the Minister's reply, does he not feel that he himself, purely on humanitarian grounds, can make such a recommendation?

†The MINISTER: In the normal course of events a reprieve is granted by the hon the State President on the recommendation of the Minister of Justice. Those cases have already been disposed of. We are talking here about a limited number of cases in which a reprieve was not granted. If I understand him correctly, the hon member is now asking whether we shall again look at that category of persons. I do not want to be cynical now, but there is a very strong feeling outside that these people did not ask twice whether their victims should get another chance or not. That is the attitude outside. We must look at this matter in a very objective and clinical way, and that has already been done. We shall not carry out the sentence before we have asked Parliament to state its attitude. I intend putting this question to Parliament within a few weeks.

Mr P G SOAL: Mr Chairman, further arising out of the hon the Minister's answer, does that mean that the hon the Minister did not tell us of the limited number of which it applied? Will he give us that figure and will he then confirm that, if it is decided at some subsequent date to reintroduce the death penalty, those people will be hanged?

The MINISTER: Mr Chairman, the law of the land is that. . . .

Mr P G SOAL: No, I know the law of the land.

The MINISTER: Mr Chairman, it is not that I think the hon member does not know the law.

Mr P G SOAL: But do you know it?

The MINISTER: Perhaps he can just check after I have finished. [Interjections.]

The law of the land is that a person, even if not reprieved, may still approach the State President up to the very last moment. We have so many instances of people approaching the courts at the very last moment with applications to suspend an execution. In some cases such applications have been successful and in others not. Therefore these people may still, under a

cont'd

Shortsighted profession

Daring to say what a lot of people had been thinking — that eyeglasses cost too much — has earned DP MP Robin Carlisle the wrath of the optometric profession, which vehemently denies that it's to blame for high prices.

Carlisle, whose accusations were directed to certain specific optometrists, refuses to apologise or retract any of his controversial statements (*Business & Technology* April 23). Instead he's pushing government to implement Competition Board recommendations that would end maximum or minimum price-fixing, allow greater advertising, and permit optometrists and optical dispensers to

work with or for nonmembers of the profession. All of this would, of course, open up the profession to competition and bring down prices dramatically as it has around the world.

Not all of Carlisle's recommendations are anathema to optometrists. SA Optometric Association director Peter Brauer says his organisation supports many of the board's findings and has been instrumental in many of the reforms now being promulgated by the SA Medical & Dental Council. Optometrists do indeed want deregulation that would allow them to expand their scope. For instance, they are prevented by law from treating eye illnesses they detect; that's the preserve of ophthalmologists — physicians specialising in eye care. Optometrists have also recommended an end to the ban on window displays and asked to be allowed to enlarge their signboards.

But Carlisle is focusing on deregulation that would bring down prices in what he says is an R800m/year industry. (In 1990, about 2m people wore eyeglasses or contact lenses, while professionals estimated that at least another 6m needed them.)

He claims that mark-ups for medical-aid patients can be as high as 207% and as much as 500% for nonmedical-aid patients, though he concedes that only some professionals are culpable of gouging. He says simple deregulation could drop prices by as much as 60%. Price lists made up under oath from Frames Unlimited — a 30-branch discount chain that's not owned by an optometrist — bear this out.

Brauer says Carlisle's claims are "defamatory, misleading and inaccurate" and that margins are closer to 47% (which results in a mark-up that's effectively much higher). The optometrists' association has threatened to sue Carlisle for his statements.

Optometrists certainly protect their turf. In recent months they have also instigated legal proceedings through the Medical & Dental Council against several fellow optometrists and some non-optometrists who run discount eyewear businesses, such as Frames Unlimited.

Says Brauer: "The optometrists' council has decided that optometrists can advertise only the availability of certain lenses but not the price. The council's thinking is that there is a professional service involved in providing a lens and that advertising lens prices could mislead the public because there are many different types of lenses."

Optometrists also oppose any deregulation that would allow them or optical dispensers to work for nonmembers of the profession. Large discount stores such as Clicks and Pick 'n Pay could use their bargaining clout and economies of scale to keep down costs.

Though it's a reform that's found its way into the Pharmacy Amendment Bill, now with the Cabinet, Brauer is unconvinced. "Pressures to contain costs would impinge on professionalism. For example, a store manager could encourage an optometrist to use a lens that is bought in bulk but might not be suitable for the patient's individual needs." Ultimately, society needs to strike a balance between individual choice, which may be deficient but is personal, and enforced guidance from a professional that may be sage but could be tyrannical.

Health Minister Rina Venter recently rejected that same argument about pressure on standards when it was made by pharmacists, another cartel fighting deregulation.

Many of these issues havve already been sorted out in the US, UK, Australia and Canada through extensive deregulation. In the US, widescale advertising, discount outlets and service innovations — ranging from in-store optometrists to contact lenses by mail — have all kept prices well below the inflation rate for at least the past 15 years. ■

No. R. 842 **14 May 1993**

REGULATIONS UNDER THE MEDICAL SCHEMES ACT, 1967 (ACT No. 72 of 1967)

The Minister of National Health intends, in terms of section 41 of the Medical Schemes Act, 1967 (Act No. 72 of 1967), to make the regulations contained in the Schedule hereto.

Interested persons are invited to submit any substantiated comments on the proposed regulations or representations they wish to make in regard thereto to the Director-General: National Health and Population Development, Private Bag X828, Pretoria, 0001 (for the attention of the Registrar of Medical Schemes), within three months of the date of publication of this notice.

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SCHEDULE

Definitions

1. In this Schedule "the Act" means the Medical Schemes Act, 1967 (Act No. 72 of 1967), and any expression to which a meaning has been assigned in the Act shall bear such meaning and, unless the context otherwise indicates—

"prescription" means all the medicine that a medical or dental practitioner or other person legally authorised to do so prescribes at one time for one person for the sickness condition under treatment;

"sickness condition" means a physical or mental defect, physical or mental illness, physical or mental deficiency or injury in man.

Registration of medical schemes

2. (1) An application for the registration of a medical scheme shall, subject to section 14 of the Act, be accompanied by—

(a) the name under which the scheme is to be registered;

(b) the full street address of the head office of the scheme;

(c) the date of which the scheme will come into operation; and

(d) the fee prescribed in regulation 11 (1) (a) in respect of an application for registration.

Written proof of membership

3. (1) Every registered medical scheme shall issue to each of its members written proof of membership which shall contain at least the following particulars:

(a) The name of the scheme;

(b) the surname and first name and further initials (if any) of the member and his dependants;

(c) the membership number;

(d) the date on which the member becomes entitled to benefits of the scheme concerned;

(e) if applicable, an indication of whether there are any sickness conditions that have been specifically excluded from benefits; and

(f) if applicable, the fact that the rendering of services is confined to a particular category of supplier of services.

No. R. 842 **14 Mei 1993**

REGULASIES KRAGTENS DIE WET OP MEDIESE SKEMAS, 1967 (WET No. 72 VAN 1967)

Die Minister van Nasionale Gesondheid is voornemens om kragtens artikel 41 van die Wet op Mediese Skemas, 1967 (Wet No. 72 van 1967), die regulasies in die Bylae hiervan vervat, uit te vaardig.

Belanghebbendes word versoek om binne drie maande na die datum van publikasie van hierdie kennisgewing gemotiveerde kommentaar op of vertoë in verband met die voorgestelde regulasies in te dien by die Direkteur-generaal: Nasionale Gesondheid en Bevolkingsontwikkeling, Privaat Sak X828, Pretoria, 0001 (vir die aandag van die Registrateur van Mediese Skemas).

BYLAE

Woordomskrywings

1. In hierdie Bylae beteken "die Wet" die Wet op Mediese Skemas, 1967 (Wet No. 72 van 1967), en het enige uitdrukking waaraan 'n betekenis in die Wet geheg is, daardie betekenis, en tensy dit uit die samehang anders blyk, beteken—

"siektetoestand" 'n liggaamlike of geestesgebrek, liggaamlike of geestesongesteldheid, liggaamlike of geestestekortkoming of besering by die mens;

"voorskrif" al die medisyne wat 'n geneesheer of tandarts of iemand anders wat by wet daartoe gemagtig is, terselfdertyd vir een persoon voorskryf vir die siektetoestand wat behandel word.

Registrasie van mediese skemas

2. (1) 'n Aansoek om die registrasie van 'n mediese skema moet, behoudens artikel 14 van die Wet, vergesel gaan van—

(a) die naam waaronder die skema geregistreer moet word;

(b) die volledige straatadres van die hoofkantoor van die skema;

(c) die datum waarop die skema in werking tree; en

(d) die geld wat by regulasie 11 (1) (a) ten opsigte van 'n aansoek om registrasie voorgeskryf word.

Skriftelike bewys van lidmaatskap

3. (1) Elke geregistreerde mediese skema moet aan elkeen van sy lede 'n skriftelike bewys van lidmaatskap uitreik wat minstens die volgende besonderhede bevat:

(a) Die naam van die skema;

(b) die van en eerste voornaam en verdere voorletters (as daar is) van die lid en sy afhanklikes;

(c) die lidmaatskapnommer;

(d) die datum waarop die lid op voordele van die betrokke skema geregtig word;

(e) indien van toepassing, 'n aanduiding of daar siektetoestande is wat uitdruklik van voordele uitgesluit is; en

(f) indien van toepassing, die feit dat die lewering van dienste beperk is tot 'n spesifieke kategorie diensverskaffers.

(2) A registered medical scheme shall at the request of a member or former member provide a certificate of membership to such member indicating the dates of admission to and assation of membership and any restriction on or exclusion from benefits in respect of such member and his dependants.

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Restrictions on payments

4. (1) A registered medical scheme shall not in its rules or in any other way limit, exclude, withhold or retain, as the case may be, any payment to a member of such scheme in respect of a benefit which such member or a dependant of such member is entitled to, an account of—

(a) the late submission or resubmission, as the case may be, of a claim pertaining to such benefit, before the last day of the fourth month following the month during which the service on which such claim is based was rendered or during which such claim was returned for correction;

(b) the non-payment, partially or in full, of any amount owed by a member to a supplier of a service.

(2) If a registerd medical scheme is of the opinion that a claim is incorrect or unacceptable for payment it shall notify the member within 30 days of his submitting a claim that such claim is incorrect or unacceptable for payment, stating the reasons why such claim is incorrect or unacceptable.

(3) After a member has been notified as referred to in subregulation (2) such member shall be allowed a reasonable time to correct and resubmit such claim, as contemplated in subregulation (1) (a).

Payment of benefits

5. A registered medical scheme shall—

(a) pay to a member or to the supplier of a service, subject to its rules and these regulations, any benefit due to the member of the scheme, on or before the last day of the month following the month of receipt of the claim pertaining to such benefit; and

(b) together with such payment forward to the member a payment advice containing at least the following:

(i) The name and the membership number of the member;

(ii) the name of the supplier of the service;

(iii) the date of each service covered by the payment;

(iv) the amount charged for each service concerned and the amount of the benefit allowed for each such service; and

(v) if applicable, the reason for the rejection of the payment of a benefit in respect of any claim.

(2) 'n Geregistreerde mediese skema moet op versoek van 'n lid of voormalige lid hom van 'n lidmaatskapsertifikaat voorsien waarin vermeld word die datum van toelating tot en die datum van beëindiging van lidmaatskap en enige beperking op of uitsluiting van voordele ten opsigte van sodanige lid en sy afhanklikes.

Beperkings op betalings

4. (1) 'n Geregistreerde mediese skema mag nie in sy reëls of op enige ander wyse ten opsigte van 'n voordeel waarop 'n lid van sodanige skema of 'n afhanklike van sodanige lid geregtig is, 'n betaling aan sodanige lid beperk, uitsluit, weerhou of terughou nie, na gelang van die geval, weens—

(a) die laat indiening of herindiening, na gelang van die geval, van 'n eis met betrekking tot sodanige voordeel, voor die laaste dag van die vierde maand wat volg op die maand waartydens die diens waarop sodanige eis berus, gelewer is of waartydens sodanige eis vir regstelling tereggestuur is;

(b) die wanbetaling, gedeeltelik of volledig, van 'n bedrag wat 'n lid aan 'n diensverskaffer verskuldig is.

(2) Indien 'n geregistreerde mediese skema van oordeel is dat 'n eis foutief of vir betaling onaanvaarbaar is, moet hy die lid binne 30 dae na die indiening van sy eis in kennis stel dat sodanige eis foutief of vir betaling onaanvaarbaar is en die redes meld waarom sodanige eis foutief of onaanvaarbaar is.

(3) Nadat 'n lid in kennis gestel is soos in subregulasie (2) bedoel, moet sodanige lid 'n redelike tyd gegun word vir die regstelling en herindiening van sodanige eis soos in subregulasie (1) (a) beoog.

Betaling van voordele

5. 'n Geregistreerde mediese skema moet—

(a) behoudens sy reëls en hierdie regulasies, aan 'n lid of aan 'n diensverskaffer enige voordeel verskuldig aan die lid van die skema betaal op of voor die laaste dag van die maand wat volg op die maand waarin die eis met betrekking tot sodanige voordeel ontvang is; en

(b) tesame met sodanige betaling, aan die lid 'n betalingsadvies stuur wat minstens die volgende bevat:

(i) Die naam en die lidmaatskapnommer van die lid;

(ii) die naam van die diensverskaffer;

(iii) die datum van iedere diens wat deur die betaling gedek word;

(iv) die bedrag wat vir iedere betrokke diens gehef is en die bedrag van die voordeel wat vir iedere sodanige diens toegestaan is; en

(v) indien van toepassing, die rede vir die weiering van die betaling van 'n voordeel ten opsigte van enige eis.

Charges by suppliers of services

6. A supplier of a service who has rendered any service to a member of a registered medical scheme or to a dependant of such a member shall within 30 days from the rendering of the said service furnish to the member concerned an account or statement reflecting the following particulars:

(a) The surname and first name and further initials (if any) of the patient;

(b) the name of the scheme in question;

(c) the membership number of the member;

(d) the date on which each service was rendered;

(e) the nature and the cost of each service rendered, including the particular item code number pertaining to such service (if applicable), and where the supplier of a service supplied medicine direct to the member in question or to a dependant of that member, the name and quantity of the medicine;

(f) the name of the referring medical practitioner or dentist;

(g) In the case where such account or statement refers to the use of an operating theatre where an operation was performed on the member or a dependant of that member—

(i) the name of the medical practitioner who performed such operation;

(ii) the name or names of the medical practitioner or practitioners who assisted at such operation; and

(iii) the procedure that was performed; and

(h) in the case of a first account or statement in respect of orthodontic treatment, a plan of treatment indicating—

(i) the expected total charge that will be levied by the orthodontist for the treatment;

(ii) the expected duration of the treatment;

(iii) the initial amount payable by the member; and

(iv) the monthly amount payable by the member.

Appeals to council

7. Any person who is aggrieved by any decision referred to in section 27 (1) of the Act and who wishes to appeal, shall do so in the form of an affidavit directed to the council and forwarded by registered post or delivered by hand to the registrar at his office address, to reach him not later than three months after the date on which the decision concerned was made.

Procedure at meetings of council of committees of council

8. (1) The person presiding at any meeting of the council or at any meeting of a committee of the council, as the case my be, shall be responsible for the proper conduct of the meeting.

Vorderings deur diensverskaffers

6. 'n Diensverskaffer wat 'n diens gelewer het aan 'n lid van 'n geregistreerde mediese skema of aan 'n afhanklike van so 'n lid, moet binne 30 dae vanaf die lewering van bedoelde diens, aan die betrokke lid 'n rekening of staat verstrek waarin die volgende besonderhede uiteengesit word:

(a) Die van en eerste voornaam en verdere voorletters (as daar is) van die pasiënt;

(b) die naam van die betrokke skema;

(c) die lidmaatskapnommer van die lid;

(d) die datum waarop iedere diens gelewer is;

(e) die aard en die koste van iedere diens wat gelewer is, met inbegrip van die bepaalde itemkodenommer wat op sodanige diens betrekking het (indien van toepassing), en waar die diensverskaffer regstreeks aan die betrokke lid of aan 'n afhanklike van daardie lid medisyne verskaf het, die naam en hoeveelheid van die medisyne;

(f) die naam van die verwysende geneesheer of tandarts;

(g) in die geval waar melding in sodanige rekening of staat gemaak word van die gebruik van 'n operasieteater waar 'n operasie op die lid of 'n afhanklike van daardie lid uitgevoer is—

(i) die naam van die geneesheer wat sodanige operasie uitgevoer het;

(ii) die naam of name van die geneesheer of geneeshere wat by sodanige operasie geassisteer het; en

(iii) die prosedure wat verrig is; en

(h) in die geval van 'n eerste rekening of staat ten opsigte van ortodontiese behandeling, 'n behandelingsplan ter aanduiding van—

(i) die verwagte totale vordering wat deur die ortodontis vir die behandeling gehef sal word;

(ii) die verwagte duur van die behandeling;

(iii) die aanvanklike bedrag wat die lid moet betaal; en

(iv) die maandelikse bedrag wat die lid moet betaal.

Appèlle na raad

7. 'n Persoon wat hom veronreg voel deur 'n beslissing bedoel in artikel 27 (1) van die Wet en wat appèl wil aanteken, doen dit in die vorm van 'n beëdigde verklaring wat aan die raad gerig word en wat per aangetekende pos versend of per hand bestel word aan die registrateur by sy kantooradres sodat dit hom uiterlik drie maande ná die datum waarop die betrokke beslissing gegee is.

Prosedure op vergaderings van raad of komitees van raad

8. (1) Die persoon wat voorsit op 'n vergadering van die raad of op 'n vergadering van 'n komitee van die raad, na gelang van die geval, is verantwoordelik vir die behoorlike leiding van die vergadering.

(2) A committee of the council shall elect from among its members a chairman, unless the council has appointed a chairman.

(3) The majority of the members of the council or of a committee of the council shall constitute a quorum at a meeting.

(4) The decision of a majority of the members of the council or of a committee of the council present at the meeting of the council or of a committee of the council shall constitute a decision of the council or of a committee of the council, as the case may be.

(5) In the event of an equality of votes on any matter, the person presiding at the meeting concerned shall have a casting vote in addition to his deliberative vote.

(6) (a) Confirmation of an ordinary meeting and notice of a special meeting of the council shall be given by the registrar and shall be accompanied by an agenda specifying the matters to be dealt with at the meeting.

(b) In the case of an ordinary meeting, such confirmation shall be sent by post or delivered by hand to each member of the council at least 14 days before the date of such meeting.

(c) In the case of a special meeting, such notice shall be given within such time and in such manner as the chairman may deem sufficient.

(d) No matter shall be dealt with at a meeting other than those matters specified in the agenda of the meeting, except such matters as, by unanimous decision of the meeting, are considered urgent.

(7) All meetings of the council, including appeals to the council, shall be open to the public: Provided that it shall be competent for any member to move at any time during a meeting of the council that the council go into committee to discuss any particular item on the agenda and if such motion is seconded and carried non-members, with the exception of the registrar, shall retire from the meeting.

(8) Any member of the council may attend any meeting of a committee of which he is not a member, but he shall not be entitled to vote at such meeting or be entitled to fees and allowances for attending such meeting.

(9) Any member of the council may register with the registrar a general or specific written request to be given timely notice of the date, place and agenda of any meeting or of all meetings, as the case may be, of a committee as such member shall, time permitting, be so notified.

(10) The council or a committee of the council may adjourn a meeting to any later day or hour, but no matter not appearing on the agenda of such meeting shall be dealt with at such adjourned meeting, except such matters as, by unanimous decision of the meeting, are considered urgent.

(11) The names of all members attending a meeting of the council or of a committee of the council, as the case may be, shall be recorded in the minutes of such meeting.

(12) If no quorum is present at a meeting of the council or of a committee of the council, as the case may be, 15 minutes after the meeting should have commenced, the chairman of the meeting concerned shall declare the meeting postponed to a day or an hour to be determined by him.

(2) Tensy die raad 'n voorsitter aangestel het, kies 'n komitee van die raad uit eie geledere 'n voorsitter.

(3) Die meerderheid van die lede van die raad of van 'n komitee van die raad maak op 'n vergadering 'n kworum uit.

(4) Die besluit van 'n meerderheid van die lede van die raad of van 'n komitee van die raad wat op 'n vergadering van die raad of van 'n komitee van die raad teenwoordig is, maak 'n besluit van die raad of van 'n komitee van die raad, na gelang van die geval, uit.

(5) In die geval van 'n staking van stemme oor 'n saak het die persoon wat op die betrokke vergadering voorsit, benewens sy gewone stem 'n beslissende stem.

(6) (a) Die registrateur moet bevestiging van 'n gewone vergadering en kennis van 'n buitengewone vergadering van die raad gee, wat vergesel moet gaan van 'n sakelys waarin die sake gespesifiseer word wat op die vergadering behandel gaan word.

(b) In die geval van 'n gewone vergadering moet sodanige bevestiging minstens 14 dae voor die datum van sodanige vergadering aan iedere lid van die raad per pos gestuur of per hand bestel word.

(c) In die geval van 'n buitengewone vergadering moet sodanige kennis gegee word binne die tyd en op die wyse wat die voorsitter voldoende ag.

(d) Geen ander sake as dié wat in die sakelys gespesifiseer word, word op 'n vergadering behandel nie, behalwe die sake wat die vergadering by eenparige besluit dringend ag.

(7) Die publiek het vrye toegang tot alle vergaderings van die raad, met inbegrip van appèlle na die raad: Met dien verstande dat 'n lid die reg het om te eniger tyd gedurende 'n vergadering van die raad 'n mosie voor te stel dat die raad in komitee gaan om 'n bepaalde item op die sakelys te beredeneer, en indien sodanige mosie gesekondeer en aangeneem word, moet nie-lede, met uitsondering van die registrateur, die vergadering verlaat.

(8) Enige lid van die raad kan 'n vergadering van 'n komitee waarvan hy nie 'n lid is nie, bywoon, maar hy is nie daarop geregtig om by sodanige vergadering te stem nie en is nie geregtig op gelde en toelaes vir die bywoning van sodanige vergadering nie.

(9) Enige lid van die raad kan by die registrateur 'n algemene of spesifieke versoek indien om betyds kennis te kry van die datum, plek en sakelys van enige van of al die vergaderings, na gelang van die geval, van 'n komitee, en sodanige lid moet, as die tyd dit toelaat, aldus daarvan kennis gegee word.

(10) Die raad of 'n komitee van die raad kan 'n vergadering tot enige later dag of tyd verdaag, maar geen saak wat nie op die sakelys van die verdaagde vergadering verskyn, word op die voortsettingsvergadering behandel nie, behalwe die sake wat die vergadering by eenparige besluit dringend ag.

(11) Die name van al die lede wat 'n vergadering van die raad of van 'n komitee van die raad, na gelang van die geval, bywoon, moet in die notule van sodanige vergadering opgeteken word.

(12) Indien daar 15 minute nadat 'n vergadering van die raad of van 'n komitee van die raad, na gelang van die geval, 'n aanvang moes geneem het, nie 'n kworum op die vergadering teenwoordig is nie, verklaar die voorsitter van die betrokke vergadering die vergadering uitgestel tot 'n dag of tyd wat hy bepaal.

(13) The proceedings of meetings of the council or of a committee of the council shall be recorded in the form of typed minutes and be certified, after approval, at the next meeting by the signature of the chairman concerned.

(14) The minutes of a meeting of the council or of a committee of the council shall be a concise summary of the matters discussed and the decisions taken, unless a meeting decides otherwise in relation to a specific matter.

(15) The registrar shall forward a copy of the minutes to each member of the council or to each member of the committee of the council concerned, as the case may be, as soon as possible.

(16) The chairman of the council may *ex officio* attend meetings of any committee of the council, but he shall not preside nor have a vote at such meetings, unless the council has appointed him chairman or member of such committee.

(17) The agenda for an ordinary meeting of the council shall be as follows:

(a) Minutes of the previous meeting and matters arising;

(b) minutes of meetings of the executive committee held since the previous meeting of the council and matters arising;

(c) minutes of meetings of committees of the council and matters arising;

(d) reports of committees;

(e) reports from previous meetings;

(f) matters concerning complaints;

(g) applications for exemption in terms of section 3 of the Act;

(h) policy matters; and

(i) other matters.

(18) It shall be competent for a member of the council to move at a particular meeting that any item appearing on the agenda for that meeting be advanced in the agenda or be dealt with later during the meeting.

(19) Members desiring to speak on any subject shall address the chair.

(20) The preceding subregulations shall *mutatis mutandis* apply to meetings of the executive committee: Provided that unless specifically so directed by the council, the executive committee shall not deal with—

(a) minutes of council meetings and matters arising; and

(b) appeals.

(21) Any motion or amendment proposed and not seconded shall lapse.

(22) A motion or amendment may be withdrawn with the consent of the meeting.

(23) If an amendment is proposed, it may be followed by other amendments, and the last amendment shall be considered first.

(24) If every amendment is rejected, the original motion shall then be put to the vote.

(13) Die verrigtinge van vergaderings van die raad of van 'n komitee van die raad word in die vorm van getikte notules opgeteken en, na goedkeuring daarvan, op die volgende vergadering gesertifiseer deur middel van die handtekening van die betrokke voorsitter.

(14) Tensy 'n vergadering anders met betrekking tot 'n spesifieke saak besluit, is die notule van 'n vergadering van die raad of van 'n komitee van die raad 'n bondige opsomming van die sake wat bespreek is en die besluite wat geneem is.

(15) Die registrateur stuur so spoedig doenlik 'n afskrif van die notule aan iedere lid van die raad of aan iedere lid van die betrokke komitee van die raad, na gelang van die geval.

(16) Die voorsitter van die raad kan *ex officio* vergaderings van enige komitee van die raad bywoon, maar op sodanige vergaderings sit hy nie voor nie en het hy nie stemreg nie, tensy die raad hom as voorsitter of as lid van sodanige komitee aangestel het.

(17) Die sakelys vir 'n gewone vergadering van die raad is soos volg:

(a) Notule van die vorige vergadering en sake wat daaruit voortspruit;

(b) notules van vergaderings van die uitvoerende komitee wat sedert die vorige vergadering van die raad gehou is en sake wat daaruit voortspruit;

(c) notules van vergaderings van komitees van die raad en sake wat daaruit voortspruit;

(d) verslae van komitees;

(e) verslae van vorige vergaderings;

(f) sake met betrekking tot klagtes;

(g) aansoeke om vrystelling kragtens artikel 3 van die Wet;

(h) beleidsake; en

(i) ander sake.

(18) 'n Lid van die raad het die reg om op 'n bepaalde vergadering voor te stel dat enige punt op die sakelys vir daardie vergadering voor of na ander punte op die betrokke sakelys bespreek word.

(19) Lede wat oor 'n onderwerp wil praat, moet die voorsitter aanspreek.

(20) Die voorafgaande subregulasies is *mutatis mutandis* van toepassing op vergaderings van die uitvoerende komitee: Met dien verstande dat, tensy hy uitdruklik deur die raad daartoe gelas is, die uitvoerende komitee nie die volgende behandel nie:

(a) Notules van raadsvergaderings en sake wat daaruit voortspruit; en

(b) appèlle.

(21) 'n Mosie of amendement wat voorgestel is en nie gesekondeer word nie, verval.

(22) 'n Mosie of amendement kan met die instemming van die vergadering teruggetrek word.

(23) Indien 'n amendement voorgestel word, kan ander amendemente daarop volg, en die laaste amendement word eerste oorweeg.

(24) Indien al die amendemente verwerp word, word die oorspronklike mosie tot stemming gebring.

(25) If an amendment is carried, it shall be regarded as a substantive motion and in all other respects be treated as an original motion as far as further amendments are concerned. (299)

(26) (a) When a matter is put to the vote, the chairman of the meeting, subject to the provisions of paragraph (b), shall ask for a show of hands for or against the motion or amendment and shall then declare that the vote appears to him to be in the affirmative or the negative, as the case may be.

(b) It shall be competent for a member to ask for a vote by secret ballot, and such a request shall be granted if at least three other members support it.

Conditions for continuation of membership

9. (1) If a registered medical scheme requires that the continued membership referred to in section 20 (1) (d) of the Act should be subject to a qualifying period of membership, such period shall not exceed five years: Provided that membership fees may be paid to cover any period lacking in order to qualify: Provided further that a member's membership of any other registered medical scheme shall also be taken into account when such period is being determined.

(2) If a registered medical scheme requires that the continued membership referred to in section 20 (1) (e) of the Act should be subject to a qualifying period of membership in respect of the deceased member, such period shall not exceed five years: Provided that membership fees may be paid to cover any period lacking in order to qualify: Provided further that the deceased member's membership of any other registered medical scheme shall also be taken into account when such period is being determined.

Investments

10. (1) Assets equal in value to at least 20% of the aggregate value of all the assets of a registered medical scheme shall continously be held in the Republic in one or more of the following classes of assets:

(a) Money in hand in the Republic;

(b) any amount standing to the credit of the scheme concerned in an account with an office in the Republic of a bank as defined in the Banks Act, 1990 (Act No. 94 of 1990), or with a mutual building society registered in terms of the Mutual Building Societies Act, 1965 (Act No. 24 of 1965), or with the Post Office Savings Bank established by section 52 of the Post Office Act, 1958 (Act No. 44 of 1958);

(c) bills, bonds or securities issued or guaranteed by—

(i) the Government of the Republic or a provincial administration;

(ii) a local authority in the Republic authorised by law to levy rates upon immovable property;

(25) Indien 'n amendement aangeneem word, word dit as 'n substantiewe mosie beskou en in alle ander opsigte, sover dit daaropvolgende amendemente betref, as 'n oorspronklike mosie behandel.

(26) (a) Wanneer 'n saak tot stemming gebring word, moet die voorsitter van die vergadering, behoudens die bepalings van paragraaf (b), 'n handopsteking vir of teen die mosie of amendement vra en moet dan verklaar dat dit vir hom voorkom of die stemming daarvoor of daarteen is, na gelang van die geval.

(b) 'n Lid het die reg om te versoek dat stemming per geheime stembrief geskied, en so 'n versoek word toegestaan as minstens drie ander lede dit steun.

Voorwaardes vir voortsetting van lidmaatskap

9. (1) Indien 'n geregistreerde mediese skema vereis dat die voortgesette lidmaatskap in artikel 20 (1) (d) van die Wet bedoel, onderworpe is aan 'n kwalifiserende tydperk van lidmaatskap, mag sodanige tydperk nie vyf jaar oorskry nie: Met dien verstande dat ten einde te kwalifiseer, ledegeld betaal kan word om enige tydperk wat kortkom te dek: Met dien verstande voorts dat 'n lid se lidmaatskap van enige ander geregistreerde mediese skema ook in berekening gebring moet word wanneer sodanige tydperk vasgestel word.

(2) Indien 'n geregistreerde mediese skema vereis dat die voortgesette lidmaatskap in artikel 20 (1) (e) van die Wet bedoel, onderworpe is aan 'n kwalifiserende tydperk van lidmaatskap ten opsigte van die afgestorwe lid, mag sodanige tydperk nie vyf jaar oorskry nie: Met dien verstande dat, ten einde te kwalifiseer, ledegeld betaal kan word om enige tydperk wat kortkom te dek: Met dien verstande voorts dat die afgestorwe lid se lidmaatskap van enige ander geregistreerde mediese skema ook in berekening gebring moet word wanneer sodanige tydperk vasgestel word.

Beleggings

10. (1) Bates, in waarde gelyk aan minstens 20% van die totale waarde van al die bates van 'n geregistreerde mediese skema, moet deurlopend in die Republiek in een of meer van die volgende klasse bates gehou word:

(a) Geld in kas in die Republiek;

(b) 'n batige saldo van die betrokke skema in 'n rekening by 'n kantoor in die Republiek van 'n bank soos omskryf in die Bankwet, 1990 (Wet No. 94 van 1990), of by 'n onderlinge bouvereniging geregistreer kragtens die Wet op Onderlinge Bouverenigings, 1965 (Wet No. 24 van 1965), of by die Posspaarbank ingestel by artikel 52 van die Poswet, 1958 (Wet No. 44 van 1958);

(c) wissels, skuldbriewe of effekte uitgereik of gewaarborg deur—

(i) die Regering van die Republiek of 'n provinsiale administrasie;

(ii) 'n plaaslike owerheid in die Republiek regtens gemagtig om belasting op onroerende eiendom te hef;

(iii) the Rand Water Board;

(iv) Eskom;

(v) the Land and Agricultural Bank of South Africa;

(vi) the Local Authorities Loans Fund Board; or

(vii) any institution which is, in the opinion of the registrar, financially sound and which has been approved by him;

(d) South African Reserve Bank stock.

(2) For the purposes of subregulation (1) "value"—

(a) in relation to a fixed asset, means the difference between the cost price and the aggregate amount provided or written off for depreciation or diminution of value since the date of acquisition;

(b) in relation to other assets, means the value in terms of which the assets are recorded in the financial statements of the said scheme and in terms of which the auditor has expressed an opinion.

(3) For the purposes of subsection (1) the aggregate value of all the assets of a scheme shall not include the value of any insurance policies issued by a person lawfully carrying on insurance business within the meaning of the Insurance Act, 1943 (Act No. 27 of 1943).

Fees payable

11. (1) The following fees shall be payable to the registrar in respect of the matters indicated:

(a) An application for the registration of a medical scheme: R500,00;

(b) the registration of a medical scheme: R10,00;

(c) an application for permission to change the name of a registered medical scheme: R10,00;

(d) the changing of the name of a registered medical scheme: R30,00;

(e) the registration of amendments, per A4 page or part thereof: R10,00;

(f) the inspection of documents in terms of section 25E of the Act, per document: R4,00; and

(g) the making of a copy of or the making of an extract from a document in terms of section 25E of the Act, per A4 page or part thereof: R4,00.

Withdrawal

12. Government Notices Nos. R. 2768 of 21 December 1984, R. 422 of 22 February 1985, R. 429 of 14 March 1986 and R. 1969 of 15 September 1989 are hereby withdrawn.

Commencement

13. These regulations shall come into operation on the date of commencement of the Medical Schemes Amendment Act, 1993 (Act No. 23 of 1993).

(iii) die Randwaterraad;

(iv) Eskom;

(v) die Land- en Landboubank van Suid-Afrika;

(vi) die Raad van die Leningsfonds vir Plaaslike Besture; of

(vii) enige instelling wat volgens die oordeel van die registrateur geldelik gesond is en wat deur hom goedgekeur is;

(d) Suid-Afrikaanse Reserwebank-aandele.

(2) By die toepassing van subregulasie (1) beteken "waarde"—

(a) met betrekking tot 'n vaste bate, die verskil tussen die kosprys en die totale bedrag voorsien of afgeskryf vir depresiasie of vermindering van waarde sedert die datum van verkryging;

(b) met betrekking tot ander bates, die waarde waarteen die bates in die finansiële state van bedoelde skema aangeteken is en waaroor die ouditeur 'n mening uitgespreek het.

(3) By die toepassing van subregulasie (1) word by die totale waarde van al die bates van 'n skema nie die waarde van enige versekeringspolisse uitgereik deur iemand wat wettiglik versekeringsbesigheid binne die bedoeling van die Versekeringswet, 1943 (Wet No. 27 van 1943) dryf, ingereken nie.

Gelde betaalbaar

11. (1) Die volgende gelde is aan die registrateur betaalbaar ten opsigte van die aangeleenthede soos aangedui:

(a) 'n Aansoek om die registrasie van 'n mediese skema: R500,00;

(b) die registrasie van 'n mediese skema: R10,00;

(c) 'n aansoek om toestemming om die naam van 'n geregistreerde mediese skema te verander: R10,00;

(d) die verandering van die naam van 'n geregistreerde mediese skema: R30,00;

(e) die registrasie van wysigings, per A4-bladsy of gedeelte daarvan: R10,00;

(f) insae in dokumente kragtens artikel 25E van die Wet, per dokument: R4,00; en

(g) die maak van 'n afskrif van of 'n uittreksel uit 'n dokument kragtens artikel 25E van die Wet, per A4-bladsy of gedeelte daarvan: R4,00.

Herroeping

12. Goewermentskennisgewings Nos. R. 2768 van 21 Desember 1984, R. 422 van 22 Februarie 1985, R. 429 van 14 Maart 1986 en R. 1969 van 15 September 1989 word hierby herroep.

Inwerkingtreding

13. Hierdie regulasies tree in werking op die datum van inwerkingtreding van die Wysigingswet op Mediese Skemas, 1993 (Wet No. 23 van 1993).

Doctors take on medical insurers

CT 15/5/93 (299)

Staff Reporter

MEDICAL aid services are forcing general practitioners to drop standards of patient care, according to a group of doctors who united this week to lobby for higher consultation charges.

Doctors found it difficult to provide high quality services on the money they received from medical insurers, said Dr Tony Behrman, vice-chairman of the Cape Medical Association and spokesman for the new group, the Peninsula Independent Practioners Association (IPA).

He said: "Medical aids will only pay a maximum of R34,10 for a 15-minute consultation and we can't compromise the quality of patient care in the name of cost containment."

Patients are fooled into believing that general practitioners' tariffs were the cause for soaring medical aid subscriptions, said Dr Behrman.

He said 50% of the cost of all medical aid subscriptions are due to accounts from private hospitals, the pharmaceutical industry and retail pharmacies.

The IPA called on doctors to join it. The group has 200 members who in turn represent 250 000 patients.

Move to cut costs

S/Times [C/Metro] E/

cuts out doctors

16/5/93

THE cost of health care could be cut dramatically as increasing numbers of community pharmacists are now offering primary medical treatment without consultation fees.

By PETA KROST

At the South African Pharmacy Society's annual general meeting this week, 200 pharmacists pledged to commit themselves to further education in primary health care and its practice.

So far 32 pharmacists have obtained the relevant accreditation to examine and diagnose patients as well as to prescribe medication up to schedule four.

The areas they may cover include upper respiratory tract, ear, nose and throat infections, sexually transmitted diseases, diabetes and high blood pressure.

"Before the end of the year new regulations may be passed allowing pharmacists, who have the specified additional education, to treat patients with antibiotics and other higher schedule medicines under certain conditions," said Mr Gary Kohn, president of the Pharmacy Society of South Africa.

"But unlike doctors, pharmacists won't be charging consultation fees. And the move also cuts down on time wasted waiting for a doctor's appointment, they claim.

"The general public will benefit from this move as greater discretionary powers for pharmacists has proved to be a cost-saving practice," said the Department of National Health and Population Development's director of pharmaceutical services, Mr Peter Hearn.

But the Medical Association of South Africa (MASA) has hit out at the move and said patient's lives could be endangered.

"Contrary to what is being presented to the public, pharmacists do not receive training which prepares them to make proper diagnoses, essential prior to prescribing treatment," said chairman of the Federal Council of MASA, Dr Bernard Mandell in a statement.

He said MASA had obtained evidence of pharmacists whose treatment of patients "has nearly ended in their death".

Mr Kohn said MASA's reaction was "a smear campaign because they feel their profession is being threatened".

Pharmacists had iniatitated this move to reduce medical costs and not to usurp the role of the doctor, he said.

While Mr Hearn said that primary health care services had always been practised by pharmacists, the Browne Commission recommended in 1992 that pharmacists be allowed more discretionary powers and access to higher schedule drugs.

But before being given these powers, a pharmacist "must satisfy the SA Pharmacy Council that he is competent to have access to the additional medicines prescribed", said Mr Hearn.

To this end, primary health care training has been incorporated into pharmacy students' training and many practising pharmacists are taking courses.

A Cape Town pharmacist, who cannot be named for professional reasons, set up a consulting room in his chemist two months ago.

It took him eight months of study and regular lectures to obtain accreditation.

He argues that the step by pharmacists balances the move by doctors to dispense medicines.

Cape GPs set out to heal medical aids 'malaise'

Health Reporter 299

GENERAL practitioners representing about 250 000 patients in the Western Cape have formed an association to stop medical aids "forcing inferior standards of patient care in the name of cost containment".

The initiative, which involves 190 doctors and their proxies, follows in the wake of a proposed change to the Medical Schemes Act giving the power to medical aids to scrutinise doctors' accounts before paying out. At present, medical aids are obliged to pay out for certain services.

The doctors, who formed the Peninsula Independent Practitioners' Association this week, aim to sign up as many GPs in the Western Cape as possible.

"Membership is increasing hourly," said Dr Tony Behrman, vice-chairman of the Cape Western branch of the Medical Association of South Africa and spokesman for the new organisation.

"The only sector of the healthcare cake that has steadily increased while all other providers of service have decreased is the pay-out to private hospitals and the pharmaceutical industry and profession." ARG 17/5/93

The IPA would negotiate realistic tariffs for consultative services and medicines to the benefit of all patients in the Western Cape, said Dr Behrman.

Workers raise a cheer for medical plan

Star 17/5/93

299

As the private health sector continues to flounder in a crisis of escalating costs and hard-pressed medical aids, two Witbank men claim to have found a way through. The Star's Health Writer, DAVID ROBBINS, spoke to them about a managed health-care plan which could soon be implemented on the Eastern Transvaal coalfields.

IT'S not exactly a medical aid, and it's not quite like the health maintenance and preferred provider organisations which will increasingly dominate the health skyline of South Africa once the Medical Schemes Act has been amended.

It's more like a health co-operative, the details of which have already kindled the interest of the ANC, Cosatu and National Union of Mineworkers (NUM) in the Witbank region.

It also raised a cheer and "a clear mandate" from a crowd of thousands at a workers' rally on May 1.

Originators of the plan, Dr Pierre de Waal and financial adviser and computer expert Johan Louw, have already created a limited company, Kredmed, to give substance to their thinking on managed health care.

They say, with some enthusiasm, that it's a unique concept. The scheme, they add, will be controlled by the members; there'll be no shareholders to satisfy; all profits will be reinvested into the community at a primary health-care level.

De Waal spent some time practising in Witbank among the thousands of mining families living in the area. He became interested in community health problems, and especially in the affordability of health care. He began to serve on the ANC's health forum for the area. Louw, meanwhile, was serving on the financial and development forums. It did not take them long to get together and work out the details of the plan.

Basing their initial calculations on local NUM membership figures only (36 000), Louw and De Waal have come up with what they believe to be a viable and sustainable package for the financing of health care.

Like a conventional medical aid, members and employers will share the cost of contributions. This income will be used in various ways. A small portion will buy medical insurance on behalf of the individual member plus any dependents to cover surgery, hospital and other extraordinary health-maintenance costs.

Another portion is placed into a short-term savings account, again on behalf of the individual member, who uses this money to fund routine medical expenses. A special system is available for the chronically ill, or for those members who become chronically ill after joining Kredmed. Other portions of each contribution service a long-term savings plan payable to the member on retirement, administration costs and a stabilisation fund from which members can apply to borrow if the short-term savings component is insufficient for their routine needs.

Louw and De Waal point to some of the major advantages of the plan:

● Since for routine medical matters, members are in fact spending their own money, abuse of the scheme by individual members is eradicated. Any credit left over in an individual's short-term savings account could be paid out to him on an annual basis, although Kredmed would encourage the member to leave it in the scheme to build up a healthy credit.

● Cost-effective medical treatment is simultaneously encouraged since the provider is confronted by what amounts to a private patient rather than a member of a medical aid and the "open cheque book" attitude that medical aids could encourage.

● Although the fund will be administered by Kredmed, it will be under the direct control of a negotiating body elected from membership. All policy decisions will be made by this body, which will also decide on requests for loans from the stabilising fund and also monitor those members who overspend on routine health matters.

● Since the scheme is without shareholders and a profit motive, the commission payable from the insurance company administering the medical insurance component of the Kredmed health package will be reinvested in health care as a whole.

It has been calculated that using only the 36 000 NUM membership base, more than R1 million a month could be generated. Under the guidance of the negotiating body, the intention is to use this money for the bulk buying of medicines, and also for community health projects, entering in this way into a partnership with the public health sector at a grassroots and visible level.

● Medical practitioners will be encouraged to register with the Kredmed scheme, where records would be kept of their cost-effectiveness, which in turn could be rewarded with a system of incentives. Unnecessary skimping on treatment will be avoided because the patient is in control. The patient will go where the best value for money is to be found.

● Under such a scheme medical costs could come down, and in any event Kredmed can guarantee that contributions will not be increased more than once a year. The increase will be linked to the current consumer price index, but Kredmed claims it should never exceed 15 percent because use of the private sector will be complemented by a managed health-care system.

Kredmed would welcome inquiries. Telephone (0135) 996-159. □

Star 20/5/93

Southern lives up to expectations

By Stephen Cranston

In line with expectations, Southern Life increased earnings per share by 19,2 percent to R196 million in the year to March.

A final dividend has been declared of 45,5c, making a total of 77,5c for the year. The dividend cover has been maintained at 1,5 times.

But Southern's GM (investments) Carel de Ridder says that the 1,5 percent increase in investment income to R1,09 billion reflects the downturn.

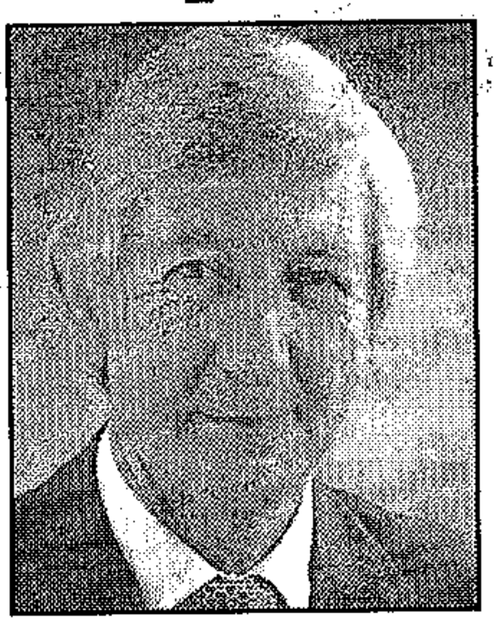
Investment income was affected by lower interest rates and only a marginal increase in dividends on share investments.

Property investments contended with rising vacancies and tougher rent negotiations.

De Ridder is hopeful that investment income will look healthier this years, particularly as 10 percent of equity investment is in gold shares.

Premium income, however, increased by 30,8 percent to R2,613 billion and single-premium income almost doubled from R430 million to R828 million.

There was a much slower increase in the more important recurring premium income, which was up from R391 million to R434 million.



Neal Chapman . . . cost containment efforts are proving successful

Chairman Neal Chapman says the increase in operating costs was restricted to 12,7 percent, which he says is an indication that cost containment efforts are proving successful.

Southern's tax bill increased by R30 million to R78 million, of which R15 million was attributable to higher indirect taxes and levies and the introduction of the dual tax system.

MD Jan Calitz says the life insurance industry can expect a sharp increase in Aids-related claims.

Already more than one percent of applicants for life insurance to Southern Life are found to be HIV-positive.

Southern has declined more than R36 million in life cover and the HIV infection rate has shown an 80 percent increase over the past year.

Special reserves of R250 million for Aids-related cases have been set up and Southern is receiving "good market response" to its Exclusive Life policy, which is more competitively priced than other products.

This involves testing for HIV every five years up to the age of 40, and when HIV is found to be positive, the sum insured is reduced to 10 percent of its original level.

Southern Life has moved strongly into the healthcare field and its Med-Help products account for 10 percent of new individual recurring premium income.

This is expected to peak at around 15 percent.

Calitz says the changes to the Medical Schemes Act offer considerable scope for innovation.

Southern is in a good position to offer managed healthcare products as it owns the second-largest medical scheme administrator Affiliated Medical Administrators and it acquired 50 percent of Medicor with ten private hospitals.

Giant med-aid scheme

By TERRY BETTY

THREE medical-aid schemes in the public service — Bonitas, Pro Sano and Sanitas — have united under the Bonprosan banner.

The funds have an income of more than R1,3-billion and a million beneficiaries.

Medscheme executive director Piet van der Merwe says Bonprosan will deal with the abuse of medaids by beneficiaries and the medical business.

It will provide the schemes with a common front to negotiate with suppliers, educate the beneficiaries and contain costs.

Mr van der Merwe says it will be able to promote or oppose legislation that affects medaids.

Bonprosan is still a confederation because the operations of the three have not been merged.

The eventual aim is to include all State and parastatal schemes.

Mr van der Merwe estimates that 11 schemes are likely to be targeted. He believes they would make annual payouts of about R3-billion and negotiate on behalf of 3-million beneficiaries.

Bonprosan will suspend direct payment to individual health-care providers if they are found to be abusing the system.

How AIDS is hidden from medical schemes

ST Times 23/5/93

DOCTORS in private practice throughout South Africa are circumventing medical aid scheme limits on the treatment of AIDS by submitting claims for the treatment of other ailments.

And AIDS is one reason why medical aid contributions are currently increasing faster than inflation, says Representative Association of Medical Schemes (Rams) chairman Stefanus Roodt.

Between 1985 and 1990, contributions rose by 34 percent.

The estimated average cost of treating an AIDS patient is R280 000 for a life expectancy of 8,5 years from diagnosis to death.

Most of South Africa's 186 registered medical aid schemes offer a maximum benefit of R600 a year for AIDS.

By JAMES BRITTAIN

Former Johannesburg General Hospital HIV clinic consultant Dr Steve Miller said he knew of numerous doctors who hid the AIDS virus in their claims to medical aid schemes.

Treatment is disguised as being for AIDS-related illnesses like pneumonia and tuberculosis.

A GP, who may not be named for ethical reasons, said he "never" declared his AIDS patients to medical schemes "because it would destroy their chances of proper treatment".

No statistics are available for the number of "legitimate" AIDS patients who are members of medical aid schemes, but even a small number would inflate the cost of benefits to other members.

Mr Gary Taylor, chief executive of Medscheme, which administers claims from 1,4-million patients, said that if one percent of any scheme's patients were treated for full-blown AIDS, monthly contributions for all other members would rise by 31 percent.

To solve the problem — which could threaten smaller schemes with bankruptcy — medical aid administrators are trying to devise new ways of approaching AIDS treatment.

Packages

A pilot project by a group of schemes — Affiliated Medical Administrators, Medicaid, Medscheme and Transmed — offers AIDS and HIV packages.

They cost considerably more than the average monthly contribution, but guarantee full cover to patients, including those who are HIV positive but still healthy.

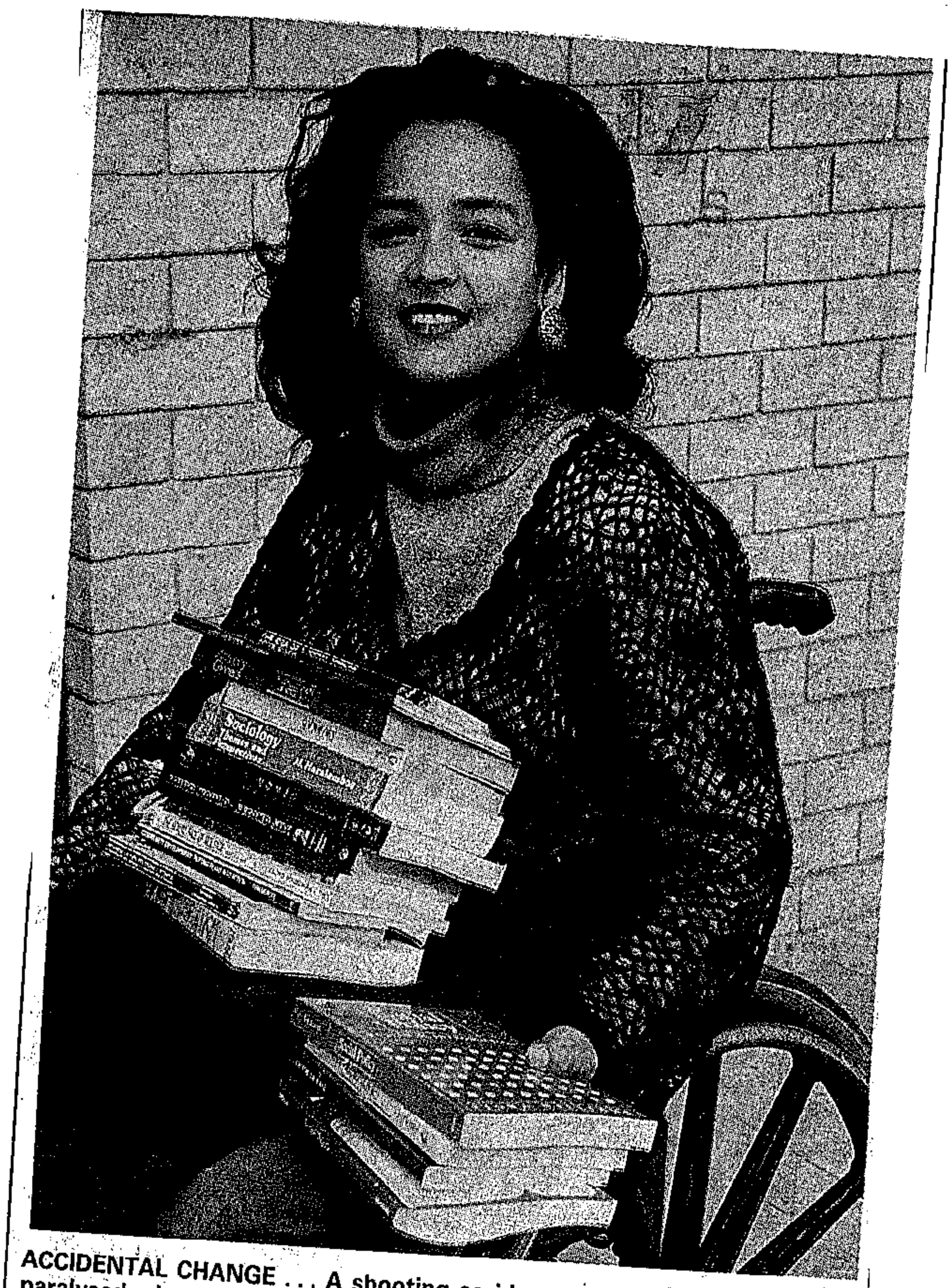
However, to qualify for the package, members must declare that they have the virus.

Mr Quentin Robinson, a director of Medicaid — one of South Africa's largest administrators — said a more open approach would not only ensure more effective treatment of AIDS, but could extend life expectancy to 14 years.

"Medical aid schemes are ignoring AIDS. If a member is HIV positive and the scheme knows it, patients cannot get the treatment they need.

"Most of our policies currently pay out between R600 and R2 500 a year, which is hopelessly inadequate.

"What we have to find is a way to provide proper benefits for AIDS patients without loading the subscriptions of other members," he said.



ACCIDENTAL CHANGE . . . A shooting accident which left Shanaaz Majiet paralysed, changed her view on gender issues Picture:AMBROSE PETERS

On course to break barriers

By JESSICA BEZUIDENHOUT

SHANAAZ MAJIET manoeuvres her blue wheelchair around her cosy flat at a University of Cape Town residence, carrying three cups of coffee on her lap, with ease.

She could be just another student having people over for coffee — but this brave 23-year-old is a paraplegic who is making things happen.

She lost the use of the lower part of her body in 1986 when she was accidentally shot by an ex-boyfriend.

Seven years after the incident, Shanaaz, now a law graduate doing a post-graduate diploma in organisation and management, is fighting for women's rights and those of disabled people. ST Times (C/Metro)

As regional convenor of the National Women's Coalition in the Western Cape, Shanaaz is looking at the needs of women. 2315193.

Her "sudden" disability, made her realise, that a lot of people — both men and women — "see women and they see disabled women". This needs to be changed, along with a lot of other misconceptions about gender issues, she says. 299 (ESOP)

A lot of past wrongs in our country are directly responsible for the stress a lot of mothers experience, she says.

Meanwhile Shanaaz is preparing for further studies at the University of London, starting in October this year. Shanaaz, who was accepted to do a master's degree in Community Disability Studies in Developing Countries, is currently battling to get a bursary, but "I'm not giving up hope".

Star 24/5/93

Medaids unite

Three public-sector medical schemes joined forces yesterday to form a confederation with an annual benefit payout of R1,3 billion. (299)

Bonprosan — comprising Bonitas, Pro Sano and Sanitas medical schemes and representing more than a million beneficiaries — intended to recruit more public sector schemes which supported similar objectives, CEO Piet van der Merwe said. — Staff Reporter.

Guguletu blind share vision of progress

South 2215 -2615193

By Sabata Ngcai

WHILE most blind people cannot read or write, an enterprising group who refuse to accept the label "disabled" are staffing an office in Guguletu.

The office belongs to the Western Cape Blind Association (Weba), which represents the interests of black blind persons.

Weba is based in a tiny backyard shack in Guguletu, scarcely large enough to hold the trappings of a normal office.

Inside is a small kitchen table and a wooden bench borrowed from the house where they are renting the "office" at R15 a month.

Two blind people, assisted by a sighted helper, perform all the tasks of the organisation. Their tasks include Weba's administration and fundraising.

Mrs Evelyn Siwa, the association's organiser, expertly uses a braille machine borrowed from the Athlone School for the Blind to draft letters to businesses requesting funds.

After her letters are drafted she passes them to her colleague, Mr Malibongwe Mxobo, Weba's chairperson, to type on a typewriter.

A volunteer sighted person, Ms Nomzuzu Ngqaleka, checks for mistakes before the letter is ready to be posted.

Weba's two sighted volunteers from the Guguletu community hold the portfolios of secretary and treasurer.

Siwa said the fact that they were unable to get more sighted volunteers was a handicap.

299

"We have been trying for a long time to call meetings in the community to let them know that there are blind people in the township and ask them for help, but no one seems interested," she said.

Weba was formed in May 1991 to uplift the standards of blind people in the Western Cape.

"We called it Weba because we wanted to cater for all blind people outside Cape Town," said Siwa.

She said the 50-member association was formed to make people aware that the blind were human beings who were capable of doing what others could do.

"There is a tendency among some members of our community to perceive blind people as useless creatures," Siwa said.

"We want to make people aware that we can make a meaningful contribution to the running of community affairs."

Siwa said Weba was also pushing for the abolition of special schools created for blind people.

"This makes us feel alienated, and not part and parcel of the community," she said.

Siwa, who studies through correspondence, said her college was unable to provide books in braille and she had to ask a sighted person to help her study.

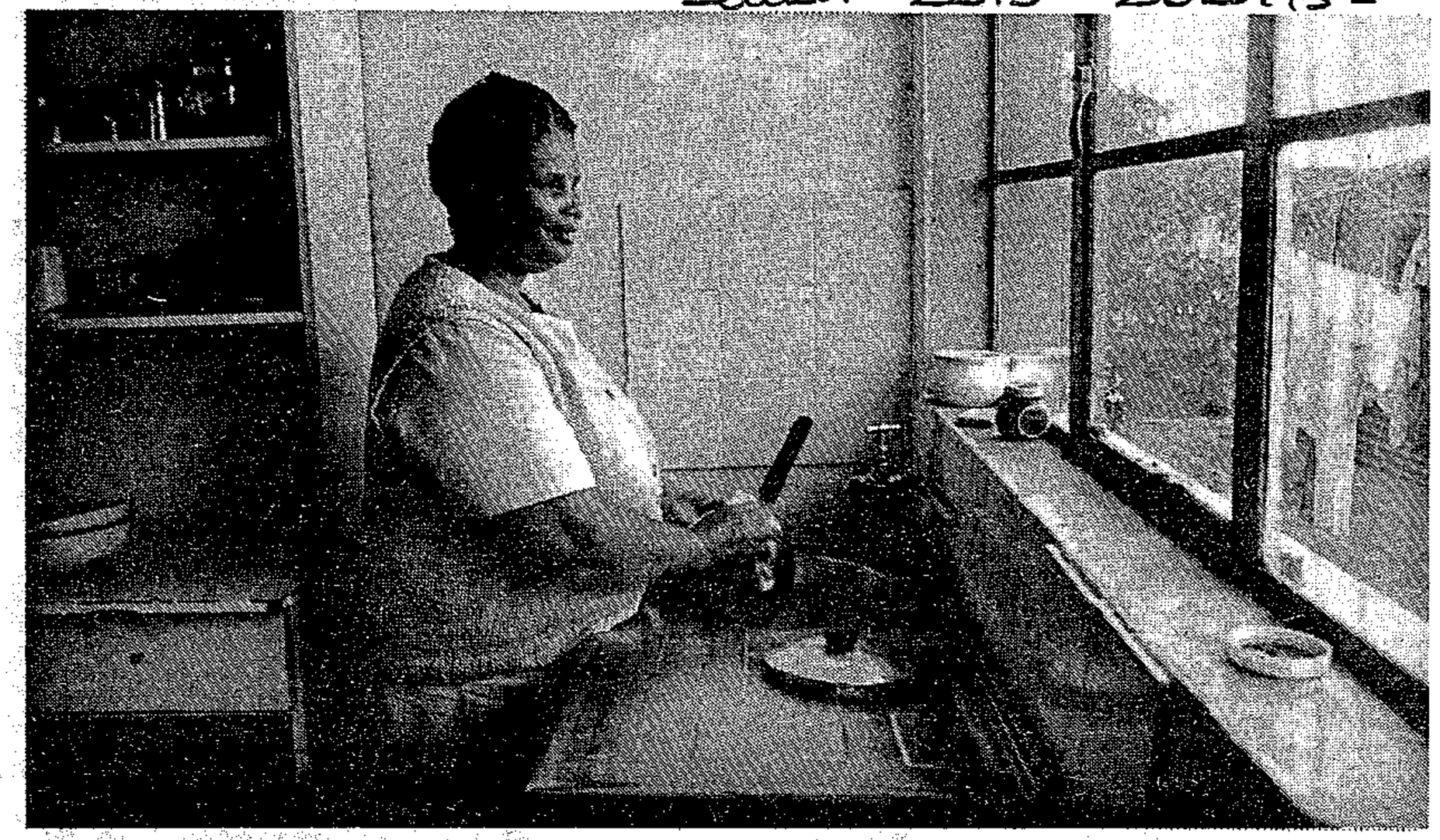
"Blind people should be given a chance and be allowed to attend the same schools as fully sighted people," she said.

She said Weba, although still cash-strapped and battling to raise funds, intended to offer skills training on "daily living" to blind people.

"They should learn to be independent and do what fully sighted people are doing," Siwa said.

"They should not expect someone to cook or wash for them, for example."

The only income Weba receives is from donations collected from Guguletu residents.



NOT DISABLED: Blind Guguletu resident Maria Gwala does all her household chores

Photo: Yunus Mohamed

Health care system must heal itself or choke on greed

BDM 27/5/93 - (299)

PETER BENINGFIELD

THE health care industry is in disgrace. We are widely perceived as unscrupulous, unethical and relentless in our exploitation of human suffering for commercial gain. Truly, if capitalism ever had an unacceptable face, this must be it.

Like the country as a whole, it is undergoing painful and profound changes which, if properly managed, could lead it onward and upward to a better future. But it is also bedevilled by the ruthless sectoral self-interest and the partisan bickering which characterises our political process.

The health care industry is a very broad association of bodies which range from manufacturers through pharmacists and doctors to the medical aids. This uneasy alliance somehow has to get to grips with the radical transformation required of SA's health care system.

The driving force behind this change is cost containment in the interests of providing affordable, accessible, high-quality health care for all SA's people by 2000 — only six years away.

It is interesting to note that US President Bill Clinton has appointed a high-powered task force, headed by his wife, to make sweeping changes to the US health care system. The task force's proposals might well contain such draconian measures as a government-imposed freeze on doctors' fees and medicine prices. Even at their mildest, they are still likely to give the US government a much more active role in controlling health care costs.

Why such a drastic departure from free-market principles in the world's foremost capitalist economy? This is how one US commentator explains it: "The health care free market has proved that it doesn't work, so only massive government intervention will."

This chilling verdict has ominous implications for us in SA.

We have to face the unpleasant truth that our health care system is ill — afflicted by soaring costs, cumbersome controls, overservicing in the private market and underfunding in the public sector, not to mention fraud and outright theft.

SA's private sector health care market spends about R10bn a year on itself. Public sector expenditure runs to a very similar amount — R11bn.

The problem is that the private market caters for a mere 20% of the population, while the public sector has to take care of the remaining 80%. And this is far from being the only or even the most glaring discrepancy in our delivery system.

Of our total expenditure, an almost negligible 4% goes to primary or preventative health care. About 69% is spent on secondary or curative care, and the balance on the tertiary level — heart by-pass operations and the like, regarded in some circles as elitist treatment to keep rich, old white people alive beyond their allotted spans.

Whether you share this view or not, it is indisputable that our priorities in the allocation of health care funds are badly disordered.

Our health care system was essentially designed to provide whites with a First World service, and is now belatedly being forced to adapt to meet the demands of a developing country in the Third World.

Government alone is not to blame.

All participants in the health care industry have to bear some of the responsibility. If we are to survive as an industry, let alone prosper, we should accept that responsibility and deal with its consequences.

In doing so, let's agree first of all that there's nothing wrong with the profit motive. By all means, let us serve our own ends — but let us serve society at the same time.

The days of unfettered laissez-faire capitalism — when a company's sole duty was to its shareholders and its social responsibility consisted of paying its taxes — are long gone.

Business is now expected to conduct itself in a manner acceptable not just to its owners but also to the community in which it operates; in short, to behave like a useful and respectable corporate citizen.

If we don't succeed in getting our house in order, there is little doubt that some sort of order will be imposed upon us. That order is likely to be imposed by a new government which might be inherently suspicious of the profit motive in health care. Our survival depends on our ability to demonstrate to such a new government and its constituents that the health care system is capable of behaving responsibly in a free market.

We will require a real co-operative effort.

The participants are deeply divided by short-sighted self-interest. This has resulted in seemingly petty turf battles between the professions, brutally aggressive lobbying by special-interest groups and some highly dubious competitive practices.

Through public manifestations of our differences, we have consistently portrayed ourselves as a squabbling and greedy industry.

What we need now is a general realisation that we have to overcome these differences; that we have to concentrate on the crucial issues that unite us and set aside the lesser ones that divide us; and that we have to make common cause to restore our ailing industry to health.

What we need, in bottom-line terms, is to introduce self-regulation, and to do so soon.

I propose the establishment of a private health care forum to unite all the major players in the system and commit them to self-regulation.

Such a forum should not be a cosy circle of friends or a mutual admiration society. It should not advance the cause of nepotism, nor should it fight for narrow and self-serving sectoral interests. What it should do is agree on standards of conduct acceptable to the community in which we operate and enforce these impartially, vigorously, publicly and if need be, ruthlessly.

In other words, it should be an industry bulldog which is not only equipped with a full set of teeth but does not hesitate to use them.

To achieve this, it should be small — with probably no more than between eight and 12 members — and it should have real power. Its members should not be administrators or flunkies or time-servers but the true movers and shakers of the industry. Nothing less than the chief executives of the main players will do.

It isn't going to be easy. It is going to be a real labour of Hercules — the cleaning up of the Augean stables, to be precise. But it has to be done.

The issue which stands out most prominently is that of cost — and, in particular, the cost of medicines. When the cost of medicines soars from 18% to 30% of the total health care bill in the space of just 10 years, then something has gone very wrong with the pricing system.

Here again I believe there is a strong case for self-discipline to limit the need for controls. The industry has to return to the traditional trading practice of cost plus, rather than working downwards from a recommended retail price. Instead of being professional traders, we should return to being trading professionals.

Current changes and such strong indicators as the ANC's health policy all point to one thing: that SA's pharmaceutical market of the future will be characterised by larger volumes and smaller margins. Prudent businesses and professionals will understand and accept this, and adjust their strategies accordingly.

I would like to suggest that the local and multinational pharmaceutical companies set aside their differences to take the lead in determining and applying the therapy required for this recovery process.

☐ Beningfield is SA Druggists MD. This is an edited excerpt from his address to the Pharmaceuticals 1993 conference in Midrand yesterday.

No. R. 966 **4 June 1993**

LABOUR RELATIONS ACT, 1956

FURNITURE MANUFACTURING INDUSTRY: AMENDMENT OF SICK BENEFIT SOCIETY AGREEMENT

I, Leon Wessels, Minister of Manpower, hereby—

(a) in terms of section 48 (1) (a) of the Labour Relations Act, 1956, declare that the provisions of the Agreement (hereinafter referred to as the Amending Agreement) which appears in the Schedule hereto and which relates to the Undertaking, Industry, Trade or Occupation referred to in the heading to this notice, shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 20 March 1994, upon the employers' organisation and the trade union which entered into the Amending Agreement and upon the employers and employees who are members of the said organisation or union; and

(b) in terms of section 48 (1) (b) of the said Act, declare that the provisions of the Amending Agreement, excluding those contained in clause 1 (1) (a), shall be binding, with effect from the second Monday after the date of publication of this notice and for the period ending 20 March 1994, upon all employers and employees, other than those referred to in paragraph (a) of this notice, who are engaged or employed in the said Undertaking, Industry, Trade or Occupation in the areas specified in clause 1 of the Amending Agreement.

L. WESSELS,

Minister of Manpower.

SCHEDULE

BORDER INDUSTRIAL COUNCIL FOR THE FURNITURE MANUFACTURING INDUSTRY

SICK BENEFIT SOCIETY AGREEMENT

in accordance with the provisions of the Labour Relations Act, 1956, made and entered into by and between the

Border Furniture Manufacturers' Association

(hereinafter referred to as the "employers" or the "employers' organisation"), of the one part, and the

National Union of Furniture and Allied Workers of South Africa

(hereinafter referred to as the "employees" or the "trade union"), of the other part,

being the parties to the Border Industrial Council for the Furniture Manufacturing Industry,

to amend the Agreement published under Government Notice No. R. 1457 of 11 July 1986 (hereinafter referred to as the Re-enacting Agreement), as amended, extended and renewed by Government Notices Nos. R. 431 of 27 February 1987, R. 848 of 16 April 1987, R. 341 of 4 March 1988, R. 478 of 17 March 1989, R. 1243 of 16 June 1989, R. 779 of 5 April 1990, R. 1889 of 9 August 1991, R. 923 of 27 March 1992, R. 1704 of 26 June 1992 and R. 354 of 5 March 1993.

No. R. 966 **4 Junie 1993**

WET OP ARBEIDSVERHOUDINGE, 1956

MEUBELNYWERHEID, GRENS: WYSIGING VAN SIEKTEBYSTANDSVERENIGINGSOOREENKOMS

Ek, Leon Wessels, Minister van Mannekrag, verklaar hierby—

(a) kragtens artikel 48 (1) (a) van die Wet op Arbeidsverhoudinge, 1956, dat die bepalings van die Ooreenkoms (hierna die Wysigingsooreenkoms genoem) wat in die Bylae hiervan verskyn en betrekking het op die Onderneming, Nywerheid, Bedryf of Beroep in die opskrif by hierdie kennisgewing vermeld, met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 20 Maart 1994 eindig, bindend is vir die werkgewersorganisasie en die vakvereniging wat die Wysigingsooreenkoms aangegaan het en vir die werkgewers en werknemers wat lede van genoemde organisasie of vereniging is; en

(b) kragtens artikel 48 (1) (b) van genoemde Wet, dat die bepalings van die Wysigingsooreenkoms, uitgesonderd dié vervat in klousule 1 (1) (a) met ingang van die tweede Maandag na die datum van publikasie van hierdie kennisgewing en vir die tydperk wat op 20 Maart 1994 eindig, bindend is vir alle ander werkgewers en werknemers as dié genoem in paragraaf (a) van hierdie kennisgewing wat betrokke is by of in diens is in genoemde Onderneming, Nywerheid, Bedryf of Beroep in die gebiede in klousule 1 van die wysigingsooreenkoms gespesifiseer.

L. WESSELS,

Minister van Mannekrag.

BYLAE

NYWERHEIDSRAAD VIR DIE MEUBELNYWERHEID, GRENS

OOREENKOMS VIR DIE SIEKTEBYSTANDSVERENIGING

ooreenkomstig die Wet op Arbeidsverhoudinge, 1956, gesluit deur en aangegaan tussen die

Border Furniture Manufacturers' Association

(hierna die "werkgewers" of die "werkgewersorganisasie" genoem), aan die een kant, en die

National Union of Furniture and Allied Workers of South Africa

(hierna die "werknemers" of die "vakvereniging" genoem), aan die ander kant,

wat die partye is by die Nywerheidsraad vir die Meubelnywerheid, Grens,

tot wysiging van die Ooreenkoms gepubliseer by Goewermentskennisgewing No. R. 1457 van 11 Julie 1986 (hierna die Herbekragtigingsooreenkoms genoem), soos gewysig, verleng en hernu by Goewermentskennisgewings Nos. R. 431 van 27 Februarie 1987, R. 848 van 16 April 1987, R. 341 van 4 Maart 1988, R. 478 van 17 Maart 1989, R. 1243 van 16 Junie 1989, R. 779 van 4 April 1990, R. 1889 van 9 Augustus 1991, R. 923 van 27 Maart 1992, R. 1704 van 26 Junie 1992 en R. 354 van 5 Maart 1993.

1. SCOPE OF APPLICATION OF AGREEMENT

(1) The terms of this Agreement shall be observed in the Border Furniture Manufacturing Industry—

(a) by all employers who are members of the employers' organisation and by all employees who are members of the trade union and who are engaged or employed in the said Industry;

(b) within the Magisterial Districts of Albert, Aliwal North, East London (excluding that portion which, prior to the publication of Government Notices Nos. R. 1877 of 4 September 1981 and R. 1079 of 10 June 1988, fell withing the Ciskei), Fort Beaufort (excluding that portion which, prior to the publication of Government Notice No. 1904 of 30 August 1985, fell within the Magisterial District of Stockenström), Queenstown (excluding that portion which, prior to the publication of Government Notice No. R. 1904 of 30 August 1985, fell within the Magisterial District of Stockenström) and Stutterheim.

(2) Notwithstanding the provisions of subclause (1), the terms of this Agreement shall apply—

(a) only to employees for whom minimum wages are prescribed in the Main Agreement;

(b) to apprentices only in so far as they are not inconsistent with the provisions of the Manpower Training Act, 1981, or any contract entered into or any condition fixed thereunder.

2. CLAUSE 12: BENEFITS

In subclause (1) (d) substitute the expression "R10,00" for the expression "R4,00".

3. CLAUSE 16: CONTRIBUTIONS

In subclause (3) substitute the expression "10th day" for the expression "seventh day", and add the following new paragraph after the expression "determine.";

"Should any amount due in terms of this clause not be received by the Council by the 10th day of the month following the month in respect of which it is payable, the employer shall pay interest on such amount or on such lesser amount as remains unpaid, calculated at the rate of two per cent per month or part thereof from such 10th day until the day upon which payment is actually received by the Council: Provided that the Council shall be entitled in its absolute discretion to waive payment of such interest or part thereof.".

Signed at East London, on behalf of the parties, this 10th day of March 1993.

N. G. TERBLANCHE,

Chairman of the Council.

G. M. MANN,

Vice-Chairman of the Council.

W. J. CHERRY,

Secretary of the Council.

1. TOEPASSINGSBESTEK VAN OOREENKOMS

(1) Hierdie ooreenkoms moet in die Meubelnywerheid, Grens, nagekom word—

(a) deur alle werkgewers wat lede is van die werkgewersorganisasie en deur alle werknemers wat lede is van die vakvereniging en wat onderskeidelik betrokke is by of werksaam is in genoemde Nywerheid;

(b) in die landdrosdistrikte Albert, Aliwal-Noord, Fort Beaufort (uitgesonderd die gedeelte wat voor die publikasie van Goewermentskennisgewing No. 1904 van 30 Augustus 1985 in die landdrosdistrik Stockenström geval het), Oos-Londen (uitgesonderd die gedeelte wat voor die publikasie van Goewermentskennisgewings Nos. R. 1877 van 4 September 1981 en R. 1079 van 10 Junie 1988 in Ciskei geval het), Queenstown (uitgesonderd die gedeelte wat voor die publikasie van Goewermentskennisgewing No. R. 1904 van 30 Augustus 1985 in die landdrosdistrik Stockenström geval het) en Stutterheim.

2. Ondanks subklousule (1), is hierdie Ooreenkoms van toepassing—

(a) slegs op werknemers vir wie minimum lone in die Hoofooreenkoms voorgeskryf word;

(b) op vakleerlinge slegs in die mate waarin dit nie onbestaanbaar is met die Wet op Mannekragopleiding, 1981, of met 'n kontrak daarkragtens aangegaan of 'n voorwaarde daarkragtens vasgestel nie.

2. KLOUSULE 12: BYSTAND

In subklousule (1) (d) vervang die uitdrukking "4,00" deur die uitdrukking "R10,00".

3. KLOUSULE 16: BYDRAES

In subklousule (3) vervang die uitdrukking "sewende dag" deur die uitdrukking "10de dag", en voeg die volgende nuwe paragraaf in na die uitdrukking "stuur";

"Indien die Raad 'n bedrag verskuldig ingevolge hierdie klousule nie ontvang teen die 10de dag van die maand ná die maand ten opsigte waarvan dit betaalbaar is nie, moet die werkgewer op sodanige bedrag of op sodanige kleiner bedrag wat onbetaal bly rente betaal, bereken teen twee persent per maand of gedeelte daarvan vanaf dié 10de dag tot die dag waarop die Raad die betaling werklik ontvang: Met dien verstande dat die Raad geregtig is om na goeddunke die betaling van sodanige rente of 'n gedeelte daarvan kwyt te skeld.".

Namens die partye op hede die 10de dag van Maart 1993 te Oos-Londen onderteken.

N. G. TERBLANCHE,

Voorsitter van die Raad.

G. M. MANN,

Ondervoorsitter van die Raad.

W. J. CHERRY,

Sekretaris van die Raad.

No. R. 969 **4 June 1993**

MANPOWER TRAINING ACT, 1981

EXTENSION OF THE APPRENTICE TRAINING SCHEME FOR THE LOCAL AUTHORITY UNDERTAKING

I, Leon Wessels, Minister of Manpower, acting in terms of section 39 (3) of the Manpower Training Act, 1981, hereby extend the period fixed in Government

No. R. 969 **4 Junie 1993**

WET OP MANNEKRAGOPLEIDING, 1981

VERLENGING VAN DIE VAKLEERLINGOPLEIDINGSKEMA VIR DIE PLAASLIKE OWERHEIDSONDERNEMING

Ek, Leon Wessels, Minister van Mannekrag, handelende kragtens artikel 39 (3) van die Wet op Mannekragopleiding, 1981, verleng hierby die tydperk

Substitution could boost health care

Star 5/6/93

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USING cheaper equivalent drugs is a potent means of curbing spiralling medicine prices, but patients must not lose the right of choice, writes a Finance Staffer.

WIDER use of generics could slash South Africa's rapidly mounting medicines bill by millions of rands, says Lennon generics chief executive David Stubbins.

At the South African Association of Medical Schemes conference at Sun City this week, he said the annual saving from substituting the generic equivalent for just one single original product - a well-known antibiotic - could amount to R6,4 million.

"If we pick half-a-dozen widely used original products at random and calculate the price difference between them and their generic equivalents, we see that subsitution of these products alone could save a staggering R25 million a year. Extrapolate that across the full pharmaceutical spectrum, and the potential saving runs into hundreds of millions of rands," Stubbins said.

Storm

"The use of generics is obviously a very potent means of curbing the apparently uncontrollable upward spiral in medicine prices. It has been suggested that generic substitution, widely practised overseas, should be one of the mechanisms for achieving this.

"Yet when it was allowed in South Africa briefly in the mid-Eighties it drew a storm of protest from vested professional and commercial interests.

"The authorities backed down and a legal technicality was used to disallow it. Since then, any debate on the merits of generic substitution has inevitably provoked a factional squabble."

However, growing public outrage over high medicine prices was forcing the authorities to re-examine the situation, and it was unlikely that the advent of substitution could be resisted indefinitely.

The maximum medical aid price system — under which medical aid members were reimbursed only for the cost of a generic equivalent no matter what was prescribed, introduced by many schemes — amounted to a kind of de facto generic substitution.

"Patients have rights, like any consumer. These include the right to be informed, the right to be consulted and, ultimately, the right to choose. To exercise this right, they need the help of professional pharmacists, who should be empowered to substitute medicine — provided this is done with the patient's consent," Stubbins said.

Myths

"We must avoid the imposition of mandatory substitution, as has happened in some states in the US, as this removes the patient's right of choice. The most desirable kind of generic substitution is one in which the patient, the doctor and the pharmacist cooperate in arriving at a course of treatment which will cure the patient without inflicting an unnecessarily painful financial blow on him or her."

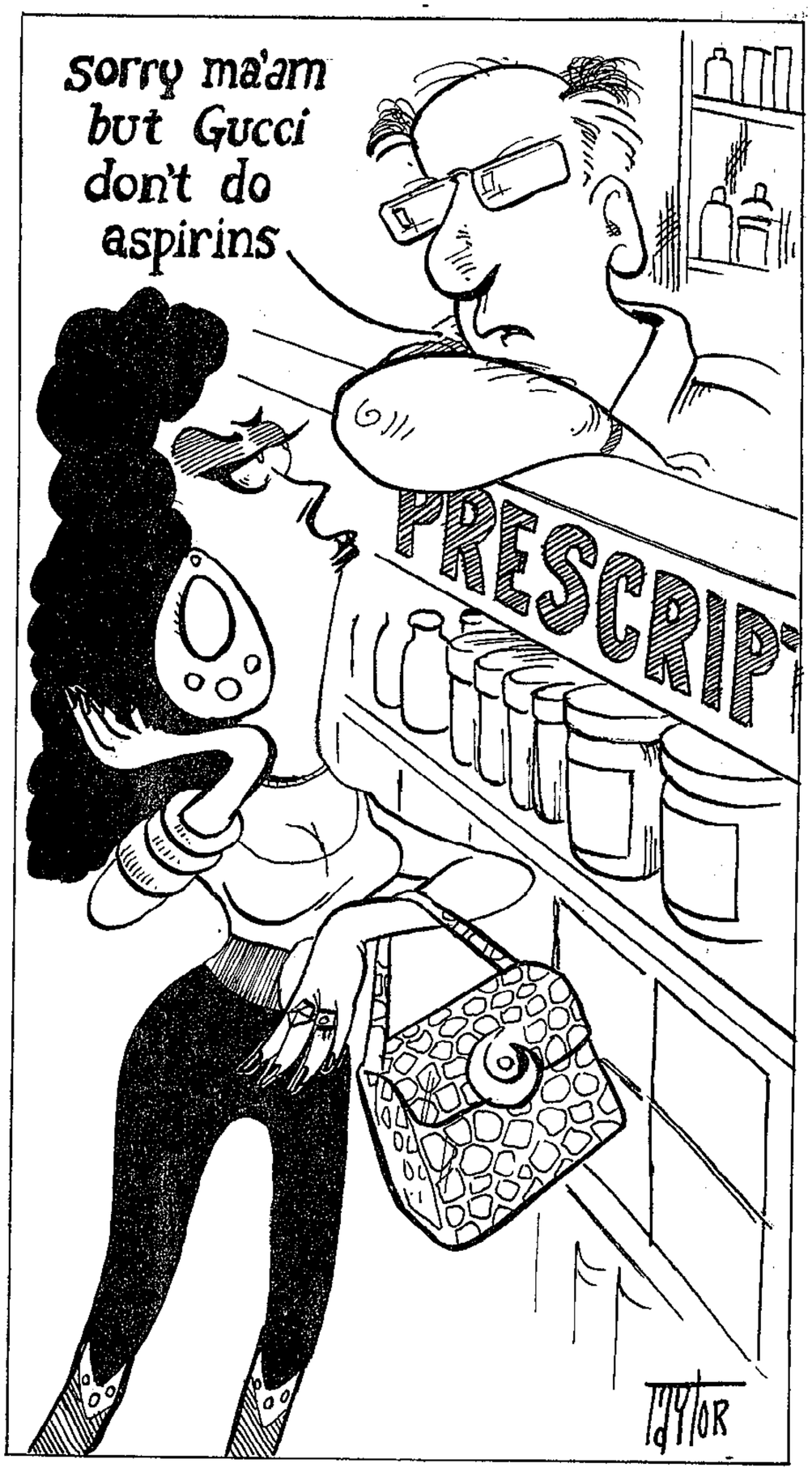
Stubbins said the polemic surrounding generics had spawned myths such as that they were not equivalent to the originals, and that because they were considerably less expensive they were of lesser quality.

"All generic medicines sold in South Africa are registered with the Medicines Control Council. It is a requirement for such registration to show that the product is therapeutically equivalent — in plain English, that a similar dosage taken under similar conditions will have a similar effect to the original's.

"In order to achieve this, the generic must contain the same active chemical ingredient in the same strength and dosage form as the original. In some instances the generic company actually sources this active ingredient from the original manufacturer.

"The quality question is simply not an issue. The generic costs less primarily because it does not enjoy patent protection and therefore has to compete head-on with other generics in the marketplace. It also does not have to fund a corporate research and development treasury. But as far as manufacturing technology and capability are concerned, the major generic manufacturers are in the same league as the multinational producers of original medicines."

Generics 'will cut millions from bill'



Key guidelines for the best in medaid cover

6/6/93

Business Times Reporter

ADEQUATE and affordable health-care provision is one of the most important issues facing companies and employees.

Momentum Health managing director Adrian Gore says a company reviewing its medical-aid membership should look out for the 11 mandatory principles he has compiled.

Mr Gore says: "Every financial director has a stack of medical-aid brochures, each claiming to be the best. Because of changes in the Medical Schemes Act from September, it is no surprise that confusion reigns."

Major changes to the Medical Schemes Act include the removal of a scale of benefits tariff, scrapping of minimum and maximum benefits and removal of guaranteed payment for medical-service providers.

Mr Gore's principles:

Comprehensive cover: Only about a third of medical-aid expenses are hospital costs.

Out-of-hospital expenses can be financially devastating and cover must be provided here as well. It must increase with medical inflation and not be subject to a limit.

Benefits should be based on costs incurred: It doesn't take a genius to work out that if hospital cover is set at R300 a day, or R30 000 a bypass, for example, the patient will either be overpaid or underpaid. It has no relevance to the actual costs.

Cost containment: A medical-savings account approach provides the best kind of incentive. It forces individuals to choose between health care and other uses for their own money. It limits abuse of the system by both patients and health-care providers.

Lifelong

Value for money: Standard medaids schemes are unattractive to the healthy who make no claims and for the very sick who are not adequately covered. Low claimers will stay in a scheme if there are individual tangible benefits such as a savings account.

Guaranteed renewable cover: It is no use joining a scheme and becoming ill in your first year of membership only to discover that you are a bad risk and your cover is cancelled. You won't be able to get cover anywhere else by then.

Cover throughout life: Employees and their spouses should have lifelong cover. Many schemes stop cover at age 65 or 70 on the grounds that you will have accrued enough in a savings account to cover any big bills. But most medical costs arise over the age of 70. It is frightening how fast you could go through your R100 000 savings.

Funding for pensioners: Mr Gore, an actuary, says sound actuarial provision must be made for a member's own needs in advanced age. Failure to do so will leave the employer with a huge unfunded liability and the member potentially without cover. There should be a reserve of R500 000 for every pensioner plus spouse on the scheme. Most schemes have barely a few thousand rands per pensioner in reserve.

The other four guidelines can be grouped under a common-sense banner. The scheme should be easy to understand, administratively simple, efficient, especially in relation to tax, and flexible.

Mr Gore considered these elements when structuring Discovery, Momentum Health's product range.

Aimed at companies with 50 or more employees, the scheme has attracted members from many listed companies.

'Presmed's earnings to grow 20%'

EDWARD WEST

PRESIDENT Medical Investments (Presmed) was confident of achieving annual compounded earnings growth of at least 20% for the five-year period to end February 1996, chairman Naudé Bremer said in the group's annual report.

Presmed operates six private hospitals and 10 day clinics. In the year to end-February 1993, the group's growth pattern was maintained in spite of the reduction of the size of the market and increased competition, Bremer said.

Earnings a share climbed to 23c (19,3c) on a 19% increase in turnover to R95,8m (R80,38m). The dividend was lifted 25% to 5,25c (4,19c).

The charging of contracted-in medical aid fees contributed to retaining market share. The smaller patient base was largely due to reduced medical aid membership as well as medical aid members running out of cover before year-end.

Last year was the first in which doctors reported inquiries from patients about the cost of hospitalisation prior to admission, Bremer said.

A pyramid company to Presmed, President Medical Investment Holdings (Preshold), was expected to be listed on July 1 following the closure of a R11m rights issue on May 28. Funds from the rights issue would be used to fund the three new day clinics, Bremer said.

Professionals satisfied with Sanlam

Star 8/6/93

ONE marriage which seems to have been made in heaven, is between the Professional Provident Society and Sanlam, and has been happy for over 30 years.

The Professional Provident Society (PPS) was founded on July 8 1941 by a group of concerned dentists who realised they were unable to obtain non-cancellable sickness and disability benefits from assurance companies who were active in SA at the time.

The aim and object of the founders was to create a mutual organisation in terms of which professional men and women could assist one another in times of illness or in the event of permanent incapacity.

Today, PPS is a substantial organisation, with a membership of more than 50 000 graduate professionals from all professional groups and its assets are valued at over R700 million.

Members subscribe for "shares" in the Society, which are in fact units of benefit that provide them with the amount of cover they require. All surplusses from the operation of the Society are annually credited to members in proportion to their shareholding and each member's accumulated lump sum is paid to him on resignation or retirement from the Society, tax free.

The association goes back to 1958 when Sanlam started to underwrite the Society's group life scheme. Two years later the Society decided to launch its own retirement annuity scheme for members and Sanlam successfully tendered to underwrite the scheme.

This scheme, with assets in excess of R1,5 billion, is still administered by Sanlam, together with the PPS group life scheme.

For Sanlam, PPS represents its largest corporate member.

Sanlam markets all the PPS products, which include two further items not underwritten by Sanlam. These are four different types of shares, essentially to provide disability income and Profmed, the Society's medical aid scheme.

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Desmond Smith, Sanlam's newly appointed managing director has worked closely with the Society for about 16 years. Smith estimates the group life scheme might be the largest in South Africa, but he confirms it is the biggest handled by Sanlam.

However, while PPS is financially the most valuable, it is not the largest in terms of membership. Individual members pay substantial annual contributions thereby creating large volumes of income.

"PPS is a unique organisation in terms of its legal status. Originally it was registered as a friendly society or a benefit fund essentially to provide disability cover for its members.

However, PPS out of surplus funds and investment income, is declaring a dividend almost equal to the individual contributions. This is tantamount to members obtaining free benefits while building up a retirement fund with both income and benefits being tax-free," reports Etienne Huggett, PPS general manager.

Sanlam has a separate department at its head office in Bellville, which acts as an interface with PPS and the agents.

The one important issue for PPS is independence. Through a market survey, the Society was able to confirm to its members that the Sanlam relationship was justified.

Other life companies wishing to gain a share in the action or even to take over the underwriting from Sanlam have been unsuccessful.

ing day) was paid out in benefits.

Looking for a healthy policy

Star 8/6/93

299

The Steinmetz report, given wide coverage in The Star recently, has made far-reaching recommendations designed to rationalise South Africa's ailing health services. Health Writer DAVID ROBBINS asked two major stakeholders and one expert observer to respond in detail to these recommendations.

THE creation of a single health department, new funding arrangements for hospitals, pharmaceutical and academic hospital reforms — these are among the most important Steinmetz recommendations.

But the composition of the committee which made them has already been questioned.

"A single businessman (Gerard Steinmetz) and 15 senior civil servants together have a very narrow perspective," says the ANC. "It seems incredible that a government ostensibly committed to negotiations could, in September 1992, set up a committee with such narrow experience. Once again, the views of the majority of South Africans, and even the views of most nurses, doctors and other health workers, were simply not solicited."

The Medical Association of South Africa (Masa) echoes this criticism, commenting that since a significant number of Masa's membership was employed in the public health sector, the association would have been ideally positioned to provide "appropriate input".

And Dr David Harrison, executive director of the Durban-based Trust for Health Systems Planning and Development, describes the Steinmetz report as "an attempt to accomplish too much with too little discussion".

But what of the recommendations themselves?

Firstly, there's the restructuring of the health service into a "decentralised one-channel structure", which means a single health department with powerful regional authorities.

Harrison sees a commitment to a unitary health system, but reservations are expressed about leaving the private health sector out of the restructuring process.

"It's not clear whether the private sector will be further regulated, limited, or integrated into regional managements," Harrison says. "We're simply not told how Steinmetz sees this R8 billion-a-year industry."

The ANC sees other dangers. "The committee recommends that 14 health departments be brought into one central and nine regional health departments. This sounds better, but the proposed powers of these regional departments appear to be even greater than those of the present provincial health departments. One form of fragmentation could simply be replaced by another."

The ANC is also concerned that the central department will not have effective control over the regional authorities.

"Although it is right that the national department should not be responsible for the provision of health services, it cannot absolve itself, as the report suggests, of the responsibility for these services. It must ensure that service provision is in line with national policy by controlling the national budget."

Then there's the new method of funding. The recommendation here is that hospitals and other health institutions are no longer funded via a budget, but directly through the services rendered to individual patients.

This shift away from the funding of institutions on a historically established budget is welcomed by the ANC, but the proposed solution — the funding of the individual — is criticised as "the totally discredited 'fee for service, third party payment' system that is largely responible for the collapse of the private health care sector".

The ANC says: "It is also a system that actively promotes over-servicing and other forms of abuse."

Harrison calls the new fund ing recommendation a good budgeting idea, but questions its effectiveness.

Masa is even more forthright: "The conversion of health institutions and services into private enterprises, with powerful incentives to treat patients who are capable of paying for health care (private patients) is likely to deprive State-dependent patients, and force State-sector providers into an already over-serviced private sector, with potentially destructive effects to both sectors."

A more rational approach to funding, according to the ANC, "would be to allocate funds on the basis of the size of the community to be served and the standards of service to be provided".

Most controversial of the Steinmetz recommendations is the suggested closure of three of seven academic hospitals.

"There may well be good arguments for rationalising the medical schools," says the ANC. "However, the argument offered — that we are producing too many doctors because, despite the brain drain, the number of doctors registered with the SA Medical and Dental Council is not declining — is facile.

"Much more serious discussion is required concerning the numbers, types and training of all categories of health workers needed for South Africa.

"Doctors, and their training, are obviously important, but so are nurses, members of the allied medical professions, managers, and possible new categories of health workers."

The management and autonomy of academic hospitals concerns Dr Harrison: "I see a glaring deficiency in this report, according to which the academic hospitals will fall under neither the national nor the regional authorities.

"Is there to be total management autonomy? We believe this to be impossible. Or is this a loose end which Steinmetz forgot to tie up?"

Other recommendations in the Steinmetz report concern the redistribution of doctors to service the many neglected rural areas; an overhaul of pharmaceutical policy, with the emphasis on generic medicines and a new stock-control system to reduce the current high levels of theft; and a system of reciprocity between the public and private sectors to enable health-care facilities to be better used and serviced.

Masa says of this last recommendation: "The report pays lip service to the relationship between the public and private sectors. We agree that a carefully designed, well-integrated relationship should evolve at both provider and funding levels.

"Medical schemes could administer and manage State funds, and private health service professionals and other service providers could deliver services to State patients. However, the public sector should be reluctant to enter into commerce with taxpayers' money (as the Steinmetz report suggests), or fund and deliver health services which are not part of their responsibility."

Responding to the recommendation that newly graduated doctors should be contractually obliged to serve for a set period in rural areas, Harrison remarks: "Relegating graduates to some far-flung rural settlement because there is no organised health service there may fail precisely because there is no organised health service there."

Harrison does maintain, however, that the report demonstrates a commitment to a unitary health service, that it makes a serious attempt to achieve appropriate budgeting and financial control mechanisms, and that it is serious about mobilising funds for primary health care.

The ANC, by contrast, finds that "the clear implication in the report is that the answer to balancing the public health budget is to cut services".

"Faced with the unpleasant and difficult tasks of rooting out theft and fraud, estimated by the committee at R500 million a year in stock losses alone, of cutting jobs in the bureaucracy, and of eliminating the duplication of services, this committee of civil servants has opted instead for the easy option (for them) of cutting services.

"It must not be allowed to happen," the ANC concludes. "Now is the time for better alternatives." □

Clinic sees benefit of structural changes

BDay 11/6/93

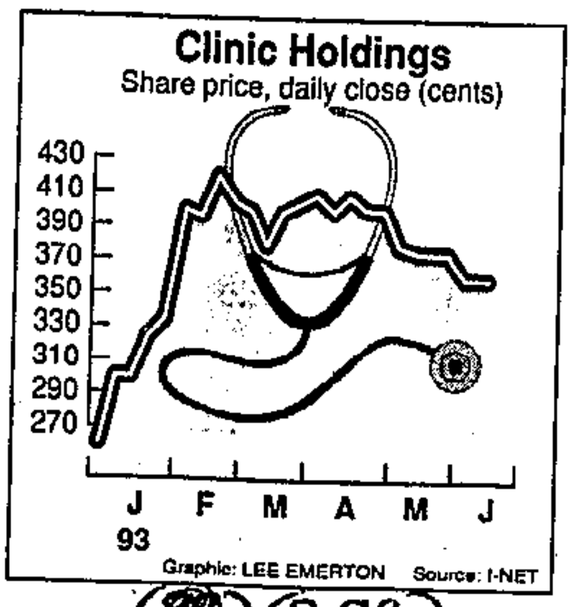
MARCIA KLEIN

PRIVATE hospital group Clinic Holdings, which has announced significant structural changes over the past few months, has increased earnings by 15% to 16,72c (14,5c) a share in the six months to end-March.

In April the group announced plans to merge the hospital trading operations and property interests in a R585m deal as well as a rights offer of R395,6m to finance the deal.

Although actual turnover figures are not given, turnover based on an index increased by 17% in the six month period. Operating profit rose by 16% to R52,6m from R45,5m.

Directors said despite the recession and "the disappointing tariff increases published in the 1993 medical schemes scale of benefits", the group had, as forecast, shown real growth in turnover and operating profit.



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A change from the previous period's report is that results reflect rent paid for the two months to end-November and financing costs from December 1 relative to the acquisition of the property interest.

After rent of R7m (R17m) and financing costs of R23,6m from a previous R920 000, pretax profit declined by 20% to R22,1m from R27,6m.

But a lower tax charge enabled the group to show a 15% rise in attributable profit to R16,6m (R14,4m). The interim dividend was 8% higher at 6,5c (6c) a share, with an increased dividend cover to 2,57 (2,42) times.

Directors said the health care industry was faced with "unprecedented challenges" in the current environment. The new Medical Schemes Amendment Act, a reduction in the membership of medical aid schemes and the 1993 medical schemes scale of benefits would "have a direct bearing on trading results".

But the group continued to be well positioned to meet the challenges.

Star 15/6/98

Health-care costs make you ill

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BITTER PILL
Illness has become an extremely lucrative business. **LANA JACOBSON** looks at the just some of the reasons behind spiralling health-care costs.

IMAGINE a world full of healthy people ... What would happen to the world economy? What would happen to the mega-billion-rand drug industry? What would the powerful pharmaceutical companies dream up next?...

Perhaps they could package "consumer friendly" sacks of unpolluted air. Perhaps that's on their drawing boards.

It is hardly a secret that medical costs in South Africa have reached the stratosphere in price and that prescription drugs are the main target of consumers' and health-care reformers' wrath.

But, can anything be done?

Invariably, when the topic is scrutinised, the debate boils down to paying exorbitant prices for drugs or not having them at all.

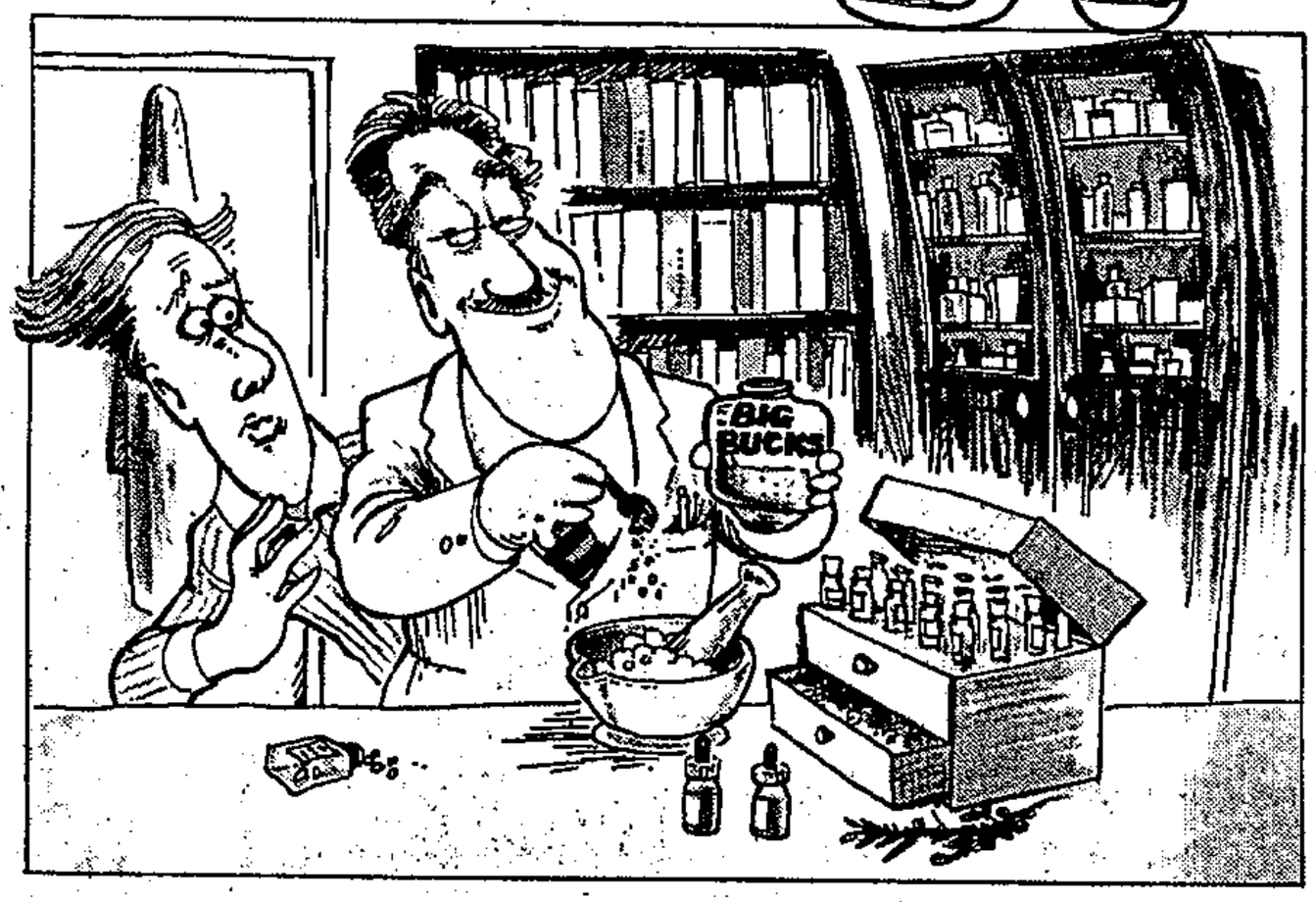
Pharmaceutical research laboratories make a powerful argument that developing tomorrow's antidotes is a big-money venture.

"It costs upwards of $200 million (about R640 million) to get a product to market," says a spokesman for American multinational Johnson & Johnson.

Moreover, says Martin Jennings, Glaxo corporate affairs manager in Isando, drugs may be expensive, but they offer substantial savings and personal freedom from a lengthy stay in the hospital.

"More attention should be given to the debate of quality of life aspects in the treatment of disease," he says.

The current market-oriented, under-insured US health-care industry has become a focal point of President Bill Clinton's administration. By appointing his no-nonsense wife, Hillary, Clinton is determined to get medical costs to return to earth and that a majority of Americans be able to afford adequate health insurance.



While the critical situation in the US may seem strikingly similar here, we actually face a double whammy: Our marketplace is small and few active ingredients for medicines are manufactured in South Africa, other than paracetamol and aspirin.

"All active ingredients are imported, and our weakening exchange rate makes it nearly impossible to keep costs down," says a retailer of a large pharmaceutical firm.

Typically, aside from the capital employed for development, a medication's price must include the costs of:

- Sugar-coating or encapsulating;
- Packaging and labelling;
- Marketing;
- Quality control;
- Storage;
- Distribution.

What is most alarming is the quantum escalation of prices from factory to patients. While the mark-ups in the US and the UK are typically in the range of 20 percent, in South Africa the figure is well above 100 percent, not including VAT. The reason is largely due to much heftier profit margins by wholesalers and pharmacists.

And then there are the inflation-busting price increases ordered by the pharmaceutical companies. There is no shortage of examples.

In the US, Wyeth-Ayerst raised the price of Premarin, an oestrogen replacement used during menopause, 131 percent between 1985 and 1990, according to a recent Senate report.

Johnson & Johnson stirred outrage last year by charging the equivalent of R3 900 for a dose of its colon-cancer treatment Ergamisol, even though another firm sells a veterinary drug with the same active ingredient, Levamisole, for just R42.

In its defence, J & J said that it reformulated its version for human use and the price of its drug was comparable to other cancer treatments available here.

And there's an ulcer medication that costs R300 for 30 pills. "That price was an instant cure for my ulcer," quipped one patient.

Other overlooked factors include salary demands, labour union problems and the increase in price of the actual organic compounds. And we haven't even touched on replacing ageing plant and equipment.

True, it can be argued that people are living longer; they are taking expensive pills that may not always cure the condition, but do allow sufferers to maintain and prolong their life span.

But the bitter pill doesn't end at the pharmacy counter. Consumers must either pay more to medical aid schemes as they continue to increase patients fees, or limit their benefit payments.

Medical aid companies reason that there are only two ways of controlling the escalation. Either they give less return for members' money, or they increase their fees. Generally they seem to do both!

Irate members who are relatively healthy, and never reach their allotted yearly limit also complain that the healthy support the sick and infirm.

Perhaps before reaching for the medicine cabinet, you should settle for a scotch on the rocks, a long walk, or a session of deep breathing. It will certainly be much cheaper ... and maybe, just maybe, healthier as well.

Med-Aid hope for patient-operated painkiller

Health Reporter

THE maker of a device that enables patients to administer their own post-operative painkillers is to meet six of the biggest medical aid societies to persuade them to allow patients to claim for it.

The disposable infusion device is part of a new trend in post-operative care called patient-controlled analgesia (PCA).

It is worn on the wrist and the patient presses a button when a dose of painkiller is needed.

A lock prevents the button being pushed too often so that dose injected, under the skin or directly into the veins, is given time to take effect.

British anaesthetist Dr David Rowbotham said the device was routinely used in hospitals there because it was cost-effective.

He said each person's pain control need differed and doctors tended to err on the side of caution when prescribing injections.

The device enabled patients to establish their own levels and made them happy because they were in control.

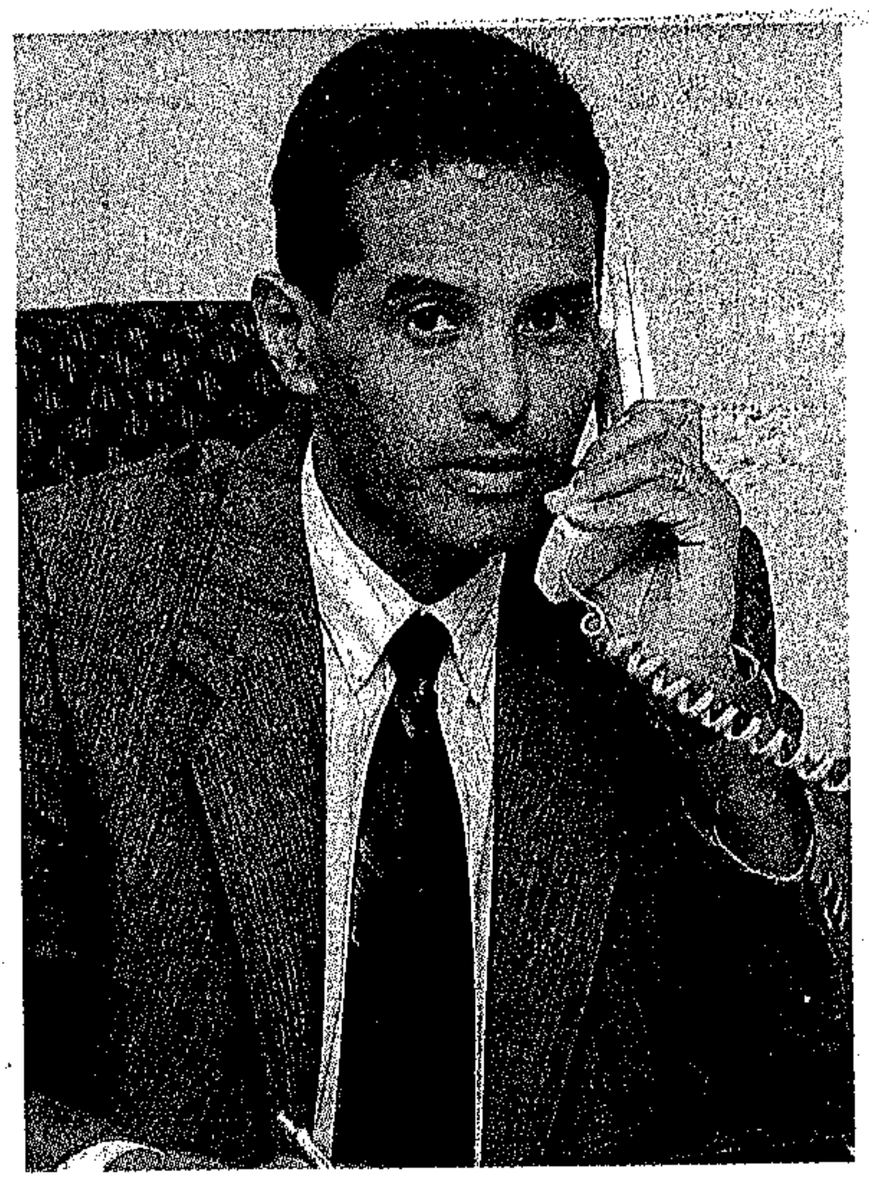
Consequently, patients moved about sooner after operations, avoiding secondary complications such as chest infections. They were also discharged from hospitals earlier.

Adcock Ingram product manager Mrs Elaine Gregory said 7 000 South African patients had used the disposable device, which was introduced here six months ago.

She said the meeting with medical aid societies was to discuss making it a reimbursable item. It cost about R200 but some private hospitals marked it up considerably.

The device has been used most frequently after hysterectomies and orthopaedic, cardiovascular and neuro surgery.

Mrs Gregory said nurses were particularly supportive of the device.



ON CALL . . . Mr Faldie Kamalie mans the new hotline

Hotline on Medical aid

By JESSICA BEZUIDENHOUT

A MEDICAL aid company, concerned about the alarming increase in the abuse of medical aid schemes, is to start the country's first abuse hotline. Pro Sano's hotline, due to start this week, will operate from Mondays to Fridays and the public can phone in with fraudulent claims.

The company, a state-assisted medical aid scheme for state employees, loses up to R25 million a year as a result of abuse, said Mr Faldie Kamalie, appointed to investigate fraudulent claims.

"This directly contributes to increases in membership subscription fees," he said.

Calls will be confiden-

Medical aids to be more cost-effective

CT 23/6/93 (299)

EQUAL STATUS FOR ALL HEALTH CARE AS NEW ACT TAKES EFFECT

THE new Medical Schemes Amendment Bill, as accepted in February, will come into force on September 1 1993. With this, health care, treating all concerned parties equally, becomes available.

The amendment to the Act is intended to make health care less expensive through the cost-effective use of all medical services. Not only will the amendments be backed by healthy business principles but will also increase competition through deregulation.

The amendments to the Act retain the status quo by giving equal status to all the participants in the health care arena. In practical terms, this means that only insurance companies registered under the Medical Schemes Act will be allowed to administer medical schemes.

To be able to provide less expensive health care, medical schemes and insurance companies will have to work together. Costs can be reduced drastically by pooling risks and re-insuring.

Co-responsibility

According to Dr Laubscher, GM of Visimed, his company has successfully applied the principles of the amendments since early 1992, namely risk-managed health care cover.

Laubscher says that in this way one fosters co-responsibility by members for their expenditure. The principle of risk management is also based on closer co-operation between medical schemes, service providers and the insurance industry.

Visimed, which has been serving South Africa for 25 years, is a member-controlled, voluntary medical scheme offering health care on a basis where the member accepts accountability for his or her expenses, where major medical expenses are re-insured and where those members who use the scheme judiciously are accordingly reimbursed through a unique bonus system.

The company offers a total solution in health care with four risk-managed plans: Visimed Totalist Plan which ensures total peace of mind through 100% cover of all hospital costs; the Economist which is an economical version of the Totalist; the Traditionalist plan which is a traditional medical aid; and the Hospital Plus Plan which insures the member against major medical incidents that require a hospital stay. Visimed thus offers a plan for every individual's requirements.

Freedom of choice

This affordable solution has been achieved through the company's effective re-insurance strategy, through AMA Insurance Co Accident and Miscellaneous Acceptance who are the underwriters for the Standard General Insurance groups. A unique feature of this agreement is that the company is directly advantaged if a positive claims experience is maintained.

Laubscher added that within the framework of future health care cover in South Africa, the Visimed approach is regarded as a responsible contribution to health care, where the member is still assured of freedom of choice concerning service providers.

The company regards this as a step towards the solution to the current cost spiral in health care and is busy with agreements for future co-operation with various service providers.

Laubscher said the amendment provided scope for the expansion of a risk-managed approach and the company was looking forward to expanding on this health care approach in future.

Popular plan improved

MORE than 80 000 people have invested in Old Mutual's popular FlexiCare health insurance since it's launch in November 1991. The total cover by the policy holders insured now amounts to more than R2,3 bn.

Meanwhile, the organisation has considerably improved its product to the benefit of its clients. These improvements include, *inter alia*, an increase in the maximum hospital benefit from R400 to R500 per day as well as a new benefit for those in high-care units. Considerable improvements have also been made to the hospital benefit cover for maternity stays.

According to the assistant general manager (marketing) of the organisation, Dave Hudson, the success of the product can be ascribed to its extraordinary flexibility.

Large expenses

FlexiCare has a number of features which make it attractive to the public, such as guaranteed cover for the full term of the policy; and the insured's proceeds can be increased considerably by a no-claim bonus. The less the insured claims, ... will be.

Hudson ance was sion of ... expenses it could ... cal aid.

Be ...

It was ... was us... tween the medical ... tual cost ... cedures ...

New plan tops up benefits

LIBERTY LIFE has introduced Extracover, which extends its Medical Lifestyle benefits by providing cover for about 200 additional procedures which are less expensive and occur more frequently.

Gavin Came, deputy general manager of the marketing and legal services individual business division, said Extra-cover topped up medical aid cover in a wide range of additional procedures and was aimed at reducing the shortfall between health costs and medical aid benefits.

"Among the procedures covered are: a knee dislocation, appendectomy, spine biopsy and a perforated septum repair."

The organisation has also enhanced its existing Medical Lifestyle policies by introducing three features at no extra cost — new-born child cover, hospital accident cover and emergency transportation cover.

In terms of the new-born child cover, a baby is covered for the first 31 days after birth and if the mother was covered by Medical Lifestyle for at least 12 months prior to giving birth, the baby is guaranteed cover after that. The hospital accident cover provides for benefits to be payable from the first full day in hospital resulting from a motor vehicle, train or aeroplane accident. There was previously a three-day waiting period.

Emergency transportation required as a result of listed life threatening situations will be paid for.

Popular plan improved to benefit clients

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FlexiCare has a number of features which make it attractive to the public, such as guaranteed cover for the full term of the policy; and the insured's proceeds can be increased considerably by a no-claim bonus. The less the insured claims, the better his benefits will be.

Hudson said health insurance was aimed at the provision of cover for large medical expenses and that in this case it could be a useful means to supplement a person's medical aid.

Be aware

It was well-known that there was usually a difference between the benefits paid out by medical aid funds and the actual cost of major medical procedures in particular. This is where health insurance comes to the rescue.

According to Hudson, it is important for a person to become aware of the limits of his medical aid before investing in health insurance. A capable financial adviser or broker could recommend the correct level of supplementary cover for each individual.

Health insurance is of course a pre-requisite for those who do not belong to a medical aid. Major medical procedures such as a heart bypass operation can cost R30 000 or more.

Healing hands . . . Johannesburg Hospital's blind physiotherapist Ernst Kruger (70) checks Daniel Mqushekile from Mafikeng who will soon be able to be measured for an artificial limb. Picture: Stephen Davimes

Blind physiotherapist has helped thousands

By Shirley Woodgate (299) Star 25/6/93

The computer era arrived too late for Johannesburg Hospital's blind physiotherapist Ernst Kruger (70) to capitalise on the limitless benefits it offers to the unsighted.

But the thousands of disabled people countrywide who he has literally put back on their feet during a career spanning 44 years would definitely have missed out if electronics had been an option when he went in search of a job.

His healing hands have notched up many successes: Trevor Dreyer, who lost a leg after an accident, walks confidently down the passage on a pneumatic post-amputation module expertly fitted in the orthopaedic rehabilitation clinic by Kruger.

Kruger has treated people of all ages, including a man almost 100 years old, in his career.

Blind by the age of eight due to a hereditary condition related to retinitis pigmentosa, Kruger went to school at the Pioneer School for the Blind at Worcester.

The Middelburg youngster then set off for a two-year course at the North London School of Physiotherapy.

Back in South Africa, he joined the staff of the old "Johannesburg Gen".

He married Monica Booysen in 1952 and, ignoring their blindness, the couple embarked on a lifetime of helping the disadvantaged.

Monica is an acknowledged Braille expert.

Kruger is threatening to retire a second time, but nobody can imagine the department without him.

On the other hand, the man who found time to launch the country's only Braille press; serve on the National Council for the Blind, the SA Guide Dog Council and the Wilds division of Lions International; and help found the blind bowlers' association, the Northern Light Social Club and the country's first car rally for the blind — needs time to work in his garden, listen to the radio and do a bit of voluntary work.

BDay 29/6/95

Health service ideas outlined

GERALD REILLY

PRETORIA — Funds for core health services should come from general taxation supplemented by a premium-based social insurance system from wages and salaries, and a payroll tax on employers.

This suggestion was made at last week's annual meeting of the Medical Association of SA (Masa).

A Masa spokesman said funds could be further supplemented by earmarked taxes on certain goods or activities which could have adverse implications for health, including alcohol and tobacco.

Delegates warned that unless health service priorities were set, limited funds and other priorities would overwhelm the system.

A first step should be the determination of minimum health care and the ceiling of state responsibility.

Masa believed core health services should be built on the premise they would provide greatest assistance to the poorest.

Meanwhile Masa federal council chairman Bernard Mandell said Masa again called for the urgent integration of a health care system into a broad multisectoral programme.

It was vital that health care be made more available, equitable and affordable, he said.

Difficult choices lay ahead between costly therapy and palliative treatment in fixing minimum levels of accessible care.

Mandell said discussion at the meeting centred on a fair allocation of resources to all levels of the health system and the extent to which co-operation between the public and private sectors should be encouraged.

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SOCIAL SECURITY _ MEDICARE

1993

SA health care: the absolute minimum

Star 6/7/93

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How is South Africa's crisis-beset health care system to be restructured for the future? The Medical Association of South Africa (Masa), representing the powerful medical profession, has entered the debate by producing policy proposals which were ratified by the association's Federal Council last month. Health Writer DAVID ROBBINS looks at the main points.

AFFORDABLE, nonracial, comprehensive, effective — this is Masa's vision for health care in South Africa. More specifically, its new policy document, entitled "Towards a health policy agenda for the people of South Africa", concentrates on the provision of minimum levels, or core health services, to all, and how these are to be financed.

The policy document also stresses the importance of the private sector in the future health' system, and insists on people's right to arrange private funding alternatives to cater for their health needs.

Although core services are not defined in detail, the principle that they should be available to all is well established.

The policy document indicates that they should operate at primary, secondary and tertiary levels, and that everyone, whether economically active or not, should have "reasonable access, on affordable terms and without unreasonable waiting times".

The core services, which will have to be identified through negotiation between all the health stakeholders, should also be seen as the "floor" of South Africa's health-care system and the "ceiling" on the State's obligation to assist people to gain access to the system.

Masa is more explicit with regard to how these core services, the necessary research to support them, and the training of the necessary health care workers, are to be administered and funded.

Guiding principles here include stressing the need for a single health ministry, and that funding be set up in such a way as to enable the State to provide greater assistance to those least able to provide for themselves.

"The State financing system can be successful," Masa says, "only if it is economically sustainable and secures the best use of available money and personnel.

"Because health care needs can be addressed only with available resources, we will be forced to prioritise care. This will mean that difficult choices must be made between costly therapy and palliative treatment."

It is inevitable, therefore, that certain medical procedures will fall outside the core services, and will require to be paid for either by private means or via medical aids and private insurance.

The administration of core health services, says Masa, should be the responsibility of a single ministry of health which would set funding objectives and action plans based on appropriate research and consultation with "relevant informed community and provider organisations".

The administrative and management information systems used by the State could be provided by existing private sector infrastructure (for example, the medical schemes), according to the Masa proposals. The State should also be encouraged to use certain core services already existing in the private sector.

All this is in line with Masa's belief that valuable medical systems and expertise which already exist should not be abandoned in the search for a more equitable health service for South Africa.

It also underlines Masa's insistence that "society should be free (and remain free under any future dispensation) to arrange alternative private funding for health care".

But how is the State's obligation to provide core services for all to be funded? The Masa document provides several firm suggestions.

- General tax revenues as at present.
- A compulsory premium-based social insurance system funded by employees and employers, especially to ensure that core services are available to the aged and chronically ill.
- Extra earmarked taxes on certain goods or activities which adversely affect health (cigarettes, alcohol, motor cars) could provide a further source of revenue for the State's core health services.

The Masa document specifically mentions other finance-raising methods which should be avoided, most notably the direct charging of patients for core health services.

Masa also makes recommendations with regard to reducing the costs of providing core-health services. These include:

- Eliminating the wastage associated with the fragmentation and duplication in our current system.
- Mobilising resources to support research into more efficient health delivery systems.
- Introducing evaluation techniques such as cost-benefit analysis.
- Increasing efficiencies by treating patients in the community rather than in hospitals, by introducing greater economies in the use of pharmaceuticals, and by delegating various medical tasks to less highly trained personnel.

The Masa document offers policy recommendations regarding a wide range of other health issues such as primary health care, academic hospitals, medical technology, managed health care delivery systems, and the funding of health research.

But it is the emphasis on core services for all and the suggestions on how to fund such services which will almost certainly bring the Masa document into the mainstream of the health policy debate. □

More customer-orientation urged for medical schemes

Star 6/7/93

By Stephen Cranston

Medical schemes need to become more customer-oriented to ensure the continued role of the private sector in the provision of health care, says Ken Magennis, the incoming executive director of the Representative Association of Medical Schemes (Rams).

He said yesterday the public sought greater flexibilty and would no longer be prepared simply to take the medical aid format their companies offered them, but would ask for a choice of packages from full cover to catastrophic cover only.

If patients accepted that they would only use a limited range of doctors and hospitals, then subscriptions could be reduced.

Magennis said cross-subsidisation of retired members by younger members would become less possible as young people were more likely to opt for cheaper limited cover schemes.

To ensure adequate cover after retirement, a portion of the subscription should be channeled into an appropriate long-term fund.

Ken Magennis . . . public would ask for a choice of packages

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Such contributions should enjoy tax benefits as they would relieve the state of health burdens.

Under the amendments to the Medical Scheme Act, Rams would cease to be a statutory body, but the industry had agreed to continue operating as a voluntary body.

With deregulation, the entry into the healthcare market of insurers and the threat of replacement of medical aid by a national health insurance system, the movement would need to continue to address issues as one body, he said.

Although compulsory scales of benefit would fall away, Rams would continue to set guidelines as the public wanted to know it was being exploited.

Magennis said it was essential that a system of voluntary accreditation be set up so that, for example, doctors who either over-serviced or neglected to treat their patients could lose accreditation.

He said that schemes had to be seen to be combating fraud and wastage. The public would demand more detailed reporting of the financial affairs of medical schemes.

On top of price inflation, medical costs had increased by 34 percent from 1985 to 1990 as a result of more usage and a switch to more expensive medicines and procedures. Such increases would need to be contained.

Star 6/7/93

Medical aid body to stay

The Representative Association of Medical Schemes is to continue operating as a voluntary body after it is dissolved by law as a statutory body in January next year. This was said yesterday by Reg Magennis, director of health policy and economics at the Medical Association of SA, who takes over next month as Rams executive director. — Sapa.

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Over to the other side

Trying to work out who's who in the medical industry isn't that simple any more, especially when chiefs start changing hats.

Certainly it will take some time for the industry to get used to former Medical Association of SA (Masa) health policy director Reg Magennis moving over to head the medical schemes sector as executive director of the Representative Association of Medical Schemes (Rams). Magennis (35) has spent the past three years at the front of the doctors' lobby fighting the very reforms that Rams has been pushing government to implement.

Indeed, so intense was that opposition that Masa called for Health Minister Rina Venter's resignation at one stage.

But a compromise that saw Venter write Rams out of the statute books ended the stand-off and the Medical Schemes Amendment Act finally became law in February, though it's not expected to take effect until early next year after the enabling regulations are amended.

Magennis

Says Magennis: "There were differences between doctors and schemes about what changes needed to be made to the law, but now that the Act has ushered in change, the situation needs to be managed, and I believe I am ideally placed to provide vision and direction, particularly on issues that involve interaction between schemes and the profession."

But observers are sceptical that his sympathy for doctors could see Magennis give in to pressure from the powerful doctors' lobby on issues that affect their interests. His predecessor, Rob Speedie, who's moving over to hospital group Presmed as joint-MD, earned a reputation as a hard-nosed negotiator who knew how to distinguish "the public interest" from "doctors' interests."

Magennis is adamant: "If there's a stand-off between Masa and Rams, I will clearly have to represent the schemes full out. But the new legislation is drafted to facilitate greater co-operation between the two groups."

He explains that previously, both Rams and Masa would recommend scales of benefits and tariffs for medical procedures and services, but Rams would always have the final say. "With Rams out of the Act, there will have to be greater co-operation and partnership between the providers and financiers of health care. The future of private-sector health care will depend on the strength of this relationship and on the relationship between schemes and government."

Still, there is likely to be many scraps as the industry starts implementing the new legislation. In a nutshell, the Act deregulates private-sector health care extensively by ending the guaranteed payments that schemes traditionally made to doctors and members on receiving a claim. This gives schemes greater scope to keep costs in check. The Act also allows schemes to employ doctors and other health-care workers, and to run and own hospitals in managed health-care structures.

Doctors are particularly concerned that managed health care will see professional standards suffer under cost constraints imposed by schemes. On this score, Magennis believes that a system of voluntary accreditation of medical schemes and health-care providers is necessary to safeguard the public. "Such a system would distinguish those who are prepared to stand up to public scrutiny. Clearly this policy would have to be negotiated, but it should cover issues such as payment of health providers, therapeutic and clinical guidelines, and marketing and advertising practices."

Venter, however, points out that the SA Medical & Dental Council is already entrusted with safeguarding standards.

Magennis is also concerned with the financial soundness of schemes and other health-care financiers, for example insurers, given the proliferation of a host of new and untested medical-cover packages and the increasing trend away from having the healthier and younger clients subsidise the aged and ill. This has also been a concern for doctors.

Venter's response has been to appoint a commission of inquiry under Judge David Melamet to study the financing of health care. But she stresses that all risks can't be excluded. On this issue, Speedie stresses that the Registrar of Medical Schemes already checks the financial reports of every scheme. He also points out that schemes are required by law to put up a minimum of R2m in trust before they operate.

Magennis, a CA with a Masters degree in Business Leadership from Unisa, would also like to see the State better utilise medical schemes to administer public health services. "The State needs to define the core services it will be responsible for and allow those who qualify for them to obtain these services in the private sector at negotiated rates and terms."

Mirryéna Deeb

cally disabled children.

According to Cape Provincial Administration (CPA) spokesperson Mr Krige Visser, the CPA is trying to change the legislation "so that grants would become available."

This will not happen in the immediate future though.

Before the creation of the centres, many of the handicapped children not getting grants were left alone at home while their mothers went to work. If they were unable to walk they spent the day just lying in bed without supervision.

They are moved around, their muscles are massaged and they are fed at the centres. Most importantly, they are with other children.

At the Ziyazama Centre in Like many other disabled childt, he has a history of abuse: he was stabbed while living at home. The centre is the one place where he is both cared for and safe.

The centres are part of a project of the Disabled Children Action Group (DICAG), an organisation run by parents fighting for the rights of their disabled children.

Most of the funding for the centres comes from the community, although a small amount comes from charity organisations.

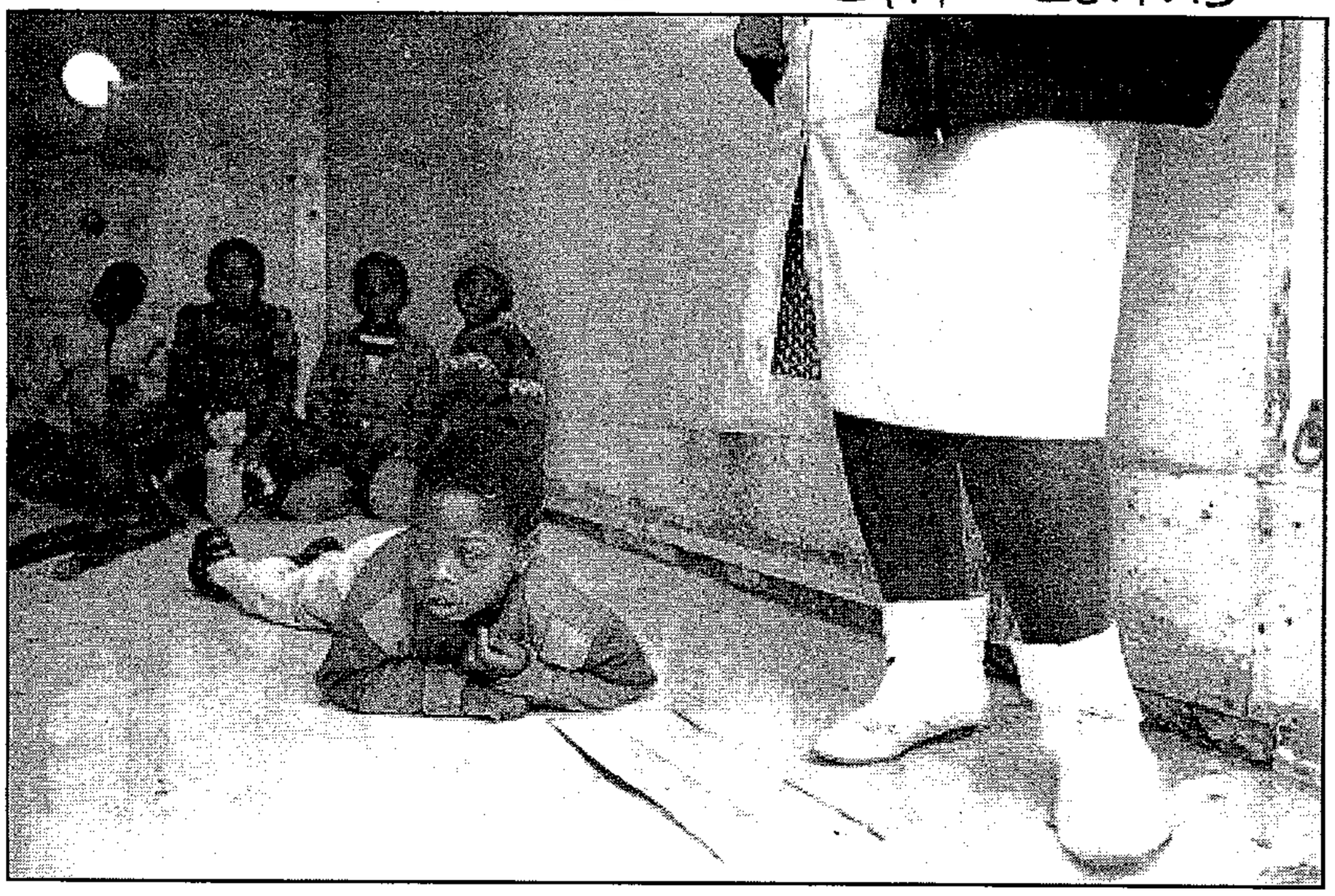
Because DICAG is not affiliated to a welfare organisation it does not qualify for a CPA subsidy.

National co-ordinator of the project, Ms Vuyo Mhlale, said: "We are affiliated to Disabled People of

Parents create a place for disabled kids

Parents of retarded children have taken it upon themselves to overcome their children's disabilities and unhelpful laws. **SHANNON NEILL** reports:

South 24/7 - 28/7/93



GRANTLESS: Vuyolwethu Zokufa (4) cannot walk and has no state support Photos: Yunus Mohamed

IN THE middle of a rain-washed, windswept plot in Guguletu stand two shipping containers. The containers are no longer used for cargo. They are used by handicapped children who lack the benefits of a state-subsidised centre.

One of the containers stands open. In it two women are preparing a bean stew for the children.

The other container is closed. The children, about 11 of them, are shut inside. The door has to stay closed when it's cold or raining, otherwise the children get sick. The only light inside the container comes from a tiny round window.

There is no toilet, no water and no electricity. The children have no toys. Yet this is an improvement on what they had before.

Many of these children are ineligible for state grants. The single-care grants are only given to children who have been certified severely mentally handicapped by a social worker and two doctors. There are also no grants for physically disabled children.

Khayelitsha, a deaf, dumb and mentally disabled boy arrives at the centre. He did not go home all weekend and staff at the centre are unclear where he had been.

(299)

South Africa (DPSA), an initiative of disabled people, not the welfare organisations. We want our efforts recognised as separate from those of the welfare organisations who did little for disabled people in the past.

"The facilities at the centres are inadequate because we desperately need funding. But it is still better for the children to be at the centre, rather than at home alone.

"Last year three children were burnt to death when the shacks they were locked in burnt down."

She said that many of the children were unable to get into Cape Mental Health centres because these were usually exclusively for children with only one handicap.

According to Mhlale there are schools for blind children, and schools for mentally handicapped children, but no schools for children who are both blind and mentally handicapped.

Another problem, said Mhlale, is that African children were excluded from most privately run schools for mentally handicapped children on the grounds that they do not speak English or Afrikaans. There are also long waiting lists for these schools.

"Sometimes children wait for years to get into a special school, then when their name comes up they are told they are too old."

Because of these problems DICAG set up its own centres for children who are unable to get into state and privately-run centres.

The centres are run by parents who are sent on courses to teach them how to look after the children. They are given training in simple occupational therapy so they can help those with physical disabilities.

DICAG has also approached the child health unit at the University of Cape Town. The unit provided a doctor who visits most of the nine centres in the Peninsula area.

"The doctor assesses the children and then refers them to the schools available. This is one of the main things we are doing at the centres, trying to prepare the children so that they can be integrated into the schools in their area," Mhlale said.

Sowetan 30/7/93

Doctor blacklisted

By Musa Zondi

BONITAS Medical Aid Scheme has advised its clients not to patronise a Soweto doctor because of alleged over-prescription.

The doctor in question, Dr B Gwala, has replied that he is being harassed because he is giving his patients the best available drugs on the market. (299)

"I decide what's best for the patient and prescribe accordingly.

"I never treat patients on average but as individuals," says Gwala. (35)

Professor Paul Luthuli, chairman of the scheme, says he has sent a number of people to talk to Gwala.

But Gwala would not budge and "as a trustee of public money, I won't pay what I feel is gross abuse", Luthuli said.

At the beginning of the month Bonitas sent out letters to Gwala's patients to inform them they would have to pay the doctor in cash.

The medical aid group said it would reimburse them to the maximum payable.

Gwala is adamant that as a medical doctor he has no responsibility to the medical scheme but to his patients.

"I would rather see one patient a day who thinks I am serving him properly than see hundreds who are not satisfied."

Phone advice: Doctors to bill

(85) (299) CT 6/8/93

Medical schemes won't pay

Staff Reporter

DOCTORS are now allowed to charge patients for telephone consultations — but medical aid schemes will not pay for them.

Some doctors have welcomed the move, saying patients have been "stealing time" with long telephone calls, while others have described the practice as "iniquitous".

Dr Norman Levy, a member of the Medical and Dental Council, said yesterday the council had laid down certain conditions under which doctors could charge for telephonic consultations.

These include:

- The patient had to be one whom the doctor had seen on a previous occasion, and could not apply to new patients;
- The doctor had to inform the patient about the charge before the consultation, and the patient had to agree to it;
- No charge could be made for calls inquiring about test results;
- The rates charged had to be the same as those for a normal repeat consultation in a doctor's rooms;
- The doctor had to make it clear that he was available in his rooms, and
- A professional, therapeutic service had to be rendered.

Dr Levy said medical aid schemes had announced that they would not pay for telephonic consulations.

A doctor, who cannot be named for professional reasons, described the move as "iniquitous" and said he had no intention of implementing it.

"As a family doctor in practice for 35 years, I would not dream of levying a charge for a phone call from a patient. It is part of the goodwill of one's practice."

A group of three doctors in the northern areas have already implemented the scheme.

"In selective cases we are charging for telephone calls, for instance if the patient says he cannot come in to our rooms. The idea is to help patients," one of the three doctors said.

He said it would stop patients who interrupted consultation in their rooms with long, detailed telephone calls, which amounted to "stealing time".

"I think it is unfair if I do a consulation over the phone, prescribe medication, carry the responsibility and don't get paid."

State inquiry to probe medical aid

(299)

ARG 7/8/93

PRETORIA.— President De Klerk has appointed a commission of inquiry to investigate medical schemes, according to the Government Gazette.

The commission, to be headed by Mr Justice D A Melamet, will investigate among other things:

- Whether the way in which medical schemes are organised and funded is adequate.
- The feasibility of the insurance industry providing medical schemes and how it is affected by existing legislation.
- The feasibility of making provision for future medical costs through mutual aid societies and benefit funds.

Medical aid industry to be investigated

ADRIAN HADLAND

PRETORIA — The medical aid industry would be investigated by a commission of inquiry, the National Health Department announced at the weekend. BIDay

The commission, appointed by President F W de Klerk and headed by Judge D Melamet, would seek to introduce a more equitable system while placing the provision of medical expenses on a sounder financial basis, a statement said. 9/8/93

The commission would examine a number of areas, including the possible application of actuarial supervision to medical aid schemes and activities of mutual aid societies and benefit funds. (299)

It would also investigate whether schemes were sufficiently funded, and explore the way the funds enabled individuals to make provision for future medical expenses.

Included in the commission's terms of reference were:

- ☐ The provision of lifelong medical cover after retirement;
- ☐ The protection of members' rights and accrued interests;
- ☐ The marketing of mutual aid societies and benefit funds; and
- ☐ The regulation of those societies and funds, determination of their benefit levels and management of their contributions.

Parties had until October 8 to submit representations to the commission, the department said.

Govt probe into medical aid welcomed by industry

B Day 10/8/93

(299)

CHARLOTTE MATHEWS

SPOKESMEN for the medical aid industry have welcomed National Health Minister Rina Venter's weekend announcement that a commission of inquiry would be held into the industry.

"In its earlier representations to the government regarding the inadequacies of amendments to the Medical Schemes Act in terms of protection of the public, the Medical Association of SA had called for the establishment of such a commission," Masa said in a statement.

Masa said the major flaws of the amended legislation, effective in 1994, were the lack of adequate risk management and financial controls to ensure medical scheme members were not exploited and faced with unexpected financial hardship when health care was most needed.

Industry spokesmen suggested one of the major areas the commission would focus on would be medical benefit schemes that fell outside the scope of the present Medical Schemes Act. Medical schemes may pay benefits in respect of illness or medical treatment. In the past year several schemes had been initiated which offered members the option of placing a proportion of their contributions into "benefit funds".

Medscheme deputy MD Leslie Hollis said: "We welcome the investigation because we feel that many of the benefit funds are starting to act like medical schemes and that is what the Minister is trying to sort out.

"This inquiry is aimed at providing control over a vehicle that is intended to be used for future health care funding. There is no such control at the moment."

MIB Healthcare Services MD Malcolm Wilson said benefit funds were uncontrolled and there was a danger of abuse of public funds. But, he said, the funds had addressed the problem of long-term health care. This had caused some concern because increasing longevity could present the funds with financing problems.

Momentum Health MD Adrian Gore said: "I think the primary problem is the issue of escalating costs and a system that will cause problems in the future with people ageing.

"In the past there were large numbers of young and healthy people entering medical aid schemes but now they are reluctant to subsidise the old and sickly who will have to rely on themselves plus the scheme. That is a problem from an actuarial perspective."

Gore agreed a legislative framework for benefit funds was crucial. "There are all types of funds being created and this is also of concern."

No more, say blind workers

Long overlooked, disabled workers are now fighting for protection under labour legislation, reports

Waghied Misbach:

PETER Klaartjies was five years old when a severe bout of meningitis claimed his sight.

Doctors could not do anything, Klaartjies says, so he has learnt to live without sight.

Now, at 38, however, in the mottled blue-grey of his eyes, there is only anger.

It's so strong it has brought him to the pavement outside the Civilian Blind Workers offices in Salt River where he works. Every lunchtime he carries a placard calling for a living wage.

"I have been here for 19 years," he says, "and I am paid R360 a month."

Klaartjies is married and has four children aged 13, 10, nine and three. His wife doesn't work.

"How can I survive with this money?" he says. "At the start of the month all my money is gone."

The major problem for Klaartjies and other disabled workers is that they also get a government pension which decreases with the increase in their wages.

"And now that we have asked for an increase they want to take our pension away," he says.

Klaartjies says he gets an extra R333 a month from the government as a pension, which makes for a mere R693 he earns in a month.

He has asked for an increase of R400. Other workers have asked for similar increases.

Klaartjies is a cane worker, and after working at Civilian Blind for almost two decades describes himself as an allrounder — able to make different kinds of baskets.

"I just want to be paid for the work I put in," he says.

Protests

Other workers complain about low wages and are determined to continue their lunchtime protests until their demands are met.

Civilian Blind shopsteward Mr Frank Sam says many workers ask for loans to meet their costs, but are only granted money if they do not belong to the union.

Sam says the workers also don't have social benefits like medical aid and Unemployment Insurance Fund. He is determined that protests will continue until their demands are met.

He says Cosatu will meet with the Civilian Blind management this week in an attempt to solve the problems.

However, the general manager of Civilian Blind, Mr Brian Collins, points out his organisation has no control over the laws of the country.

"At the moment they receive a pension, and until that falls away, they will not be in line to join the UIF, " says Collins.

Collins points out that a medical aid scheme is available, but workers simply cannot afford to join.

It's a problem that has spurred the Paper, Print, Wood and Allied Workers Union (Ppawu) to call for changes in legislation.

Earlier this month, a group of blind workers marched on parliament to hand over memorandums to Minister of Health, Rina Venter, and the Department of Manpower.

The union has been in dispute with the South African National Council for the Blind (SANCB) for the past 18 months over wages and the closure of workshops in Natal without consultation and retrenchment packages.

Ppwawu branch organiser in the Western Cape, Mr Shaheed Mohamed says visually disabled people are not the only ones exposed to harsh conditions.

He says disabled workers in general are not protected by legislation which include the Labour Relations Act, Basic Employment Act and the Wage Act.

Starvation

"They earn starvation wages of as little as R60 and less a week with no benefits," says Mohamed.

He says there is "appalling" accommodation and other facilities for black disabled workers, compared to their white counterparts.

Mohamed says his union, with the Disabled People's Organisations of South Africa (DPSA), and civics and churches, have banded together to create a forum to deal with the problems.

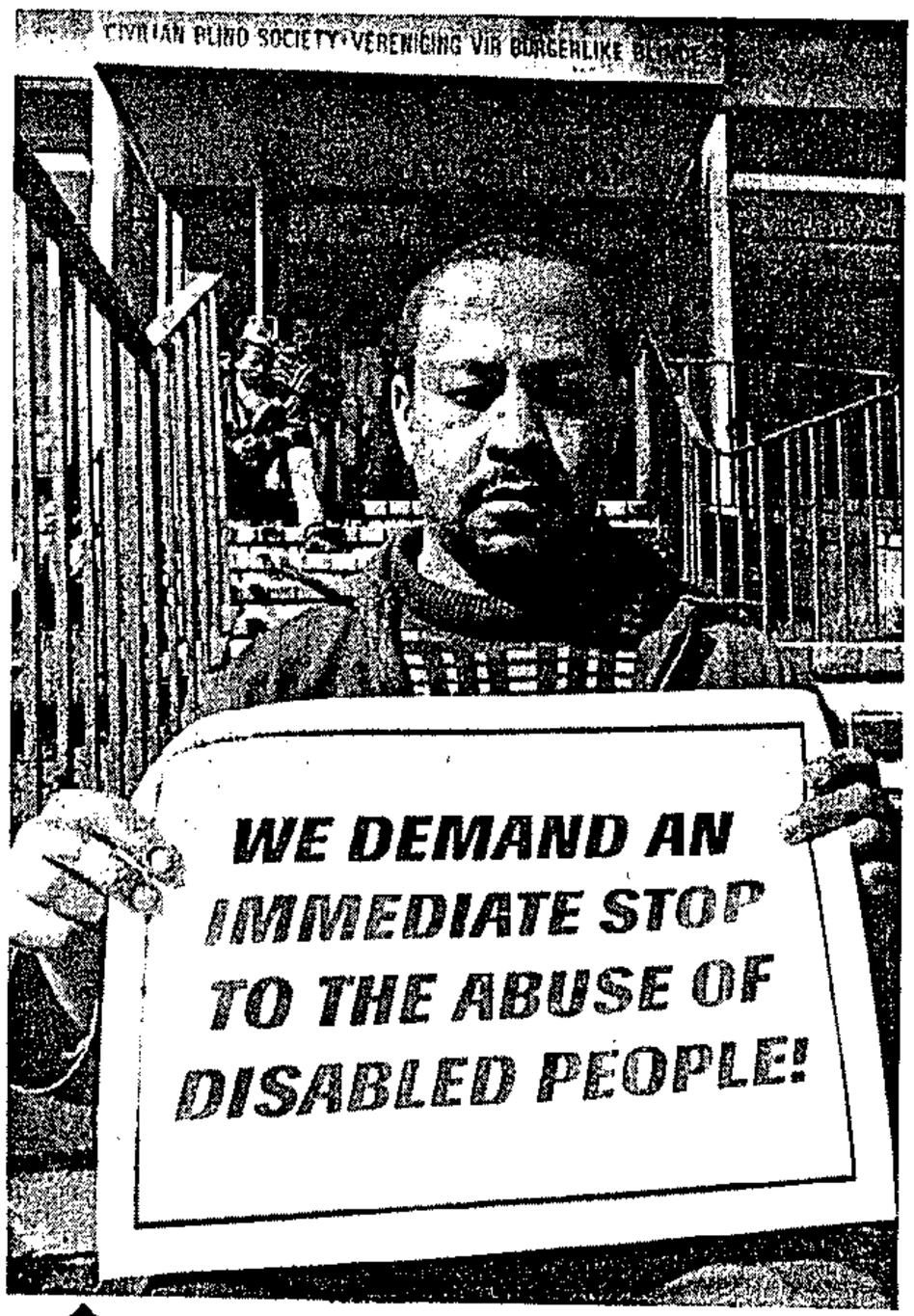
"We are committed to making sure disabled people should not suffer under apartheid as well as under a democratic government."

Mohamed says the forum is carefully monitoring the Technical Committee dealing with the Bill of Rights, which is currently considering submissions by Lawyers for Human Rights (LHR) Disability Unit. The draft Bill of Rights exclude the proposals of the LHR.

In the memorandum handed to the SANCB, the forum also called for an investigation into the closure of workshops for disabled people in Natal and Transvaal.

The union claims they were not consulted about the closures and the workers were not paid retrenchment packages.

The memorandum has also asked for the provision of free adult education for the blind and at least five to 10 percent of all homes to be allocated to the disabled when the housing crisis is addressed.



DEMONSTRATION: Blind worker Peter Klaartjies is among thousands of disabled workers not protected by current labour laws

Judge invites all interested parties to make submissions

Medical aid probe begins

Star 3/9/93

299

THE Melamet Commission of Inquiry hopes to finish its work 'into what is an international problem' by the end of February

■ STAFF REPORTER

The commission of inquiry into the provision of medical aid was launched in Johannesburg yesterday when its chairman Mr Justice D Melamet called for submissions from interested parties.

The judge said he had invited 82 concerned individuals and organisations to make written or oral submissions. Members of the public were also welcome to make suggestions.

The commission will consider how sound the financial base of medical schemes were as well as the provision of affordable medical care for people after retirement.

Professor David Reekie, a member of the commission of inquiry, said one of the problems with medical aid was that the process went through a third party in the form of medical aid schemes.

This meant there were no incentives to conserve — patients were not encouraged to reduce expenditure since they were largely not responsible for the cost — while those who provided medical care could increase their income by doing extra tests that would not necessarily provide better care.

Reekie added that the medical profession did not have anything to fear from the commission as much of the work would reduce risks of non-payment and bad debts.

Judge Melamet said the commission hoped to have its work finished by the end of February. Some of the commissioners may travel overseas to consider how other countries were dealing with what was essentially an international problem.

Inquiries should be addressed to the secretary at (011) 333-8707.

Melamet launches medical aid probe

B/Day 3/4/93

KATHRYN STRACHAN

A MAJOR probe into the medical aid industry launched yesterday was expected to open "a can of worms", the commission's chairman Judge David Melamet said yesterday. (299)

Speaking at a news conference at the Rand Supreme Court, Melamet said the Commission of Inquiry into the Medical Schemes Amendment Act had been set up to halt the explosion in medical prices.

The inquiry was also aimed at investigating whether laws covering medical schemes conflicted with those governing insurance schemes.

Melamet appealed to the public to submit their suggestions which would be vital to the probe.

An important reason for spiralling medical costs was the lack of incentives for patients, health providers and medical schemes to conserve.

The result was an overutilisation and abuse of medical services, he said.

Commission member Colin van der Meulen said the inquiry was the second step following from the introduction of the Act, which is expected to be in place early next year.

The commission's terms of reference were to inquire into whether the way medical schemes were funded was sufficient and whether their financing should be subjected to actuarial supervision.

The inquiry would also investigate the way in which the insurance industry could help people provide for future medical costs, with particular reference to the extent to which existing legislation placed unnecessary limitations on the scope of insurers.

Prof Duncan Reekie, also on the commission, said the inquiry could find that less, rather than more, regulation was the key to containing costs.

However, deregulation could also create its own problems by allowing medical schemes to provide for the young and healthy only rather than providing "cradle to grave" cover as they currently did.

The role of the commission was to pre-empt some of the complications, he said.

NO FACILITIES . . . The container has no ventilation or sanitation but is home to 55 disabled children in Khayelitsha

Picture: FANIE JASON

Crude container home to 55 disabled children

By TAMMY MBENGO

ABOUT 55 disabled children are being housed in a container that has no ventilation and sanitation in Khayelitsha, Cape Town.

The children, some of whom are in wheelchairs, cross a busy main road to relieve themselves in bushes.

Earlier this year, the community formed the Disabled Children Action Group (Dicag) to try to assist the children. The group liaises with the Disabled People of South Africa (DPSA).

Its chairman, Nosiseko Dlakavu — who is also a rehabilitation officer with the Nonceba Project for the Disabled — said this week that many organisations and companies had been approached for assistance, with little success.

She said plans were being made to create vacancies at the Njonga School for the Disabled in Khayelitsha.

The deputy director of the Cape Mental Health Society (CMHS), Grace Matlape, said the children's circumstances were "appalling".

However, the government did not help children in informal settlements until they had "organised themselves".

Mrs Dlakavu said there were wide disparities in government grants for disabled children. Coloured children received R305 a month, whites R345 and blacks R150.

Parents — many of whom were unemployed — had staged several demonstrations against the low grants.

A spokesman for the Cape Provincial Administration, Penelope Hoerdood, declined to comment.

"We will have to investigate first," she said.

Seminar handicapped by its ultimate targets

By MICHAEL O'REILLY

THE organisers of a national conference on disabled children are struggling to assemble the conference delegates in Cape Town — because many of them are disabled.

The three-day conference, to be held from Wednesday to Saturday under the auspices of the Disabled Children's Action Group (Dicag), is part of a year-long programme to address the perceptions, laws and discriminatory practices that hamper the advancement of children who have disabilities.

To date, it has been a logistical nightmare, according to Dicag consultant Minnie Venter.

Smaller airlines do not provide for people in wheelchairs and most hotels offer only one room with wheelchair facilities.

Although it is being run in conjunction with the Children for Africa Conference at the University of Cape Town, the Dicag conference has to be held at SACS Primary which, unlike UCT, has easy access for disabled people.

The disabled seek jobs, not quotas

STimes [Buss] 12/9/93

The Institute for Personnel Management says imposing quotas for hiring disabled employees would be detrimental to both the disabled and employers. TERRY BETTY reports.

(299) (131)

AMID the fuss about affirmative action in favour of blacks and women, little is said about employment for the disabled.

They do not need charity, merely jobs they are capable of doing, says Institute of Personnel Management affirmative action division member Chareen Grobler.

The disabled comprise more than 12,7% of South Africa's population, yet only 1% of them are employed.

Miss Grobler defines disability as anything that prevents someone from doing a normal job. The affliction could be the result of accident, a stroke, heart attack or some illness.

Miss Grobler says the disabled generally work in administrative jobs which do not require much physical effort.

Only 2% of employers take a poor view of hiring disabled people. Such employers may have had a bad experience with the disabled.

"You find people with disabilities in all spheres of life. Some are nice and some are not so nice. It is important to select the right person in the first place."

Miss Grobler would like to see the end of stereotyping of the handicapped.

"People often think blind people can be employed only as switchboard operators. But a blind person can be fully productive in many jobs, such as working with computers."

Miss Grobler admits that a few disabled people choose not to work because they would forfeit welfare benefits which give them security. "However, they would be people drawing on their disability insurance policies. The State grant is only R370 a month from September.

"People prefer to work — it is important for their dignity and pride.

"Work solves many problems. It encourages people to accept their disability, it stops them from withdrawing into themselves and it boosts their image of themselves."

The biggest barriers to employment opportunities for disabled people are the negative attitude of some employers, lack of public or other transport and the poor access to many buildings.

Another problem is that some employment agencies refuse to find work for the disabled. Some like to be seen to have on their books only the glamorous and the good looking.

The disabled are often exploited. People phone the Association for the Physically Disabled thinking they can get cheap labour.

Miss Grobler says: "Fortunately, we have a countrywide network and know who these people are.

"The advantage of hiring a disabled person is that he or she is generally prepared to work harder than average. Because of SA's high rate of unemployment and the prejudice they face, disabled people capitalise on their opportunities."

Miss Grobler says a quota system for employment of the disabled has been suggested.

"But some businesses would hire disabled people merely to fill their quota. That would often result in the wrong people being hired, someone being paid a pittance to do nothing," she says.

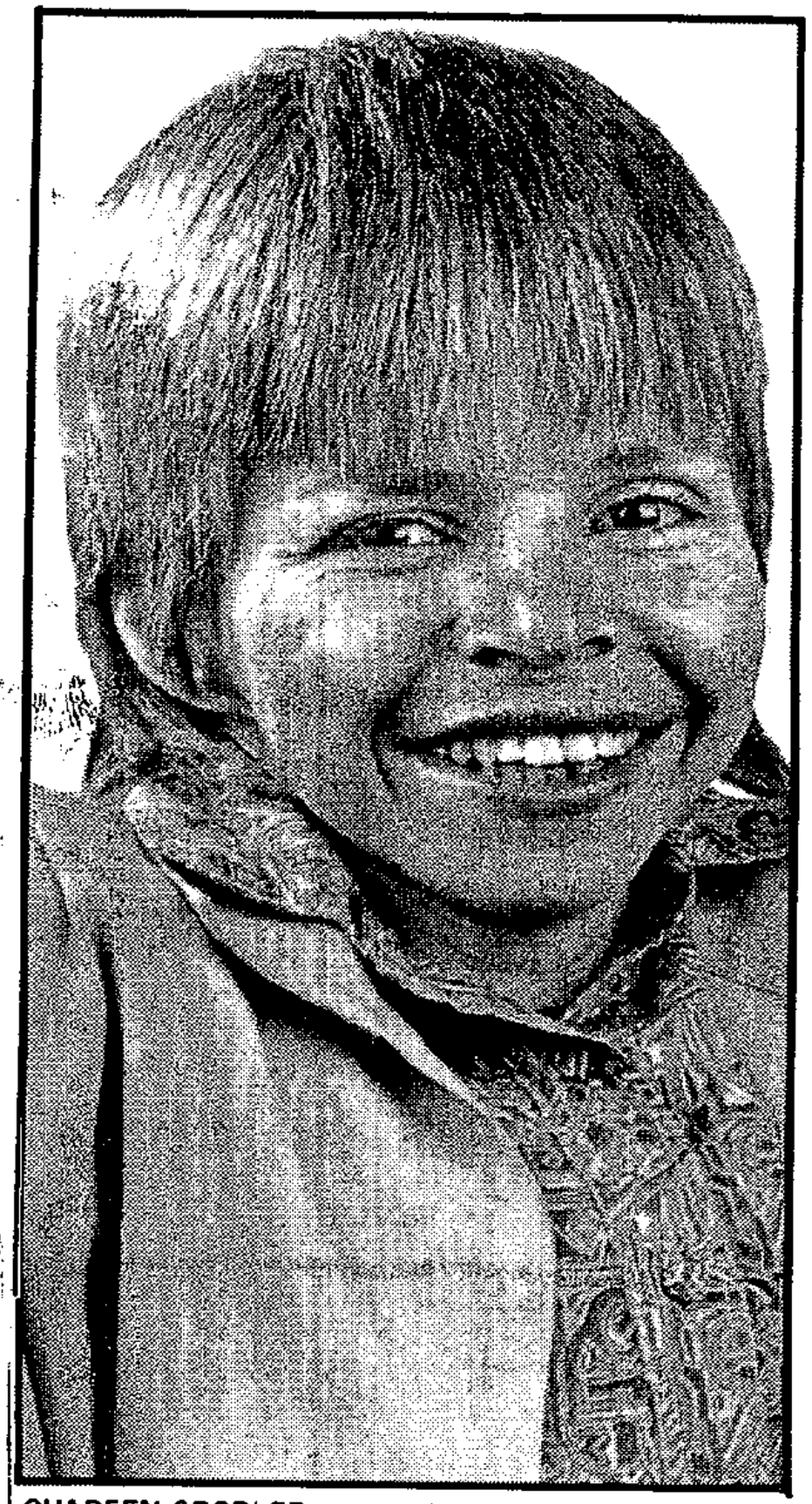
"This kind of tokenism is detrimental to disabled people and to their employers."

Renwick Management Services managing director John Sherratt says prejudices against handicapped people are less prevalent at higher levels.

"Prejudices seem to be greater at lower levels in an organisation where individuals may be less worldly or intelligent."

He says the trend is to pay people according to their performance rather than status, and people are assessed holistically based on whether they fit into the culture and are capable of doing the job.

Mr Sherratt says most new buildings are being designed according to European standards, such as having ramps, so that handicapped people can get on with their own business.



CHAREEN GROBLER . . . work is important for dignity

Discovery opens the door to cheaper medical-aid cover

ST Times [Buss] 19/9/93

By JULIE WALKER

MOMENTUM Health medical scheme Discovery has been refined and opened to the entire corporate market — not only to those with more than 50 staff members.

Momentum's Adrian Gore says the product, launched eight months ago, has been well received and the claims record is excellent. Feedback from marketers indicates great demand from small companies for better health cover. (299)

Mr Gore says: "We are making Discovery available to the whole corporate market from the one-man close corporation upwards."

The amounts paid into each facet of Discovery can be tailored to the needs of individuals. Contributions relate to age, as well as options on the three health-care financing components, instead of the conventional salary plus dependants.

A 40-year-old with a 37-year-old wife and two children may pay between R300 and R1 000 a month. At the higher rate, and using values projected at 15%, he will have accrued almost R1-million to cover health-care costs in retirement or to bequeath on death.

An economy plan costs from R300 a month. It provides for lower-income employees and excludes the long-term funding facet.

Discovery comprises three facets. There is a personalised medical savings account, from which members make day-to-day claims. Individuals are not exposed to the wastefulness of others because they manage their own medical expenses.

Any balance at the year-end, plus interest, is carried over and can be paid out in cash on a member's leaving the scheme.

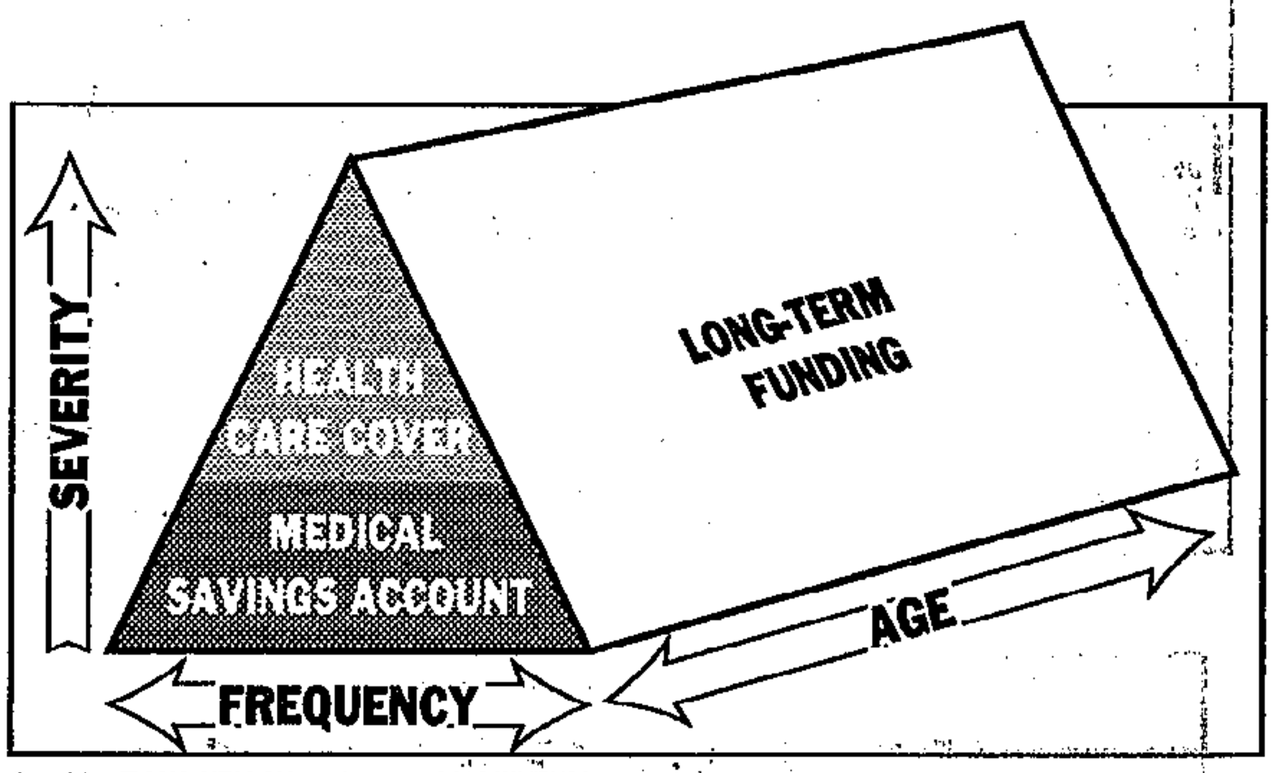
The second facet is cover for large unforeseen medical expenses. There is no need for top-up cover because Discovery meets all expenses, not only those within the scale of benefits. It also covers out-of-hospital expenses should these exceed the medical savings account's balance. It pays for medicine to treat chronic ailments, such as high blood pressure, diabetes, cancer and arthritis.

The third angle provides long-term funding for retirement. Mr Gore says medical-aid schemes rely on young and healthy members to subsidise pensioners. But medaid membership is falling for several reasons, not least of which is the revolt by the healthy against paying for someone else's sickness.

"They want value for money," says Mr Gore.

Discovery offers an actuarially determined, tax-efficient funding mechanism to enable members to provide for their retirement. A part of each member's contribution is invested in a personal asset account which ensures that the cost of benefits can be maintained in old age.

This asset account is payable as cash on death or termination of membership of Discovery.



Graphic: FIONA KRISCH Source: MOMENTUM

Bill heightens pharmacy dispute

KATHRYN STRACHAN

THE division between medical aid schemes and the pharmacy industry over the deregulation of pharmacy ownership increased this week when new legislation was put before Parliament.

Representative Association of Medical Schemes (Rams) executive director Reg Magennis said the proposed amendments to the Pharmacy Act would help stem the rising cost of medicines by deregulating pharmacy ownership.

Rams hoped the path would finally be cleared for medical schemes to achieve economies of scale by owning their own pharmacies.

However, Pharmaceutical Society executive director Boet van der Merwe said attempts by medical schemes to encroach on pharmacy ownership were, in fact, efforts to regulate and control.

Medical scheme dispensaries would not necessarily reduce the cost of medicine, but could merely transfer costs to another sector.

Community pharmacies were not responsible for rocketing medicine prices as many cost-containment measures had been implemented.

"If schemes were to examine their records dispassionately they would find that the jump in medicine payments could well be attributed to the advent of the dispensing doctor," Van der Merwe said, adding that overservicing by many doctors should also be brought under control.

The two organisations were also at loggerheads over the Pharmacy Council provided by the amendment Bill. While Rams was concerned about the unfettered powers that the Bill gave the Pharmacy Council to decide who could run a pharmacy, the society said the council was the appropriate body to adjudicate what was in the interests of the public.

Bumper earnings at Specialty Stores

From MARCIA KLEIN

JOHANNESBURG. — Specialty Stores has bucked the declining retail trend by reporting a 30% rise in earnings to 38,3c (29,4c) a share in the six months to end-August.

Results place the retail group — whose major operating subsidiaries include Milady's, The Hub and Mr Price — on track to meet its forecast of real earnings growth in the current year.

This would be its ninth successive year of earnings increases, joint MDs Stewart Cohen and Laurie Chiappini said yesterday.

The share closed untraded yesterday at a high of R11 after climbing steadily from a low of 510c at this time last year.

Interim turnover was up 27% at R209,5m (R164,4m) in difficult trading conditions as each subsidiary gained market share. The tough conditions, and the significant growth of the Mr Price cash operation, affected margins, which dropped to 7% (7,4%). Operating income was up 2% at R14,7m (R12,2m)

A 10% rise in finance costs to $4,5m (R4,1m) and a 19% rise in taxation R3,9m (R3,3m) — reflecting the lower corporate tax rate — resulted in a 30% higher attributable income of R6,3m (R1,9m).

A 15% higher interim dividend of 11,5c (10c) a share was declared.

Cohen said Mr Price was being extended, and had 46 stores at end-August. It will open four new stores today. Chiappini said the 141-store Milady's chain had achieved budgeted profits, while The Hub performed satisfactorily.

CT 23/9/93

ment in expansion, gearing was tightly controlled at 49% (40%).

The directors said the trading environment in the next six months could be affected by events leading up to the election. Barring severe disruption, it expected to show a real increase in earnings in the full year. About a third of the group's profits wer earned in the first half.

Most of the group's expansion in the current six-month period would be in the Transvaal. The directors said that six years ago 75% of the business was based in Natal. Now, about 40% was Natal-based following a strategic decision to expand into other areas.

Storeco Limited, which holds 63,2% of Specialty, increased its interim earnings by 30% to 76,8c (59c) a share, and declared a 15% higher dividend of 23c a share.

Warning on firm's medical aid tax 'loophole'

Business Editor

ACCOUNTING firm BDO Spencer Steward expects the tax loophole many firms think they have found by providing noncontributory medical aid to be closed.

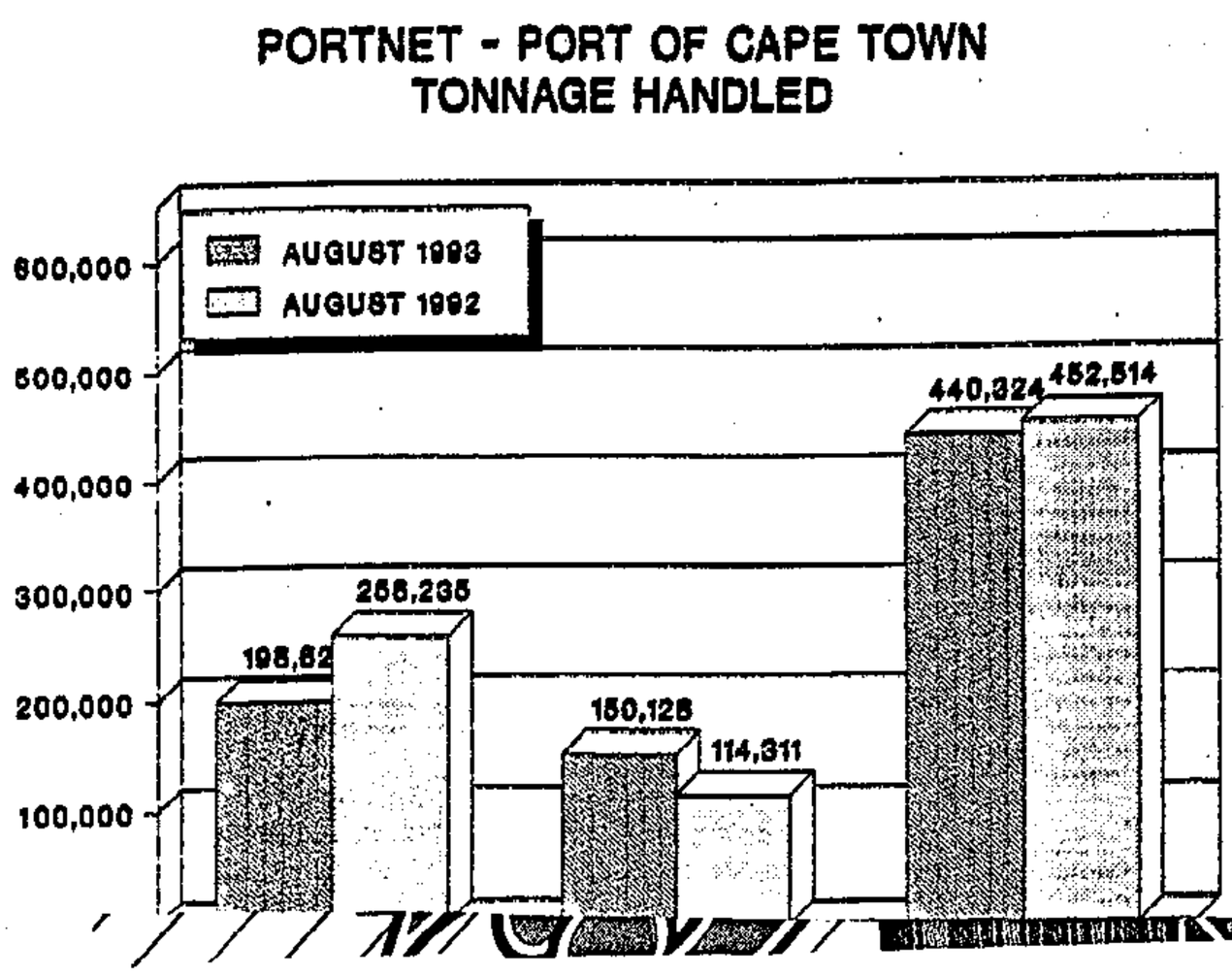
In its current tax news it CT 23/9/93 says: "In an attempt to structure employee remuneration packages more effectively many employers put their employees on to a medical aid scheme on a noncontributory basis and adjusted their salaries accordingly.

"The result is lower taxable earnings with full medical aid benefits. (299)

Rules

"In order for this to stand up to scrutiny by Revenue, however, employers should ensure that:

- The rules of the medical aid scheme permit non-contributory members (failing which the payment of an employee's portion by the employer constitutes a taxable fringe benefit);
- Employees are aware that their qualifying earnings for UIF and pension purposes are reduced; and
- Payslips and IRP5 reflect the factual position."



Back to profit for Penrose

PENROSE Holdings reported a decline in turnover and losses in the six months ended June 1993, but the printing and publishing company was finally making a profit, chairman Albert Alletzhauser said yesterday.

Turnover fell to R9,49m (R12,3m) and Penrose reported an attributable loss of R1,54m (R1,36m) — equal to 7,1c (7c) a share.

Alletzhauser said Penrose made a net profit in July and August.

Privileges you can use as a pensioner

Sowetan 24/9/93

(299)

By Tsale Makam

OLD age brings many hassles, one of them being the illnesses that seem to plague only the old.

For instance, the over 65 age group represents a large segment of the diabetic population.

In South Africa about 27 percent of health-care costs are devoured by medicine.

So financial independence in retirement cannot be overemphasised in this regard.

When one retires, the medical aid also stops. However, some companies, depending on the insurance scheme, keep their retired employees on the medical aid scheme.

They usually deduct medical aid contributions from one's monthly pension payments. This way, when an illness strikes the retired person, he or she will not be a financial burden to family or friends.

Health conditions

But most adult health conditions are such that the elderly rely on certain medications and have to take them regularly. The cost of medicines, another highly debated issue, is rising every day.

To cut the cost of medicine, firstly, it is important to take care of one's health from an early age. Early diagnosis and treatment will save you money and time in your later years.

Secondly, take the medicine that has been prescribed to you, no more, no less. Thirdly, ask your pharmacist or doctor where possible to fill your prescriptions with generic medicines.

What are generic medicines? One writer described them aptly as the "no-name brands" of medicine.

These are cheaper because they have not eaten into the medical pockets by being researched and promoted into the market.

International companies

Generic medicines, on the other hand, are manufactured by international companies who spend about 20 years and millions of rands researching the medicine before it could be marketed.

Usually the company that developed the product marketed it for up to five years without competition.

Medical aid companies are also trying to save by applying the principle that they will not pay more for a medicine than the cost of a generic medicine.

Pensioners should also take advantage of all the specials and free services that are offered to them — not only in health care.

For example, in off peak-hour periods pensioners travel free of charge in Johannesburg City Council buses.

Hospitals charge a special fee for pensioners and the unemployed.

Ask your local club for the aged about the privileges you can make use of as a pensioner.

Speaking at a health conference at Midrand last week, Dr Jay Hughes, right, and Tom Breedlove of the Proudfoot Centre of Excellence for Health Care in the US.

Picture: ROBERT BOTHA

Call for urgent cramming

KATHRYN STRACHAN

THE National Education Co-ordinating Committee (NECC) has warned that the two-week postponement of black matric exams would be meaningless if it did not coincide with a period of intensive learning. B/Day

The NECC, which spearheaded the campaign to have the exams delayed to allow pupils to make up time lost through teachers' strikes, violence and classroom disruptions, said it welcomed Education and Training Minister Sam de Beer's announcement on Friday. 27/9/93

It would assume its share of responsibility in ensuring the two weeks of grace was used well, together with its affiliates the Congress of SA Students (Cosas) and the SA Democratic Teachers' Union (Sadtu). (522)

It hoped other groups, particularly the Education and Training Department (DET), would also throw their weight behind catch-up activities.

But schools in Soweto were thrown into fresh disarray last week when Sadtu members hounded principals from their schools and barred them from returning until teachers' demands had been met.

Teachers are demanding the refund of money deducted from their salaries during their participation in a strike earlier this year. The union claims the principals are responsible for reclaiming the money, although principals were not consulted by the DET when it decided on the deductions.

Pensioners' medical costs spiral

CHARLOTTE MATHEWS

THE funding of medical expenses for retired employees had become a major cost and was about to overtake retirement funding as a percentage of salary bills, Southern Life assistant general manager Mike Hogan said on Friday. B/Day

Hogan told a conference on pensioner health care funding that over the past 10 years retirement funding contributions had remained steady at about 10% of an individual's salary bill but medical scheme contributions had risen to 10%-12% from 2% of salary 10 years ago, reflecting compound medical inflation of 35% a year. 27/9/93

In the past, many medical schemes have been implicitly funding pensioners' medical costs by loading normal pay-as-you-go contributions by 10% and building up a reserve.

In practice, the higher cost of claims has dissipated this reserve. The cost of providing medical cover for pensioners has had to come out of contributions, but historically the contribution rates for pensioners have been considerably less than that of in-service members.

It has always been assumed that there will be a sufficient flow of younger, high-contributing and low-claiming members to subsidise the higher-claiming, lower-contributing pensioners. (299)

Medical aid schemes are now planning to phase out pensioner subsidies because of the lack of reserves and the increasing ratio of pensioners to in-service members and are moving towards relating contribution rates to claims experience. (300)

Realistically, pensioners will not be able to afford the cost if their claims are separately costed and paid for. Research conducted for Southern Life shows the true medical cost per pensioner is now between R700 and R800 a month, against the average pension of R490 a month according to the 1992 Mouton Report.

Southern Life has developed a scheme to prefund retired members' medical costs, the integrated funding plan. It undertakes an actuarial evaluation of a medical aid scheme, identifying the cost of prefunding for active in-service members and the fund's liability for existing pensioners. Medical claims are projected to estimate an affordable level of funding. Southern Life also offers advice on legal and tax matters, administration systems and asset management.

The advantages of prefunding retired members' medical aid costs are increased security of members' benefits, smoothed contributions from year to year and accelerated tax relief on contributions. Contributions to a medical benefit fund can be transferred from one fund to another.

ICAN BREWERIES ... report was based on selectively ... tions. Findings were also based on "so-called indepen-

... ment, but declined to comment further ... will be had seen Shill's scheme. (123)

B/Day 27/9/93

... I can't give you details at this parti... lar stage. In the fairly near future I believe

How best to care for us all?

Star 29/9/93

299

AT the recent conference of the International Federation of Health Funds, David Robbins saw an outline of the future begin to emerge

What role will South Africa's hard-pressed medical aids play in a future health system? How will the introduction of a national health insurance scheme (NHI), or a national health system (NHS), affect the private sector, including the private health funders?

How, for example, can the private health funders make an impact on the massive problems of inequity and inaccessibility to basic health services for millions of South Africans?

Beneath the questions and confusion stood one immutable certainty on which all 160 delegates at the International Federation of Health Funds held in South Africa were agreed: times were changing. Here was a conference about the future, about innovation and survival.

An array of overseas experts had been assembled to help in this process. Two Americans spoke about managed health care in the United States through well-established conglomorates like the Blue Cross Blue Shield Association and the Kaiser Foundation Health Plan, providing comprehensive health care to 20 million and nearly 7 million Americans respectively.

These are huge organisations. The Kaiser Foundation organisation employs over 9 000 physicians and 75 000 other health and administrative workers. The organisation has its own hospitals, its own pharmaceutical formulary from which all its doctors are obliged to prescribe.

The examples were inspiring, but most people were aware that in a system dominated by the private sector there were millions of Americans who had no health insurance whatever.

Tom Ryan, current president of the International Federation of Health Funds, told delegates that in Ireland there was a growing realisation that neither the public sector alone nor the private sector alone could provide adequate health cover for all. Only a strong partnership between the two sectors would ensure success, he said.

Even in Africa? Evidence from Zimbabwe suggested that such a partnership was crucial.

Dr Ralph Mgijima, the ANC's secretary for health, said that South Africa would probably opt for a health insurance system.

He caused some discomfort when he suggested that a future health department could stop the tax relief currently given on medical aid contributions. In this way, R1,3 billion could be released for direct state spending on essential health services.

Such action could also place in jeopardy the medical aid cover currently enjoyed by lower-income whites, and around a million other medical aid members who were not white. "If the subsidy goes," one delegate pointed out, "contributions will have to be increased. Those who can't afford them will lose their cover, and be forced on to the mercy of the State."

"I don't think there's a fixed blueprint for the future yet," someone said in a group discussion, "but private and public sectors will have to be involved."

And the possible shape of the future to emerge from the regional conference?

Something like this: a State sector concentrating on primary health care issues and the deli very of core services; a private sector building on this foundation, assuming more responsibility in the community (perhaps even employed on an agency basis by the state) and turning more and more to managed health care as a means of greater cost efficiency and of spreading the net of affordable health care ever wider.

Retail pharmacies at risk

Star 4/10/93

■ BUSINESS STAFF

The future of retail pharmacies hangs in the balance.

The outlook, says Carl Schnell, chairman of Natal Wholesale Chemists (Plus), hinges on the decision of the parliamentary standing committee on health matters on who may dispense scheduled medicines in the future.

Medical aids are campaigning to be allowed to dispense medicines themselves.

But, Schnell warns: "Medical aids will have to get their own houses in order before they're able to pass on cheaper prices.

"For example, the average medical aid's overheads are 6 percent of turnover. They don't store medicines, don't deliver and are paid up front.

"Pharmacy wholesalers, on the other hand, also run at about 6 percent, but they store, deliver and have to wait for payment. So medical aids have a lot to learn about efficiency before they'll be able to pass on savings."

In addition to high overheads, Schnell says most medical aids are not taking advantage of a maximum pricing system, whereby if a generic equivalent to the prescribed medicine is more cheaply available, the patient has the option of taking the substitute or paying the difference.

"Medical aids to have adopted this system are saving their subscribers millions. But very few are doing it.

"Medical aids shouldn't open pharmacies unless they control the prescriber. Far more beneficial would be for medical aids to give incentives to doctors for prescribing cheaper generics."

Factors influencing rising medicine costs:

- The tender system. In some cases the private sector is paying 500 percent more than government institutions for the same product.
- Price discrimination by medicine manufacturers.
- The failure to legislate for generic substitution.

According to Schnell: "What we are about to do is going to cost consumers dearly. If the standing committee allows dispensing willy-nilly, it will destroy a retail pharmacy healthcare network built up over many years."

Four medical aids to merge

B1Day 5110193

KATHRYN STRACHAN

FOUR medical schemes representing a collective bargaining power of 1,2-million beneficiaries and an annual benefit payout of R3bn yesterday announced plans to join forces.

Medihelp chairman Koot Myburgh said his organisation shared common goals with three other schemes, Bonitas, Pro Sano and Sanitas, which in May this year had formed a confederation called Bonprosan. (299)

The move was aimed at cutting medical expenditure by strengthening the group's collective bargaining position with suppliers.

Although membership to date was mainly of state, provincial administration and parastatal employees, membership was available now to the private sector.

Negotiators approve wide range of fundamental rights

BD ev 8/10/93

DELEGATES at SA's multiparty talks yesterday approved a wide-ranging set of fundamental rights, including a strict limitation clause.

Presented with the 10th progress report by the technical committee on fundamental rights, the negotiating council at the World Trade Centre rapidly approved clauses ranging from freedom of expression to economic and environmental rights, Sapa reports.

A clause on children's rights was also passed, including a provision stipulating the right of the child to be treated "in a manner which takes account of his age" if detained. Technical committee chairman Prof Lourens du Plessis said this would directly affect children already detained.

A limitation clause — "one of the toughest in the world", according to another committee spokesman — was also approved by the council.

The clause says the rights approved can be limited only if "such limitation ... is reasonable ... justifiable in a free and democratic society based on freedom and equality ... and shall not negate the essential content of the right in question".

A suspension clause — which apparently worried only the PAC, which reserved its position — was also passed.

The clause states that entrenched rights can be suspended if a state of emergency is declared but "only to the extent necessary to restore peace and order".

Such an emergency could be declared if state security was threatened by war, invasion or "general insurrection". It should last for 21 days unless a two-thirds majority of the national assembly decided to extend it "for consecutive periods of no longer than three months at a time".

The PAC said the clause was "very draconian".□ Our Political Staff reports from Cape Town that the Women's National Coalition yesterday slammed constitutional plans to exclude black women from the policy of equality for all women.

The coalition, which represents 80 women's organisations, including the NP's Women's Action and the ANC's Women's League, called on the negotiating council to ensure that the law recognised equality for all citizens.

"We reject completely the notion of the promise of immediate equality to white, coloured and Indian women to the exclusion of African women under customary law," the coalition said.

Medical card allows credit, discounts

KATHRYN STRACHAN

A NEW healthcare payment card, which will allow patients to pay bills immediately and save up to 30% on certain prescription medicines, was launched in Johannesburg last night. BIDay 8/10/93

Changes to the Medical Schemes Act mean that from January patients will have to settle medical bills immediately, before claiming from medical aids.

The Prodoc medicard, which has the financial backing of Standard Bank, will allow consumers to pay doctors immediately and have medical aid claims submitted electronically to debit their bank accounts.

They will also receive up to 30% discount on prescription medicines from participating pharmacies and benefit from an interest-free period of up to 55 days.

Prodoc spokesman Chris Archer said the new legislation, precipitated by widespread abuse of the system, would mean doctors were no longer guaranteed payment from medical aids. But Prodoc guaranteed payment immediately so patients could negotiate cash discounts. (299)

Archer estimated that 25% of medical costs were misappropriated or fraudulently spent.

The new legislation would also see the maximum and minimum benefits system fall away, so medical aids would no longer need to guarantee payment of a minimum of 70% of costs and a maximum of 100%.

"With Prodoc we can show that our doctors are more cost-effective and we can therefore negotiate with medical aids to contract directly with our doctors to pay more realistic fees," he said.

Health plan targets corporate market

CHARLOTTE MATHEWS

FIRST National Bank, Aegis Insurance and Fedlife Assurance are launching a health funding scheme for individuals which offers a savings element, medical insurance and long-term investment for post-retirement health costs. BIDay 13|10|93

"We believe that in Med Relief we have come up with a product that is comprehensive, simple and customer-friendly," Fedsure group CE Arnold Basserabie told a media conference yesterday. (299)(85)

The medical insurance element of the scheme is underwritten by Aegis.

It offers medical cover to a maximum of R150 000 for an individual and R300 000 for a family for premiums of up to R223,08 a month.

Emergency medical services and benefits through International SOS Assistance are included. The medical insurance scheme has a R5 500 excess, which may be covered by an optional hospital policy.

First National Bank offers a savings fund linked to a debit card which is intended to be presented to doctors and pharmacists to pay bills immediately.

The minimum monthly contribution to the fund is R100 but a credit balance earns preferential interest rates.

An optional endowment policy is available through Fedlife which is intended as a long-term investment for future medical costs.

According to Med Relief's brochure, 70% of all medical bills are incurred in the last three years of a person's normal lifetime but at that stage medical insurance can be expensive and difficult to secure.

The minimum contribution to the endowment policy is R100 a month and it has a waiver of premium benefit so that policy contributions are paid by Fedlife if the policyholder is permanently disabled.

The scheme will be targeted at the corporate market from 1994.

Presmed riding high

Star 22/10/93 299

President Medical Investments (Presmed) has increased earnings by 23 percent (to 14c a share) for the six months to August, thereby improving upon its stated objective of 20 percent growth.

Prospects have been boosted by today's announcement that it is to acquire 100 percent of Carstenhof Clinic, a plastic surgery hospital.

The transaction will lift Presmed's earnings (on a fully diluted basis) from 20,1c to 22,6c a share and raise tangible net worth by 81 percent to 116c a share.

The R22,9 million deal with the present owner, Absa, will be satisfied by the allotment and issue of Presmed and Presmed Holdings (Preshold) shares (at prices of 400c and 195c a share respectively).

As a result, Absa will have 14 percent of Preshold and 8 percent of Presmed.

Joint managing director Carl Grillenberger says the Carstenhof acquisition heralds a new phase in Presmed's growth.

NEWS

Spending to be monitored

Doctors, medaids in bid to slash health care costs

Star 26/10/93

299

BY STEPHEN CRANSTON and JACQUELINE MYBURGH

PATRIOTIC Health Front rejects scheme as a unilateral move that should have been discussed in the National Health Forum

The medical profession and the medical aid movement have come together to try to reduce medical costs by R500 million next year.

An agreement between the Representative Association of Medical Schemes (RAMS) and the Medical Association of South Africa (Masa) was announced yesterday.

In terms of the agreement, the scale of benefits received by doctors will be increased by 12 percent for the first half of next year.

RAMS chairman Keith Hollis told Sapa the move could mean an 11 percent increase in members' contributions payable from January 1, as opposed to the 18 percent increase instituted at the beginning of the year.

If the R500 million level of savings is achieved, the scale of benefits will be raised by 5 percent to 17 percent for the second half of the year.

RAMS executive director Reg Magennis said doctors would focus on cutting the amounts spent on hospitals and medicines.

"Doctors will look carefully at the length of patients' stays in hospital and think carefully before someone goes to hospital," he said.

"The choice of drugs will be watched and doctors will be a lot more conscious of cost."

However, if the use of medicines and private hospitals continues to increase, the scale of benefits could be reduced to 9 percent above 1993 levels for the second half of next year, Magennis said.

The joint announcement has been rejected by the Patriotic Health Front — an umbrella body which includes the ANC, PAC, SACP and Cosatu — as a unilateral decision that should have been tabled and discussed in the National Health Forum.

SA Health and Social Services Organisation national publicity secretary Dr Aslam Dasoo said: "We would welcome any constructive approach towards cutting the costs of health care, but do it in the appropriate way to create legitimacy."

The project to cut costs will be monitored by a joint RAMS/Masa computerised process and regular feedback will be provided to doctors on their progress.

It is the first time the two organisations have shared information in this way — until now they have had an adversarial relationship.

"This development acknowledges the crucial role of doctors, and hails a new era of trust and co-operation between health-care insurers and the medical profession," said Masa secretary-general Hendrik Hanekom.

"Private health care can be reformed in a manner that will result in affordable, high-quality medical care for a larger proportion of the South African population," he said.

RAMS and Masa have agreed to achieve a number of other goals, including the continued availability of health services of acceptable quality and the optimum use of health-care resources.

...t • Strict money measures at university

New scheme could cut medical costs

Sowetan 26/10/93

By Musa Zondi

■ BIG SAVING Move could mean smaller increase in contributions:

299

HEALTH bodies have joined hands to try to reverse the spiralling cost of medical care with an historic agreement.

The agreement, announced yesterday, stipulates that the Representative Association of Medical Schemes will increase the scale of medical aid benefits for doctors by 12 percent and, in turn, doctors have undertaken to cut costs on medicine and hospitalisation.

This increase will be for the first half of the year and for the second half, the scale will increase to 17 percent — if doctors can achieve the desired saving of 8 percent.

In simple terms, this saving would make it possible to keep costs of subscribing to medical aid schemes down. If the costs are down, this would mean that people who do not belong to medical aids yet could afford to join, says Rams' executive director, Mr Rex Magennis.

Rams chairman Keith Hollis told *Sapa* the move could mean an 11 percent increase in members' contributions payable from January 1, as opposed to the 18 percent increase instituted at the beginning of the year.

This will be equivalent to saving R500 million nationally in hospital and medicine costs. But if the desired saving is not achieved, the scale of benefits will be reduced to 9 percent for the second half of next year.

Affordable

"The agreement will be an extremely powerful means of reforming private health care in a manner that will result in affordable high-quality medical care for a larger proportion of the South African population," Dr Hendrik Hanekom, secretary-general of Masa, said.

The executive director of Rams, Mr Reg Magennis, said his organisation was delighted with the outcome of the negotiations which took two months.

The Patriotic Health Front — an umbrella body overseeing health care — yesterday rejected an announcement by the Rams that the scale of benefits for doctors' services would be increased by 12 percent, reports *Sapa*.

The joint announcement on the increase was made yesterday by Masa and Rams.

The national publicity secretary of the South African Health and Social Services Organisation, Dr Aslam Dasoo, told *Sapa* he did not believe the move would reduce the cost of health care but would instead serve to increase the personal wealth of private practitioners.

Dasoo claimed the increase in the scale of benefits would have no effect on most people in need of medical assistance.

Health care body rejects fee increase

B/Day 26/10/93

THE Patriotic Health Front — an umbrella body involved in monitoring health care — yesterday rejected an announcement by the Representative Association of Medical Schemes (Rams) that the scale of benefits for doctors' services would be increased by 12% for the first half of 1994.

The announcement on the increase was made earlier yesterday jointly by the Medical Association of SA (Masa) and Rams.

SA Health and Social Services Organisation national publicity secretary Dr Aslam Dasoo said he did not believe the move would reduce the cost of health care but would instead serve to increase the personal wealth of private practitioners.

Dasoo claimed the increase in the scale of benefits would have no effect on most people in need of medical assistance.

He said the medical aid scheme structure had been the subject of review and analysis "but principally by those parties involved with vested interests in the medical aid industry, including Rams, Masa, pharmaceutical companies and other aspects of big business together with the government".

Dasoo said several parties in the health care sector were neither consulted nor party to any analyses carried out by these groupings and "therefore all of their findings we would regard as spurious and any consequent recommendations we would regard as highly suspect".

(299) (93)

He said the "crisis" in the medical aid industry could be solved only once all parties accepted that the private health sector was inextricably linked to public health services and "any attempt to restructure the private health sector will always impact on the public health services".

Dasoo said tariffs and other issues affecting the public and private health sectors should be tabled at the National Health Forum so that all relevant parties could participate in the debate and the approach would "be far more holistic and sensible".

Members of the the Patriotic Health Front included, among others, the ANC, the PAC, the National Education, Health and Allied Workers' Union, Cosatu and the SACP, Dasoo said. — Sapa.

Doctors urged to 'play ball'

Star 28/10/93

■ BY JACQUELINE MYBURGH

The increase in benefits that medical aid schemes will pay doctors next year is an incentive for doctors to cut costs and does not mean that the medical aid schemes will be spending more money.

If doctors "play ball" by prescribing less and eliminating unnecessary admissions to hospital, the medical aid industry hopes to save R500 million in the first half of next year.

Target

299 (93)

Sources in the industry said that if the target were met, the scale of benefits would be increased to 17 percent in the second half of 1994.

If doctors did not "play ball", the scale of benefits payable to them would be decreased to 9 percent in the second half of next year.

The sources added that the 11 percent increase in members' contributions payable from January 1 was inflation-related.

Clive Stuart ... Medicaid MD.

Under the agreement struck between medical aid schemes and the medical profession, medical schemes would, essentially, not be paying out more because doctors would be prescribing less and cutting down on hospitalisation of patients.

Clive Stuart, managing director of the Medicaid scheme, said doctors were being told that they were the "gatekeepers" and had to decide whether to send a patient to hospital and what medicine to prescribe.

"The idea is that doctors can save us more than the added 5 percent by astute management of patients," he said.

Income

"That is why we are talking about potential savings after an increase in income," said Reg Magennis, executive director of the Representative Association of Medical Schemes.

Some of the savings related to judicious management of medicines and hospitalisation could impact on doctors' incomes, but this would not be significant, he said.

"There will be more money coming the doctors' way if they cut costs and then increase consultation fees. That is restoring the right kind of decision-making in the health care system."

The more long-term significance was that health care would become more affordable and accessible to the public, said the Medical Association of South Africa.

Star 30/10/93

Warning on medical inflation

(299)

FINANCE STAFF

MEDICAL costs will take up a growing portion of people's income if inflated prices are allowed to continue in certain sectors of the health care industry, says Medicaid Administrators deputy chairman and CEO Jeff Slome.

In recent years, salary increases have been below the inflation rate, while medical cost increases have been higher, resulting in medical expenses soaring.

"Service industries traditionally find themselves balancing quality against cost. But in health care, quality is non-negotiable: it has to be excellent," Slome says.

"This creates tremendous pressure to develop innovative ways to keep premiums to a minimum.

"We have succeeded in holding subscription increases to well below the rate of medical inflation. This cannot continue without the support of all sectors of the health care industry.

"The biggest component of medical expenditure is medicines (32 percent), followed by hospitalisation fees, which make up 20 percent of total costs.

"Advancing medical technology, although it is expensive, helps to bring down hospitalisation costs by reducing the time patients spend in hospital. Half of all surgical procedures can be performed on a outpatient basis, and this should rise to 60 percent by 1996.

"Medicine costs are proving more difficult to reduce ... the fact remains that over-the-counter prices are ridiculously high. The solution may lie in amending legislation to allow medical schemes to own and manage dispensaries."

Medical aid in bid to avert legal action

THE Consolidated Employers' Medical Aid Society, which has had problems with delayed payments of claims, is to meet the Registrar of Medical Schemes today to argue against the company being placed under judicial management. 18/11/93

A spokesman for Consolidated Employers' administrators, Affiliated Medical Administrators (AMA), said proposals for restructuring the company had the backing of AMA parent company, Southern Life.

BDay

KATHRYN STRACHAN

Consolidated Employers had the financial means to pay the claims, of about R40m a month, but administrative difficulties had caused delays. Consolidated Employers has 70 000 members. (299)

Registrar Danie Kolver said the central council for medical schemes was investigating a number of schemes to assess the soundness of their financial positions.

CATCH-22 . . . SA National Epilepsy League community worker Khandas Mkhandawire explains the difficulties epileptics face when their disability pensions are cut off.

Epileptics claim unfairness

CIPress 21/11/93

EPILEPTICS throughout the Transvaal are having their disability grants cut off and being told to go and find jobs despite being declared 100 percent disabled and unable to work by district surgeons.

The TPA's pensions department this week denied it had adopted a policy of cutting off epileptics' pensions, and insisted epileptics were treated the same as other applicants for disability grants.

A pattern is emerging to show that epileptics – some of whom have been getting disability grants for years – are now being told they no longer qualify and should get jobs.

In the past few months, City Press has noted a definite increase in the number of epileptics complaining about having their disability pensions cut off.

The SA National Epilepsy League (Sanel) also believes the TPA has adopted a deliberate policy of reducing the number of epileptics getting government grants. (299)

Sanel's chief community worker in the southern Transvaal region, Solly Makgatle, said it appeared that the TPA's drive to reduce the number of disability grants had affected epileptics.

Makgatle said some epileptics responded well to treatment and could work as long as they took medication regularly.

He said epileptics were in a Catch-22 situation when their disability grants were cut off. Many could no longer afford to get the correct medication and some could not afford hospital and clinic fees, so stopped their medication altogether.

Makgatle said it was very difficult for epileptics to get jobs because they were discriminated against by employers who, with the high levels of unemployment, would prefer to take on a person without a disability.

The TPA's attitude is that "a social pension is not a right" and that "social pensions cannot accommodate those persons who, due to the bad economy are unable to find suitable jobs".

This was the TPA's message to two Heidelberg epileptics whose pensions have been summarily cut off.

Mokete Tsotetsi, 23, of Ratanda has suffered epileptic fits since birth and started getting his disability pension in 1989. It was cut off in July and pensions clerks told him to go and get a job.

For 59-year-old Jermina Selepe, the cutting off of her disability grant was a cruel blow. She was told to wait until next year when she turns 60 and then apply for an old-age pension. She has relied on her pension for the past eight years.

This week the TPA's explanation of these cuts was that both Tsotetsi and Selepe's grants had been 'temporary' and that neither qualified any longer, even though their circumstances had not changed and both had been declared disabled and unfit for work.

The TPA may deny there's a pattern or a policy operating here, but what is happening to epileptics can hardly be explained as a string of coincidences.

Water Board and the municipalities themselves.

Figures are available for a total of 27 towns. The weighted average consumption for all these towns is 290 l/c/d.

VW leaves aid scheme

Own Correspondent

PORT ELIZABETH. — Volkswagen, the Eastern Cape's biggest employer, is quitting the Midland Medical Plan (MMP) after rejecting a 27% increase in contributions.

According to MMP, the rise was imposed after "serious losses" in the Volkswagen account.

Volkswagen SA confirmed yesterday that it had left the scheme.

Volkswagen's 7 000 workforce makes up 15% of the MMP membership.

MMP director Mr Bruce Dyke said VW management and employee bodies were not prepared to accept "inevitable increases".

Volkswagen said a management/union team was evaluating options and had guaranteed similar medical aid cover from December 1.

Medical aid giant on the way

ARGT 23/11/93 (299)

Business Staff

A NEW dimension is being planned for medical aid assistance with the announced merger of two of the country's major medical aid administrators.

The biggest medical aid administrator Medscheme and Medicaid announced yesterday they are to merge to create a R2,5 billion premium-income operation.

The new company intends to move into providing affordable medical aid to the low income sector while also putting greater emphasis on managed health care and primary care.

The new company will have 600 000 members and more than two million beneficiaries.

An additional 40 000 members has been added over the last six months.

The group will process more than 1,3 million claims a month.

Existing Medscheme shareholders will hold 70 percent of the new company. Medicaid, part of the Price Forbes group, will hold the remaining 30 percent.

Keith Hollis, chairman and MD of the combined operation, says: "While we intend maximising the synergy between our combined 1 500-strong workforce and advanced technologies, this is not a rationalisation exercise. We anticipate substantial growth."

Mr Hollis says the new group will move incrementally into managed care programmes and primary care.

An important goal is to devise an affordable healthcare package, costing about R100 a month, to make medical aid available to the lower-paid.

The stokvels system could be a vehicle to get into this market, Mr Hollis says.

Medscheme and Medicaid to merge

BDay 23/11/93

KATHRYN STRACHAN

TWO of the largest medical aid administrators yesterday announced they would join forces next week to face the challenges of the new medical aid legislation which comes into effect in January.

Medscheme, the largest administrator, and Medicaid will merge to create a R2,5bn premium income operation. The new company, called Medscheme, will administer 65 medical aid schemes and serve more than 600 000 members. (299)

Keith Hollis, chairman and MD of the combined operation, said the amendment to the Medical Schemes Act was aimed at deregulating the industry and paved the way for innovative new packages.

The amendment does away with guaranteed payment for doctors as well as minimum and maximum benefits.

The complexity of the packages had become "a nightmare" to administer and a combined team would be better placed to streamline administration. The savings would be absorbed by administration costs, which would increase dramatically.

Hollis said improved service was necessary to manage the "new-look medical care". The new legislation would allow schemes to provide wider services. For example, the black public sector scheme Bonitas would be able to pay for a wider range of primary health care services.

Medscheme, Medicaid to merge

299
CT 23/11/93

JOHANNESBURG. — Two major players in South Africa's health care industry have decided to merge from December 1.

Medscheme — SA's largest medical aid administrator — and Medicaid will join to create a R2;bn premium-income operation, to be known as as Medscheme (Pty) Ltd, incorporating Medicaid.

The MD and chairman of the combined operation, Keith Hollis, said the move would benefit almost two million beneficiaries.

Former Medicaid CEO Jeff Slome and former Medscheme MD Andrew Jackson will serve the new company as joint deputy MDs.

Hollis said the amendment to the Medical Schemes Act, due to take effect in January, was aimed at deregulating the industry and paved the way for innovative new packages.

The amendment does away with guaranteed payment for doctors as well as minimum and maximum benefits.

R2,5-bn medical aid merger

Star 23/11/93

■ BY STEPHEN CRANSTON

Medscheme, the biggest medical aid administrator, and Medicaid, are to merge to create a R2,5 billion premium-income operation.

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Jeff Slome, formerly chief executive of Medicaid, and Andrew Jackson, formerly the Medscheme deputy MD, become joint deputy MDs.

Sowetan 25/11/93

■ PUPILS SUFFER Children take a back seat while teachers bicker:

By Glenn McKenzie

MICHAEL LENNETH struggled to pull himself on top of a desk in the empty school. Once seated, he explained what he saw that first day his school had been locked up.

"No one told me anything. In fact, I didn't know what was happening," Lenneth said.

Lenneth is partially paralysed in one arm and one leg. The 18-year old Tladi resident has been attending JC Merkin School for Disabled Children in White City for several years. He had no choice he said, it was the only primary school of its kind in the township.

On Friday, Lenneth wondered if his school was closed for good.

Not permanent

School administrators said they locked the school because a demonstration by Sadtu and Soweto Civic Association members on Friday morning threatened pupil and staff safety. The closure was not permanent, they insisted.

"We created this school for crippled children. It's not our business to close it," said Mr Guy Houghton, director of the Association for the Physically Disabled.

Sadtu members denied using violence. They say they were merely protesting at what they saw as the school's permanent closure.

"We don't believe they won't close it unless they put it in black and white. They have given us conflicting stories," said Sadtu representative Mr Sethloho Khesa.

Meanwhile, standard 6 students were unable to complete their exams on Friday.

And on Saturday, about 60 disabled students who lived in the school's hostel were loaded into buses and escorted to Protea police station. From there they were taken to Hope School in Westbridge where they were to be picked up by their parents. Some of the children come from regions outside the PWV.

Protesting civic members, teachers and parents say their response to the move was to occupy the school. They were determined to "prevent (administration) from taking any equipment," they said.

For Sadtu and civic members, the disruption was over the future of the school. Some teachers and parents were worried that a new JC Merkin "expansion" in Germiston was just an excuse to phase out the Soweto school.

The APD said they were not sure what the dispute was really about. They said there was no reason to worry about the school closing, and they wouldn't force children or teachers to move to Germiston. The fuss made by "certain bad elements" was just a power struggle, they said.

What was clear was that both union teachers and school administrators claimed to be victims of the other's actions. Each group blamed the other for the school's closure. (299)

Khesa said that Houghton and other administrators had been urging teachers and parents to move to the Germiston school "expansion." They saw that as a sure sign that the Soweto school was being phased out. But the APD said that Sadtu was just using the expansion as an excuse to demonstrate. Houghton said Sadtu was involved in a power struggle with non-Sadtu teachers. He said Sadtu should not worry about teachers being forced to leave.

"There is massive mistrust, mistrust of the owners of the school. And it is unfounded," Houghton said.

Khesa said the JC Merkin dispute won't be solved until the issue is debated from a public forum open to the Press.

"We can tell you our story, and they can tell you their story and nothing will be solved until we meet and negotiate," Khesa told *Sowetan*.

Houghton agreed that negotiations were necessary to reopen the school, but he said he was unwilling to "politicise" the future of the school.

"We are not prepared to get involved in a political thing," he said. Only parents should be involved in deciding the pupils' future.

But Sadtu and civic officials said the community felt the school belonged to them.

"If people wanted to destroy this school, if they didn't want it, they would have burnt it down a long time ago," said a civic member who refused to be named.

And while the adults battled over Soweto's only primary school for disabled children, groups of children on crutches and in wheel chairs waited quietly outside the gates of the school on Monday.

APD, Sadtu, and civic representatives all agreed that the children were the losers in the struggle.

"At the end of the day, it is the children who suffer," said the APD's Houghton.

"If people wanted to destroy this school, if they didn't want it, they would have burnt it down a long time ago"

Parents, teachers and members of the Soweto Civic Association gather at JC Merkin School for the handicapped in Soweto.

Crippled kids wonder why

Medical aid schemes forced to rethink strategy on AIDS

BiDay 30 1114B

MEDICAL aid schemes were being forced to reformulate health care funding for AIDS, as the disease would eventually take on such proportions that the formal health sector would be unable to cope, the National Health Department said yesterday.

Highlighting World AIDS Day tomorrow, the department said that until now medical schemes had imposed the most stringent limits available under the Medical Schemes Act — R600 for AIDS a family a year. Doctors responded by submitting accounts for AIDS under "disguised" diagnoses which were paid unwittingly by medical schemes. (92) 299

However, a recently established Medical Aid Administrators' Working Group was paving the way for dealing with HIV infection in a more open way.

KATHRYN STRACHAN

Practitioners, then, would no longer need to hide diagnoses from the medical scheme and the patient would not be penalised for such disclosure.

The overriding question was whether the funders and providers of health care could put together cost-effective benefit packages. Medscheme administrators said if schemes were to heed appeals to pay all AIDS-related claims, subscriptions would rise 31% for every 1% of their membership with AIDS.

Indiscriminate use of expensive treatment, such as AZT, the efficacy of which was still debated, would cause spiralling costs — and conventional approaches to curative care needed to be re-examined.

Medscheme said a more realistic model had recently been proposed by practitioners. The proposal reflected the principle that opportunistic infections should be more effectively prevented, fewer patients should be admitted to hospital, and less aggressive and expensive treatment should be given in terminal stages.

This was in line with the World Health Organisation strategy which advocated community home-based care, it said.

It is estimated that 500 000 people could be infected by the end of the year, with 550 becoming infected daily.

From 1982 to the end of September, 2 264 cases of AIDS were reported.

Meanwhile, Aidslink will mark World Aids Day tomorrow by handing over nearly R80 000 to organisations providing care and support for people infected with the AIDS virus.

Life saver for medical aid

299

CT 6/12/93

Own Correspondent

DURBAN. — Southern Life have stepped in and arranged the necessary financial support for ailing medical aid society Consolidated Employers', enabling it to continue trading.

In a statement yesterday, Affiliated Medical Administrators (AMA) said this meant "no practitioner, hospital or supplier of service can turn a Consolidated member away on the basis of uncertainty as to his medical aid".

Day of fun for disabled

By Mokgadi Pela

GRIM EXISTENCE Impaired face more discrimination than other people in society:

Sowetan 6/12/93

HUNDREDS of people in South Africa observed the International Day of the Disabled on Friday.

In Soweto, celebrations took the form of a wheelchair mile race, basketball tournament and track racing.

The situation in South Africa is being aggravated by the unabating violence which claims about 52 lives a day. For every three people killed violently, one acquires permanent disability, according to the Disabled People of South Africa.

Spokesmen for the disabled communities said the events aimed to raise public awareness about disabled people and to promote their human rights. One pamphlet stated that:

- Disability is a human rights issue.
- Abuses of the disabled happen every day in all countries.
- These abuses are based on old prejudices.
- They are institutionalised in the administrative system of each country.

The pamphlet further said: "Everywhere disabled people are the poorest in the community. They are denied access to buildings, information, independence, opportunity, choice and control over their lives."

299

Polio victims

In a media release, the DPSA said at least half of all impairments could be prevented or cured.

DPSA said 300 000 children were being disabled by polio every year.

Other figures show that 1 million people are disabled by malnutrition while 20 million blind people could have their sight restored by cataract operations.

The World Health Organisation estimates that 98 percent of disabled people in developing countries are totally neglected. The majority of those countries have no free medical care or social security systems.

Statistics further show that 60 percent of disabled people live below the poverty line in America, Canada and Britain.

In these three countries, the majority of disabled children receive segregated education and are twice as likely to be unemployed when they grow up.

According to the International Labour Organisation, the level of unemployment among disabled people is two or three times that of non-disabled people.

Fm 3/12/93

CHRISTMAS TOURISM

How many will come?

Christmas is only three weeks away but there's no clear trend yet on whether this will be a good or bad season for tourism. The regional organisations that promote tourism feel that this season will be better than last year's. But those at the coalface, whose fortunes depend on the number of tourists who pass through their doors, say that if they don't get a last-minute rush it will be a worse season.

Most foreign tourists have already made bookings — they're expected to arrive in about the same numbers as last year — so the success of the holiday season depends on undecided domestic travellers. "I have a gut feeling we'll have a slightly better season this year than last," says Gordon Oliver, CEO of Captour, which promotes tourism in and around Cape Town. "We had 50 000 people coming to our tourist information office last December, we're expecting 60 000 this December. Feedback from hotels is lousy but they are expecting the trend of last-minute bookings and walk-ins that has been developing for the past few years to continue."

Spoornet and SA Airways are not as optimistic. Spoornet has halved the number of extra passenger trains it will put on over Christmas, to 150 this year, says Matti Geldenhuys, manager of mainline passenger services. "Last year we had to cancel some special trains because of lack of demand. If there is demand this year we can either make up longer trains or put on more trains."

SAA is putting on only a few extra flights, says spokesman Annelda Duvenage. But it can use larger aircraft and turn them around faster if needed.

The wait-and-see game that tourists now play, and the cheap overseas holidays available, are also affecting bookings on the Blue Train, says manager Hennie Hartman. "At this stage accommodation is still available for December."

However, Durban expects a boom. Durban Unlimited tourism director Ted Hurst says surveys indicate that the city's hotel occupancies will be 70%-plus this Christmas, roughly 10 percentage points up on last year.

Hotels in Durban and elsewhere, however, are keeping rooms full partly through discounts. Says Hurst: "The bed-and-breakfast rate at several Durban three-star hotels is R89 per person per night, sharing." Protea Hotels' Debbie Reynecke says bookings are down on last year, "so we're offering special packages." In Cape Town the group is offering families of four five nights in either of its two four-star hotels, the Capetonian and the Ritz, for R899. On the Garden Route that package costs R799. In Natal it's offering two people sharing two nights, including breakfast, for R229.

The Sabi Sabi Game Reserve is offering accommodation at R670 per person per night until December 20, but between December 21 and January 15, "when it's the busiest time of the year, the charge goes up to R1 275," says the reserve's Sharon Joss.

Mala Mala is taking a tough line on discounts. "We don't offer specials," says GM Kian Barker. "We stick to our rates — R1 475/person to December 15, after which it goes up to R1 575/person, where it remains until December 15 next year because we won't compromise the product."

The vacancies at Cape Town's hotels could be partly due to the development of more hotels and good informal accommodation, such as guest houses and bed and breakfasts in nearby towns such as Paarl and Stellenbosch. Paarl Publicity Association manager Delene Smuts says: "Three years ago we had nothing. Now we have the five-star Grande Roche and we can offer 650 beds. The owners of Mooikelder, an old farm just outside Paarl, dropped their prices from R165 per person per night to R100 and drinks are free."

The car-hire industry is giving off differing signals. Budget Rent-A-Car MD Tony Langley does not see any major change this season. "We could get walk-ups, which will boost business, but Christmas day and New Year's day both fall on Saturdays, which shortens our season."

Imperial Car Rental MD Carol Scott has another view. "We're over the moon. Judging by November, which was our best month yet, we'll have a bumper Christmas. Advance bookings in Cape Town already exceed those for last year."

With the end of SA's isolation, domestic tourism has probably changed forever. One beneficiary is Zimbabwe. There has been a surge in SA tourists going to Zimbabwe, says Zambezi Adventures co-MD Margriet Luchs. "Everyone seems to want to go there. We're much busier than last year, taking them to Victoria Falls and chartering houseboats for them." ■

GET ON BOARD FOR THE CHINA TRADE SHOW

With just about a month left before the China Ocean Shipping Co (Cosco) starts loading samples for free transport to Beijing, time is running out for SA exporters who want to sign up for the March 22-25 SA-Chinese Exhibition (Sacex). The trade show will take place at Beijing's World Trade Centre.

"Renfreight will close its Cosco bookings on January 6 and loading will then take place at Durban harbour until about the 14th for shipping to China," says Joe Brady of Times Media Exhibitions, the show's organiser. "So anyone still wishing to get on board must now act fast."

Brady says the exhibition represents a great opportunity for companies to get a foot into the vast Chinese market at top level. China was the world's fastest-growing economy last year, expanding by 12,8%.

The US$10 000 show fee includes the airfare, exhibition costs, translation and matchmaking services, and seven nights at the four-star Beijing Sheraton hotel. A lower, group-participation fee is available to smaller exhibitors.

Brady says the show will be getting wide publicity with advertisements in the 10m circulation *People's Daily* newspaper, in the 2,5m circulation *Economics Daily*, and in 19 Chinese trade and technical journals. A press conference in Beijing a week before the show will highlight the event for the local media. Posters and banners will be put up throughout Beijing to promote the show.

Brady says that with the strong interest in the show, he expects to meet his target for exhibitors. "We are looking for 150-200 exhibitors to make the show worthwhile for both the SA companies and prospective Chinese buyers.

"SA's departments of Trade & Industry and Foreign Affairs will have stands, while SA Airways and Satour will be backed up by major hotel groups such as Sun International, which see big potential in the vast Chinese market. SA foods will be prepared by top hotel chefs and the Soweto String Quartet will perform."

ANC Department of International Affairs deputy head Aziz Pahad says: "We believe that this is an important initiative which should get the co-operation and support of all South Africans. We will therefore ensure that a senior member of our organisation represents us at the exhibition."

Project manager Jo Melville says Sacex will, in fact, involve four different exhibitions: business, travel & tourism; mining, heavy industry, construction & plant; light industry, technology, medical & scientific; and commodities. "Any company prepared to give up one business lunch a week for four people for one year can afford to be at Sacex and experience the opportunities offered by the world's most dynamic market."

OIL INDUSTRY

Ready for investment?

This week's showcase conference in Cape Town for the sub-Saharan oil and mining sectors was unprecedented in both size and scope.

It drew about 450 delegates from 38 countries, including 21 in Africa. VIPs who registered included at least 11 Ministers and deputy Ministers and an army of bureau-

Paralysed, but 'fit to work'

South 10/12 - 14/12/93

By Barbara-Ann Boswell

MRS AGNES Greenfield walks with a crutch, the result of a fall which left the 53-year-old Grassy Park woman paralysed in her left leg.

The accident has rendered Greenfield unfit to work. But when she applied for a disability grant from the House of Representatives (HoR) in September 1992, she was told she could not get one as she was fit for work.

Greenfield then sought the help of a doctor and reapplied. She has been waiting ever since.

"Every time I go to their (HoR) offices, they tell me that I have to wait and that they are still processing my forms," said Greenfield, who has no income. (299)

"In the past year, I've been there more than 10 times and they tell me to wait, or that they have lost my files."

As a result Greenfield has to go back to her doctor and social worker to fill in her forms again, and the money she was due to receive this year has expired.

Experiences like Greenfield's prompted Mr Abe Braaf from the Urban Advice Office Collective to hand over a memorandum, listing various problems, to the HoR.

According to Braaf, clients visiting the HoR offices to apply for disability or maintenance grants do not see the same official every time.

He says rude remarks are often passed, and clients are refused access to the people they are sent to see.

The memorandum also says that women claiming maintenance for their children are maltreated by inefficient HoR officials.

"Males get long visits and officials seem to listen to their problems, but women are in and out of their offices and get empty promises," says Braaf.

"Females are not present when maintenance cases are heard, and warrants of arrest sometimes take up to six months to execute.

"Women applying for maintenance grant files are not given file numbers or proof of their complaints. Cases drag on for more than three years without any final agreement or arrangement, and cases where men are in arrears of R6 000 are scrapped," says Braaf.

AGNES GREENFIELD

He says disability grants are often stopped when jealous neighbours phone the HoR to stop people receiving disability grants.

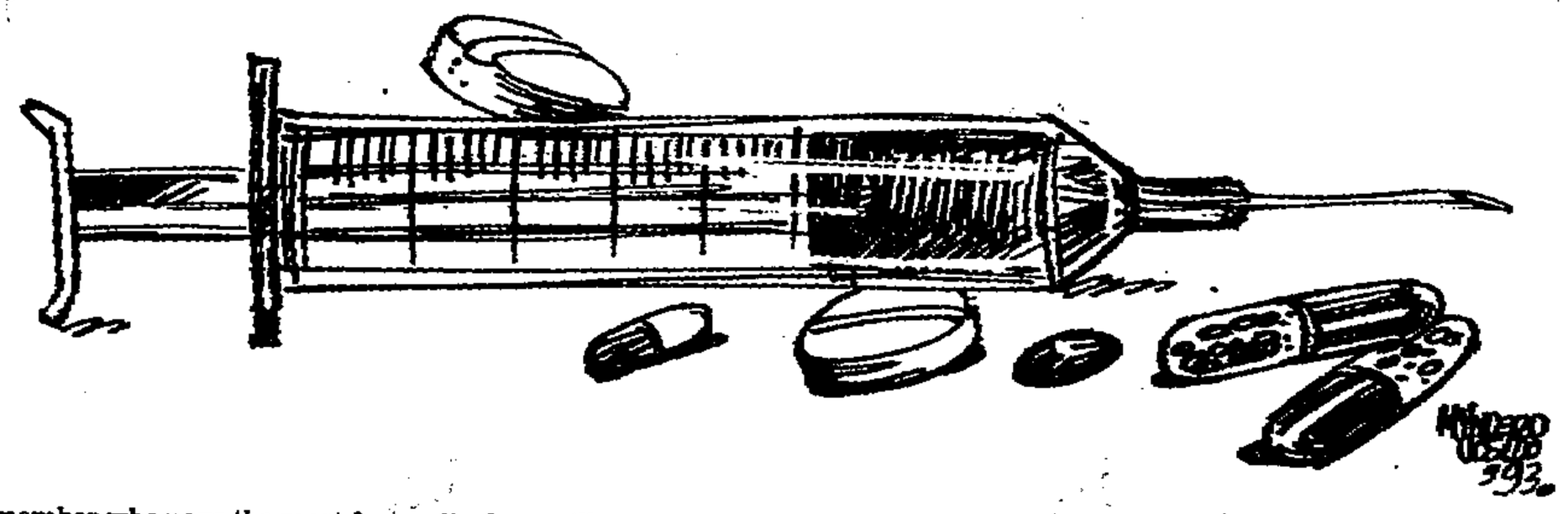
Dr Ebrahim Jarodien, chief director of the Department of Welfare in the HoR, said he had received the memorandum and that problems "of service and communication. will be looked into because we'd like to see all parties happy".

Braaf is appealing to members of the public who have difficulties with the HoR to write down their grievances and send them to Box 31151, Grassy Park, 7945

New therapy for medical aids

ST Times [Buss]

By TERRY BETTY



THE Medical Schemes Amendment Act in the New Year, bringing dramatic changes to the industry.

Medical schemes will become more flexible and compete directly with the insurance industry.

But what does this mean for medical scheme members?

Presmed joint managing director and past Representative Association of Medical Schemes (RAMS) executive director Rob Speedie suggests the following implications :

☐ Medical schemes are no longer obliged to cover medical costs from the first rand.

Mr Speedie says this change will allow members to pay an excess. "For example, a member will pay the first R1 000 of health care expenses in a particular year, after which the medical aid will kick in." Or the excess could apply to each bill where the member pays the first portion and the medical aid the balance. This introduces an element of self-insurance and an awareness of costs.

☐ Medical aids are no longer obliged to cover everything, and can structure packages to suit the client profile — younger and healthier people may get cheaper packages, while those wanting extensive cover could pay more.

This does not mean company employees can structure the insurance as they wish. Mr Speedie says: "Medical schemes will have to be geared to handle the proliferation of products and limit the available options for cost and administrative reasons." 12/12/93

☐ Under the old Act medical schemes could not pay more than the statutory scale of benefits, and members had to pay the balance if doctors charged more. This created an opportunity for insurers to provide "top-up" cover.

"Now schemes will be able to pay any percentage, and obviously, the greater the degree of cover, the higher premiums the member will have to pay."

Under the old Act, service providers who abused the system, for example by over-servicing patients, but charged scale of benefits, were guaranteed payment from the medical schemes.

Now the medical schemes can challenge providers and refuse to pay or pay only a portion of the bill. "The change also means people may be responsible for settling their own accounts before claiming from the medical aids," says Mr Speedie.

☐ A married woman no longer has to belong to her husband's medical aid.

This can be to her advantage if she works for a company with a non-contributory medical aid when her husband's is contributory.

"However, the advantages will have to be weighed up, as it is the principal member who pays the most for medical aid. (299)

"Important things to look at are the limits on medicine, consultations, dentistry, specialists, hospitalisation and related charges.

"Other issues such as homeopathy cover and the limits on spectacles are not as important, since they account for only 5% of the payout and distract attention from the real issues."

☐ The pricing structure of medical aids is changing radically. Medical schemes have started to risk-rate groups of people, where before premiums were based solely on salary and number of dependants.

Such risk-rating could be extended to individuals.

"People with a poor claims record will pay more for their medical aid. Whether schemes will start with a clean slate on January 1, or take past claims into account, remains to be seen."

Mr Speedie says no-claim bonuses are becoming a feature. "Members with a good track record may have premiums lowered in the following year, or if they paid too much in the past they may have the excess refunded as a bonus."

Mr Speedie says discounting for dependants is likely to change. "While there will still be a discount, it will not be as great as it is now.

"For example, in our company a husband and wife pay R900 a month to medical aid, where a family of four pays only R150 more.

"This is unsustainable, especially when it comes to extended families."

Mr Speedie says several other changes will be seen in the industry, which are not a result of the new Act, but of competition from insurers.

For example, while medical schemes may not act as life assurers, unit trusts or DTI's, they may act as an agent or a conduit for them, and are starting to offer products with a savings element in conjunction with financial institutions.

Mr Speedie says certain elements of old medical aids will be retained, such as continuation of cover.

"However, if a person has not been a member of any medical aid for longer than three months, the medical scheme is entitled to appraise that person as a fresh risk and may refuse membership, load subscriptions or exclude liability for some pre-existing conditions."

PresMed extends network

CHARLOTTE MATHEWS

PRESIDENT Medical Investments (PresMed) has bought Faerie Glen Hospital and 25% of Wilgers Hospital, both in Pretoria, for R24,75m to be settled by the issue of new shares in PresMed and PresMed Holdings (PresHold), it said today. BIDCM 17/12/93

The acquisitions are in line with PresMed's strategy of building a network of hospitals and day clinics.

Faerie Glen Hospital is being acquired for R8,75m. Pre-tax profit for the year to February 1993 was R1,8m.

Vendors of Wilgers Hospital have warranted it will earn an audited profit before interest on shareholders' loans and tax of at least R12m in the year to February 1994. (299)

Medical aid scheme gets tough, saves R4 m

299

JOHAN SCHRONEN
Staff Reporter ARG 23/12/88

A MEDICAL aid scheme serving a large section of the banking industry got tough with unscrupulous doctors and private hospitals and slashed more than R4 million from claims in one year.

Deputy general manager of Bankmed Brian Wynter said abuse of the scheme by practitioners and hospitals was varied and ranged from subtle discrepancies to gross overcharging.

Mr Wynter said some members had also contributed to the problem.

A clinical audit department had been established about a year ago to scrutinise suspicious accounts.

A team of four consultant medical practitioners and a theatre sister found several serious irregularities.

Mr Wynter said in one case a hospital claimed R5 395 on behalf of a patient for 500 bottles of disinfectant used when only R10,99 should have been charged for 500 millilitres.

In another, an account reflected 250 boxes of laxatives for which R8 140 had been claimed. The account should have been R32 for 250 g.

An account for treament of an infant with bronchitis was reduced by R12 493.

Mr Wynter emphasised that the problem of inaccurate and inflated accounts was limited to a small section of the medical fraternity and subscribers and was not a reflection on the providers of medical services as a whole.

SOCIAL SECURITY - Medicare

1994

Limit set on calls to doctor

JOHANNESBURG. — One of the biggest medical aid schemes has set a limit on members' consultations to stop abuse of services.

Dr Maurice Benton of National Medical Plan said yesterday the limit of 11 consultations a year applied only to visits to general practitioners.

The step had been taken to stop what schemes saw as the abuse of services, he said.

National Medical Plan estimates about 30% of claims, amounting to R120 million a year, border on abuse. — Sapa

Life industry faces competition

B/Day 4/11/94

CHARLOTTE MATHEWS

LONG-term assurers are bracing themselves for competition for health insurance business this year. Amendments to the Medical Schemes Act that took effect on January 1 allow medical schemes to offer a wider range of benefits. (299)

This is one of several measures that will affect the life industry this year. Others include changes to regulations governing withdrawals and loans against life policies, changes to rates used in benefit illustrations, and discussions on long-term and short-term insurance Bills.

Financial Services Board head of legal services Franso van Zyl said such Bills were planned for 1994 but depended on political developments.

He said the changes were being made in consultation with the industry and would update existing legislation as well as introduce new provisions.

Another change is the coming into operation of the regulation allowing withdrawals from a life assurance policy to be made only after the first five years, or one loan against and one partial surrender of the policy to be made within the first five years. The combined value of the loan and partial surrender should not exceed premiums plus 5% compound interest. The purpose of the regulation is to demarcate the life and savings markets.

Also from January 1, amendments to the Medical Schemes Act will allow medical schemes to offer a greater range of benefits. Presmed joint MD Rob Speedie, writing in Cover, said the changes would generate considerable competition between medical schemes, and between medical schemes and health care insurers.

In another area, the life industry has generally agreed to adjust growth rates used in illustrating benefits to 9% and 12% from the present 12% and 15% with effect from March 1 1994.

Institute of Life and Pensions Advisers president Gerard Ehmke said possible legislative changes in 1994 included increases in estate duty and taxation of lump sum retirement benefits.

HEALTH CARE

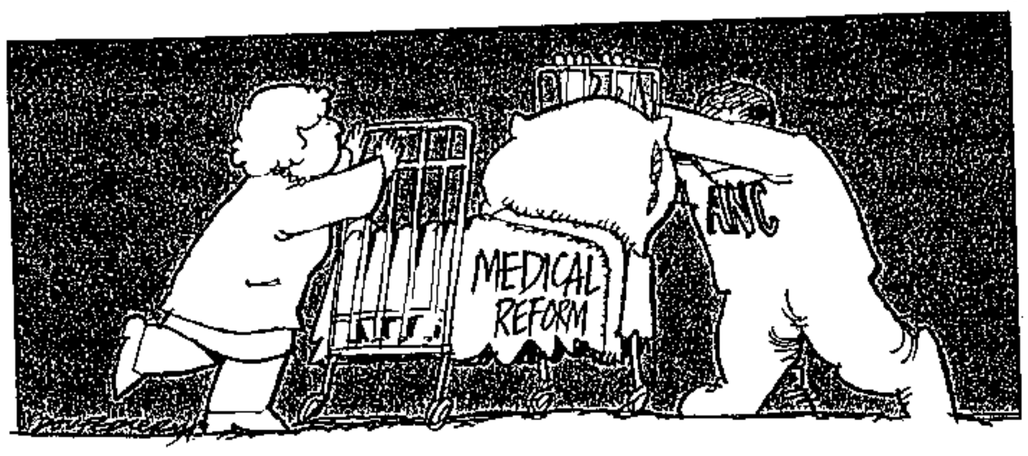
Fm 14/1/94 (299)

Reopening the medical schemes debate

After three years of public and backroom wrangling, the Medical Schemes Amendment Act, which promises far-reaching deregulation of the health-care industry, came into effect on January 1. Now the ANC is threatening to derail the legislation because it feels that it was not consulted and that the Act boosts the private sector while ignoring the concerns of the majority who are not covered by medical schemes.

"The Act doesn't solve any problems in this country," says ANC health secretary Ralph Mgijima. "It's a response to the private sector and not to the people on the ground. It does not solve the crisis. What's needed is a change of the whole system. This is just papering the cracks."

Mgijima says he also had a problem with the Pharmacy Amendment Bill, which Health Minister Rina Venter withdrew from parliament in November after objections from pharmacists, who would have lost some of their control over drug dispensing and who didn't think the Bill went far enough to control the high cost of medicines.



Mgijima adds that the signing of the Medical Schemes Amendment Act goes against the wishes of the National Health Forum, which includes representatives of the State health sector and the Patriotic Health Front, including ANC-aligned organisations such as Cosatu. He says a "big row" can be expected when the forum meets next week and pressure will be applied to keep the Act from being implemented.

Nevertheless, Venter says the Act is law. "They cannot stop it. They will have to repeal it. But I can't see why they would want to stop it except if it is that they are giving in to pressure which I, on the contrary, have resisted. I accept that they must be playing politics and that they feel they must challenge every single issue."

Representative Association of Medical Schemes' Reg Magennis says: "For three years the Act was debated. There was arguing and carrying on and fighting. Now the ANC wants to block it because they are unsure about certain points or because it doesn't offer a comprehensive alternative to the present system. That's a hazardous thing to do. But the concerns must be addressed."

There are 186 schemes, covering about 20% of the population, now operating under the Act. The legislation aims to loosen the regulatory straitjacket that has led to medical scheme contributions increasing at double the inflation rate for the past decade (*Business* December 3). Critics say the old system led to overuse by patients and overservicing by medical providers abetted by third-party payers who had little incentive to curb those practices. The system was also collapsing because of the lack of controls against fraud.

One problem Mgijima has with the Act is that while in the past medical schemes were obligated to reimburse doctors, the new legislation gives the schemes the right to withhold payments from doctors who they feel are not submitting valid claims. Without guaranteed reimbursements, Mgijima argues, doctors will want cash payments up front, which will hurt poor patients.

Magennis points out that while payments to doctors may not be guaranteed any longer, nonpayment is "most unlikely except in exceptional circumstances" and that a member with a valid claim is guaranteed reimbursement. He adds that medical schemes would much rather write out cheques to the limited number of doctors than to myriad patients.

He also says more doctors may indeed request payment from patients up front but medical scheme members can and should complain to their scheme if the administrators are causing the problem by being too strict with doctors. "Medical schemes are committees of representatives and 50% of representatives are employees — ANC supporters perhaps — able to influence the management committee."

Adds Magennis: "With the new Act there is far more opportunity for negotiations between providers and medical schemes. There's also the possibility of incentives to use services more effectively and the reward may be lower costs."

While Mgijima feels that government has not consulted the ANC, Venter argues that all political parties had an opportunity to make inputs but they chose not to do so. "In four years I have never got one single well-thought-through criticism from the ANC. The only criticism we hear is that the plan is unilateral or piecemeal or that there were no negotiations."

As for the piecemeal argument, she says, "you do not reform a system in one shot."

She also disputes charges that there was not enough consultation. For instance, she points out that during her tenure a major reform has been the refocusing of the R10bn health budget away from hi-tech medicine and toward primary health care, including the building of 151 clinics. "We have had the full co-operation of the role players, the grass-roots people who deliver the goods. I have not sat high up in Pretoria and dictated where to build those clinics. But I did not consult with political parties. I left the decisions up to the communities."

When it comes to putting the Act on hold, Magennis feels it would hurt the new government. "If there were a wait-and-see attitude on reform, the infrastructure would be destroyed. If the cost spiral were allowed to continue, medical schemes would go out of operation, hospitals would close down. The Act helps save the infrastructure for a future government to use for its national goals."

He says his group supports a proposal to open medical schemes to State-subsidised patients using vouchers, for example.

As for the Pharmacy Amendment Bill, Venter does not believe it's a dead issue. She says the major reason she withdrew it was to give the various councils that oversee the doctors, pharmacists and nurses time to sort out their differences.

On January 1, the 16-member Pharmacy Council began a five-year term with nine new members, including its first black pharmacist and several members with ANC links.

At their first meeting next month they will be able to evaluate the situation and decide which way to go with reforms. Says council registrar Chris van Niekerk: "The composition of the new council lays the foundation for wider and fresher input in the decisic n-making process, which is necessary at this stage."

Maureen Sullivan

SA FUTURES EXCHANGE

Making a meat market

SA may soon get its first commodity futures market — in red meat. The SA Futures Exchange (Safex) is discussing the idea with the red meat industry and plans to host a conference in March. Then Safex will make an official proposal to establish the market. After that, if all goes well, brokers here will begin trading red meat futures, like in Chicago, Argentina, Brazil and Australia.

"It's just such common sense," says Safex consultant John Wixley of the Commodity

*Read the fine print. That's the message from Health Writer **David Robbins** as South Africa's seven million medical aid beneficiaries face a deregulated future in which cost-saving initiatives are springing up all over*

Now patients have a part to play

Star 17/1/94 (299)

There's a lot of paper generated by the country's more than 100 medical aid schemes around this time of the year. Notices relating to increased costs and contributions, mostly, and also quite often to hikes in benefit limits too. This year, of course, there's the added news that the medical aid industry has been deregulated.

This means that the State, through legislation, will no longer impose specific rules and regulations by which medical aids are supposed to conduct their business. The old scale of benefits, for example, set annually in the past by the statutory body known as Rams (Representative Association of Medical Schemes) has disappeared, although many medical aids have opted to continue to adhere to it, for the time being at least.

Rams has changed its role to a voluntary association which represents the medical aid industry. The stage is now set for the introduction of managed health care, where medical aids no longer simply pay part of members' medical expenses in exchange for set monthly contributions, but are in a position to shape the kind of care being offered, and in the process to substantially reduce costs.

But there's an increasing responsibility for this process being placed on the medical aid member. That's why it's becoming crucial to read the fine print contained in those "notices to members" which are so prevalent as one year closes and another begins.

Take my own medical aid as an example. In my "notice to members" there's the usual stuff about cost and utilisation increases (17 percent), an adjustment for the 4 percent VAT increase which came into effect last April, a 10 percent increase in benefit limits, all adding up to a contributions increase of a surprisingly low 14 percent. Not bad.

But then the fine print begins. The containment of the contributions increase is due to the introduction of an "important measure", it said. A mechanism known as the Maximum Medical Aid Price (MMAP) which is designed to "encourage the use of generic medicine wherever possible".

Before going into the key role individual patients will play in the administration of MMAP, a word about generic medicines.

Major international pharmaceutical companies spend huge amounts of money on the research and development of new products. These come on to the market as proprietary medicines, protected by international law from being copied. But this protection applies only for a specific period of time, inside which the company is expected to recoup his research and development costs. Thereafter, the identical medicine can be, and usually is, manufactured by other companies at vastly reduced prices simply because no research and development costs need to be added.

It should be stressed that generic doesn't mean inferior. The MMAP scheme has been developed by the Pharmaceutical Society of South Africa; and in any case all medicines, whether proprietary or not, are subject to the scientific scrutiny of the Medicines Control Council before they appear on the shelves of your local chemist.

But the MMAP scheme will be applied only at the specific request of the patient.

Let's look at an example. You go to your doctor who prescribes a proprietary medicine which costs R52. With over 8 000 medicines available in South Africa, it is hardly possible for doctors to be able to keep track of where generics are available.

If your medical aid is offering MMAP, however, you can ask your doctor to say so on the script. Get him to write "or MMAP equivalent". Your pharmacist will then subscribe a generic if one is available.

The MMAP scheme has listed 150 proprietary medicines which have recognised generic alternatives. For example, the generic alternative for the R52 medicine prescribed by your doctor costs only R12. If you fail to tell your doctor about your medical aid's MMAP scheme, the R40 difference between the two products will be for your account.

Keith Hollis, chairman of Rams, says that the MMAP scheme being adopted by some medical aids is just one of the ways in which medical aids are increasing their control over the use of expensive medicines.

In some medical aids, people suffering from diabetes or asthma or other chronic diseases, must apply for increased benefits, and these are financed by a depression in the medicine limits for short-duration illness. Other ways of control include the drawing up of a set formulary (a list of drugs that can be prescribed out of the full range of 8 000).

Does this mean that war has now been declared between the country's medical aids and the immensely powerful pharmaceutical companies which provide us with our drugs? It seems not.

Rams executive director Reg Magennis says that these new cost-containment moves by medical aids have met with positive reaction from the pharmaceutical companies.

"It seems that they are now prepared to talk about prices, especially that all-important end price to the consumer. We are naturally keen to start negotiations with the manufacturers on these and other issues."

All this adds up to good news. The best news, however, is that patients are beginning to be jostled away from the position of passive recipients of health care to customers who are obliged to read the small print.

Nitty-gritty skills offer helps build organisations

(299) ARG 22/11/94

DI CAELERS
Weekend Argus Reporter

A UNIQUE diploma in community leadership being offered this year by the Community Development Trust is part of a thrust to see more effective and efficient community organisations in South Africa.

Last year the CDT fieldworkshops on subjects like raising and managing money, working with and managing committees and building winning organisations, but this year it is narrowing its focus.

The forthcoming workshops, says the CDT, will be aimed at people involved in the "nitty-gritty" of running organisations.

The diploma will involve seven in-depth workshops as well as assignments, but delegates who attend only a particular workshop and complete the relevant assignment will receive a certificate of competence.

Only 50 delegates will be accepted per workshop and organisations are encouraged to send at least two delegates to each workshop.

Workshop topics for this year are:

- How to structure and manage committees (February 22);
- How to research and plan a community project (April 26);
- How to prepare budgets and fundraising proposals (May 24);
- How to establish a code of conduct and resolve conflict (July 26);
- How to set up administrative and financial systems (August 23);
- How to write brochures and press releases (September 27), and
- How to review an organisation's strengths and weaknesses (November 8).

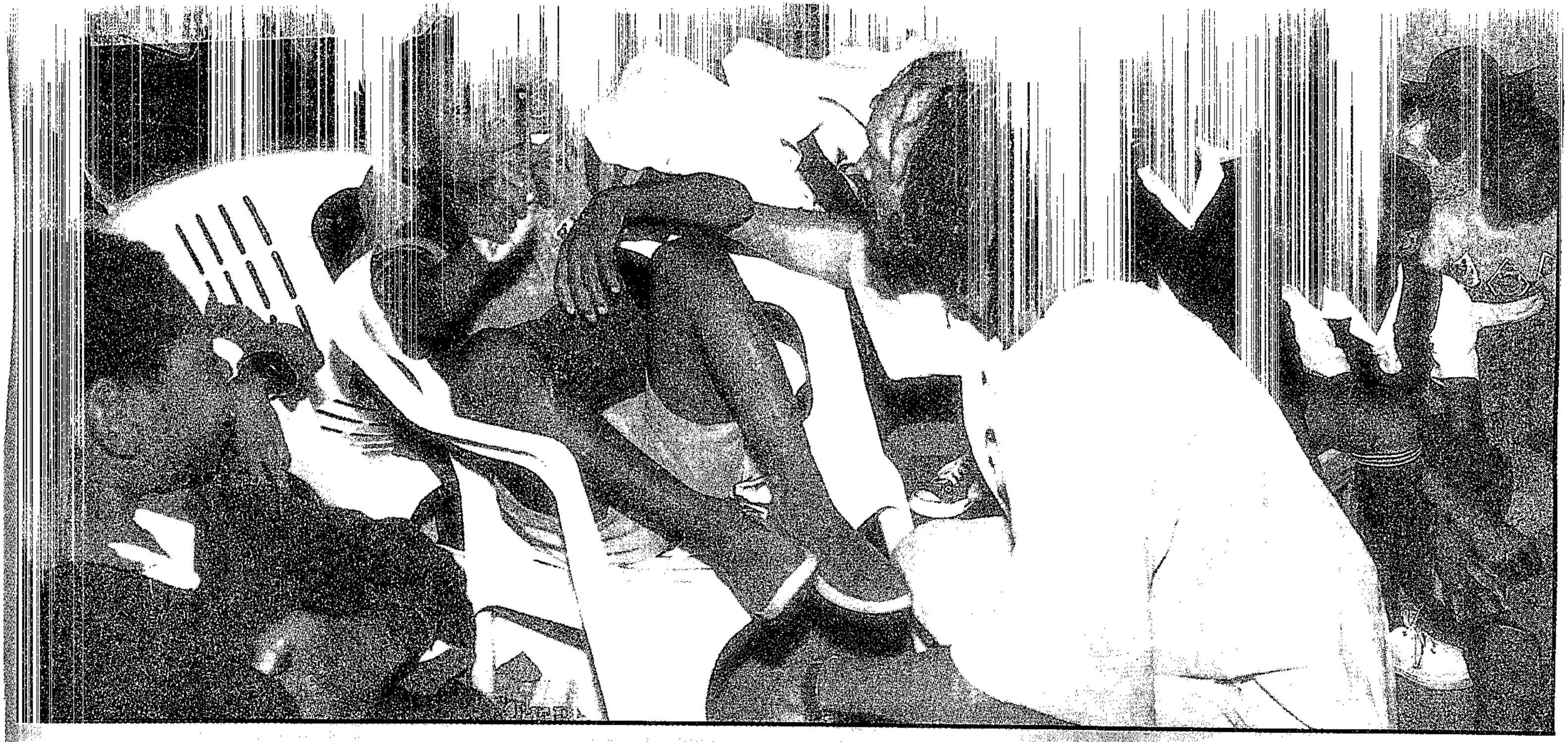
The CDT is a non-profit organisation that provides training and advice services to schools, creches, welfare bodies, civic associations and other community organisations.

It aims to provide management skills that will enable community organisations to serve their people more effectively, assisting in the process of economic, social and political reconstruction in South Africa.

All the workshops, at R60 per delegate, will be held at the Teachers' Centre, Molteno Road in Claremont, and will run from 9 am to about 3.30 pm. Registration is at 8.30 am.

Notes from last year's workshops are now on sale at between R10 and R35 from the CDT.

For more information telephone the Trust at ☎ 531-1658 or write to Box 38570, Pinelands, 7430.



A home away from home for disabled kids

C1Press 23/11/94

By PEARL RANTSEKENG

WHEN singer Blondie Makhene visited the Don Sexwale Paraplegic School in Orange Farm south of Johannesburg this week, the singer was greeted by a chorus of little voices – jubilantly chanting Blondie's hit *Too Many People Are Suffering.*

The singing kids had no thought of their own troubles – even though they are disabled. Aged from three months to 16 years, these kids are getting some education and specialised care – thanks to school supervisor Pinkie Mntambo, who is like a Mother Theresa to them.

Mntambo said she started caring for the disabled kids of her community in 1991 because she was deeply touched by their plight. Many of their parents had to go to work by day and it was hard for them to find somebody to take care of the children. Mntambo decided to care for these kids at her home. (C99)

"When I started this I only had four children to look after," she said. "But eventually they increased to 20. So I asked some of the children's parents who were not working to give me a hand. Fortunately four mothers volunteered to help without any payment."

At first the parents had to pay R35 a month to provide for the children – but some could not afford it, said Mntambo. "So we asked the community for donations. Some people would donate money and others food."

Early this year, Mntambo said, she was approached by a school inspector from the area who suggested that they move to the educational centre while the paraplegic school was being built.

At the centre, said Mntambo, they have been provided with everything from food to transport and have been promised payment by the director of the paraplegic school, Mzwandile Khumalo.

About 100 disabled adults also attend the school. They are taught sewing, shoe repairing and woodwork. The school has about 200 pupils.

MOMENT OF JOY . . . Singer Blondie Makhene shares a smile – and a song – with some of the disabled children who have found a home at the Don Sexwale Paraplegic School in Orange Farm.

Patients can pay with 'plastic' now

CIPRESS 23/11/94

MEDICAL services can now be paid for on a special credit card.

Changes to the Medical Schemes Act this month set off a flurry of activity from various health sectors and financial institutions

The result was the first co-owned medical credit card available to the South African public.

Called the Prodoc/-Standard Bank medicard, which is backed by the bank, it allows patients to pay "up front" for all kinds of medical services, while simultaneously and automatically completing the user's medical aid claims.

The card also ensures that medical aid refunds reach the user's bank account within days.

One of the major changes to the Act is that patients may have to "pay up front" for all kinds of medical services, including doctors, specialists, clinics, pharmacists and physiotherapists.

An advantage is that the new Act recognises women as equal to men.

Under the old Act a married woman had to be a dependant of her husband's medical aid and could not get cover in her own right.

It should be pleasing to note that under the new Act, a woman can have cover in her own right even though her husband qualifies for his own membership. Husbands may be dependants on their wives' medical aid as well.

Prodoc chief executive, Chris Archer said the idea of a medical payment card to counter rising costs was conceived five years ago, but only became practically possible with changes to the Medical Schemes Act.

"Patients want the very best medical attention that money can buy. But what if that is more than they can afford?" Archer asked. (299)

Statistics show that the cost of belonging to a medical aid had increased by a staggering 322 percent in the seven years from 1980 to 1987, compared to the 152 percent increase in the Consumer Price Index and the 149 percent increase in the cost of medical services over the same period.

Yet despite this, many medical aids have been unable to meet the ever-increasing demands of members, and some have even been forced to close.

Currently, only about 20 percent of the population belongs to a medical scheme.

January 28 to February 1 1994

Southbusine

'Medical aid equality will cause problems'

South 28/1 – 1/2/94

THE PROPOSED removal of gender discrimination from legislation governing medical aid schemes will add to the financial crisis facing the industry, says health economist Ms Di McIntyre.

Medical Aid schemes are facing a cash crisis with the loss of their young, high-income earners to medical aid insurance schemes and increased expenditure to private hospitals, says McIntyre, co-ordinator of the Health Economics Centre at the Department of Community Health at UCT.

However, McIntyre pointed out that this should not stop the legislation being scrapped, as the industry problems were much deeper rooted.

"The removal of gender discrimination merely adds to their problems," says McIntyre.

With the new legislation, single women who marry can remain on their own medical aid schemes instead of joining their husbands' scheme. And with women generally earning less than their husbands, contributions to the medical aid schemes will be less.

Because contributions are generally based on salary, and the wife's salary is generally lower than the husband's, they will tend to select the wife's funds, says Barry Cookes, assistant general manager at Old Mutual Employee Benefits.

Cookes argues that there may be other problems with the removal of the gender discrimination legislation.

"For example, a husband who switches to his wife's scheme may experience problems returning to his employer's fund should his wife subsequently leave employment for any reason, for example ill-health or pregnancy."

There were also implications for employers with large amounts of women employees. With these families opting for the women's medical aid scheme, and the employer having to pay half the contribution, the resulting financial pressure would be significant. (299)

But other factors are contributing to the crisis, says McIntyre.

With more private hospitals being built, medical aid payout costs have spiralled — increasing by between 35 and 40 percent a year, she says.

For example, private hospitals in South Africa have more Magnetic Resonance Imaging Scanners — basically a hi-tech X-Ray machine at a super-expensive price — than all the hospitals in the United Kingdom and Australia put together.

The prices of medicines have also skyrocketed, says McIntyre.

She says young and healthy high-income earners are increasingly looking towards medical insurance schemes.

"They are asking why they should be paying between R300 and R400 a month when they hardly go to the doctor. So they try to get cover for catastrophic events.

"In the past the medical aid schemes used the higher contributions from these high-income earners to cross-subsidise the pensioners and low-income earners. Now they are left with these older members, they are using a great deal of their resources."

McIntyre says more research is necessary to develop a model for South Africa's medical aid schemes. This will include the possibility of a national medical aid scheme. However, this would not mean the end of current medical aid schemes, said McIntyre.

WAGHIED MISBACH

Radical surgery for medical aids

Star 1/2/94

299

HEALTH CURE

South Africa's ailing medical aid industry could be put to good use as a basis for a brand new social health insurance scheme, according to a new report from Witwatersrand University's Centre for Health Policy. Health Writer **DAVID ROBBINS** looks at the details.

Medical care in the private sector has become too expensive, and many medical aids are facing the prospect of financial collapse.

In recent years, contributions have been rising at nearly double the inflation rate. This has resulted in a trebling of contributions over the past decade.

Many individuals and not a few employers have been forced out, leaving tens of thousands of individuals without medical protection.

However, 7 million South Africans are still protected by the country's more than 200 medical schemes. And what does the future hold for them?

Researchers Max Price and Patrick Masobe, in the Centre for Health Policy report, give some of the reasons for the rising cost of medical aid cover:

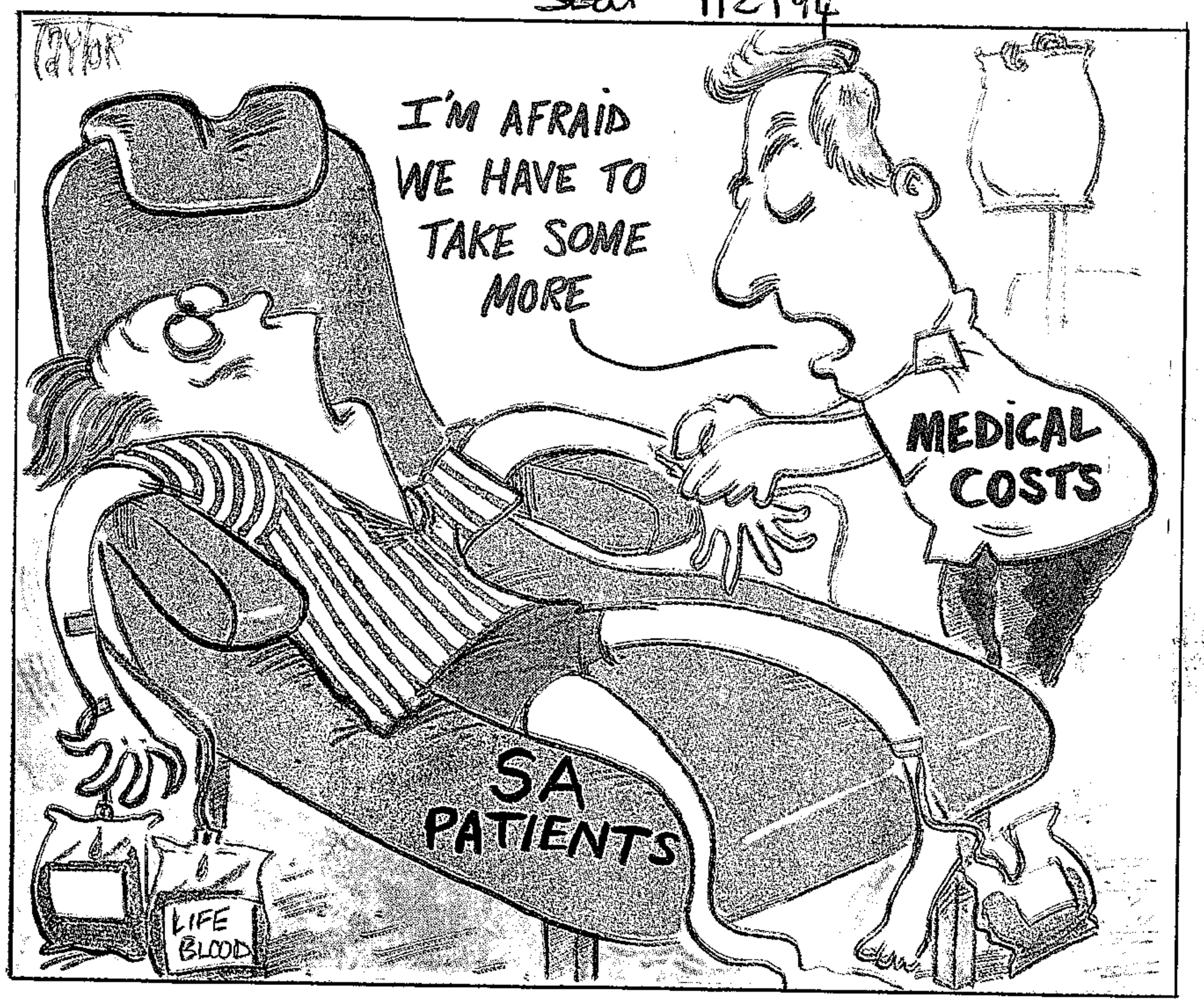
- Supplier-induced demand and consumer ignorance.
- The declining international value of the rand.
- Increased costs resulting from expensive new technologies.
- Growing consumer expectations.
- The general ageing of the population.

This last aspect is of critical concern to medical aids. As people age they need more medical attention; as people go on pension, however, their contributions are drastically reduced.

The report says: "As the proportion of elderly has increased, and the number of employed contributors decreased (through generally shrinking workforces), the costs for the employed members have become too high. Schemes will either collapse or they will have to shrink the range of benefits."

The amendments to the Medical Schemes Act, which came into effect this year and had the intention of deregulating medical aids, will through increased competition aggravate and accelerate the problem, say Price and Masobe.

"It is true," they say, "that the amendments have opened the way for medical schemes to achieve greater control over cost escalation. However, the amendments will in fact quickly result in the elimination of cross-subsidisation (healthy for ill, young for elderly) which rendered medical cover affordable (at least in the past) for the elderly and sick."



It's an unhappy prospect for millions of medical aid members and their dependants. Increasing contributions, diminishing cover, the possibility of collapse and a consequent loss of everything stare many schemes in the face. It's true, there is a lot of talk about managed health care, cost-saving deals between schemes and providers. But what about basic affordability and that crucial principle of cross-subsidisation?

"In the absence of State intervention, this situation will eventually have reached a crisis leading to the collapse of numerous medical schemes."

Plans are already under way to establish a commission of inquiry, by August, to examine what contribution, if any, medical aids can make to the health needs of a democratic South Africa.

Perhaps the Centre for Health Policy report holds some of the answers: "The crisis in private health care may just have provided the opportunity for radical change, ensuring greater access, equity and comprehensiveness in private sector care, and reducing the burden on the public health services at the same time."

The report talks about income-related premiums to provide a basic health package for all members. This money would be paid into a central fund and distributed to medical aids in terms of their risk profile. This is another way of saying that cross-subsidisation would be ensured, and that the elderly and the sick would be looked after, at least in terms of that "basic health package".

At least four basic conditions would have to be applied, say Price and Masobe. First, medical aids must be prohibited from excluding any member, regardless of state of health. Second, medical aid contributions must be related to income rather than age or health profile. Third, the size of these premiums must be centrally fixed. And, fourth, medical schemes and insurance companies must be allowed to sell "top-up" or other health packages, provided the purchaser was already contributing to the statutory "basic package".

"It is quite conceivable that such an approach could be used as a building block for a social health insurance system," says the report.

And what do medical aids think? Reg Maggenis, executive director of RAMS (the Representative Association of Medical Schemes), says: "We would fully support this line of thinking. It certainly does overcome the general problems of risk-taking and inequity which would become a greater feature of the private sector under the new Medical Schemes Act.

"The policies expressed in the Centre for Health Policy report would have the effect of strengthening the role of the private sector in serving the aged and the chronically ill. In this way, the private sector will be more capable of playing an effective role in implementing national goals which are socially accepted. Medical aids could also be used, in the future, to address the needs of unemployed and low-income-earning people."

In addition, medical aids could continue to offer services that are inevitably excluded from the basic package, Magennis said.

TOMORROW

Most parents believe that their children will get adequate career guidance at school. They're wrong.

Market logic can resolve the private medical care crisis

B/Day 25/2/94

ADRIAN GORE

(299)

TALK rands and cents on issues of life and death and your audience immediately feels queasy. Yet marketplace logic has the potential to rescue private medical care from its current crisis.

That crisis has been building for some time. In the private health care sector of the '80s and early '90s, there was no incentive to contain costs.

The Medical Schemes Act compounded the problem. Its restrictive requirements imposed "minimum benefits" and insisted on the scale of benefits, with guaranteed payment to health care professionals who abided by this code.

Consider the effect. In 1982, 1 894 399 medical scheme members paid in R837 598 736, an annual contribution per member of R442. By 1991, 2 378 312 members were contributing R7 364 825 or R3 097 each a year — an annualised rate of increase of 24,1%. Over the same period, the CPI went up 14,6% and salaries increased 13,7%.

The average middle-class salary in 1991 was R4 040. By that stage the average medical aid scheme contribution represented 7,6% of pay. If contribution increases continue to outstrip salary increases at the same rate, by 2004 a quarter of a salary earner's pay will be taken up by medical aid contribution.

That spiral was caused by a system of perverse incentives.

Once contributions are paid, members can freely enter the medical marketplace, consume any service from a GP visit to an MRI scan, and send the bill to someone else — their medical aid scheme.

Behaviour becomes socially destructive as members consume as much as they can rather than as much as they need. The imposition of limits only compounds the problem as it creates a "use-it-or-lose-it" mentality.

Perverse incentives apply to the supply side, too. When physicians and hospitals increase costs, they often increase their incomes.

Excesses can be corrected by consumer vigilance. But our medical aid schemes delegate cost considerations at the point of sale to medical scheme administrators. It may be naive to expect vigilance from this quarter. Administration fees are a percentage of contribution income. Therefore, medical scheme administrators, it can be argued, had an interest in allowing the inflationary spiral to continue — at least until adverse reaction from members and companies raised the threat of a fall in membership.

In 1982, with membership at 1 894 399, administration fees stood at R59 628 913 or R31,48 per member. By 1991 membership was 2 378 312 and fees were R420 665 274 or R176,88 per member. In other words, total administration income rose at an annualised 24,2% over this period.

Compare 24,2% annual income growth with increases in the earnings of JSE-listed companies in the '80s and one sees how well rewarded the medical scheme industry was during the '80s. Company earnings for 1982-91 rose just 10,9% a year.

Today's situation is further complicated by resistance from newer members to cross-subsidisation of the old and sick, falling rates of growth in medical scheme memberships and the plight of pensioners who rely on the implicit promise that the schemes will continue to meet their health care needs.

An actuarial calculation indicates that the approximate liability per pensioner family currently stands at R530 000! The existing reserves of the medical scheme movement (about R1,2bn) are negligible relative to pensioner needs and expectations should younger members halt cross-subsidisation. Pensioner contributions would then have to rise astronomically.

In future, the focus of state funding will fall on broad-based primary and preventative care. Resources might not be available to finance a safety net of curative care for older members of population groups whose reasonable expectations are for First World medical care. Clearly, a paradigm shift needs to occur in the search for sound solutions to financing private sector health care.

Sound solutions are those formed and shaped by the empowerment of individuals. Better results will be achieved if individuals bear the cost of their bad decisions and reap the benefits of their good ones. Since resources are scarce, someone must choose between health care and other uses of money; as often as possible, these choices should be made by the individuals, not bureaucracies.

Two influences are apparent in the product development in SA: an individualistic approach embodying marketplace logic, and a more interventionist precedent from Third World Singapore. The core concept is that of a medical savings account.

Each member has his own medical savings account into which deposits are made periodically. The medical savings account is used to cover day-to-day medical expenses such as visits to the GP, prescribed medication and spectacles.

Amounts in the account not spent grow with interest and, ultimately, when the member leaves the scheme, any balance remaining is paid out in cash. Large unforeseen expenses such as chronic conditions and hospitalisation are covered by insurance or medical scheme cover.

The medical savings account can essentially be housed in a normal bank account, although there are two strong reasons why a dedicated medical savings account approach should be taken. First, structured properly, the medical savings account can enjoy taxation benefits which a normal bank account cannot, and second, a dedicated medical savings account creates the necessary financial discipline which clearly a normal bank account, with easy access to funds, does not have. Since the funds in the medical savings account are likely to be called on at any time, investments such as unit trusts or longer-term investments would not be fully appropriate.

The medical savings account approach is based on the commonsense hypothesis that when people spend their own money, they are more prudent. US consulting actuaries Milliman & Robertson found that annual expenditure in 1992 averaged $971 for people who bought their own medical care and $3 313 for Medicaid recipients.

In Singapore, the medical savings account approach has been used nationally. All employees must put a percentage of their pay into the medical savings account held by government. Drawings are made to meet specified medical expenses. The system has proved so successful surpluses are building up.

It enjoys many advantages:

- ☐ Members spend their own money on medical goods and services;
- ☐ Instead of the use-it-or-lose-it mentality, members can save what they do not spend for future use;
- ☐ Members can ration their own health care spending; and
- ☐ Doctors must satisfy patients rather than some third-party payer. This means the doctor-patient relationship will be maintained.

However, the medical savings account cannot be relied upon to provide for health care needs in the long term. Long-term funding should be dealt with through a separate actuarially based long-term funding mechanism to ensure members can stay affordably covered throughout their lives without relying on subsidies from other scheme members.

The savings account concept is not the only alternative to traditional SA health care financing. Two other options being debated are managed care and a national health service. But the medical savings account emphasises individual empowerment — a theme that strikes a chord with believers in market mechanisms and those committed to a new democratic dispensation.

☐ **Gore is Momentum Health MD.**

Compulsory medical aid could be around the corner

ARG 14/3/94 (299) ~~258~~

☐ Rams says it would support any future legislation

ROGER FRIEDMAN
Staff Reporter

COMPULSORY medical aid for all employed and self-employed South Africans could be around the corner.

Executive director of the Representative Association of Medical Schemes (Rams) Reg Magennis said his organisation would support any future legislation compelling all working people to become members of a national scheme offering the minimum level of health services.

Those people who could afford services above the minimum level could buy into piggy-back private schemes — but the national scheme would be compulsory for all.

The question of how to fund a compulsory scheme "equitably" was still being debated.

● All working people could pay the same percentage of their salaries.

● There could be constant premiums or differential rates.

Meanwhile, racially differentiated tables of contributions were on the way out, said Medscheme group chief executive Keith Hollis.

Mr Hollis said racially differentiated tables were introduced to the industry about 10 years ago after the granting of special exemptions by the registrar of medical schemes.

He said, on average, black members claimed little more than half of what whites did.

Asians claimed about 10 percent more and coloured people about 30 percent less.

If everyone paid the same, black members would unwittingly be subsidising whites.

Among the reasons for claims discrepancies between racial groups were the paucity of services in some areas, ignorance about health services, and susceptibility to different illnesses.

About three years ago the registrar permitted a move to "experience ratings" which took account of geographical location, age, family size and claiming level.

Mr Hollis said medical aid schemes were phasing out racially differentiated tables.

Mr Magennis said the differentiated tables arose out of the peculiarity of the South African situation where discrepancies in income were often linked to race.

Lessons on voting

Sowetan 21/3/94

By Russel Molefe

THERE were four million disabled people in South Africa eligible to vote in the April 27 elections, the chairman of the Self Help Association of Paraplegics, Mr Friday Mavuso, said at the weekend.

He was speaking at a voter education workshop for the disabled at the association's centre in Mofolo attended by about 2 000 people on Saturday.

The workshop was conducted by Matla Trust to enlighten the disabled on election procedures at voting stations.

Mavuso said disabled people could form their own political party and become a government if they wanted to judging from their numbers countrywide. (299)

He appealed to the broader community to respect disabled people as they were also human beings.

New health schemes cut costs

Bibby 22/3/94

BEATRIX PAYNE

CORPORATE and individual members of medical aid schemes may soon be able to choose health care options that cut the cost of monthly premiums as the industry restructures in the wake of amendments to the Medical Schemes Act passed in January.

The amendments had been designed to cut costs and improve efficiency in the industry, Representative Association of Medical Schemes (Rams) executive director Reg Magennis said yesterday.

They also allowed medical schemes to own assets such as hospitals or to make preferred provider arrangements with doctors or other service providers.

Magennis said these arangements were termed "managed care".

Because owning health care facilities was a high risk for many schemes, there were several forms managed health care could take, including Health Maintenance Organisations (HMOs) or Independent Practitioner Organisations (IPAs).

Magennis said that by working together health insurers and providers could control costs and wastage caused by overprescribing and unnecessary surgery.

"The bottom line of these agreements will be to bring down premiums paid by employers and members of schemes," he said.

Medical aid schemes in an HMO could invest in hospital facilities and employ doctors and specialists.

All members of the scheme would be resident in the locality served by the clinic or hospital. Unless referred, members would have to pay for services received at institutions outside the scheme.

2919

Fred Kennedy, the administration manager of one such scheme, Vaalmed in Vanderbijlpark, said the HMO was able to offer medicines at 50% less than the normal price charged by buying supplies directly from manufacturers.

He said the scheme provided a "tremendous" saving to employers and employees because monthly contributions were lower than those of other schemes.

Under the scheme, an employee earning more than R2 500 a month with four dependants would be charged R520 a month, he said. Under other schemes the same employee would pay about R800 a month.

But Magennis said joining an HMO could restrict people's freedom of choice and jeopardise their ability to afford health care while on holiday or far away from the HMO facility.

A medical insurance scheme could alternatively enter into an IPA — a contractual agreement with a group of doctors.

The management of the IPA would remain independent of the medical scheme but practitioners would undertake in a contract with the scheme to keep a tight rein on surgery and medicine costs, he said.

Contractual agreements with doctors could take a variety of forms, but all would be characterised by close co-operation between the service provider and the insurer.

Gavin Humphrey, manager of H&H Medical Centre, an IPA based in Bank City, Johannesburg, said contractual arrangements ensured doctors provided a quality service as they had to secure a flow of clients.

"Quality could suffer if the doctor worked on an eight-to-five salaried arrangement," Humphrey said.

Doctors, dentists to snub med-aid scheme

299

JOHANNESBURG. — The South African Medical and Dental Practitioners are to withdraw approval of the Affiliated Medical Schemes Administrators' Meds medical aid scheme, SAMDP members decided here at a meeting.

SAMDP, an organisation representing about 20 000 doctors and dentists, said yesterday the non-recognition action would start on April 20. It said it had not been able to negotiate adequate cost containment programmes.

Members meeting at a political health forum at a Jan Smuts hotel warned that recognition could be withdrawn from other medical aid schemes.

The SAMDP said it had been negotiating with AMA which had remained "arrogant and intransigent" ARG 28/3/94

"After careful consideration the SAMDP has decided to declare the Meds medical aid scheme as non-approved. This has been done in response to pressure from our membership who complained that Meds has been particularly problematic to them," a SAMDP resolution said.

"We note that other medical aid schemes are also giving our members similar problems. The prominent example is Meddent. We hope that we will not have to take action against such medical aid schemes," the resolution said.

Doctors and dentists would not refuse to attend to Meds patients but would refuse to honour the medical aid card. — Sapa.

Doctors break with aid group

CT 28/3/94 (299)

Arrogant attitude alleged

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Doctors withdraw medical aid recognition

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"After careful consideration the SAMDP has decided to declare the Meds medical aid scheme as non-approved," the SAMDP said. — Sapa.

Medical scheme lashes out at 'greedy' GPs

(291)

(Q 29/3/94)

Staff Reporter

THE Affiliated Medical Schemes Administrators (AMA) hit out at the decision by the South African Medical and Dental Practitioners (SAMDP) organisation not to recognise their medical aid schemes, and claimed that doctors' desire for increased profit was at the root of the SAMDP decision.

Director of AMA, Mr Lowdon Scott, said yesterday it was an "absolute lie" that AMA had not tried to contain costs, as SAMDP had claimed.

He said SAMDP had wanted the medical aid schemes to pay for ethical drugs, not only the generic drugs which appeared on their maximum medical aid price list.

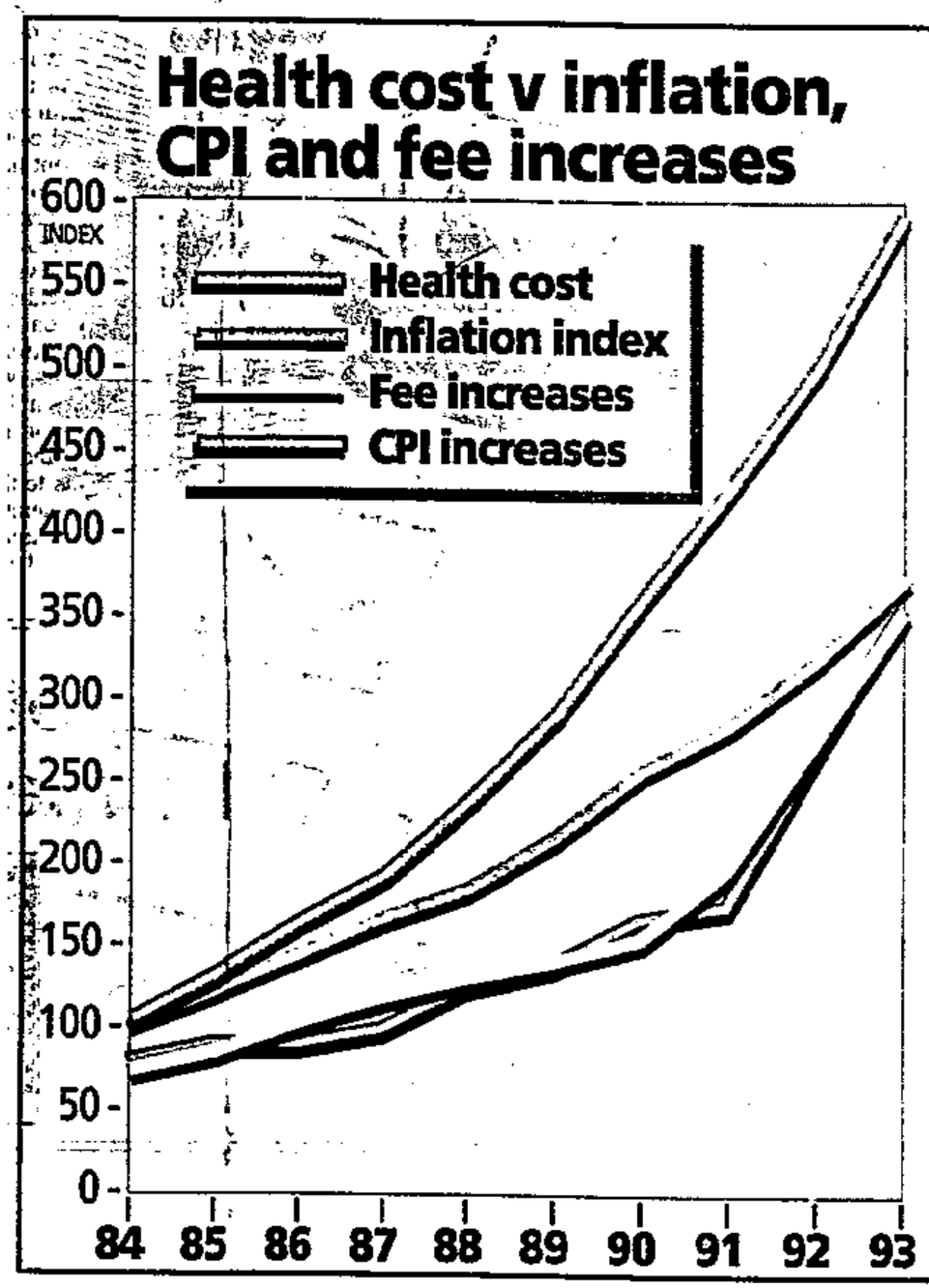
"The 20% profit that dispensing doctors make on an ethical drug which costs R200 is obviously greater than the profit on an equivalent generic drug which costs R70. This is at the root of the decision by SAMDP, which is mostly made up of dispensing doctors," Mr Scott said.

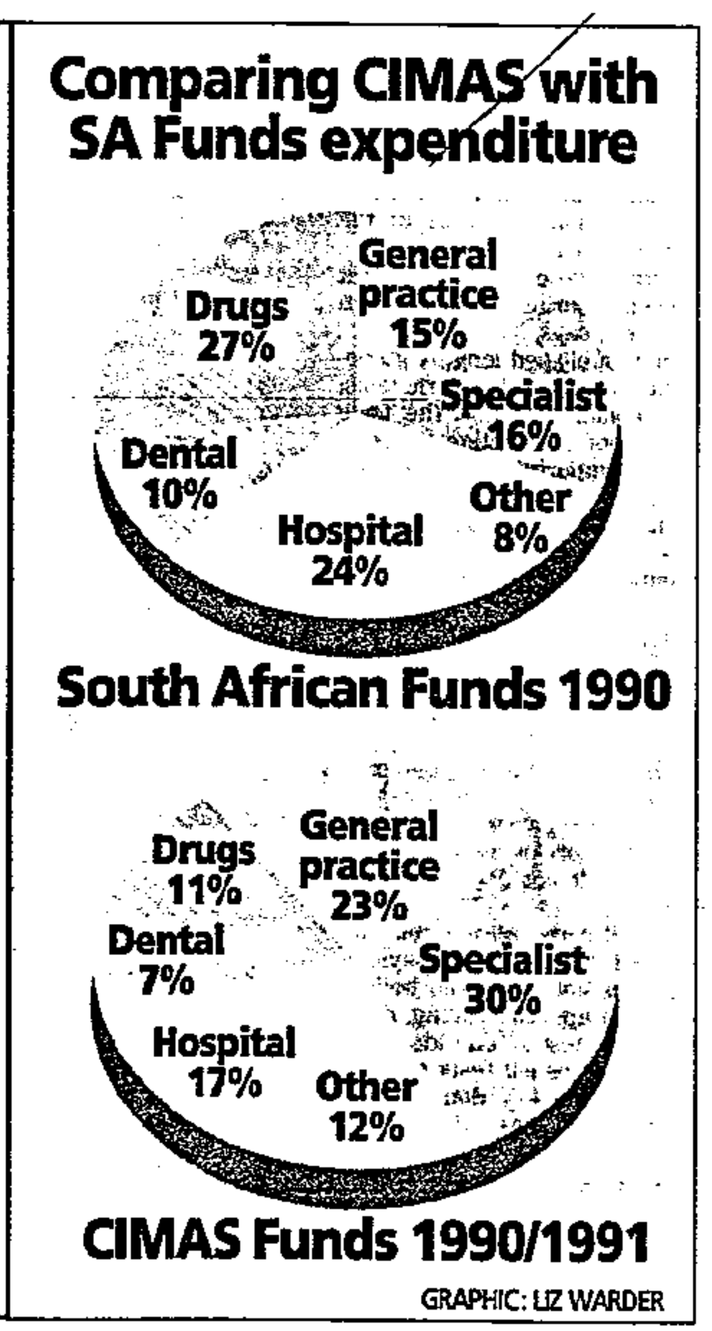
Dr Joe Maelane, chairman of SAMDP which consists of about 2 000 doctors and dentists, claimed yesterday the AMA was cheating doctors and "not giving members sufficient cover".

What does the future hold for South Africa's ailing medical aid industry? With a new state policy concentrating on rural and preventive care, the emphasis will be different. Zimbabwe could hold important clues. Health Writer ***David Robbins*** *reports*

Zimbabwe medaid in good health

Star 6/4/94





In spite of some hostility in the early years of independence, Zimbabwe's medical aids are alive and well and offering cover to increasing numbers of Zimbabweans. Over 75 percent of members are now black; and the industry could soon be involved in a health-care-provision partnership with the State.

But it's been a rocky ride. Richard Hore, chief executive of Cimas, Zimbabwe's largest medical aid group, recalls being advised shortly after independence by a government official: "You'd better find yourself another job. There'll be no place for medical aids in socialist Zimbabwe."

The call, in the heady days of independence, was for free medical care; and this soon became policy — at least for those earning Zim$150 (about R75) or less a month. So far so good, except that there was no attempt to ensure that the system was not abused.

The result was gross overcrowding of Zimbabwe's government health care facilities. Consequent attempts by Cimas to build a private hospital for its members were thwarted by a government concerned with what it perceived as a perpetuation of white privilege.

Cimas abandoned the hospital idea, but went ahead, on the basis of membership demand, with the design of a private hospital medical aid scheme to supplement the existing scheme which provided general medical cover only. The State then attempted, through their own Tax Commission of 1985, to withdraw tax rebates on medical aid contributions.

"But we were able successfully to argue that medical aids functioned as redistributors of wealth, with the rich subsidising the poor (through a sliding scale of contributions) and the healthy the sick," Hore explains.

So the medical aids, and the tax rebates which underpinned them, survived; but only on condition that their accounts were submitted for annual audit by the Receiver of Revenue, and that medical aids imposed no restrictions on members with pre-existing medical conditions.

"These conditions haven't destroyed any of us," Hore says. "On the contrary, private medical aids have thrived. In the case of Cimas, the number of beneficiaries covered has increased from around 80 000 at independence to nearly 300 000 today, most of the increase coming from our black communities."

Even the Private Hospital Scheme, criticised at inception for being designed for rich whites only, now has a majority of black members.

Hore attributes the success of private medical aids in Zimbabwe — the provision, as he calls it, of a "First World service in a Third World environment" — to two main factors: a sensitivity to the market, and the containment of costs. (See box).

Sensitivity to the market over the years since independence has resulted in the design of several additional packages, including a Primary Package which costs around Zim$25 (R12) a month for members only (the cost shared by member and employer) and offers access to a general practitioner, a small drugs fund, a State hospital and specialist services. Over 30 000 people are already covered by this scheme.

"I believe that our future lies in catering to this end of the market," says Hore.

He points out that since independence, the Ministry of Health has initiated three studies on the practicability of introducing a national health service in Zimbabwe. Each time, the studies have revealed that the country's tax base is too small for this to be successfully achieved.

Meanwhile, the State health system is in financial difficulties, and the recent introduction of user charges is providing cost recovery of less than 2 percent when it was hoped for something in excess of 10 percent.

This can mean only that health care is slipping beyond the reach of large sections of Zimbabwe society.

A prominent health economist has recently proposed that "a compulsory health insurance scheme be introduced for those not covered by medical aids, and that such a scheme be administered by the existing medical aid societies", Hore explains.

"Now the Minister of Health has established a committee consisting of all interested parties, including representatives of medical aid societies, to examine the practicalities of introducing such a scheme.

"So after 14 years," Hore concludes with a smile, "the wheel has turned a full 360 degrees."

Containing costs

■ The pie charts compare medical aid expenditure by Cimas (Zimbabwe's largest medical aid) with that of medical aids in South Africa. Of special interest is expenditure on drugs which jumps from 11 percent to 27 percent once we come south across the Limpopo.

■ The graphs compare general national inflation with medical inflation; or, expressed differently, the comparison is between the consumer price index (CPI) and annual medical fee increases.

The difference between the two countries is plain to see. But how has the Zimbabwean medical aid industry succeeded where South Africa's has struggled?

Cimas boss Richard Hore has for many years negotiated successfully with health care providers (doctors, private hospitals, etc) on the basis that increases should be tied to the consumer price index.

"How we have held them to this often unpopular figure is simple," Hore says. "For those providers who adhere we pay direct for services rendered to our members. For those who don't, we pay our members direct and the providers are left to collect their fees. The administrative and other difficulties associated with the latter option go without saying."

Medscheme punts workplace health plan

BEATRIX PAYNE

EMPLOYERS could cut medical costs by upgrading workplace health programmes, Medscheme MD Jeff Slome said last week.

He told a healthcare insurance conference that employers should ask themselves how healthy their workforces were, rather than concentrating simply on providing medical cover.

With health care costs soaring, preventative health and primary and occupational health programmes would become increasingly important, Slome said.

Companies should also focus on strengthening the ties between doctors and medical scheme administrators, because "conventional medical aid cover will never be enjoyed by the majority of South Africans".

"The greater the success in (such) fields, the greater the financial benefit to the company and its employees," he said.

Staff health care could be managed through on-site facilities, pre-employment screening, AIDS programmes, occupational hygiene and a greater emphasis on safety.

Johnson and Johnson Health Management Institute MD Johnny Koortzen said companies could secure a 100% return on their investment from an employee lifestyle programme. Such programmes could cost from R24 to R900 an employee each year, depending on staff levels and services provided.

Research from companies running lifestyle programmes had shown that productivity could rise by up to 80% and absenteeism could drop 18%.

Medical body drops threat to schemes

Star 2014/94

■ BY CHRISTINA STUCKY

The South African Medical and Dental Practitioners (SAMDP) organisation, which had threatened not to accept certain medical aid schemes as of today, has called off its action.

After two weeks of negotiations an agreement has been reached with the medical schemes industry.

The SAMDP, representing 2 000 members nationwide, had said it would not accept medical schemes administered by AMA, MCG and CompCare. (299)

The SAMDP objected in particular to what it considers to be inflated levies as well as a list of generic drugs put forward by the schemes.

Action against CompCare and MCG has been suspended for two weeks pending further negotiations, according to SAMDP chairman Dr P J Maelane.

Report recommends strict control of medical schemes

KATHRYN STRACHAN

MEDICAL aid schemes needed stricter controls and greater transparency, and their committees needed to play a more active role in management, the Melamet commission into the manner of providing for medical expenses recommended.

The commission's report was yesterday handed over to Health Minister Rina Venter in Pretoria.

Commission chairman Judge David Melamet said the recommendations for stricter control also applied to the office of the registrar for medical schemes.

Melamet said medical schemes had expanded rapidly and the understaffed registrar's office did not have the capacity to cope with the large amounts of money streaming in.

The report recommended that medical schemes should fall under the Financial Services Board.

The board had far more resources, including the services of actuaries, to deal with the many transactions and prevent long delays in payment, said Melamet.

The commission added that as the insurance industry had also become a major player in the medical insurance field, it would be an advantage to have both the medical aid schemes and the insurance companies under the auspices of the Financial Services Board.

Melamet said greater transpareney was necessary to ensure members understood their rights, and that schemes understood their obligations. The commission's scope was restricted to the investigation into the viability and solvency for future private medical schemes.

Other recommendations included the funding of individual schemes, and the role of the insurance industry.

Handicapped young fall prey to abusers

ARG 23/4/94 (299)

DI CAELERS
Weekend Argus Reporter

■ Disabled children, already disadvantaged by their handicap, face the additional agony of being easy targets for abusers — sexual and physical. And if that's not enough, they're now falling victim to the HIV virus too.

"RAMPANT" abuse of South Africa's disabled children, who face double the risk of non-handicapped youngsters because they're easy targets, has set off a new and horrifying threat — these children are falling prey to the HIV virus.

Already three positive cases have been identified in the Western Cape and a further five in the northern Transvaal, but experts says this is definitely only the tip of the iceberg and indicates the emergence of an extremely serious situation.

Accepted figures that one in three children are abused indicate, says Linda Olayi, adult educator for Resources Aimed at the Prevention of Child Abuse and Neglect (Rapcan), that statistics for disabled children specifically would be much higher.

"Handicapped children are in a very disadvantaged position. They don't have the correct vocabulary, to say no or to report what's happening to them. And the abuser knows that no-one will listen to the child anyway."

Washeila Said, Western Cape national project co-ordinator of the Disabled Children's Action Group (Dicag), told Weekend Argus parents of these children needed plenty of education, both to recognise the symptoms of abuse and those of HIV and Aids in case the virus had been transmitted.

"One of the biggest problems is that parents think their child's got tuberculosis because the symptoms are similar to those of the HIV virus. By the time the child's been treated for TB and they later find out it's actually much more serious, the abuser has probably vanished without trace."

She said the rate of abuse of disabled children was horrifying and blamed their vulnerability. Further, a serious gap in Aids education existed in respect of these children that needed to be rectified "otherwise it'll get out of hand".

Ms Olayi, discussing the abuse issue generally, explained that abuse of these children was not only sexual but also physical and verbal from parents, siblings and carers who found themselves in a "no relief" situation.

A vital aspect of reducing the sexual abuse was to educate parents on how their children would communicate what was happening to them: "At the moment we're getting cases like a child becoming preoccupied with masturbation and instead of seeing that the child is trying to tell her something, the mother hits the child.

"The unfortunate result is that when a child gives a clue, the parents are not listening. They see it as attention-seeking behaviour or hit the child for telling lies."

She said "the community itself is not very tolerant of these children; there are no relief centres, no resources or support system, and mothers are often blamed for the child's handicap".

This resulted in extreme stress levels for all involved and as much as parents needed to be taught to recognise symptoms of sexual abuse, they also needed to learn to channel their own frustrations away from the child.

Dicag's national advocacy manager Shanaaz Majiet agreed, saying her organisation and others were conducting workshops to "give mothers the space to define their own understanding of abuse" and "to voice their frustrations and powerlessness".

In cases of sexual abuse the abuser was often the husband or lover which threatened the family economically if the situation was exposed, and also threatened their position in the community.

THE MELAMET COMMISSION

Getting tough on medical schemes

Fm 29/4/94

Reading between the lines of last week's Melamet Report on the financial health of medical schemes, it's clear that medical schemes stand accused of incompetence and inefficiency for almost wholly turning over their duties to administrators who have no legal responsibility to members.

The report, compiled by a three-member commission chaired by Judge David Melamet, says somewhat scathingly: "A disquieting fact that appears from the submissions is that more than half of the 16 members of the controlling body of the Representative Association of Medical Schemes (Rams) are professional agents (and not the schemes themselves) . . . This is not healthy. Rams is in the main an association of agents with the principals taking a back seat."

The recommendations, not surprisingly, call for stricter controls, greater transparency and increased input in the management of funds by actuaries; legal, accounting and insurance professionals; and experienced hospital and business administrators. The commission wants the Council for Medical Schemes — now the industry's controlling authority — to be subordinate to the Financial Services Board. It also suggests that there might be room for a single Private Health Finance Act to regulate all financing of health care.

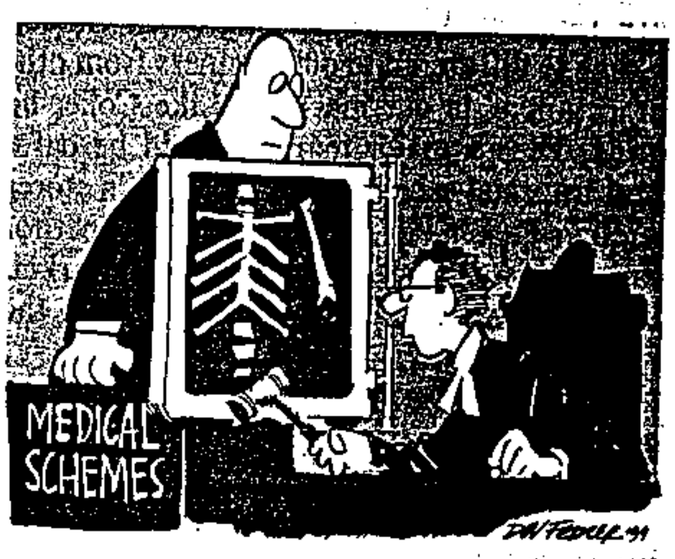
President F W de Klerk appointed the commission last year because of uncertainty over the impact of the Medical Schemes Amendment Act, which took effect in January. The Act ended minimum benefits for members and guaranteed payments to doctors and other health-care providers. But there are concerns that increased premiums for older and sicker people (risk rating) and less subsidisation of these members would jeopardise the soundness of many schemes.

Welcoming the report as a job well done, outgoing Health Minister Rina Venter nevertheless warns that there is a need for continued input from the Department of Health on private sector health-care policy, if the Council for Medical Schemes is to become a subcommittee of the Financial Services Board. "The financing of health is not purely a financial service, though we welcome greater financial expertise and the monitoring structures of the Financial Services Board. There is a need to avoid duplicating services."

Rob Speedie, joint MD of hospital group Presmed and former Rams executive director, says the thinking that schemes should be treated as banks and insurers is sound. "They are, after all, holding in trust large amounts of public money." Making the council subordinate to the Financial Services Board also has merit, he says. He points out that the council's registrar now relies heavily on the board's staff. (299)

But he stresses that schemes essentially offer a short-term service and he questions the need for the extensive, costly use of actuaries at every level of management. On this point, the Medical Association of SA's George Veliotes expresses doubt as to whether the board has sufficient expertise in health care. "It's not enough to have accountants and actuaries running the show. Clinical skills are also required."

Melamet's commission wants the schemes to submit a list of their assets and liabilities to the registrar every six months and report on any uncertain financial situations that occurred during this time, a move that will unquestionably benefit scheme members and avoid "sudden bankruptcies." It also envis-



ages imposing duties on scheme auditors that are similar to those placed on bank auditors. Says the report: "There are more than 230 schemes reporting to the registrar, with an annual contribution from employers and members of R7bn. From last January 1 all the indications are that the Office of the Registrar will be called upon to supervise an increasing number of hybrid and innovative schemes with different determinates as to adequacy of reserves and funding."

Also recommended are greater powers for the registrar to acquire information timeously and make onsite inspections of a scheme's books. Says the report: "A system of funding that has a record of seven years of underwriting losses out of 10, based on a pay-as-you-go means of income generation, is a major cause for concern. Cost increases are not readily explainable by obvious issues such as the growth in the numbers of dependants, or by the declining value of the rand."

Melamet also recommends that Rams appoint an ombudsman to deal with complaints received from providers and users.

On the controversial question of continuing the tax deduction on employer contributions to schemes, the commission stresses the importance of keeping this benefit and extending it to the insurance sector. But it suggests that employees could pay a fringe-benefit tax on employer contributions to discourage abuse. Rams executive director Reg Magennis warns that this could have implications for schemes, especially if tax policy leads to members resigning from schemes.

But the report says the issue requires more investigation. Venter, however, says this can't be conducted until a new government gives clear guidelines as to how it will treat the private sector. "Government needs to put its plans on the table: will it utilise the private sector or diminish it?"

A seemingly controversial recommendation that the report makes is that schemes should no longer be required by law to provide for retired members. What it seems to be saying, however, is that this benefit is vague. Says Speedie: "While pensioners theoretically have the right to stay on as members, schemes can in practice get rid of them by hiking contributions dramatically — a practice that's already been tried." The effect of this recommendation would be that employers and employees need to make certain what benefits they can expect to receive on retirement. This, of course, increases the importance of transparency for schemes and their benefits. As this recommendation stands, however, Speedie says the practical implications are horrific: "Who's going to offer post-retirement cover?" Venter says this recommendation needs further investigation. "The authorities need to ensure that pensioners are not dumped on the State."

With regard to managed health care, the report suggests that schemes report to the registrar annually on the nature of all contracts concluded in this area. It also recommends that comparisons be made between the US and the SA experience.

Rams' Magennis says competition between schemes and insurers is encouraged by the report, and the use of brokers and agents would also be facilitated. "This trend will intensify the practice of risk-rating and will probably lead to higher marketing and administrative costs." He is also critical of the report for failing to adequately address the role that medical schemes can play in extending basic health services to poorer communities.

The ANC hasn't yet commented on the investigation, which it initially suggested wouldn't hold much sway because it intended appointing its own commission of inquiry into medical schemes. Melamet subsequently, however, did appoint an ANC nominee — Alex van den Heever of the Industrial Development Corp — to assist commissioners Duncan Reekie, an economics professor at Wits, and Colin van der Meulen, an actuary.

Mirryéna Deeb

High drug prices blamed for medical scheme crisis

ST Times 11/5/94

By CAS St LEGER

PRIVATE patients in South Africa spend more on medicine than anyone else in the world, the Melamet Report on medical schemes has found.

Mr Justice D A Melamet's report on the commission of inquiry into the Manner of Providing for Medical Expenses, released last week, recommends:

- Tighter financial controls of medical schemes;
- Supervision of schemes and benefit funds by the Financial Services Board;
- A move to managed health care; and
- Changes in employers' taxation.

Much of the blame for the struggling state of the country's more than 200 medical schemes — which have 6,3-million beneficiaries and which collect annual subscription income of R7,3-million — is laid squarely on the pharmaceutical industry.

The Pharmaceutical Society of SA, though, has dismissed the finding as "misleading" (299)

The Melamet Report criticised the high price of drugs to the private sector. It said expenditure on medicines was far higher in the SA medical schemes movement than elsewhere.

Of the R6 892,2-million paid out in benefits by medical aid schemes in 1991, the largest item, at 29 percent (R1 194,6-million), was paid out for medicines.

The report said the view of a "monopolistic cost" on medical schemes was reinforced by international comparisons.

Medicines cost the British National Health Service 10,3 percent of its expenditure in 1991. The cost to the SA public sector that year was only 9,9 percent. The US figure is only 8 percent.

"The SA private sector figure is approximately three times the UK figure."

It was clear that the provincial tender system had a part to play in holding down manufacturers' prices in the public sector.

The report said the total medical schemes income had risen eight-fold over the past decade, while total income per beneficiary had risen only six-fold.

The Pharmaceutical Society's executive director, Mr Ivan Kotze, said the medical profession had taken over much of the community pharmacy's function over the past decade.

"If the long-awaited access by pharmacists to higher schedules comes about, costs could be brought down even further — as patients would not have to consult doctors so frequently," he said.

Mr Kotze said the private sector did support the public sector's medicine bills through the two-tier system of medicine pricing.

"The greater use of generics would also, and quite dramatically, reduce the medicine bills," he said.

Medical schemes members urged to play bigger role

ARG 19/5/94 (199)

☐ Few know their rights, obligations, responsibilities and liabilities

LIBBY PEACOCK
Staff Reporter

EXPERIENCED and qualified members of medical schemes rarely have the time or the inclination to serve on the scheme's committee, and so members are not well-enough informed enough about their rights.

At the same time committee members are not properly acquainted with their obligations, responsibilities and liabilities.

It should therefore be made mandatory that the committees of medical schemes contain accounting, business, legal — and, if possible, actuarial — expertise.

This is recommended in the report of the Commission of Inquiry, chaired by Judge D A Melamet, into the Manner of Providing for Medical Expenses.

A "disquieting" fact appearing from submissions to the inquiry was that more than half the 16 members of the controlling body of the Representative Association of Medical Schemes (RAMS) — which before Junary 1 had statutory recognition, but was now a voluntary association of medical schemes — were professional agents.

"This, in our view, is not a healthy situation. RAMS is in the main an association of agents, with the principals taking very much a back seat."

The report recommends that RAMS considers the appointment of an ombudsman to deal with complaints arising from the operation of medical schemes — as has been done by the South African Insurance Association and the Life Offices Association of South Africa.

The report states further: "The largest item of expenditure by schemes is medicines and pharmaceuticals. One informed witness ... argued that 'the interests of 2 800 or so retail pharmacists are being put before the 7,5 million members and dependants of medical schemes'."

In the early 1980s almost all medicines dispensed in the private sector "passed through a limited number of wholesalers to retail pharmacists and price competition was rare".

The possibility of new retailing technologies in large-scale multiple outlets was effectively barred.

"In the middle to late 1980s and early 1990s... the structure of and the regulatory protection awarded to retail pharmacists appears to have imposed a monopolistic cost on medical schemes.

"This view is reinforced by international comparisons. Expenditures on medicines as a percentage of total health care expenditures is far higher in the South African medical schemes movement than elsewhere."

● Executive director of the Pharmaceutical Society of South Africa Ivan Kotze said it was "simply not true that community pharmacists held 7,5 million medical scheme members to ransom".

Patients tended to over-utilise doctors' consulting and dispensing services, often in order to buy medicines for minor ailments ... so that medical schemes would meet the cost — rather than having to pay cash at the pharmacy.

"If the long-awaited access by pharmacists to higher schedules comes about, costs could be brought down even further — as patients would not have to consult doctors so frequently, provided medical schemes covered the medicine costs of such pharmacy-initiated therapy."

He said that while the Melamet report implied a "community pharmacy monopoly", it failed to address the "very real monopoly of the medical profession".

There were many aspects of the report with which the society agreed — one being that the professional administration of medical schemes should be subjected to control by the Financial Services Board — but issues such as over-servicing by doctors and over-prescribing had to be addressed to make control effective.

Doctors not happy with medicine list

BEATRIX PAYNE

MEDICAL aid schemes which introduced a Maximum Medical Aid Price (MMAP) list may encounter increasing opposition from doctors concerned about the use of generic medicines, medical sources said yesterday.

SA Medical and Dental Practitioners (SAMDP) national chairman Joe Maelane said the lists were designed "unilaterally" by medical schemes and did not take into account the needs of the doctors who had to treat the patient.

The SAMDP recently declared a dispute with medical schemes Compcare and MCG and schemes administered by Affiliated Medical Administrators over the introduction of MMAP and other cost containment measures.

But the dispute was temporarily resolved in mid-April after negotiations brokered by the Representative Association of Medical Schemes.

National Association of Independent Practitioner Associations (NAIPA) chairman Ernest Snyman said the MMAP list "forces doctors to use generic medicines, and while there are good generic substitutes a large percentage of them are not up to the standard of the original products".

But MediKredit GM Wolf Furst said use of the MMAP list had allowed medical schemes to save up to 23% on the total medicines bill.

About 68 schemes, almost a third of the industry, operated MMAP lists.

The MMAP listed the maximum price that a medical aid would pay for 136 generic medicines a doctor could choose to dispense.

Furst said there was "nothing wrong with the quality of generics, they have been used extensively by the state in public sector hospitals over the last twenty years".

Generic medicines underwent the same approval procedures as original medicines before they were registerd by the Medicines Control Council.

He said the MMAP list was first introduced in 1985 but had had a "slow take off" until diminishing funds and increasing costs from 1992 onwards had forced many schemes to introduce the list.

Cape Independent Practitioners Association constitutional affairs officer Steven Jooste said doctors welcomed cost containment measures as long as they were negotiated between medical aid schemes and doctors.

He said many doctors by-passed the list by prescribing medicines not listed.

"Medical aid schemes should sit down with doctors and jointly consider how to keep within budgets."

Fund to assist former workers

JACQUIE GOLDING

ANGLO American Coal Corporation (Amcoal) and the NUM have established a fund to assist small-business and economic empowerment, the company said this week.

The fund aims to assist former Amcoal employees retrenched because of the closure of collieries in the past few years, said an Amcoal spokesman.

The retrenched workers are helped to establish and develop their own income-generating projects, to improve their skills and to equip them to find other jobs in the formal sector.

Amcoal initially allocated R1m to the fund but recently contributed a further R1,7m. It said it supported community development projects that could benefit both workers and their communities.

The fund, which is managed by a joint committee of 10 members — five appointed by Amcoal and five by the NUM — has so far spent R600 000 on various projects, including the Mhala development project designed to train workers in semi-skilled activities in the Eastern Transvaal.

More than R300 000 has been spent on the development of this community-based centre.

The joint union/Amcoal committee meets at regular intervals to consider the fund's activities and to review applications for project assistance. It also monitored administration and control of the monies and determined the form the assistance would take, Amcoal said.

E Cape medical plan crashes

Own Correspondent

PORT ELIZABETH. — One of the Eastern Cape's largest medical aid schemes, Midland Medical Plan (MMP), has collapsed, leaving 60 000 members without cover. (299) CT 3/6/94

The MMP has a debt of almost R20 million. This excludes claims still on the way.

MMP's administrators have warned members are legally responsible for all claims which the medical aid can no longer pay.

The MMP crash is the second medical aid crisis in the Eastern Cape this week, following the last-minute rescue on Wednesday of the Midland Chamber Group (MCG) medical fund.

MMP, started here by a group of local doctors in 1961, hit financial trouble in November.

However, members were led to believe the scheme was on the road to recovery after the appointment of a specialist medical aid administration company, Norwich Life subsidiary D & E.

Altogether 150 people have lost their jobs.

The Registrar of Medical Aids, Mr Danie Colver, was not available for comment yesterday.

Probe into police medical aid plan

CT 3/6/94 25(299)

Staff Reporter

POLICEMEN will not be forced to use only the doctors contracted by their medical aid scheme — at least, not until late September, when a working committee set up yesterday reports on the issue.

Mr Paul Botha, national secretary of the South African Police Union, said in a statement the police medical scheme, Polmed Medihelp, had planned to sign contracts with medical practitioners fixing them to certain tariffs for treatment of union members.

But SAPU and Polmed members found this "unacceptable" because they would be forced to consult contracted doctors, or to pay the difference between the set prices and their own doctors' fees.

Mr Botha said the planned changes were stopped pending a decision by a combined working committee of Polmed Medihelp, SAPU and South African Police Services management, set up yesterday.

Tighter regulations for medical schemes

BEATRIX PAYNE

REGULATIONS governing the running of medical benefit schemes were likely to be tightened following the collapse last month of Botshelo Health Care Systems, the Registrar of Medical Schemes said at the weekend.

Registrar Danie Kolver said his office had been negotiating with the Financial Services Board (FSB) and the Commissioner for Inland Revenue about introducing tighter regulation mechanisms for benefit funds.

Concern over the regulation of benefit funds was triggered when Botshelo Health Care Systems was declared provisionally bankrupt last month.

And rumours have circulated in the market that liquidators could find a R600 000 "hole" in the benefit fund's books.

In its recently released report on the payment of medical expenses the Melamet Commission recommended that the FSB supervise and regulate benefit funds.

This had to be done "as a matter of urgency as there are apparently 60 such funds operating today without any supervision or regulation", the report said.

Kolver said funds that provided funding for medical expenses should be under some form of financial or administrative supervision. But he was not considering setting up an additional regulatory board.

He said the ideal arrangement would be for his office to supervise health insurance schemes based on indemnity funding while the FSB supervised insurance driven schemes and benefit funds not operating in health care.

"We can certainly accommodate the problem between my office and the FSB," he said.

FSB deputy executive office Andre Swanepoel said the board had been in discussions with the Registrar but would give no further details. But he said the discussions would also consider the position of stokvels and friendly societies.

Medscheme director Jeff Slome said last week he was not surprised that Botshelo had gone into liquidation.

Many benefit schemes had operated in the market without any form of regulation or supervision. He said members of the public were often uninformed about these schemes many of which did not have sufficent funds to provide suitable cover for the old or sick.

Rising costs plague medical aids

Star 10/6/94

■ BY THABO LESHILO

The most comprehensive research to date into health benefits, conducted by Old Mutual, shows the industry is dogged by rising costs and liquidity problems. (299)

The survey shows that medicines account for the single biggest expense (26,4 percent), followed by hospitals (22,6 percent), specialists (17 9 percent) and general practitioners (11,3 percent).

An average 20 percent increase was experienced in health plan costs last year, accounting for eight to 11 percent of the total costs of company payrolls.

The research was conducted among 69 companies in the top 300 listed on the JSE, representing 453 000 workers and 37 000 pensioners.

Perhaps the most worrying aspects of the findings were those related to liquidity and pensioners.

Despite liquidity problems, it was found that 60 percent of companies surveyed did not carry out actuarial valuations into the current liability of funds.

Although pensioners accounted for 13 percent of the membership of medical aid schemes, their representation on the different boards of trustees was only one percent, compared with 49 percent for companies and 37 percent for employees.

Sixty-two percent of the companies surveyed supported cross-subsidisation of the old and the less healthy members by younger and healthier ones, much to the dismay of the latter.

MEDICAL AID SCHEMES

Gasping for air

The collapse last week of the Port Elizabeth-based Midland Medical Plan highlights the growing crisis facing medical aid schemes and the private-sector health industry. In the same week, the Midland Chamber of Industry announced drastic measures to save its Midland Chamber Group, a local rival of Midland Medical, from a similar fate.

In addition, the Johannesburg-based Botshelo Health Care Systems — a medical benefit fund — also collapsed.

Midland Medical went under with little warning; in its last financial year, it reported a R12m surplus. It left its estimated 40 000 members and dependants, as well as health-

care providers, with thousands of rands in unpaid bills and scant recourse. It was only last month that D&E Administrators took over the scheme.

Says D&E chief Robin Melville: "We performed a due diligence assessment of the scheme and were confident that the information at the time reflected a deficit of R6,2m." But, he adds, once the January and February accounts were appraised, the deficit had risen to R9,8m. By May 31, the schemes' auditors calculated the deficit at R16,5m.

"The final straw came when doctors and health-care providers refused to treat Midland Medical members without immediate cash payments — a credit cut they had also imposed on Midland Chamber Group members," Melville says. D&E and the Midland Medical board decided, after consulting Registrar for Medical Schemes Danie Kolver, to liquidate the scheme and transfer all members to D&E's Tafelberg scheme.

Melville says members and health-care providers could still recover some of their losses. "Midland Medical has a number of unsecured loans to hospitals and doctors as well as a number of properties that could raise R10m-R15m." He estimates its outstanding claims at R25m-R30m.

Its fall should ring warning bells for all scheme members. Certainly, the recent findings of the Melamet Commission into the funding of schemes (*Business* April 29) were spot-on when it recommended that financial statements be submitted to the registrar at least twice a year and any faltering financial situation be reported at once.

The commission also recommended that the registrar's office fall under the direct supervision of the Financial Services Board and that schemes and administrators be responsible to the board. Judge David Melamet accused schemes and their administrators of incompetence and expressed dismay that many schemes had virtually abdicated all responsibility to administrators, who owe members no legal obligation.

Melville blames huge membership drives by the two schemes over the past year for many of their financial problems. Midland Medical was clearly unable to handle the increased numbers. "Members were signed on without any cognisance of their claims experience and a lot of discounting took place, which is prohibited by the registrar." Industry observers say union pressure to increase benefits also strained the scheme.

Meanwhile, Midland Chamber Group members will have to accept a 20% rise in premiums from July and reduced benefit limits, with a goal of cutting costs by 10%. For their part, employers will be asked for a loan to the scheme equal to a month's subscriptions. Medscheme has been appointed joint administrator.

Reacting to the collapse of Botshelo, Kolver says he has arranged with Inland Revenue, which registers medical benefit funds, that all registration applications be sent to his office for approval first.

Employers subscribing to benefit funds can qualify for tax exemptions if Inland Revenue decides that the fund is geared to aid members during sickness, disability or unemployment. But that has meant that the funds escape the registrar's safety requirements, which include a R2m fidelity deposit and supervision by the registrar's office. ■

MCG members may have to cough up

(299)
ARG 11/6/94

Weekend Argus Reporter

THE threatening collapse of the Midland Chamber Group (MCG) Medical Fund in Port Elizabeth has forced the Medical Association of South Africa (Masa) to advise doctors to make arrangements with fund members regarding payment.

Masa Eastern Province chairman Johan Snyman said doctors had sympathy with MCG members who were uncertain about the future of their scheme and Masa had called on doctors to see members of the scheme, especially in emergencies.

Dr Snyman called on patients to discuss the situation with doctors and arrange to settle their accounts.

"We realise MCG members are not guaranteed cover for healthcare, for which they have been paying their subscriptions."

He said doctors who had been serving MCG members were at risk of losing payment for services rendered.

If the scheme was not saved, members would become responsible for acounts for April, May and June.

Handicapped Eric is king of the handymen

By PETA KROST

A CRIPPLED man, who has refused to give in to his disability, has set up a one-man repair business in a scrap combi which also doubles as his home. ST Times ECI Metro

And the people who live at New Crossroads, near Cape Town, are so impressed by his courage in the face of overwhelming odds and his determination to be independent, that they have nicknamed him "King".

Recently, when Eric Banci, 34, was driven through the streets of New Crossroads by a community worker to arrange a disability pension, locals cheered and shouted "King, King!" as he passed by as a mark of respect.

Without a wheelchair and unable to walk, he is usually combi-bound. He lives, eats, sleeps and works in little more than a one-by-two metre space inside the left-for-scrap vehicle in a friend's backyard.

But his reputation as a hardworking and honest repairman, who can "miraculously" fix anything from a radio or a television set to shoes, has spread. And people come from all over the township with work for him.

"As a little boy I learnt to fix these things by watching my uncle at work but I have no diplomas.

"After I fix something for one person, they tell all their friends and I get more work," Mr Banci said.

He is not short of work but money is a problem and he still "can't make a living".

"People fetch their things and promise to pay the following day and never come back. They know I can't go after them for the money because I can't get around," he said.

If he had more money, he could fulfill his modest dream of buying a wheelchair and having a bigger place in which to work. 12/6/94

When Mr Banci, a Transkeian, moved to Cape Town to seek his fortune in 1977, he was fit and healthy.

But in December 1983 he developed pains in his hips which spread to his back and within months he lost the use of his legs. (299)

"I don't know what caused it — no doctor has ever told me but they couldn't fix it," he said.

He spent three months at Tygerberg hospital expecting the doctors to help him regain the use of his legs but when he realised it was not possible he discharged himself.

For a long time he lived with friends. Every time he began to feel that he was a burden, he moved on.

"It was a problem because I sometimes wasn't able to make it to the toilet on time and I knew people didn't like that," he said.

Eventually, he moved into the combi that was standing on blocks and regained partial independence.

A friend provided electricity and others bring him water to wash himself and his clothes.

Mr Banci does not feel sorry for himself and believes his disability has made him work harder.

"All I want is to be in a situation where I am not dependent on anybody else to survive and make a living. People get very tired of me always asking favours," he said.

DISABLED BUT NOT UNABLE ... Eric Banci doing technical repair work in his combi home

Picture: TERRY SHEA

Medical aids' growing headache

Times (Buss)

By SVEN LUNSCHE

MEDICAL aid costs look set to rise further judging from the findings of an extensive survey of the industry by Old Mutual.

The survey, which was conducted among 70 top companies "reveals an industry suffering from a combination of rising costs and declining reserves," says Old Mutual.

Medical schemes experienced an average 20% increase in their health plan costs during the past year and these now accounted for between 8% and 11% of the total payroll bill.

Most companies respond to rising costs by lowering the benefits offered by medical aid, but Old Mutual comments that the approach indicates a lack of knowledge of those measures which are likely to prove most effective.

"Many medical aid schemes have elected to offer members choices in terms of contributions and corresponding benefits, but an unintended consequence of providing member flexibility has, in many cases, been financial pain for the scheme as a whole," says Old Mutual.

The survey shows that 31% of respondents plan to make changes to their medical aid schemes. They are likely to be headed by a move to self-funded savings schemes and a limit on the number of doctor visits.

Other changes are likely to include managed care options for medicines and hospitals and reduced or capped benefit limits.

Old Mutual also expresses concern regarding the level of protection and assistance afforded pensioners, which, on average, account for 13% of membership of the average medical aid scheme. 12/6/94

About 40% of respondents to the survey indicated they would be redesigning their retiree benefits, mainly towards a policy of contribution prefunding (as opposed to the current pay-as-you-go system). (299)

"For people already retired, reduced benefits are a distinct possibility," warns Old Mutual.

The survey also breaks down the expenses faced by medical aid schemes. These are headed by the cost of medicines (26,4%), followed by hospitals (22,6%), specialists (17,9%), and general practitioners (11,3%).

Shock over medical fund crash

The Argus Bureau

PORT ELIZABETH. — The medical aid scheme industry has received another shock with the cash-strapped Midland Chamber Group medical fund opting for voluntary liquidation — leaving 38 000 members owing at least R15 million.

The decision, taken by the MCG central committee, was based on the outcome of a ballot of individual members. The members rejected a rescue package MCG hoped would save the fund. (299) ARG

Eastern Cape companies affected by the liquation are Volkswagen, Delta, Mercedes-Benz, Firestone, Eveready, Pyotts, Valley Textiles and Lennons.

Reacting to the collapse, Johan Snyman of the Medical Association of South Africa's Eastern Cape branch, expressed shock.

He said the collapse would cause further financial hardships for the health industry and predicted that doctors in the area would be severely affected.

Earlier the National Union of Metalworkers of South Africa, representing the majority of MCG members, rejected the rescue package and recommended that the fund be liquidated.

The MCG rescue package, which was supported by employers and doctors, included a 20 percent increase in subcriptions and a reduction in benefits.

Health cost hikes will hit workers

BEATRIX PAYNE

COMPANIES were attempting to cut costs by shifting the burden of medical aid expense to employees, Old Mutual said at the weekend. B/Day

Medical aid costs had risen 20% over the past financial year, and business was trying to reduce its expenditure by pushing employees toward flexible benefit packages and by capping benefits. (299)

Old Mutual's new health benefits survey of 69 employer organisations showed that medical scheme contributions accounted for about 9% of the total payroll for most companies.

Many employers were considering introducing managed health care options which would limit members' choice to specific doctors who charged negotiated rates for medicines and services.

Old Mutual assistant GM Henk Beets said pensioners were likely to be increasingly vulnerable to reduced cover as many employees favoured moving away from schemes that cross-subsidised the elderly.

He said pensioners accounted for 13% of the membership of the average medical aid scheme but represented only 1% of the members of most management committees.

Many companies were considering introducing contribution pre-funding for pensioners by employees and the company rather then the current "pay as you go" system. 13/6/94

Some medical aid schemes were too expensive and not structured to meet the needs of unionised and low-income workers, many of whom had opted out of medical aid schemes in favour of access to on-site clinics.

Plea for medical aid crisis probe

BIDay 15/6/94

BEATRIX PAYNE

THE ANC had called on government to urgently establish a commission of inquiry into the crisis in the medical aid industry, ANC health secretary Ralph Mgijima said yesterday.

Despite the ANC having requested the commission in its recently released health plan, as yet nothing had been done.

But Mgijima said the ANC understood government had many constraints. He said current legislation needed to be examined as it did not provide for the financial needs of schemes and had contributed to the recent collapse of two medical schemes in the Eastern Cape.

In addition, many medical schemes were pressured by service providers who were too expensive or who over-serviced patients to make money.

He said at present government did not have enough information with which to implement a national health insurance system.

Mgijima anticipated that the commission would focus, among other things, on the financing of the insurance system.

He said national health insurance could be privately administered, or through a combination of state and private structures. Medical aids could also pool resources and make risk adjustments to provide cover.

Government would need to determine how many people were covered by medical aids and what the attitudes of these organisations were to managed health care systems and other cost cutting measures.

Mgijima said he was concerned that some schemes excluded potential members on the basis of their risk profiles. "It is undesirable for medical aids to exclude members who are HIV positive, have chronic diseases or are beyond a certain age," he said.

The commission would also need to consider whether or not to provide national health insurance to those in the informal sector. (299)

Mgijima said the commission would need input from consumers and financial experts who were aware of the needs of a national health insurance system.

But he said it was unlikely that medical aids would be directly represented on the commission. "This would be a commission of inquiry so medical aids would be expected to submit reports and provide inputs."

Sapa reports that Health Minister Nkosazana Zuma yesterday invited nominations for the Council for Medical Schemes.

The Health Department said each nomination should state the full names and address of the person nominated and must be submitted with a curriculum vitae indicating the person's qualifications and experience.

"The council consists of 11 persons who are appointed on account of their knowledge and experience of medical schemes; two members of registered medical schemes; and two employees or members of any employer or institution who pays subscriptions or contributes to any medical scheme of which such persons are members," said the health department.

Nominations can be submitted to the Director-General, National Health and Population Development, Private Bag X828, Pretoria 0001 before August 1.

Cautious welcome for medical aid probe

BIS CM 16/6/94

BEATRIX PAYNE

PROPOSALS by the ANC and Health Minister Nkosazana Zuma to establish a commission of inquiry into the medical aid industry have been cautiously welcomed by medical aid schemes. Representative Association of Medical Schemes (Rams) executive director Reg Magennis said the commission should explore the role medical schemes could play in future government initiatives.

But he cautioned against continuous changes to legislation. The medical aid industry had only recently been deregulated and was trying to adjust to the new environment.

Magennis said the commission should attempt to facilitate negotiations between service providers and medical schemes as this would be the key to controlling costs.

D & E Administrators MD Robin Melville said the crisis facing the industry was not the fault of industry regulatory bodies, such as Rams and the registrar of medical schemes. It resulted from a "cross-section of factors" and "if anything the registrar and Rams has been proactive in setting the ground rules". (299)

The commission should be made up of Rams, the larger administrators and the "key" service providers.

The government should step in where the market failed and be involved only in drawing up legislation.

D & E — which administered 23 schemes — had the infrastructure for the processing and payment of claims which, Melville said, would be of value to a national health insurance system.

Medscheme chairman Keith Hollis said a commission would be welcome, but it was essential for medical aids to be represented on the commission and give it credibility.

The current payment and reimbursement system was good and Hollis said the scheme could provide management facilities for a national health insurance system. He said protocols and benefit levels had to be established to suit the needs of members who were HIV-positive.

Melville said scheme members should be allowed to decide their scale of benefits and if they were willing to subsidise members who had AIDS.

If government legislated for guaranteed cover for people with HIV or AIDS it would have to take cognisance of the financial implications this would have for medical schemes, Magennis said.

Pensioners suffer as medical aids totter

Star

FINANCE STAFF

THE draining of funds by AIDS sufferers and pensioners may be a fatal blow for the ailing medical aid industry.

This was just one disturbing issue highlighted by an Old Mutual Health Benefits Survey released last week.

The survey revealed that medical aid industry reserves were dwindling in the face of cost escalations which averaged 20 percent over the past year. And these are about to be unloaded on to members.

(299)

Henk Beets, assistant general manager (employee benefits), said it was clear that because medical aid schemes had responded too slowly to cost escalations, members had been disempowered and were being manipulated.

Pensioners appear the most vulnerable. Beets says it may already be too late to salvage lifetime medical benefits. Although most of the 69 JSE-listed companies surveyed are aware of the potential R15 billion liability incurred through lifetime cover for pensioners (the industry has just R1 billion in assets), few had done anything about this.

Just 14 of the companies surveyed have introduced pre-funding to provide medical benefits for future pensioners, and 35 of the balance envisage introducing similar provision in the future, while most small companies — with less than 1 000 employees — have no intention of doing so.

Instead, 40 of the respondents intend reducing pensioners' benefits.

Heather McLeod, an actuary and executive consultant in the health benefits field, said that as no guidance to future management of pensioners' medical benefits had been offered by the Melamet report which preceded changes to the Act governing medical aid, this area had degenerated into a free for all.

The problem is compounded by the fact that pensioners, who make up 13 percent of memberships, are poorly represented on medical aids' boards.

The controversial cross-subsidisation issue (by healthy younger members of older, less healthy members) forms the basis of the pensioner problem. But while most of the 69 respondants favouring cross-subsidisation would like this reduced, 41 have no idea of how to go about it.

According to McLeod, offering different cover options to employees has proved only 27 percent effective in containing costs and, as a major contributor to liquidation of many schemes, has worrying long-term consequences.

Companies surveyed aim to implement the following changes: 49 will introduce a self-funded medical savings scheme to supplement medical aid, 48 intend to limit doctor's visits, 46 hope to stipulate the use of only generic drugs, 44 will cap or reduce limits, and 35 plan to introduce a managed health care option for hospitals. Only one of the medical aids has looked at taking out insurance to cover losses.

These moves, says Beets, will shift costs from the employer to the employee and limit the employee's freedom of choice. But he queries just how appropriate these will be as far as those earning low incomes and pensioners who have little disposable income to meet the additional expense are concerned.

Medical schemes 'need change'

BEATRIX PAYNE

MEDICAL schemes and service providers should take on the financial risk of funding health care in order to effectively control rising medical costs, medical management consultant Healthscope's director Stan Eiser has said.

Medical schemes should be underwritten by insurers prepared to take the risk if the scheme collapsed, he said.

There was a misconception that medical aids funded medical care, but these schemes were merely a conduit for payment from the member to the service provider.

He said the problems now manifesting themselves in the industry were a direct result of this misconception.

"Until the industry realises this and assumes the risks of the descisions it makes these problems will go from bad to worse."

Eiser said medical aids took no financial risks themselves, but shifted risk to the member.

"When a scheme goes down it is the member who has to bear the risk and pay the service provider."

This was a major problem for service providers who were unlikely to get their money back.

Many schemes had recently introduced cost-cutting measures such as benefit and contribution reductions. But in the long term these measures would make the member pay more rather than ensuring the providers charged less.

"Every time a benefit is cut it shifts 100% of the costs to the member," Eiser said.

Managed health care (MHC) systems where the scheme and the service provider took joint risk and attempted to control costs had proved effective in the US, Eiser said.

Under an MHC system doctors negotiated with the administrator or the scheme over how much to charge for a service. The doctor would pay the excess if he or she overcharged, but if the doctor charged below the negotiated rate he or she could pocket the difference.

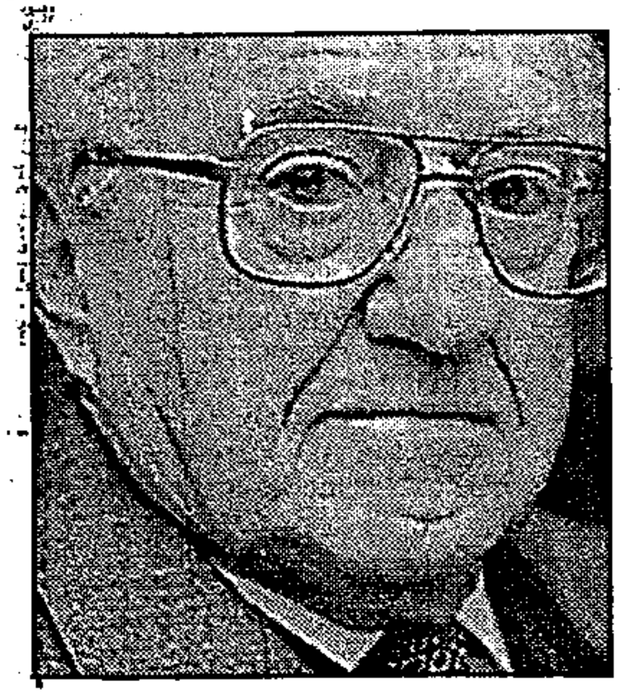
Eiser emphasised that when setting rates and tariffs service providers and financial managers needed to work together to ensure all parties were satisfied.

MEDICAL AID CRISIS: *Proposals to put schemes on a better financial footing come under fire*

Second opinion, please

Star 18/6/94

299



THE recommendations of the Melamet Commission, set up last year by the Nationalist government under the chairmanship of Mr Justice D A Melamet (left) to examine the state of the medical aid industry in South Africa, are *not* what the doctor ordered. Health Writer DAVID ROBBINS explains why.

MOST people know that medical aids are in some sort of crisis. Costs are increasing, cover is decreasing, but nobody seems to know where it's all going to end.

The Melamet Commission was designed to provide some answers. Chaired by Mr Justice D A Melamet, assisted by economist Professor W D Reekie and actuary Colin van der Meulen, the commission was asked to look into "the manner of providing for medical expenses"; in other words, to examine the viability and solvency of private medical aids.

Of course, a lot of medical schemes are neither.

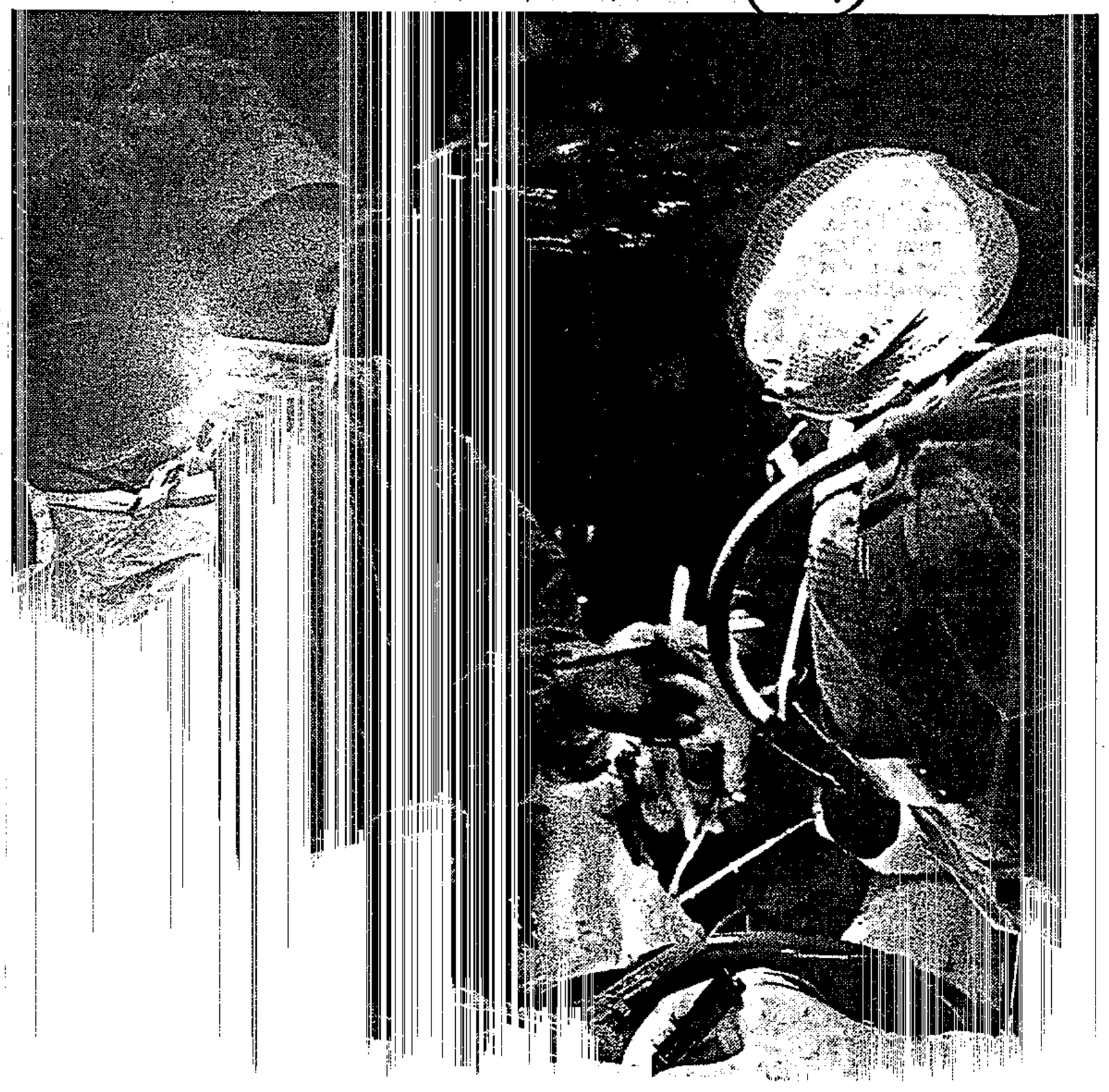
At the root of this complex issue lies a failure on the part of many schemes to plan adequately and methodically for the future. The crisis in medical schemes is relatively new in South Africa; for several decades they operated on low contributions because schemes, to re-establish a sound financial footing, become more like insurance companies.

In this way the commission has placed safe business practices above the safety of the client.

But many people are saying "no", most notably economist Alex van den Heever, now based at the Wits Centre for Health Policy, who sat on the Melamet Commission as an adviser recommended by the ANC.

VAN DEN Heever explains that many of the trends which have weakened the cover offered by medical schemes are the stock in trade of the insurance industry. Chief among these trends are the principles of exclusion, individual risk rating, no guarantee of continuation of cover, and the provision of specific benefits rather than general cover.

"One of the results of this is that a



schemes to plan adequately and methodically for the future. The crisis in medical schemes is relatively new in South Africa; for several decades they operated on low contributions because their members were generally young and healthy, and medical costs were low.

ON THE COMMISSION: Professor W D Reekie.

Now, faced with an ageing population and increased costs, the demand often exceeds existing funds, and the only way to balance the books is to announce another contribution increase.

This state of affairs has been exacerbated by several other factors: the rapidly rising cost of medical care in the past decade; the lack of control by medical aids over the providers of services and the wasteful over-provision of services which resulted; and increasing competition from the insurance industry.

ON THE COMMISSION: Colin van der Meulen.

Under pressure from these sources, many medical schemes have shifted the emphasis away from the traditional medical scheme position of cross-subsidisation based on a mixture of young and old, healthy and ill, rich and poor. They've moved instead to the idea of individual risk rating.

In simple terms, this means that the higher your risk, in terms of age or latent illness, the more you pay. This has resulted in the exclusion of many people from medical aid cover.

Also, the principle of guaranteed continuation cover (after falling seriously ill or going on pension, for example) has often been undermined by huge contribution increases. People have lost their cover simply be cause they could no longer afford it.

In a nutshell, the Melamet Commission's response to these ills has been to recommend that medical

these trends are the principles of exclusion, individual risk rating, no guarantee of continuation of cover, and the provision of specific benefits rather than general cover.

"One of the results of this is that a great many younger people especially are being tempted to under-contribute towards their own medical care," Van den Heever says.

An even more fundamental criticism of the gist of the Melamet Commission is that the recommendations will ultimately reduce the number of people covered by private health funders, and will push many ageing and ailing people on to the mercy of the State health system.

This is happening already, and it is precisely what the State does not want.

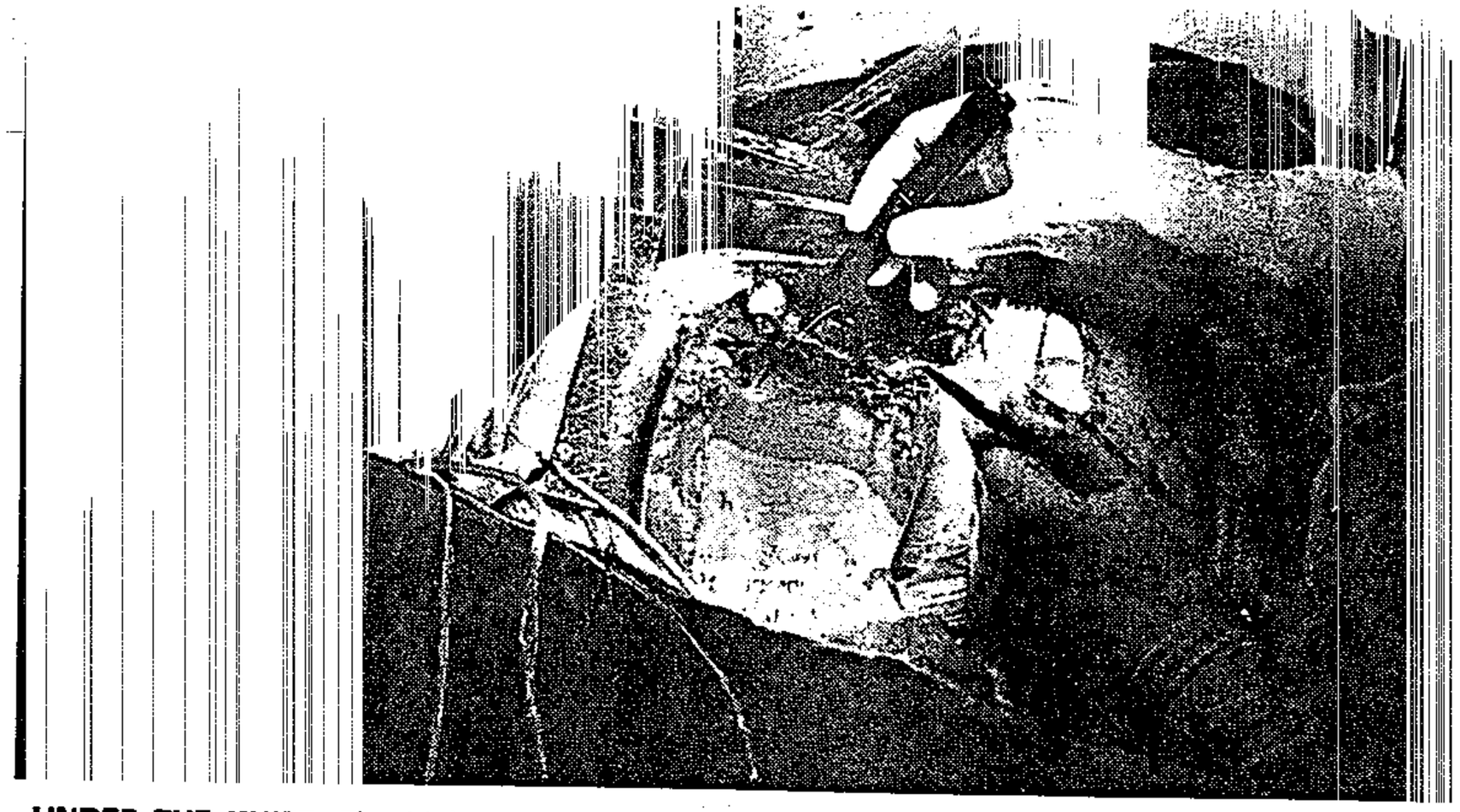
"The overriding principle," says Van den Heever, "must be that people who can afford to pay for their own health care should be encouraged to do so. The way forward is not to undermine medical aids, but to make them more accessible and more efficient."

The first step in this direction is to set up a further commission (as suggested in the ANC's health plan) to look at some of the details of how a restructured medical aid sector could usefully take part in a future health system.

The aim will clearly be to lay the foundations for a national health insurance system in which appropriately regulated medical schemes will play an important role.

SOME of the most important changes likely to be considered are:

- The reinstatement of the principles of cross-subsidisation and community risk rating (as opposed to the risk rating of individuals) to ensure that as many people as can afford to are guaranteed a minimum level of health cover for life.
- The sharing of the financial responsibility between all medical schemes with regard to what is being called a "core benefit package". This will entail the pooling of resources, but won't prevent individual schemes from offering more elaborate cover to those who can afford it.
- Increased responsibility for the continued viability of medical schemes to be placed on medical scheme administrators.



UNDER THE KNIFE: The Melamet Commission's recommendations will push many ageing and ailing people on to the mercy of the State health system, and this is precisely what the State does not want.

'Utilise existing health infrastructure'

WHAT do medical aid schemes say about the Melamet recommendations? Here are the comments of REG MAGENNIS, executive director of the Representative Association of Medical Schemes.

"THE focus of the commission tended to be on levelling the playing field between medical schemes and the insurance industry. As a result, the commission did not adequately address the possibility of using the infrastructure of medical schemes to help with the introduction of national health insurance in SA."

Magennis says the existing medical aid infrastructure should be used as a basis for "funding, administering and managing" a national health insurance system that offers a core benefit package to as many people as possible.

"A comprehensive policy which constructively engages medical schemes in this way could provide a sound basis for establishing cross-subsidy throughout national health financing. This is because, by engaging medical schemes, the Government would have established a national health insurance pool by linking medical scheme and State funding into a national risk pool. As a result, policies such as individual risk rating would not need to be introduced to protect the financial situation of medical schemes."

All this spells good news for medical aid members and for people who wish they were members but can't afford it. If medical aids are included in the overall national health plan, membership seems certain to grow, and services relating to core benefits (those services essential to basic health) will almost certainly improve as providers become compelled to talk about efficiency and cost-effectiveness with the powerful new configuration of funders.

Van den Heever says: "A clear differentiation must also be made between plans which offer basic medical cover, and those which complement such cover (usually insurance products).

"Those which offer substitutes should be subject to the same essential requirements which will govern medical schemes, especially indemnity-type cover, guaranteed continuation of cover until death, and transferability. The reward for providing these safeguards could be continued tax relief on contributions.

"Those arrangements, on the other hand, which complement the basic cover, such as top-up insurance and hospital plans, should not be subject to tax relief. This will be the surest way for the State to direct the efforts of the industry towards the principle of maximum basic coverage for the greatest number of people."

Medical aid schemes to be scrutinised for soundness

Star 21/6/94

■ BY DEREK TOMMEY

One of the most unpleasant experiences is to discover that your medical aid is broke and unable to pay your bills.

But members will soon be able to find out how solvent their schemes are and avoid unpleasantness.

Republic Ratings, which assesses the financial soundness of large and small firms, is to take a hard look at schemes.

Republic's director, Dave King, says that in line with his company's policy when rating organisations which take in public money, the results of the investigations will be widely publicised.

He says this will provide a valuable service to both the man in the street and to employer bodies. (299)

For the first time they will be able to compare the claim-paying ability of various schemes and determine the merits of individual premium quotes.

He says Republic's investigations have already highlighted a number of disturbing factors.

One has been the lack of financial controls in an industry which takes over R10 billion a year in contributions. Another has been the way contributions have spiralled.

In 1982, the average annual contribution was R442. By 1992 it had risen to R4 110 — a compound annual increase of 25 percent.

King estimates that contributions at present average about 8 percent of average salary. If contributions continue to grow at the current rate, they could average 25 percent of the average annual salary in 10 years' time.

He says that almost half of the open medical aid schemes reported losses in 1992 and that some of them appear to be in serious difficulties.

One reason is that the big rise in individual contributions had led to a declining trend in membership, especially among the young, as people switched to either "self insurance" or "catastrophe" schemes offered by insurance companies.

This has long-term effects as it reduces the cross-subsidisation by the young of pensioner members. The fact that medical aids have hitherto not provided for these "actuarial liabilities" exacerbates the problem.

King says that in the 10 years to 1992, the average annual administration fee charged each member rose from R31 to R222 — an effective annual compound increase of about 22 percent.

"We hope our investigations do not show that administrators have been unrealistically compensated relative to their efforts to ensure that their schemes are adequately funded," he says.

Medical aid finances to come under scrutiny

BEATRIX PAYNE

REGULATION of the R10bn-a-year medical aid industry would be tightened up, industry sources said yesterday.

Representative Association of Medical Schemes (RAMS) executive director Reg Magennis said yesterday that, following a series of collapses, the organisation planned to conduct an "accreditation programme" to ensure members were financially solvent.

The terms of the programme — to be conducted with the Registrar of Medical Schemes — were expected to be finalised at a meeting of the RAMS council at the end of the month.

"It will place RAMS in the hotseat in terms of the performance of its own members but will enable the organisation to isolate potential problems and prevent collapses," Magennis said.

Republic Ratings director Dave King said the credit rating agency planned to investigate the 37 open medical schemes that used public money.

"We have been alarmed at the relative lack of financial controls in an industry which takes in R10bn per annum."

Almost half of the open medical schemes had reported losses in 1992 and many of them still appeared to be in financial difficulty.

Most open schemes would co-operate in the research, but he expected some resistance from "weaker" schemes.

The company also planned to investigate the financial situation of the 60 unregulated medical benefit funds in operation.

King said although medical aids would have to pay a fee to have their operations rated, the agency would not profit from this as it made its money from fees from its subscribers.

The results of the ratings would allow employers and individual scheme members to assess the claims-paying ability of various schemes.

"The man in the street is largely unaware of the risk of his medical scheme not being in a position to pay legitimate claims."

As medical scheme membership costs have risen over the last few years, membership has fallen and reserves have declined leaving the elderly and remaining members financially vulnerable.

Administration fees for medical aids rose 22% from 1982 to 1992 while average growth in earnings for JSE companies over that period was only 11%, King said.

"We hope that our investigations will not indicate that administrators have been unrealistically compensated relative to the effort they have put in to ensure that the schemes are adequately funded."

Ratings loom for medical aids

299

ARLT 22/6/94

Business Staff

REPUBLIC Ratings, which assesses the financial soundness of large and small firms, is to take a hard look at medical aid schemes.

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Private medical costs rising rapidly

(299)

ANS 23/6/94

WITH medical inflation soaring, the cost of private health care is rising rapidly. And there is a substantial gap between actual medical costs and medical aid payouts.

This is especially so for major medical treatments which place a severe strain on a patient's finances, says Liberty Life, one of the number of South African companies with extensive health insurance options available.

The company has recently developed its "New Series Medical Lifestyle", which provides "High-Series cover" and "Extended-Series cover".

Among the services offered by Liberty Life is a hospitalisation benefit, aimed at covering accomodation and related costs.

An example of high series cover, paid out for a heart bypass operation and 10 days in hospital, can be broken up as follows: daily benefit (excluding the first three days): R3 745 (R535x7); intensive care benefit for one day: R1 580; Ten-day benefit: R1 580; medical procedure benefit, severity 5: R35 300.

The total benefit would be R42 205.

Medical aids "must adapt"

BEATRIX PAYNE

THE struggling medical aid industry would have to cut costs and forge alliances if it was to survive in a deregulated operating environment, the Representative association of Medical schemes (Rams) said last week.

Executive director Reg Magennis said "competition is likely to heat up" and the industry would undergo a major shakeup after medical aids were deregulated in early January.

Recent reports about the collapse of two Eastern Cape medical schemes had shown that many scheme members who had pulled out of medical aids had been dissatisfied with increasing contributions and lower benefits.

But Magennis said the increasing dropout rates were a symptom of the old regime under which medical aids had to provide defined services packages and had difficulty containing costs. "Even though people are leaving medical aids they still need health care and medical aids can now reorganise and adapt under the new regulations."

The new regulations would allow medical aids to enter into agreements and contracts with service providers and offer more flexible packages to members.

But market sources warned that price wars had been the downfall of recently liquidated MMP and MCG medical aid schemes.

If medical schemes were to offer various benefit packages they would have to ensure that contributions covered expenses.

The industry would be boosted if the state decided to operate its planned national health insurance programme with the private sector through contracts with medical aids.

But he said medical aids would not be prepared to enter into contracts unless they had some say when negotiating costs with health providers.

Relations in the industry were set to change as medical aids began to negotiate terms with doctors, hospitals, the state and life assurers.

Magennis said while some medical aids had started negotiations and offered various packages "this is just the beginning of an evolutionary process and the industry has a long way to go". He said the public could expect several medical aid schemes to nationalise as a result.

Medical aids would be looking to strengthen their negotiating positions through better information systems, managerial ability and an increase in membership.

"All medical aids are considering their positions and whether or not to combine with other medical aids or contract with scheme administrators."

Uncertainty over R12m claims

BDay 28/6/94

BEATRIX PAYNE

MEMBERS of liquidated 37 000-strong MCG medical fund were still in the dark over who would settle roughly R12m in outstanding claims after the scheme was liquidated last week, industry sources reported yesterday.

But Midland Chamber of Industries spokesman Ian Dimbleby said he would be meeting the liquidator today to discuss the fund's finances and how claims would be settled.

Sources said that when a medical aid scheme was liquidated, members usually became liable for outstanding claims.

Employers in the region said they were negotiating alternative cover for employees but were waiting to hear from the liquidator before arrangements for the payment of outstanding claims could be made.

Delta Motor Corporation placed its 1 000 workers previously covered by MCG under Sizwe Medical Fund and was exploring "alternative arrangements" to assist employees in the payment of outstanding claims.

Volkswagen SA corporate benefits manager Clive Forrester said the company was still discussing alternative cover for the 4 500 members of staff who were covered by MCG.

It was likely that employees would be covered by Sizwe Medical Fund.

A Mercedes Benz spokesman said the company was still examining tenders from various schemes with the union, and would make a decision in the next week. (299)

He said employees would be treated free of charge at the company's on-site clinic by an in-house dispensing doctor.

South City Health Care consultants' director Donald Alexander said about 10 of the larger employers and about 70 of the smaller companies in the region had made inquiries about alternative cover through schemes administered by Sanlam subsidiary Sanmed and Old Mutual.

Craven "A" Menthol	R2.70	R4.00	
Craven 120's Menthol	R2.90		
Craven 120's Virginia	R2.90		Cavalla Kings

Call to improve medical aid

PRETORIA. — Efforts to improve medical aid for formal-sector workers and the self-employed should be made by the government, small business and large corporate insurers, according to a Human Sciences Research Council (HSRC) report released yesterday. CT 29/6/94

The report, Financing health care: Experiences and opinions of some South Africans, is the result of a survey of 2 000 people by Dr Ina Snyman. (299)

It recommended the setting up of a national unitary health insurance system to guarantee basic health services for all.

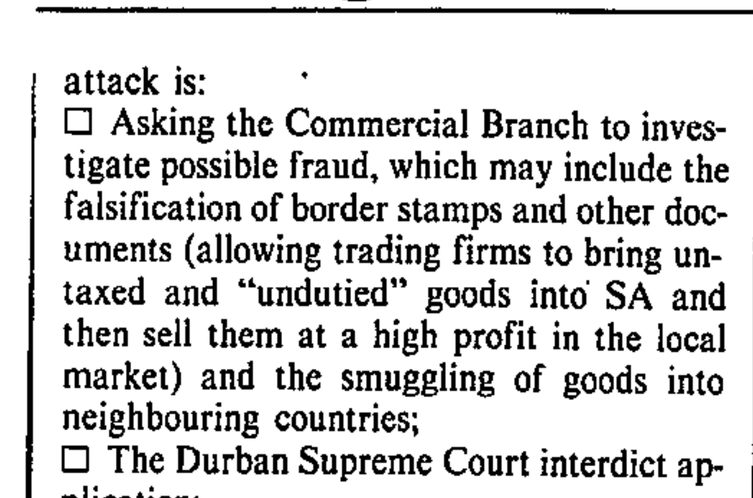
"Social assistance should be provided in those instances where participants cannot contribute enough for essential basic services or cannot contribute at all," said the HSRC.

"This system would be compulsory. It would be just like paying tax, since everyone would benefit from it, regardless of whether a person has temporarily been exempted from contributing or not."

The report recommended that small businesses be encouraged and assisted in providing basic medical benefits to staff. — Sapa

e freight forwarders

attack is:
☐ Asking the Commercial Branch to investigate possible fraud, which may include the falsification of border stamps and other documents (allowing trading firms to bring untaxed and "undutied" goods into SA and then sell them at a high profit in the local market) and the smuggling of goods into neighbouring countries;
☐ The Durban Supreme Court interdict application;
☐ The formal court action against the department, seeking an order that Conlog and Renfreight are not liable for the duties; and
☐ An application submitted to President Nelson Mandela to appoint a commission of inquiry into the vexed issue of the liability of forwarders for frauds by customers. The



commission would also be asked to look into changing the Customs & Excise Act.

Customs & Excise's Colesky says: "We are negotiating with government to allow us to increase our complement of trained personnel because our current 13% understaffing may possibly allow for frauds to be more easily perpetrated. But, even if our current 1 600 complement is brought up to scratch, it could still take about a year to train the new staff properly."

He adds that he wants to follow the example of the Auditor-General's office, which has been separated from the civil service and can now pay market-related wages.

"The problem is that as soon as we train our staff to a certain level, they receive attractive offers from the private sector," says Colesky.

Arnold van Huyssteen

MEDICAL AID SCHEMES

Controlling the council

Health Minister Nkosazana Zuma last month called on the public to nominate members to the Council for Medical Schemes — the authority that regulates the schemes and determines the policies that affect medical aid members, about 25% of the population.

It's a decision that Zuma and her department apparently hope will bring transparency to the appointment of one of SA's most powerful public financial trustees.

But it's a move that could well open the door to vested interests — particularly doctors and trade unions — seeking to exploit the industry by recklessly mandating that the schemes provide greater benefits, say some critics.

Says private hospital group Presmed joint-MD Rob Speedie: "The 15-member council is, by law, meant to be a council of experts and not representatives, though provision is made for two members to come from the ranks of registered medical schemes and another two employees or employers subscribing to a scheme. Inviting public nominations could transform the council into yet another forum for vested interests controlling private funds. The council should be an organisation meant to represent schemes and member interests."

Under the law, there's nothing to prevent Zuma from asking the public for nominations. Formerly, appointments have been made by the Minister, acting on the advice of her department in selecting industry experts.

Representative Association of Medical Schemes (Rams) executive director Reg Magennis says the actual selection of council members and not the process is what counts. "The rules have to recognise the balance between limited funds and unlimited needs, otherwise the public interest won't be served." In any case, he adds, vested interests are no cause for concern "as long as council members have the necessary skills and represents a multidisciplinary mix." Magennis, a former health policy director for the doctors' Medical Association of SA, adds that Rams would, in any case, be able to challenge any vested interests trying to dominate the council, a claim that some believe is somewhat naive.

The issue of vested interest groups masquerading as neutral bodies and looking for spots on government-appointed commissions certainly isn't new. When former Health Minister Rina Venter was trying to reform private-sector health care, she spent months fighting off the doctors lobby, which wanted to be represented on the council. The Medical Association argued that the presence of doctors on the council was essential to safeguard medical standards and patient interests.

Venter, however, pointed out that the SA Medical & Dental Council was constituted

BUSINESS

specifically to safeguard the public interest in relation to medical treatment. "Why does the Minister need two councils advising on the same issue?" she would ask. When the Medical Schemes Amendment Act went into effect in January, doctors were not represented on the medical schemes council.

Medical Schemes Registrar Danie Kolver stresses that the council should ultimately be made up of experts, particularly those with legal, financial and medical schemes experience.

He points out that the council makes policy and advises the Minister on how schemes should operate. "But the council also has a quasi-judicial function. It provides a swift and free mediation mechanism for members and health-care suppliers. Where the disputes committee of a scheme makes a decision that adversely affects members or health-care providers, they have an immediate appeal to the council."

Of course, the recent findings of the Melamet Commission into the financial state of medical schemes points to a desperate need for expertise at every level of the schemes industry to save it from collapse (*Business* April 29).

The commission recommended that "provision should be made in the controlling authority — the council — for expertise in accounting, law, actuarial sciences, hospital administration, business administration and the insurance sector."

Kolver says he is in the process of tabling the commission's recommendations to the Minister, though he would like to avoid a situation in which actuaries come to dominate the schemes. "We have just managed to get rid of legally sanctioned direct payments to doctors; we don't want to replace this with automatic jobs for actuaries." ■

Health care: Funds going under as cost outstrip contributions

Medical aids still poorly

299 WM 1-7/7/94

There has been no let-up in the pressure on medical aid schemes. **Reg Rumney** reports

THE closure of two medical aid schemes in the Eastern Cape will renew fears about the soundness of this health care structure so many South Africans rely on.

Since around six million South Africans are members of medical schemes, cracks in this edifice would have serious consequences.

Representative Association of Medical Schemes director Reg Magennis says two schemes, MMP, and MAG, have been put into voluntary liquidation by their own management committees, which comprised employees and employers.

Magennis says both schemes were operating in the same area and were faced with the same sorts of problems. "They were under pressure from unions and employers to keep contributions down."

The role of the unions in these closures echoes comments by Old Mutual's Henk Beets, who believes unions are gearing up to make the same impact in the area of health benefits as they did in the provident fund marketplace.

"Health benefits will be the next major negotiation issue between unions and management." Unions may also come to be better represented on the management committees of medical aid schemes.

An independently conducted survey, for Old Mutual, looked at the health care benefits of 69 organisations in the Top 300 companies listed on the Johannesburg Stock Exchange.

While 44 percent of the members of all the companies surveyed were union members, the survey found that few companies included union representatives among the employee representatives on the management committees or boards of the medical schemes.

And though pensioners stand to lose the most if a scheme goes under, they were poorly represented in the companies surveyed, at one percent of management committee or board members.

Beets reminds that provident funds tend to have a 50-50 split between workers and management, unlike pension funds, which generally have one or two staff representatives.

The role for unionised medical aid members may become increasingly important, but the real underlying problem, as identified by the survey, is that the medical schemes industry is suffering from a combination of rising costs and declining reserves.

Magennis puts the problems of the two liquidated medical schemes down to an inability of the medical schemes to control costs. "They were unable to contain costs, but were starved of revenue."

Medical costs worldwide have spiralled out of control, but they have been aided by the peculiar "guaranteed payment" system in South Africa, which assured any doctor or other medical service provider who charged the RAMS scale of benefits of payment — what some people still think of as a doctor or hospital being "contracted in".

Medical schemes have long pinned their survival hopes on the change in legislation allowing them to offer more flexible health care cover, and doing away with guaranteed payment.

Companies themselves are concerned about cost. The cost to companies of their health plans rose on average by 20 percent over their last financial year.

While costs rise, the changing tack of the medical schemes in offering a range of benefits and contributions may not itself be helpful.

Old Mutual actuary Heather McLeod reckons that five years ago the money management of medical schemes was simple: they had to match money in with money out.

That has changed in the last year, she notes, with greater choice of benefits design in the name of consumerism. Trouble is this has thrown out of kilter the simple cross-subsidisation mechanism (younger and healthier subsidise older and sicker) on which medical schemes used to

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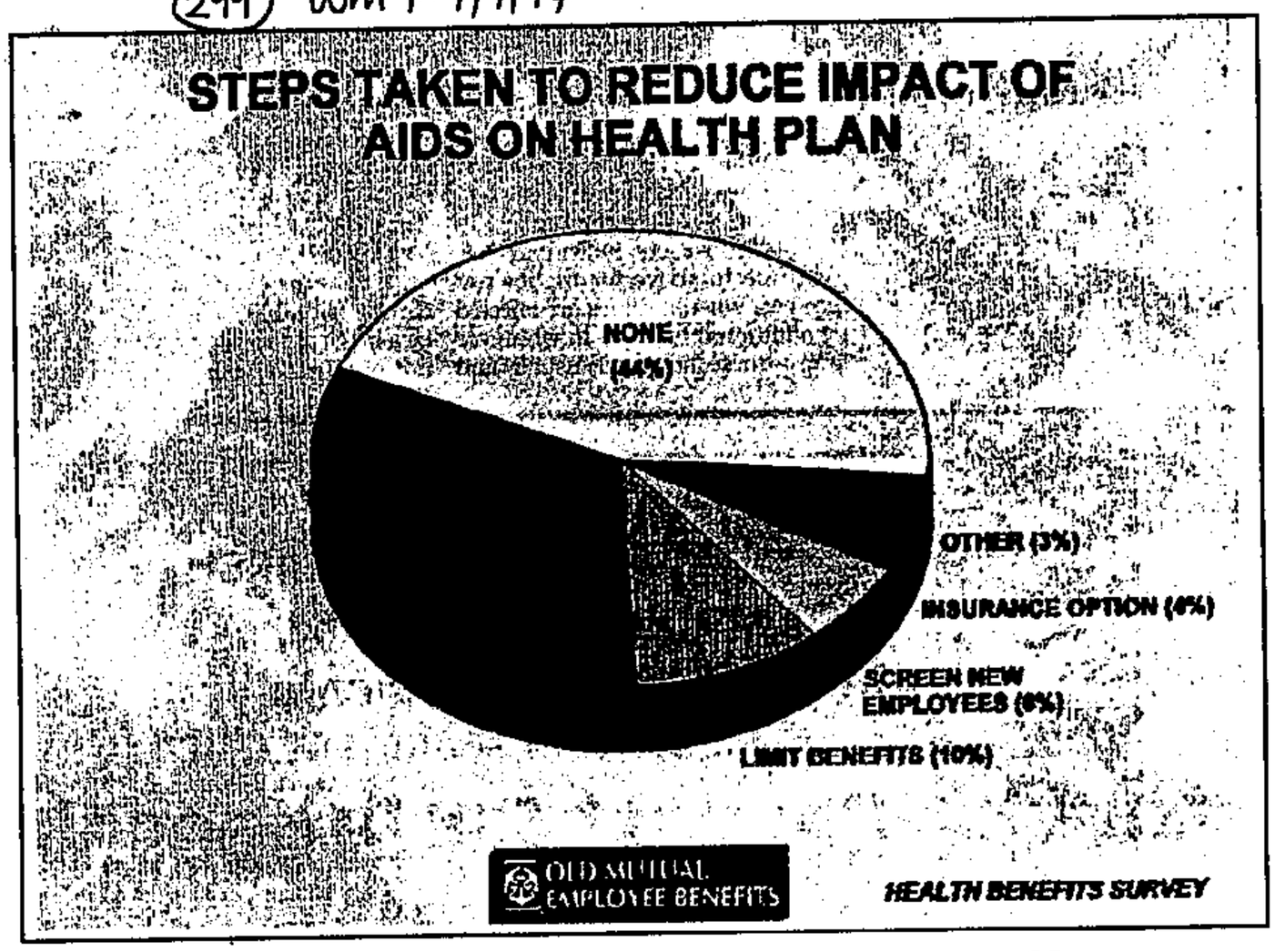

Little being done to combat Aids' effects

DESPITE the potential damage of the Aids virus to already financially strained medical aid schemes, 44 percent of respondents to a recent study said no measures were being taken to lessen its possible effect.

Measures taken have mostly been limited to Aids education, with 32 percent of respondents stating they had an educational programme in place.

Another 10 percent said they would limit benefits if a member contracted the virus, while six percent said the screening of new employees was used as a way around the problem.

Asked whether current or prospective employees were screened for Aids, only 24 percent of respondents indicated HIV blood tests were being performed.

Medical aids still on sick list

299 WM 1-7/7/94

■From PAGE B1

rely, and brought about a mismatch of contributions and benefits.

While money in, money out should be replaced with a regime of building up reserves, the OM survey shows most of the schemes surveyed still paid out 99 percent of contributions.

Actuarial valuations should be the order of the day, but they are not. McLeod reckons funds should probably be brought into the ambit of the Financial Services Board.

For its part, the medical schemes movement is trying various ways to prop up the schemes.

Magennis notes that RAMS is busy in negotiation with health care service providers on a range of issues, including a new information system which will enable medical schemes to track costs better. And on the cards is a system of self-regulation, where RAMS can intervene before a particular scheme gets into hot water.

In the end, the proliferation of choices is likely to be reduced in future — under pressure from the medical profession, says Magennis.

Meanwhile, better communication to members about transformations of the company's health plan is essential. The OM survey found companies still mostly relied on circulars and newsletters to communicate changes to their health plans — fodder for file 13.

Medical schemes 'save money plan' nets R150m

KATHRYN STRACHAN

A PLAN to contain runaway expenditure by medical schemes had produced an overall saving of 2,5% in the first four months of this year — which translated into an annual saving of about R150m, the Representative Association of Medical Schemes (Rams) said at the weekend.

However, this fell below the plan's target of 8% set by Rams and the Medical Association of SA (Masa) late last year.

Rams executive director Reg Magennis said it had been difficult to assess the exact degree of response the plan would get when the 8% target was set, particularly in the unsettled environment of the beginning of the year.

A positive trend was beginning to emerge, and Rams hoped it would gain momentum through the year.

While there had been a saving of 7% in medicine expenditure this year, hospital expenditure continued to grow, leaving an average of 2,5%.

According to Magennis the principle objective of Rams at present was to build a stronger relationship with the hospital industry. A meeting was held last Thursday, and the industry was eager to take part in the plan to contain costs, he said. (299)

Rams and Masa entered into an agreement of co-operation at the end of last year in terms of which doctors would be rewarded for savings in medicine and hospital expenditure.

While certain medical schemes showed savings, others did not and member contributions could still require an interim adjustment. To strengthen the private health sector, Masa agreed to postpone an increase to which doctors were entitled for savings so far. This increase would now be introduced in January.

The savings achieved this year would form the basis for Rams/Masa negotiations — due to begin in the next two months — on doctors' scale of benefits for next year.

"The positive trend achieved indicates improved utilisation of limited financial resources," he said.

Masa spokesman Dr Herc Hoffman said it was difficult to contain hospital expenditure as the costs were largely beyond doctors' control. "As part of Masa's drive for cost-effective quality health care, we are providing doctors with guidelines on how to avoid wastage and to exercise better control in this area," he said. "I must also urge the hospital industry to support this initiative."

Hoffman added that he was concerned about the new trend of risk-rating in health insurance. This, he said, would lead to the ultimate demise of private health care.

The "cherry-picking" of people deemed to be good risks was disturbing the foundation of health insurance, he said.

There was a worldwide trend of returning to the principle of cross-subsidisation where the young and healthy of today should be obliged to make provision for later years by contributing to the communal risk-pool, Hoffman said.

Hosmed in surplus

Star 16/8/94

■ BUSINESS STAFF

The Hosmed Medical Aid Scheme, managed by Trilogy Healthcare Administrators, has reported a surplus of more than R1,2 million for the six months to June.

Trilogy managing director Rob Davey says the surplus follows an underwriting loss of R3,4 million for the year to December 1993.

"The loss was due to a number of negative market factors as well as a higher-than-expected claims experience throughout the industry.

"The turnaround this year can be attributed to our improved systems, better assessment of claims and cost containment initiatives."

(299)

MEDICAL AID

Prefunding retirement

It would be prudent for employers to acknowledge their medical aid liabilities for pensioners, says Graeme Kerrigan, joint MD of employee benefits consultants, Alexander Forbes. He expects legislation in SA to follow that of the US and notes that accounting practices in the UK are being reviewed on similar lines.

With medical aid costs approaching (and sometimes exceeding) pension costs for employers, the pay-as-you-go attitude of most SA employers is possibly not tenable. Kerrigan says that, when prefunding was legislated in the US, General Motors took a write-off of US$25bn to cater for the health care of retired employees.

Pensioners claim between two and three times as much from medical aid as active members, resulting in severe cross-subsidisation. "Historically," Kerrigan adds, "most employers have agreed to subsidise retired employees' medical aid contributions, without recognising the extent of the long-term liability this creates." He argues there should be an actuarial valuation of these liabilities, in much the same way that pension liabilities are assessed.

Pre-funding medical costs would be much less accurate than planning pension liabilities, so an actuary is likely to take a highly conservative approach. For many companies, there would be an immediate depression of published profits. But Kerrigan argues there are tax-efficient vehicles available for funding the liability.

Though it had broader scope than pre-funding, the recent Melamet Commission was charged to report "whether or not the manner in which medical schemes are funded is sufficient and whether it is desirable to subject their financing to actuarial discipline and supervision."

Melamet concluded that a controlling authority be established with expertise in accounting, law, actuarial science, hospital and business administration. The commission also suggested the introduction of a Private Health Finance Act, because of the number of organisations — some controlled, others not — now involved in financing health care.

Liberty Life, a leading supplier of health insurance products which fall outside the control of the Registrar of Medical Schemes, says Melamet's findings, if adopted, will augur well for the life assurance industry. Melamet also felt the pay-as-you-go funding concept and cross-subsidisation, were no longer tenable. The commission felt that the conducting of medical schemes for profit, including the distribution of profits to shareholders who are not members of a scheme, must be permitted.

Melamet has acknowledged that deductibility of health care contributions is a legitimate cost of doing business and argues that section 11(1) of the Income Tax Act should be extended to employer contributions to insurance policies. That means such contributions would be taxed as fringe benefits in the hands of employees.

Taken together with the ANC's draft for a minimal national health plan, there is so much theorising and so many tax implications that nothing is likely to be decided in a hurry. Yet another commission is on the cards before all the parameters of a health-care structure are drawn. But, where employers are contributing, they would be advised even now to consider the implications of pre-funding. ■

Strict monitoring could keep medical schemes on their feet

BEATRIX PAYNE

STRINGENT financial monitoring of medical schemes could prevent financial collapse, the Representative Association of Medical Aid Schemes (Rams) said on Friday.

Rams executive director Reg Magennis said schemes' reserves should be checked and made accountable to a central agency in the same manner as the reserves of banks were monitored by the Reserve Bank.

Commenting on the BB rating given to Hosmed medical scheme by Republic Ratings last week, Magennis said it was possible Hosmed's rating was intended to "create a scare" in the industry.

This would encourage larger medical schemes to seek ratings to promote their organisations.

Rams had appointed chartered accountants to review Hosmed's financial position at its request.

Some schemes had low financial reserves because of the tightly regulated financial environment under which they had operated in the past, he said.

Changes in the Medical Schemes Act, introduced earlier this year, would make it possible for schemes to control financial risk by tackling rising medical costs.

However, tighter operating and reporting norms were needed to help the industry and prevent further collapse of schemes.

Rams was, in the next few months, to produce an assessment of medical aid schemes based on financial statements submitted to the Registrar of Medical Aid Schemes in July. B1Sep4

It also intended to develop a data base showing the monthly financial position of each medical aid in order to help monitor the industry. 22/8/94

The assessments would be done in conjunction with accountants Ernst & Young. If a scheme was in a vulnerable position Ernst & Young would help it improve its financial position. (299)

Hosmed administrator Trilogy MD Rob Davey said the scheme was financially secure and would be in business for a long time.

It was not vulnerable to the loss of a single client as Republic had indicated.

It had a broad base of clients in commerce, industry and among parastals, he said.

Sanmed finds little to like in ANC plan

EDWARD WEST

CAPE TOWN — Extending the current system of medical aid schemes to all employees as envisaged by the ANC's national health plan would be inefficient and unaffordable, Sanmed, one of SA's largest private medical aid companies, said yesterday.

Sanmed has recently completed a study on the Melamet Commission's report into medical aid schemes, the ANC's national health plan and a World Development Report which followed a World Bank investigation of medical health care for underdeveloped countries.

MD Tommie Malan said the provision of free services could have an unfavourable effect on the medical industry. "The proposal that there should be no request for paying for health services at the time of illness will increase the tendency to abuse the system," he said.

The costs of a medical bill would have to be funded by tax, but taking into account all the other obligations that had to be funded by tax, it would be naive to think an extraordinary tax increase would be awarded to the bill.

"Instead of providing the basic cover free of charge, one should rather consider incorporating it in a welfare or unemployment grant, or something similar, as the responsibility which lies with the patient would induce him not to abuse the paid service," said Malan.

A ceiling should be placed on the cost of the basic medical service package required by government, otherwise the cost situation could get out of control.

Sanmed director Nick du Preez said while the intention in the ANC's national health scheme of giving free services to wide categories of people was laudable, the proposals were too expensive for SA.

Health services expenditure was currently some 4%-5% of GDP. If the ANC's plan was implemented, the percentage would increase to between 15%-17% of GDP.

Du Preez said the medical industry was locked into a debate as to what medical procedures the national medical scheme should cover. The basic package envisaged in the national health scheme would have to exclude many worthwhile medical procedures to be affordable, he said.

Sanmed finds little to like in ANC plan

EDWARD WEST

CAPE TOWN — Extending the current system of medical aid schemes to all employees as envisaged by the ANC's national health plan would be inefficient and unaffordable, Sanmed, one of SA's largest private medical aid companies, said yesterday.

Sanmed has recently completed a study on the Melamet Commission's report into medical aid schemes, the ANC's national health plan and a World Development Report which followed a World Bank investigation of medical health care for underdeveloped countries.

MD Tommie Malan said the provision of free services could have an unfavourable effect on the medical industry. "The proposal that there should be no request for paying for health services at the time of illness will increase the tendency to abuse the system," he said.

The costs of a medical bill would have to be funded by tax, but taking into account all the other obligations that had to be funded by tax, it would be naive to think an extraordinary tax increase would be awarded to the bill.

"Instead of providing the basic cover free of charge, one should rather consider incorporating it in a welfare or unemployment grant, or something similar, as the responsibility which lies with the patient would induce him not to abuse the paid service," said Malan.

A ceiling should be placed on the cost of the basic medical service package required by government, otherwise the cost situation could get out of control.

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Medical aids to go ahead

PRETORIA. — Three medical aids on Saturday unanimously decided against further postponement of an agreement with the Medical Association of South Africa (Masa).

The agreement — offered by Medihelp, Polmed and Medcor — allows doctors, dentists and physiotherapists arrangements for the submission and payment of claims to replace statutory requirements which expired at the end of last year.

Medihelp general manager Mr I J Marais said yesterday that at the request of Masa the implementation date of the agreement had been postponed on three occasions to provide adequate time to formulate national contractual guidelines. (299)

The schemes decided against further postponement. CT 17/10/94

Mr Marais said further postponement would cause confusion and unnecessary administration costs.

He added the schemes were prepared to continue with negotiations and would also incorporate any acceptable amendments. — Sapa

Fedsure buys majority stake in Medhelp

BTDay 20/10 94

FINANCIAL services group Fedsure had acquired a R25m majority stake in health care administrator Medhelp, the group said yesterday.

Fedsure said Medhelp-administered Reef Medical Scheme would be incorporated into the group's new health care insurance company, Fedhealth.

Strategy and information GM Dave Avnitt said the group had previously

BEATRIX PAYNE

offered health care products to a limited market. Fedhealth would broaden its exposure to the sector.

The Reef Medical Scheme provided cover for about 60 000 members and dependents. (299)

Fedhealth would be 100% controlled by holding company Fedcare, which had capital of more than R42m, he said.

Fedsure would hold a 60% stake in Fedcare, with Reef Medical Aid director Rod Harpur holding 30% and the balance held by Hollandia Reinsurance.

The group was undecided on whether to finance the acquisition through cash or a share issue. (292)

Fedsure CE Arnold Basserabie said he expected the initial annual income from premiums to touch R230m. However, the acquisition would not affect the group's earnings or net asset value for financial 1994.

Avnitt said Fedhealth was an attractive acquisition but "minuscule in the group context".

The move was part of the group's strategy to move into broader financial services. "The move allows us to combine the strengths of the life assurance and medical aid industries and brings our actuarial skills to the medical aid business," Basserabie said.

This was in line with recommendations made by the Melamet commission, which stressed the need for acturarial supervision of companies providing health care products.

'Huge' MIF claims paid to foreign tourists (299) CT 20/10/94

THE weakening rand had led to a huge jump in the value of claims being made to the state Medical Insurance Fund by tourists, CEO Willem Swanepoel said.

He said the biggest claim paid out yet by the Multilateral Motor Vehicle Accidents Fund (MMF) had been R7m to a Japanese tourist "but even bigger claims are in the pipeline, although whether we will pay them is another matter.

"The main reason is that the rand has become so weak," Swanepoel said.

He earlier told the parliamentary Public Accounts Committee that the claims by foreign tourists injured in road accidents in South Africa had become "a big headache and our insurers complain that they do not like them.

"I am sure that if Paul Getty was injured in an accident his claim would take up the whole GDP of South Africa," Swanepoel said.

Swanepoel went on to say that the fuel levy should be increased by at least one cent a year and accident insurance claims should be capped.

He said the technically insolvent fund provided "luxurious" benefits that were "unbelievable by third world standards".

The fund provided unlimited cover and even paid out for general damages such as "pain and suffering" which caused no financial loss to road accident victims.

Swanepoel said that the main reason why the fund, which had a deficit of R4,4bn, was insolvent was because of high medical costs, SA's "notorious accident rate", huge awards made by judges and the fact that the fuel levy was not beng reviewed regularly to keep pace with medical inflation.

The fuel levy is the main source of income for the fund.

Fraudulent claims, which were a major drain on funds in the past, were more or less under control now that a new computer system had been installed.

'Not watertight'

"But I cannot say that it is completely watertight," Swanepoel said.

He said the period after an accident in which claims could be made should be shortened from the present three years to one year because of the difficulty of determining the cause of accidents after such a long period. — Reuter

Fin 21/10/94

care will become 30% cheaper.

Says Medi-Clinic financial director Craig Tingle: "The present hospital tariff system distorts costs by allowing simple and frequent procedures to cross-subsidise complicated surgery and high-care costs."

The proposals — the work of the Joint Hospitals Committee, representing the industry — also call for an end to the basic theatre fee of R178,50. This is to be replaced with a flat rate per minute for theatre time. Tingle says this should cut costs substantially for frequent and simple procedures. He adds that certain sophisticated procedures, such as open-heart surgery, could become cheaper because of the large pharmacy component of the account. "Under the present system, six 10-minute procedures cost R1 629 while a more complicated one-hour procedure costs only R736,50."

(299)

But the proposals don't enjoy unanimous support from the industry. Presmed joint MD Carl Grillenberger says: "The proposals appear to favour hospitals that have been cited as the most expensive, particularly those that have invested large amounts in hi-tech and high-care facilities. Cost-conscious hospitals have been overruled and expensive care will simply become prohibitive. Can cost increases of up to 91% be funded by the critically ill in today's economy?"

He adds that the proposals could serve as a perverse incentive to administer more expensive and complicated care.

Tingle says the proposals are based on real costs at a typical multidisciplinary hospital and the results checked by auditors appointed by the Representative Association of Medical Schemes. ■

MEDICAL COSTS

Fin 21/10/94

Sickening price hikes

Private hospitals are pushing medical schemes for tariff increases that could see specialised ward rates rocket by up to 90% and certain theatre rates by 71%

(299)

But they propose to slash the medicines bill — which makes up around 40% of the total hospital bill — by 22%. Rates for day

Medical aid for state plan

Staff Reporter

THE medical aid fund industry can help the government achieve its health care objectives with minimal costs, says Sanmed chief adviser Mr Deon Harmse. 299

He told an International Federation of Hospital Engineering meeting in the city yesterday that using the existing medical aid fund infrastructure to provide for the uninsured would be far more efficient than setting up additional cover. CT 21/10/94

The cost of the National Health Plan would be 14% of GNP.

Extending the existing medical aid industry's infrastructure by creating compulsory basic medical aid package for the lower end of the market is far more efficient — and at the expense of the private sector," he said.

Star 27/10/94

National health insurance mooted

Cape Town — The Department of Health is considering the possibility of national health insurance to replace the system of medical aid schemes, Department of Health Director-General Coen Slabber said yesterday.

He told Parliament's select committee on health that medical aid schemes were not working well and could become unaffordable.

"We must consider if the time is right for South Africa to look at a national health insurance scheme," he said.

"Committees under the Department of Health are considering this and all must report to the Minister by the end of November," he said.

A possible scheme would initially include only employed people, but could be extended to all South Africans in time.

In the past four years, medical aid schemes had lost 10 percent of their members but payouts had risen by 26,8 percent.

"Medical aid schemes cannot contain their costs," said Slabber.

"They can only do this if they prescribe to doctors what they are prepared to pay for."

▶ **More reports — Page 7**

Medi-Clinic income up 15,9%

ET 17/11/94 (299)

Deputy Business Editor

FURTHER improvement in margins enabled Medi-Clinic Corporation to lift operating income 15,9% to R23,8m on a 14,5% increase in turnover to R138,3m for the six months ending September 30.

Financing the group's expansion programme resulted in a decline in interest received to R515 000 against R1,4m for the corresponding period the previous year.

Attributable earnings increased to R16,1m (R14,6m) with earnings at share level up 13,9% to 12,4c a share.

An interim dividend of 2,5 cents (2,2c) will be paid.

Constantiaberg Medi-Clinic, the directors said, had recovered particularly well after the decline in occupancies during the previous year. This trend, experienced by most of the hospitals, was expected to continue.

The two large capital projects which had been commissioned at the end of the period under review — the cardiac unit at Panorama Medi-Clinic and the establishment of the Hoogland Medi-Clinic in Bethlehem — had performed particularly well.

Negotiations were at an advanced stage to take over the Medicor group of 11 hospitals, whose bed capacity represented about 60% of that of Medi-Clinic.

Fin 18/11/94

cedures which the NAPH claims are under-remunerated in the tariff structure.

Not surprisingly, the NAPH has proposed tariff hikes that would see specialised ward rates rise by up to 90%. At the same time day care costs would drop by around 30% by replacing the basic day clinic theatre charge — R151,40 plus R6,20 per minute for the first 30 minutes (the charge then drops to R3,10 per minute) — with a flat rate of R15,90 per minute.

A statement by the NAPH says: "The tariff for wards, theatres and equipment will be changed to reflect the actual cost of providing these services."

But to accommodate the proposed hikes on high-care and hi-tech services, the mark-up on drugs and consumables supplied in hospitals (40% of the health bill) will be reduced to only 10%, the NAPH says.

But Day Clinic Association chairman Brian Kenyon queries how long hospitals can afford to run pharmacies on a mark-up of only 10%, given that hospitals usually have to carry a wide variety of drugs and hold substantial stock. But because of the ANC's threats to introduce price control on drugs, it's possible that private hospitals have decided to introduce voluntary cuts and recoup their losses by escalating high-care ward and theatre charges.

Says Kenyon: "Cutting day care prices to below cost will simply mean that the high care and hi-tech procedures will have to cross subsidise the common treatments — which will burden the very ill and spur the growth and prescription of hi-tech care — a trend that's being discouraged worldwide in favour of cost-effective treatment."

Day clinics fear the NAPH's proposed tariffs could amount to predatory pricing. They say once the day clinics are priced out of the market and close down, the clinics and hospitals will be free to charge what they like for their services — without having to meet the competitive rates day clinics have become renowned for.

The proposals could also be inflationary. Kenyon points out that the Workmen's Compensation Commissioner pays out hundreds of millions of rand each year for expensive orthopaedic and rehabilitative surgery and care. "Hospital stays are long and procedures expensive. The Commissioner pays the Representation Association of Medical Aid Schemes (Rams) rate and if Rams adopts these proposals, the fund could run into financial difficulties."

NAPH stresses that the proposals are being tested extensively by itself and Rams to measure cost efficiency. (299)

But Kenyon remains sceptical: "This time last year Rams announced, with great confidence, that the tariff agreement between itself and the Medical Association of SA would save the health care industry R500m. To date Rams has been silent as to whether even a small proportion of this amount was saved. It's clear that Rams does not have the systems in place to measure the impact of any change in tariffs." ■

MEDICAL CARE Fin 18/11/94

Costs under the knife

Medical schemes are expected to approve new tariffs for private hospitals next week that could ultimately put day clinics out of business. Day clinics are able to discount common and uncomplicated procedures — also offered at fully fledged clinics and hospitals — by up to 40% because they don't offer overnight facilities, operate kitchens or employ 24-hour staff.

Another advantage, says the National Association of Private Hospitals (NAPH), is that they don't have to cross subsidise the complicated procedures that overnight facilities have to contend with — pro-

ARG: 19-20111194

Naidoo shocked by high medicine prices

299

DURBAN. — The government had to intervene in the price of medicines, which were out of reach for the majority of the population, Minister without Portfolio Jay Naidoo said yesterday.

"Government has to do something about the prices of medicines, which are inaccessible to the majority of people who are not on medical aid.

"There is something wrong which makes the prices of medicines 20 times higher than in other countries," Mr Naidoo told a news conference.

He said the government would have to intervene. "It will be a strategic decision of cabinet."

The government would also have to intervene in other sectors of the economy to ensure the basic needs of the population were met.

"Government has to intervene in areas that meet the basic needs of our people, such as the provision of telecommunications, electricity, public transport, health, education infrastructure — and there are other strategic areas," Mr Naidoo said.

Mr Naidoo earlier told the conference that those opposed to state intervention in the economy were not prepared to change past wrongs.

"We need a strong state that intervenes to correct the inequalities of the past. Those who argue against that don't want to change the past," he added.

Mr Naidoo told the news conference that the most important sectors of big business were "coming on board" and accepting they had to contribute to the success of the reconstruction and development programme.

But he said the government was keen to get smaller businesses involved and he urged black business to organise itself and make practical proposals to the government on developing this sector of the economy. — Reuter.

Medical aid funds need major surgery

(ST Times (Buss)

By TERRY BETTY

AN informal rating of open medical aid schemes — those accessible to the general public — has found that many are in need of urgent restructuring.

The survey by Republic Ratings found that only two out of 31 schemes — Bankmed and Sanmed — were "very strong".

Eleven schemes were "vulnerable", 14 "adequate" and four "strong". Several schemes being formally rated were omitted from the survey. 20/11/94

Dave King, managing director of Republic Ratings, says the situation is likely to worsen as many schemes have exhausted their means of restoring financial stability.

He also pointed out that average fees extracted from open schemes by their administrators have risen 200% over three years.

Industry sources say that administration costs account for 5,8% of medical scheme expenditure, which is low compared with international standards. Mr King says administrators' fees are based on a percentage of membership contributions.

"It is in the administrators' interest to keep costs rising," he says.

Increases in administration costs partly account for sharp increases in membership contributions, says Mr King. The average annual contribution per member in the total medical aid industry was R442 in 1982, rising to R5 220 in 1992.

Mr King says common characteristics of vulnerable schemes are:

- ☐ Solvency margins are less than one third of the 25% minimum statutory requirement;
- ☐ Negative cumulative retained cash flows over the past three years;
- ☐ A significant decline in membership — up to 63% over the past year in some cases; (299)
- ☐ Negative or marginally positive cash coverage ratios.

He says he has been surprised at the relatively poor financial controls in an industry that gathers R12-billion of the public's money each year and is larger than the short-term insurance industry.

Reg Magennis, executive director of the Representative Association of Medical Schemes, says he opposes the methods Republic Rating used to break into the medical aid market and establish a paying clientele.

He says the medical aid industry was approached by Republic in a manner it interpreted as blackmail.

He says RAMS is developing standards for improved statutory reporting.

● See Republic Ratings' table, Money Page.

ARG 25/11/94

New plan to solve health care needs

□ More co-operation between state, private sector

299

LIBBY PEACOCK
Health Reporter

SOME primary health care needs in deprived areas could be solved by greater co-operation between private doctors and the state health service.

This was the view of Tom Sutcliffe, deputy director general of hospital and health services in the Western Cape, who was speaking at the launch of Cape Primary Care, a company owned and run by general practitioners.

Formed by the 1 000-strong Cape Independent Practitioners' Association, it aims to deliver "affordable, quality health care" by providing doctors in the scheme with a broad range of services, including central database management, bulk purchasing and negotiation with suppliers, medical schemes and government agencies.

Association chairman Steven Jooste said Cape Primary Care would address the "astronomical increase" in private sector expenditure on health care.

The real issue lay in controlling costs.

"While the state is committed to providing all South Africans with quality primary health care and universal accessibility, it faces enormous challenges to make this a reality.

"At the heart of the health care crisis is the need for the private and public sector to collaborate to meet these challenges."

Dr Sutcliffe said the Western Cape's health service was the best in the country, but it was not perfect.

In the Western Cape this year there was a R268 million over-expenditure on the budget. More than 70 percent of the budget was spent on salaries.

Of the rest, 85 percent was spent on hospitals and only 15 percent on primary health care.

And of the money spent on hospitals, half was spent on Tygerberg and Groote Schuur.

Also, 82 percent of the budget was spent in Cape Town.

This problem had to be adjusted, but any change to the services or downscaling threatened to be "almost catastrophic".

"Tygerberg Hospital is anything but an extravagent provision... but it is a hospital limping along under enormous loads and is significantly understaffed and stressed.

"Any intervention aimed at downscaling would threaten to collapse it."

There was a need to re-organise and shift resources to where they were needed and would incur lower costs.

Dr Sutcliffe said a plan had to be drawn up to put services into areas which had not had their fair share of access to health care.

This would mean an area like George would function as an independent health region. The hospital would be upgraded so that it retained patients and limited referrals.

Another initiative in the pipeline was to foster greater co-operation with the private sector.

"By providing some sort of contractual relationship between the state and private practitioners for the treatment of indigent patients, we may solve some of the primary health care requirements in those areas and take a load off the hospitals."

Dr Sutcliffe said he believed the province would be divided into four health regions: the Cape metropole, the West Coast, the central Cape and the eastern area.

Each region would be divided into districts which would run their health services as autonomously as possible.

Medical scheme ratings shock

Star 26/11/96

299

A THIRD of SA's medical aid schemes are 'vulnerable'. LEIGH ROBERTS looks at the options for those who fear their schemes are not up to scratch.

MEMBERS of open medical aid schemes might be anxious about their benefits after a recent survey disclosed that some schemes were at a high risk of being unable to make good members' claims.

Members of these high-risk schemes have a couple of options open to them to safeguard their interests.

This week, medical aid schemes (those open to the public, not company in-house funds) joined the ranks of banks and insurance companies when they received independent credit risk ratings from Republic Ratings.

The overall results were shocking.

As the accompanying table shows, a third of the 31 schemes were informally rated "vulnerable". The results of schemes being rated formally are expected next month.

While the survey has caused an uproar in the R12 billion-a-year industry, it is hoped that it will lead to greater transparency and in the long term to a more efficient market.

Republic Ratings managing director Dave King says the credit ratings will allow the market to compare a scheme's risk assessment with the service it provides — the premiums paid and benefits received.

"It makes no sense being with a scheme with a vulnerable rating when you could be with a scheme with a strong rating if the schemes offer similar benefits and charge comparable premiums," he says.

Reg Magennis of the Representative Association of Medical Schemes says that while he cannot comment on the accuracy of the opinions expressed by Republic Ratings, he acknowledges that the financial condition of schemes has been of great concern to the industry.

Name	Credit Risk Indicator
Cape Medical Plan	cbr
Northern Medical Society	cbr
Beland	cbr
Commercial and Industrial	cbr
Erica	cbr
Good Hope	cbr
JCCI	cbr
Protea	cbr
Tafelberg	cbr
Colsolidated Employers	cbr
Meds	cbr
National Medical Plan	cbr
Southern	cbr
Visimed	cbr
Bankmed	9
Sanmed*	9
Profmed	7
Mumed 850 Plan	7
Witbank Coalfields	7
Azalea	7
Bestmed	6
Lomed	6
Sizwe	6
CAMAF	6
Medsure	6
Insbroke	5
Nimed	5
NBC	5
Alliance	5
Meddent	5
Medical Services Plan	5
MK Medical	5
Compcare	5
Ommed	5
Finmed	4
Medicaid	4
Multimed	4
Premier	4
Maximed	4
Hosmed**	3
Alicare	3
Symed	3
Stability	3
Ermas	3
Universal	3

cbr = currently being formally rated.
* Sanmed incorporates the Topmed, Selfmed, Bonmed, Swamed and Helpmed schemes, which operate out of one legal entity.
** Hosmed has subsequently been accorded a "non-secure" formal rating of "bb".
10,9 = very strong
8,7 = strong
6,5 = adequate
4,3 = vulnerable.
Source: Republic Ratings

Magennis advises members concerned about the state of their medical aid scheme to contact their employer to obtain clarity on the scheme's financial position.

They should also "realise that all registered schemes are ... under the supervision of the Registrar of Medical Schemes (a statutory watchdog) which requires schemes to report their financial position every six months and submit monthly reports, and can prevent a scheme from accepting public money the moment it fails to comply with acceptable standards".

Neville Koopowitz, director of financial planning company The Pride Group, says the employer should consider the alternatives. However, he warns against changing schemes without thorough investigation.

Factors to consider include the financial stability of the scheme, the financial backing offered by the parent company, actuarial expertise, and administrative ability (for instance, the turnaround time of claims).

Another option to consider is a switch to a savings-based type of scheme. With this, each member has his own savings account, funded by his monthly premiums, and makes withdrawals when cash is needed.

The problem with this sort of scheme, says Koopowitz, is that members have to be aware when their cover runs out.

Employees have a right to a say in any decision to change schemes, he adds.

Some unscrupulous employers might promote change to cost shift instead of cost containment — where the company saves by paying less but the employees end up paying more by reduced benefits or co-payments.

After years of rising premiums and declining benefits, healthy employees might be tempted to opt out of the medical aid system altogether and go the total health insurance route.

This is unlikely to be a wise move, adds Koopowitz. Apart from the member having difficulty in getting back into the system after having left it, there are problems with the structure of health insurance products.

These pay out on stated benefits only (listed illnesses and surgical procedures) whereas a medical aid provides cover for all medical procedures.

WORKING TOGETHER: Ethel Tladi, secretary of the Sivukile Association for Disabled People in Langa, puts the finishing touches to a curtain. In the background are, from left, treasurer Linda Maroti, chairman Zenith Nako and vice-secretary Priscilla Gunuza.

Giving new hope to the disabled

ARG 20/12/94

☐ But township centre needs money

LIBBY PEACOCK
Health Reporter

299

ETHEL Tladi had polio as a child. Now the wheelchair-bound mother of an 11-year-old daughter, she

in the project and used for locks on the doors and other necessary items.

Recently thieves stole the association's only fridge.

Talking about the difficulties dis-

disability grant of R390 a month.

Alfred Patiwe is also disabled. His shack caught alight while he was inside. Somebody helped him escape, but he lost his wheelchair in the blaze.

Ms Tladi and Mr Patiwe live in Langa and are members of the recently founded Sivukile Association for Disabled People, which aims to provide a training centre for the disabled in the area.

The driving force behind it is Pastor Zondani Mthwana of the Vineyard Fellowship church in Langa, who last year lost both legs as a result of blood circulation problems after a kidney transplant.

Mr Mthwana said one way to help the disabled and needy to uplift themselves was through the creation of jobs.

There were no other associations or "really meaningful" facilities for the disabled in the area.

"There are so many needs, we don't know where to start."

The Sivukile Association has about 40 members, who spend five days a week sewing curtains, duvet covers, pillow cases and other items to sell to the community.

But since its inception at the beginning of the year no real profits have been made.

Proceeds have had to be reinvested

abled people experienced in the townships, Ms Tladi said she paid about R150 a month for transport.

Disabled shack dwellers had to cope with a lack of toilets and running water in their homes and had difficulty manoeuvring their wheelchairs inside shacks and on rough, sandy ground.

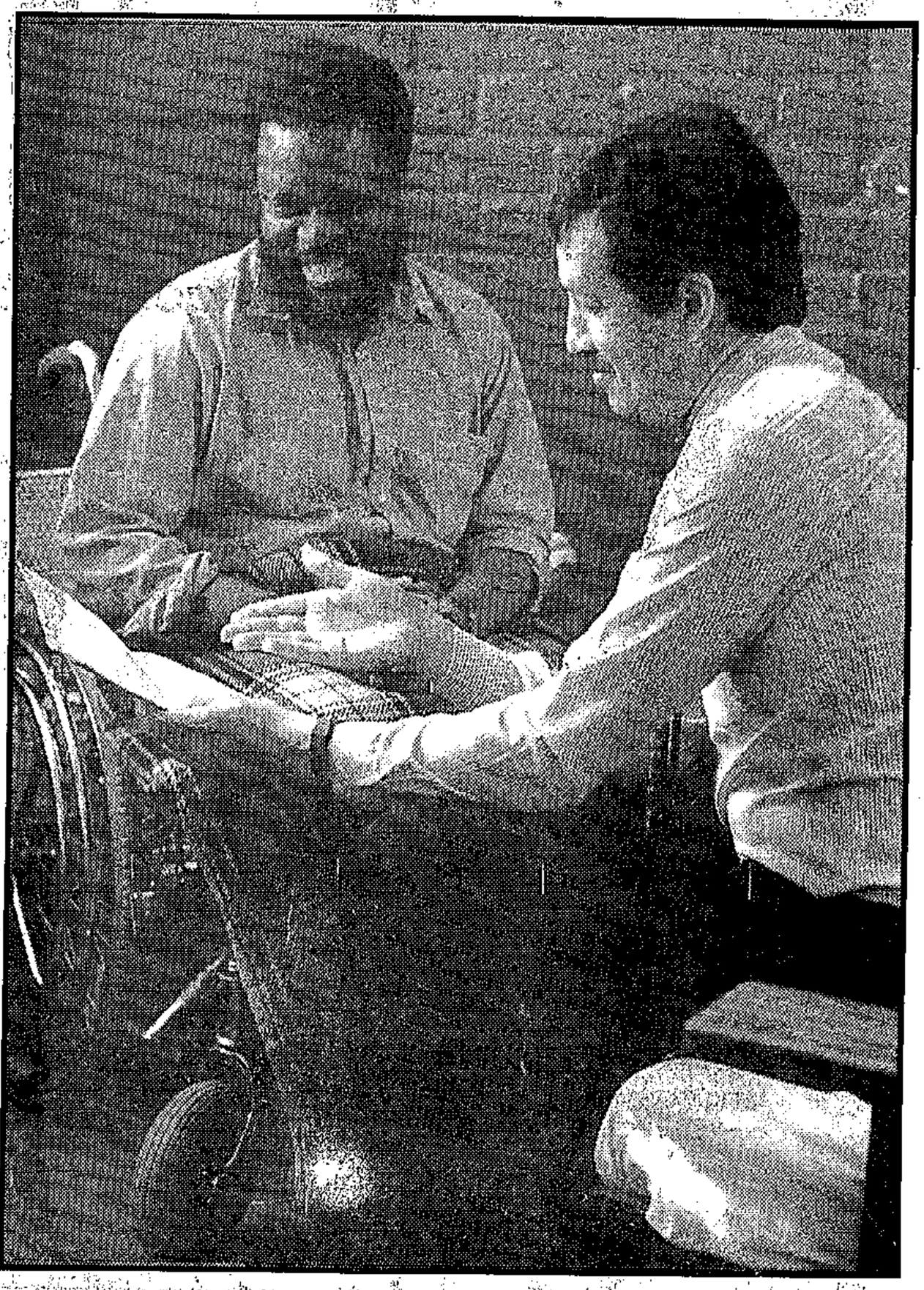
Association chairman Zenith Nako, who lost his leg when he was hit by a train six years ago, said the community "rejected" disabled people and did not support their fundraising efforts.

Also involved in the project as an initial facilitator to raise funds and obtain facilities and equipment is Groote Schuur Hospital organ transplantation unit head Del Kahn, who met Mr Mthwana at the time of his transplant.

Professor Kahn said: "I feel part of the privileged few, not only financially, but also health-wise. I feel sympathy for those who have neither wealth, nor health."

He said some of Sivukile's immediate needs were three containers to house workshops, sewing machines, carpentry machines and tools, tools for leather work and material and wood.

● Anybody able to help is asked to write to the Sivukile Association for Disabled People, PO Box 80, Langa, 7455.



PROPOSAL DISCUSSION: Groote Schuur transplant head Del Kahn, right, discusses proposals to raise money for Sivukile with clergyman Zondani Mthwana, who is the driving force behind the upliftment project.

Pictures: ROY WIGLEY, The Argus.

Wide support for health insurance

BD 23/12/94 (299)

KATHRYN STRACHAN

WHILE there has been speculation that doctors would resist the National Health Insurance (NHI) plan being proposed by government, a recent survey of doctors found that as long as certain conditions are met, there could be a high degree of support.

A study conducted by Marc Blecher of Cape Town University's Health Economics Unit showed that confusion existed about the concept.

Doctors' acceptance was crucial, he said, in the light of the fact that powerful lobby groups could affect the workability of the various models proposed by the Health Department.

While there was initial scepticism, he found that once the NHI was clearly understood — and certain conditions were covered — there was overwhelming approval from doctors.

While most doctors were amenable to some form of NHI, the approval depended on details of the NHI system such as payment mechanisms, workload, income and effects on professional autonomy.

The most crucial point for doctors was that they should retain autonomy (in their choice of medications and investigations) and the right to make final decisions. The NHI was seen as an alternative to the idea of managed health care which doctors perceived as a threat to their autonomy and control over the quality of care.

Doctors prefered that the doctor/patient relationship should not be interfered with by a third party payer, but this trend had inevitably increased as the cost of medicine rose.

Remuneration was the second most important issue to doctors. The Medical 1 Association of SA is pressing for a fee-for-service system, and the Health Department is calling for a capitation system where the doctor was paid a lump sum by the NHI for each patient registered.

Another factor to emerge from the research was that NHI was seen as a possible alternative to the current medical aid system which was seen to be profit driven and fragmented.

While the NHI was one of the most common forms of financing health care worldwide, Blecher said there were still many aspects of its usefulness to SA which needed research.

SOCIAL SECURITY _ MEDICARE

1995

NOVEMBER - DECEMBER

Medical schemes awarded ratings

BEATRIX PAYNE

REPUBLIC Ratings has accorded AMA-administered medical schemes National Medical Plan, Southern Health, MED and CEMAS ratings of A+, A, A- and BBB respectively for their claims paying ability, Republic director Dave King said yesterday.

But he said the structural problems facing medical aids had placed a risk ceiling on all schemes. "Due to the inherent business risk no local medical scheme can qualify for a rating higher than the AAA band."

Schemes rated in the A-band had a strong capacity to "honour their commitments timeously".

CEMAS had been in serious financial difficulty last year, but a R40m capital injection had improved the scheme's underwriting result. It reported a profit of R6m in the 10 months ended October 1994 from a R67m loss in 1993. The rating accorded the scheme indicated that "its financial standing remains considerably below that of its sister schemes".

AMA had agreed late last year to co-operate with the rating agency and the ratings were accorded after a probe into the financial stability, asset quality, reserving structure, membership composition and strategic position of each scheme.

All the schemes showed an improved underwriting performance, reflecting the actuarial and financial risk management skills available to them through their administrators.

An informal Republic rating of all open medical schemes — schemes taking in public money — has shown a need for restructuring.

MEDICAL FUNDS (299) FM 27/1/95

Amputation prescribed

Medical benefit funds have until February 15 to register as medical schemes, says a circular from Registrar of Medical Schemes

Danie Kolver.

Many small funds, most sponsored by insurance brokers, are not likely to satisfy minimum requirements for membership numbers and investigation could show they have inadequate capital bases.

Benefit funds were introduced mainly as part of the self-insurance vogue that followed the inability of medical aid societies to provide full reimbursement for members' medical bills.

D&E Fund Administrators' Peter Nieuwoudt says there are about 67 registered benefit funds which conduct the business of medical schemes. He sits on a select committee with the Life Offices Association, the Financial Services Board, the Commissioner for Inland Revenue and the Registrar. They collectively organised the investigation.

The latest move is intended to identify funds offering tax breaks — which cannot be provided by registered insurers.

The Commissioner is convinced that because medical funds have no logical overseer, they can exploit loopholes that would be obvious if they made regular, detailed returns. (They are not controlled by the Registrar who regulates the traditional medical aid schemes, nor by the Financial Services Board which regulates insurance companies.)

For example, medical fund benefits have been linked to deferred compensation schemes. Capital build-up in the schemes is held in the taxed fund of a registered insurer but, in a medical benefit fund, is not taxed.

Southern Life legal adviser Jennifer Preiss warns that the attention drawn by dubious practitioners to the marketing of medical benefit funds could lead to a ban on structures with an acceptable purpose. Southern has considered using a medical benefit fund structure to prefund benefits for pensioners.

Nieuwoudt, though agreeing the investigation into benefit funds is necessary, warns against "throwing out the baby with the bath water."

To encourage the member to take responsibility for management of his own costs, the net saving in contributions would be available as a personal savings plan. A benefit fund is a tax-efficient means of achieving this objective, he adds.

Several abuses of the concept were marketed. The one which irritated the Commissioner — and was quickly quashed — was the reimbursement of surplus personal savings in the fund, created by tax-deductible contribution surpluses or low-claim bonuses which had formed a reserve. Some enthusiastic marketers showed how the medical benefit fund could be used to circumvent the Commissioner's requirements for deferred compensation and various schemes based on the temporary sacrifice of earnings were sold.

The committee that initiated the investigation believes the solution lies in suitable registration or recognition.

The matter will probably not be resolved for the 1995-1996 fiscal year. It's more likely the investigation will, meanwhile, scare off dubious operations. ■

Ratings show improvement

Medaid schemes on mend

299

Star 4/12/95

THERE has been a turnaround in the ratings of South African medical aid schemes with many now showing a sound financial position in a formal rating exercise, in strong contrast to a dismal performance on informal ratings last year. LEIGH ROBERTS reports.

GOOD news for some medical aid members. All but one of the 14 open medical aid schemes that agreed to a formal rating by credit risk agency Republic Ratings (RR) have come out as financially strong.

This is in sharp contrast to the results of those 31 open medical aid schemes that were rated, informally, by RR last year: almost a third were considered to be vulnerable to paying their members' claims (WeekendStar, November 26-27 1994).

The difference between a formal and informal rating is that in the former case a scheme has allowed RR access to its financial records and confidential documents, while in the latter a scheme has refused such permission and the rating is based on published available information and the research capability of RR.

For the past year RR has been investigating the ability of open medical aid schemes (those open to the public and not in-house dedicated company schemes) to pay their members' claims.

Commitments

The research was precipitated by a spate of collapses and near collapses of medical aid schemes that resulted in a loss of millions of rands to the public.

As the accompanying table shows, 12 of the 14 medical schemes have been formally rated in the A-band and above and are thus considered to have a strong capacity to honour their commitments timeously.

Of the two schemes below the A-band, one is considered to be adequate while the other attracts a speculative rating.

Commenting on the results of the formal ratings, RR managing director Dave King says: "The ratings process provides the man in the street with an independent assessment of each scheme's creditworthiness, which enables him to evaluate the merits of different premium quotes."

The formal rating procedure entailed an intense investigation into a scheme's financial stability, asset quality, reserving structure, membership composition and strategic position.

It also included an investigation into the management expertise, systems capabilities, and support provided by the administrator of the scheme.

King expressed the hope that all other medical schemes would co-operate in the ratings process in the future and allow the agency full access to their confidential records.

"Schemes which have nothing to hide have nothing to fear from the ratings process, and it would be irresponsible for them not to embrace the principles of full disclosure and transparency," he said.

King stressed that the ratings were short term in nature and that they should be seen in the context of "significant structural problems impacting on the medical sector as a whole, which have served to place an 'industry risk ceiling' on all participants".

The structural problems, according to King, are:

- Sharply escalating medical costs, especially in the past four years, which has resulted in rising premiums and declining membership.
- Inherent structural defects in the medical aid system which have discouraged efficiency and provided the framework for abuse by some service providers, members and administrators.
- The emergence of substitute products, like catastrophe insurance schemes, which has led to younger, healthier members leaving the schemes and causing a relative increase in the pensioner component of the schemes.
- Generally low solvency margins, with very few schemes exceeding the registrar of medical schemes' recommendation of 25 percent.
- The fact that pensioners' future commitments have not been actuarially provided for by the schemes.
- Relatively poor financial controls, disciplines and systems capabilities of the system as a whole.

A Hosmed spokesman comments on the scheme's rating: "The Hosmed rating is based on historical figures for the 1993 year which are now outdated. Due to rerating of contributions and successful cost containment measures, the scheme expects to reflect a surplus for 1994 representing an excellent turnaround.

"Results for recent months have been excellent, indicating a substantial reversal trend.

"As at December 1 1994 the administrators, Trilogy Healthcare Administrators, received new owners in the form of Thebe Investment Corporation along with the Price Forbes Group.

"This is a major step forward for Trilogy which will further enhance opportunities in medical aid and other employee benefits."

How the schemes rate

	Rating
Cape Medical Plan	aa–
Northern Medical Society	aa–
Tafelberg	aa–
National Medical Plan ("NMP")	a+
Southern Health	a
JCCI	a
Beland	a
Medical Expenses Distribution Society (MEDS)	a–
Erica	a–
Commercial & Industrial (CIMAS)	a–
Protea	a–
Good Hope	a–
Consolidated Employers' Medical Aid Society "CEMAS")	bbb
Hosmed	bb–

Source: Republic Ratings — aaa = extremely strong; aa = very strong; a = strong; bbb = adequate; bb = vulnerable; b = highly speculative. ± = relative position.

Future medical aid c a threat to retiremen

The increasing difficulty of medical aid schemes to maintain cross-subsidies has made it vital for people to plan in advance for health care during retirement, writes **TERRY BETTY**.

MEDICAL aid schemes have traditionally relied on the income of young and healthy members to pay for the claims of older members.

However, for many medical aids this is no longer feasible. Higher premiums and new alternative insurance products have led younger members to leave the funds, increasing the pensioner component of medical schemes.

Republic Rating's informal rating of open schemes shows that total membership of the funds has declined by around 20% since 1989.

Over the same period the pensioner proportion of the funds has grown from 6% to about 8,5%. This is the average — in some funds more than 30% of the membership are retired individuals.

This is unsustainable because pensioners have a far higher claims rate.

Adrian Gore, managing director of Momentum Health says: "The cost of claims for an 80-year-old can be expected to be 160% higher than for a 60-year-old and 270% higher than for a 40-year-old."

He says a 4% to 5% increase in cost can be expected for each year from age 65 upwards.

Neville Koopowitz of the Pride Group says: "Statistics have shown that members incur 75% of their medical expenses in the last three years of their lives."

Rod Leerkamp, actuary at Alexander Forbes Healthcare says retired members of medical aids tend to claim two to three times more than other members.

He says, as a rough guide, given escalating premiums, someone retiring at age 65 will need between R150 000 and R200 000 in the bank to cover future medical aid contributions.

This figure takes into account cross-subsidisation of premiums. The amount would be far greater if people were budgeting for their actual expenses, or paid the full amount of the premium themselves.

Dave King of Republic Ratings explains that the risk of being priced out of a medical aid depends on the nature of the fund and the contractual obligations of the employer.

If the company has its own medical aid and guarantees retirees that they will be provided with a certain level of health cover at a certain price, then there is little problem.

The biggest risk is faced by members of open medical aids — funds that cater for more than one company.

Mr Leerkamp says many companies are currently investigating the extent to which their medical aids are underfunded. He warns that in most cases they do not have the resources to boost the reserves to the correct level.

He gives an example in America where General Motors had to provide R90-billion to cover its liability on its medical aid.

Momentum Health's figures show that the net assets of all medical schemes at the end of 1992 was R1,5-billion. Distributing these reserves among the pensioners and ignoring the rest of the membership base, gives each pensioner R8 200 for future liabilties — negligible in terms of their needs.

Mr Gore says schemes are collectively carrying a pensioner liability of R35-billion.

Mr King gives the example of a particular medical aid with 25 000 members that has a R500-million actuarial shortfall — this translates into a shortfall of R20 000 per member.

What can you do?

People already many years into retirement with no means of saving extra money can do little about the problem.

However those with many years to save have a range of options.

If you are on a soun medical aid at retiremen then stay on it. The potenti future expenses will be f greater than the premium It will also be cheaper t buying your own cover b cause in most cases pre ums are subsidised.

Start saving as soon possible through retirem annuities, unit trusts or en dowment policies.

When saving, calcula contributions accurately ensure that you are able retire with sufficient mo ey, says Mr Koopowi Take care to choose t right vehicle for saving.

"Setting aside a sum money, such as in a u trust or endowment poli can be limiting as you a relying on just that pot

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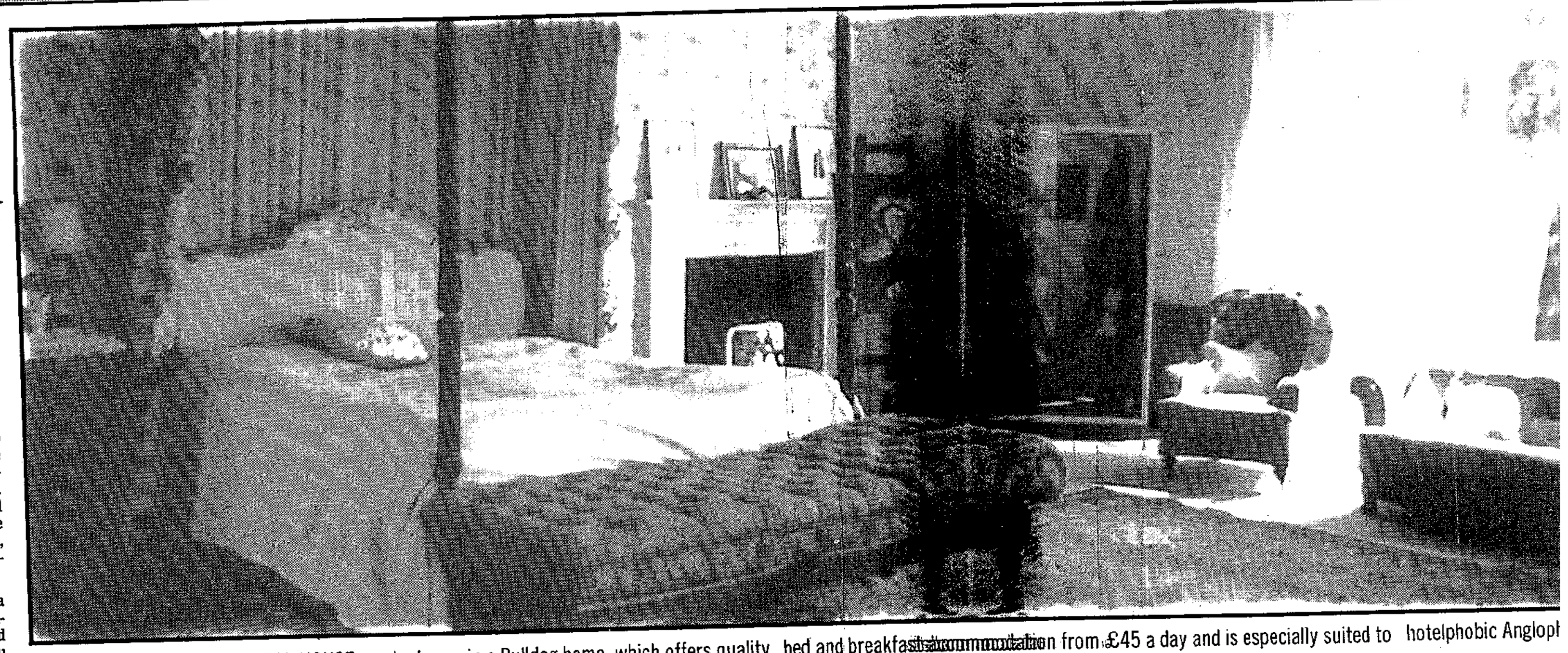
ST(BT)12/2/95

money to cover medical expenses — it is possible to spend it in a short space of time if you are very sick," says Mr Koopowitz.

Many medical aids and insurance companies are offering to pre-fund post-retirement medical aid premiums. Premiums paid early on are calculated so that the personal fund of the individual supplements premiums during retirement. Therefore premiums will not escalate at the same rate as the claim pattern, but remain stable and affordable.

Before putting extra money into such a fund, ensure it is actuarially sound and likely to exist when you retire.



REAL PERSON'S REAL HOUSE . . . bedroom in a Bulldog home, which offers quality bed and breakfast accommodation from £45 a day and is especially suited to hotelphobic Anglopl

Expert hits out at medical schemes on response to Aids

(299)

ARG 13/2/95

☐ *'Most reacted in knee-jerk way to disease'*

LIBBY PEACOCK
Health Reporter

MOST South African medical schemes have reacted in "an almost knee-jerk" manner to HIV-infection and Aids, by either offering no benefits for people with the disease, or limiting benefits to such an extent that patients essentially receive no benefits at all.

That's according to specialist paediatrician and health-care consultant John Heavens who claims that by modifying the financing, consumption and supply of health services in order to deliver accessible and quality health-care, HIV and Aids can be rationally managed in an affordable way.

Dr Heavens was writing in Alexander Forbes Consultants' quarterly publication.

He said the approach of most medical schemes to offer virtually no benefits to Aids sufferers negated "the prime reason for the existence of medical schemes" — to provide funding for the health-care requirements of its members.

Negative consequences of the approach were that costs were not contained, but only shifted to either the individual or the state, or that infected people did not disclose the infection and continued to claim for health-care services.

Also, little or no data was collected on HIV-infected people and so there was no means of generating management information about local rates of infection, actual costs and outcomes.

Dr Heavens said: "Instead of burying one's head in the sand and hoping that the problem will go away, it is essential to take a much closer look at the problem and try to address the issues."

Managed health-care processes and services which could help to manage Aids and HIV in an affordable way included:

● Medical schemes offering cover for HIV infection and Aids on the basis that individuals disclosed their infection as soon as they knew about it, and immediately entered an approved managed health-care programme. Confidentiality had to be guaranteed.

● Expertise was needed to develop and maintain the guidelines and treatment protocols — such as frequency of check-ups, preventive and therapeutic treatment and approach to terminal care — on which such programmes were based.

● Infected individuals had to be monitored closely, and if there was a significant membership base, programmes should be able to negotiate discounts and rebates on medicine.

Dr Heavens said information systems were "essential to the success of such programmes", and that there was "clear evidence" that by using such an approach, costs could be contained and patients' quality of life, productivity and longevity "significantly enhanced".

South Africans have been spoilt, with easy access to medical aids, but all that is coming to an end except for the very well-heeled, writes Consumer Reporter ***Nikki Whitfield***

If you're feeling sick, emigrate

(299) Star 9/3/95

By the turn of the century, the cost of belonging to a medical aid could become much more than the average worker can afford. Shocking statistics have shown that in the last 10 years, members' annual contributions rocketed by more than 1 000%, showing a compound growth almost double the rate of inflation.

If this trend continues, by the year 2000 the annual contribution to a medical scheme will be more than 25% of the average employee's salary, according to one estimate.

Dave King, managing director of Republic Ratings, said the industry's problems affected everyone, and "steps must be taken to ensure transparency as thousands of members could face financial ruin".

In the period 1982 to 1993, the average annual contribution per member had shot up from R442 to R5 220, showing a growth of 25% a year compared to inflation's 14%.

Detailing figures in The GP Bulletin, King said the administration fees of the open medical schemes showed an increase of 30% compounded since 1989, the biggest increase in the industry.

"The Registrar lays down as a guideline that the administrators' fee should not exceed 10% of premium income but this is not strictly applied, with some administrators charging considerably more.

"A few years ago, administration fees amounted to about R300-million a year, but over the past three years this has risen in excess of R600-million per annum."

If these cost trends are compared to historical wage trends, medical aid contributions in 1991 were about 8% of wages. If the trend continues at the same rate, by the next century the contribution will be more than 25% of the average employee's salary.

"At that point, medical cover will be unaffordable," King said. "With income tax at 40%, medical contributions of 25% will be beyond the pocket of most emloyees."

Don Scott, deputy chairman of AMA Healthcare Consultants, said one of the main reasons for the cost escalation in the 10-year period was because South Africa's medical aid population had been "one of the most spoilt populations in the world in terms of medical services".

"In the past, all members had to do was flash their medical cards and they had access to whatever they needed whether they really needed it or not.

"Medical technology is very expensive, and up until 1993 medical schemes were obliged to pay if an account was presented to them," Scott said.

"Things are changing now that expenses can be curtailed. Schemes can say they no longer have to pay for expensive selective procedures, treatments can be limited and medicines limited to generics in an attempt to find the most cost effective treatment."

He said the changes were implemented to contain the spiralling inflation of medical schemes.

"But until we have diagnosis for procedural codes, medical schemes as funders cannot determine whether treatment is appropriate, inappropriate or just plain unnecessary."

He said procedural codes were being investigated by the Medical Association of South Africa.

The King report stated that the consequence of high cost increases was the decline in membership growth. Membership figures began to drop in 1989 — as heavy increases started coming through — when people either self-insured or took out catastrophe cover.

"The insurance companies are 'cherry-picking' youngsters, suggesting they meet their own everyday medical bills. If they have to go to hospital for something serious or have an accident, that's where the policy takes over.

"Younger people naturally move to the sort of options that make better commercial sense," King said.

"In 1992, more than half the schemes declared underwriting losses. In 1993, of the 50 open schemes, only a handful have a solvency margin in excess of 25%, the Registrar's minimum requirement."

Reg Magennis, executive director of the Representative Association of Medical Schemes (RAMS), said the problem was that medical aid membership had become static and older members contributed to the cost increases.

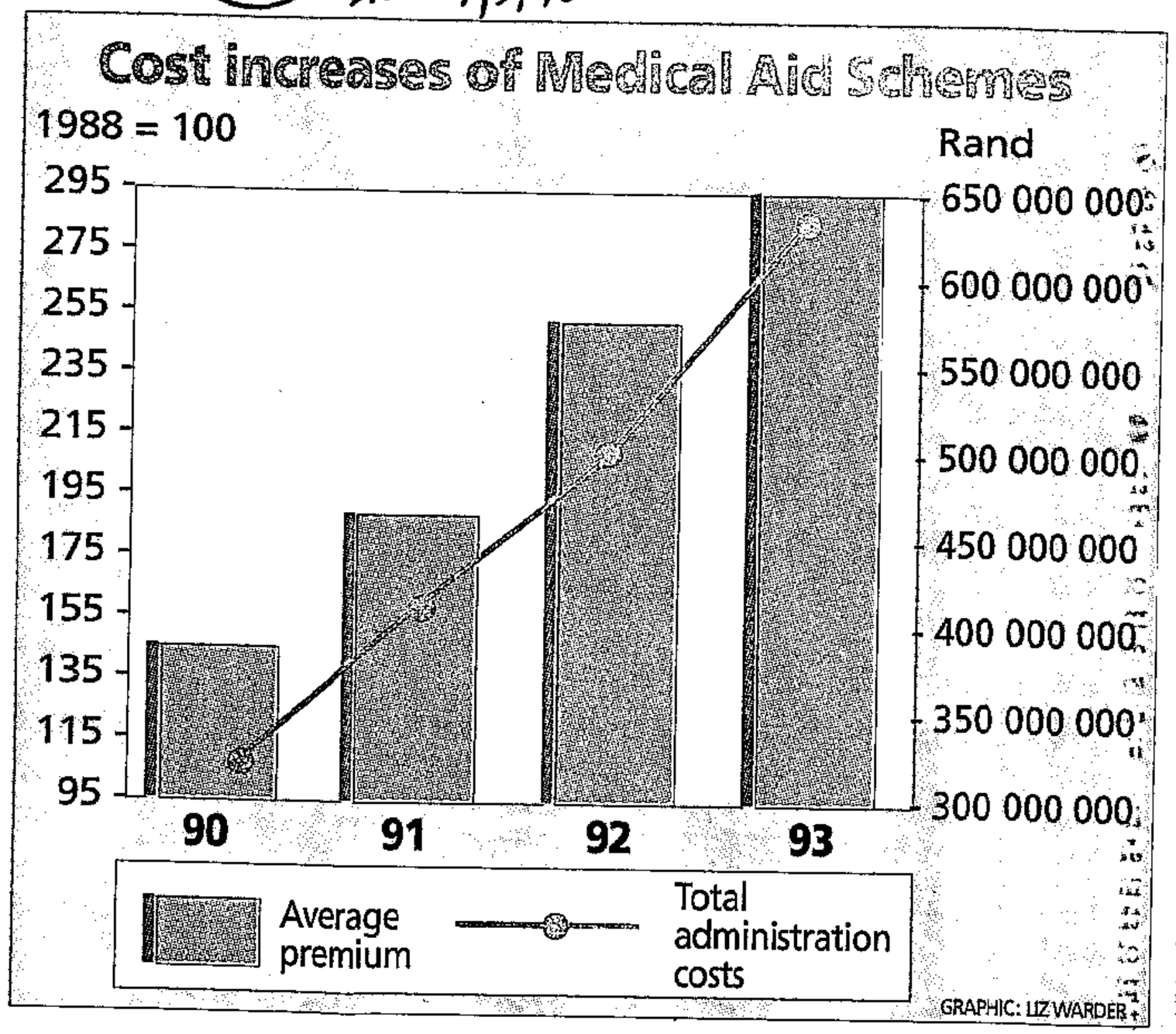
"An older population costs more to sustain. Younger, more affluent members haven't been coming in to schemes to the same extent as lower income earners with large families. This puts more of a demand on services. A member with four dependents will pay the same as one with three, but will have more usage of the scheme."

Magennis said the system of fees for service members — for example doctors, pharmacists and hospitals — was another important contributing factor. Hospital costs had increased significantly, putting pressure "on parties to add to the service fee".

"A percentage of the increase cannot be accounted for by new technology. It has to be accounted for in terms of increased service. Therefore people should ask themselves: If you are cash-strapped, is there not a case for economising on these services?"

Magennis said the Medical Schemes Act was regulated last year, which allowed schemes to enter into a contract with doctors, pharmacists and hospitals to see whether a service was entirely necessary.

"Essentially, medical schemes are non-profit organisations, and parties who sit on their governing structures are the employers and employees who belong to the scheme. It is therefore in the interest of schemes to bring down costs."



Star 9/3/95

Unhealthy rise in cost of med-aid

(299)

■ CONSUMER REPORTER

In one decade, the cost of belonging to a medical aid scheme shot up by more than 1 000%, scaring off many younger or more affluent members.

If current trends continue, up to 25% of an average employee's pay will go in medical aid contributions by the year 2000.

These figures were given by Dave King, of debt rating agency Republic Ratings.

Members' average annual contribution in 1982 was R442. By 1993 this sum had leapt to R5 220. Biggest cost increases were in medicines and hospitals at 27%.

▶ **If you're feeling sick, emigrate – Page 19**

Healthcare faces a major shake-up

CT(BR)6/4/95 299

By Bruce Cameron

ASSISTANT EDITOR

The healthcare industry, including medical aid schemes, faces a major shake-up as government moves towards implementing some type of national healthcare scheme.

Old Mutual's assistant general manager for employee benefits, Barry Crookes, says in a paper on the issue that it is inevitable that there will be some form of universal primary healthcare.

"The result will be significant changes in the way medical schemes operate and possible increases in employers' labour costs."

Consequences of a national scheme he says are likely to include:

☐ Employers facing a substantial revision of the medical cover they provide for workers with, among other things, the possibility of 3 percent being added to payrolls;

☐ Significant changes in medical aid schemes, which are likely to change to systems more akin to health insurance;

☐ Implications for the pharmaceutical industry, with the possibility of the introduction of a nationally-approved drugs list; and

☐ Healthcare providers, in particular general practitioners, having to provide some form of "subsidised" service on a part-time basis.

Crookes says employers should start quantifying their real expenditure on healthcare now and consider the options available to them.

The government is insistent it will provide primary healthcare for all citizens, particularly those who have been excluded in the past. It is only a question of how it will be done.

At the moment a committee under Jonathan Broomberg is considering various options, including the controversial "Deeble" model, named after Australian doctor and health economist John Deeble, who proposed a compulsory universal primary healthcare system for all, regardless of ability to pay contributions.

The committee has to report before April 23. It has to meet four non-negotiable principles laid down by the health minister, Nkosazana Zuma. These are:

☐ Universal and non-discriminatory access to quality healthcare;

☐ Affordability and sustainability of services;

☐ Efficiency and cost control and

☐ Consistency with RDP projects.

Once the Broomberg report has been debated by the Cabinet it will be released for public debate.

Another Old Mutual senior manager and health cover expert, Heather McLeod, said in an interview that one of the problems for the Broomberg committee was to define primary healthcare, including what the percentages of preventive care were in relation to curative care.

Crookes says that social health insurance models, which seemed the most likely course, required people formally employed to contribute, at a relatively low level, to a fund providing a package of primary health care benefits for which both they, and the unemployed, qualify.

Employers would be expected to provide cover for all other levels of care required by their employees and their dependents.

McLeod says most employers already see between 8 and 11 [illegible]ent of payroll going on health costs. [illegible] could increase by another 3 percent.

Crookes says that bec[illegible]e of the likely changes, employers sh[illegible]d rethink their approach to providing [illegible]ealth benefits, rather than simply expan[illegible]g their medical schemes.

"To accurately determine the likely impact of a system of national health insurance, employers should begin by identifying their total healthcare expenditure and facilities they provide.

"This will form the basis for evaluating the most appropriate mechanisms for the inclusion of all workers and their dependents in health plan arrangements."

Crookes says many companies do not know the real costs of employee healthcare as, over and above direct payments to medical aid funds, many provide occupational health facilities, the cost of which is often lost in operating expenses.

He expects medical aid schemes to move towards the provision of benefits that are insurable, as opposed to primary healthcare, which is likely to be provided by the state.

Medical aids may have to fund public health care

(299)

ST 16/4/95

By CAS St LEGER

PEOPLE with private medical cover may find themselves forced to help pay for health care for South Africa's needy.

The national health insurance committee appointed by Health Minister Dr Nkosazana Zuma to draw up recommendations for funding primary health is considering the possibility of levying a charge on private medical aid schemes and health insurance.

It is also considering finding the money in existing budgets or through a payroll tax — a levy on wages and salaries to be split between employers and employees.

The health insurance industry said this week it was unhappy with the committee's proposals.

"Costs should rather be borne by the whole body of taxpayers," said Barry Crookes, the assistant general manager, employee benefits, at Old Mutual.

He said a levy on private health cover would financially affect policy holders. Instead, funds needed to be allocated by the Department of Finance. "It is not appropriate for the Department of Health to say we want an 'X-percentage' levy," he said.

But the committee's co-chairman, Dr Johathan Broomberg, a health economist, said a levy on private health cover would not automatically lead to higher premiums.

"It should have no net effect on people's pockets. There are large savings to be achieved in medical schemes which should offset effects of the charge."

The committee, whose other chairman is Dr Olive Shisana, special adviser to Dr Zuma, is also proposing to build the public health sector using private sector muscle. Under the proposal, private doctors, nurses, dentists and other health workers would be asked to tender to care for state patients.

Dr Hendrik Hanekom, the secretary-general of the Medical Association of South Africa, said he was "encouraged" by the plan and was looking forward to the final document.

He said he was glad the committee had moved away from the Deeble plan, the controversial proposal to offer basic care by virtually nationalising doctors put to Dr Zuma by Australian Dr John Deeble.

Dr Broomberg confirmed that the committee appeared to have "discarded" the Deeble proposal.

He said that, because of the reallocation within the Budget towards primary health care, the amount of money needed was smaller than first thought.

The committee recommended:

- Strengthening the public sector by creating district health authorities;
- Building up clinics and outpatient departments with more doctors, nurses and allied health workers and an improved supply of drugs;
- Contracting groups of private health professionals to treat patients referred by the state.

The committee will present its proposals to Dr Zuma at the end of the month.

Cerebral palsy sufferers given voice

Help at hand for people with disabilities who are unable to communicate

(299) ARG 8/5/95

Health Reporter

PAUL MARSHALL was born with severe cerebral palsy, which left him both physically disabled and unable to speak.

Up to the age of 12 he could only communicate through gestures and guttural sounds.

But then he got the opportunity to use Blissymbolics, a system whereby users point at symbols to communicate. And from there he's gone on to traditional reading and is also completely computer literate.

Today Mr Marshall, from Ontario, Canada, uses an alphabet board for one-on-one communication and a variety of voice pruduction devices for group communication.

He is also an international advocate for the rights of nonverbal people and travels throughout the world to contribute to the growth of Alternative and Augmentative Communication.

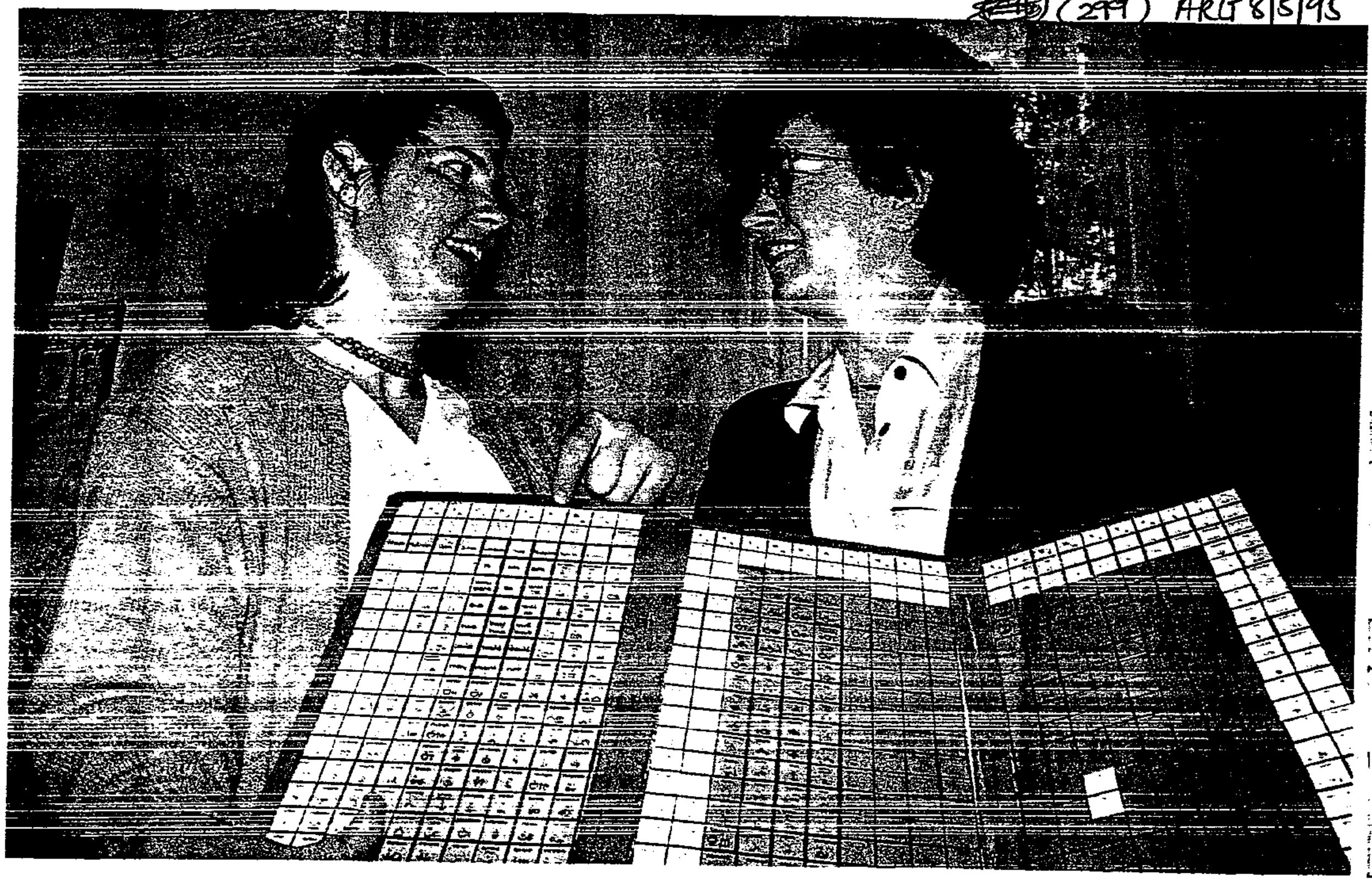
Annalu Waller, who is originally from South Africa but now lives and works in Scotland, also has cerebral palsy.

The condition has not affected her as badly as it did Mr Marshall, but her speech was affected.

Dr Waller has a B Sc in Computer Science from the University of Cape Town and did her Masters in Biomedics at the UCT Medical School.

She is now a research fellow in the Department of Mathematics and Computer Science at the University of Dundee.

Both Mr Marshall and Dr Waller are in Cape Town to share their experiences and knowledge at a conference and public meeting to be hosted by Interface, Total Communication for People with Disabilities, a voluntary organisation established in 1984 to provide access to strategies, techniques and equipment for people with handicaps.



Picture: NIC BOTHMA.

ALTERNATIVE COMMUNICATION: Annalu Waller, who has cerebral palsy, and Suzanne Clancy, Canadian life skills coach for people with disabilities, particularly people who cannot speak, with a Blissymbolics board. Blissymbolics is a language that involves pointing at symbols to denote meaning.

Interface works with people who are "non speaking" and provides services by working with parents, families, therapists and teachers.

The conference, on Friday, May 19, is titled "Communication and Integration, Supporting the Challenge".

Dr Waller said it was often "nice and easy" for people without disablities to put those who were disabled "in boxes".

Yet disabled people were often imaginative people, even writers.

"It is up to us to release that ability. We try to get people to realise that even if people have disabilities, they never stop learning. We need to create opportunities for learning," she said.

"You may have a very severely physically disabled person, who needs a way to express himself," she added.

● For more information about Interface, or the conference, contact Interface resource co-ordinator and trainer Jane Cunningham on ☎ 689 1953

MEDICAL AID FOR PENSIONERS

Waiting for the bang

~~300~~ (299) FM 12/5/95

Sanlam calls the accounting of post-retirement benefits — mainly medical aid for pensioners — a time bomb. The SA Institute of Chartered Accountants (Saica) is close to issuing guidelines. The effect could be to encourage employers to acknowledge the liability with, in some cases, a serious impact on their bottom lines.

By custom, most employers pay, or subsidise, pensioners' medical aid benefits. Also by custom, the liability was funded on a pay-as-you-go basis. That was tolerable when medical costs were a minor budget item. Now that they approach the dimensions of the budget for pensions, the liability can no longer be ignored.

In the US, the accounting standard SFAS 106 on Employers' Accounting for Post-Retirement Benefits Other than Pensions had enormous impact. General Motors had to provide US$30bn. In 1992, the UK accounting profession fell in line, concluding that post-retirement benefits are liabilities to be recognised in financial statements.

Some — but so far, only a few — SA companies have made provisions. Gencor started with R100m in the 1993 accounts. A few others have done the same. Times Media is among companies which will anticipate what is likely to become an accounting principle and, says financial director Lawrence Clark, will make a provision this year.

Joubert Ferreira, group benefits senior actuary at Sanlam, says there are four essentials:

- ❑ The subsidy of medical aid contributions should preferably not depend on the future prosperity of the employer;
- ❑ Costs shouldn't fluctuate unnecessarily;
- ❑ The funding vehicle should be flexible enough to cope with all changes introduced by government; and
- ❑ The method of funding should be tax-efficient.

A Saica task force has produced a draft opinion, broadly in line with the decisions of accountants in the US and the UK. Saica emphasises that the document is not final. Some issues and suggestions confronting the task force have been:

- ❑ Post-retirement benefits may be considered as a form of deferred compensation. Pension and provident fund benefits are fully funded. Other post-retirement benefits generally are unfunded; and
- ❑ Following actuarial review, some companies have made provision for the estimated present value of post-retirement medical benefits. Most do not disclose any such provision.

Some accountants argue that the current service cost should be recognised as an expense and matched to the benefit received during the working life of the employee. The cost of benefits, both while the employee is in service and after retirement, should be recognised actuarially.

The problem is that immediate recognition of the liability could strain balance sheets. That leaves two options, immediate full funding or funding over a period.

Either way, there could be tax complications. Charges relating to post-retirement benefits will generally only be deductible for tax purposes when payments are made. But the balance sheet effect will be felt many years before the tax relief can be sought. Presumably, it will be necessary to persuade Revenue to bring tax treatment in line with pension and provident fund financing. ■

INTEREST RATES

On the brink

The market was waiting early this week for Reserve Bank Governor Chris Stals to push up official interest rates.

Money supply data for March show the broad aggregate M3 surged R7,5bn in March, an increase of 3,1%. Over 12 months, M3 rose 12,5%. Measured on a seasonally adjusted basis from mid-November last year, it rose 11,7% annualised, which is outside the Bank's guideline range for the year of 6%-10%. Also of concern is the R5bn jump in private-sector credit in February to an annual 18,3% growth rate.

And April's gross gold and foreign exchange reserves plummeted for the second month in a row — by US$543m (or R1,9bn) to $2,8bn (R10,2bn). This is the lowest level since the November issue of the $750m (R2,6bn) global bond.

Stals may be holding his hand because some of the data reflects the situation before the February rise in Bank rate. Or he may be taking an optimistic view on the balance of payments.

Strong outflows in short-term capital were turned around in the first week-and-a-half of this month.

This is confirmed by swings in the amount banks borrow daily from the Bank to meet their daily cash shortages. This fell from levels above R8bn in late April to below R3bn this week. Stals may also be holding out until details of the proposed Y50bn ($600m or R2,2bn) Samurai bond are finalised — he is in Japan with Finance Minister Chris Liebenberg this week.

But he will probably need to raise rates soon. Transnet group economist Ulrich Joubert says important, foreign interest-rate differentials are not conducive to borrowing abroad, which would boost domestic reserves: "With interest rates in Europe and the US still in an upward phase, and with the cost of forward cover high, it still makes more sense for corporations to borrow locally."

Japanese rates look more attractive for SA borrowers than many other markets and a Samurai bond would ease things on the capital account. But the possibility of a stronger yen, and increased currency risk for SA, cannot be ruled out. ■

INSURANCE

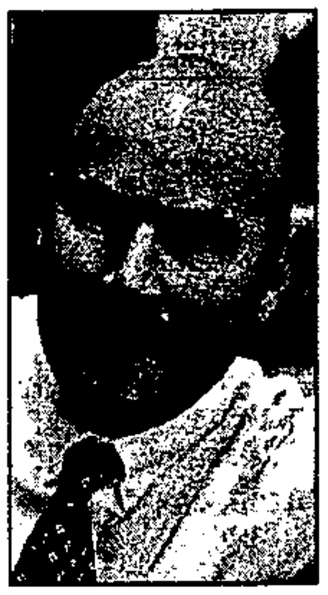
Interesting times

Two insurance managing directors quit their jobs — one peacably, the other with unconcealed rancour.

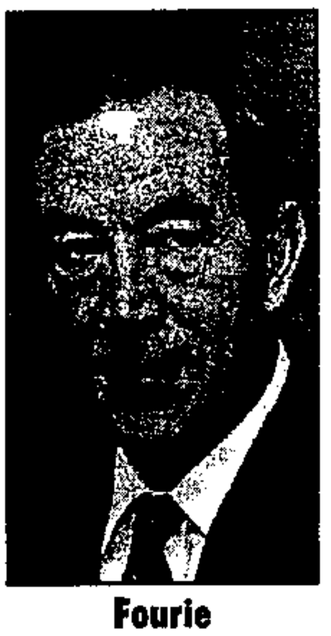
Nico Fourie, short-term insurance manager at the Financial Services Board, resigned to take up the vacant CE slot at Standard General.

There was plenty to excite delegates at the Insurance Institute conference this week in Somerset West.

Many were wondering whether Brian Seach, past chairman of the Insurance Association and MD of Aegis Insurance, would turn up. And, if he did, would he



Cavalieri



Fourie

throw light on his argument with Aegis' co-owners, Momentum Life and RMB Holding?

He did appear but was low-key about the events which caused the upheaval.

Meanwhile, Paolo Cavalieri, after nearly two years at AIG Insurance, decided to join Hollard as group marketing director. Cavalieri (36), once a GM at StanGen, produced an underwriting profit at AIG in a year when major insurers were not able to

MEDICAL SCHEMES

In the recovery ward

FM 12/5/95 (299)

Deregulation and competition have been good for private sector health care. Registrar for Medical Schemes Danie Kolver says the average accumulated funds of schemes stand at 18,4% of annual contributions — 2% up on the previous year.

Kolver suggests that innovations such as co-payments, prior authorisations, excesses, self-funding arrangements and pre-funding measures for post-retirement cover are kicking in to restore schemes to good health. "Schemes have accepted that they are no longer third-party funders. They are managing members' fees better."

He adds there has been an increase in the amalgamation and transfer of schemes for more effective management — a move that is in line with a policy directive from the Council for Medical Schemes.

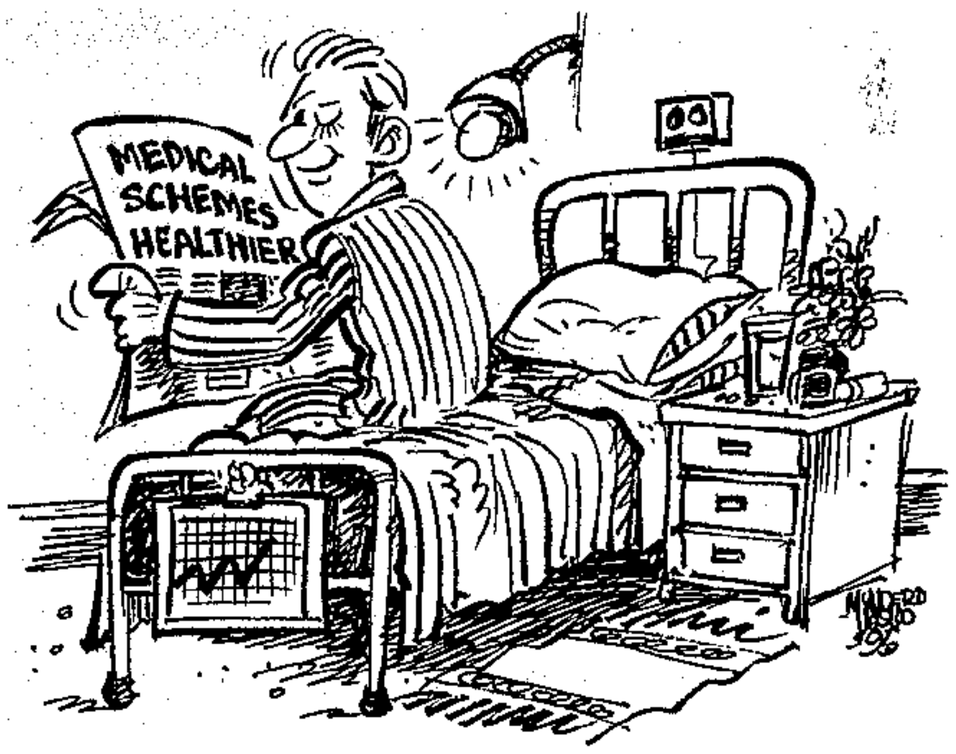
Schemes have managed to contain the drug bill for prescription drugs by restricting medicine benefits to a system of "maximum medical aid pricing" which is based on the prices of cheaper generic equivalents of various drugs.

But Kolver insists that schemes need to be able to own retail pharmacies if the drug bill (30%-40% of scheme payments) is to be cut effectively. Put simply, this would enable schemes to cut out most of the mark-ups charged at wholesale and retail level — up to 100% on the manufacturers' price. Schemes have the authority under the Medical Schemes Amendment Act which took effect last January. But they have been unable to run their own pharmacies because the Pharmacy Act still vests retail pharmacy ownership exclusively with registered pharmacists. The Pharmacy Council — legally constituted to protect the public but made up largely of pharmacists — remains adamant that nonpharmacist ownership should be allowed only at its behest.

Other changes are pending. Medical Benefit Funds will soon fall under the regulation of the Registrar's Office and public schemes are now obliged to submit financial statements bi-annually — a recommendation made last year by the Melamet Commission of Inquiry into the financial wellbeing of schemes.

Regrettably, though, the full Melamet report has never been considered formally by Health Minister Nkosazana Zuma. Melamet's recommendations included direct supervision of schemes by the Financial Services Board, greater accountability for medical scheme administrators and greater professional input by actuaries and professionals with legal, accounting and hospital administration experience.

Melamet was also adamant that individual members should be free to move between schemes rather than having to belong to schemes designated by their employers. This, Melamet said, would increase consumer choice and encourage competition between schemes to provide an improved service. It now appears that the new Council for Medical Schemes, appointed last month by Zuma after a year's delay, will consider the Melamet report.



Kolver warns, though, that stricter financial controls are imminent anyway. He plans to make public the financial soundness of individual schemes and has already appointed an inspector to investigate certain schemes on site. The first appointee, Tony Leveton, a health consultant and former medical scheme administrator, is likely to pinpoint problems long before they are manifest in schemes' financial returns.

One development has been a move away from community rating (where everyone pays the same premium) to risk rating based on claims experience and patterns of use in the past year. However, the Broomberg/Shisana Committee of Inquiry presently investigating a national health insurance system is said to be considering a return to community rating exclusively and compulsory scheme membership for all.

In Kolver's view, "community rating is complex and needs careful consideration." Compulsory membership would swell the risk pool and spread risk. But it's argued that people with fewer dependants should also pay less than people with more dependants if equity is to be a consideration.

❑ Drug manufacturers Eli Lilly and Glaxo Wellcome are buying Medikredit, the Pharmaceutical Society's retail prescription processing agent. The move is bound to attract the attention of the Competition Board which is investigating vertical integration in the drug industry. *Mirryéna*

OLD MUTUAL

MEDICAL AID SCHEMES ARE IN NEED OF THERAPY

(299)

ST(BT)14/5/95

CHANGES to the Medical Schemes Act have removed the obligation of medical aids to pay automatically for their members' healthcare treatment, says Barry Crookes, an assistant general manager with Old Mutual's employee benefits division.

This change, coupled with the general debate on a National Health Insurance scheme and recommendations made in the Melamet Report on medical schemes, make a change in mindset necessary for employers offering medical aid cover to their employees.

"Most people accept that some reallocation of public-sector healthcare spending is necessary to extend the scope of primary healthcare facilities to areas where none exist," says Mr Crookes. With healthcare expenditure already at 8,5% of GDP the nation cannot afford to spend more, therefore the existing budget must be more wisely used.

Mr Crookes says a likely scenario is for a joint public-private sector venture. The nation's healthcare is the subject of an investigation by John Broomberg and Olive Shisana.

Mr Crookes believes that there will be a continuation of medical schemes and the big question of costs faces employers. Several of the country's largest employers have made substantial cash provisions for the future costs of caring particularly for their pensioners.

"Companies will have to ask themselves how appropriate it is that they should continue to meet the medical costs of their employees once they have retired.

"This was never a problem while medical costs were relatively low, but inflation in recent years has made the costs onerous," says Mr Crookes.

He does not foresee employers severing their obligations to pensioners although there is no legal obligation to carry on paying.

"Pensioners have no strong legal rights but we are reaching a stage where they can club together and institute a class action against their former employers should such a step be attempted. Bad publicity would probably result in a greater cost to employees in any event."

Another possibility is that employers might offer medical aid for their staff but not their dependents.

The second aspect of cost-containment is linked to the medical aid mentality: the medical aid is paying my bill therefore I don't have to consider how much things cost.

"It is not a system that lends itself to cost management," says Mr Crookes. Medical practitioners themselves must share some of the responsibility for wasting money on unnecessary tests and follow-up visits by patients.

One alternative financing system gaining acceptance in the US is that of managed care, which involves a sharing of costs between health-care providers and financiers — the equivalent of risk-sharing with medical-care providers. For example, an employer could arrange for a group of medical people to provide health services to its employees and pay a fixed amount — say R50 a month per employee regardless of whether the employee needed treatment or not.

"This gives an incentive to the doctor not to insist on follow-up visits which are not essential. He or she will not get a double consultation fee but will waste time and reduce his or her profit," says Mr Crookes.

Currently, the scale of benefits offered by medical aid schemes is insufficient for certain procedures and for these reasons, many individuals believe they need to top up their cover with an insurance policy such as Old Mutual's Flexicare. More than 100 000 Flexicare health-care policies have been issued — a testimony to the need for top-up medical aid assistance.

Mr Crookes says Old Mutual Actuaries & Consultants also consults with many employer bodies to discuss employee benefits to help them decide on the best course of action.

Medical plans at risk

(299) BD 24/5/95

Beatrix Payne

MEMBERS of medical aid plans not registered under the Medical Schemes Act were at risk as they were not controlled by government regulations, Insurance Brokers Council of SA executive chairman Eric Craig said yesterday.

"The council is most concerned about the current lack of control being exercised over unregistered medical funds. We don't know how many of these schemes operate."

Some doctors had refused to treat patients on unregistered medical plans and they were forced to pay cash for consultations.

Medical Aids Registrar Danie Kolver said he had recently asked the attorney-general's office and police to investigate two unregistered medical plans after receiving complaints.

They were Cambridge Medical Plan — formerly International Medical Assistance Group — and Medsave Medical, Traditional and Burial Scheme.

He said the organisations had "substantial membership" but could not say whether members had lost money. "There is the potential for abuse of funds by unregistered plans, and operating a medical insurance scheme without being registered as a medical aid is unlawful."

It was the public's responsibility to ensure that the scheme they had joined was registered in terms of the Medical Schemes Act.

Cost-effective health care

Beatrix Payne

HEALTH-care strategies which focused on the patient's overall lifestyle, provided cost-effective treatments and monitored the patient's progress could reduce employers' overall medical aid contributions and minimise the risk profile of employees, Glaxo economist Francois Wessels said yesterday.

Such a programme — disease management — was far superior to simple "pharmaco-economics", which calculated the economic effects of a drug but could encourage treatment of only one aspect of the disease.

Disease management was a patient-directed programme which provided disease-specific treatment guidelines in the most cost-effective way. It also focused on maintaining the quality of life and could advise patients on healthier lifestyles.

The programme centred on partnerships between health-care providers and qualified consultants.

Glaxo attempted to provide a consultative service to health-care providers, to guide them through introducing disease management systems.

Health funds 'may disappoint'

Beatrix Payne

IT was likely that primary health care funding in SA would fall "far short" of the average salary earner's expectations, Momentum Health MD Adrian Gore said at the weekend.

One funding model being considered by government would make a maximum of R180 a person available annually for primary health care purposes, he said. But studies indicated that the average medical aid scheme member spent R900 annually on primary health care.

Government statements indicated that funding primary health care for the poor was a priority, and others would have to fund their own health care and hospitalisation needs. People were "in for a shock" as the nature of health care changed.

Many medical aid funds, determined to improve their financial position, were reducing benefits and raising contributions.

Funds could face a R35bn bill for health care for pensioner members, yet they had an asset base of only R1,5bn and there was increasing resistance to cross-subsidisation. It was therefore vital for salary earners to consider health care in any financial planning, said Gore.

Medical schemes back national plan

(285) (299) Star 22/6/95

■ BY DAVID ROBBINS
HEALTH WRITER

The medical schemes movement has committed itself to a constructive partnership with the State in providing affordable health care to all.

At conventions called by the Representative Association of Medical Schemes (Rams) in Cape Town and Johannesburg yesterday, delegates agreed that the private sector should accept the challenges contained in the national health insurance system (NHIS) report released by the minister of health earlier this week.

Rams chairman Keith Hollis said: "We appreciate the consultative approach adopted by the committee which compiled the report, and we welcome the philosophy of freedom of choice for individuals between private or public care, and a move towards the principle of cradle-to-grave medical scheme cover, regardless of age or existing health problems."

The NHIS proposals, which call for free primary health care for all and encourages much greater co-operation between the private and public sectors in achieving this, would have several positive effects on the current medical scheme situation.

"Because an element of competition has been introduced between the two sectors, quality is bound to increase while the cost of basic medical care will decrease," Hollis said.

He added that his association was particularly supportive of the proposal which would protect the aged, the chronically ill and the recently retrenched.

None of these categories, if the NHIS proposals are put into effect, will any longer be excluded from medical scheme membership or full benefits.

Concern was expressed at the Rams conventions over some proposals in the report, most notably the possibility of removing the tax concessions currently enjoyed by contributors to medical schemes.

"The principle of a dedicated health care tax also requires careful investigation in consultation with the business community," Hollis said.

'Subscribers will fund health care'

~~365~~ 299

CLAIRE BISSEKER

CT 22/6/95

THE government's proposed National Health Scheme (NHS), which aims to provide free primary health care to all citizens by the turn of the century, will be little-used by the employed medical aid subscriber who will, however, bear the brunt of financing the new scheme.

Health Minister Dr Nkosazana Zuma's committee of inquiry into a NHS has proposed a two-tier system in which the existing private practitioner and private health insurance industry are allowed to function parallel to a public primary health care system where treatment is free.

But the committee estimated that those with medical aid would make limited use of the scheme (0,5 visits a year) compared with the rest of the population at 3,5 visits by the year 2000.

As the NHS will be financed largely through taxation, possibly augmented by user-charges on private medical insurance and the removal of tax concessions on medical aid contributions, the employed and especially the medical aid subscriber will subsidise the unemployed.

Healthy growth in Medscheme reserves (299)

Beatrix Payne BD 23/6/95

THE financial condition of the medical scheme industry had improved over the past year and tight financial management had seen Medscheme-administered funds' reserves grow an average 33% during financial 1994, Medscheme deputy MD Jeff Slome said yesterday.

Membership increased to 599 000 from 526 000 the previous year and was set to increase substantially after government's committee of inquiry into health care proposed the introduction of a mandatory basic hospital cover package for all employees.

"Currently only 40% to 45% of the employed population are members of medical aid schemes, so membership of medical schemes could almost double," Medscheme chairman Keith Hollis said.

Income from contributions rose 19% to R3,2bn and total reserves as a percentage of contributions rose to 21,2% (18,8%).

Reserves increased 65% in the open schemes, 42% in the in-house schemes and 21% in the government schemes.

Membership of open schemes increased 33% to 172 298 and membership of government schemes rose 5% to 270 512.

Slome said the collapse of a number of medical schemes in the Eastern Cape last year had triggered an increase in membership of open schemes.

The Registrar of Medical Aids recommended that reserves should represent 25% of contributions but the current industry average was 19%, Slome said.

Administrative costs accounted for 6,5% of contributions.

The schemes had collectively achieved a surplus of R163m and had investments and cash resources of more than R1bn.

He said the schemes were all solvent but claims were higher than they should be. Many younger members who had cross-subsidised older members were leaving medical schemes, which could place the health care of older members in jeopardy.

Accounting standards set to be introduced for SA companies would compel them to make provision for employees' post-retirement medical costs.

According to the SA Institute of Chartered Accountants, local companies faced liabilities in this area that could run into billions of rands.

As a result Medscheme had registered an employer Retirement Planning Fund which companies could use as a vehicle to set aside funds to meet liabilities when an employee retired.

Employers would be able to increase the reserve funds through lump sums or monthly contributions, all of which were tax deductible.

The funds would be invested in unit trusts which provided transparency at all levels. The financial institution managing the funds could be chosen by the employer.

Medical schemes form life assurance group

(299)

BD 26/6/95

Samantha Sharpe

SEVERAL major medical aid schemes and administrators have joined forces to create a new black empowerment player in the SA life assurance industry — BonLife Assurance.

The life assurer said its shareholders would comprise medical aid administrators Medscheme and NMA Administrators which administer over 60 funds, black medical aid fund Bonitas, Sanitas and Bensure Management Services.

BonLife chairman Paul Luthuli said the company, capitalised at more than the R10m legally required for a long-term insurance license, would target two relatively unexplored markets — high and low income earners.

"Middle income South Africans are among the most heavily insured in the world. BonLife has no desire to focus on this over-serviced market, although BonLife cannot neglect this area," he said.

BonLife MD Christopher Cunningham-Moorat said that over recent years the medical aid movement had witnessed the intrusion of life companies into the low-risk segment of the medical market that addressed dread-disease and hospital insurance cover. This had left medical aid schemes to cope with the costly end of the medical security spectrum.

"The formation of BonLife can thus be seen as a reversal of this trend — encroaching vigorously as it does into the assurance market."

Cunningham-Moorat said the company was in discussion with several other medical aid societies to involve them in BonLife. "What is remarkable is that no other life office appears to have sought an alliance with the medical aid societies. Here you have huge captive markets which are ripe for life products."

He said BonLife had taken advantage of the important changes sweeping through the SA life industry, with unprecedented demand for innovative life products from trade union members and the growing black middle class.

Marketing would be conducted through the unions, employer associations, medical aid societies, insurance broking houses and some individual brokers.

This would keep operating costs to a minimum, making it possible to offer minimum monthly premiums at the entry level of R40 — well below the R75 minimums of other assurance companies, he said.

Luthuli said the company was expected to grow into a huge force in the life industry, and was perfectly positioned to administer a national health insurance scheme.

ARG 3/7/95

Warning on unregistered medical aids

Health Reporter (299)

PEOPLE have been warned to to be careful when joining unregistered medical schemes, some of which have been set up as profit-making ventures.

Louis Tager, chairman of the Business Pratices Committee, says there has been an increase in the number of unregistered medical schemes, which are not subject to any statutory control.

Members faced the risk of finding themselves with unpaid medical bills.

To check whether a medical scheme is registered, contact the Registrar of Medical Schemes on ☎ (012) 312 0010.

Medical aid flat rate slammed

CT(BR) 3/7/95 (299)

BY JOHN SPIRA

GAUTENG BUSINESS EDITOR

Momentum Health has raised serious reservations over key features of the Broomberg-Shisana committee recommendations on national health care financing and delivery.

Adrian Gore, managing director, points to three "serious" flaws.

The first is that cost implications of mandatory contributions by employers — in effect, an additional tax — have not been sufficiently considered, he says. "It is perverse to shed rather than create jobs."

The second, says Gore, is the suggested "community rating" — a flat rate by all medical aid scheme members. The intention is to ensure that price barriers are not erected to bar the sick and elderly from medical aid schemes; but it ignores differences in needs by various groups.

The third is the obligatory acceptance of applicants into medical schemes irrespective of age or health status, he adds.

"The draft," says Gore, "provides an incentive for socially destructive behaviour. It would be in individuals' interests to make no contribution to a scheme until they were sick. A medical scheme would be forced to accept the applicant and carry the cost of treatment for a flat fee that came nowhere near meeting the costs."

He notes that there are 200 000 pensioners and 90 000 pensioner dependents in the system for whom medical aid schemes have made little or no long-term provision. "We need to come up with mechanisms to fund their requirements and ensure the needs of future pensioners are properly financed but a community rating approach is not the way to do it."

Nissan sets precedent with health care model

BD 11/7/95

Kathryn Strachan

A UNIQUE managed health care plan devised for Nissan workers could become a model for other SA companies.

Nissan SA, together with Numsa, insurance brokers Alexander Forbes and medical aid administrators D&E, devised a plan giving the company's hourly-paid workers at its Rosslyn plants a choice of different levels of health care.

In the past, hourly-paid workers have been largely excluded from joining company medical aid schemes because they do not have the same status as permanent salary earners.

Private medical aid schemes for such workers have failed because of high claims and costs.

Some have been "fly-by-night" operations which have collapsed.

"By developing the plan in partnership with the workers' union we are ensuring the managed health care plan will meet workers' needs and will be accepted by them," said Brian Moor, human resources director of Nissan SA.

The first level of the scheme, fully paid for by the company, is intended to cover basic requirements such as medicines and general practitioners.

Workers can choose to join module two or three, which will cater for hospitalisation, optometry, specialists and dentistry.

These modules will be subsidised by the company, with the level of subsidy still to be finalised.

To reduce costs and ensure claims are held at reasonable levels, while making medical care accessible, a clinic has been opened.

The staff is employed by the managed health care plan. Nissan's workers and their families must use the clinic for treatment or referral to specialists.

Families who live at a distance will utilise their local medical facilities but will be covered.

Sanlam launches niche medical aid fund to meet the needs of teachers

CT(BR) 1/8/95

299

BY FRANÇOISE BOTHA

STAFF WRITER

In line with insurance industry trends towards low-risk niche market products, Sanlam has announced the launch of a medical fund aimed to meet the needs of teachers.

Edumed, which is set to start operations in December, has been designed and negotiated with Sanlam by members of the Cape Teachers' Professional Association.

The marketing manager of Sanmed, André Fourie, said: "It is the first time that a medical fund tailored especially for teachers and educationists has been launched.

"Until now, they have belonged to schemes in conjunction with the personnel of government institutions".

The fund is open to all teachers, educationists and their administrative personnel. It will cover their spouses and children.

"A valuable bonus of Edumed is that it will be managed by teachers with a specialised understanding of the unique requirements of educationists," Fourie said.

The association has established a committee that will handle policy decisions and act on behalf of the fund's members until a management committee is constituted.

Benefits of the fund include greater allocations for claims in areas such as dentistry, spectacles and contact lenses.

The surplus of the fund would be retained for the use of members.

Medical aids investigated

Non-contributory medical aid options have come under the inland revenue department's spotlight and employees who opted for this approach have found that it could effect their pension fund payouts.

Geoff Kroon of Deloitte and Touche said some of these medical aid schemes were coming unstuck. Under the scheme the company would pay the employee's contribution to the to reduce their taxable income. — Staff writer.

(299) CT (BR) 4/8/95

Half of nation's population may be on medical aid in two years

ET(BR)14/8/95 (299)

BY FRANÇOISE BOTHA

STAFF WRITER

About half of the South African population is expected to be covered by medical schemes within the next two years — compared with only 15 percent at present, says Robin Melville, the managing director of D & E Medical Aid Administrators.

"There are currently only 6 million people nationwide on medical aid — and that includes not only the principals, but also their beneficiaries.

"By 1997, we expect that 50 percent of the 41 million people in South Africa will be members of private medical aid schemes. The other 50 percent will be supported by the national health plan, which covers the indigent and the unemployed," he said.

Melville said a large number of his blue-chip clients were taking the managed fund route in order to avoid a heavy impact on costs.

D & E Medical Aid Administrators, which receives R800 million a year in contribution income from its members, attributes its 25 percent membership growth during last year — and the more than 20 percent increase achieved in the first six months of this year — to the move to managed funds.

Robin Melville

These funds differ from traditional medical aid funds in that the employer is charged a flat fee per employee for the medical services, regardless of whether the employee uses the medical services or not.

In light of the substantial increases in medical aid costs to companies and employees, the fact that the three parties can "control the costs" has been a big factor in its favour, says Melville.

Trade unions, which are now insisting on medical benefits as a standard condition of employment, have welcomed these moves.

"In fact, they are saying they will take their colleagues to task if they do not go onto it," he said.

As a result, an increasing number of employers have taken ownership of their funds to give all employees the benefit of managed health care. In 1993 the number of Morkels staff who benefited from medical schemes increased from 900 to 1 420, Melville said.

"Because of the way in which it also boosted morale, it is now costing the company less in medical expenses than it did three years ago," he said.

Medical schemes do better

BD 13/9/95 (299)

Beatrix Payne

MEDICAL schemes finished 1994 in a far stronger financial position than the year before following the deregulation of the Medical Schemes Act early last year, which allowed schemes to introduce flexible health cover packages.

This is the finding of a recent survey by the Representative Association of Medical Schemes (Rams).

The survey — based on financial statements to end-December last year of 147 of the 221 schemes administered by the Registrar of Medical Schemes — showed membership of medical aid schemes increased 3,6% over the year.

Accumulated funds per member for the industry increased 23% to R1 308, boosting the industry's reserves for claims settlement from 2,4 to three months. Accumulated funds as a percentage of contributions rose to 23,3% last year from 18,9% in 1993.

Rams executive director Reg Magennis said the figures reflected the relative strength of inhouse and state medical schemes.

Open schemes' accumulated funds were at 19,4% of contributions, below the registrar's benchmark of 25%. However, the 6,3% growth in membership of private schemes would improve their financial position, he said.

Exempt schemes — schemes exempt from the provisions of the Medical Schemes Act but subject to other legislation such as the Industrial

Continued on Page 2

Medical schemes

(299)

Continued from Page 1

BD 13/9/95

Council Act — were cause for concern, he said. Funds as a percentage of contributions were at 4% so members of these schemes were likely to face a contributions increase to boost reserves.

Medical costs per member at private hospitals increased 32%, but costs for provincial hospitals fell 10%. The use of private hospitals had risen as medical aid members moved away from provincial hospitals, he said.

Another jump in private hospital costs was likely this year and tough negotiations between service providers and medical aids were on the cards. Last year's increase in costs at private hospitals had been out of kilter with salary increases.

Magennis said many medical aids were likely to enter into preferred provider arrangements with hospitals, clinics and doctors.

A preferred provider arrangement occurs where a medical aid guarantees it will finance its members to attend specific hospitals in exchange for discounts on certain services.

Administration costs at most schemes increased 14% during the year to R28,30 (R24,86) a member. Administrators were compelled to include advisory and management services.

US company in SA health-care deal

(299) CT(BR) 13/9/95

By John Spira

GAUTENG BUSINESS EDITOR

In a deal involving R140 million, the United States' largest health care management organisation has teamed up with Anglo American and Southern Life to form a company which aims to revolutionise South Africa's health care system.

The new business, to be known as Southern HealthCare JV, will be jointly owned by Anglo American and Southern Life, each with a 40 percent stake, and America's United HealthCare Corporation, which will own the remaining 20 percent.

The project will require an investment of R140 million.

Anglo and Southern will acquire their stake in the company by providing the development funding, while United HealthCare will earn its stake by reinvesting the royalties and fees received for providing technical and commercial know-how for managing the new business.

In addition, United will have the option to convert its rights to royalties into an additional equity interest that would make it an equal partner with Anglo and Southern.

Southern HealthCare JV plans to be operational by July next year and will be based in Johannesburg.

Kathy Walstead-Plumb, a senior vice president of United, will relocate to Johannesburg as the chief executive.

Ideal fit

United, formed 21 years ago, offers a broad range of products through 21 owned and managed health plans with enrolment of nearly 4 million.

Its non-geographically bound speciality-care management companies serve the needs of an additional 25 million lives. Last year, United generated revenues of $3,8 billion.

It ranked 11th overall and first among health care companies in the most recent Fortune magazine survey of America's most admired corporations.

Walstead-Plumb said this was United's first venture outside the United States.

"We've done the deal because South Africa is an ideal fit, with conditions in the managed health care industry similar to those which prevailed in United States in the 1970s.

"We bring not only our expertise and experience to the deal but also our information technology network, developed at a cost of $300 million."

The Southern HealthCare JV initiative is expected to create 350 jobs in its first year of operation, building up to 1 000 jobs in its fifth year.

Southern Life's Arrie van der Zwan believes there is considerable scope to bring down health care costs in South Africa. "This is what Southern Healthcare JV aims to achieve."

HEALTH CARE (85) (299)

Rosy glow

FM 15/9/95

Medical schemes appear to be looking healthier as the benefits of deregulation start kicking in, claims a survey released this week by the Representative Association of Medical Schemes (Rams).

According to the survey that analysed 147 of the 221 schemes registered with the Registrar for Medical Schemes, accumulated funds per member strengthened from R1 067 to R1 308 — representing an improvement of 23% or R522m. As a percentage of contributions, accumulated funds increased from 18,9% in 1993 to 23,3% in 1994. The registrar recommends accumulated funds amount to 25% of contributions.

Says Rams CE Reg Magennis: "The savings can mostly be attributed to the greater use of managed health-care practices for medicine script management. Limited general practitioner and dental benefits have also affected savings since it is at these levels of health care that the greatest wastage or abuse usually takes place."

Scheme membership is also up by 3,6% for the same period and a 6,3% growth in open (public) scheme membership is expected to contribute to the financial strength of these schemes, states the report. Magennis says the ratios show that in-house or closed and State schemes continued their sound performances — a factor he attributes to a strict matching of benefits with contributions, higher accumulated fund levels and tighter cost management.

Open or public scheme reserves, however, are still below the 25% recommended minimum at 19,4%. "But their reserves have increased from R697m to R919m — a 28,2% improvement in accumulated funds per member," adds Magennis.

Ironically, the good news comes when government is considering reregulating medical schemes which it claims are in crisis because of the deregulation since last January when the Medical Schemes Amendment Act took force. The Act ended guaranteed payments and minimum benefits and gave schemes the go-ahead to risk-rate (according to age and sex) rather than community-rate — a move government now wants to reverse.

Magennis denies risk-rating has contributed much to the improved performances. "Employers still control scheme benefits and have in general not allowed a significantly greater use of risk-rating."

He believes the proposals to reintroduce community-rating are geared mainly to ensure that the young are covered now and later — an argument that's rejected by insurers and actuaries who claim that the young simply can't afford to cross-subsidise the aged and ill and consequently won't take cover. ■

Medical aids improve their credit status

ARG 16/9/95 (299)

Own Correspondent

■ Since the medical aid industry was deregulated last year, it has been better able to contain costs, but the rising costs of private hospitals and specialists — well above the inflation rate — are still a source of concern.

JOHANNESBURG. — A survey of 147 medical aid schemes shows an improved short-term and long-term financial position.

The medical aid industry came under fire last year when many schemes were awarded poor credit ratings by independent agency, Republic Ratings.

This week, the industry body, the Representative Association of Medical Schemes (RAMS) released its own survey of the financial condition of their member schemes for last year.

In all, 147 schemes were included in the RAMS survey representing 65 (there are 221 in total) of the schemes registered with the statutory Registrar of Medical Schemes.

The accummulated funds of the surveyed schemes improved by 23 percent over the previous year, and represent 23,3 percent of annual contribution income. Among the open schemes (that is, open to the public and not in-house company schemes), reserves improved by 24 percent to 19,4 percent of contribution income.

Although the reserve position is better than last year's, reserves are still below the 25 percent level recommended by the Registrar.

Medical scheme membership in 1994 grew by 6,3 percent in the open schemes and by 3,8 percent in the in-house schemes.

The survey showed that the industry is benefiting from a wide range of measures introduced by the schemes to curb rising medical costs. In 1994, the rise in medicine costs was curtailed to 6 percent, but the costs of private hospitals and specialists continued to escalate well above the inflation rate and partially reflects the impact of a shift of private patients from provincial into private hospitals.

The report states that the growth in hospital and specialist costs is likely to attract significant attention by medical schemes in future, particularly if the benefits paid out to members are to remain a high percentage of actual claims.

Medical schemes provided close to 100 percent cover to members for hospital services. Medicine benefits paid out to members were only 77 percent of the total claims. Medical and dental benefits paid out comprised between 84 and 88 percent of claims.

1994 was a significant year for medical aid schemes as the industry was deregulated and became free to introduce structural changes. Systems of reimbursement to medical service providers were no longer prescribed by the Medical Schemes Act and it became possible to introduce new methods for addressing the cost and quality of medical services and supplies.

Medical schemes 'have to adjust'

PORT ELIZABETH — Medical schemes will have to adjust to the cultural and social needs of black members, says Sizwe Medical Fund chairman Nthato Motlana. (299)

"While our black communities were previously disadvantaged, they do appear to have a better understanding of the concept of ubuntu (humaneness)," Dr Motlana said in remarks prepared for delivery at the fund's first report-back in Port Elizabeth. ARG 23/9/95

"Administrators of schemes may be pleasantly surprised at how well they (black clients) accept and respond to the concept of running the scheme for mutual benefit, that if a few members misuse or use benefits carelessly it ultimately affects all members by forcing up their monthly contributions, or getting fewer benefits."

Dr Motlana warned prospective members, especially those nearing retirement, not to join untested schemes.

"Once on pension they cannot change schemes and could find themselves left high and dry in their old age," he said.

The Sizwe medical scheme was founded by Dr Motlana and other doctors 16 years ago, and currently serves 70 000 members and their dependants. — Sapa.

Schemes aim at containing costs

BO 26/7/95 (299)

THE health benefits industry is undergoing rapid and substantial change as medical-aid scheme sponsors battle to get to grips with soaring medical costs.

The majority of respondents to Old Mutual's 1995 health benefits survey, released this month, indicated that they had made significant changes to their medical aid schemes in the past 12 months — despite the fact that half the respondents in last year's survey had already instituted cost-saving measures.

The survey's respondents were drawn from the top 300 companies listed on the JSE and the top 200 unlisted companies. Collectively, they represent about 660 000 active employees and 82 000 pensioners and widows.

Old Mutual Health Benefits assistant GM Barry Crookes says there appears to be a direct correlation between expressed concern about costs and the degree of change.

"But a lack of adequate management information suggests that many of the changes were more acts of desperation than carefully considered strategies."

The survey revealed that more than 70% of employers could not quantify their total health costs.

In many cases, a portion of the cost of the health benefit is hidden in general overheads or salary bills, especially where benefits such as on-site clinics and first aid stations are offered.

"It is clear that to make more informed decisions, sponsors and administrators not only need a knowledge of trends and developments in the market but also a far greater understanding of the total cost of providing the health benefit — including hidden administrative costs associated with medically related activities."

But, he says, the fact that employers and trustees seem to be taking a far more active role in developing appropriate solutions for their medical-aid arrangements augurs well for the future.

"The trend is towards making members more responsible for managing their medical costs. The most common measures adopted were the introduction of greater choice in terms of contributions and corresponding benefits, increased co-payments and other incentives for members to reduce costs.

"Prescription medicine benefits have been redesigned and there has been a significant shift towards managed care — preferred provider arrangements with specific suppliers of health care — which 40% of respondents saw as the most effective way of containing costs."

Medicines and hospital services remain the highest expense funded by medical aid schemes, and together account for almost half the total bill.

The survey reveals that the relative cost of medicines has declined slightly in the past 12 months — apparently reflecting the increasing use of generic medicines.

But the relative costs of hospitals show a marginal increase suggesting more steps are required.

"In general, control over costs seems to have been enhanced and there has been a substantial improvement in the claims/contribution ratio over the past three years."

Many medical schemes anticipate more change in the year ahead.

Says Crookes: "It is clear that members face further increases in premiums and the introduction of managed health-care initiatives, particularly in the form of contractual arrangements between their scheme and providers of medicine and hospital services."

Quick remedy needed as membership profile of medical aids grows ever older

(299) BD 26/9/95

THE problem of meeting the medical costs of pensioners without penalising current members of a medical aid scheme is one of the most important issues facing medical aid societies in SA.

D&E Medical Aid Administrators MD Robin Melville says the industry's problems are being exacerbated by several factors.

These include the ageing membership profile of more established medical schemes, the loss of cross-subsidisation as younger members seek alternatives and the traditional "pay as you go" method of funding medical schemes, where there is no advance provision made for retirement.

Melville says that to resolve the growing problem it is essential that medical aid subscriptions are unbundled into current and post-retirement medical costs.

He says that it is the ultimate responsibility of employers and employees, not their medical schemes, to ensure that members are able to afford the high cost of post-retirement medical aid.

To achieve this, D&E has set up a subsidiary company, D&E Fund Administrators, which allows employers to prefund medical costs of employees in a vehicle which is both separate to and independent of the medical aid scheme.

Melville warns: "Employers need to act timeously to fund for these costs, especially given the likelihood that our accounting practices will require a company to provide for, and disclose, its liability for the future health-care costs of its members, as is the case in America."

Old Mutual Actuaries & Consultants director Heather McLeod says prefunding is gaining acceptance, with medical schemes increasingly moving away from the traditional pay-as-you-go basis of funding their liabilities.

She says although most companies support the cross-subsidisation of pensioners, this is under threat from the ageing profile of medical aid funds.

As a result — as indicated by Old Mutual's 1995 health benefits survey — there has been a significant increase in the number of funds intending to prefund for future pensioner liabilities — 74% against 57% in 1994.

Metlife Health Services (MetHealth) actuary Andrew Birrell says many medical aid schemes have failed to meet their commitment to members in the past through a lack of long-term financial planning.

"This problem has to be addressed by subjecting schemes to actuarial disciplines when setting contribution rates, analysing scheme experience and building up adequate reserves — as called for in the recommendations of the Melamet commission report."

MetHealth, a subsidiary of Metlife, delivers health-care financing and managed care products, as well as administering medical aid business and acting as a consultant to medical aid schemes on the structuring of their benefits.

Old Mutual's McLeod says a number of companies have begun to take advantage of the changes to the Medical Schemes Act by offering additional forms of medical coverage. Most offer first-aid stations, while some offer an in-house doctor and on-site dispensary for prescription medicine.

Medical insurance is also seen as an effective way of providing cover, especially among smaller companies.

In most instances, says McLeod, insurance is offered as a top-up to the existing medical aid.

But a small number of employers also offer a stand-alone plan as an alternative to the medical scheme.

Warning over bogus medical schemes

(299)

CT 29/9/95

SPECIAL CORRESPONDENT

JOHANNESBURG: The Bonitas Medical Fund issued a warning to members and the public yesterday to beware of unregistered and untested medical schemes flooding the market.

Principal officer Mr Yekani Tenza said all medical schemes had to meet criteria laid down by the Registrar of Medical Schemes. It was unlawful for any organisation to operate as a medical scheme without receiving approval of the registrar.

He said Bonitas had received several reports of bogus agents luring the unsuspecting into joining unregistered "schemes". The black community was the prime target for such approaches.

In addition to the floating of medical scams, many new schemes were being launched which were financially unproven.

Mr Tenza said some of the tricks employed by bogus agents included:

- Members were promised loans if they joined the scheme;
- The names of registered medical schemes like Bonitas were used to delude members;
- Claims were made that the "new scheme" had merged with Bonitas;
- Inflated and unrealistic benefits were offered, and
- Existing Bonitas members were coerced to complete application forms.

The public was asked to report contact with representatives of bogus and untested schemes to a medscheme branch or provincial representative.

MEDICAL SCHEMES (299)

Heavy petting

FM 20/10/95

While medical aids struggle to deliver affordable, accessible health care to humans, the animal market appears to be a much safer bet.

Three years after launching SA's first medical insurance for pets, PetSure has announced a joint venture with SA Oil Mills — manufacturers of Dogmor and Catmor pet food. The scheme will qualify Dogmor and Catmor consumers for R1 000 of free veterinary care, per pet, a year.

Says PetSure MD Shaun Leveton: "All pet owners have to do, once they have registered their pet with PetSure, is regularly send us the bar codes that are found on the back of each Dogmor and Catmor product pack. This will ensure the pet's continuing cover, a certificate of insurance and a policy which provides cover of up to R500 a year for veterinary fees resulting from illness and a further R500 for veterinary fees resulting from accidents, for each of their pets."

Certainly, the deal is likely to be welcomed by pet owners faced with veterinary bills that increasingly match their own medical bills. Says SA Veterinary Association vice-president Dr Anthony Erasmus: "Only 12% of pet owners use the services of a vet. The association sees this as an excellent manner in which our services can be made available to the broadest segment of the public while increasing owner education on how best to care for pets."

The policy issued to each owner contains a detailed list of benefits for which they will be reimbursed and any registered vet can be consulted, says Leveton. The scheme now has 5 000 members.

PetSure also offers valuable lessons for the ailing medical schemes sector in catering for less fortunate people. Leveton, a former medical aid administrator, says he has invested heavily in purpose-built information systems that enable PetSure to manage the cost of veterinary care and rule out fraud and misuse. In line with modern managed health care principles, PetSure emphasises diagnostic and treatment protocols — step-by-step manuals — that monitor treatment outcomes. "Service is paramount," adds Leveton, who boasts a one-hour processing time for all claims along with weekly payments to members.

Direct payments to vets are excluded, to avoid potential fraud and error. Other sound management techniques include limited risk rating for certain breeds, puppies and kittens while community rating remains the norm for the general cover plan.

There is also product variety that includes a catastrophic hospital plan that offers cover of up to R5 000 at a cost of around R120 a year.

Membership fraud is avoided through an identifying microchip capsule that is injected into the soft skin around the neck of the animal — something that might, however, be unacceptable to human counterparts, though highly tempting for medical schemes and their administrators.

A shortcoming is that membership is limited to pets aged between six months and eight years for the Dogmor scheme. For the general PetSure plan, animals from eight weeks to 10 years old qualify. The premium for older animals will be loaded. The scheme is underwritten by Hollard Insurance. One of its biggest benefits could be that it doesn't qualify for government's proposed regulation of private health care. ■

Manuel closes medical scheme

Star 31/10/95 (299)

A medical aid consultancy that left a trail of unpaid accounts, bounced cheques and its administration in tatters has been closed by the Trade and Industry Minister Trevor Manuel.

His ministry said in a statement yesterday the closure of Access Medical Aid Consultant (Amac) (Pty) Ltd followed an investigation by the ministry's Business Practices Committee.

Amac operated from a private home in Florida Park on the West Rand.

The statement said many members had been prejudiced and there were "many dissatisfied and disillusioned members".

Committee chairman Professor Louise Tager found the company traded while technically insolvent, prejudiced members by not paying bills and had assets totally inadequate to protect its members.

This was despite the fact that the Medical Schemes Act regulations required a guarantee of at least R1-million before a medical scheme could be registered.

The investigation was launched when members complained that Amac failed to pay medical accounts for up to five months while other accounts had not been paid at all. The report said many Amac members were prejudiced by the company's practice of debiting the bank accounts of members to cover "costs" that had, according to management, been absorbed by Amac. Manuel declared the harmful business practices carried out by the company unlawful. – Sapa.

Hambros lays JSE plans aside

Linda Ensor

LONDON — Merchant bank Hambros has shelved plans to enter the SA stock market pending the outcome of a review of its London equity trading arm Hambros Equities.

Weekend reports said the 20-strong equity dealing office, which specialises in mining stocks, had been planning to take advantage of the JSE's big bang tomorrow.

But the recent closure of its Australian operation has added to questions about the future of the London operation which could be put up for sale as part of its parent's group review.

A decision on the business, profitable from soon after its launch in 1994, would be announced with Hambros's results on November 15.

So far six of the JSE's 45 member firms have linked up or been bought outright by British, US or European banks, and three have teamed up with SA banks.

Investment bankers and stockbrokers from US, Britain and Europe have visited SA in the hope of winning government privatisation business, big fees from corporate mergers and acquisitions and rising interest in SA shares.

But merchant bank NM Rothschild has decided against establishing an office, claiming the market is overcrowded.

Finger pointed at medical aid funds

(299)

Beatrix Payne

BD 7/11/95

PRIVATE hospital and clinic groups had to increase provisions for bad debt in the last financial year after payment delays by medical aids and changes in medical scheme legislation, industry sources said yesterday.

"Medical aids are dragging their feet on the payment of accounts," Clinic Holdings executive director Graham Anderson said yesterday.

The group had increased its debt provision over the last year as days outstanding had increased at an "alarming rate". The net effect was that the rise in costs and interest payments had become a big portion of group expenditure.

Timeous payment of bills by medical aids would help solve the problem, he said. "We have no financial relationship with most of the patients, but they (medical aids) expect us to bear the brunt of the situation."

Presmed joint MD Carl Grillenberger said a slowdown in bill payments had affected the whole industry. His group had increased its provision for doubtful debt and stepped up its debt collection activities as a result.

Representative Association of Medical Schemes (Rams) executive director Reg Magennis said in the past medical aids had guaranteed payment to service providers if costs were in the negotiated scale of benefits. But many more schemes had begun to query hospital bills, and until the query was resolved the hospital would not receive full payment.

But Mediclinic finance director Craig Tingle said increased use of private hospitals had triggered the increase in bad debt provision.

Rams research showed that medical costs per member at private hospitals had increased by 32% last year from 23% in 1993. The figures show many patients were attending private hospitals rather than public hospitals.

Tingle said bad debts were a constant concern, but his group had not experienced a sudden increase in debts. "The trick is to get the patient to pay upfront."

The introduction of joint payment systems where individuals took responsibility to pay a portion of medical bills was unlikely to be responsible for the increase in debt. Magennis said medical schemes paid almost 96% of hospital claims.

Firms 'may have to' provide hospital cover

Beatrix Payne (299 BD 17/11/95

FINANCIAL statements might be hit when a national health insurance system and accounting standards requiring greater disclosure of medical benefit liabilities were introduced, Old Mutual said yesterday.

Actuaries and consultants director Heather McLeod said the national health insurance system was likely to require employers to provide at least public sector hospital cover for all staff and their dependants and pensioners.

To date less than one third of all full-time employees are members of a company medical aid scheme.

Current unfunded liabilities in the health benefits industry were estimated at R34bn, she said.

"Massive liabilities and the question of prefunding will affect companies at the same time as the proposed NHIS," she said.

"The present situation in SA is to account for unfunded post-retirement benefits on a pay-as-you-go basis where costs are only recognised when incurred.

"No provision or disclosure is made for payments and contributions and potential future liability."

Some companies had started to make provision for the estimated value of post-retirement benefits, she said.

However, she also said that most companies in SA did not currently make disclosures of such provisions.

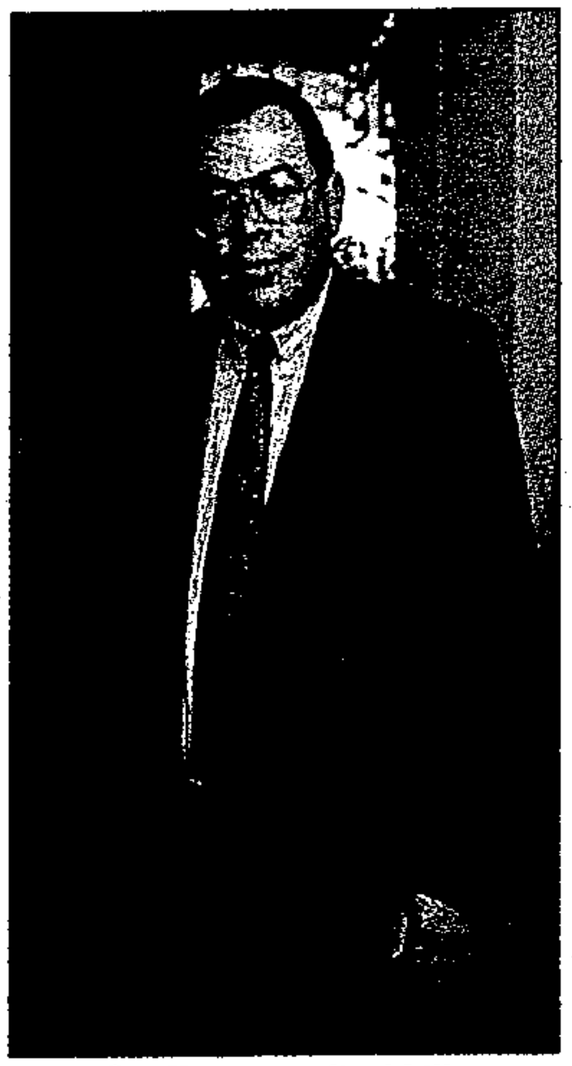
What the doctor ordered

(299) FM 17/11/95

A review of drug usage and disease management could help contain spiralling medical costs.

Both are principles of managed health care, which propounds a multi-disciplinary approach rather than the present ad hoc, symptom-based one. The philosophy also seeks to replace the inflationary fee-for-service method with options such as fixed fees and capitation (fee per patient) charges — geared to end over-usage.

Reviews of drug usage were pioneered here by Quality Health Services. Its Cape Town-based doctor, John Cowlin, says the programmes have succeeded in the management of "chronic" (long-term) medication, cutting bills by up to 40%.



Cowlin . . . *medical bills cut by 40%*

Using computer-based peer review protocols to determine suitable regimes for chronic drug users, reviewers can decide whether a prescription is appropriate and cost-effective. They may, for example, decide that an older, cheaper drug is as clinically effective as a newer but more expensive one. Or they may recommend that a cheaper generic is as effective as a more expensive, patented drug.

Says Cowlin: "We may even recommend the use of the latest, most expensive drug where such treatment would effectively eradicate an ailment that would otherwise require surgery. We could also recommend a drug that needs to be taken only once a day, as opposed to four times a day, to ensure the highest level of efficacy and greatest cost-effectiveness."

Of course, the medical reviewer's verdict of what constitutes the most cost-effective and appropriate drug could have dire consequences for drug manufacturers that don't make the grade.

Cowlin says manufacturers are given every opportunity to argue the suitability of their drugs. He adds that the decision to use or not to authorise a particular drug is taken after an investigation that is assisted by the medical faculty at the University of Cape Town. He stresses that his company is independent and does not trade in drugs.

Cowlin says initial manual scanning of scripts — Quality Health Services processes 600 000 a year — often shows incorrect dosages, adverse drug reactions and unnecessary prescriptions.

Most of the main script managers or assessors are linked to major medical scheme administrators or hospital groups; or (more recently) drug manufacturers and their customers are medical schemes and other health-care funders.

Quality Health Services, jointly owned by medical schemes administrator Medscheme, has a brief to review the chronic medication scripts for members of schemes administered by Medscheme and Cowlin.

In practice, members who know they need medication for longer than three months are asked to apply for extended medicine benefits and usually qualify when they undergo a GP examination that will determine the likely extent of the additional benefits that will be needed. From that point, members will have their scripts routinely evaluated and will have reasonable access to drug information and assistance where needed.

Where reviewers encounter problems with scripts — overdosing, drug interaction, incorrect medication — the GP is notified and the matter sorted out quickly. Where repeated abuses or problems arise, further action may be required including the medical scheme's refusal to reimburse any bills emanating from the practitioner involved. Difficult cases are assessed by specialists, including pharmacological experts. So standards of peer review are high.

Other players in the marketplace now include Mediscor's Chronimed (SA Druggists-owned), Afrox affiliated Direct Medicines and Total Support Management (including Pharmarama, Optimum, Interpharm) — recently acquired by Smith Kline Beecham subsidiary Diversified Pharmaceuticals.

Health-care management is no longer confined to drug usage. For hospital bills, some assessors already boast savings of 43% on ward charges, 29% on theatre fees and 27% on dispensing costs. If these claims are accurate, one might well ask what role medical scheme administrators perform.

There is criticism that savings are seldom passed on to members but used instead to offset administrative costs. And where assessors are linked to drug manufacturers, there are fears that drug usage reviews could be used to promote products — a concern that is likely to be addressed by the Competition Board investigation into vertical integration in the drug industry.

Though a drug usage review promises substantial savings on medicines, disease management could be the point of departure for the control of the total health-care bill.

A patient-directed programme, it provides disease-specific guidelines for quality health care in a cost-effective way.

Says Glaxo pharmaco-economist Francois Wessels: "Disease management should focus on the patient, not only the medication. The best management practices for specific diseases will now be evaluated and therapeutic and diagnostic guidelines developed by clinical experts."

This exercise can succeed only if the latest information is built into the programme. So information technology support will be crucial, says Wessels. Continual monitoring of the medical, financial and quality-of-life-implications of therapeutic guidelines will also be important.

Lastly, patient education is needed. This could involve teaching an asthma patient, for example, about the ailment and how to use inhalers and other devices to ensure proper, responsible medication — and perhaps recommending a change in lifestyle.

"The patient would become a more responsible co-manager of his or her disease. And the futility of trying to manage individual components of the health-care bill would be avoided."

ST 19/11/95

Medical aids to choose the family doctor (299)

By CAS St LEGER

VISITING a doctor of your choice may become a thing of the past.

The teaming up of group medical practices and medical aid schemes will result in patients being told which doctors they can visit.

Next year a major medical aid group will launch the pilot project, which will see companies pay a flat rate for their employees, regardless of the number of visits they make to the doctor or dentist.

Only the well-heeled will be able to afford to visit the medical practitioner of their choice.

Doctors are divided on the issue.

"Medical standards will go down the tubes," said an angry gynaecologist in private practice. "How are we supposed to make ends meet on a flat-fee basis? Patients will be turning up every five minutes for treatment."

A general practitioner from Centurion, who has already banded with colleagues in a group practice, said: "It will suit us and our patients. We are already planning towards it."

Under the new flat-fee scheme — known as capitation — employees will have to use the doctors, specialists or dentists at the assigned group practice or pay out of their own pockets for the privilege of choosing their own doctor.

While there will be variations from scheme to scheme, medicines will probably be supplied from an essential drug list, similar to the list proposed for government hospitals and clinics a few months ago.

Peter von Hoesslin, marketing director of the Medicross Healthcare Group, said this week that Medicross would be pioneering South Africa's first capitation system in January.

"We are not yet in a position to reveal the names of those involved or details of the scheme but it will be at the forefront of things to come."

Groups of self-employed doctors operate the 30 Medicross clinics countrywide like franchise operations. By the year's end, ready for the move into the pilot scheme, there will be at least four new clinics.

Before fully-fledged flat-fee services — or "managed health care" — can be launched, changes need to be made to the Medical, Dental and Supplementary Health Service Professions Act, so that all health workers, including nurses and pharmacists, can be included in group practices.

Regi Magennis, the executive director of the Representative Association of Medical Schemes, said group practices were to be welcomed as a way of reducing overheads and avoiding unnecessary diagnoses.

Dr Herc Hoffman, chairman of the Medical Association of South Africa's private practice committee, said that, in principle, managed health care could broaden access to health care, contain spiralling costs and ensure quality of care. But there was concern that patient choice could be limited and doctor-patient relations interfered with, he said.

Medical plan may put doctors in reach of all

ET 21/11/95 (93) (299)

STAFF REPORTER

THE introduction of a flat-rate scheme of payment for medical services, called capitation, could mean that many people, for the first time, will be able to afford to see a doctor.

The system is to be launched by the Medicross Healthcare Group in January and will enable companies to pay a flat rate for their employees — no matter how often they visit the doctor or dentist.

Dr Tony Behrman, vice-chairman of the Cape Independent Practitioners' Association (Cipa) and a branch councillor of the Medical Association of SA (Masa), said last night that capitation was "the future of medicine". He predicted it would make serious inroads into the fees-for-service style of practice, which was already dwindling because of high costs.

Capitation entails a teaming-up of group medical practices and medical aid schemes.

Employees would have to use the practitioners at their assigned group practice. If they went to a doctor of their choice, they would have to pay out of their own pockets.

Dr Behrman said patients could choose an approved doctor for a specified period. If they wished to change physicians, they would do so at the end of this period.

Doctors could run "substantial risks" with capitation if, for example, they were faced with an epidemic and had to treat patients for a flat rate, Dr Behrman said. Doctors could form "risk pools" which would receive the flat rate, siphon some money to them and keep the rest as insurance against such occurrences.

Capitation also held benefits for doctors, who would be encouraged to band together and be motivated to contain treatment costs.

The major benefit, however, would go to the patients.

"It covers large numbers of patients who in the past couldn't afford medical care," Dr Behrman said.

He did not think South Africans would be tempted to make more visits to the doctor under the capitation scheme. The average number of annual visits was between 1,8 and three. This would probably rise to between three and 3,5 visits a year.

Caution

The chairman of the Medical Association of South Africa's private practice committee, Dr H Hoffmann, said the association believed doctors and patients should manage health care initiatives with caution.

His concern was that some management techniques could limit patient choice.

"The introduction of capitation payments could be premature, given the lack of health care data. This could pose a financial risk for both health services providers and patients."

Gap in medical aid cover likely to grow in 1996

(299) Xtra 5/12/95

By Medical Reporter

The rate at which medical aids reimburse doctors and hospitals will rise between 5 and 8% next year, but premiums for medical aid packages equivalent to 1995 will probably rise by between 12 and 20%.

That's according to Professor Alan Rothberg, director of policy at the Representative Association of Medical Aids (RAMS).

Rothberg said the RAMS tariff for general practitioner (GP) and other medical consultations had been increased by 8%, pushing up the medical aid rate for a GP consultation from R45 to R48.

Hospital theatre and-ward fees had been increased by only 5%.

But premiums for the same medical aid package as this year would probably be more than double.

Packages could be restructured though, to contain premium increases.

Members could, for example, be offered various forms of co-payment, or managed care, he said.

Traditional healers poised to launch own medical scheme

Star 28/12/95 (299)

By Bruno Jubasi

Hundreds of traditional healers affiliated with the newly formed Traditional Healers Organisation for Africa will be launching their own medical aid scheme early next year, and they are calling on employers and the Government to recognise it.

The president of the organisation, Nhlavana Maseko, said traditional healers should be recognised as professionals who played an important role in primary health care.

"Our country has to import Cuban doctors because we cannot cope with the demand for primary health care. This can be made better by the availability of traditional healers who deal with thousands of patients throughout the country every day," he said.

Maseko said his organisation was starting its own medical aid scheme as it realised that many employed patients were unable to pay cash.

"We are training senior promoters of the medical aid scheme, who will teach our practitioners how to keep proper records of their employed patients and their families."

Maseko added he had been working for most of his life on the struggle to gain recognition for traditional healers, both from the Government and the business sector.

"It is crucial that our democratic government support us as we play a very important role in the health of the nation. We have even started training our healers on the nature of the HIV / Aids virus," he said.

SOCIAL SECURITY — MEDICARE

1996 — 1997

Tax subsidy on medical aid may go

~~255~~ (299)

CHRIS BATEMAN

Tg | 12/96

TAX subsidies on medical aid payments could be reduced or stopped, leaving individual employees with a heavier tax load, according to plans due to be finalised by the national health department on April 1.

This emerged at the weekend as part of the government's initiative to bolster the public health sector.

Pretoria is also trying to reduce the number of private patients being cared for by the state to have more money available for outreach programmes aimed at giving everyone access to health care.

The department of health aims to compel companies to provide a basic health care or hospital plan for all staff.

The proposals will be submitted to the cabinet when it resumes sittings next month.

Depending on agreement between Health Minister Dr Nkosazana Zuma and Finance Minister Mr Chris Liebenberg, the plan is to provide free primary health care to all.

Other measures include introducing user charges at provincial hospitals and continuing to give free care to pregnant women, new mothers and children under six.

By David Robbins
Health Writer

Late last year a Gauteng pensioner by the name of Toni Wernars received a letter from her medical scheme informing her that her contributions would shortly rise from R136 a month to R594. That's an increase of over 300%, far too much for Wernars' budget to accommodate.

The medical scheme in question, Meds, explains that a total of 422 members are in Wernars' position. These members, all pensioners, have been affected by a restructuring of the income brackets on which contributions are based, and also by the gradual removal of pensioner discounts.

But R594 is more than Wernars' entire pension. So what is going on?

Roly Buys, chief executive officer of AMA, the company which administers Meds and eight other medical schemes, provides a historical overview.

"When medical schemes were first introduced into South Africa, the age profile of the membership was young, and medical costs were low and stable. This is no longer the case

"Now, 15% of the membership is on pension – in some schemes it's much higher – and costs are anything but low and

15% of the members are on pension

stable."

Buys underscores several factors which quite apart from general inflation have helped in the spiralling cost of medical care: the vested interest of providers, especially those whose positions were protected by law; the shift in membership preference from low-cost public to high-cost private hospitals; the "no limitations" condition applied to medical care which has encouraged widespread over-provision and abuse by care providers and also by medical scheme members and their dependents.

"The result of all this was that medical schemes began to face serious financial crisis," says Buys. "And the only way to balance the books was to increase contributions and introduce limitations on the amount of care available to members."

Inevitably, the ageing membership profile was to feel the pinch, particularly pensioners who usually receive a fixed income regardless of the fluctuation of medical scheme contributions.

Whether medical schemes (which are run by their own membership and administered by companies like AMA for an average fee of around 6% of total contributions) should be blamed for this, or whether erstwhile employers should also be held responsible is another matter.

According to an AMA statement, "employer groups historically have provided for the long-term funding to ensure a pensionable income for their employees, but have neglected to provide for long-term funding for medical cover".

"The reality for medical schemes," says Buys, "is that they must balance their books or go under. They have no income other than contributions from members.

"In Wernars' case, Meds scrapped the R0-500 income bracket contributions because they were unrealistically low, placing affected members in the R0-1 000 bracket instead."

But Wernars has the opportunity of reducing her contributions by reducing her benefits, an option which might be more attractive to the young and healthy than to Wernars.

"Perhaps," suggests Buys, "the best question to ask is: what is the value of the services you require and in fact use, compared to your contributions?

"Although the cross-subsidy of the elderly and ill by the young and healthy still exists, a lot of the latter category have been attracted to insurance schemes which cover people on an individual risk basis."

Buys foresees that medical scheme contributions will continue to rise. But he also sees the possibilities inherent in managed health care, an option made possible by the recent deregulation of schemes.

This has freed schemes from the role of being only a third-party payer of medical bills; they are now in a position to negotiate directly with health care providers to ensure a better deal for their members.

AMA's efforts in this direction are not unimpressive. For example, through a process of planned care and evaluation, hospital admissions have dropped 16% below the medical-scheme-industry average between 1994 and 1995.

Encouraging though such figures are, Reg Magennis, executive director of the Representative Association of Medical Schemes (RAMS), provides a somewhat critical perspective.

"From the outside," he says, "activity within the industry often looks like little more than a race to control costs by limiting benefits on one side and simply making medical cover unaffordable for high risk groups like pensioners on the other. It's not difficult to see the bankruptcy of such a race.

"But the good news is that there are companies within and close to the industry which have seen the light. These companies have already invested over R1-billion in management skills and information systems. Deregulation will encourage even more investment, and this will transform the medical scheme industry."

Magennis says that this will happen, and is already happening, in the following ways:

- The development of greater employer involvement in scheme design and management, especially with regard to protecting retirees like Wernars. The grouping of schemes into large and powerful buyers of services (as opposed to the old role of merely paying the bills).
- The widespread introduction of pre-funding, a process of individual cross-subsidy where at the start of their careers people begin to finance their own health requirements for later life. When large numbers of people do this under a single scheme, enormous investment capital is generated.
- Large-scale contracting with health provider facilities and the employment of or contracting with health professionals. In this way managed care can be more effectively introduced and over-provision eradicated.

"This is the future," says Magennis. "It'll be a future where health providers will be in partnership with medical schemes, and where expertly designed packages will provide real cover for all categories of

Efficiency and quality will be assured

member.

"Efficiency and quality will be assured simply because we are likely to see an explosion of competition between providers and between managed care organisations.

"The second rate health facility and medical scheme simply won't survive; and the chances are extremely good that quality health care will become affordable once again."

All this might sound a little academic to Wernars, of course. Nevertheless, her case demonstrates the weaknesses of an ailing system and also points the way forward to its necessary transformation.

Meanwhile, let us not delay the transformation process – and thereby perpetuate the individual discomfort of people like Toni Wernars – by further abusing our already battered medical schemes.

We all know the sort of thing: those unnecessary visits to the doctor or specialist; those extra items eased on to already overloaded prescriptions; and even the acquisition of brand-name dark glasses, cosmetics and footwear not infrequently paid for by our much-maligned medical schemes.

Roll on the time when medical aids protect us all

(299)

There's plenty of evidence to indicate that medical aid contributions are rising to a point beyond the reach of ordinary people. What lies behind these increases and what does the future hold for South Africa's medical schemes and the millions of people who depend on them for healthcare?

Star 30/1/96

MONEY

OPEN MEDICAL AID SCHEMES 1992 - 1994

RATING	NAME	PREMIUM INCOME R-m	RESERVES R-m	% CHANGE - 2 YEAR MEMBERSHIP GROWTH	% PENSIONER RATIO	DELIVERY COST/ PREMIUM INCOME	% SOLVENCY	% FINANCIAL BASE	3 YEAR CASH FLOW AS % OF CPI	TIMES CASH COVER MONTHS' CLAIMS
AA	Medihelp	1056	304	(4)	5	[illegible]	29	38	14	0,7
AA	Sanmed	603	350	17	4	6	58	69	6	0,8
A+	[illegible]	450	212	10	12	4	31	62	19	6,3
A+	Bonitas	857	253	13	2	7	29	42	13	1,1
A+	Capemed	176	50	(8)	13	7	29	40	8	3,1
A+	Northern	462	67	74	11	9	15	30	4	2,6
A+	[illegible]	122	22	61	3	[illegible]	18	34	7	2,1
A	MSP	110	26	(32)	17	8	23	39	9	3,0
A	SAAV	158	11	17	17	3	20	29	1	1,2
A	Medent	298	47	(15)	12	10	16	39	3	1,8
A	NMP	391	59	15	8	5	16	28	5	1,0
A-	Meds	114	35	(79)	17	6	30	43	[illegible]	0,6
A-	Sizwe	242	30	43	3	10	12	33	10	2,7
A-	NBC	108	19	13	7	9	17	31	7	2,4
BBB	SIMAS	173	11	(10)	8	3	7	21	1	0,3
BBB	Finmed	159	12	3	9	8	7	23	3	1,4
BBB	GEMAS	177	8	(73)	11	9	3	18	[illegible]	0,1
BBB-	Visimed	115	9	18	17	15	8	18	6	2,2

Graphic: FIONA KRISCH

Source: REPUBLIC RATINGS

(299) ST 4/2/96

Slow cure for medical funds

An analysis of medical schemes' costs and income shows the industry is making a slow recovery from the heavy liabilities of previous years, writes **JULIE WALKER**.

TRENDS in the nation's medical aid industry improved strongly during 1994 but 1995's figures are likely to show a slight reversal.

These are some of the findings of Republic Ratings' analysis of the 21 largest open medical aid schemes which account for 86% of the R8-billion-a-year open industry. An open scheme is one which actively canvasses membership and is not restricted to any one employer group. Republic says recent amalgamations have reduced the number of such schemes to around 50, of which 21 collect premium income of more than R100-million a year. Dave King, managing director of Republic Ratings, says 18 of these 21 schemes co-operated with the rating process; the other three declined to give access to their books. All 21 are incorporated for general statistics.

Republic first surveyed the industry two years ago. Since then, the average solvency ratio jumped more than 10 percentage points to 26,5% between 1992 and 1994 and the financial base (accumulated funds plus provisions for claims) from 29% to 40,7%.

Membership rose by 0,7% in 1994; in 1992 it fell by 12,5% and by a further 3% in 1993. This is an important reversal because funds will tend to lose their younger members while retaining the older ones with a higher claims rate.

Mr King says Sizwe and Bonitas have been particularly successful in attracting black membership. Most of the members of the failed Eastern Cape schemes MCI and MCG joined Sizwe. But excluding these two, the balance of the industry continued to lose members.

Sizwe and Bonitas are effectively black-owned and managed, and Republic suggests that any medical aid scheme wishing to grow in the new South Africa needs to focus on the needs of the emerging market.

A fund's one-year performance should not be seen in isolation. For example, it is relatively simple in the short term for a scheme to bolster its reserves by way of high tariff increases. But this can lead to a loss of members, mainly younger ones, which will prejudice a scheme's medium-term stability especially if the fixed-cost base is high.

In contrast to the position two years ago, general management of the medical aid funds is markedly tighter. There is a far greater focus on analysing costs, claims and settlements as well as on asset management and maximising of investment returns. While abuse still prevails, the potential for abuse has been scaled down.

Perhaps most pleasing for members is the halved rate of increase in tariffs in 1994 — down to 10,5%. But Mr King says many of the schemes will declare underwriting losses for 1995, due in part to the high cost-increases at private hospitals. "This is going to result in the need for significant tariff hikes for 1996. Certain options have already announced increases of more than 30%," says Mr King.

Managed health-care concepts are currently flavour of the month, and medical aids are generally trying to control the costs of chronic medication and hospitalisation. While this has resulted in a steady rise in administrative and delivery costs, it could be a small price to pay if claim trends can be successfully controlled.

Republic says the most pleasing aspect of the survey is that the 18 schemes identified in the table all achieved secure ratings of BBB or better: they have the ability to pay claims timeously. Mr King warns that some of the larger funds could possibly not qualify for a secure rating as they have incurred large losses recently. Some smaller schemes will also be accorded non-secure ratings.

PULSE-TAKER: Dave King of Republic Ratings

Roll on the medical aid

There's evidence aplenty to indicate that medical aid contributions are rising to a poi the future hold for South Africa's medical schemes and the millions of people who

LATE last year, a Gauteng pensioner by the name of Toni Wernars received a letter from her medical scheme informing her that her contributions would shortly rise from R136 a month to R594. That is an increase of more than 300 percent, far too much for Ms Wernars' budget to accommodate.

The medical scheme in question, Meds, explains that 422 members are in a similar position to Ms Wernars. These members, all of whom are pensioners, have been affected by a restructuring of the income brackets on which contributions are based, and also by the gradual removal of pensioner discounts.

But R594 is more than Ms Wernars' entire pension. So what is going on?

Roly Buys, chief executive officer of AMA, the company which administers Meds and eight other medical schemes, explains the background.

"When medical schemes were first introduced into South Africa, the age profile of the membership was young, and medical costs were low and stable. This is no longer the case. Now, 15 percent of the membership is on pension – in some schemes it's much higher – and costs are anything but low and stable."

Mr Buys underscores several factors which, quite apart from general inflation, have contributed to the spiralling cost of medical care: the vested interest of providers, especially those whose positions were protected by law; the shift in membership preference from low-cost public to high-cost private hospitals; the "no limitations" condition applied to medical care, which has encouraged widespread over-provision and abuse by care providers and by medical scheme members and their dependents.

"The result of all this was that medical schemes began to face serious financial crisis," Mr Buys says.

"The only way to balance the books was to increase contributions and introduce limitations on the amount of care available to members."

Inevitably, older members were to feel the pinch, particularly pensioners, who usually receive a fixed income regardless of the fluctuation of medical scheme contributions.

Whether medical schemes (which are run by their own memberships and administered by such companies as AMA for an average fee of around 6 percent of total contributions) should be blamed for this, or whether erstwhile employers should also be held responsible, is another matter.

An AMA statement argues: "Employer groups historically have provided for the long-term funding to ensure a pensionable income for their employees, but have neglected to provide for long-term funding for medical cover."

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"Perhaps," Mr Buys suggests, "the best question to ask is: what is the value of the services you require and in fact use, compared to your contributions? Although the cross-subsidy of the elderly and ill by the young and healthy still to an extent exists, a lot of the latter category have been attracted to insurance schemes which cover people on an individual risk basis."

Mr Buys foresees that medical scheme contributions will continue to rise. But he also sees the possibilities inherent in managed health care, an option made possible by the recent deregulation of schemes. This has freed schemes from the role of mere third-party payers of medical bills: they are now in a position to negotiate directly with health-care providers to ensure a better deal for their members.

AMA's efforts in this direction are not unimpressive. For example, through a process of planned care and evaluation, hospital admissions have dropped 16 percent below the medical-scheme industry average between 1994 and 1995.

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"From the outside," he says, "activity within the industry often looks like little more than a race to control costs by limiting benefits on one side and simply making medical cover unaffordable for high-risk groups, like Toni Wernars and other pensioners, on the other. It's not difficult to see the bankruptcy of such a race.

"But the good news is that there are companies within and close to the industry which have seen the light. These companies have already invested over R1 billion in management skills and information systems. Deregulation will encourage even more investment, and this will transform the medical scheme industry."

Mr Magennis says that this will happen, and is already happening, in the following ways:

- Increasing employer involvement in scheme design and management, especially with regard to protecting pensioners like Ms Wernars;
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beyond the reach of ordinary people. What lies behind these increases, and what does
epend on them for their health care? Argus Correspondent DAVID ROBBINS reports.

ARG 5/2/96 (299)

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Firms' duty to pensioners under spotlight

CT(BR) 8/2/96 (299)

BY ANN CROTTY

Johannesburg — Employees and legal experts will closely watch the outcome of the legal dispute between Barlows and Randgold over which is responsible for paying R35 million of medical-aid subsidies for pensioners.

The dispute was mentioned in Rand Mines' annual report for last year. It arose after Randgold bought mines from Rand Mines, a Barlows' subsidiary.

This is one of the first times that responsibility for pensioners' medical-aid subsidies has been raised in law. But it could mark the beginning of a flood of cases.

"Early retirement, extensive retrenchments and steep increases in medical costs have meant that a lot of companies are looking at their obligations on this front and trying to find ways of getting out of them," one labour lawyer said.

Last year, pensioners at Premier Foods were notified in a letter from the Premier retirement fund that their medical-aid benefits had been terminated as part of management's drive to cut back on head-office costs.

"In view of the financial results of the company and the many demands being made, they have had to review their subsidy policy and we have to advise that the policy has been amended to discontinue the payment of the subsidy in respect of medical-aid premiums," the letter said.

According to the letter, dated July 20 last year, the change applied to the medical-aid deductions for July last year.

Responding to the charge of callousness, Premier Foods management said the termination was only applied "to a small band of 17 or 18 people who were earning very good pensions".

It was not possible to get firm figures on the numbers affected. But it seemed likely to be considerably more than the small band management suggested.

One of the affected pensioners, who had received the subsidy for the seven years he had been a pensioner, was emphatic that he was not on a "very good pension". He said that it was difficult to see why management had said the pensioners' medical aid placed a burden on the company and then limited action to just 18 pensioners.

Premier Foods has thousands of pensioners, among whom there must be hundreds of former managers who spent their working life with the group.

Legal experts said though Premier would possibly not be obliged to pay the subsidy, it had been a tacit condition of employment. Premier had acknowledged an obligation through custom and this could give the pensioners cause for battle.

Post-retirement medical aid costs hurt balance sheets

CT(BR) 8/2/96 (299)

BY ANN CROTTY

Johannesburg — Escalating medical aid costs, widescale retrenchments and a trend towards early retirement mean that corporate South Africa will pay much more for post-retirement medical aid subsidies.

The implications are more dramatic given that there will be less chance of reserving medical aid benefits for an elite section of the workforce.

In July last year the South African Institute of Chartered Accountants emphasised the need to account for these obligations: "Enterprises should report information about their practices (or obligations) in respect of unfunded post-retirement benefits to employees, regardless of whether or not the amount of such future payment can be reliably measured."

Most companies do not bother to mention their obligations for post-retirement medical aid contributions though they frequently amount to hefty sums.

In Transnet's case the decision to acknowledge and disclose the obligation means that it has a R3,1 billion liability on its balance sheet.

Anglo's liability in the financial 1995 balance sheet amounted to R202 million.

In addition there was the R74 million cost of benefits incurred last year that were charged to the income statement.

Engen merely acknowledges it has such liabilities. It says in the notes to its financial statements that "post-retirement medical costs are charged to the income statement in full when incurred".

So in effect the vast majority of South African listed companies over-state their true value.

The vagueness in accounting treatment seems to be largely attributable to uncertainty over the nature of the obligation and the fact that it can only be estimated.

Most companies are not contractually obliged to contribute to their employees' post-retirement medical aid costs. However, they are obliged through custom to do so.

As companies cast around for ways to tighten their cost structures, it is inevitable that some will examine the extent to which these obligations are legally binding.

(299) (~~286~~) Star 29/2/96

By 2000, most people on medical aid will be covered by a Florence Nightingale concept of managed health care. Janine Simon reports on a possible revolution.

It's do or die for private sector health care this year. To stay solvent, it must find a way to limit costs; to legitimise its existence, it must become more accessible and extend its coverage.

The sector is pinning its hopes for achieving both those aims on managed health care.

The term means intervention in the way health care is delivered, ideally, as American managed care expert John Wardle puts it, "quality care where patients get the right care, at the right time and place, done right".

In a crude form this can mean slapping limits on treatment simply to reduce overall costs.

But the real aim, and the one for which consumers should fight, is for quality care. Decisions must be clinically sound, based on the most appropriate, and therefore most cost-effective, care.

Keith Hollis, Medscheme's executive chairman, says the ground is moving as major players rush for foreign skills and train locals in preparation for launching South African versions of the managed care concept.

Most expertise is American, but the US experience has to be creatively applied to South African needs.

The industry there is complex, with many models of managed health.

Just two of the versions being worked on in South Africa are Independent Practice Associations, (IPAs) where doctors form their own group practices and contract themselves to Health Maintenance Organisations (HMOs), or other sponsors like the government, employees or third party players; and direct contact models where HMOs contract with individual practitioners, and manage the treatment process from a central point.

All versions aim to control costs by using only appropriate, affordable treatments, avoiding unnecessary drugs and tests, specialist care, hospitalisation, or surgery. In many cases GPs are given financial incentives not to refer unnecessarily.

The decision on what constitutes appropriate care is tough and controversial.

South Africa currently prides itself on the quality of its care, but has no way of measuring it. "There's a lot of very expensive care but no way to measure outcome," says Sanlam's managed health care advisor Dr Martin de Villiers.

Savings must come from shift in emphasis to GPs

So part of the shift to managed care is about moves to implement diagnostic and treatment codes to supply and share better information.

"Information is the key," says Wardle, general manager of Southern Healthcare JV, the joint venture between Anglo American, Southern Life and US managed care giant, United Health Care (UHC), which has set the industry abuzz.

"UHC was chosen because it has excellent information and processing tools. Decisions are made on information, not opinion."

South Africans have still to see how treatment decisions are called.

Having exercised restrictions over the last 25 years, HMOs have transformed USA health care. They've brought with them ruthless competition, to the point where two dollars makes a significant difference on a premium, and introduced an ideology previously foreign to the health care sector: consumerism.

In best case scenarios, managed care has shifted the emphasis on to thorough, preventive medicine.

"Fee for service is an incentive to keep people sick, managed health pays to keep them healthy," says de Villiers pithily.

But it has strident critics: doctors rail against being told how best to treat their patients, and patients lose some element of choice. Opponents point out that despite initial savings, managed health care has not extended health cover to at least 35 million Americans unable to buy it.

And there are wild cards: how do managed care packages deal with the high-risk patients medical aids drop like lepers: the aged and people with HIV?

But private health care can no longer afford the open chequebook of South Africa's fee-for-service system.

Medical aid premiums are rising an average of 25% a year. To keep solvent, benefit packages have shrunk and practitioners, especially GPs, are being strangled by slow payments and low professional fees.

Despite the R14-billion being spent on private health care, half those who have jobs still aren't covered by medical aid. Unions and a determined health minister, Dr Nkosazana Zuma, want that changed.

Medical cover for employees will become mandatory, should the proposed National Health Insurance System be adopted. But at current rates, employers simply can't afford to extend comprehensive cover to all employees.

"We have to cut the cost of comprehensive products to free money to cover the uninsured," says Malcolm Steinberg, medical director for Integrated Health Services (IHS), a subsidiary of the Thebe Investment Corporation, which is setting up GP controlled, multi-disciplinary managed care networks accessible to both insured and uninsured-insured employees.

Steinberg says savings must come from cutting total costs and shifting the emphasis from hospitals and drugs to GPs. The health care industry, he says, is in a product development phase which should last into next year.

Doctors are beginning to be canvassed to join HMOs and some have already opted to form IPAs. By April the first details of new health insurance packages and managed care options on medical aid schemes should start filtering through to consumers, and by mid-year these products should be up and running.

Southern Healthcare JV is planning public meetings for medical providers, and hopes to have contracts with Gauteng medics in place during the third quarter of 1996, Cape Town by January 1 and Durban and Port Elizabeth by mid to late 1998.

Hollis says Medscheme, which administers 65 medical aids with 150 different plans, is at a "delicate" stage of negotiation and Sanlam, says de Villiers, plans to be in the market by August 1.

IHS says it is six to nine months ahead of other players. "We've already done the negotiating with doctors in some parts of the country, represent GP groups in Gauteng and Mpumalanga, and are beginning in other parts," says MD Stan Eiser.

Consumers would now do well to ask their medical aids what is being done to get the most cost-effective care, and to compare their benefit packages with premium increases.

The reality will probably be that, unless they fall into the 10 to 15% of top earners who can afford premium medical aid rates, they will choose, or be forced to opt for, some form of managed care principle in their health care package.

Be patient and cautious, advises Hein van der Merwe, editor of *National Focus*, a monthly periodical aimed at educating the public about managed care.

Issues like the history of the organisation and how it plans to sustain the low cost of its medical cover package are vital.

Doctors, too, must assess which of the host of new organisations they will choose to service. Issues like how they'll be paid, at how much risk, are crucial, warns the Medical Association of South African.

But, says Wardle, they can expect swifter payments, and better consultation fees.

The year ahead is expected to be fraught with problems, not least of which will be for suppliers and doctors to reach common ground on cost containment.

Health care insurance benefits the rich most

(299) BD 19/3/96

PETER HILSENRATH

ECONOMIC policymakers must reconcile the often competing objectives of efficiency and equity.

Most economists emphasise efficiency, but at least pay lip service to improving equity. Sometimes politicians are given an option that improves efficiency and equity. These are rare opportunities that should be seized. One such case is taxation of employer contributions to medical schemes.

Health insurance is currently provided to employees on a tax-free basis. Employees with salaries in excess of the amount associated with the top marginal tax rate receive a subsidy of 45%. There are few, if any, good reasons for this subsidy. It encourages excessive levels of insurance, rendering consumers insensitive to health care prices; it generates paperwork, filing claims; and it provides the greatest subsidies to those who least need it, the well off.

Economists recognise the need for insuring against large losses for risk-averse individuals, but it makes no sense to pay insurers to cover routine care that can easily be financed from individual or family cash flow.

An alternative approach is to permit an individual tax deduction (as opposed to deductions for employer contributions), limited to an amount consistent with an insurance policy protecting only large health care expenses.

Insurance policies covering only serious episodes of care such as admission to hospital, and with no cover for routine expenditures such as occasional visits to physicians or dentists, would have considerably lower premiums. These premiums would be affordable to many more South Africans, who could then receive private care.

Consumers would shop for routine care, much as they do for other goods and services, and bring much greater levels of efficiency to this part of the economy.

Government finances would at least initially receive a boost as more employee compensation became taxable. In the longer run, as the number of people insured by the private sector increased, the effect on revenues could be negative. However, this would be offset by fewer demands on public sector resources.

Government should embrace such reform as it appeals to a broad range of ideological persuasions. Free market advocates like the emphasis on consumer choice and the enhanced role for the private sector. Progressives like the improved equity that follows.

Only vested interests within the health care sector feel threatened. A more consumer-driven, price-sensitive market may well undermine demand for many health services.

Politics is, of course, the art of the possible, and politicians might have a difficult time implementing such reform. American economists have been recommending similar reform for years.

US President Bill Clinton recognised the arguments but backed away in response to industry pressures and labour interests, which felt tax-free health care benefits were hard-fought gains that should not be abandoned, especially by Democrats. The drafters of the Clinton plan also believed that tax-free health insurance contributions would make employer-mandated insurance (a central feature of the Clinton plan) more palatable.

Republicans and Democrats now seem unwilling to address systematic reform to health care and have failed to implement a budget for next year, largely because of disputes over Medicate and Medicaid.

One hopes SA will show greater leadership and be more decisive. Health care will be a growing part of the economy — driven by new technologies, rising incomes and, sadly, new epidemics.

Not all health services are worthwhile and choices have to be made. Ultimately, the question is how well a mixed public and private system will integrate consumers, insurers, providers and government to allocate scarce health care resources properly.

□ Hilsenrath is Syfrets' chief economist and assistant professor in the graduate programme in hospital and health administration at the University of Iowa.

LETTERS

Hospital network born

ST(BT) 7/4/96 (299)

By JULIE WALKER

GOVERNMENT proposals to introduce a compulsory hospital insurance plan for all salaried employees and the need to control costs have led to the formation of National Hospital Network, a group of 90 healthcare facilities spread throughout the country.

Participants in NHN are Hospiplan, Lifecare, Maddocs Healthcare Organisation, Meulkin Group, PE Medical Group, JSE-listed Presmed and other independent hospitals and day clinics.

There will be 90 facilities around the country offering the most comprehensive range of services and delivery points. To organise 90 facilities is a feather in NHN's cap — the only other hospital groups are Clinic Holdings with more than 20 hospitals, and Apex with 36.

Carl Grillenberger of Presmed, Sam Rossolimos of Maddocs and Marc Resnick of Lifecare are the driving forces behind the formation of NHN. The rationale is that the rocketing cost of private healthcare makes it unaffordable for many people and unacceptable to the funders of private health care.

NHN will embrace the principles of managed health care where cost is controlled while quality is maintained. Hospitals share the financial risk with the funder.

NHN has started negotiations with national employers and medical aid schemes on affordable hospital packages. NHN will also encourage doctors to participate in managed healthcare programmes.

State intervention could push up insurance costs

(299) ARG 18/4/96

The aim of affordable and sustainable health insurance for all is laudable, says Adrian Gore, managing director of Momentum Health.

"However, in addition to the Government's aim of introducing mandatory hospital coverage for all employed, is the worrying desire to introduce legislation to 'stabilise' the health insurance market. Can stability be achieved by State intervention?" asks Gore.

Gore believes the danger is that intervention may achieve the exact opposite of the reformers' intention – higher costs and an even larger pool of uninsured.

Gore says the American experience provides excellent lessons in what not to do when drafting legislation intended to contain costs and increase access to health insurance.

Will South African reformers pay any attention as two of the controversial issues – community rating and guaranteed issue – appear to be widely endorsed in official circles?

"Unexpected costs afflict America – even though their officials tend to commission more detailed projections than ours.

"The Government-funded Medicare programme of subsidised health for older Americans is an example. In 1965 when the programme was launched, officials projected that by 1990 the programme would cost the taxpayer $9-billion a year. In reality, by 1990 Medicare was costing in excess of $100-billion a year.

"The aim of more recent reform in the US has been to increase the number of insured while containing costs. In some states, this is attempted through community rating and guaranteed issue," he adds.

"Community rating allows variations but in its basic form it requires an insurer to charge the same price to everyone without taking underlying risk factors into account," explains Gore.

"The consequence is that often the healthy perceive poor value for money and cancel their cover. Once the healthy leave, the community rating rises. The relatively healthy then begin questioning value and are also tempted to leave. And so the cycle continues.

"The result is an increase in costs and the number of uninsured."

Gore contends the only real protection against this "death spiral" is the fear among those who cancel their cover that they may not easily be able to re-access health cover in the event of sickness. However, guaranteed issue removes this fear as it means an insurer cannot turn away anyone.

In effect, people then time their cover applications in line with needs. If they're healthy, they avoid this cost. When health deteriorates, they seek cover.

"A third problem," says Gore, "is reduced choice. Guaranteed issue and community rating have resulted in insurers losing money on health insurance business. So they withdraw from the market."

"The cost spiral is another worrying aspect. In South Africa, the potential for the mandatory hospital package to escalate unacceptably is well illustrated by the US Medicare example.

"Badly thought through reform could end up hurting those it intends to help," he adds.

HEALTH CARE ISSUES UNDER THE MICROSCOPE

Ant Lester ... New Labour Relations Act sets the scene for a shake-up

New LRA set to change pension and medical aid management

(299) ARG 18/4/96

The new Labour Relations Act (LRA) will place retirement funds and medical schemes firmly on the negotiating table – at both plant and industry collective bargaining levels.

According to Ant Lester, assistant general manager at Old Mutual Employee Benefits, revisions the act will bring to the collective bargaining process will result in significant changes to the design and management of retirement funds and, to a lesser degree, medical schemes.

"The act sets the scene for a shake-up in which sectoral funds, spanning and industry or industries, could be given a significant boost, with clear implications for employer-based benefit funds."

Lester added that the joint decision-making is required in terms of Section 86 of the new act which stipulates that employers consult and reach consensus with a workplace forum on changes to the rules of any employer-controlled pension, provident or medical aid scheme.

At the same time, the powers and functions of Statutory Councils and Bargaining Councils – new bargaining forums which will operate at sectoral level – include the ability to set up and run pension provident and medical aid funds for the benefit of their members.

"With trustee boards representing both employers and trade unions in a sector of the economy running retirement funds, the influence of individual employers and unions will be reduced. This could result in a number of changes to industry practice as we currently know it," said Lester.

He commented that although the last few years had seen the emergence of negotiated funds, most retirement schemes are either union or employer-driven. In future, funds jointly established for a sector or industry are likely to find favour.

Old Mutual's 1995 Health Benefits Survey, which is based on feedback from a sample of the country's top 500 listed and private companies, reveals that the trend towards greater union involvement is reflected in the way in which medical schemes are managed. Although a management committee remains most common (55%), 29% of funds now have a board of trustees (20% in 1994) on which union and pensioner members have greater representation.

Only 11% of employers had experienced medical-aid related industrial action, but well over half believed that the introduction of non-negotiated changes would result in such action.

Kobus Hanekom, senior manager (legal consultancy) at Old Mutual Employee Benefits said that in dealing with labour disputes, the Act introduces workplace forums at plant level. With the intention of preventing unfair labour practices from developing, it prescribes greater employer disclosure, consultation and joint decision making with these forums.

He added that the more effective resolution of labour disputes would also be facilitated by laying down minimum criteria of what constitutes a fair labour practice in respect of critical issues like unfair dismissals, strikes and lockouts.

"The act replaces the Industrial Court with the Commission for Conciliation, Mediation and Arbitration and the Labour Court requires that all disputes first be conciliated," said Hanekom.

"Only if this process is unsuccessful, may it be referred to arbitration which, in most cases, will be final and binding. Only in a small number of cases can issues be referred to the Labour Court for a decision."

Kobus Hanekom ... New act prescribes greater employer disclosure

Medical aid denies rumours

ARG 24/4/96 ~~25~~ (299)

Health Reporter

THE Prosano medical aid, with a membership of 78 000, is "very strong" financially, and rumours that it is in trouble are unfounded.

So says Bernard Wentzel, chairman of Prosano, reacting to members' fears after certain pharmacists refused to give them medication. The Argus has received many calls from Prosano members worried that the medical aid scheme is foundering. Mr Wentzel said Prosano was subject to rumours "and some kind of onslaught".

"We're not clear what the reasons are, but we believe that one or two pharmacies have not been paid. The clearing house for paying pharmacies is being investigated to see what the problem is. We can only assume there is a lack of communication or a technical reason for non-payment."

Mr Wentzel said Prosano had a turnover of R500 million a year and was "transparent".

Joint venture sets out to change healthcare industry in SA

CT(BR) 6/5/96 (299)

THE SPIRA INTERVIEW

Cosmetic plugging is not managed healthcare, contends Southern Health Care JV

BY JOHN SPIRA

There is an industry out there that is undergoing radical transformation whose result will benefit all South Africans.

The transformation has proceeded at a low-key level, punctuated by announcements that have not created the effect that the goal warrants.

The industry is medical care and the prime player is Southern Health Care JV, a joint venture between Anglo American, Southern Life and United HealthCare from the United States.

Southern Health Care JV was formed last September and plans to be running by next month, says Arie van der Zwan, a Southern Life director involved with the joint venture.

He notes that over the past few years managed healthcare has become a hot topic, so much so that "the conference industry is doing very well out of it".

There are as many definitions as opinions being aired on what constitutes managed healthcare. For Van der Zwan it is about preventative healthcare as opposed to curative healthcare. And it is about high-quality cost-effectiveness and accessibility.

"At Southern Life we discovered managed healthcare four years ago. Looking at the shape of the medical aid industry, we concluded that the managed route had to be the long-term solution.

"We concluded that all we had to do to reach that goal was to buy a computer system and change the dollar signs to rand signs."

So Southern bought a computer from the US and soon discovered large differences between the way the system operated there and the way it operated here.

"We realised that an off-the-shelf system, which we had to customise, initially worked for about 70 percent of the requirements—not nearly enough. If you're not doing things like building systems and accessing health providers, a system will only tell you part of the story.

"After spending a fair amount of money, we finally wrote it off. We paid our school fees, in the process learning that you have to have a holistic system, an integrated entity."

Now Van der Zwan's primary concern is the state of the healthcare industry in South Africa. "It's the difference between the tricameral parliament and full democracy. People are taking a medical aid system under enormous threat and tinkering at the edges. They believe that by plugging cosmetics into an existing industry you will have managed care and simultaneously rescue what you already have.

"We know from bitter experience that it can't work that way."

In making a strong case for managed healthcare, Van der Zwan nevertheless accepts that the current medical aid system will be around for a long time, though it will decline.

"It won't disappear because you will have individuals and groups who will say, 'Thank you, but I am happy to pay a premium. I've been going to the same doctor for the past 30 years. That he isn't on your list of doctors doesn't interest me. I'm prepared to pay more for freedom of access rather than having to accept what you think might be good for me.'"

And, adds Van der Zwan, the existing system will be perpetuated by those who append limitations to medical aid and dress it up in in the guise of managed healthcare.

"They believe that if you put someone on a chronic medication programme, that's managed care. But it's only one facet of managed care, which in fact is a whole combination of things of which chronic medication is but one technique."

Van der Zwan believes the only workable solution is a radical transformation, the first part of which is to accept the associated difficulty, pain and investment.

"The investment is not purely financial; it's an investment in getting human capital on board to help you manage the transformation and, most importantly, help you educate people."

Managed care myths abound, he says, especially when it comes to providers. "Managed care is perceived as provider bashing: beating doctors and all the other providers into submission. But a system that sets out to make you feel like a loser in order to make me feel like a winner carries the seeds of its own destruction. The provider and the managed care organisation must both feel good."

Consumers, too, need to be educated, since they are accustomed to a blank cheque scenario.

"They don't understand their capacity to negotiate on the services they receive and the cost thereof. Providers can be flexible, but the individual is too accustomed to signing the invoice, popping it in the mail and the medical aid pays.

"With the limitations that are being placed on a number of schemes, people are running out of benefits."

Van der Zwan says the current system deals with illness, but under managed care the consumer needs to understand that the system is designed to keep him healthy rather than catch him at the end.

"If, for example, one suffers from diabetes, managed care monitors that condition and educates the member as to measures to take to prevent complications. It's proactive.

"If you compare the incidence of breast cancer in South Africa with that in the US, there it's routine for women over the age of 35 under managed care plans to have a two- to three-year mammogram until 50, when it becomes annual.

"Accordingly, the rate of radical treatment of breast cancer is lower, because it can be caught earlier and dealt with.

"We're talking here of a shift to preventative care. That's going to involve a lot of education, which isn't easy, because the public has been bombarded with information that is, sadly, top of the junk mail throwaway list. We're simply going to have to find a way of explaining the change to the end consumer and how much it will benefit him."

Compounding the problem is that about 30 percent of the nation's medically insured are semi-literate or illiterate.

In getting the new system running, Van der Zwan emphasises that the computer element is crucial, because in order to be effective it has to tightly track massive amounts of data.

"For one thing, it has to pick up and communicate the full medical history of every consumer. It's at that level of detail. For another, when a provider's way of treating moves out of sync, it has to be picked up and discussed. It highlights exceptions on a detailed level.

"You must have a tried and trusted huge computer systems behind what is a user-friendly front. Getting to this stage requires a long time period over which data needs to be assembled. You have to develop trends. It isn't a quick fix."

Van der Zwan says the industry has to guard against being too proud to recognise what it does not know.

"It needs to appreciate that managed care adds up to a considerable investment in time, money and people. It's a transformation process. Our joint venture is transforming the industry."

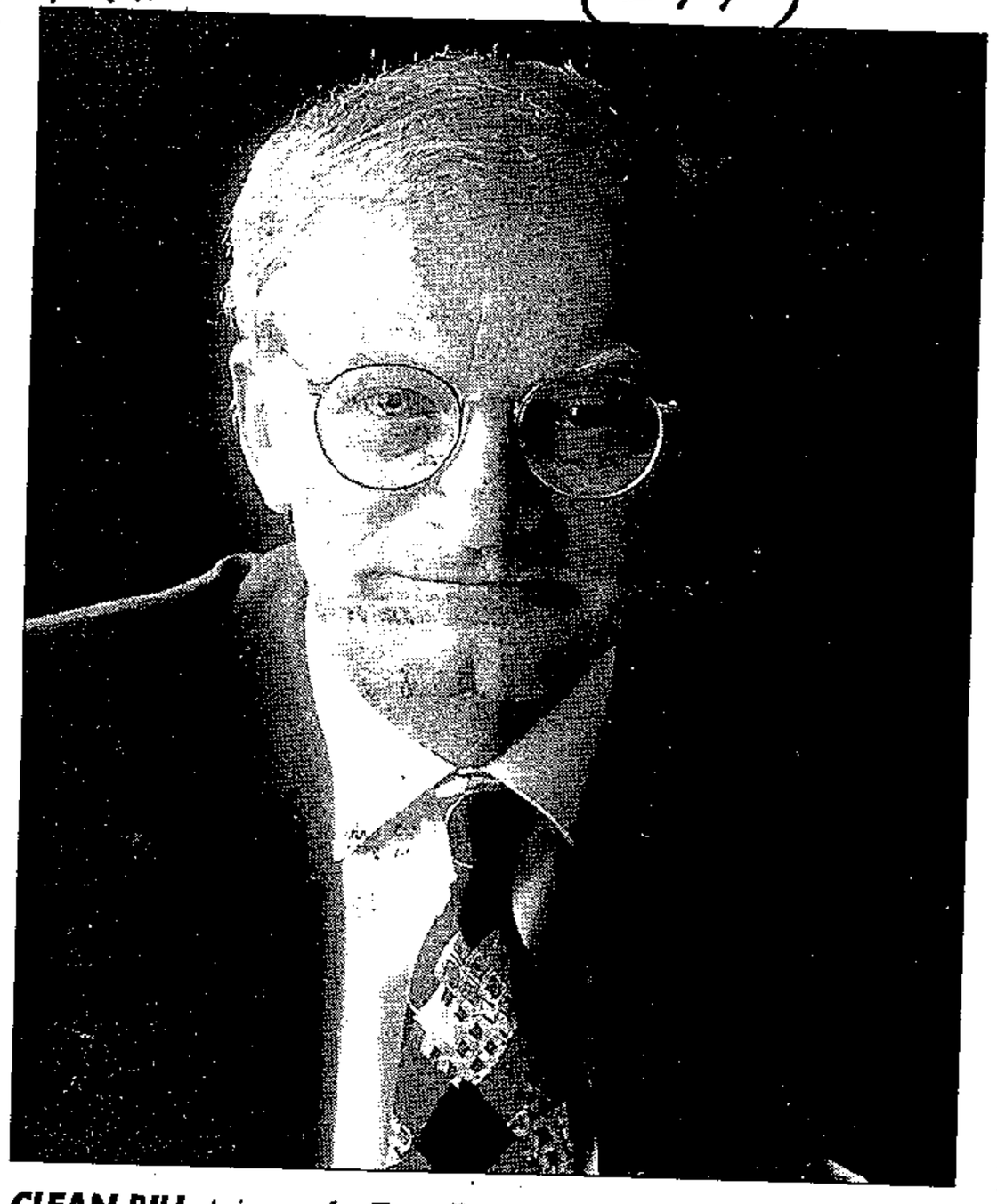
The process also involves the delivery of primary healthcare to the entire nation. The medical aid industry has about 2,5 million principal members, covering about 10 to 12 million people.

"Not enough," says Van der Zwan. "We have to look beyond the bounds of the present insured population. We have to ensure that in some shape or form, at least at a primary level, we support the state in achieving affordable healthcare."

Southern Health Care JV hopes to open its doors soon.

"We're fairly well down the road. At inception we'll have products backed by a computer system suitable for local conditions."

United HealthCare's Kathy Walstead-Plumb is here for two years with several other Americans. They're tasked with getting the joint venture running, after which South Africans should have reached a level of competence to take over from them.



CLEAN BILL *Arie van der Zwan has paid his school fees*

Public to benefit from focus on medical aid plans

(299)

ST (BT) 9/6/96

REPUBLIC Ratings has the most tangible impact on the man in the street by scrutinising the financial soundness of the healthcare industry.

"We have a broad strategy to rate the whole of the healthcare industry and we started by focusing on the so-called open medical schemes where membership is not tied to a single employer," says Dave King, managing director of Republic Ratings. "All things being equal, an open medical scheme has a higher risk profile than does an in-house scheme because the employer body linked to an in-house scheme clearly has a strong moral obligation to meet any shortfall in the fund, whereas a multi-membership fund cannot rely on a single body to bail it out in the event of difficulties."

So far, Republic has rated almost all the 23 open schemes with annual premium income exceeding R100-million, and intends to have rated most of the smaller schemes by July this year.

Next to be rated will be the hybrid schemes — those now having the characteristics of an open scheme which historically served a specific body such as a local authority, for example Jomed and Pretmed.

"Previously, people who worked for a local authority had to belong to a specified medical aid scheme, but in future we believe that the employees will have a choice. This means that the former in-house scheme will be subject to competitive pressures for the first time."

Mr King says it can be a daunting task for employees suddenly faced with an important choice. They need information about the financial security of their scheme. If they choose badly, they could find that their claims are not covered and their premiums unrecoverable.

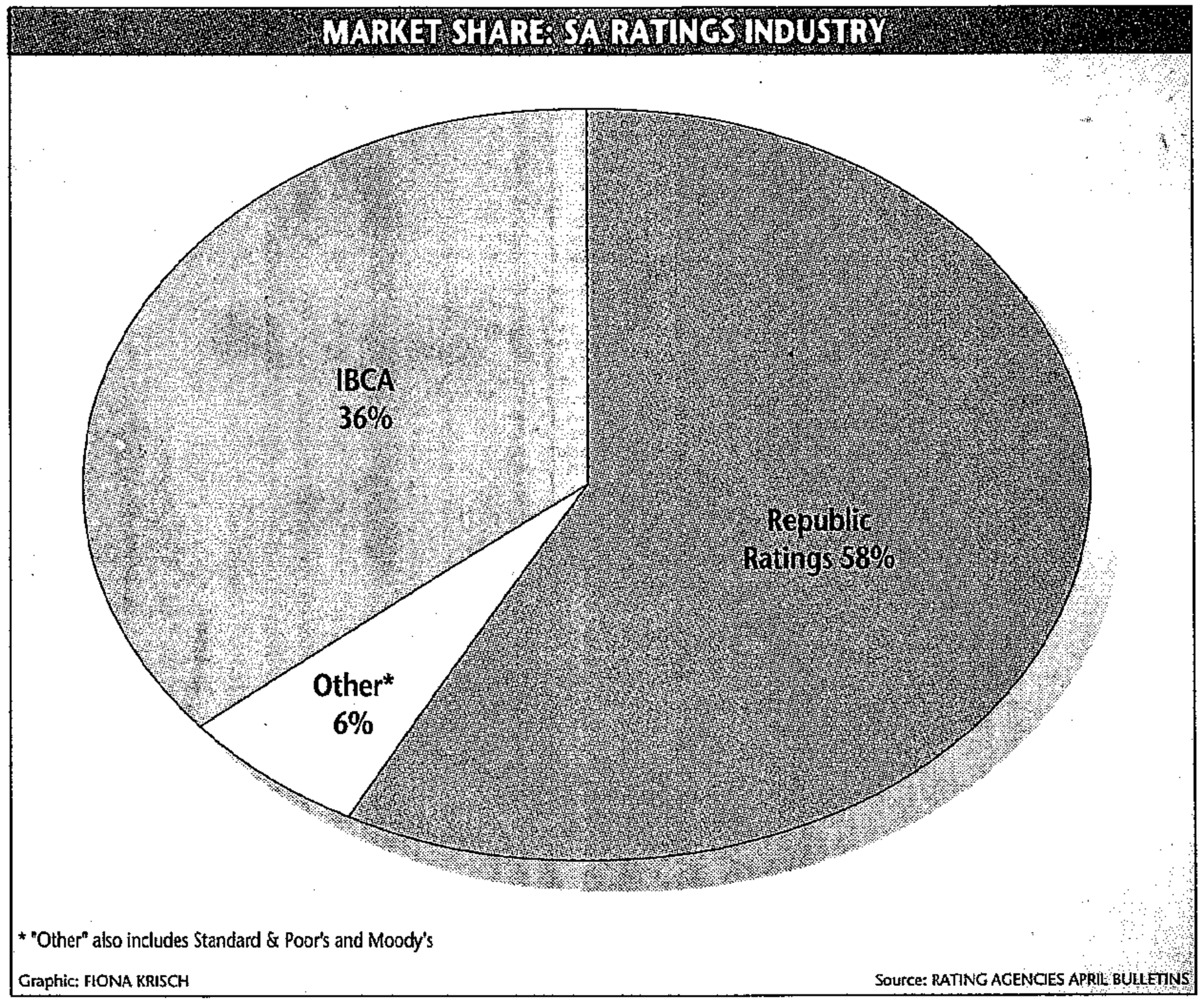
Republic then aims to rate the schemes launched by the life offices in recent years. The life assurance industry has spotted medical insurance as a potential market and has been highly innovative in introducing personal savings schemes and other incentives to contain the expenditure on medical treatment.

After that, Republic will look at the approximately 150 in-house medical schemes. "With in-house schemes, the employer bodies are most at risk. Actuarial shortfalls have been estimated for most companies' pension and provident funds but little attention has been paid with respect to the post-retirement costs of pensioners which have to be funded by in-house medical schemes. If a company finds it needs to make up a large amount to cover future costs, it comes directly off the bottom line and affects shareholders' returns. Everyone has a reason for wanting to ascertain the health of their medical aid scheme," says Mr King.

Republic Ratings will also assess service providers such as drug manufacturing companies and private hospitals.

Mr King says issues such as membership trends, efficiency in administration and cost control all have a direct effect on the claims-paying ability of medical schemes. "Cost containment is becoming the big issue and many schemes are beginning to introduce measures incorporating the concepts of managed healthcare, particularly in the areas of chronic medication and pre-authorised treatment procedures.

"The trend so far has been a marked improvement in the maiden year of implementation of such measures, but after the initial downtick, the rate of cost increase tends to resume parallel to the original rate. It is important that the industry takes permanent steps to curb the rate of cost increases because ultimately, this is the only solution to the problems facing the industry."



Listing could be on the cards

REPUBLIC RATINGS is considering a JSE listing, primarily to broaden its shareholder base.

"We are an African organisation and a listing would give us an African shareholder profile. But a listing does present us with a strategic dilemma," says Dave King.

His biggest reservation is the potential for Republic's perceived independence to be jeopardised by allowing institutional shareholding.

"In the broader context, a stake in Republic Ratings would not make a material difference to the overall performance of any one financial institution, but it would make a difference to the reputation and perceived objectivity of Republic Ratings if too large a slice of the equity were held by one of the market players which are themselves likely to be subject to rating evaluation," says Mr King.

But Mr King says Republic Ratings is not in need of capital at the moment and there is no hurry to list. First prize would be to place a limit — perhaps 3% to 5% — on the amount of shares any single party could hold. This would ensure a good spread of holders and maintain independence of the business itself.

But this could also impose limits on the tradeability of such a counter, which could result in its operating at a discount or, ironically, on a low market rating.

A listing would also ensure transparency of operation.

"Transparency applies to us too," says Mr King. "We cannot expect transparency from our clients if we are not prepared to open ourselves up to examination."

South Africa joins the international business community

THE ratings business has finally come of age in South Africa, many years after the rest of the business world has regarded it as essential and even compulsory.

"Only a few years ago, credit risk was a secondary issue in the South African context as industries were highly protected and in many sectors there was a highly negative reception to the principle of being rated. But South Africa's early objections to ratings were typical of what has happened throughout the rest of the world. We just had to get through it, and we have," says Dave King.

Issues such as profound political changes, deregulation, the loss of protection through reduction of trade and tariff barriers as agreed to at the last round of GATT, the falling away of the "big brother" mentality of corporate protection, and the government's more hard-nosed approach to ailing business, as well as the advent of so many new local and provincial authorities, all of which seek to borrow, have all contributed to the change in attitude. Mr King maintains, however, that rejoining the international community precipitated the biggest change of heart among South African businesses so that there is now a general acceptance of the role a ratings agency plays.

The evidence is overwhelming.

"Almost every capital market and money market participant, from the government, parastatals, banks and corporate debt issuers, have been formally rated by Republic, indicating wide acceptance within the wholesale sector.

"An even more telling sign that ratings has a role is manifested in the retail sector. Most major medical aid schemes, insurers and retail banks have already been accorded ratings by Republic in response to consumers' growing awareness of the importance of credit risk.

"Also, a number of influential financial institutions are now being rated to enable others to quantify and allocate counter-party risk and they themselves want to deal only with rated entities. Today, there is no doubt that it makes a difference to be rated," says Mr King.

In the past he has always had to try and persuade participants to agree to be rated, but now participants are approaching Republic with requests to be rated. "After the disasters of Masterbond, IGI, Crusader Life, Supreme Holdings and others, the country's insurance brokers and other service providers are becoming more aware of the risks to themselves of recommending investment into unsound businesses."

Mr King says it is significant that the country itself has been rated and this has material effects on South Africa's standing in the international community.

"A few weeks ago, just a rumour that South Africa's sovereign rating was to be downgraded made a big impact on the equity, capital and foreign exchange markets. Rating is beginning to be taken seriously and indications are that it may soon be legislated."

By this he refers to the duties and obligations of fund managers of money market funds, which are due to be introduced in the not-too-distant future. The study group appointed by the Financial Services Board to investigate the establishment of such funds recommended unanimously that only rated paper should be considered for inclusion in money market funds and that a fund's maximum exposure to any particular type of paper should be determined by the rating.

Mr King says this begs the question of who rates the rater?

"If and when ratings become compulsory, who is qualified to undertake the task? Will a number of ratings agencies spring up in South Africa overnight, none able to do a proper job? This causes a dilemma, and I believe that some form of accreditation will become necessary," says Mr King.

Nationwide medical aid money scam

Patients prescribe themselves cash

The Argus Correspondent

PRETORIA - Systematic medical aid scheme fraud involving an apparent nationwide syndicate has been uncovered in the Pretoria area.

The matter is so serious that the Representative Association of Medical Schemes (Rams) and Business Against Crime is to approach the Office for Serious Economic Offences this week.

A press investigation discovered that several Pretoria doctors were cashing in on medical aid schemes by giving patients cash advances on the strength of their medical aid cards.

Claims are then sent to the medical aid scheme as if the patients had been treated.

The investigation was told that certain doctors allegedly claimed from the medical aids double the amount the patients wanted and kept the balances for themselves.

It was discovered that in some instances in the Marabastad area, medical aid scheme members were able to buy groceries from a shop whose owner was apparently related to one of the doctors allegedly involved in the scam.

"I rarely go to the doctor for treatment and this is the only way I can recover my monthly contributions," said a nursing sister who asked not to be named.

She said she had been dealing with a particular doctor for nearly two years.

"He's not the only one. I'm also having dealings with another one who's apparently a shareholder in a clothing shop at the Asiatic Bazaar where I buy my children's clothing and school uniforms," she said.

She said the doctor would get her to sign a blank letterhead and would then phone the shop to advise them how much credit she could have. He would then claim double this amount from her medical scheme.

A man took Pretoria journalists to a Mabopane surgery. When the receptionist asked if he was ill and needed to see the doctor, the man told her: "I need money."

She asked him if he had his medical aid card with him. He said he did. She then asked him to sign a blank letterhead with the doctor's name on it.

Speaking to the doctor on his phone extension she said in Sotho: "Doctor, we've got a customer here."

She listened to him for a moment, and then said: "Yes I've got everything ready. He only wants R100."

The doctor then emerged from his consulting room with two R50 notes in his hand. He checked the medical aid card against the signature on the letterhead and handed the man the money, saying: "I'll fill in the rest of the details later."

After leaving the surgery, the man told journalists: "I've been dealing with this doctor for the past six months after I was introduced by a friend. We then went to the surgery of a Soshanguve doctor. Hanging in his waiting room was a big notice reading: 'We don't exchange medical aid cards for cash'."

As the man greeted the receptionist the doctor came out of his consulting room. He greeted the man, using his first name and adding: "Are you back again?"

The doctor told the man to tell his receptionist how much he wanted. The man said he wanted R400. The doctor then told the receptionist to check the man's limit with his medical aid scheme, which she did.

While she was on the phone, the doctor was checking his own records. She told the doctor there were sufficient funds in the man's medical aid, but the doctor said he had discovered the man's previous cash advance had not been repaid by the medical scheme.

The doctor told the man he could only have the R400 in three weeks, since the medical scheme had not yet paid him. "You shouldn't come too often or it will be spotted by the medical aid."

While some doctors said they had put warning signs up after being approached by several people who needed cash, some bluntly refused to comment or said it was a private matter.

Another Soshanguve GP said: "Yes, most doctors are involved in this scam. Some people will even threaten you if you can't help them while Dr So-and-so has always helped them."

He said he had proof and details of the doctors who were involved in the scam - but regarded the matter as very sensitive.

The investigation revealed that most of the doctors involved in the racket had qualified in the past five years. Many of them had large study loans they had to repay.

A receptionist at one of the surgeries said she was being paid R25 for every new person recruited to the card-for-cash scheme.

All kinds of people took advantage of the scheme - policemen, nurses, teachers and students from the local technikon and college - to make some extra cash, the receptionist said.

Most people the journalists spoke to in the Mabopane-Soshanguve area were aware of the scam, saying it was very common in Marabastad and other areas.

John Pugsley, the financial director of Representative Association of Medical Schemes, said Rams, in conjunction with Business Against Crime, had established a committee to investigate the scam which was already rife in the KwaZulu-Natal area.

"We believe there is a syndicate involved out there which probably consists of doctors, pharmacists, wholesalers and other people."

Mr Pugsley said the committee would soon approach the Office for Serious Economic Offences for assistance, as the matter was taken very seriously.

South African Medical and Dental Council spokesman Daan Naud said the council was bound by law to investigate any complaints against the conduct of its members.

But the council could only open an inquiry after written complaints from people.

Medical aid abusers bleeding schemes dry

(299)

Star 4/9/96

OWN CORRESPONDENT

Fraud and abuse are major contributors to the rocketing costs of medical aid cover in South Africa.

The newly established Medical Aid Fund Investigators (Mafi) estimates that up to a quarter of the money paid out by medical aid schemes is due to cheating in one or another form.

In 1994 the Representative Association of Medical Aid Schemes (Rams) paid out more than R12-billion, which means a loss of between R2-billion and R3-billion, said a spokesman for Mafi.

Rams' director of finance and administration, John Pugsley, said members of medical schemes who were tempted to misuse their medical scheme benefits must realise they were co-responsible for the theft from other members of their scheme and would also contribute to the increase in member contributions.

He added that medical schemes were non-profit organisations providing health cover to about 6,5-million people. A Rams survey estimated the total benefits for 1994 would reach R13,5-billion.

Rams supported the appeal by the Medical Association of South Africa to report fraud and abuse to the police, as well as to Rams for co-ordination via its special committee operating in conjunction with Business Against Crime, said Pugsley.

Mafi lists four categories of abusers/defrauders: members, service providers (doctors, hospitals, dentists, pharmacies, etc), syndicates and – of major concern and perhaps the most dangerous – various service providers working together.

The spokesman said medical aid schemes had been dealing with fraud for some time. However, there was no communication between the schemes, and dishonest members just moved on to another one.

He said it was only recently that schemes started to look at the total picture and began working together in an attempt to eliminate the problem.

Mafi, established just over a year ago, became a company only recently and has been involved in more than 100 investigations countrywide. About R500 000 in voluntary payments has been recouped so far.

The spokesman said a distinction was drawn between fraud and the misuse or abuse of medical schemes: abuse, for example, was when members over-utilised schemes.

Some of the investigations Mafi has been involved in include script manipulation, people renting or selling their medical aid cards, patients getting the same medication from various doctors, and addicts abusing their schemes.

As for syndicates, there are various ways to get medicines which have passed their expiry dates and stolen medicines on to shelves. But how easy is it to trace fraud and misuse? With modern technology it was not difficult, said the Mafi spokesman.

Mafi is strongly in favour of managed health care, better control and co-operation between the schemes. The company also feels much more could be done in terms of educating members about their schemes.

Anyone with information concerning abuse or fraud can phone Mafi at 663-6552, fax 663-6501, or write to Box 10560, Hennopsmeer 0046. Informants may remain anonymous.

Managed care systems will limit costs

(299) BD 5/7/96

Adrienne Gillomee

THE SA medical aid industry is set for a major revamp with the introduction of managed care systems into some of the country's medical aid funds.

Exorbitant contributions by members has forced the industry to start developing a model to overcome this, while measuring and delivering health care to clients without jeopardising standards.

"Neither the employee nor the employer can afford contributions to medical schemes any longer, as the annual increase in contributions is almost double the inflation rate.

"If the situation continues, the SA medical aid industry will be destroyed," says Sanlam Health medical director Herc Hoffman.

He estimates that of about 4-million principle members in SA, more than 70% will be subscribing to managed care in the next five years.

He believes there are between 10- and 12-million people who are not insured through medical aid because they cannot afford the monthly contributions.

"The advent of managed care will give lower income earners the chance to belong to a medical aid they can afford."

Anecdotal evidence from the US suggests members saved up to 30% on medical aid contributions during the first three to four years of managed care being introduced.

Managed health care is a "gatekeeper" model, which tries to prevent both over- and underservice in the industry — doctors overservicing patients, patients exploiting their medical aid and using their medical aid as a no-limit slush fund.

The Medical Aid Fund Investigators estimate that up to a quarter of the money paid out in 1994 by medical aid schemes was due to cheating.

The aim is to cut costs to both the medical aid scheme and members without compromising on quality, says Hoffman. Through lower costs, the scheme also hopes to widen the net to make medical aid accessible to more people.

The managed health care scheme will establish a service network of doctors, hospitals and other paramedical officers which clients can go to. Doctors will be selected on a range of criteria, including their qualifications, whether they have medical liability insurance and previous track records.

"The purpose of managed care is not to cut corners," says Momentum Health MD Adrian Gore. "Most schemes impose a series of limitations on spending, such as restricting the number of visits to a doctor or putting a cap on rand values of claims. Managed care aims to give clients quality service through more effective control over spending."

Poor track record

There are, however, various obstacles facing managed care. South Africans have a poor track record in medical aid schemes.

Members believe they should use their medical aid to the fullest, and the figures support this sentiment.

Existing members account for some of the world's highest medical bills. In SA, for every 1 000 principal members insured by medical aid, between 800 and 1 000 beds are being used a year, at an average cost of R1 200 a bed a day.

"The worldwide norm is between 200 and 240 bed days a year," says Hoffman.

The number of hospitalisations per 1 000 principal members a month is 84 in SA, compared to 17 in the US. Medicine expenditure forms more than 30% of the total budget of medical aid schemes in SA compared to between 10% and 12% elsewhere.

But Hoffman says this is also due to high medicine prices and not just abuse by members. Sanlam Health has started a management programme and negotiations with medicine suppliers to combat the high costs.

However, it is clear that much of the success of managed care rests with the client.

"One needs to persuade clients to use their schemes cost effectively, which will eventually lead to lower premiums," says Gore.

Another snag is that managed health care organisations will have to set up provider networks in conjunction with doctors and hospitals who have to agree to adhere to the scheme's standards.

Some doctors have been less than enthusiastic about managed care. Many fear they will lose their independence and be tied to rules laid down by the managed schemes.

They are also concerned that patients would not be able to visit the doctor of their choice. There is also the problematic issue of clinical information — regarded as confidential — which managed care schemes will need from doctors that are part of the provider network.

"Doctors believe their autonomy will be suppressed. Doctors must accept that they have to be accountable for cost incurred, otherwise the sustainability of the private health care system will be jeopardised," says Hoffman.

There are benefits for doctors who choose to be part of the service network. They will be paid within 30 days of a consultation and be paid more than the scale of benefits to compensate for the greater administrative burden on them.

Medical aid schemes are optimistic about the prospects.

Gore believes the group will have a managed care network in the market during the next year and a half.

Hoffman says Sanlam Health will phase in a gradual managed health care programme from the beginning of next month. The full programme is expected to be in place by early next year.

Last hope for struggling medical aid industry

(299) ARG 6/9/96

THE trend towards managed health care in medical schemes holds both good and bad aspects for the member, but overall, managed health care could be the last hope for an embattled industry.

For many years, medical aid funds have warred against escalating costs which have been rising from an inherent weakness in the system: an incentive for members and service providers to spend more, rather than less.

The term managed refers to the medical aid scheme's involvement (as financier) in the traditional relationship between service provider (doctor, hospital etc) and patient (the fund member).

It encompasses a broad range of cost containment measures

For instance: capitation payments, where a doctor is paid a set monthly fee for each patient irrespective of the number of consultations; and second surgical opinions and pre-admission certificates issued by the fund before a member can be admitted to hospital.

It also extends to funds negotiating buying contracts with medical suppliers so as to harness bulk discounts, for example on prescribed medicines and ophthalmic supplies.

The use of generic medicines in preference to their traditional counterparts is another example.

Today, managed health care in South Africa is on the brink of spreading its wings with the advent of managed health care plans. This is when the service provider (including the hospital) is brought into the circle with the member and the medical aid fund.

One example of this is a health maintenance organisation (HMO), where the HMO owns the hospital and employs doctors to provide care to the fund members.

The big advantage of managed health care is that it can stop the escalating costs of medical funds, which means lower increases in member's contributions.

The main negatives are firstly, the member may lose freedom of choice when it comes to deciding on a doctor, specialist or clinic and, secondly, the possibility of under-service in medical care.

The horror of a managed health care bureaucracy making decisions on behalf of the patient and doctor is illustrated by a story told by Momentum Health managing director Adrian Gore.

Prior to international travel, the US Secretary of State, Les Aspin, required vaccinations. In order to save $1,55 (R6,66) a slightly inferior vaccination was administered, which resulted in him being hospitalised in an intensive care ward.

New technology bitter pill for medical aid cheats

(299)

CT 24/7/96

ANEEZ SALIE
HEALTH WRITER

TECHNOLOGY has finally caught up with medical aid cheats, to the benefit of pharmacies, who are set to make big savings.

No longer will anyone be allowed to present a prescription or make purchases purely on the strength of medical aid cards.

Increasingly, fraudulent use is being made of expired or inoperative cards and unauthorised users or beneficiaries have also been exploiting legitimate cards.

In isolated cases, some pharmacists have also reportedly colluded with legitimate card-holders, who are given cash for goods supposedly bought, only to have the same items resold. The pharmacist would then claim from medical aid.

Another practice is for card-holders to make purchases, knowing they have reached a ceiling on the amount they can claim and that the purchases will not be honoured.

Now chemists are to be linked nationally by computer to MediKredit, the medicine claims processing organisation that consolidates pharmacy claims throughout SA on behalf of 554 medical schemes.

Annually, more than eight million claims are processed, with a value of R1,25 billion. More than 18 million prescription items are checked.

MediKredit's HealthNet system now links pharmacy terminals with its head office computer — via central processing offices in main centres — says spokesman Mr Doug Gordon.

He says MediKredit's latest HealthNet technology has been developed to give the pharmacy terminal immediate limited access to the relevant medical scheme computer, to check if the client should be accepted for medical scheme credit or rejected.

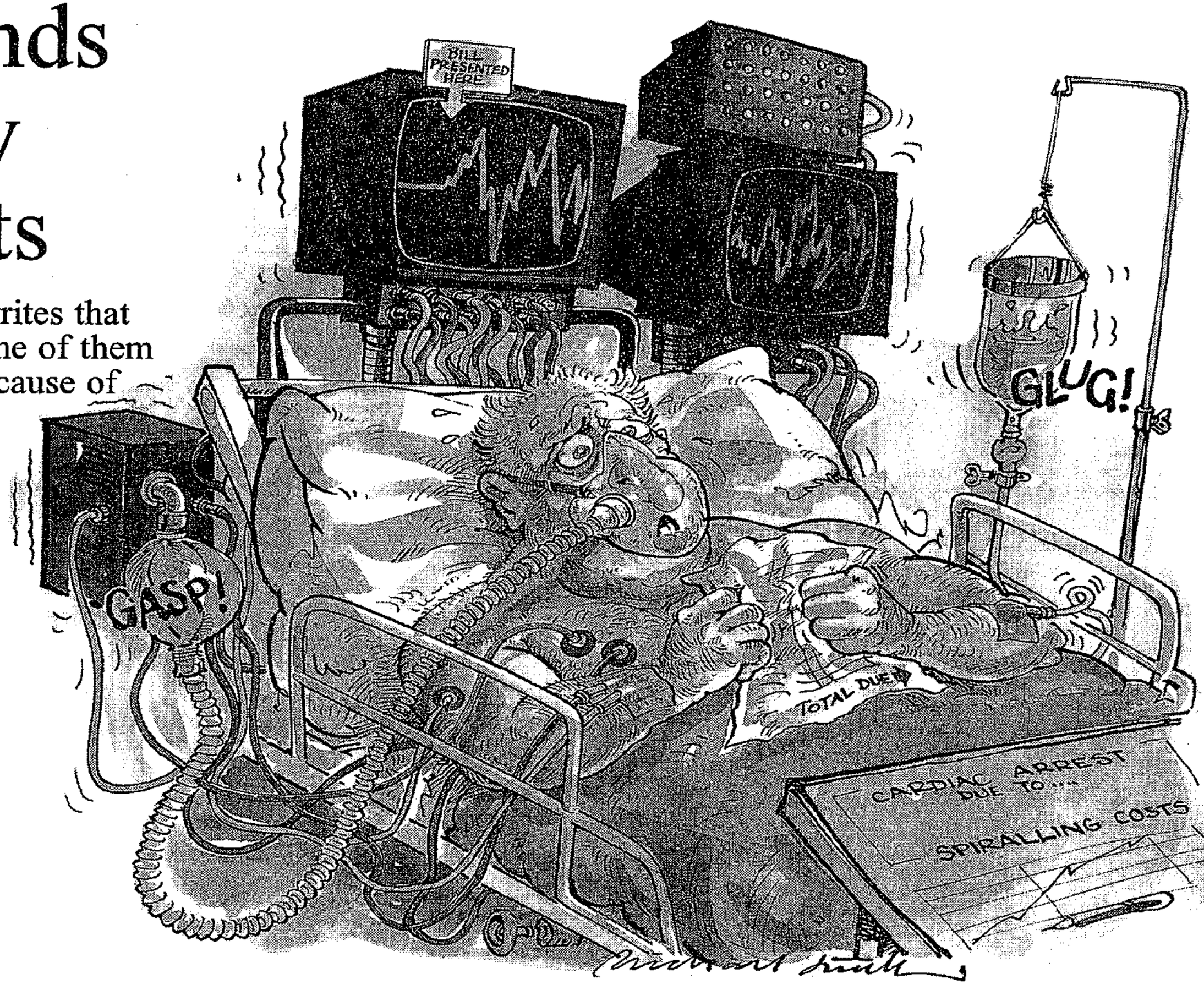
This should reduce payment rejections, improving pharmacies' cash flow and profitability.

Medical aid funds threatened by spiralling costs

(299)

ST(DT) 15/9/96

LEIGH ROBERTS writes that escalating claims, some of them fraudulent, are a key cause of the industry's woes



THERE is a whole lot going on in the medical aid industry: a looming hike in the monthly contributions of fund members, soaring medical costs, and most troubling of all, a few funds which are in troubled waters.

Medical aid fund members have become resigned to paying higher and higher contributions — for seemingly fewer benefits — as premiums have risen by 5% to 10% above inflation each year.

And, despite some positive industry developments, next year looks no different as the industry battles to win the war against spiralling claims, which cause premiums to rise.

Independent credit rating agency Republic Ratings has assessed the financial security of most of the open medical aid funds in the market. ("Open" refers to their public membership, as opposed to a private fund which limits membership to employees of that company, for instance Eskom.) Republic's investigations reveal some worrying industry trends.

The most troubling trend, says managing director Dave King, is that the industry does not seem to have made any real headway in controlling claims costs.

Two years ago, after deregulation, most funds brought in some cost containment measures (ranging from pre-authorisation for hospitalisation to managed health care). The measures were designed to halt wide-scale "abuse" of the medical aid system — from the over-treatment of patients, to duplicated claims, to outright fraud.

But while the measures successfully cut claims costs in the first year, there was a sharp rise in the claims pattern in 1995 (hence the need for higher contributions in the current year).

It seems some service providers and members have "found their way around" the cost containment measures and still abuse the system, says King. It is estimated that up to 30 cents of every rand of claims are due to abuse and system inefficiencies.

So what is the answer to the cost spiral? Effective managed health care and more stringent cost containment, replies King. "All service provider industries should be closely scrutinised to find out why the unacceptably high rate of medical inflation continues unabated. While there may be some valid reasons for this (the depreciation of the rand is one), during our investigations we came across far too many cases of 'over-servicing' by certain service providers."

But providers are not the only ones to blame. There is still much abuse by members, and the administrators who run the funds need to ensure that appropriate systems are installed to reduce such abuse, says King.

In recent years, open medical funds have been under the spotlight because of their generally low financial solvency ratios. But the good news for most fund members is that the financial standing of their funds is improving, although slowly.

The table on this page lists the open funds which have been rated by Republic Ratings, or are still in the process of being rated, based on their 1995 figures. The funds make up the majority of the open-fund market (86% of total premiums received). All the rated funds in the table have been awarded a secure listing, which means that the chance of the fund not being able to pay its members' claims is fairly slim.

But there are a further 18 open schemes which have not agreed to a rating. "Based on publicly available information, some of these funds show highly satisfactory positions (for example, Witbank Coalfields, Mumed, Good Hope, Profmed, Beland, and CAMAF all reflect solvency ratios which are well above the industry norm).

But it's interesting to note that the consolidated position of the 10 other funds in the open market indicate a far from satisfactory condition — the overall solvency ratio is only 7,8% as opposed to the recommended minimum of 25%," says King.

Four of these schemes, notes King, warrant particular mention. Prosano Medical Scheme's solvency margin is down to 7,1% after two years of losses. The extent of the underwriting losses (R31 million in 1994 and R62 million in 1995) incurred over such a short time span is worrying.

Stability Medical Aid's total reserves are less than R2,5-million and the solvency margin is only 1,6%. The fund showed an overdraft of R8,6-million at the year-end in 1995, as opposed to cash deposits of only R4,6-million.

Both Hosmed and East Coast Medical Schemes reflect negative net asset positions, based on 1994 figures.

If a fund collapses, members will be faced with non-payment of medical bills. Members of one of the "new generation" funds (which include a savings element) will also lose their accumulated savings if the fund goes belly-up.

HOW SOUND IS YOUR MEDICAL AID?

Funds with a secure rating

Sanmed	AA
Medihelp	AA
Bankmed	AA-
Bonitas	A+
Capemed	A+
Meddent	A+
Tafelberg	A+
NMP	A
Meds	A
MSP	A
Natalmed	A
Munimed	A
Bestmed	A
SAKAV	A
Northerns	A
Southern Health	A-
NBC	A-
Medshield	A-
Visimed	A-
NIMAS	A-
CIMAS	A-
Sizwe	A-
Premier	BBB+
Finmed	BBB
CEMAS	BBB

FUNDS STILL BEING RATED
Fedhealth, Lifemed, Medlife, Sanitas

KEY
AA is the best rating but any rating of BBB and above means the fund is secure

Graphic: FIONA KRISCH Source: REPUBLIC RATINGS

Medical aid reimbursement rates to go up

(299) Star 16/9/96

Medical aid reimbursement rates for doctors and private hospitals will increase by an average of 8% from January 1 next year.

Declan Brennan, executive director of the Representative Association of Medical Schemes (Rams), said in a statement yesterday: "The increases were arrived at after discussion with major role-players. While the professions requested very high increases, Rams felt it could not ask individual medical scheme members to shoulder abnormally high increases.

"There was no reason," he added, "why health professionals should get higher increases than the average man in the street. This was particularly so in the light of the consumer price index and salary and wage increases in the region of 7 to 8%."

Brennan said that while doctors' consultation benefits would increase by 25%, there would be no increase for medical procedures or after-hours fees.

"In this way we encourage quality consultations and eliminate unnecessary procedures, while keeping the increase average down to 8%. More importantly, we expand health care, which is consistent with the objectives of the National Health Plan," added Brennan.

A restructured scale of benefits for dental treatments took effect on June 1 and Rams felt it was still too early to judge the economic impact. Claims are to be monitored monthly.

Discussions are continuing on the reintroduction of fixed fees for day clinics, and the current 1996 scale will remain in place until the situation is resolved.

On supplementary health professions, such as physiotherapy, Brennan said no increase would exceed 8%.

He said the association was sympathetic to the financial pressures faced by providers of health care, but the solution lay with patients and providers managing their health care more efficiently. – Sapa.

NEW FUNDING OPTIONS FOR FRAGILE MEDICAL AID INDUSTRY

LAYING OFF PART OF THE RISK

(299) FM 27/9/96

If promulgated, the Insurance Amendment Bill, tabled in parliament last week, will pave the way for radical changes in the way SA's R5,6bn medical aid industry funds itself.

It may restore health to ailing schemes; it has far-reaching implications for the life industry, for companies with in-house schemes to administer and for multi-employer schemes; and it might disadvantage some private-sector retirees who now benefit from cross-subsidisation in medical aid cover.

In terms of existing legislation, the management of medical aid funds has been seriously restricted. They have been allowed to buy unit trusts which fall outside the scope of the Insurance Act. But these are not generally profitable investments in under five years. Or they could buy a sinking fund policy from an insurer. But this is basically a savings policy taken out for at least five years.

The proposed relaxation will allow medical schemes access to insurance products which don't require a five-year lock-in period. Old Mutual's Gary Scott says this could put them on the same footing as retirement funds.

An amendment has already been made to the Medical Schemes Act — to allow medical schemes to make use of insurance or reinsurance to spread risk.

Investment products typically offered by insurance companies are "pooled vehicles," which provide the economies of scale smaller medical aid funds cannot realise on their own. It's difficult for them to build substantial reserves over and above those required for solvency.

Medscheme's Gary Taylor says about 95% of contributions received is paid out to members as benefits and 5% is kept as administration fees.

The change could undermine the position of members who are poor health risks. The basic philosophy of medical aid, says Anglo American medical scheme chairman Peter Eustace, is that the rich subsidise the poor, the healthy subsidise the sick and the young subsidise the old. And, if strict underwriting principles are applied, funds will take on only the young and healthy.

Medical schemes could opt to pre-fund for all members rather than buy cover for the good risks. But that implies higher contributions from all or lower benefits — or both.

Anglo's Eustace argues that the ageing members of a scheme must not be suddenly burdened with a doubling of their medical aid contributions.

Sanlam actuary Rod Leerkamp is sceptical about the practicality of pre-funding. Companies often change medical schemes and it will be difficult to transfer reserves, he says.

In any event, this option is some way down the line. Southern Life's Rod Stevenson points out: "The regulatory provisions relating to pre-funding, for post-retirement medical benefits, must still be addressed. It has not yet been decided whether the registrar of medical schemes or the Financial Services Board would be the most appropriate regulator."

In the short term, the flow of money into "fund policies" will probably be small. Many medical schemes will be committed to more traditional investment options.

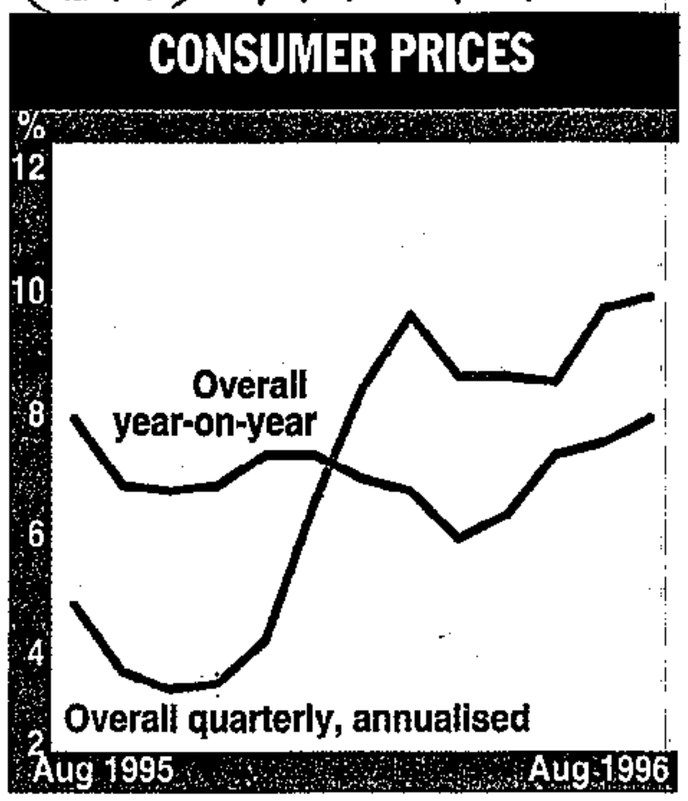
There will be tax implications for medical schemes. The tax regime applied to traditional schemes business is not necessarily appropriate to the pre-funded business. The Katz Commission is investigating the taxation of benefit funds in general, which could include medical benefit funds and schemes.

The Insurance Amendment Bill has been endorsed by the Standing Committee on Finance and referred to the Assembly and Senate. *Stephen Hill-Haas*

INFLATION FIGURES

ROCK-STEADY STATISTICS

At a time when official figures are coming under close scrutiny, some economists are suspicious of the relatively small impact of the rand's 20% depreciation on the consumer price index.



At 7,5%, the August figure is only 2% above the April inflation trough. But this is year-on-year. On a quarterly basis, the figures tell a different story (see graph).

Average inflation over the three months to end-August was 9,1% higher than the average in the previous three months. The effect is more pronounced if certain components are stripped out. The unprocessed food category is notorious for price fluctuations. On the other hand, the mortgage interest component of housing varies only when banks alter their lending rates. Eliminating both gives a figure for core inflation.

In this case, too, the year-on-year figure is lower than the quarterly one — 8,6% compared with 10,2%.

But irrespective of how it's read, the CPI is "rock steady," says Central Statistical Service head Mark Orkin. He explains the process.

Each month, 6 000 questionnaires are sent out, in 60 formats, asking for prices for 600 different products. Respondents are required by law to provide figures.

Numbers which fall outside a specific range, or which show suspiciously little change over time, are queried. And an elaborate methodology is followed to assemble and assess the information.

The service is looking at ways to improve the CPI series. "We're thinking of

Hospitals slam medical schemes' tardiness

By Janine Simon
Medical Correspondent

Private hospitals have thrown their weight behind retail pharmacies fighting slow payments by medical aids, and say their debtors' book would shrink by R400-million if the industry paid within 30 days.

The Hospital Association of South Africa (Hasa), representing 152 institutions and 19 700 beds, this week criticised the medical aid industry's inefficiencies and delaying tactics in paying accounts.

Private hospitals were increasingly unable to continue to treat medical-aid patients on the terms and conditions prescribed by the medical-aid industry through the Representative Association of Medical Aid Schemes, said Hasa executive director Dr Annette van der Merwe.

This follows the accusation by the Aggrieved Pharmacists Association (APA) that the medical aid industry is withholding billions in payments. The pharmacists say they will consider contracting out of the medical aid system unless the industry agrees, by month end, to play fair.

Dick Williamson, Hasa board member and CEO of Afrox Health Care, said contracting out was not viable for hospitals as members could not cover hospital bills: "Employer groups should insist that scheme administrators guarantee payment within 30 days, or face penalties."

Van der Merwe said Hasa backed APA claims that medical schemes and their administrators delayed payments. They had an incentive to do this for as long as possible, thereby getting interest on "considerable amounts of money".

~~288~~ (299) Star 11/10/96

CONTROVERSIES IN THE MEDICAL AID INDUSTRY

SOMEONE MUST PAY THE PIPER

(299) FM 11/10/96

A low level war is being waged between the regulators of the medical aid industry on the one hand and commercial medical aid societies, intermediaries selling insurance-type products and insurers offering the products on the other.

And there are differences between the latter.

Controversy was triggered by an amendment to the Medical Schemes Act, which partially deregulated the industry in January 1994.

This allowed medical schemes to operate on an "excess" basis and opened the way for innovation.

At that point, only a nominal administration fee was paid to the few intermediaries active in this field.

Their main source of income was commissions paid by insurance companies when they added the hospital top-up component to "traditional" medical schemes.

But deregulation made it possible to pay commissions, under the Insurance Act, to intermediaries selling products with an insurance component.

Samantha Knowles

This attracted more than 10 000 intermediaries to the market — "many of whom do not have the knowhow and experience to competently present alternative schemes to companies reviewing their health-care arrangement," says Information Logic MD Samantha Knowles.

"Nor do they have infrastructure and after-sales service capabilities."

While some medical aid schemes blame the intermediaries, Representative Association of Medical Schemes Declan Brennan says the basis of medical schemes as providers of cover — from cradle to grave — is being undermined by insurance companies "cherry-picking the good risks out of the system. Because they are good risk, cover can be offered at a lower average cost." Traditional schemes will suffer membership losses, coupled with inflation.

As a result, the members remaining will be placed at risk on unprofitable schemes.

They will mainly be older people, says medical schemes broker Knowles, as "new generation" schemes have particularly strict criteria for age profiles at point of entry.

Brennan points out that medical insurance can be terminated at any time. This is in sharp contrast to a medical aid scheme, which cannot terminate membership if members' contributions to a scheme happen to fall below benefits paid on their behalf by the scheme.

It's the alleged failure of the Registrar to react to these problems that has provoked the various players in the industry.

What is needed, Knowles says, is an amendment to the Medical Schemes Act to allow medical aid administrators to pay a reasonable commission.

She says it also requires agreement between administrators, the Registrar and other bodies to conform to a reasonable level of remuneration for intermediaries, which will result in specialists providing a broader service to the public and corporate market.

The average administration fee now ranges between 2%-5% of contributions paid.

Knowles says that certain schemes pay brokers up to R3 000 per member in commission for the introduction of a new group.

Aubrey Sonnenberg, of the Association of Health Benefits, says fees paid to an intermediary are small in comparison with fees paid to the administrator.

Sonnenberg believes that, over time, the differential in remuneration — between old and new generation products — "will be reduced by market forces. And a uniform commission rate will eliminate the incentive to switch business and resolve some of the perceived problems.

"Furthermore, uncompetitive medical schemes pose a threat to the sustainability of benefits for existing members — particularly pensioner members." *Stephen Hill-Haas*

NOBEL PRIZE FOR ECONOMICS

NOBEL ENDEAVOURS

The Bank of Sweden Prize in Economic Sciences, in Memory of Alfred Nobel was awarded on Tuesday to James Mirlees of Cambridge, and William Vickrey, Professor Emeritus at Columbia University.

The 60-year-old Scot and the 82-year-old Canadian won US$1,12m — more than R5m — for work on the theory of incentives under asymmetric information.

Much of Vickrey's research centres on how auctions can best be designed to generate economic efficiency, assuming auctioneers have incomplete information about buyers' willingness to pay. This has policy implications for financial market efficiency, for example where countries hold forex auctions. In such situations informational advantage can be exploited strategically.

Mirlees, who was tax adviser to Columbia, contributed to solving problems associated with optimal income taxes, based on government's incomplete knowledge about the productivity of individuals.

They join other noted economists like Milton Friedman who won in 1976, and Ronald Coase, the 1991 laureate. ■

Scheme to beat cost of medical aid funding

BD 11/10/96 (299)

Adrienne Gilliomee

THE cost of post-retirement medical aid is growing at such a pace that current members could end up spending as much as two thirds of their pension income on medical costs. And it is getting worse.

From companies' point of view, medical aid liabilities are threatening to outstrip corporate earnings if the trend continues.

Employees are faced with the prospect of unaffordable contributions after retirement, forcing them to reduce benefits or leave the scheme.

Research conducted by Momentum Health shows that as a person ages, his medical scheme contribution as a percentage of income increases greatly.

The outlook is particularly grim for employers: Many commit themselves to helping contribute to the medical aids of retired employees but do not provide for this on a continuing basis. Most believe they will be able to do so out of cash flow.

Research shows that SA companies are putting aside a total of between R12bn and R15bn to account for future liabilities.

A further concern is the increasing cost of medical aid as a percentage of the company payroll. Momentum Health CE Adrian Gore says 4% of payroll costs in the 1980s related to medical aid contributions. The figure is currently closer to 10%, which he terms "an unsustainable rate of growth".

Momentum Health last week launched a new medical insurance product to help plan for post-retirement medical costs.

Funds are held within a provident fund, separate from the medical scheme. The employer contributions are therefore tax deductible.

Medi-Clinic slates medical aids

Stand on tariffs 'irresponsible' – but profits rise

(299) AR G 18/11/96

ALIDE DASNOIS
BUSINESS EDITOR

Hospital group Medi-Clinic produced profits of nearly R50-million for shareholders in the six months to September in spite of what chairman Edwin Hertzog calls the "irresponsible" approach of the medical schemes association to private hospital tariffs.

Attributable profits of R49,8-million, earned on turnover of R469-million, are 58 percent up on levels a year ago.

But Mr Hertzog cautions against comparisons because this year's figures are swollen by the R220-million Hydromed group acquisition in March, which increased Medi-Clinic's beds by 700 to nearly 3 800. He says profits were compressed by an increase in nurses' salaries in line with the public sector salary rise in July.

Medi-Clinic had to take all the pain of the salary increase, he says, because the Representative Association of Medical Schemes (Rams) refused "for the first time in history" to reimburse private hospitals for the increase.

"The whole approach of Rams to tariffs for private hospitals can only be described as irresponsible, outdated and against the general principles of the market," Mr Hertzog says.

He complains that private hospitals are forced, "through the punitive measures applied by Rams", to charge only the Rams tariff – which increased by five percent last year and 4,5 percent this year.

From January next year, though, the Rams tariff for ward and theatre rates goes up eight percent, which should take the strain off Medi-Clinic's margins, says Mr Hertzog.

Agreements on managed health care with Sanlam Health and Southern Healthcare will begin showing results from next year, he says, while economic growth is making medical insurance available to more people.

As a result and in spite of the weaker rand, which puts pressure on capital investment, Mr Hertzog expects Medi-Clinic "to continue its steady growth pattern".

Capital spending in the six months totalled R37,9-million and Medi-Clinic has approved plans to spend a further R103,6-million. The group is tendering to buy the old Volks Hospital in Oranjezicht and a start has been made on the building of the 50-bed Klein Karoo clinic in Oudtshoorn.

In line with a decision to own the hospitals it runs, Medi-Clinic announced in August a R250-million deal to buy 12 hospitals from Rembrandt and Southern Life.

With the exception of the Milnerton Medi-City and the Louis Leipoldt in Bellville, the group now owns all the hospitals under its administration and the purchase of the Milnerton Medi-City from Southern Life is also on the cards.

Medical fund near collapse

(MG) 13-19/12/96 (299)

Pro Sano, the third-largest medical aid scheme in the country, has run up R90-million losses and now faces serious charges of bribery and corruption.

Marion Edmunds and **Mungo Soggot** report

A TOP medical aid scheme for public servants is on the verge of collapse, racked by financial mismanagement and corruption allegedly involving leading insurance and consulting groups.

Papers filed in the Cape Town Supreme Court this week by the Department of Health claim Pro Sano Medical Aid has been allowed to run up losses of nearly R90-million while its ruling council took bribes from companies eager for its business.

The scheme, the country's third largest, provides medical cover to 70 000 members, most of them teachers, postal and municipal workers and staff at Telkom and Eskom.

The members contribute nearly R44-million a month into the scheme.

But the health department's registrar of medical schemes claims the council has been operating an ambitious kickback network, involving high-profile groups including Metropolitan Life.

Department registrar Daniël Kolver says the Pro Sano council cannot be trusted to save the scheme amid "wholesale and continuing irregularities which are seriously prejudicial to members".

Kolver says the court must move quickly to put the scheme into judicial management, as compromising evidence could disappear.

He says prolonged uncertainty could herald the scheme's collapse, depriving its members of medical cover.

The application is due to be heard in court on Friday, and Kolver is also calling for a commission of inquiry. Kolver sprang into action after presenting on November 15 a forensic report to the Council of Medical Aid Schemes. The chairman of the council is Justice David Melamet.

The papers detail a string of allegations against the Pro Sano council, but Kolver says he does not want to vilify anybody by naming names. The council's current chairman Shuayb Patel, who took office in November, said his predecessor was Bernard Wentzel who resigned last month. In the previous year Lionel Kearns was chairman. The organisation's principal officer until last month was Dr Louis Kathan, whose predecessor was Solly Fourie. The current principal officer is Sidney Stadler.

The papers say that in 1990 the council quietly set up its own company, Bon Sano, which has been used to ferry under-the-table payments to council members.

Bon Sano's illicit funtions included sponsoring council members' overseas travel and paying salaries to several key current and past employees of Pro Sano.

Bon Sano took on Pro-Sano's funeral policy for which it received R1,069-million a year. However, Kolver said: "it is not apparent what services, if any, Bon Sano, is to perform in consideration of which it receives this very substantial income)"

Kolver's list of irregular payments received by Pro Sano's council include:

● R638 631 from consultant Willmore Spies, which company received commission and administration fees from one of Pro Sano's policies, the Admed insurance policy.

The department's papers claim that Wentzel had demanded "commission" from Willmore Spies for the commission that Willmore Spies got from Pro Sano.

Willmore Spies, which received commissions totalling R4,4-million between 1991 and 1995, was subbroker to consultant Alexander Forbes, which earned R4,2-million. Willmore Spies also received unauthorised administraion fees worth R1,4-million, while Alexander Forbes bagged undisclosed administration fees worth R2,3-million.

● R10 000 from Metropolitan Life, which was used to fly two members of the management council to a conference in Boston in the United States this year.

Within months of the payment, Pro Sano struck an in-principle agreement with Metropolitan Life that one of its subsidiaries would take over Pro Sano's administration from Medscheme.

● R6 000 from Quality Health Holdings for part of the expenses of the wives of the chairman and the principal officer to attend the same Boston conference.

● A portion of the cost of university education for the son of the chairman of the management council was paid by Medscheme and Quality Health Holdings.

Kolver questions the relationship between Pro Sano and two Old Mutual employees who set up an investment company, Sterling Investments.

The two employees earned commissions on investments they made for Pro Sano.

Kolver also questions Medscheme's administration and scolds top accountant Ernst & Young for failing to blow the whistle on Pro Sano's doctored accounts for the year to December 1995.

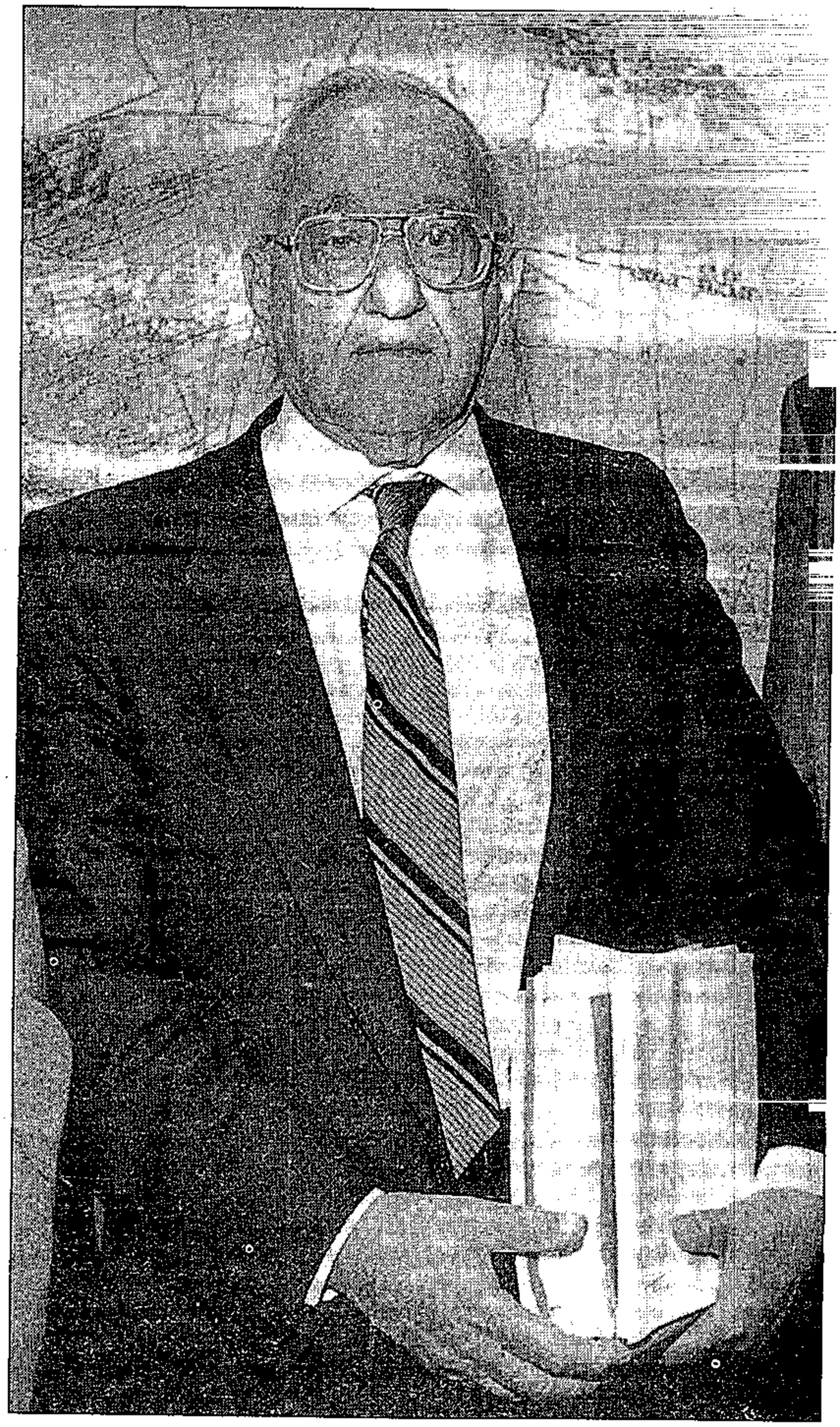
"It is necessary to establish why Ernst & Young issued an unqualified audit report when it had earlier formed the view that the respondent was conducting business in insolvent circumstances and had reported it to the Public Accountants' and Auditors Board."

He said that the auditors' statement that Pro Sano was "trading itself out of a deficit situation was at the very least misplaced optimism."

Patel told the *Mail & Guardian* the council intended to fight the application. He said the registrar had failed to note that there had been major changes in policy this year, adding that the scheme was on track for a surplus in 1996. "There is lots of politics in all this."

Kolver points out that Pro Sano proceded to lose another R22-million from December 1995 until mid year.

The bad news for the members of the scheme is that, like all medical aid policy holders in South Africa, their premiums are expected to increase — possibly as much as 25% in a looming industry shake-up.



Melamet: Chairman of Medical Aid Schemes Council which blew the whistle

Public service medical aid loses R87-million

'Gross mismanagement' alleged

ARG 14/12/96

DENNIS CAVERNELIS
STAFF REPORTER

The Pro Sano Medical Aid Scheme has lost R87-million in the past two and a half years, the Cape Supreme Court heard during an application for the scheme to be placed under judicial management.

The Registrar of Medical Schemes, Daniël Kolver, brought an application for the Pro Sano Medical Aid Scheme to be placed under judicial management in terms of the Medical Schemes Act and the Companies Act. Pro Sano is the third largest medical scheme in South Africa, with 210 000 members and dependants. They are drawn mainly from the public service, including teachers, the Post Office, local government and Telkom.

Mr Kolver said in his affidavit that Pro Sano's "financial position has deteriorated dramatically. Since December 31 1993...the respondent has lost nearly R87-million."

Mr Kolver said that an inspection of Pro Sano revealed "gross mismanagement and maladministration in the conduct of its affairs," including "significant irregular payments" made to Pro Sano's principal officer and the chairman and members of its management council.

He said the payments were made "in an apparent attempt to buy influence with Pro Sano ..: it appears some of these payments may have amounted to bribes".

Mr Kolver said members of the scheme were "at risk of losing the substantial investments they had made ... and being left without any medical aid whatsoever".

Mr Kolver has asked for an order that the vice-chairman of the Council for Medical Schemes, Anthony Leveton, and chartered company secretary Brian Wilson be appointed as Pro Sano's judicial managers.

The case will be heard on January 15 after further papers have been filed.

Mr F D J Brand presided. J J Gauntlett, SC and G W Woodland, instructed by the State Attorney, appeared for the applicant and M A Albertus, SC and H L Schreuder, instructed by Mallinicks, for the respondent.

Cape medical aid scheme accuses registrar of racism

BD 17/12/96 (299)

Reinie Booysen and Linda Ensor

PRO Sano, a Cape-based medical aid scheme catering mainly for black, Indian and coloured public servants, has accused the registrar of medical schemes of racism after the Cape Supreme Court on Friday postponed an application for the scheme to be placed under judicial management.

Judge Fritz Brand postponed the urgent application brought by registrar of medical schemes Daniël Kolver until January 15 to allow Pro Sano — the third-largest medical aid scheme in SA — more time to draw up opposing papers.

Pro Sano chairman Shu'ayb Patel said the registrar's decision to seek provisional judicial management of Pro Sano instead of "informal" judicial management — essentially the appointment of two independent members to the medical aid's ruling council — was motivated by racial prejudice.

Patel said the registrar rejected Pro Sano's proposal that he take into account "membership profile, affirmative action and black economic empowerment" in making his appointment of independent members on the Pro Sano council.

"In his letter to our lawyers he said he could not accept our proposal because. his intention was to secure 'proper business skills and expertise'," Patel said. "His response creates the impression you do not get blacks with proper business skills and expertise."

Patel said Pro Sano's proposed amendment of its constitution, empowering the registrar to appoint two independent members to its council, would not have forced the registrar to appoint black members to the council. "In any case, we were prepared to negotiate on this matter."

In papers presented to the court, the registrar said the scheme was in a precarious financial position, possibly insolvent and that its members were in danger of losing their health benefits.

Kolver also alleged gross mismanagement and maladministration, as well as the fraudulent receipt of commissions by management, who allegedly accepted undue payments and benefits to themselves in breach of their fiduciary duties.

Fears were expressed in court that there would be a "run" on the medical aid scheme because of financial difficulties.

"Experience has shown that such an order (of provisional judicial management) would be very detrimental to the business of a company," the judge said. He did not want to deprive Pro Sano of the opportunity of convincing him that it had recovered financially.

"There is sufficient cashflow to persuade me that there is no immediate danger of creditors not being paid or members being prejudiced," Brand concluded.

However, he also said that with R22m having been lost over six months, Pro Sano was running out of reserves "at an alarming rate". Its accumulated funds of R32,8m at end-December last year had plummeted to R10m by June 30.

Pro Sano has about 73 000 members, drawn mainly from parastatals such as Telkom, Eskom and the Post Office, as well as local governments.

Jeremy Gauntlett, who represented Kolver, argued that unless an order was granted against Pro Sano, hospitals and clinics would tell the scheme's members they would not accept them.

Rejecting claims by Pro Sano management that it was solvent, Gauntlett said auditors Ernst & Young had qualified their audit in June saying the scheme was in dire straits.

Pro Sano counsel Mohamed Albertus argued, however, that the scheme had R113m on call to pay out the estimated R40m claimed by hospitals, clinics and doctors each month. He said the company had been cleaned up, with inefficiencies and maladministration eliminated and a surplus of R14,6m generated in the year to end-November.

There was consensus among the parties that serious irregularities had occurred which necessitated investigation. In particular, the scheme's administration by Medscheme needed to be probed.

Pro Sano has sought legal advice to claim R80m in damages from Medscheme for allegedly breaching its obligations under an administration agreement.

Shu'ayb Patel: 'Several of the allegations against Pro Sano are untrue'

PHOTOGRAPH: RODGER BOSCH

State to crack down on medical aid scams

M+G 20-23/12/96 (299)

Following revelations of irregularities at a Cape medical aid company, the Department of Health plans to fight corruption in the industry, writes Marion Edmunds

THE Department of Health is planning a crackdown on corruption in the billion-rand medical insurance industry, introducing strict new laws and policing as a priority next year.

Sources say last week's shock disclosures in the *Mail & Guardian* of corruption and financial irregularities at the huge Cape-based medical aid company Pro Sano are only the tip of the iceberg, with other companies involved in more serious offences, yet to be exposed.

But the disclosures about Pro Sano's financial irregularities and its loss of millions of rands has strengthened the department's hand in its plans to bring the industry to heel.

Sources say the department has deliberately kept its plans low-key, so as not to jolt the industry's powerful players.

However, the department was to host an open workshop on Friday to discuss the proposals and the question of Pro Sano.

One of the experts addressing the workshop, Alex van der Heever from the influential Centre for Health Policy, said the Pro Sano case demonstrated the need for a review of current legislation and a rethink on the role of medical aid schemes.

"Given that Pro Sano is the one medical scheme that did not get away, its case demonstrates the need to have regulations to prevent things reaching the stage they did," he said.

"I think it is the government's responsibility to protect consumer rights and the intermediary has not been acting in the interests of the consumer," he said.

Van der Heever is also a member of the Council for Medical Schemes. He said the government lacked the capacity and legislation to deal with the industry that was driven more by profit than a desire to protect members.

"The industry is fragmenting and corruption here could be seen as symptomatic of the fragmentation because people can shift fragments around to their own benefit," Van der Heever said.

"We can either define the relevant legislation more strictly to ensure uniform transparency, or we can deregulate and let people sort themselves out and say 'Buyer, beware', but we don't really think that that is fair for the consumer. The government has a responsibility to protect the consumer."

The department was coy about the workshop earlier this week, saying it was just a public relations exercise. The department also did not wish to comment on Pro Sano, saying it was *sub judice*.

Last Friday, the Supreme Court granted Pro Sano a stay of execution after the department's registrar of medical aid schemes applied to have the fund put into judicial management.

In papers before the court, registrar Daniël Kolver detailed a string of allegations about corruption among former Pro Sano management involving several top companies. The scheme, which provides medical benefits to thousands of public servants, has lost close to R90-million.

Pro Sano chairman Shu'ayb Patel said several of the allegations were untrue, and that he was considering suing Kolver.

Kolver was on leave and could not comment on his allegations, made under oath, and based on a forensic audit.

Shu'ayb Patel: 'Several of the allegations against Pro Sano are untrue' PHOTOGRAPH: RODGER BOSCH

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Kolver was on leave and could not comment on his allegations, made under oath, and based on a forensic audit.

Medical aid, insurance firms set for big shake-up

(299) ST 8/12/96

By PAT SIDLEY

THE multibillion-rand medical aid and health insurance industries face a massive shake-up if proposals by the Health Department aimed at regulating the funding of the private health care sector are implemented.

Their purpose is to ensure that fewer employed people use the public health system, which is straining under the weight of free primary health care and free care for children under six, their mothers and pregnant women.

But the plan has enraged the insurance industry, which has vowed to fight back during consultations planned by the department.

In terms of the proposals, insurance companies offering health care packages may find their products heavily restricted or forced out of the market if they continue to exclude elderly and sickly people from membership.

But medical aids have welcomed the plan, which will allow them to register with a beefed-up Registrar of Medical Schemes if they offer a similar basic package to all prospective members and cover health funding needs from the cradle to the grave.

They will also continue to receive a tax exemption on contributions to the scheme, while their members will be protected from the collapse of a fund which has many sick and elderly members by a "risk-equalisation" fund.

Insurance companies keep their risks to a minimum by insuring only younger and healthy people, which means consumers generally pay less for their schemes.

However, these consumers are forced to put money aside to ensure adequate health cover in their old age. It is this "pre-funding" which the department opposes.

In a separate attempt to keep employed people out of the public health system, the department is drawing up plans for a social health insurance system — a basic health care package which all low-income employees will be obliged to buy.

Both plans are in line with departmental policies set out in the report of the commission of inquiry into a national health system, which was chaired by Health Department director general, Dr Olive Shisana, and health care specialist, Dr Johnny Broomberg.

An earlier draft of the plan to regulate the funding of the private health care industry suggested that two types of medical scheme be allowed. One would allow companies to offer plans which excluded the sick and elderly, but would attract tax on the contributions. The other would cover all prospective members throughout their lives, and be exempt from tax.

But insurance companies argued that younger, more healthy people would leave the more expensive medical aids and opt for the cheaper insurance product, or no cover at all.

Instead of accommodating the insurance companies' suggestions, the committee concerned decided one type of scheme should be allowed to register with the Registrar of Medical Schemes — the "community-rated" schemes or traditional medical aids, which extend cover to all types of members from the cradle to the grave.

Adrian Gore, Momentum Health's chief executive officer, said the plan would prejudice consumers and be "disastrous" for the country. Younger and healthier people would still leave medical aids and opt for no cover at all, leaving medical aids in a "death spiral", with a steadily increasing load of older, sicker members.

The Life Offices Association, which represents the life assurance industry, will discuss the plan with the department this week.

Judge orders investigation of Pro Sano

(299)

Linda Ensor

CAPE TOWN — A full-scale investigation of the Pro Sano Medical Aid Scheme, the third-largest scheme in SA, was ordered last night by a Cape Town Supreme Court judge to determine its financial soundness.

Accounting firm Deloitte & Touche, assisted by an independent consulting actuary, will be appointed to undertake the investigation in terms of the Medical Schemes Act and to submit a report by December 31 this year.

Pro Sano has 73 000 registered members, most of them public servants and Telkom and Eskom employees, who with their dependants number about 210 000.

Judge Fritz Brand's order came after a day of intense negotiations between the scheme's executives and registrar of medical schemes Daniël Kolver, who applied last month to have Pro Sano placed under provisional judicial management.

Kolver argued that the scheme was in a precarious financial position and possibly insolvent, having lost R87m or 89% of its accumulated funds in just more than two-and-a-half years.

There was a danger, he said, that members could lose their health care benefits.

In his affidavit, Kolver accused the scheme of gross mismanagement and maladministration, and alleged that bribes and improper commissions had been received.

However, Pro Sano chairman Shu'ayb Patel denied the submissions, saying the scheme was financially sound.

Patel said that the scheme was projected to have accumulated funds of R53m by end-December last year.

Although these claims were disputed by Kolver, he agreed to withdraw his application yesterday on condition that an investigation took place.

In terms of the order, Deloitte & Touche will have extensive powers of investigation, including access to all Pro Sano's securities, books, records, accounts and documents.

If Deloitte considers it necessary to submit reports on aspects of the investigation before end-December, it may do so.

If, on the basis of the report, the registrar still wishes to apply for judicial management at the end of the year, he can do so.

Pro Sano, which was ordered to pay the costs of the investigation and the registrar's court application, undertook to call on its auditors, Ernst & Young, and its administrator, Medscheme Holdings, to co-operate with the investigation.

Kolver brought the application for judicial management on December 13 last year, but Judge Brand postponed the matter until yesterday to allow Pro Sano time to reply.

Medical aid agrees to full probe

CT 17/01/97 (299)

RONALD MORRIS

PRO Sano Medical Aid Scheme yesterday evening in the Supreme Court agreed to a full inquiry into its financial soundness.

This comes weeks after the Registrar of Medical Schemes, Mr Daniel Kolver, applied to the court to have the scheme placed under judicial management on the basis that it had lost R87 million and had been subject to "gross mismanagement and maladministration".

Pro Sano is the third largest medical aid scheme in the country.

Kolver claimed in papers before the court that Pro Sano's financial position had deteriorated dramatically since December 31, 1993.

Investigations had revealed "gross mismanagement and maladministration" including "significant irregular payments to its principal officer and the chairman of its management council", the court was told.

Kolver withdrew the application yesterday and in terms of an order granted by Mr Justice F D J Brand, Pro Sano agreed to the appointment of accounting firm Deloitte and Touche to undertake the investigation.

The firm must deliver a written report to Kolver and Pro Sano by December 31.

Mr J J Gauntlett, SC, and Mr G W Woodland, instructed by the state attorney, appeared for the registrar. Mr L Kuschke, SC, and Mr H L Schreuder, instructed by Mallinicks, appeared for Pro Sano.

Pro Sano considers taking legal action

'We want to put an end to rumours'

(299) ARG 18/1/97

ADELE BALETA
STAFF REPORTER

The council for Pro Sano Medical Aid Scheme – the third largest scheme in South Africa – is to consider taking legal action for alleged defamation against the registrar of medical schemes Daniël Kolver, it has been disclosed.

Recently appointed Pro Sano chairman Shu`ayb Patel said yesterday that "slanderous" statements made by Mr Kolver about Pro Sano's principal officer, Sidney Stadler, and the council in general, were at issue.

The alleged offensive statements were made in court papers last month when Mr Kolver applied to have Pro Sano placed under provisional judicial management.

He alleged that the scheme was on the brink of insolvency after having lost R87-million of its accumulated funds in the past two and a half years.

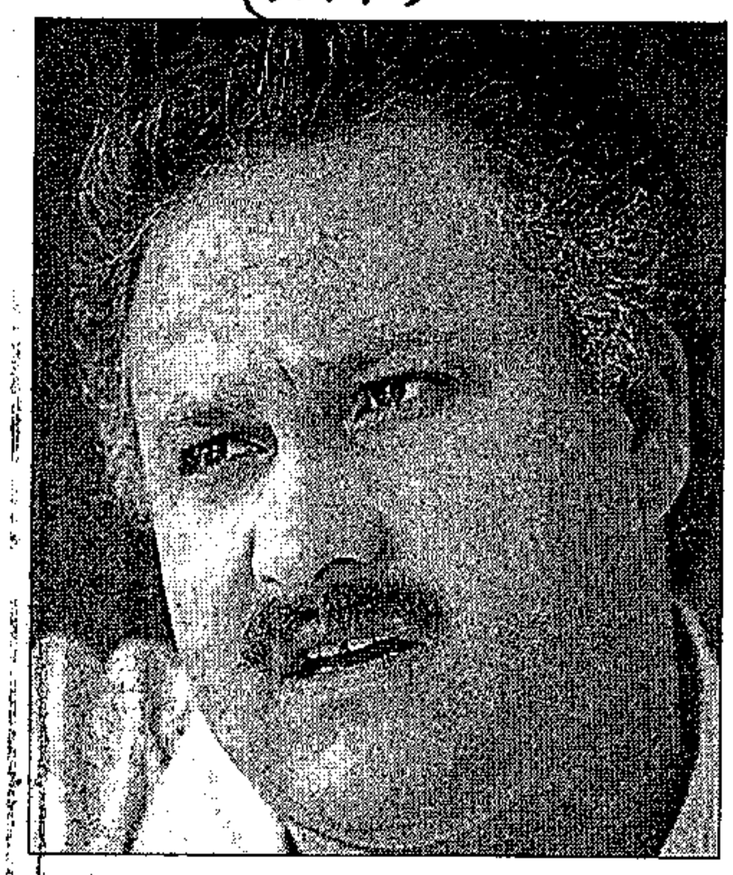
Mr Patel said the council may consider suing Mr Kolver for implying members of the current council were linked to alleged fraudulent actions by council members who had voluntarily resigned.

But in what Mr Patel has hailed a "victory" for Pro Sano, Cape Town Supreme Court judge Fritz Brand on Thursday ordered a full-scale investigation of Pro Sano to determine its financial soundness.

The accounting firm Deloitte & Touche, assisted by an independent consulting actuary, would be appointed to undertake the investigation in terms of the Medical Schemes Act and to submit a report by December 31 this year.

Pro Sano has 71 000 registered members, most of them public servants and Telkom and Eskom employees, who with their dependents number about 210 000.

Mr Patel said in papers that the scheme was projected to have accumulated funds of R53-million by the end of December last year and although Mr Kolver disputed these claims he agreed to withdraw the application yesterday on condition that an investigation took place. The order came after a day of tough talks between the scheme's executives and Mr Kolver.



Fighting back: Pro Sano chairman Shu`ayb Patel

Mr Patel said in an interview yesterday: "I feel great. We were always in the driving seat and we expected things to work out in our favour.

"We said from the start Mr Kolver could not go ahead on judicial management. This could only happen if there was a threat of insolvency or if the scheme was unable to pay its bills. This was never the case."

He said the court order had made things "come full circle as what was ordered was exactly what Pro Sano had suggested in the first place".

"We were always willing to open our books. Our terms of the agreement was in effect converted into the judge's order."

Pro Sano's 1996 books were being audited and the results were due in April, but he said for now it was "business as usual and we will continue to build our scheme".

He said Mr Kolver's application had caused "great harm" to the scheme.

"It was irresponsible action from the very person who is supposed to protect the interests of the public.

"For about a week we had to call all service providers and suppliers to reassure them of our financial soundness and to appeal to them continue to treat our members. We have always been able to pay our bills."

Mr Patel lashed out at Mr Kolver's handling of the matter, saying that he stood by a previous statement reported in the Sunday Argus, where he accused the registrar of taking steps that were unethical, verging on racism and harmful to the scheme.

"Pro Sano was singled out as being insolvent, but Mr Kolver knows that at the end of 1995 at least 21 schemes were in dire trouble. No action was taken against them. This type of behaviour makes us suspicious," Mr Patel said.

Mr Patel confirmed a possible merger between Pro Sano, Bonitas (the black government employee medical scheme) and Sanitas (the Indian government employee scheme). Talks on the matter have been put on the back burner because of the court application, but the schemes would issue a joint statement next month on their plans.

"Financially it would make sense for us to amalgamate. It's a bigger scheme and this lowers the risk pool. It also means we can charge lower subscriptions."

In addition, he said the schemes were created during the apartheid era and membership was based on enforced racism: "We cannot continue the legacy of apartheid by maintaining the status quo".

Talks with the largest medical aid Medihelp (the white government employee scheme) had ground to a halt because "they follow old politics". But Mr Patel said another attempt to sit round the table would be made later.

His message to Pro Sano members was: "Our scheme is managed by a competent and skilled team who want to build it into what our members want.

"We hope that it will become the biggest and best scheme in South Africa. We want to put an end to rumours that have been hounding the scheme."

...ical aid: are w... ...ng a fair shake?

(299)

The theory that contributions from the young and healthy will subsidise the old and infirm until it's their turn to benefit is not working as intended

Star 5/2/97

By David Robbins
Health Writer

More than 6,5 million South Africans are dependent on the medical aid industry for their health care. But what sort of deal are they getting? And should the state, whose primary responsibility is the wellbeing of public health services, become involved in what after all is the heartland of the private sector?

Take the second question first. For a start, medical schemes are supposed to be non-profit making, and in that sense aren't really private sector institutions. Furthermore, international experience shows that judicious regulation of private sector health can considerably ease the demands on public health facilities. While attempts to nationalise entire health systems have generally not succeeded, some form of legislative control of the private sector is essential if that sector is to play a meaningful part in providing health care for all.

Look at it another way. If the medical aid industry was to collapse, or if membership contributions were to become prohibitive, where would the uncovered people turn? To the public sector, of course, placing added strain on the central fiscus.

The private sector is therefore of fundamental concern to the state, whether we're talking about countries in the developed world, or about South Africa. And there's nothing really new in this. The Medical Schemes Act has been on our statute books for decades.

Now let's turn to the first question: what sort of deal are medical aid members getting for their money? The answer must be that the deal is currently fairly unsatisfactory. Medical costs are soaring and contributions have to keep pace; severe limits on specified expenditure have been imposed; pensioners are often finding themselves squeezed at precisely the time when they most need cover; and many people with chronic conditions don't really know where they stand.

Most medical scheme members would welcome real improvements to the current system. Health care in general would certainly benefit from improved efficiencies in the private sector. It will come as good news to many, therefore, that the national Department of Health is currently examining ways of achieving precisely these ends.

But to more fully understand the department's endeavours, it's necessary to look at some of the current realities in more detail.

To begin with, all medical aids in South Africa were based on what is called the "community-rated principle". This meant that members shared their communal risks. As health-care costs inevitably rise with advancing age, so the community-rated principle ensures that the ill and aged were subsidised by the young and healthy until their turn came to be subsidised by a new generation of members. Put in a different way: members paid in their healthy lives for services which they would need later on.

For decades this community-rated principle worked well. But in the 1980s, several factors emerged which began to put pressure on the system. Most prominent among them were the sharp and continuing rises in medical costs, and the entry of the insurance industry into the medical aid market.

Let's look at rising costs. Medical schemes were powerless (in terms of the controlling legislation) to oppose or attempt to limit these. Their impotence was exacerbated by their increasing dependence on professional administrators who, because they were paid for their services through a percentage of members' contributions, had no incentive to limit these contributions.

Tariffs were annually agreed to between the Medical Association of South Africa and RAMS (the Representative Association of Medical Schemes). But RAMS had become increasingly dominated by the professional administrators whose profits were indirectly dependent on increasing provider tariffs which in turn forced up medical scheme contributions.

The situation was, and still is, exacerbated by attractive-looking insurance packages which came on to the market and enticed many people away from the ailing medical schemes. Insurers were able to undercut rising medical scheme contributions by adopting an individual "risk rated" principle. This means that many young and healthy people are enticed away from the medical schemes. As a result, considerable damage has been inflicted on the cross-subsidised community-rated safety net which had existed in medical schemes for so long.

Even worse, medical schemes tended to be left with the elderly and infirm, thus forcing contributions even higher. Something had to give.

What ultimately did give was the community-rated safety net. In 1989, the Medical Schemes Act was amended to allow medical schemes to risk rate. In other words, people who got old could be charged extra, as could people who developed conditions (such as diabetes) requiring chronic medication.

In general, the situation is not satisfactory, and significant numbers of people, especially those who would normally be protected by community rating, are turning to the state for their health care. What does the Health Department propose?

Alex van den Heever, a member of the departmental working group and also on the staff of the Wits-based Centre for Health Policy, replies: "At the heart of the proposals lies the conviction that community-rated schemes can work and that they are definitely worth saving. From the point of view of the public good, community-rated schemes are the most efficient vehicles for providing lifetime health cover to those who can afford to pay for it."

But how is community rating to be strengthened? Here are some of the suggestions:

- To enhance the position of medical schemes (as opposed to their professional administrators) as accountable agents of their members, and to encourage direct medical scheme engagement with providers with regard to costs and quality of care.
- To introduce tighter controls on insurance products by clearly demarcating the dividing line between community-rated medical scheme cover (which is closely associated with the health policy objectives of maximum good for the maximum number) and individual health insurance policies, and by examining the tax subsidies currently available for both classes of product.

"A medical scheme has a tax deduction associated with it," Van den Heever explains.

"The way forward is to allow this deduction only for community-rated medical schemes. Within a public finance context, there appears to be no basis for tax subsidies to be given to the industry to only cover high-income groups who are also considered preferred risks (as opposed to high-risk people like the aged or chronically ill)."

- To protect the health funding environment by ensuring transferability of membership between medical schemes, guaranteeing the continuation of cover, and the possible establishment of an inter-scheme risk equalisation fund.

It's an immensely complicated debate. Should we be wary of what might seem to be over-regulation by the state? Or should we welcome this attempt to protect an extremely valuable part of South Africa's total health-care system? We'll be hearing a lot of clashing opinions from interested parties in the months to come.

Medical aids can help legitimate healers gain recognition

(299) (899) AR 8/2/97

ADELE BALETA
STAFF REPORTER

Eskom Medical Aid recognises traditional healers and with moves by the Government to accredit traditional healers, more medical aids may be faced with demands by members to pay their sangoma's or inyanga's bills.

Manager of Eskom Medical Aid Wilma Jankowitz said she believed Eskom was the first parastatal which had an arrangement with members whereby each employee would be given a R50 voucher a month which could also be used by members of the family to consult traditional healers.

The scheme was in place from the beginning of the year in response to members' requests.

The size of trade in herbal remedies is estimated at more than a R1-billion a year with about 350 000 practicing traditional healers in South Africa.

Representative Association of Medical Schemes (Rams) policy director Aslam Dasoo said they were likely to recommend to their members that they pay for traditional healers' bills.

"We are formulating policy in consultation with stakeholders, including the Government, on the question of traditional healers which will be circulated as a recommendation to our 180 member schemes," said Dr Dasoo.

At present, individual medical aids applied their own rules in terms of remuneration.

He said: "Schemes take their queue from various professions. If the Interim Medical and Dental Council recognised a profession as a bona fide health discipline, then medical aid schemes were likely to follow suit."

The scheme would then negotiate with the discipline – traditional healer – a scale of benefits for remuneration. "It is up to the scheme to decide if it will go into negotiations."

Remuneration is dependent on the ability of the profession to organise itself and to engage Rams or the medical aid schemes directly in negotiations around a scale of benefits.

This can proceed only if the requisite registration has been obtained from the registering body which is likely to be the Interim Medical and Dental Council.

A spokesman for the Chamber of Mines Medical Aid Society (Comass), Sister K Bekker, said: "At this point, our rules for belonging to the medical aid depend on whether a traditional healer is registered with the Registrar of Medical Aids".

She confirmed Comass would honour any claim for service rendered by a service provider who was registered with RAMS and who had a practice number.

Red alert for medical aid fund patients

A proposed radical revamp of the private health care system may cause costs to soar, writes LEIGH ROBERTS

THE popular savings-linked medical aid funds could become a thing of the past if proposed far-reaching new regulations become law.

In the past three years, "new generation" medical funds, such as those offered by Momentum Health and Fedhealth, have attracted hundreds of thousands of new members. This is primarily because their savings element allows members to keep the unused portion of their fund contributions.

But a draft discussion paper released by the department of health late last year contains proposals which, if effected, will radically reform the private health care sector — and may plunge the industry back into the troubled pre-deregulation days of 1994.

Before deregulation, medical aid funds were buckling under the strain of spiralling costs and widespread abuse of claims.

And fund members were left having to pay rocketing contributions.

Deregulation and the abolition of guaranteed payment to service providers allowed funds to move away from cross-subsidisation (where young, healthy fund members pay the same contributions as older, sickly members) and to adopt a range of cost containment measures such as individual savings accounts and managed health care. But deregulation has also triggered an exodus of younger, healthier members away from traditional funds to the more cost-effective "new generation" funds.

The main thrust of the discussion paper proposals is a return to a system of cross-subsidisation.

The rationale is apparently to push younger employees back into traditional funds and so prevent older, sickly members from being "priced out" of the system.

But while the principles are sound, many of the proposals will have to be amended or the implementation is unlikely to work, says Dave King, managing director of Duff & Phelps Credit Rating Co (formerly Republic Ratings). "The strict implementation of this system could result in the large 'traditionally poor' black sector of the population subsidising the diminishing 'traditionally rich' white sector."

Furthermore, says King, the proposals do not address the fundamental problem facing the industry, namely the unacceptable escalation in medical costs. "The bottom line is that unless free market principles are followed to bring costs under control, the young and healthy will simply opt out of the system."

In line with the proposed return to cross-subsidisation, measures like paying bonuses to low claiming members and savings accounts will be outlawed. Payments to service providers will no longer be linked to a minimum set of benefits and each fund will determine what it is prepared to pay the service provider (doctors and others). Service providers will no longer be able to recover any fee or co-payment directly from the member.

King concedes that the discussion paper does offer a number of proposals which will improve the health of the industry. "Extending legislation to include all forms of health care cover will result in greater public protection. The more stringent reporting requirements are welcomed, and so too are the diverse risk pools and higher solvency levels."

A proposal that will result in industry rationalisation is that a fund will have to cater for at least 6 000 members: 101 of the existing 185 registered funds have smaller memberships.

The accompanying table shows Duff & Phelps' latest credit ratings of the 30 major medical aid funds open to the public which have been accorded secure financial ratings. The open funds that are not listed either refused to be rated or achieved a less secure rating.

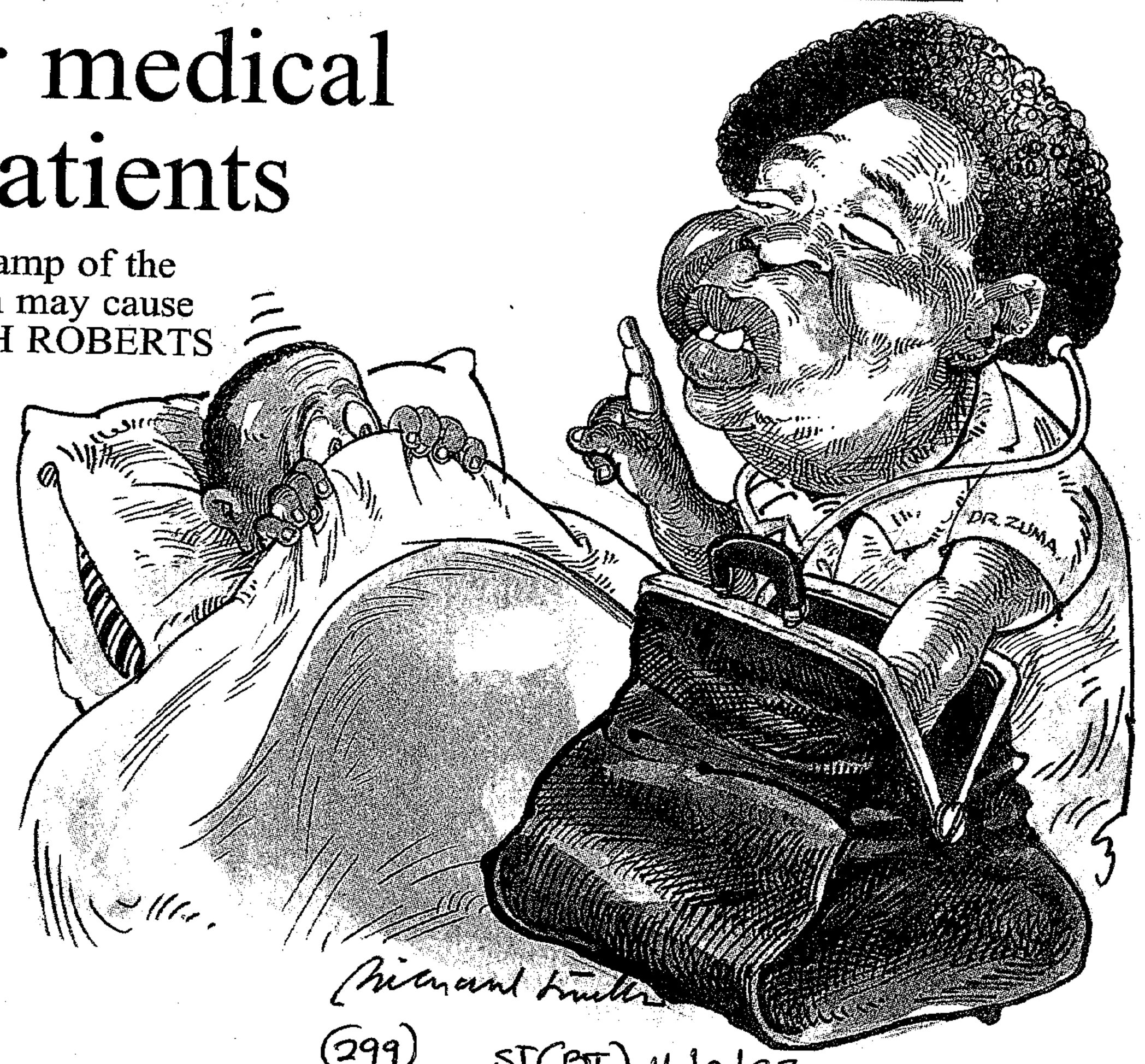
Overall, 1996 was challenging for the industry with costs continuing to rise despite good membership growth. Consequently, members face another year of contribution hikes.

HOW SOUND IS YOUR MEDICAL AID?

Bankmed	AA–
Bestmed	A
Bonitas	A+
Capemed	A+
CEMAS	BBB
CIMAS	A–
Fedhealth	A
Finmed	BBB
Lifemed	A–
Meddent	A+
Medihelp	AA–
Meds	A
Medshield	A–
Momentum Health	AA–
MSP	A
Munimed	A
Natalmed	A
NBC	A–
NIMAS	A–
NMP	A
Northerns	A
Premier	BBB+
SAKAV	A
Sanitas	BBB+
Sanmed	AA
Sizwe	A–
Southern Health	A–
Spectramed	A–
Tafelberg	A+
Visimed	A–

KEY
AA is the best rating but any rating of BBB and above means the fund is secure

Graphic: FIONA KRISCH
Source: DUFF & PHELPS CREDIT RATING CO.



(299) ST(BT) 16/2/97

Medical aid schemes' list of service providers to be probed

By Morgan Naidu

The Competition Board is launching an informal investigation into medical aid schemes which prevent members from using hospitals or medical service providers of their choice, even if these services are cheaper or more convenient.

Board chairman Dr Pierre Brooks said numerous complaints had been received from hospitals claiming they had been unfairly "excluded" from new managed-health-care medical aid schemes.

He said the board would examine the criteria by which service providers were chosen or excluded by company medical aid schemes.

The National Hospital Network's Dr Peter Botha said such schemes denied its members freedom of choice, forcing them to pay more for services from a stipulated list of hospitals or providers.

The NHN, which lodged complaints with the board, has been involved in an ongoing battle with Southern HealthCare over the company's stipulated list of providers.

Botha said huge surcharges were slapped on members who preferred to use hospitals not contracted to medical aid schemes.

Southern's chief executive officer Cathy Walstead-Plumb said her company had also approached the Competition Board to ask for an interpretation of "the perimeters of its investigation".

(299) Star 18/2/97

Rough reception for health-care 'mafia'

(299) Star 21/2/97

Despite considerable opposition, managed care is the right system for SA, says a medical aid chief

By Janine Simon
Medical Correspondent

The "Minnesota Mafia" – as some detractors have dubbed Southern Healthcare JV, Anglo American's new managed health care medical aid administrators – has had a torrid introduction to the South African market.

The company has already had to deal with a five-week dispute with community pharmacies over postal drug services; a flood of complaints from the 120 000 confused members of Anglo American Corporation Medical Scheme (AACMED) and Goldmed funds who switched to Southern in January; an informal Competition Board inquiry into their hospital networks; and resistance from doctors and specialists, culminating this week in the resignation of 14 East Rand doctors because their hospital was not contracted to the fund.

Nonetheless, Kathy Walstead-Plumb, chief executive officer of the joint venture company formed by Anglo, Southern Life and the USA-based managed health care giant United HealthCare Corporation, said she was "convinced this is the right thing for South Africa".

"For that we are willing to take the heat and fight the bullets," she said.

Southern's objective is to set up a system of provider networks, and monitor how they deliver services with case management software that cost United more than R1-billion to develop.

But it's the way in which Southern introduced its network system and third-party case management that has galled South Africans, who have accused the company of arrogance.

However, Walstead-Plumb said resistance had been expected in an industry that had never been managed before.

Only 831 doctors and a handful of specialists were contracted countrywide, but Southern had not expected its doctor networks to be in place for another 10 months, she said. The company had planned on a regional rollout, but was told by Anglo to deliver nationally.

Quality ... Kathy Walstead-Plumb wants best for patients.

But the solidarity approach was very real. "Specialists have created an all or nothing approach which flies against the principles of managed care," she said.

"I accept doctors' arguments that we're arrogant and one-sided if they mean we are sticking to our principles, but not if they say we don't listen. Southern has had hundreds of hours of meetings, and we listened, and we changed," she said.

The company was being "quite lenient" for the rest of 1997: members could visit any doctor and be paid out at medical aid rates, and they could visit non-contracted hospitals for any emergency or if there was a continuity-of-care issue, as with eye surgery or maternity cases.

The company was taking a loss, and had made significant concessions, she said.

"The most important thing for us is information. If we have to sacrifice to get that, we may have to give something initially, and then make informed choices."

Southern hopes to have South African protocols for case management in place by July.

Meanwhile, cases are being managed using United's software, and already there are telling statistical blips, she said.

Only 20% of doctors appear to be keeping records.

And 42% of AACMED members have caesarean sections, compared to a United States average of 15%.

Her advice to consumers was to get involved and get informed.

The reward, she said, was better care, and lower premiums.

Walstead-Plumb said managed care was about raising standards and making them more consistent.

The system provided excellent care when people were sick, and also tried to use the best healthcare practices to keep them healthy. For example, women over 40 would be reminded when it was time for a mammogram.

ISO used to measure the efficiency of medical aid

Star 13/3/97 (299)

MEDICAL CORRESPONDENT

The medical aid industry might be able to improve its quality of administration by using international measurements such as the SABS ISO 9002, according to registrar of Medical Schemes Danie Kolver.

NBC Administrators, which runs the NBC Medical Aid for more than 40 000 beneficiaries, this month became the first medical aid administrator to obtain the ISO 9002 registration, a tightly defined tool to measure and manage the quality of service delivery.

Kolver said the move by NBC had given him ideas as to how the industry in general could improve upon its quality of administration.

"ISO, or the principles thereof, might just be the industry yardstick for which the Central Council Medical Schemes has long been looking," he said.

NBC managing director Richard Rowe said the company had undergone an 18-month preparation for the registration. "Even my work had to be audited to check it was up to scratch," he said.

NBC believed its registration and compliance with ISO procedures would increase efficiency, shorten the time taken to process claims, simplify the training process and offer the "best available service in the industry".

Another benefit was that it focused the organisation on core activities, which eliminated guesswork and – since everything was documented – gave recourse for all action taken.

"I believe that in achieving ISO 9002 registration NBC has set the benchmark for industry, and hopes that others follow suit so that industry standards can be uplifted to internationally recognised levels," he said.

The registration is subject to twice yearly audits to strict SABS ISO 9002 criteria.

MEDICAL SCHEMES ACT (299)

FEVER PITCH

FM 21/3/97

The Health Department's proposed amendments to the Medical Schemes Act — intended to achieve affordable health care for all — threaten to reregulate the medical aid industry, which is gearing up for a hard fight.

The proposals are contained in a discussion document released in December for public comment. The document has been panned by a wide range of organisations, including the Concerned Medical Schemes Group, which represents more than 1m members and includes insurers like Momentum Health and Sanlam.

Detractors argue the amendments would eliminate many of the incentives used to contain costs since the industry's deregulation.

The key proposals are:

- A return to pure community rating, where a member's medical aid contribution depends only on income and the number of dependants, not on age or health;
- Guaranteed acceptance of any individual regardless of their health risk;
- Disallowing medical savings accounts;
- Eliminating competition between medical schemes run on different lines; and
- Emphasising pay-as-you-go rather than pre-funding.

These proposals, says Momentum Health CEO Adrian Gore, "contain elements of the worst-run health-care systems in the world, ignore the large body of evidence from the best-run systems and are in conflict with the most elementary economic principles."

In an attempt to curtail spiralling medical costs which threatened the financial viability of the industry in the late Eighties, the Medical Schemes Act was amended to allow schemes to risk-rate members by their age and health.

The new proposals would reverse this step and encourage the young and healthy (who would be overcharged to provide cover to pensioners) to opt out of medical schemes, says Gore.

To compensate, premiums would be increased and more young people would leave, "resulting in a price spiral which ends up penalising only the old and sick."

Gore also counters the myth that community rating would ensure cradle-to-grave cover for all.

To prevent the loss of young, healthy members under this system, government needs to introduce anti-competitive measures such as legislation to stop people shifting to rival schemes and to ensure compulsory participation, and an equalisation fund to spread risk evenly between schemes.

Deliberate policies to encourage market distortions usually fail.

Association of Health Benefits Advisers vice-chairman Aubrey Sonnenberg believes the proposals are a badly disguised attempt to eradicate the privately funded medical health-care market. Ideology, not pragmatism, is driving the process, he says.

Liberty Life Health Care GM Dan Pienaar also questions the real motive behind wanting to re-introduce regulations which led to the demise of medical schemes in the past.

Gill Marcus

But the department's stance against pre-funding (setting aside some portion of a member's contribution before retirement into a fund like a pension fund) is supported by at least half the medical aid industry, says Old Mutual Actuaries and Consultants' principal consultant Richard Bryant.

Proponents argue that a pay-as-you-go system is sustainable in the long term. Those in favour of pre-funding argue that the former system offers pensioners no security because if the medical scheme folds, they are left without cover.

The department is also against medical savings accounts which pay for small, day-to-day medical costs. It argues that because savings accounts provide the young and healthy with a cheaper alternative to medical aid, there will be fewer funds available to cross-subsidise the elderly.

But to ban savings accounts implies that people are not capable of financing their own health care and should not be empowered to do so.

Bryant says the real debate is not whether to back either pre-funding or the existing pay-as-you-go system, as both are sustainable. The question is whether they can coexist, since the emergence of the pre-funded system could cause the demise of the pay-as-you-go system.

Deputy Finance Minister Gill Marcus says a joint committee of the departments of Health and Finance will examine the financial implications of the proposals, something detractors claim the Health Department has not considered.

Claire Bisseker and Stephen Hill-Haas

State med-scheme 'unhealthy'

ARG 22/3/97 (89 (299)

Private sector says government proposals spell disaster

BRUCE CAMERON AND LEWELLYN JONES

The cash-strapped health-care industry will face another crisis if government goes ahead with its plans to introduce a single medical assistance plan across the board for employed people.

The government proposals could, set back the clock, negating many of the changes aimed at reducing costs currently underway in the health-care industry.

This warning comes from private health scheme administrators who represent 1,7 million people. They say costs, including medical aid membership fees, will increase, while membership will dwindle as young and healthy people opt out.

One of the major initiatives the government plans to stop is health-care scheme savings plans. Members contribute to and use these savings for day-to-day medical costs, while major trauma events which result in hospital expenses are covered by insurance.

This enables younger members to build up reserves for when they are older and have potentially higher claims.

The government wants to revert to pay-as-you go schemes and compulsory membership.

> *It will set us back a decade and destroy the lessons we have learnt*

A number of private medical schemes have joined together to oppose the government's plans. The group says it supports the government's broad aims, in particular the need for an efficient and robust private sector health-care environment.

"This will enable the government to provide health care to the poor and indigent. Our fundamental disagreement with the proposals is not what they attempt to achieve but rather how then intend to achieve the desired private sector health-care environment."

A spokesman for the group and the chief executive of Momentum Health, Adrian Gore, said the government's proposed legislation was fundamentally flawed and could result in employees paying more for medical cover.

"It sounds fantastic, but the reality is that there are two challenges that face us in the South African health-care sector: one is to contain costs, and the other is to cover as many people as we possibly can."

Legislating to achieve those two together "will create disaster in the medical insurance market".

"As soon as you charge a flat rate for everyone within a fund, the young and healthy perceive no value for money so they want to opt out."

In a normal insurance market, however, the young would not opt out of the system for fear that they would not be able to get back in if they got sick.

"But as soon as you add open enrolment, you are in effect saying: 'Come back in when you're sick, we have to accept you.'

"So as the young leave the system, the premiums to stay in the medical scheme go up because the people remaining in the scheme have a worse health profile. Ultimately the number of people covered by medical aid shrinks and the premium they pay goes up."

In New York State in the United States where a similar system to that proposed by the government was implemented, 350 000 people dropped out the medical aid system within the first nine months, and the monthly premiums rocketed 100 percent within 12 months.

"The government proposals will set us back a decade and more as it destroys all the development we have made, and the lessons that we have learned over the past five or six years.

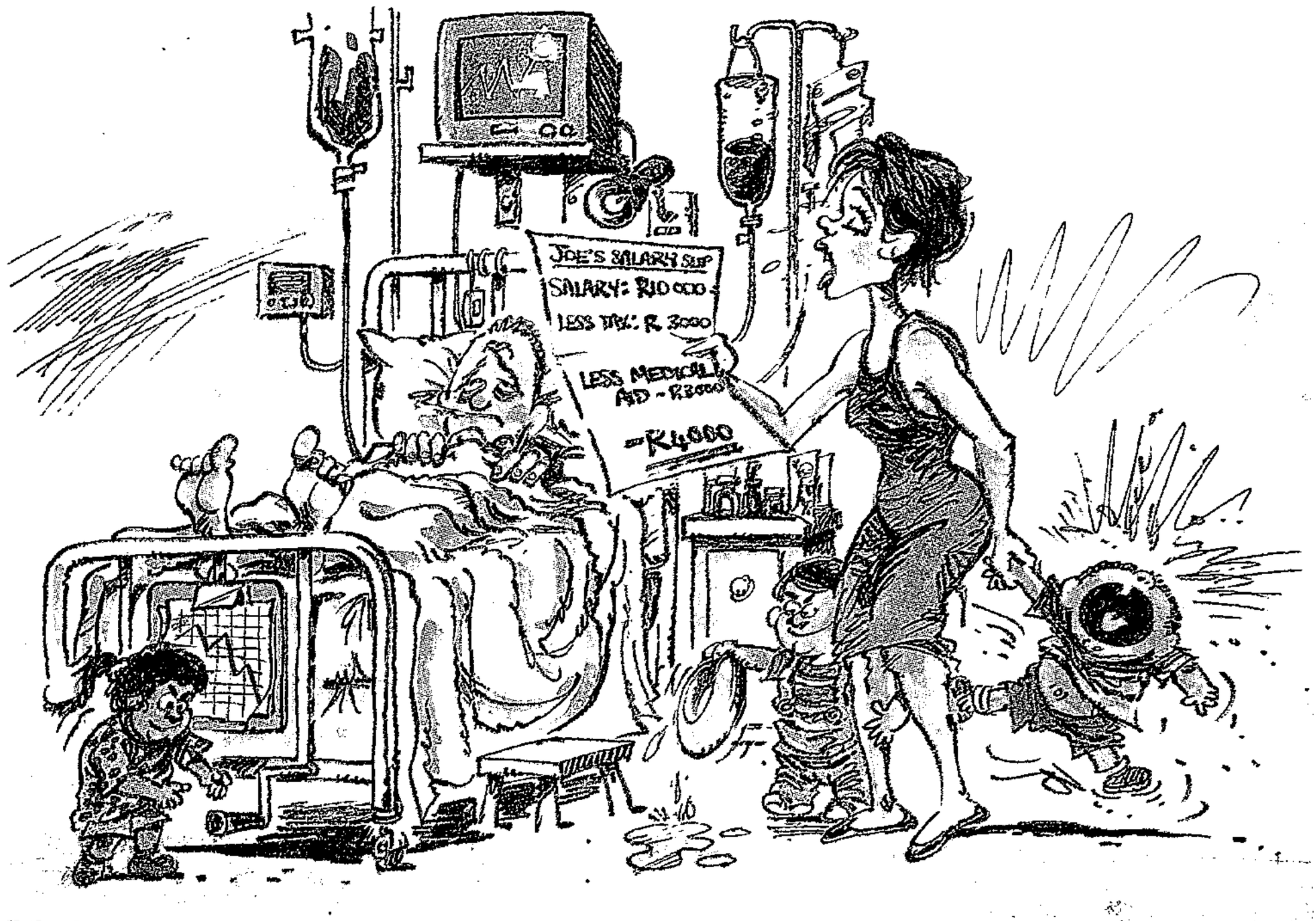
"It is a draconian system, and with today's inflation pressures the system will fail twice as fast as it did before."

Gore and others in the industry are also concerned that individuals would have no role in containing costs.

"There is no doubt that 30 to 40 percent of health-care expenses are elective – you decide if you are going to the doctor for a cold, and you decide if you are going to buy new spectacles.

"We have seen that if you empower people to control their own spending habits through medical savings accounts and other incentives - they do it, and they do it very effectively driving down medical costs."

Gore said the government and the private sector had identified the same problems, but the government's reme-



Medical aid plan is in good health

(299)
ET(BE) 9/4/97

SHIRLEY JONES
KWAZULU NATAL EDITOR

Durban — National Medical Plan (NMP), the second largest open medical scheme in South Africa, is forecasting a substantial increase in reserves against consistent membership growth, a spokesman said yesterday.

Keith Harvey, NMP's marketing director, said the scheme had come to grips with cost management, had provided a finely tuned alternative to emerging managed healthcare organisations, and had carefully managed substantial membership growth.

Membership had grown from 58 179 members at the end of 1992 to 70 000 members at the end of last year, Harvey said. He added that turnover for this financial year would exceed R550 million and that the R1 billion mark was just two to three years away.

Harvey cautioned that volume was not everything, saying there were numerous examples of disaster in the industry where administrative systems had collapsed owing to underwriting pressures.

One of the keys to NMP's success was its relationship with service providers, such as doctors and pharmacists, who were important stakeholders along with the members and corporate entities which participated in the scheme, Harvey said.

He said service providers resented large corporates dictating when they had entered the industry strictly for profit. In contrast, Harvey said none of NMP's funds left the system. Instead, they were ploughed back as benefits to members and service providers, or retained as capital.

Medical aid backlog leaves officials in lurch

No one told us we'd lose benefits, complain shocked civil servants

(299) ARG 12/4/97

ADELE BALETA
STAFF REPORTER

Thousands of civil servants, many of whom took severance packages last year, have been left without state subsidised medical aid cover as the Finance Department battles to process a massive backlog of applications.

One member, who has had open heart surgery and spends R200 a week on medication, is facing massive bills after finding out his subsidy has been discontinued.

Meanwhile state subsidised medical aid scheme offices have been plunged into chaos as thousands of civil servants flood office switchboards with questions.

One of the operators said: "It's awful. I am getting blasted from all sides with people wanting to know whether they are covered or not."

Shocked and angry members have complained that they were not informed of the possible discontinuation of their medical aid subsidy. They told Saturday Argus that they were frustrated and confused.

Shu 'ayb Patel, chairman of Pro Sano - the third largest medical aid scheme for Government employees - said several "crisis meetings" had been held in the past few months with the national Department of Finance to sort out the issue.

Former Steenberg Primary school teacher Julian Davids, 62, took a voluntary package in December after over 20 years of service. He indicated he wanted to continue with the Pro Sano medical scheme and assumed the matter was in order.

"For some reason I phoned Pro Sano to check that all was in order and was told to complete a Z583 form for the Department of Finance. At no time was I told that I might not be covered."

A week ago his wife Jennifer Davids slipped and hurt her shoulder. "We took her to Constantiaberg and duly sent the bill to Pro Sano," said Mr Davids.

But last Friday he got a letter from Pro Sano saying he had left his former employer and that therefore his subsidy was discontinued.

"I was shocked. I was never given any reason to believe I would not get the subsidy. I now have to face the prospect of paying up to R1 000 a month to remain on the scheme. I cannot afford that," he said.

"What makes me angry is that I have effectively been without the benefit since December and it's taken them nearly four months to inform me. I am completely distraught," he said.

Piet Maritz, Department of Finance Chief Director, Pensions Administration, said circulars to employer departments clearly stated medical assistance was available only to those officials who retired at the age of 50 years or older with at least 15 years service.

Those who are younger than 50 years with at least 15 years service would have to pay full membership fees and qualify for a subsidy from the age of 50 years.

Medical aid administration chaos leaves thousands of Cape civil servants bewildered

(~~165~~)(299) Star 12/4/97

By ADELE BALETA

Cape Town – Thousands of civil servants, many of whom took severance packages last year, have been left without state-subsidised medical aid cover as the Finance Department battles to process a massive backlog of application forms.

One member, who has had open-heart surgery and spends R200 a week on medication, is having to face footing massive medical bills after finding out that his subsidy has been discontinued. Meanwhile, state-subsidised medical aid scheme offices have been plunged into chaos as thousands of civil servants flood the switchboards of the different schemes to try to get clarity on the situation.

Staffers at the Cape Town and Bellville offices of the state-subsidised schemes confirmed they were battling to cope. Irate members are demanding to be informed of their status. One operator said: "It's awful. I am getting blasted from all sides with people wanting to know whether they are covered."

Shu'ayb Patel, chairman of Pro Sano – the third largest medical aid scheme for government employees – said several "crisis meetings" had been held in the past few months with the national Department of Finance to sort out the issue.

"We offered to help with our own staff at our expense as well as computers to speed up the process, but to date we have not heard anything."

Of 3 000 forms processed so far, Pro Sano had been able to inform only 1 000 of its members that they would not be getting medical aid cover. There were at least another 4 000 applications in the pipeline.

"We do not decide on who gets a subsidy; we only decide on the amount. If the state does not pay its portion, members have to pay the full amount, which can be anything up to R1 000 a month. If they don't pay, we are forced to suspend membership until full payment is received," he said.

Department of Finance chief director: pensions administration Piet Maritz pointed out that not all officials who took the package qualified immediately for a medical subsidy.

In terms of the Public Service Staff Code, medical assistance was available only to those officials who retired at 50 or older with at least 15 years' service. Those younger than 50 with at least 15 years' service would have to pay full membership fees, and qualify for a subsidy only from age 50.

His directorate had been in constant contact with all the state-subsidised medical aid schemes – Pro Sano, Sanitas and Bonitas – to assist with obtaining information from their civil pensioners. The problem had also been tackled by employing five temporary staff in the medical benefits section. Staff had been working seven days a week over the past five months to help alleviate the situation.

There was only one "crisis meeting" with Pro Sano, which Maritz described as "merely a forum to help find joint solutions". As a result, four Pro Sano staff members were already helping out to speed up the process, he said.

Cape doctors blow an ill wind

CT(BL) 18/4/97 (299)

At the start of this month, more than 100 doctors in the Western Cape went on strike — against the country's only wholly worker-run medical benefit fund. They comprised the bulk of the panel of doctors retained by municipal workers in the Cape peninsula.

The action came after the South African Municipal Workers' Union (Samwu) medical benefit fund (MBF) — founded 45 years ago as a "tickey" self-help fund — renewed annual contracts for its panel of doctors. The fund, administered by eight elected municipal workers, increased the payment to R43,35 a consultation.

"We are giving doctors who are on the panel a captive market, and we consider R43,35 to be adequate compensation," said Jessica Samson, the MBF principal officer and a former municipal worker employed by the fund since 1983.

Several doctors disagreed. They said between R50 and R65 was the market-related rate. There had been some similar grumbling in the past, but nothing had come of it. "Last year, on average, panel doctors received R10 000 a month from us. The top earner was paid R400 000 for the year," Andy Trout, the MBF acting chair, said.

TERRY BELL

According to MBF projections, the fund, with an estimated income of more than R34 million, will pay — on the basis of its new contract fee — R11,1 million to doctors this year. Payment for medication and other claims should total more than R16,8 million, while clinic costs, administration, staff and equipment is budgeted to cost R4,5 million, to leave a surplus of nearly R1,9 million. "We are going from strength to strength," said Trout.

So there was some surprise when the doctors acted. An "urgent notice" was posted in consulting rooms. Addressed to MBF patients, it said the standard of care and the relationship established with "your doctor" was "now being threatened" by the MBF. Signed "Doctors Liaison Committee (Samwu)", it called on patients to "protest loudly" and demand the right of doctors to negotiate as a group and to have a say in drawing up a "mutually acceptable contract". An abridged version of the notice appeared as an advertisement in the Cape Times on April 1, the day the action began.

"It was a problem. As far as we were concerned, we were happy to meet with all our panel doctors, but we didn't even know who some of these people were," Trout said. Cape Primary Care Holdings Limited (CPC), a company with 560 shareholder doctors based from Springbok in the north to Plettenberg Bay, and the Dispensing Family Practitioners Association were the two groups the MBF felt had no standing with the fund.

"They can't ignore us," Steve Jooste, the CPC medical director, said. But he admitted that not all MBF panel doctors were shareholders. The CPC said the matter was "a little more complex than the amounts offered" as consultation fees. It also concerned the "approach to the delivery of effective and affordable healthcare". Merely keeping the payment to doctors low was not the best way of cutting costs.

The CPC said only panel doctor Tony Behrman, the CPC administrative director, could "give all the details" relating to problems with the fund.

However, Behrman refused to comment. "This matter is being resolved between our organisations and the fund. We do not want to move into the press."

Behrman, along with 80 other panel doctors, met with the MBF committee last week. Those doctors — including Behrman — who had not signed the new annual contracts agreed to sign them "as an interim measure". They would be in force for three months, after which longer-term agreements would have to be reached.

"I think they probably feel threatened by the fund. We are expanding, and we should have our new medical centre operating in Mitchells Plain by the middle of next year," Samson said.

The fund already has a clinic in Mitchells Plain and its own optical and dental units. It caters mainly for lower-paid manual workers, many of whom earn little more than R1 000 a month.

"It remains a fund run for workers, by workers. We are driven by the needs of members, not by the need to make a profit. We think we should keep it that way," Trout said.

Health insurance will not help haemorrhaging system

(299) BD 7/5/97

Does the planned national health insurance get to the heart of health reform, asks David Harrison

IF THE SA health system is moribund then revenue from the proposed compulsory national health insurance scheme is an infusion that could give it new life.

However, any first-year medical student, or plumber for that matter, will tell you that fluids in one orifice are fluids out another, unless the seepage can be halted and the problem addressed.

So what is the central problem of the health service? Is it a shortage of money?

Not if international comparisons are anything to go by. Middle-income countries like Botswana, Malaysia, Hungary and Chile spend less money on health care than we do, yet have healthier populations. Poorer countries like Tanzania spend the equivalent of a fifth of our per capita expenditure on health services and have a better primary health-care system than we have.

The essential problem is how we use that money.

The debate about hospital services versus primary level care is old hat and will not be regurgitated here. Let us accept that SA's hospital infrastructure is good and needs to be protected (albeit with some degree of rationalisation). Compulsory contributions to provide public hospital cover for employees is a sound way to maintain and upgrade these institutions. But the real site of health reform, the place where change will have the most impact on the quality of people's lives, is far away from the big hospitals.

It is the people who live in the small towns and rural areas who need to be the central target of health reform. And, if the truth be told, the national health insurance is unlikely to affect Mrs Nxumalo and her children living in rural Maputaland or old Japhta on his smallholding beyond Bochum in Northern Province.

So what will affect their lives? What is the crux of health reform?

The crux lies in taking a distorted and clumsy primary health service and making it make sense. My point is best illustrated by a few examples.

Medicines account for one-eighth of recurrent public health expenditure. There are clinics in this country without medicines. So, health personnel (who account for five-eighths of that public spending) sit idle in these facilities because they have no means to treat patients.

Or take the example of a man diagnosed and treated for tuberculosis in a small town in which he works. There needs to be follow-up of his family and other contacts who live just out of town. Unfortunately, services outside of town fall under another health authority, so follow-up is not assured.

These situations highlight the absurdities in many parts of the country where primary health-care provision makes little sense.

Creating a rational, efficient and effective primary health service is the crux of health reform. If this is not achieved, the system will be in a state of perpetual haemorrhage and more money in will mean more money out.

The health ministry knows this and has set about establishing a district-based system, which is the most logical framework for managing health services.

The system is based on the premise that the health system must serve the interests of every person in the district and that these interests are best served by a local management team responsible for delivering quality care in an efficient and effective manner.

But interpretation of a single clause in the new constitution threatens to jeopardise the logic of the district health system and perpetuate the confusion that exists.

This clause delegates "municipal health services" to local authorities. What is meant by "municipal health services" is not clear. Certainly, if it means that strange amalgam of services rendered by many local authorities, it will annul all efforts to establish an organised health system.

At the end of the day, it probably does not matter whether primary health care is rendered by a local authority for each district so that there can be integrated, cost-effective care.

This is a fundamental element of SA health reform that needs to be entrenched now; an element that risks being ignored as hospital insurance assumes centre stage over the next few months.

There is a story told to students at the University of Cape Town medical school (or is it every medical school?). It describes a nurse instructed to ensure that a post-operative patient drank 500ml of fluid plus the equivalent of the previous day's urinary output. The following day the nurse dutifully reported that the patient tolerated the 500ml of fluid well, but fiercely resisted drinking his previous day's urinary output!

Revenue from the proposed insurance scheme will be a valuable top-up of public sector funds, but the benefit from a new source such as this risks being piddled away by illogical management of primary health care. And unlike the surgical patient, there will be no chance of getting it back.

☐ *David Harrison is director of the Initiative for Sub-District Support of the Health Systems Trust. He writes in his personal capacity.*

Medical plan reports healthy increase in reserves

(299) ET(DR) 8/5/97

SHIRLEY JONES
KWAZULU NATAL EDITOR

Durban — The acid test for medical aid schemes was their ability to manage costs and change with the rapidly evolving healthcare market in South Africa, Rob Slater, the managing director, and Keith Harvey, the marketing director, of National Medical Plan (NMP), said yesterday.

NMP, one of the country's "big three" open funds, yesterday released results for the last financial year which saw a 42 percent increase in overall reserves. These now stand at 22 percent of annualised contribution income, well within sight of the recommendation by the Registrar of Medical Schemes of 25 percent of annualised contribution income, Slater said.

In addition, as a result of a growth in membership from 65 651 to 69 781 and the realignment of premiums in January last year, the fund showed a 19 percent increase in net premium income from R426,3 million during 1995 to R508 million last year.

Despite the payment of enhanced fees to providers, managed care initiatives enabled NMP to contain claims expenditure below its budgeted forecast of a 12 percent increase. Expenditure on claims amounted to R450,5 million, Slater said.

He said that within a particularly difficult private healthcare market, NMP's results were extremely positive. While many funds relied on investment returns, NMP had become a trendsetter through its underwriting strength. Its overall claims underwriting surplus increased by 151 percent to R57,53 million for the year.

He said the two-year restructuring, during which NMP's outsourced administration had again become in-house, had resulted in significant cost containment. Although costs had increased by 5 percent, the scale of benefits had risen by 9 percent.

There had been shrinkage, he said, but adjustment had come through management rather than through denying members care.

Doctors in revolt over medical aids' tardiness

Practitioners threaten to adopt cash-up-front system or contract out, saying viability of medical practices is threatened by delays of up to a year in settling claims

By Janine Simon
Medical Correspondent

Doctors and medical aids are at loggerheads over slow payments, and 300 local practitioners are considering opting out of medical aid contracts to ask for cash up front for treatments.

Clinicross, a company representing doctors from the East Rand, southern Johannesburg and Vaal Triangle, say some medical aids can take five months or longer to process claims.

Medic Credit Control, a Randburg agency dealing with accounts of 350 mostly township doctors, says this can stretch to a year or more.

Isabelle Bourgeois says the agency is still battling to retrieve payments, some from as long as 12 months ago.

Medical aids bounce claims saying they were never received, or were incorrectly submitted, even if they were hand delivered to their offices, she says.

Practices are being threatened by growing debtors books, says Clinicross chief executive officer Dr Martyn Schickerling.

Some medical aids pay within weeks of consultation, but Medscheme, Fedhealth and Sanmed are the worst offenders, taking over four months to reimburse practitioners, he said.

Clinicross management had been instructed to implement measures to rectify the situation.

Contracting out is one option, but doctors are attempting to meet with medical aids before taking harsh action, Schickerling said.

Major medical aids have hit back, saying practitioners' appalling accounting systems and poor business practices – such as not checking benefits or membership and submitting claims by post rather than electronically – cause many of the problems.

Accounting systems blamed for delays

Employers added to the confusion by not informing administrators when members left a fund, and allowing former members to keep their medical aid cards, paving the way for fraud, said Gary Taylor, director of Medscheme, the country's largest administrator.

Few doctors checked details such as membership, registered dependants or remaining benefits, then blamed the medical aid for not being paid.

Many still used handwritten accounts processed and posted at the end of the month, rather than same-day electronic transfer systems.

Other delays were due to poor administration, such as not filling in membership numbers, or treating patients after they had left or been suspended from a scheme or exceeded their limits.

Taylor said Medscheme error accounted for six of the delays in the 22 accounts queried by Medic Credit Control

But Fedsure Health and Sanmed, giant players in the fields of the new-generation medical savings accounts and managed care respectively, admit administration problems have bedevilled payments.

Ivan Clarence, Director of Risk Management at Fedsure Health, said Fedsure's exponential growth last year had adversely affected service levels but the situation had now stabilised.

Sanmed's Senior Operations Manager Roly Buys said the scheme had switched claims-processing systems but would be paying claims within 30 days as from last month.

Solution suggested to practitioners' money woes

Dr Joe Maelane, president of the South African Medical and Dental Practitioners (SAMDP), has the ear of some the country's largest medical-scheme administrators.

Contacted last week, he was waiting for calls from Sakkie Marais, general manager of Medihelp, the country's second-largest medical aid, and was about to call Keith Hollis, chairman of the country's largest administrator, Medscheme, to sort out members' problems.

He is on equally good terms with administrators D and E, Bankmed and "all the others", says Maelane.

"We have a declaration of co-operation," he says.

Medical aids will pay SAMDP members directly, and refer any abuse of the system back to the organisation.

SAMDP members, for their part, undertake to act professionally and practise cost containment.

The reason for this bliss is simple: back in the late 1980s SAMDP members fought a "fierce battle" with Medscheme – and won.

Medscheme wanted practitioners to give a 15% discount on fees, practitioners saw no sense in the request, and refused to accept medical aid cards.

"Patients wanted to know why the medical aids were persecuting their doctors and threatened to resign en masse," recalls Maelane.

His advice to struggling practitioners: "Join the SAMDP". – Medical Correspondent.

Polmed asks for R400-m to meet debt

POLITICAL STAFF

ARG 11/6/97

The corruption-plagued police medical aid, Polmed, has asked the Government for R400-million to cover its budgetary shortfall.

Polmed's chairman, Deputy Commissioner Gert Swart, warned in Parliament yesterday that Polmed's 131 000 principal members, some of them retired, would have to contribute if the Government could not make the funds available.

It emerged yesterday that of the 556 cases of fraud being investigated by the commercial branch and Polmed detectives against police, doctors and pharmacists, there had so far been only three convictions.

Among the cases of fraud brought to court was that of a Pretoria doctor who had appeared on 13 100 charges of fraud believe to involve nearly R1-million.

Deputy Commissioner Swart told Parliament's portfolio committee on safety and security that a new administrator of the medical aid would be announced tomorrow.

A task team including representatives of Business Against Crime had been formed to find short, medium and long-term solutions for the medical aid.

New administrator for police scheme

BD 11/6/97 (299) (ਸਨ)

CAPE TOWN — The process of appointing a new administrator for the police medical aid scheme (Polmed) would be finalised when the tender was awarded tomorrow, Gert Swart, deputy commissioner of the SA Police Services' (SAPS) human resources department, said yesterday.

Briefing the National Assembly's safety and security committee, he said an investigation had shown the current administrator was not fulfilling its tasks. With the new administrator Polmed would move 20 years ahead technology-wise, Swart, who is also chairman of the Polmed board, said.

Restructuring Polmed management would result in total savings of about R210m in the 1996/97 financial year.

Polmed's investigation team was investigating about 100 cases of fraud totalling between R13m and R18m. Sixteen investigations had been completed and three people found guilty. Investigations into fraud in Polmed were being aided by doctors who were beginning to report offences by other doctors and even their partners.

Swart said important short- and long-term decisions included whether to make Polmed a separate receiver department, co-responsibility of members for payment and contributions, and the social responsibility of the SAPS as an employer.

Funding principles should be based on a fixed per capita budget as opposed to fixed benefits, he said. — Sapa.

(299) BD 12/6/97

Health insurance proposal faces hurdles

THE white paper on the transformation of SA's health system, including the proposed introduction of a mandatory social health insurance scheme, is expected to have a major financial impact on the private sector.

The proposal is seen more as a mechanism to raise additional public health finance, says Richard Bryant, principal consultant for Old Mutual Actuaries & Consultants.

What social health insurance implies is mandatory cover for all formal sector employees and their dependants, for treatment in public hospitals.

"This is an effort by government to deal with people who currently receive free treatment at public hospitals despite their ability to pay.

"It also includes the problem of members who have exhausted their medical aid benefits and who seek further treatment at public hospitals.

"Our view, however, is that the proposal cannot be realistically considered for implementation before crossing two major hurdles: acceptance by Nedlac and the department of finance."

He says contributions to health insurance will be shared by employers and employees.

"This could affect even marginally profitable businesses as a result of higher labour costs, making it possible that business and labour could both oppose the proposal.

"Labour representatives have tended to resist participating in medschemes and other arrangements since treatment at public hospitals has traditionally been free, and the cost of participation in medschemes has become prohibitive."

What is more, says Bryant, is the health insurance proposal is a direct attempt by the department of health to institute a new tax."

Since it is policy to divert national tax funding away from hospitals to primary health care, health insurance paid in the form of a payroll levy provides the department of health with a new way of funding these institutions outside of the national fiscus.

However, under the proposed scheme hospitals would retain only a portion of their fees with the balance paid to provincial health departments "in order to distribute some of the income to needy facilities which are unable to generate significant fee revenue".

Still, he says a system of social health insurance may be regarded as desirable, particularly with buy-in from stakeholders on measures such as employer and employee contributions being paid directly to public hospitals for a core package of services.

Getting alternative aids into the medical schemes

ST(BT)15/6/97 (299)

CUTTING COSTS

By PAT SIDLEY

DOCTORS at the Red Cross Children's Hospital who deal with badly burnt shack-fire victims often find it almost impossible to probe the patient's body to check for pulse rates and other vital signs.

One area of the body, however, frequently escapes burns — the soles of the feet. Now reflexologists are being asked to treat shock by working the soles of victims — especially those of children.

The results have been very promising, and reflexologists now regularly assist the trauma unit. A study is under way to assess the use of reflexology in these cases.

The question then arises why sick people cannot go to a reflexologist, a homeopath or other complementary practitioner, and have the bill paid by medical aid.

As with everything in health care, the answer is not clear. Michael O'Brien, chairman of the Chiropractors, Homeopaths and Allied Health Services Professions Interim Council, says some medical aids do accept claims for certain complementary health services. Others do not.

In some cases there is a legal answer — whether the practice has been registered with a statutory council such as the SA Interim Medical and Dental Council, or the body that O'Brien chairs.

The Representative Association of Medical Schemes (RAMS) will not issue a practice number if the complementary health discipline is not properly registered with a statutory council.

RAMS requires a motivation by other health professionals, and it makes a study of spending patterns and similar factors.

Registration with a council is no simple matter. There have to be established training courses for the disciplines which are recognised, and they have to be accepted by the statutory council. The council, in its turn, must get the Department of Health's go-ahead to register the profession.

A much harder view on the issue is offered by Wits Centre for Health Policy economist Alex van den Heever. He believes the only reason any of the complementary groups want to be registered with medical aids is to tap into the finances that would then become available. Prices and use of the service would rise if it were readily available on medical schemes.

Van den Heever says medical insurance is meant to deal with medical emergencies and catastrophes which can't be anticipated in the normal run of things — and which cannot easily be financed.

The kind of treatment offered by complementary health professionals, he believes, would not deal with medical emergencies of the kind that end up costing huge amounts in trauma centres of hospitals, or cancer treatment, and should therefore be financed out of personal reserves.

O'Brien says the disciplines which have full registration already include chiropractic services, homeopathy, osteopathy and — most recently — ayurvedic medicine (a traditional medical discipline from India). Acupuncture is making its way through the system while reflexologists have applied more recently.

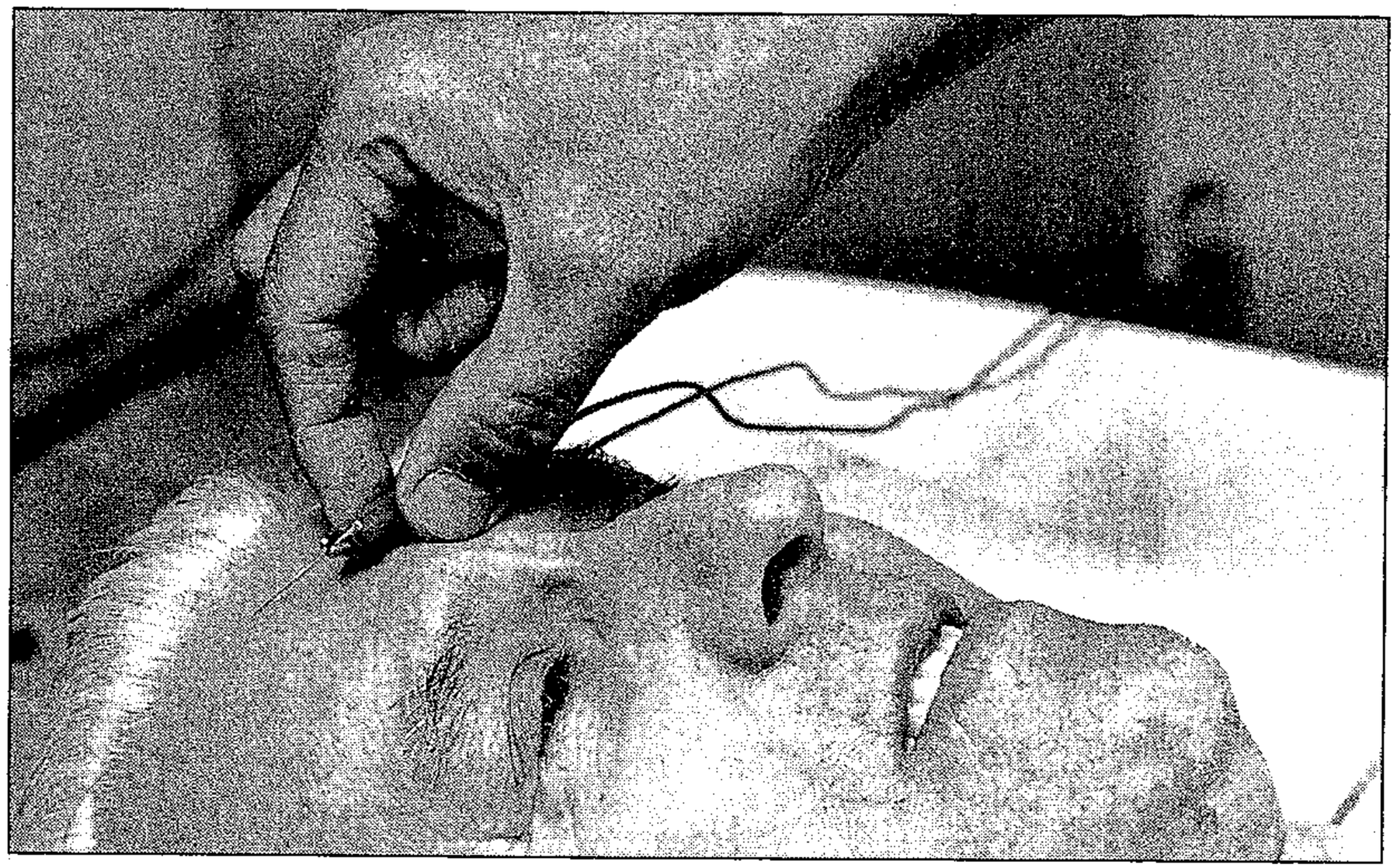
O'Brien says all his members have been polled on whether they support the national health system the country is trying to build. The question implies that members would be willing to work, not only in private practice, but as part of a health care team in public hospitals and clinics. He says the response has been highly positive.

Dr Aslam Dasoo of RAMS sounds a cautionary word. He says that to include some of the complementary health professions on medical aids may mean reducing some benefits from more conventional practitioners, such as GP's.

The issues, however, will get more complicated as time goes on. The British Medical Journal reports in its May 31 issue on a long-standing dispute in India involving practitioners of traditional medicine such as ayurveda. Of India's more than 1-million registered doctors, some 450 000 hold qualifications in the traditional medicines which are recognised by the government.

The issue in India is who may prescribe which medicines. Traditional doctors are apparently able to prescribe certain basic emergency "western" medicines. They also participate in public health programmes, including infant immunisation, and they can help diagnose and treat illnesses such as TB. But recently, the journal reports, they have been accused of prescribing modern drugs with inadequate expertise and of entering modern medicine through "the back door". The issue of prescriptions is now being dealt with by the Indian government.

But back to the question medical aid members have — how to get some of these health care procedures and medicines paid for by medical aids? The legal issues must be dealt with, but this is another option South Africans are bad at using. It's there for them. They could get a users group together within their medical scheme, go to annual general meetings, participate in elections and ensure some responsiveness from the schemes to their members.



STICKING OUT ... medical practices such as acupuncture do not easily fit into medical aid set-ups

Medical schemes' body threatens to go it alone on importing of drugs

Star 16/6/97 (299) 96

By Craig Urquhart

As the Ministry of Health continues to stall over the controversial Medicines and Related Substances Control Amendment Bill, the Representative Association of Medical Schemes (Rams) is threatening to "go it alone" and establish its own guidelines for the parallel importation of drugs.

"We will explore every avenue to obtain cheaper medicine, including the parallel importation of drugs. We refuse to be held hostage to the current structure and we will support any measures by the Government, including these bills, to obtain cheaper medicines," said Rams director of policy Dr Aslam Dasoo.

The move from the multi-billion-rand organisation, which represents 186 private medical schemes that provide health cover to 15% of South Africans, could set the standards to which the Government would ultimately have to adhere.

"The outcome of the bill does not stop private schemes from slashing the cost of available drugs as long as they are submitted to the Medicines Control Council. We're advancing the Government's intended programme because it makes good financial sense," said Dasoo.

Rams, which is facing pressures from its members because of their soaring contributions, says some schemes face bankruptcy if generic substitutions are not legalised.

Bowing to pressure from US politicians and business, the Government last week withdrew the proposed bill which would mandate that physicians prescribe only generic drugs.

SA prices are among the highest in the world

Health Minister Dr Nkosazana Zuma said she was confident the bills would be passed with minor adjustments.

She said the price of medicine in South Africa was among the highest in the world and the provision of safe, effective and affordable drugs in the right quantities to the whole population was a national priority.

She plans to import cheap medicines from overseas for use in public hospitals and clinics – a practice which is common in Europe and Africa – and legalise generic substitution.

This means that pharmacists will have to offer patients cheaper medicines as an alternative to medicines prescribed by their doctor. If doctors do not want an alternative, they will have to write this on the patient's prescription by hand.

The National Convention of Dispensing Doctors said doctors would fight in court if necessary for their constitutional right to dispense medicines. It says doctors are also questioning the safety of generic substitution and whether nurses and pharmacists should be permitted to prescribe drugs – which is recommended in the bill.

Pharmaceutical Society of SA executive director Ivan Kotze said most of the submissions were on technical points, and it was not impossible that decisions on the few important issues could be taken within a week.

Bitter fee war erupts between pharmacies and medical aids

(299) ARG 17/6/97

Chemists to charge R20,90 per prescription

ARGUS CORRESPONDENT

Johannesburg – A bitter war between the pharmaceutical and medical aid industries over price reform is set to hit medical aid members in their pockets.

The fight centres on the introduction of a professional fee for pharmacists, a key component of the national drug policy to be introduced if the controversial Medicines and Related Substances Control Amendment Bill is passed.

The concept is to replace the complicated system of profit mark-ups in the wholesale/retail pharmaceutical industry with a flat wholesaler mark-up and dispensing fee per product, to be phased in from June 26.

This week giant medical aid administrator Medscheme said it was being "held to ransom" over the issue of dispensing fees by United South African Pharmacies, which represents 1 480 of South Africa's 2 900 community pharmacies.

Medscheme spokesman Lorraine Tulleken said the medical aids had been notified that USAP intended implementing a R20,90 dispensing fee and would boycott those schemes refusing to accept the new pricing structure by withdrawing credit to schemes and asking their clients to pay cash for their medicines.

The impact of USAP's demand, evaluated as part of a survey of 10-million prescriptions across 32 medical aids, revealed that on average the cost of medicines would rise by 17%, Ms Tulleken said.

But Keith Johnson, head of the pricing committee of the Pharmaceutical Society of SA, said Medscheme's figures were debatable and had not been revealed to the other two organisations that had analysed price impact, the PSSA and Representative Association of Medical Schemes.

"I question their motives. The new structure will improve overall costs in the long-term and it is strange that they have done this," said Johnson.

Medscheme emphasised that the poor would be hardest hit by the fee which increases the costs of lower-priced drugs.

Drug prices set to spiral in pharmacy row

Star 17/6/97 (299)

Patients will be forced to pay cash for prescription medicines unless their medical aids agree to a R20.90 dispensing fee

By Janine Simon

A bitter war between the pharmaceutical and medical aid industries over price reform is set to hit medical aid members in their pockets.

The fight centres on the introduction of a professional fee for pharmacists, a key component of the national drug policy which can be legislated if the controversial Medicines and Related Substances Control Amendment Bill is passed.

The concept is to replace the complicated system of profit mark-ups in the wholesale-retail pharmaceutical industry with a flat wholesaler mark-up and dispensing fee per product. It is due to be phased in from June 26.

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Medscheme spokesman Lorraine Tulleken said the medical aids had been notified that USAP intended implementing a R20,90 dispensing fee and would boycott those schemes refusing to accept the new pricing structure by withdrawing credit to schemes and asking patients to pay cash for medicines.

The impact of USAP's demand, evaluated as part of a survey of 10-million prescriptions across 32 medical aids, revealed that on average the cost of medicines would rise by 17%, Tulleken said.

The survey was commissioned by Pharmaceutical Benefit Management, the company which processes drug claims for Medscheme.

Bonitas medical fund principal officer Bafana Nkosi said USAP's threatened boycott was discriminatory and few members would be able to pay cash.

But Keith Johnson, who heads the pricing committee of the Pharmaceutical Society of South Africa, said Medscheme's figures were open to debate and had not been revealed to either of the other two organisations that had done in-depth analysis of price impact.

These were the PSSA and Representative Association of Medical Schemes (RAMS).

"I question their motives. The new structure will improve overall costs in the long-term and it is strange that they have done this," said Johnson. "No other pharmaceutical benefit management has shown the same kind of potential increase in costs."

However, Medscheme emphasised that the poor would be hardest hit by the fee which increases the costs of lower priced drugs.

RAMS policy director Dr Aslam Dasoo said it was impossible to assess the impact of the new fee as final pricing lists were still being collated.

Dasoo said the problematic area was determining the true cost of drugs when they left the manufacturer as they were sold at different prices to different parties in retail.

"The price impact will be greater if manufacturers come on board and reveal their prices. But there will be a favourable impact nonetheless," said Dasoo.

RAMS has a mandate from all its member schemes to push ahead with introducing the new fee structure.

Medical aid schemes to fight threatened pharmacy boycott

Star 18/6/97 (Sat) (299)

By Priscilla Singh
Health Reporter

The Representative Association of Medical Schemes (RAMS), an umbrella body representing medical aid schemes across the country, said yesterday it would not accept or approve any increase in the cost of medicines in spite of pharmacies' threats to boycott medical aid members unless they paid cash for their prescribed medicine.

RAMS was reacting to a threatened boycott by the country's largest group of pharmacies, United SA Pharmaceuticals, against medical aid members belonging to schemes that did not accept the R20,90 "professional fee" to be phased in from June 26.

RAMS executive director Declan Brennan said the threat to boycott medical aid scheme members was taking unfair advantage of the sick and lower-paid workers who could not afford to pay cash.

The threatened boycott follows the introduction of a professional fee for pharmacists, which is a key component of the national drug policy which will become law if the controversial Medicines and Related Substances Control Amendment Bill is passed.

The bill is expected to be approved by Cabinet today, according to health director-general Dr Olive Shisana.

Lower income consumers will be hardest hit once the new pricing structure is phased in and avoiding the boycott would mean an average increase of 17% in the cost of medicines.

► **Pain in the pocket**
... Page 15

(299) (96)

PHARMACISTS & MEDICAL SCHEMES

FM 20/6/97

Court threat in pharmacy fight

Dispensing fee could cost more than the medicine

Medical schemes are considering legal action to halt a boycott planned by half the pharmacies in SA over the industry's refusal to accept the introduction of a R20 dispensing fee for pharmacists.

Medscheme spokesman Gary Taylor says the fee will add R12m (17%) to its average monthly medicine bill. This could lead to higher medical aid premiums, higher employment costs and could even result in members quitting their schemes.

According to a feasibility study by Medscheme subsidiary Pharmaceutical Benefit Management (PBM) some lower-income schemes will experience price increases of up to 40% and members could find dispensing fees exceed the cost of medicine.

The Competition Board has been petitioned by some Medscheme members to halt the boycott planned by United SA Pharmaceuticals (USAP) on the grounds that it amounts to price collusion.

USAP claims to represent 1 553 pharmacies and is threatening to boycott all Medscheme's 57 member schemes from June 26, unless its pharmacists are granted a R20,90 dispensing fee per script item.

If the boycott goes ahead, Medscheme's 1,6m members will be forced to pay cash for medicine bought at these pharmacies and will then have to wait up to 60 days before being reimbursed by their schemes.

USAP chairman Julian Solomon claims the R20,90 fee will not increase medicine prices if Health Minister Nkosazana Zuma's plans to reduce medicine costs prevail.

In this context the move is about ensuring the survival of pharmacists who fear they will be put out of business by Zuma's plans which would allow retailers like Pick 'n Pay and Clicks to own pharmacies.

The Representative Association of Medical Schemes (Rams) — of which Medscheme is the largest member — began negotiations with the pharmacy sector, including USAP, over a dispensing fee last year. The deadline for its introduction is July 1 but there is still no agreement on the fee.

The idea expounded by Zuma's national drugs policy is to replace traditional mark-ups of 50% by pharmacists with a dispensing fee of the same magnitude.

Claire Bisseker

Churchgoing Overbergers pray for casino cash

(292)

ARG 21/6/97

British in scramble

TWEET GAINSBOROUGH-WARING
STAFF REPORTER

Staid, church-going Overbergers in Caledon, Grabouw, Bredasdorp and Genadendal are catching the casino fever sweeping the area.

Even the Anglican Church will have a stake if British gambling giant Ladbroke's wins the bid for the proposed Caledon casino, one of five the new Western Cape Gambling Board will decide on.

As would-be casino operators compete around South Africa for lucrative licences, the name of the game has become "empowerment".

Rival companies are offering shares to members of historically disadvantaged communities to impress provincial gambling boards and Ladbroke's has chosen the conservative Overberg area for its bid.

It has offered 10 percent of shares in the proposed casino to local people and another 10 percent to a community trust for development projects – and the Overbergers are already jumping at the chance to have a share of the action.

'I'm very excited: previously gambling money would be spent outside SA'

"I'm very excited about it as previously money spent on gambling would be spent outside the country.

"Now it will stay here and we will be able to build up our communities," said Bredasdorp businessman Dirk Jantjies.

Jennifer Damons, a Genadendal housewife, said: "We can't wait; if it goes through it will bring work to our communities."

She said gambling already existed through horseracing and scratchcards and she felt the benefits of a casino would far outweigh the disadvantages.

Elizabeth Botha of business advisers and chartered accountants KMPG who have been marketing the shares, said the project had met with overwhelming acceptance.

Ladbroke Casino Holdings (SA) has set up the Overberg Empowerment Company Ltd (Empowerco) to offer shares to local people.

The KPMG "roadshows" have been held in Riviersonderend, Genadendal and Bredasdorp, attracting a cross-section from labourers to school principals and businessmen.

Ms Botha said the high level of unemployment in these areas had been a major factor in the positive response.

"In the social context a casino has major consequences, so the chairman of Empowerco will be on the board of directors of the Caledon Casino Bid Company. In addition the Anglican Church will have representation on the board through the Overberg Community Trust."

She said having two casino bid company directors closely linked to the community would ensure consultation with the community from the start of the proposed development.

The share offer would enable members of the previously disadvantaged community in the region to share in casino profits as well as being represented on its board of directors of the casino bidding company, said Mike Bennett, MD of Ladbroke Casino Holdings (SA). Each investor is required to buy at least 400 shares at R1 each, and should the bid be unsuccessful, Empowerco will refund their money with interest from the date of payment.

But should the bid be successful share certificates will be in the post to investors within 10 days followed by a shareholders' meeting to appoint a representative to the casino board.

The company earlier held a series of "workshops" to persuade Overberg residents that the proposed casino would benefit the area.

The planned R550-million Caledon project includes hotels, a casino, a spa resort, a Jack Nicklaus-signature golf course and a precinct showcasing the rich history of the Caledon area.

It would be built on 230 hectares around the Overberger Hotel and the developers have applied for the rezoning of parcels of land from agricultural to resort use.

The KPMG "roadshows" have been

to resort use.

ARG 21/6/97

'Rural' gambling licences to enjoy E Cape favour

(292)

Bisho – Eastern Cape casino sites will be selected by new economic affairs MEC Enoch Godongwana based on criteria which include "non-concentration in metropolitan areas".

The new provisions in the provincial Gambling and Betting Act were passed yesterday by the Eastern Cape legislature.

The draft had been criticised, mainly in Port Elizabeth, for creating a perception that casinos would be restricted to rural villages.

"There is nothing in this that says Port Elizabeth cannot have a licence," economic affairs committee chairman André de Wet assured the House.

Ex-economic affairs MEC Smuts Ngonyama began the debate on behalf of Mr Godongwana, who was unable to attend. Mr Ngonyama was appointed to the housing and local government portfolio in a recent executive council shuffle.

Mr Ngonyama said casino sites and the number of licences for each site would be decided by the responsible MEC.

The issue of licences would be done by a "quasi-judicial" gambling board.

The board would consider applications and issue licenses for casinos, bingo, totalisators, bookmakers and racecourses.

The board would make recommendations on casino sites to the MEC on factors that included the possible effects on the neighbourhood, tourism, job creation, financial ownership by previously disadvantaged communities, and community facilities offered by the new development.

Clause 41 of the bill stipulates that casino applications may only be made in response to calls by the MEC.

ANC MPL Gloria Barry explained further that the MEC would advertise for public comment on the location of casinos before making a decision.

"It does not state here that licences will only be in rural areas," Ms Barry said.

Mr Ngonyama said the national Act allowed 40 casino licences in the country, five in the Eastern Cape.

He urged the House to pass the bill as quickly as possible, because the delay was "allowing a very sensitive industry to slide into chaos". – Ecna

Police square up for dispute over medical aid shortfall totalling millions of rands

Star 21/6/97

By BEKIZULU MPOFU

Several thousand policemen got the shock of their lives when they received salaries slashed to as low as R3,81 in some cases after hefty medical aid deductions were made last month.

Former homeland policemen were worst affected. Most of them belonged to the Bonitus medical aid scheme, which police management said had been grossly abused by both members and service providers, resulting in shortfalls amounting to millions of rands.

Ryno Versters of the SA Police Service human resources in Pretoria said that in the past, policemen in the former self-governing states received a 100% medical aid benefit for using Bonitus. He said most of them opted for Bonitus instead of Polmed, a police medical aid fund with a limited budget, because they were reaping huge illegal benefits.

"But now the public-service regulation for the police stipulates that if a member chooses to join an external medical aid scheme instead of Polmed, then contributions are their responsibility. Investigations have shown that there has been widespread abuse of the Bonitus scheme by doctors, pharmacists and members in which people claimed for funerals of their relatives.

"This was illegal and as a result there is about R24-million outstanding to Bonitus, which it is claiming from the SAPS."

The National Police Services Union (Naposu), made up largely of former homeland policemen, said it would take to the streets over the issue in Durban today. Naposu president Owen Zama saw it as a plot to force them to join what he called a "financially embattled Polmed".

"When we wanted to join Polmed years ago, central government at the time refused us and we joined Bonitus, from which we have been getting excellent benefits," Zama said. "Now that Polmed has run into a huge deficit, they want to force us to become its members so that we can contribute to the recovery of the shortfall. To start with, we had nothing to do with the theft and losses and we were not even consulted. We want to remain with Bonitus."

Versters said that even the Polmed scheme was in deep financial trouble and its members might in future have to make a one-third contribution to the fund.

"Polmed has suffered losses over the years and in the near future people will have to start contributing to the fund when we change Polmed rules. With the amalgamation of the police services, there have been many people joining Polmed but the fund is unable to sustain increased membership," Versters said.

Spokesman for human resources management Johan Smal said Polmed's budget had been slashed from R1,6-billion to only R1-billion this year and proposals to have members contribute one-third to top up the difference were being finalised.

The South African Police Union said although the one-third contribution had not been effected, it had declared a dispute and would consider any deductions as illegal.

"We are declaring a dispute for arbitration over the issue. The department has been playing games with us in their response to our demands that the free, non-contributory scheme remains," it said.

Pharmacies label adverts 'hysterical'

(BB) (299)

Chemists breaking ranks on boycott plan, says Medscheme

Star 24/6/97

By Priscilla Singh
Health Reporter

The United South African Pharmacies (USAP) has labelled an advertising campaign by a medical administrator as "inflammatory" and "hysterical".

The advert, placed by Medscheme, focused on the supposed boycott of medical aid members by USAP pharmacies if the members did not pay the R20,90 dispensing fee.

The fee was set by USAP chairman Julian Solomon, who claims to represent half of the country's 2 900 pharmacies.

"I find the entire campaign by Medscheme quite hysterical, inflammatory and not representative of the facts.

"If anything, we increased our membership by 50 last week and now stand at about 1 600," said Solomon.

Solomon added that the dispensing fee would be implemented on Thursday, but that USAP was open to negotiation. However, Medscheme said that pharmacists were breaking ranks on the planned "cash or nothing" boycott of medical aid members who refused to pay them a R20,90 dispensing fee for prescription medicines.

The Government's drug policy requires medical aid members to pay pharmacists a professional fee for prescribed medicines they dispense in view of abandoning the previous 50% mark-up of drugs.

Medscheme public affairs director Gary Taylor said a number of individual members of USAP had, since Friday, assured Medscheme that they would not enforce the threat, and although they wanted a better deal, they would not turn away a sick patient.

Solomon said if medical schemes agreed to cover the fee, USAP would conduct all transactions on a medical aid card.

Pay upfront or do without – what new medicines structure means

Chemists to boycott non-participating aid schemes

(299) (91) (189)

ARG 24/6/97

ARGUS CORRESPONDENT

Durban – Pharmacies will boycott members belonging to medical aid schemes that do not accept a new pricing structure to be implemented this week – forcing thousands of users to pay upfront or do without medicine.

The new structure will, according to one source, hit almost a million people who can least afford it. It will introduce a professional fee replacing the old mark-up system, in line with the Health Department's National Drug Policy.

Medicine prices are currently also under scrutiny by the Representative Association of Medical Schemes (Rams) and the Pharmaceutical Society of South Africa.

A scale of benefits document will be published later this week. However, medical schemes believe the introduction of a professional fee will cause drug prices to rise – by as much as 17% for some schemes.

Chairman of the United South African Pharmacies (Usap), Julian Solomon, said the more than 1 500 members of Usap would "no longer be able to deal with Medscheme (the biggest administrator of medical aid schemes in the country) under present onerous conditions".

Mr Solomon said the administrator refused to consider any change in the status quo that could deprive medical aids of income.

The pharmaceutical society proposed a pricing structure that would consist of a five percent mark-up (to cover financing) a further R3 for running a practice (overheads) and a professional tariff of R150 per hour or R15 per script.

That is R18 plus five percent plus VAT or about R20,90 per item. Medscheme proposed a flat fee of between R14 and R15 while Rams recommended a professional fee of R19 per lined item on a script to a maximum of three items per script.

Rodney Cowlin of the Pharmaceutical Benefit Management said the new structure would have a detrimental affect on members belonging to low benefit schemes.

"Almost one million people who could least afford it will be adversely affected."

Last week Medscheme urged Health Minister Nkosazana Zuma to resubmit urgently the Pharmacy Amendment Bill. The bill would allow people other than pharmacists to own pharmacies.

"Once the monopoly of ownership has been removed, medical aids would be free to contract a wider range of providers and achieve cheaper distribution costs of their medicines."

The Pharmacy Amendment Bill, the Medicines and Related Substances Control Amendment Bill and the Medical, Dental and Supplementary Health Services Bill were resubmitted to Parliament last week.

Mr Solomon assured consumers that pharmacies would be open to negotiation with members to make alternative paying arrangements if they could not pay up immediately.

He said medical aid schemes were an administrative nightmare, but hoped they would "come to their senses" and resume negotiations.

'Managed care the answer'

(299)

Lucia Mutikani BD 27/6/97

THE successful implementation of managed health care could provide the cost efficiency desperately needed in SA heath care delivery, Sanlam Health MD Altus van der Merwe said.

Managed health care was not a "quick fix", but the only sustainable solution for medical hyperinflation and the elimination of waste. It could also lead to lower premium increases and provide access to quality health for all South Africans, he said.

Van der Merwe said Sanlam Health had been instrumental in bringing down the average number of bed-days per 1 000 members to 675 in the last five months of last year, from 858 per 1 000 during the first seven months.

"The real net saving of 22% in direct costs can be attributed to the elimination of inefficiencies. This success was achieved without undue medico-legal risks and with proper measuring and monitoring of the quality care that patients receive," he said.

"Of particular importance is the fact that the saving was effected within the requirement of the registrar of medical schemes that administration costs should not exceed 10% of contributions received by the administrator of the medical fund."

Van der Merwe said overuse was eliminated in a managed care environment, while clinical quality standards could be monitored and maintained.

He urged concerned parties to focus on patient needs and co-operate to make quality health care more affordable and accessible. This would prove that the private sector was willing, prepared and able to contribute towards attaining the government's national objectives for health care, he said.

Cutting Caesarean arrogance down to manageable size

SA doctors who do Caesars for money and their own convenience are in for a shock, writes PAT SIDLEY

MANAGED care has become infamous in the United States for practices such as "drive-by deliveries" — trying to get women who have given birth out of their expensive hospital beds as soon as possible.

Obstetricians in this country, who are paid for delivering babies on a fee-for-service basis, are notorious for an alarmingly high rate of Caesarean deliveries. Depending on who is collecting the data, anything up to 68% of babies born in private hospitals are delivered in this manner.

Momentum Health's figures for Caesarean sections are no exception to the rule — but MD Adrian Gore says its solution to the problems spawned by fee-for-service payments will reflect wisdom gained from managed care experience in the US.

The US managed care experience has produced a consumer backlash joined by physicians and more recently by employers backing their employees' rights to better health care.

Momentum Health spends 12% of its total hospital bills on maternity. If the babies are born the natural way, the bill for each birth would be about R4 550. A Caesarean section pushes up that bill to R6 400.

Gore says about 60% of the births his company finances are Caesarean sections, now falling rapidly towards 40%. The decline is thanks to the introduction of a managed maternity programme which arms mothers-to-be with the information to make better choices.

The mother is guided by in-house maternity counsellors and a range of incentives which help her make choices likely to suit both her body and her insurer's purse.

Among the incentives are ante-natal classes paid for by the company.

These classes typically will tell the pregnant women about their pregnancies and about alternative methods of delivery — including information on when Caesars are necessary, and when they are not necessary.

The incentive to avoid lengthy hospital stays is Momentum's provision of a nurse to take home. This happens if the new mother is discharged from hospital within two days of an uncomplicated birth — or three days after a Caesarean section. The nurse will help at home for another two days. It is naturally much cheaper for the insurer to pay a nurse than to pay the hospital for additional days.

Momentum has been collecting data on Caesarean deliveries. The sample is too small for firm conclusions yet, but it suggests that some doctors perform Caesarean sections almost to the exclusion of natural births.

For anyone contemplating parenthood, however, a word of warning. The maternity counsellor can be hard to find — and it takes a while for the telephone to be answered. I called looking for a maternity counsellor to test the level of information provided. After a frustrating wait (and questions I did not want to answer to a nameless telephonist), I was told all the counsellors were at a meeting.

Gore has recently returned from the US where he noted that the move in managed care and health maintenance organisations is towards satisfying consumers' demands.

The system where by the general practitioner becomes the gatekeeper to all other medical services is largely being abandoned, he says, in favour of allowing patients the choice.

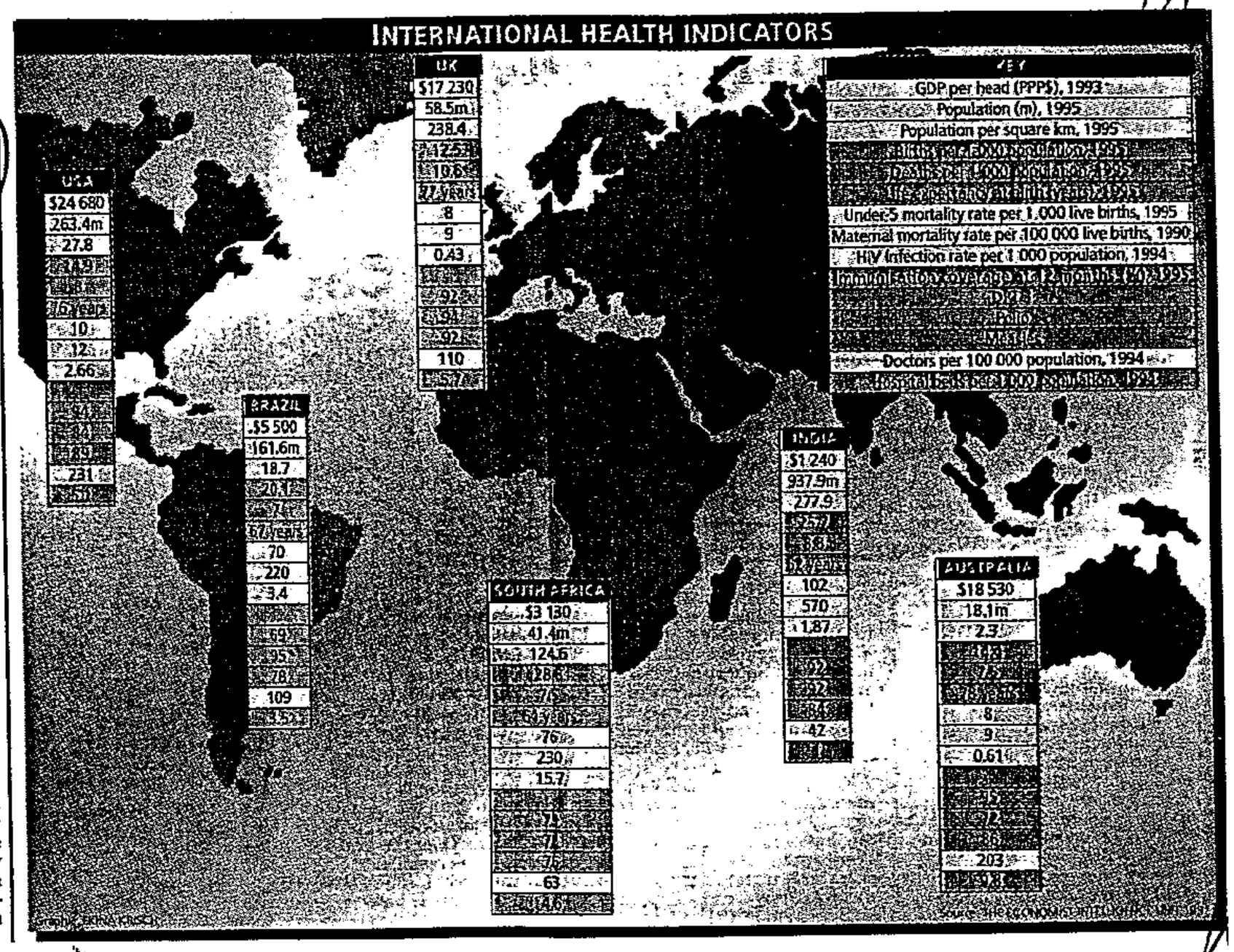
The patients, however, are increasingly being armed with information on which to base their medical choices.

He has returned, too, with another US buzzword, "demand management". To ordinary mortals this entails giving people better information.

It is done by using nurses or other health professionals on the other end of a telephone line as the first port of call for a patient.

A key area of Momentum's insurance products is its medical savings accounts. This is an area surrounded by controversy at the moment as government health planners are casting a slightly disapproving eye at this method of providing for health care financing.

The savings account allows the member the flexibility to make the health care choices herself and manage many of her own costs, as opposed to the top-down approach of many managed care groups and health maintenance organisations, according to Gore. He says it is an increasing trend in the US.



KATZ REPORT *Salary sacrifices under scrutiny*

(299)

Medical aid tax loophole may tighten

ET(BR)4/7/97

CHRISTO VOLSCHENK
ECONOMICS EDITOR

Cape Town — A popular tax loophole that allows employers to pay the total amount of employees' medical aid contributions could be partially closed if the government accepts the recommendation in the Katz commission's sixth report, released yesterday.

The Katz commission has proposed that employers only be allowed to deduct from tax the same amount as employees contribute to medical aid funds.

At present, an employer may deduct the full amount contributed to a medical aid fund.

The tax loophole allows higher-income employees to become members of medical aid funds without having to make contributions from their taxed incomes. This also cost employers nothing.

The commission's proposal would only partially eliminate the attraction of salary sacrifice, but it has proposed the government cut back further on the deductibility in due course.

The commission also suggested that the investment income of registered medical aid schemes remain tax-exempt, and that self-employed people be allowed to deduct 50 percent of their contribution to a medical aid scheme. The interest earned by a member of a medical savings account should also be subject to a withholding tax.

The commission did not recommend a rate for this tax, but said "it should not be too far below the corporate tax rate to discourage tax arbitrage".

The commission stopped short of extending tax deductibility to medical insurance plans.

"The amounts paid out by medical insurance plans are lump sum payments and, as capital receipts, they are not taxed," the commission said.

Regarding its proposal not to tax interest income of medical aid funds, the commission said the "matter should be kept under continuous review should medical schemes in due course become vehicles for the prefunding of post-retirement medical expenses".

Parliament's portfolio committee on finance will consider the report before the government decides which of the proposals to accept.

Medical aid tax dodge faces threat

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The Katz Commission on tax has recommended tightening the law to stop employers paying medical aid contributions for employees as a way of avoiding tax.

This sort of "salary sacrifice" scheme, where employees in high tax brackets accept a lower salary in return for employers' contributions to medical funds, is unfair to self-employed people, says the commission. ARG 4/7/97

It recommends employers be allowed to deduct from tax for contributions to medical aid only on a "rand for rand" basis, where for each rand contributed by employees, employers could contribute another rand and claim it as a deduction from taxable income. – Business Editor

Medicare: it's time to focus on what you buy

(299)

By Janine Simon
Medical Correspondent

Sowan 8/12/97

Private medical care in South Africa is still more focused on the transaction than the outcome of the treatment.

"No one is focusing on what they are buying," says John Wardle, who returned to the United States last month after spending two years setting up Southern HealthCare JV, the first major managed health care company to enter the medical aid market.

Southern is a joint venture between Anglo American, Southern Life and the American-based United Health Care.

Wardle said managed care would help disseminate information with which consumers could in future ask solid questions about their care.

This was one of the trends which had developed in the United States, which had many similar elements to the South African health care market at the time managed care had been introduced.

In both countries managed care had been introduced at a time when there was uncontrolled cost escalation, private-sector financing of employee health care and an over-supply of private hospital beds

There was also no reliable information, a fiercely independent physician community and a lack of consumer involvement.

Lack of consumer involvement

What was different, Wardle said, was the under-supply of private doctors in South Africa and the significant gap between the public and private sectors.

There were no anti-trust regulations, a fact which had allowed private-practitioner groups to form companies to represent professions such as surgeons, gynaecologists, ear-nose-and-throat specialists, cardiologists and orthopods.

There were also few set standards in the local private health care industry, for example on the standard of medical record keeping, and thus too little intervention by regulatory authorities.

Recent developments to accredit hospitals to national standards were a "step in the right direction", Wardle said.

The managed health care industry needed to agree about standard data coding and standard claim forms, which it had been trying to do for more than a year. "Its not that difficult, you just have to do it."

There was also a great opportunity for the private hospital sector, which was sophisticated, well managed but over-supplied with beds, to cooperate with the state.

HEALTH CARE

299 FM 11/7/97

Medical aid on knife

SA's health-care industry in turmoil as Health Minister Zuma plans medical coverage for everyone

The health-care controversy is probably the most heated of all the issues surrounding government's drive to expand basic social services. Simmering tensions persist between Health Minister Nkosazana Zuma's socialist policies and the medical schemes' commercial ethos.

But wide disparities in the provision of health care in SA cannot be ignored.

This year the medical aid schemes will spend nearly R20bn servicing 6,5m people. Another 6,8m have jobs with no medical aid. The rest of the population depends on the State, which is expected to spend R20,2bn on health care in 1997-1998.

The ideological battle between Zuma and the private health sector pivots on the Minister's determination to cap medical aid costs while increasing the number of people covered.

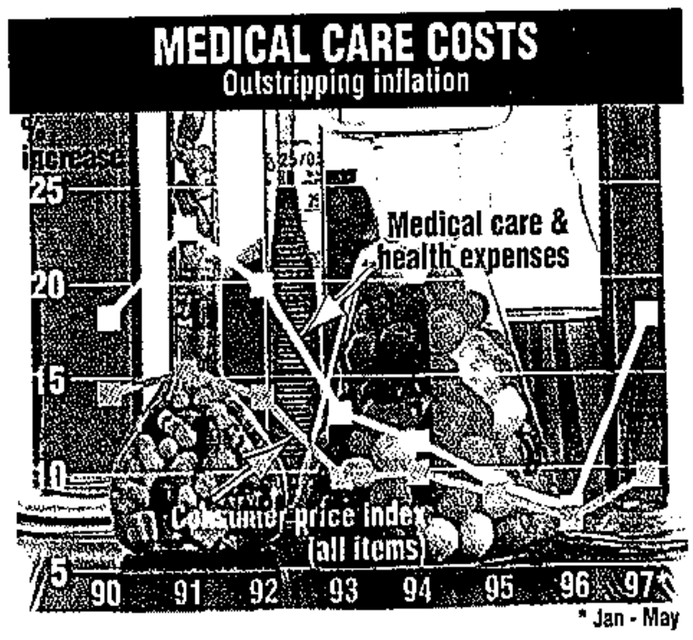
High and rising medical costs are steadily pricing private health care beyond the reach of the chronically sick and the aged. These are the patients who threaten to fall back on to a collapsing State health system. Zuma believes the solution is to force medical aids to provide subsidised cover to such high-risk groups.

Industry bodies say this is financially unsustainable. They argue that her proposals will push up premiums by an average 30% — prompting young and healthy members to bail out of the system, making private medical care less affordable for all and putting many schemes out of business.

The health-care arms of companies such as Fedsure, Momentum and Sanlam say Zuma's proposals amount to nationalisation of the medical aid industry. Her advisers reply that all government wants is affordable and wide-ranging cradle-to-grave cover from the private sector.

The debate has threatened to split the official medical aid schemes body, the Representative Association of Medical Schemes (Rams).

***Medicine queues at Johannesburg Hospital** . . . could medical aids pick up the tab?*



Leading the charge against Zuma's crusade is a faction within Rams called the Concerned Medical Schemes Group (Coms). These include the likes of Sanlam, Fedsure and Momentum — 15 companies in all, representing nearly 2m medical aid members — who have clubbed together because they felt Rams was not pressing their interests strongly enough on the issue.

Coms says the department's proposed amendments to the Medical Schemes Act will eliminate many of the incentives used to contain costs since the industry began deregulating in the late Eighties. In an attempt to curtail spiralling medical costs which threatened the viability of the medical aid industry, the Medical Schemes Act was amended in 1989 and again in the Nineties to allow schemes to base contribution rates on age and health.

Now the ANC government is seeking to reverse this step by returning to community rating, where everyone pays a flat contribution irrespective of their age or health risk. This means that the sick and aged are subsidised by the young and healthy. Medical aids will also have to enrol everyone who applies.

Coms, backed by the Life Offices Association (LOA) — representing the health insurance industry — argues that the proposals will encourage the young and healthy to opt out of medical schemes. Because they are in effect overcharged to cross-subsidise pensioners, they will per-

FM 11/7/97

edge

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ceive poor value for money, and as they may enrol at any time, they need join only when sick.

Momentum Health CEO and Coms co-ordinator Adrian Gore argues that to compensate for the loss of low-risk members, premiums will be increased and more young people will leave, "resulting in an upward price spiral which ends up penalising the old and sick."

A survey by US-based actuaries Milliman and Robertson has found that the proposals will increase medical scheme contribution rates by 30% on average. Coms has presented these findings to the department and says it is "making headway" in negotiations.

But the Medical Association of SA (Masa) accuses the industry of wanting to preserve the status quo. Masa spokesman Dr Richard Tuft says government should not be obliged to cater for those that the private sector deems unprofitable. "It is unacceptable that pensioners who have had adequate medical cover all their lives are unable to afford it when they most need it and are passed back on to a collapsing State system."

Masa is challenging the industry to devise credible alternatives, without which it considers community rating to be the only workable method to ensure universal and affordable access to health care.

Coms and the LOA propose as an alternative a system of community rating by class or category. Under this scheme enrolments would be limited, but once people were accepted into a scheme they could be rated on the grounds of age, sex, family size, income and geographic area.

To ensure those too ill to be admitted into standard schemes are brought into the net, they suggest creating a new high-risk scheme, to be privately administered and funded by a 1% levy on all schemes.

For current pensioners they suggest that schemes with a lower than average number of pensioners subsidise those with more than average.

They estimate the likely cost of caring for both groups to be 3% of the national health budget — far less, they say, than the costs of carrying out Zuma's proposals.

The department, however, has reacted with scepticism to the companies' proposals. Patrick Masobe, the co-ordinator of Zuma's advisory team, points out that the State provides a R5bn tax deduction to the private sector to create incentives to cover high-risk groups. He charges his detractors with "failing to respond to the challenges of our time" and calls for alternative solutions "motivated by more than just narrow self-interest."

In the industry's eyes, government has added insult to injury by suggesting the abolition of medical savings accounts. These allow an estimated 750 000 South Africans to cover small, everyday medical expenses through individual savings accounts linked to their medical aid policies. The Health Department claims that these savings accounts undermine community rating. But it seems to be wavering, and may be content to allow them to continue on condition they are disqualified from tax deductibility.

Further controversy lies in the department's proposal that all medical schemes provide a prescribed set of minimum benefits — a package it has consistently refused to define.

It is still not clear whether this would be a mandatory hospital package to cover the costs of employed people using public hospitals — a proposed social insurance tax contained in the Health White Paper.

Dan Pienaar, chairman of the LOA's health-care standing committee, sees the proposal as a form of dedicated tax that existing medical aid members (who do not wish to use public hospitals) will pay to cross-subsidise health care for the majority.

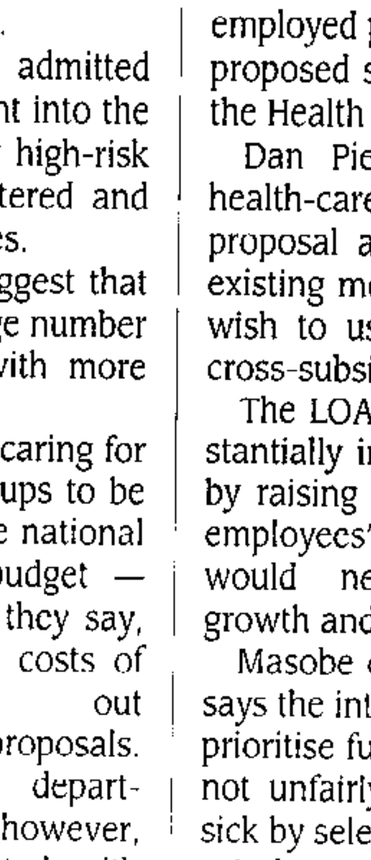
The LOA believes this proposal will substantially increase the cost of employment by raising the employers' contributions to employees' medical aid premiums. This would negatively influence economic growth and aggravate unemployment.

Masobe dismisses this as far-fetched. He says the intention is to ensure that schemes prioritise funding for necessary care and do not unfairly discriminate against the very sick by selective restructuring of benefits.

Industry sources say the department seems to be softening to the idea that only those who have jobs but do not belong to medical aid (6,8m people) should be required to take out the prescribed minimum benefit cover. But key industry players fear that the department is firmly wedded to a socialist agenda; that it wants to absorb medical schemes into a tightly controlled national health system.

Such assertions are "not only unhelpful, but tedious," says Masobe. "The only concern here is to ensure adequate, affordable and sustainable cradle-to-grave cover within the private sector." His advisory team plans to present its proposals to Zuma soon, whereafter a policy document and draft Act will be published for comment. The ensuing legislation should be presented to parliament before the end of the year.

Claire Bisseker



Arnold Pronto

Minister Zuma and Momentum's Gore *. . . clash over ideologies*

Soaring costs

ESANN
de Kock

As a medical aid contributor, you've been feeling the pinch as medical inflation has sent your premiums rocketing over the past few years.

And, if you're not, you should be concerned about your health planning for retirement.

It is no secret that many medical schemes are experiencing problems – mainly because they have been poorly managed, both financially and structurally.

Nature of medical schemes

Gary Scott of Old Mutual Actuaries and Consultants points out that a medical aid scheme, generally, constitutes three elements:

◆It is an employee benefit structured by your employer and included in your pay package;

◆It is a social club which lets you pool expenses and where you subsidise others and/or are subsidised by the rest of the club; and

◆It is a purchasing co-operative which negotiates on your behalf with medical suppliers and negotiates rates on your behalf.

Scott says your contribution in relation to that of your employer, the nature and extent of the cross subsidisation in your club and the effectiveness of your scheme as a co-operative will determine your degree of satisfaction with it.

Medical inflation

Over the past few years medical costs have soared – particularly in hospital care and medicines. This, combined with rising medical claims, has been passed on as higher medical aid premiums.

Recent statistics released by the University of the Witwatersrand show real per capita costs in medical schemes have risen at a compound rate of 9,64 percent a year since the early eighties.

This is double the inflation rate.

Martin de Villiers, Senior Strategic Manager at Sanlam Health, says rising contributions have resulted in many lower-income employees choosing not to join medical aid schemes. One of the concerns is the contribution levels and the same criteria.

"You may belong to a scheme where you, as a young and healthy person, are paying the same contribution as another member who is 65 years old with heart trouble.

"So the young and healthy are subsidising the sick and elderly."

As a result, Slawski says, younger members are opting out of the system and going for cheaper forms of cover.

This, in turn, results in dwindling subsidies and a reduction of funds for paying claims.

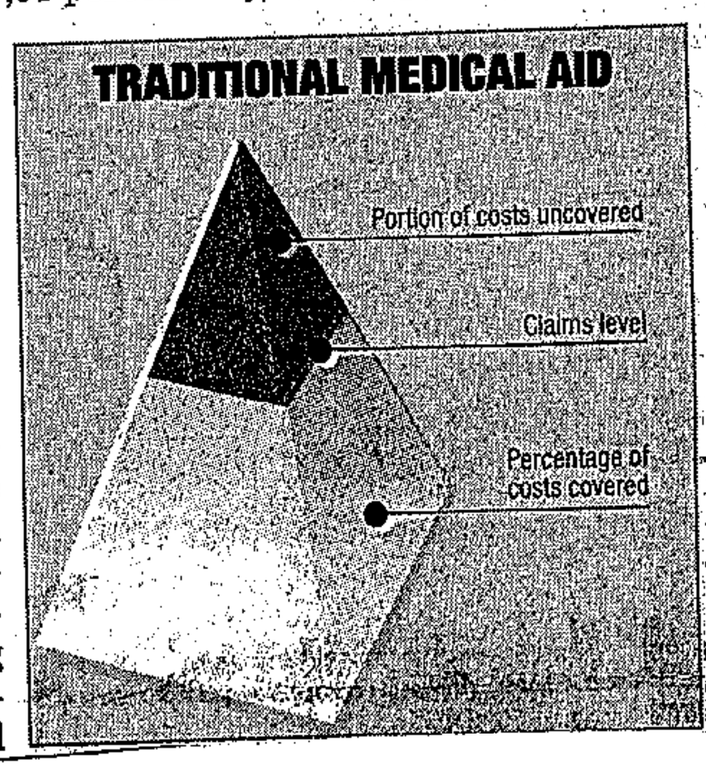
Slawski points out there has been a lack of understanding among medical aid schemes of where risk is coming from, how to manage it and how factors such as age, sex and access to health care have been driving costs.

◆**Over-treatment:** Scott says another reason why your medical aid is costing you so much is that medical aid schemes have not been controlling costs effectively.

He says people have been pampered and have come to believe that this is the norm. In many cases, patients have been getting expensive, unnecessary treatment.

"At some point, someone has to say stop and begin administering appropriate treatment. At the moment, there does not seem to be any rationing or control."

◆**Abuse:** Scott and De Villiers agree that there are no incentives to discourage over-treating patients and to prevent abuse of medical aid schemes.



Today Personal Finance publishes two different measures of consistency of performance. The first is the Personal Finance/MoneyMate consistency of performance tables for individual funds and the second is the Plexus Asset Management consistency of performance of unit trust management companies. Consistent performance over the medium to longer term remains the best factor to judge the likely performance of a unit trust.

Investec outperforms its competitors to take top spot

Investec has displaced Old Mutual as the unit trust management company with the most consistent top performance over three years.

This is the major change in the quarterly unit trust management company survey conducted by Plexus Asset Management, a unit trust specialist company, in association with Professor Eon Smit of the Graduate School of Business at the University of Stellenbosch.

Prieur du Plessis, chief executive of Plexus, says: "Having one top performing unit trust out of a number of unit trusts does not prove much.

"With enough unit trusts under management – and a bit of luck or per-

MANAGEMENT COMPANY CONSISTENCY OF PERFORMANCE

	One Year			Two Years			Three Years	
	Points	Rnk		Points	Rnk		Points	Rnk
BOE	1,33	1	BOE	1,67	1	Investec	1,33	1
Fedgro	1,75	2	Fedgro	1,67	1	Old Mutual	2,29	2
Syfrets	2,60	3	Investec	2,14	3	GuardBank	2,75	3
Standard Bank	2,71	4	RMB	2,50	4	Syfrets	3,20	4
Investec	2,86	5	Syfrets	2,57	5	ABSA	3,33	5
RMB	3,00	6	Old Mutual	2,67	6	Southern	3,50	6
Southern	3,00	6	GuardBank	3,00	7	Standard Bank	3,67	7
Old Mutual	3,11	8	ABSA	3,25	8	UAL	3,75	8
Sanlam	3,25	9	Southern	3,25	8	Sanlam	3,80	9
UAL	3,40	10	UAL	3,40	10			
GuardBank	3,71	11	Sanlam	3,50	11			
ABSA	4,00	12	Standard Bank	3,57	12			

enter the three-year category in the last quarter of 1997 and Fedgro in the first quarter of next year, a battle with Investec for top honours is inevitable.

Syfrets seems to have recovered from persistent staff losses and improved its position over all measurement periods since the last survey.

As an add-on to the survey Plexus has also looked at the risk involved in the various fund management companies achieving their results.

Plexus used a system called the Sharpe ratio which takes both returns and the volatility of performance risk measure into account.

The more volatile a fund in returns above or below the average performance

schemes and, instead, to rely on the State for their health care.

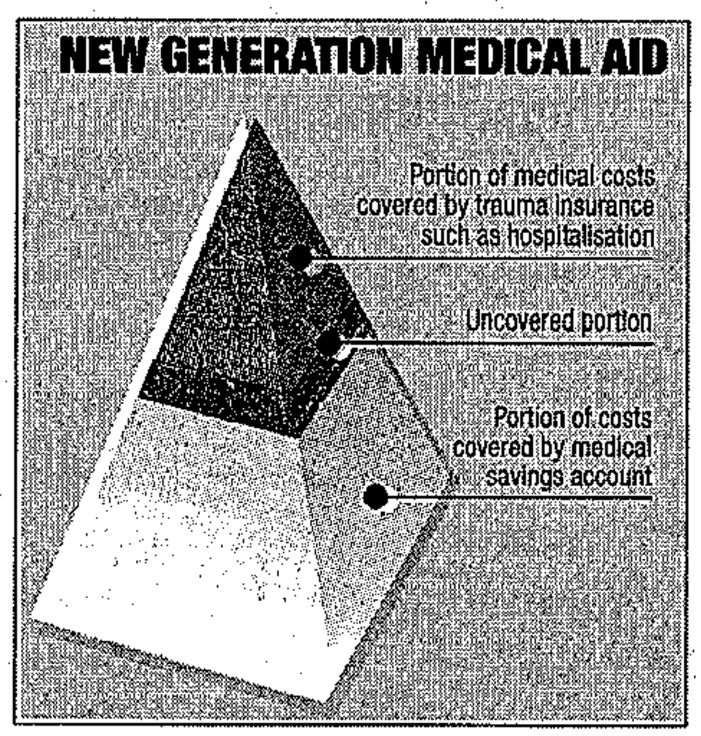
While this placed an additional burden on scarce government resources and funding, it also meant that for those who remained members of medical aid schemes, costs increased as the pool of contributors shrunk.

De Villiers points out that increases are not only related to price, but also to volume of health consumption, improvement in pharmaceutical and diagnostic technology and high expectations of consumers.

Before the industry was deregulated in 1994, he says efforts were made to reduce premiums and increase access to funds.

The result was that benefits suffered and quality deteriorated.

Today membership of traditional medical schemes is still largely race-based with about 69 percent of whites, 34 percent of Asians, 30 percent of coloureds and only 6,7 percent of black people covered by these schemes.



In an effort to find solutions to the problem of high costs, the industry warned that regulation made it impossible to properly administer medical schemes.

It suggested deregulation to enable it to exercise self-regulation and bring costs under control.

In 1994 government deregulated the industry through changes to the Medical Schemes Act.

Today, three years later, you are paying as much as ever for health care, access has not improved and abuse has not disappeared.

Unsound financial and benefit structures:

With membership of medical aid schemes often a condition of employment for higher categories of employees, the effectiveness of your scheme is high priority – especially in relation to what you pay.

◆The problem of risk ratings: Janina Slawski, actuary at Southern Life's Group Risk Management Consultancy, says one of the major factors pushing up your costs is that medical aid schemes are forced to allow members in on the same use-it-or-lose it structure, which makes members think they're getting poor value for money because if they don't use their benefits, they lose them.

Another is that of "first rand" "coverage which encourages abuse."

If your claims are paid out in full from the first rand you spend, there's no reason why you should not get medical treatment for any reason whatsoever.

Solutions

Medical aid schemes know they have to reform if they want to avoid being part of a looming crisis.

They have to tighten up financial controls and reconsider benefit structures to make it attractive for both the young and healthy as well as the old and sick to join.

De Villiers points out that some degree of reform started with the deregulation of the health care industry.

It allowed so-called New Generation schemes onto the market.

One of the benefits of these schemes was that people could have medical savings accounts.

This helped prevent cross subsidisation of people on the lower claims level.

It also meant that, if they were healthy and conscientious, they enjoyed the benefit of more money in their savings accounts and they could build up reserves for when they were older and would have potentially higher claims.

Scott says New Generation schemes show that to deal with medical aid you have to recognise that there are two reasons for a person to join a scheme:

◆To have some form of long-term medical insurance; and

◆To have an account for day-to-day medical expenses.

A savings account catering for the latter has made a lot of sense to both employers and the public.

Slawski says savings accounts are where the private sector would like to go, preferably with an element of managed care so that members are also educated on good decision-making.

Still, only some companies have opted for these schemes and the

Medical aid expectation is doomed

ARG 19/7/97 (299)

ESANN DE KOCK

South Africans with medical aids have been pampered into high expectations of health care which neither they nor the country can afford and sustain.

Strong words by the Director-General of Health Dr Olive Shisana – especially if you're someone who contributes almost 20 percent of your salary towards medical aid and whose premiums, over the past decade, have been consistently higher than inflation.

While people on medical aid have had to cough up more and more for often unnecessary and expensive medical care, the public sector has continued to lag behind.

And, says Shisana, it's been an uphill battle to bring even basic health care within reach of the poor – let alone quality health care.

With elections only two years away, the government's bottom line is clear: Bringing medical care within reach of all South Africans is a priority.

Value-for-money medical care

Shisana is clear that the small percentage of people who belong to medical aid schemes (about 20 percent of the population) have been led to believe that their contributions to these funds have automatically meant access to quality medical care. This has simply not been the case, she says.

For example, many healthy women today give birth by expensive Caesarean section rather than naturally. This is not because they have medical problems, but because it's easier. And, it enables the doctor to plan the birth instead of being on stand-by at all hours.

Over-treatment, unnecessary medication and the inflated cost of medicines have been some of the reasons why your increasing premiums have not necessarily matched the quality of care you have been getting.

STARTING ON PAGE 3 TODAY
THE FIRST IN A FIVE PART SERIES ON OPTIONS AVAILABLE TO YOU TO MEET THE SOARING COSTS OF HEALTH CARE

The public sector

The government knows that while those on medical aid are able to access health care conveniently and almost immediately and have a choice of expensive – yet often unnecessary – treatment, others sometimes have to wait or travel for days to see a doctor.

It is committed to changing the scenario where R20 billion is spent a year through the private sector on health care for about 20 percent of the population and the government has R20 billion to spend on the remaining 80 percent.

The government's proposal of a National Health Insurance Scheme to which all formally employed South Africans earning above R12 000 a year will contribute, will radically change the face of health care in South Africa.

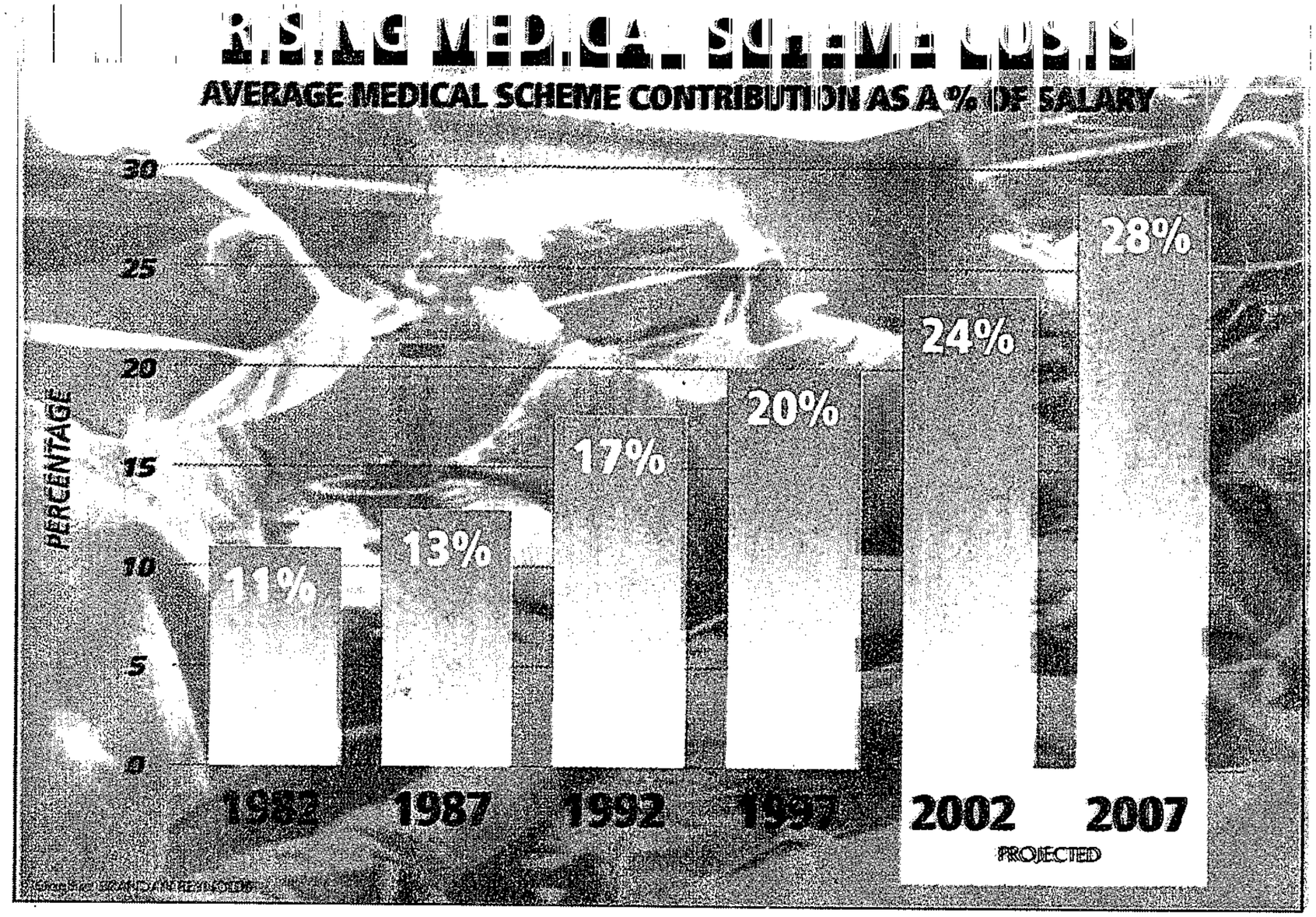
For you it will mean contributing to a national health pool and paying your own medical aid premiums.

The government says the idea is to give the poor access to quality health care and to make those who can afford it, pay for medical care.

Martin de Villiers, Sanlam's Health Strategic Manager, says government is looking at what has happened since the deregulation of the healthcare industry two years ago.

Costs have not decreased, access has not improved and abuse in the system has not disappeared, he says.

"In other words, the government says self-regulation does not exist and it therefore, once again, wants to regulate the industry to achieve its goals."



The private sector

The private sector's huge, rapidly changing market is trying to offer you products that best suit your pocket.

This sector, too, is under close scrutiny from all quarters.

Recent proposals by the Katz Commission have focused on taxing cash withdrawals from and interest credited to medical savings accounts as well as recommendations on the post-retirement funding of medical expenses through retirement fund vehicles.

The private sector is coming up with new and innovative solutions (so-called New Generation products) to problems and is actively marketing alternatives to what existed in the past.

Some of these, like the Managed Care option which concentrates on prevention and early detection of illness to save you and the industry money in the long run, have been hailed as the answer to the current problems.

There is a strong debate raging in the medical industry about the direction in which private health care should be moving, where medical aid funds have gone wrong, what they are doing right and how to fix the mistakes of the past.

The crisis is such that people on medical aid now need to start planning for their health care needs at retirement.

Many private sector players have made no bones about the fact that they don't see the National Health Insurance Scheme alleviating the state's burden.

Some believe that government has neither the finance, knowledge or manpower to provide affordable health care to all and should, instead, focus on an efficient and robust private sector healthcare environment.

Medical aid expectation is doomed

Sten 19/7/97 (299)

ESANN DE KOCK

South Africans with medical aids have been pampered into high expectations of health care which neither they nor the country can afford and sustain.

Strong words by the Director-General of Health Dr Olive Shisana – especially if you're someone who contributes almost 20 percent of your salary towards medical aid and whose premiums, over the past decade, have been consistently higher than inflation.

While people on medical aid have had to cough up more and more for often unnecessary and expensive medical care, the public sector has continued to lag behind.

And, says Shisana, it's been an uphill battle to bring even basic health care within reach of the poor – let alone quality health care.

With elections only two years away, the government's bottom line is clear: Bringing medical care within reach of all South Africans is a priority.

STARTING ON PAGE 19 TODAY THE FIRST IN A FIVE PART SERIES ON OPTIONS AVAILABLE TO YOU TO MEET THE SOARING COSTS OF HEALTH CARE

Value-for-money medical care

Shisana is clear that the small percentage of people who belong to medical aid schemes (about 20 percent of the population) have been led to believe that their contributions to these funds have automatically meant access to quality medical care. This has simply not been the case, she says.

For example, many healthy women today give birth by expensive Caesarean section rather than naturally. This is not because they have medical problems, but because it's easier. And, it enables the doctor to plan the birth instead of being on stand-by at all hours.

Over-treatment, unnecessary medication and the inflated cost of medicines have been some of the reasons why your increasing premiums have not necessarily matched the quality of care you have been getting.

The public sector

The government knows that while those on medical aid are able to access health care conveniently and almost immediately and have a choice of expensive – yet often unnecessary – treatment, others sometimes have to wait or travel for days to see a doctor.

It is committed to changing the scenario where R20 billion is spent a year through the private sector on health care for about 20 percent of the population and the government has R20 billion to spend on the remaining 80 percent.

The government's proposal of a National Health Insurance Scheme to which all formally employed South Africans earning above R12 000 a year will contribute, will radically change the face of health care in South Africa.

For you it will mean contributing to a national health pool and paying your own medical aid premiums.

The government says the idea is to give the poor access to quality health care and to make those who can afford it, pay for medical care.

Martin de Villiers, Sanlam's Health Strategic Manager, says government is looking at what has happened since the deregulation of the healthcare industry two years ago.

Costs have not decreased, access has not improved and abuse in the system has not disappeared, he says.

"In other words, the government says self-regulation does not exist and it therefore, once again, wants to regulate the industry to achieve its goals."

The private sector

The private sector's huge, rapidly changing market is trying to offer you products that best suit your pocket.

This sector, too, is under close scrutiny from all quarters.

Recent proposals by the Katz Commission have focused on taxing cash withdrawals from and interest credited to medical savings accounts as well as recommendations on the post-retirement funding of medical expenses through retirement fund vehicles.

The private sector is coming up with new and innovative solutions (so-called New Generation products) to problems and is actively marketing alternatives to what existed in the past.

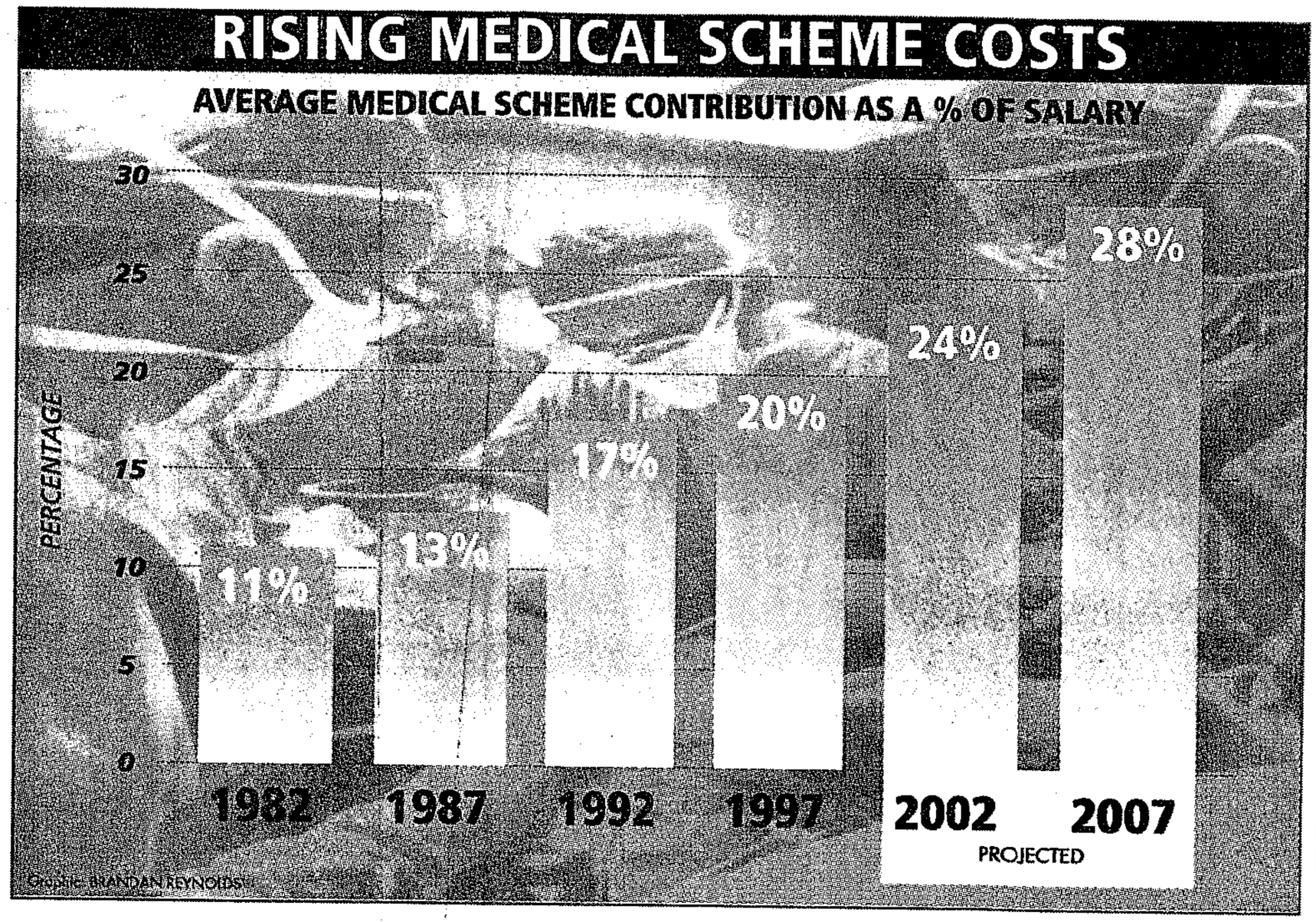
Some of these, like the Managed Care option which concentrates on prevention and early detection of illness to save you and the industry money in the long run, have been hailed as the answer to the current problems.

There is a strong debate raging in the medical industry about the direction in which private health care should be moving, where medical aid funds have gone wrong, what they are doing right and how to fix the mistakes of the past.

The crisis is such that people on medical aid now need to start planning for their health care needs at retirement.

Many private sector players have made no bones about the fact that they don't see the National Health Insurance Scheme alleviating the state's burden.

Some believe that government has neither the finance, knowledge or manpower to provide affordable health care to all and should, instead, focus on an efficient and robust private sector healthcare environment.



Soaring costs at heart of medical aid crisis

(299) Star 19/7/97

As a medical aid contributor, you've been feeling the pinch as medical inflation has sent your premiums rocketing over the past few years.

And, if you're not, you should be concerned about your health planning for retirement.

It is no secret that many medical schemes are experiencing problems – mainly because they have been poorly managed, both financially and structurally.

ESANN de Kock

Nature of medical schemes

Gary Scott of Old Mutual Actuaries and Consultants points out that a medical aid scheme, generally, constitutes three elements:

◆It is an employee benefit structured by your employer and included in your pay package;

◆It is a social club which lets you pool expenses and where you subsidise others and/or are subsidised by the rest of the club; and

◆It is a purchasing co-operative which negotiates on your behalf with medical suppliers and negotiates rates on your behalf.

Scott says your contribution in relation to that of your employer, the nature and extent of the cross subsidisation in your club and the effectiveness of your scheme as a co-operative will determine your degree of satisfaction with it.

Medical inflation

Over the past few years medical costs have soared – particularly in hospital care and medicines. This, combined with rising medical claims, has been passed on as higher medical aid premiums.

Recent statistics released by the University of the Witwatersrand show real per capita costs in medical schemes have risen at a compound rate of 9,64 percent a year since the early eighties.

This is double the inflation rate.

Martin de Villiers, Senior Strategic Manager at Sanlam Health, says rising contributions have resulted in many lower-contribution levels and the same criteria.

"You may belong to a scheme where you, as a young and healthy person, are paying the same contribution as another member who is 65 years old with heart trouble.

"So the young and healthy are subsidising the sick and elderly."

As a result, Slawski says, younger members are opting out of the system and going for cheaper forms of cover.

This, in turn, results in dwindling subsidies and a reduction of funds for paying claims.

Slawski points out there has been a lack of understanding among medical aid schemes of where risk is coming from, how to manage it and how factors such as age, sex and access to health care have been driving costs.

◆ **Over-treatment:** Scott says another reason why your medical aid is costing you so much is that medical aid schemes have not been controlling costs effectively.

He says people have been pampered and have come to believe that this is the norm. In many cases, patients have been getting expensive, unnecessary treatment.

"At some point, someone has to say stop and begin administering appropriate treatment. At the moment, there does not seem to be any rationing or control."

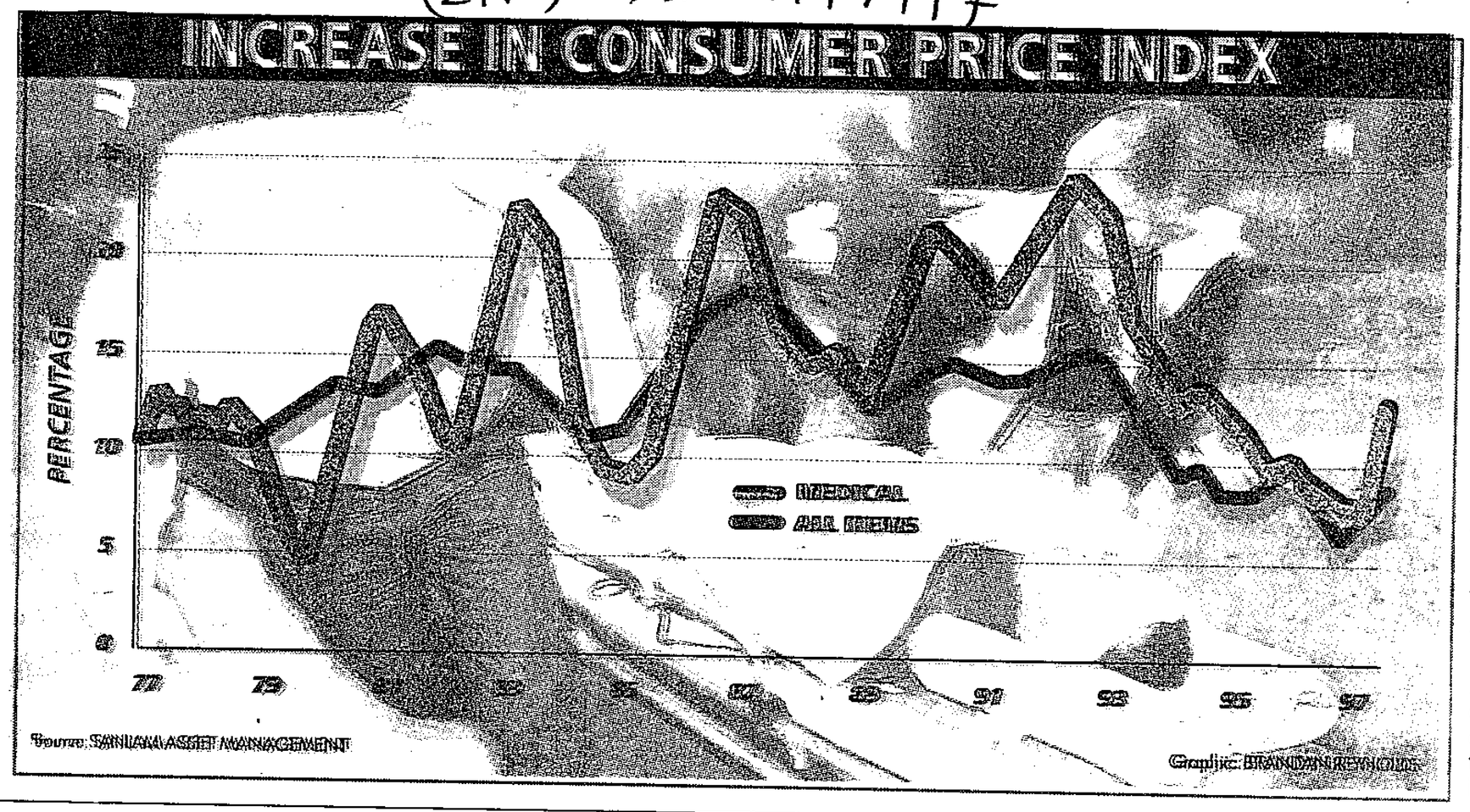
◆ **Abuse:** Scott and De Villiers agree that there are no incentives to discourage over-treating patients and to prevent abuse problem of rising costs has not disappeared.

While medical savings accounts seemed an attractive option to encourage members of medical aid schemes to moderate their claims by returning some of their unspent contributions, the Katz Commission has now proposed to tax cash withdrawals from and interest credited to these savings accounts.

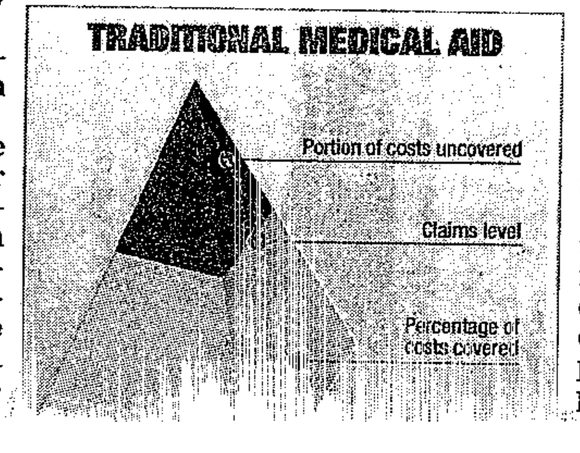
Government has said it wants to see savings funds taxed in an effort to prevent younger people from opting out of traditional medical aid schemes where they have to cross-subsidise older, sick people.

While the private sector is investigating its options and government proposals have been put on the table, unsound financial practices and benefit structures continue to plague schemes and obstruct your access to a truly efficient system of private health care.

The greatest challenge for the private health sector remains to make your medical aid cover affordable and to provide quality medical care.



RUNAWAY COSTS: The graph shows how, over the past 10 years, increases in medical costs have outstripped total inflation



ees choosing not to join medical aid schemes and, instead, to rely on the State for their health care.

While this placed an additional burden on scarce government resources and funding, it also meant that for those who remained members of medical aid schemes, costs increased as the pool of contributors shrunk.

De Villiers points out that increases are not only related to price, but also to volume of health consumption, improvement in pharmaceutical and diagnostic technology and high expectations of consumers.

Before the industry was deregulated in 1994, he says efforts were made to reduce premiums and increase access to funds.

The result was that benefits suffered and quality deteriorated.

Today membership of traditional medical schemes is still largely race-based with about 69 percent of whites, 34 percent of Asians, 30 percent of coloureds and only 6,7 percent of black people covered by these schemes.

In an effort to find solutions to the problem of high costs, the industry warned that regulation made it impossible to properly administer medical schemes.

It suggested deregulation to enable it to exercise self-regulation and bring costs under control.

In 1994 government deregulated the industry through changes to the Medical Schemes Act.

Today, three years later, you are paying as much as ever for health care, access has not improved and abuse has not disappeared.

Unsound financial and benefit structures:

With membership of medical aid schemes often a condition of employment for higher categories of employees, the effectiveness of your scheme is high priority – especially in relation to what you pay.

◆ **The problem of risk ratings:** Janina Slawski, actuary at Southern Life's Group Risk Management Consultancy, says one of the major factors pushing up your costs is that medical aid schemes are forced to allow members in on the same schemes.

One of the concerns is the use-it-or-lose it structure, which makes members think they're getting poor value for money because if they don't use their benefits, they lose them.

Another is that of "first rand "coverage which encourages abuse.

If your claims are paid out in full from the first rand you spend, there's no reason why you should not get medical treatment for any reason whatsoever.

Solutions

Medical aid schemes know they have to reform if they want to avoid being part of a looming crisis.

They have to tighten up financial controls and reconsider benefit structures to make it attractive for both the young and healthy as well as the old and sick to join.

De Villiers points out that some degree of reform started with the deregulation of the health care industry.

It allowed so-called New Generation schemes onto the market.

One of the benefits of these schemes was that people could have medical savings accounts.

This helped prevent cross subsidisation of people on the lower claims level.

It also meant that, if they were healthy and conscientious, they enjoyed the benefit of more money in their savings accounts and they could build up reserves for when they were older and would have potentially higher claims.

Scott says New Generation schemes show that to deal with medical aid you have to recognise that there are two reasons for a person to join a scheme:

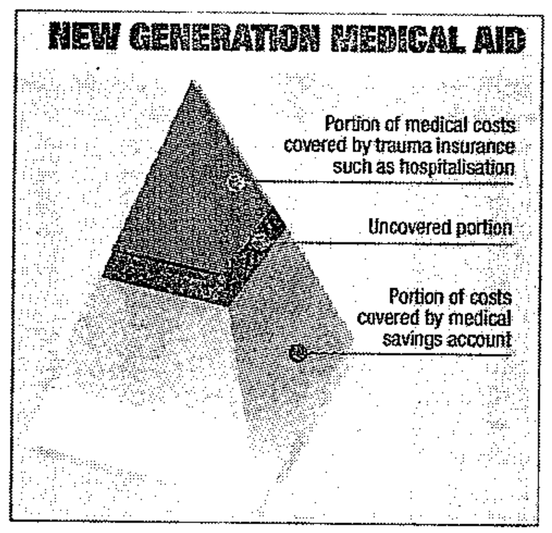
◆ To have some form of long-term medical insurance; and

◆ To have an account for day-to-day medical expenses.

A savings account catering for the latter has made a lot of sense to both employers and the public.

Slawski says savings accounts are where the private sector would like to go, preferably with an element of managed care so that members are also educated on good decision-making.

Still, only some companies have opted for these schemes and the



The MINISTER OF JUSTICE:

(1) No. Meetings take place and when requested by me or the Attorneys-General. Communication between the Ministry and individual Attorneys-General also takes place whenever necessary on a person to person basis.

(2) Yes. I anticipate that making provision for regular meetings with Attorneys-General – together and individually – will be arranged especially once the office of National Director of Public Prosecutions has been created.

(3) In the period referred to, meetings took place on 23 July 1996, 13 September 1996, 20 September 1996 and 20 June 1997 with all the Attorneys-General together. Some of the Attorneys-General were also seen on occasion on an individual basis.

Dockets to magistrate's courts: control measures

*6. Mr D H M GIBSON asked the Minister of Justice:

(1) Whether any control measures have been introduced in magistrate's courts to limit problems experienced with certain members of the South African Police Service who fail to present dockets to such courts; if not, what is the position in this regard; if so,

(2) whether these measures have been found to be successful; if not, why not; if so, what are the relevant details;

(3) whether any action has been taken against any members of the SAPS in this regard; if not, why not; if so, (a) what action and (b) against how many such members?N1764E

The MINISTER OF JUSTICE:

(1) Yes.

(2) At a meeting in June 1997, all the Attorneys-General stated that on trial dates in regional courts, over 50% of the dockets were not brought to court. Pursuant thereto the Commissioner of Police was approached. The Commissioner immediately instructed police throughout the country to remedy the problem. Almost all the Attorneys-General approached for comment presently report that in major centres, police liaison officers have been appointed to assist in the process of obtaining dockets for court purposes where investigating officers have failed to present same timeously. In general, prosecutors will first attempt to communicate with the concerned official in order to ascertain the reason(s) for the delay. If this does not bear fruits, the responsible official is reported to his superior officer and this usually has the required result. This matter is addressed at meetings with officers of the South African Police Service on a regular basis.

(3) The only action taken against members of the South African Police Service, in this regard is to report them to a higher authority in the South African Police Service. Disciplinary steps against investigating officers falls outside the area of responsibility of the Department of Justice.

Polmed: deficit in 1997- 98 financial year

*7. Mr A FOURIE asked the Minister for Safety and Security:†

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Whether it is expected that Polmed will experience a deficit in the 1997-98 financial year; if not, what is the position in this regard; if so, (a) why and (b) what are the further relevant details? N1765E

The MINISTER FOR SAFETY AND SECURITY:

Yes.

(a) and (b) On current trends Polmed will experience a deficit on the amount awarded by State Expenditure of between R500 million and R600 million. This deficit is not on the estimated budget but on the amount awarded to Polmed.

The difference between the estimated budget and the award by State Expenditure is that the budget is determined according to health care industry standards and past experience, while the amount awarded to Polmed by State Expenditure is determined in terms of the South African Police Service's total budget.

Polmed absorbed an additional 19 500 families on Polmed since 1995 as a result of the amalgamation, with the possibility of another 5000 members during 1997/1998. All these cost factors are not taken into account when an amount is awarded to Polmed.

The cost drivers in the health care industry are the following:

- medical inflation;
- increase in membership; and
- increase in utilisation by members.

Despite the above, the amount awarded to Polmed was reduced by ± R500 million (from ± R1 500 million to R1 000 million) against the estimated budget.

Severe action is currently being taken against both members and service providers with regard to the abuse of Polmed facilities, and many prosecutions are taking place.

In order to introduce effectively managed health care principles currently in practise in the private sector, it will be necessary, over time, to re-negotiate the conditions of employment with members of the South African Police Service.

SAPS: dissatisfaction concerning promotions/wages/overtime payments

*8. Col N G RAMAREMISA asked the Minister for Safety and Security:

(1) Whether he or the South African Police Service has been informed of dissatisfaction within the SAPS concerning (a) management's handling of the latest round of promotions and/or (b) wage negotiations and overtime payments; if so, what are the relevant details;

(2) whether he intends intervening into the matter; if not, why not; if so, in what manner;

(3) whether he will make a statement on the matter? N1766E

The MINISTER FOR SAFETY AND SECURITY:

(1) (a) Yes. The Interim Promotions Policy was effective up and until 1996-06-30. All promotions in terms of the said policy have been dealt with. The new promotions policy is up for negotiation at the National Negotiating Forum.

(b) I have been briefed about the relevant details regarding both the offer made by the State as well as the demands made by the unions.

I do not think that a one-sided disclosure of these details will contribute positively to the search for a negotiated agreement.

(2) Yes, I have been in discussion with at least two of the unions which have an organised presence in the SA Police Service. The latest meetings with the two unions took place earlier today. I am satisfied that they are conducting the search for a solution to the problems in good faith.

(3) No.

Value of recovered stolen vehicles

*9. Dr W J BOTHA asked the Minister for Safety and Security:†

What is the value of stolen vehicles recovered by members of the South African Police Service's vehicle theft units in (a) 1996 and (b) during the period 1 January 1997 up to the latest specified date for which information is available? N1767E

The MINISTER FOR SAFETY AND SECURITY:

(a) R3 480 169 843,00
(Three Billion, Four hundred and eighty Million, One Hundred and sixty nine Thousand, eight hundred and forty three Rand.)

(b) [Latest specified date: 1997-08-22]

R1 854 041 175,00
(One Billion, Eight hundred and fifty four Million, forty one Thousand and one hundred and seventy five Rand.)

Cape Point Nature Reserve: complaints from tourists

*10. Rev K R MESHOE asked the Minister of Environmental Affairs and Tourism:

(1) Whether he or his Department has received any complaints from international

the formal non-agricultural sectors.

In 1996 a total of 105 300 jobs were lost and during the first quarter of 1997, 41 946 jobs were lost.

Total Non-Agricultural Formal Business Sector

People employed

1994 Dec 5 343 820

1995 Dec 5 338 970

1996 Dec 5 233 670

1997 Mar 5 191 724

Jobs created/lost

Dec 1994 – Dec 1995: – 4 850

Dec 1995 – Dec 1996: – 105 300

Dec 1996 – Mar 1997: – 41 946

(b) Specific Industries

In this table we show the number of people employed for December 1994, 1995, 1996 and March 1997. The table also shows the differences between the number of people employed in December of a particular year and the number employed in December of the previous year.

Note: A plus sign (+) indicates the number of jobs created

A minus sign (-) indicates the number of jobs lost.

Mining

Number of people employed

1994 Dec 600 619

1995 Dec 582 766

1996 Dec 558 578

1997 Mar 556 779

Jobs created/lost Dec 1994 - Dec 1995: –17 853

Dec 1995 - Dec 1996: –24 188

Dec 1996 - Mar 1997: –1 799

Manufacturing

Number of people employed

1994 Dec 1 491 756

1995 Dec 1 477 819

1996 Dec 1 430 426

1997 Mar 1 416 344

Jobs created/lost Dec 1994 - Dec 1995 : –13 937

Dec 1995 - Dec 1996: –47 393

Dec 1996 - Mar 1997: –14 082

Electricity

Number of people employed

1994 Dec 40 515

1995 Dec 40 711

1996 Dec 39 857

1997 Mar 39 879

Jobs created/lost Dec 1994 - Dec 1995 +196

Dec 1995 - Dec 1996: –854

Dec 1996 - Mar 1997: +22

Construction

Number of people employed

1994 Dec 355 469

1995 Dec 337 276

1996 Dec 312 051

1997 Mar 314 814

Jobs created/lost Dec 1994 - Dec 1995: –18 193

Dec 1995 - Dec 1996: –25 225

Dec 1996 - Mar 1997: +2 763

Wholesale, Retail, Hotel and Motor Trade

Number of people employed

1994 Dec 760 328

1995 Dec 787 245

1996 Dec 775 577

1997 Mar 756 957

Jobs created/lost Dec 1994 - Dec 1995:+26 917

Dec 1995 - Dec 1996: -11 668

Dec 1996 - Mar 1997: -18 620

Transport, Storage and Communication

Number of people employed

1994 Dec 284 865

1995 Dec 280 235

1996 Dec 280 031

1997 Mar 278 763

Figures for the March 1997 quarter are preliminary.

Jobs created/lost Dec 1994 - Dec 1995: –4630

Dec 1995 - Dec 1996: –204

Dec 1996 - Mar 1997: –1 268

Banking, Building Societies and Insurance Companies

Number of people employed

1994 Dec 197 742

1995 Dec 208 352

1996 Dec 213 174

1997 Mar 212 378

Jobs created/lost Dec 1994 - Dec 1995: +10 610

Dec 1995 - Dec 1996: +4 822

Dec 1996 - Mar 1997: -796

Public Sector Community, Social and Personal Services

Government sector, parastatals, agricultural marketing boards, universities and technikons and laundries and dry-cleaning services

Number of people employed

1994 Dec 1 612 526

1995 Dec 1 624 566

1996 Dec 1 623 976

1997 Mar 1 615 810

Jobs created/lost Dec 1994 - Dec 1995:+12 040

Dec 1995 - Dec 1996: –590

Dec 1996 - Mar 1997: –8 166

(2) The above constitutes my statement on the matter.

* 13. Mr P I BIKITSHA – Home Affairs. [Written Question No 939] [Removed.]

*14. Mr B C BESTER – Home Affairs. [Written Question No 942] [Removed.]

*15. Mr F J VAN DEVENTER - Home Affairs. [Written Question No 943] [Removed.]

*16. Mr W L FOURIE – Home Affairs. [Written Question No 944] [Removed.]

Members of medical aid schemes/access to private health care services (299)

*17. Past Z K MANGALISO asked the Minister of Health: [Written Question No 946]

What percentage of the South African population (a) belonged to a medical aid scheme and (b) had access to private health care services on a regular basis in 1996? N1648E

The MINISTER OF HEALTH:

(a) Approximately 15 - 18% belong to registered medical schemes. This figure is based on the latest census figures published by the Central Statistical Services and information regarding those belonging to medical schemes that we can account for as at December 1995.

(b) The above percentage does not include persons who fund their own health care expenses and those who make use of alternative insurance policies. An estimate of almost 23% of South Africans have some form of access to private health care services.

Cases of malaria in S (297)

*18. Mrs P W CUPIDO asked the Minister of Health: [Written Question No 947]

Employers given medical aid warning

BD 2/9/97 (299)

Nicola Jenvey

DURBAN — More medical aid schemes would collapse under pressure of changes in the health care sector unless effective controls were introduced, National Medical Plan Administrators MD Rob Slater said yesterday.

He said employers should ensure they did not commit the funding of their employees' health care to organisations with unproved marketing ideas and inadequate administrative systems. His warnings follow reports last week that another medical aid scheme was in financial difficulties, affecting about 15 000 members.

Slater, who heads the largest KwaZulu-Natal-based private health care funder, said legislative controls were urgently needed to ensure the financial stability of medical schemes, especially with the government's plan to shift greater responsibility for health care to the private sector.

He believed the registrar of medical aid schemes would have to change the present 25% reserve recommendation to a legal requirement. However, this could force many smaller schemes to increase their premiums — effectively pricing them out of the market — and lead to further industry rationalisation.

"It is vital that all medical aid schemes stand up to in-depth and thorough public scrutiny. Many employers have fallen for the innovative but unproven ideas of some medical aid schemes and, as a result, many employees have lost money and been subjected to needless worry over health care," Slater said.

He said employers should look closely at medical aid schemes as potential business partners. This meant examining their financial stability, underwriting skills, claims processing times, information technology capabilities and track record in the industry.

The collapse of one relatively small medical aid scheme was "no cause for panic", but it should remind employers and members to show more interest in their funds' management.

Medical scheme crashes

Star 6/9/97 (299)

By JACKIE CAMERON

Pietermaritzburg-based Medilife Medical Scheme has crashed – leaving about 20 000 people around the country without medical cover – amid allegations that about R20-million has been misappropriated from the fund's coffers.

The medical scheme was placed under provisional liquidation by the High Court this week and moves were afoot yesterday to have the scheme's administrators provisionally liquidated, a legal source told the *Saturday Star*.

Medilife Medical Scheme, part of the Medilife Holdings group, has about 30 staff members, and Medilife Administration employs about 350 people.

"The scheme, about six years old, is the cash cow. It brings in the members' funds. It pays the administrators about 10% of the turnover. The Medilife Medical Scheme bank account is frozen, so no claims can be paid," the source said.

"Sadly, if a member needs to be hospitalised, no private hospital will take them. A provincial hospital is unlikely to help because these people are technically on medical aid, even though it will not pay."

Police have not yet been called in to investigate the allegations of financial "irregularities" involving R20-million.

The registrar of medical schemes applied for the winding up of this medical aid after receiving the 1996 draft audited results and the interim 1997 results.

"Questions are being asked about a loan of R2,5-million – which suddenly grew to about R20-million – made to at least one other company. The scheme's committee members didn't know about it," a Department of Health source said.

Medical schemes and pharmacists agree at last

BD 11/9/97

(299)

Pat Sidley

MEDICAL schemes and the retail pharmacy industry have finally reached agreement on a new scale of benefits to reimburse the costs of medicines to medical scheme members.

The new scale of benefits, effective from January 1 next year, will affect about 7-million people who belong to medical schemes.

Agreement between medical schemes and the retail pharmacy industry have been dogged by disputes.

RAMS announced yesterday that medical schemes would reimburse for pharmaceutical products according to a sliding scale using three tiers to its new reimbursement system.

It will require considerable arithmetical ability on the part of members of medical schemes, and is aimed at providing incentives for the supply of cheaper generic substitutes in place of the more expensive brand name medicines.

Cheaper drugs, which cost pharmacists up to R30 a prescription item, will be reimbursed by medical schemes at that price plus a 50% mark-up.

Drugs costing between R30 and R80 will be charged at the cost price to the pharmacist plus a dispensing fee of between R15 and R24, calculated on a sliding scale.

Drugs which cost more than R80 a prescription will be charged at their cost price plus a dispensing fee of R24.

Announcing the agreement yesterday, RAMS policy director Dr Aslam Dasoo said RAMS had found it impossible to prise loose from pharmaceutical manufacturers the prices at which drugs left their factories. The association had been forced to deal with the retail end of the industry only and would publish a list of its cost prices next week.

Medical aid schemes set for radical revamp

(299) BD 12/9/97

Pat Sidley

SA MEDICAL scheme regulations are due for a radical overhaul if proposals from the health department, now before the cabinet, become law.

According to a draft policy document of last month, with a foreword written by Health Minister Nkosazana Zuma, medical schemes will not be able to stop people becoming members on the basis of age, gender, claims patterns, experience and health risk. Nor will they be able to use these criteria to specify contributions.

"Anybody must be able to enter a medical scheme if they can afford to pay the average contribution regardless of their health condition," the document states.

Members will be able to stay in medical schemes regardless of health. This is in line with the department's earlier belief in a community rated system.

So as to protect the schemes against "adverse selection" and ensure people do not join schemes late in life or only when they are ill, certain protections are proposed, which include the following provisions:

- Applicants must have belonged to another medical scheme immediately prior to applying;
- Schemes may not deny coverage or impose pre-existing condition exclusions for more than 12 months for any condition diagnosed or treated within the six months preceding the member's application; and
- Waiting periods cannot exceed nine months for maternity or a three-month period for any other condition.

Schemes will all be expected to offer a basic minimum package. Another task group is to determine the package.

There have thus far been no studies of what the impact financially will be of any package of minimum benefits.

The department has softened its original line on individual medical savings accounts. It now proposes a maximum of 15% of annual contribution income can be put in individual medical savings accounts. The rest goes into a pooled fund.

The department has not, however, come to a final determination on the future of these funds.

The department has also softened its view over whether medical schemes can offer several options. Each option will have to offer minimum benefits when they become known, and each will have to be self-funding with no cross-subsidisation between options.

The department continues to draw up proposals for a social health insurance scheme, and is at an early stage of looking into regulations for managed health care.

DOCTORS REBELLIOUS

Medical aids set to play watchdog role

CT 16/9/97 (299)

MEDICAL AID FUNDS say a new system to oversee treatment by doctors will reduce subscription fees and ensure more responsible medical practice. **CLAUDIA CAVANAGH** reports.

IN a new system labelled by some doctors as "unethical and a waste of time", most medical aids in South Africa are insisting that doctors furnish full details regarding their patients' condition before agreeing to pay for certain procedures or admission to hospital.

Funds claim, however, that the procedure, as part of a managed healthcare programme, will result in better care and cut costs.

But some doctors are vehemently opposed, saying the move requires them to divulge confidential and personal patient information to medical aid "clerks" who then decide whether the treatment is appropriate and necessary before either granting or denying permission for it to proceed.

They feel there is a risk that information will get into the wrong hands and complain over wasted time obtaining permission on behalf of their patients.

"What happens when a patient wants an abortion or is being beaten up by her husband and she wants nobody to know. Must I tell it to a stranger over the phone who records every bit of information on a computer as we speak?" asked one doctor.

Medical aids say it is the only way to put the brakes on spiralling medical costs — currently escalating at 10% above the CPI (Consumer Price Index). To keep funds solvent, medical aid contributions have been increasing by as much as 20% per annum.

Most of the doctors' objections to the system are spurious, says Dr Aslam Dasoo, director of policy for the Representative Association of Medical Aids (Rams).

"This is common cause around the world and underpinned by solid medical protocol and backup — South Africa is in fact years behind."

That medical aids have access to patient information is nothing new either, he said, as members sign a disclosure of information contract allowing the fund access to all information regarding any treatment it will be paying for when they join.

And, says the Medical Association of South Africa (Masa), under the current system doctors in any case provide much of this information to medical aids through their accounting systems.

Says Dasoo: "It is impossible to control over-servicing or the provision of inappropriate care under the present system. This costs schemes millions of rands and translates directly into increased member subscriptions.

"Pre-authorisation is not handled by clerks, but always by a registered health worker under the cover of a medical practitioner," said Dasoo.

"In reality," said Mr Simon Crawford, a spokesman for Southern Health Care, which requires prior authorisation of its 110 000 members, "only a very small percentage — usually less than one percent — of procedures is ever turned down and this is always done on a doctor to doctor level.

"In a nutshell, our policy is not to say no, but it is important for us to know, so that the right care is given to our members.

"Through pre-authorisation, for example, our medical management department recently halted laser eye surgery on a member because our information revealed that this type of surgery, following a recent cataract operation, could cause blindness," said Crawford.

The procedure has also revealed interesting statistics. For instance, more than 60% of members giving birth in January had caesarean sections.

"Compare this to the fact that this figure is around 20% for South African mothers outside medical aids — around the same percentage as the national percentage in America," said Crawford.

"The individual data collected by Southern Health Care is strictly confidential and used to ensure the best medical outcome for the member.

Population information, like the percentage of asthma sufferers for instance — may be used to focus on management initiatives. This information may be shared, but never sold."

Dr Richard Tuft, chairman of Masa's private practice committee, says the current uncontrolled fee-for-service system pays doctors for whatever they do, providing no control of abuse, over-utilisation or inappropriate care.

"One of the objects of managed care is to reward good practice and make the doctor financially accountable for his or her practice pattern.

"It's impossible to manage the quality or cost of care without access to information. The trick is to acquire meaningful information, which will ultimately benefit the patient, without compromising the confidentiality of the doctor/patient relationship."

Masa believes details provided to medical aids should be case-specific, rather than blanket information. Most managed-care funds have not agreed.

Hospitals may publish guideline fees after medical aid scale rises 8%

(299) BD 15/9/97

Stephané Bothma

BENEFITS paid by medical aid schemes would increase by an average 8% next year, with recommended scales for doctors rising 10%, the Representative Association of Medical Schemes (Rams) said yesterday.

Benefits paid by Rams members this year are expected to exceed R20bn.

The announcement of an 8% tariff increase for private hospitals was met with concern by the Hospital Association of SA. Its executive director, Anette van der Merwe, said the organisation might publish its own guideline fee. She said the health care inflation rate was 12%.

"In the past five years our members have consistently kept increases way below the hospital inflation rate and if we do not get a more realistic increase it will be difficult to survive," Van der Merwe said. Since 1993 private hospitals had received increases of less than half of the inflation rate.

Rams said the 10% increase for doctors' services had evolved out of a new co-operative agreement between it and the Medical Association of SA with the exception of cost containment and improved quality of care.

"Due to consideration of the Maintenance and Promotion of Competition Act, regrettably no consultation has taken place with the hospital industry," Rams executive director Declan Brennan said in a newspaper advertisement yesterday.

He said his organisation again urged the hospital sector to address the spiralling costs of consumables, medicines and disposables.

Van der Merwe said the hospital industry was vulnerable to labour cost increases and falls in the rand's value. "Our industry is very labour intensive and a large portion of our equipment and consumables is imported."

She said despite a significant hike in salaries last year combined with a sharp drop in the rand which pushed hospital inflation through the roof, private hospitals fought back and managed to contain cost increases to 7%.

"Now private hospitals alone can no longer be expected to carry the burden of cost containment. The rest of the industry also has to play a role."

Van der Merwe said her organisation would decide whether to publish its own fee structure only after full consideration of all the implications of the tariff increase.

Other increases announced by Rams were 10% for psychology consultation and therapy, 5% for psychometry, 8% for day clinics, 10% for basic dentistry and increases of between 6% and 10% for other health professionals.

Eskom steps in to stabilise troubled medical scheme

BD 15/9/97 (299)

Robyn Chalmers

ESKOM's management has been forced to step in to attempt to stabilise the parastatal's medical aid scheme, which is losing several million rands a month, says executive director Jac Messerschmidt.

Describing the medical aid scheme — which provides for up to 40 000 employees — as being "in a mess", Messerschmidt said at the weekend he had been put in charge of the scheme last week and was devoting all his time to sorting out the situation.

"The medical aid fund's surplus has dropped dramatically since the beginning of this year and the cash flow projections are not all that rosy ... but Eskom has the matter in hand. We wish to ensure that service providers are comfortable that Eskom is standing behind the scheme," he said.

The old Eskom Medical Aid Society discontinued its operations last December as it could not be sustained as a viable concern in the longer term. A new medical aid managed care health scheme, Esmed, was registered from January 1 this year which offered a range of options. These were a core option for medical emergencies, a savings scheme and a managed care option. The medical aid scheme also provided for visits to traditional healers.

Messerschmidt said the managed care option was running into trouble as a result of a range of factors, including an overloaded administrative system, late payments and problems with service providers. This had led to a mismatch between costs and income.

Eskom sources estimated that about 75% of its 40 000 employees had opted for or defaulted to the managed care option, financially the most expensive and also most open to abuse.

Eskom's management board had given Messerschmidt a mandate to stabilise the medical aid scheme, regain the confidence of service providers and members as well as investigate the best way forward for the scheme.

A Mineworkers' Union spokesman said at the weekend that the union was concerned about the medical aid, and was negotiating with management.

An Esmed official was confident of progress in sorting out the problems, and said Eskom had guaranteed payment to outstanding suppliers.

□ Sapa reports the Natalmed medical aid scheme on Saturday announced it would take over the members of the collapsed Medilife Medical Scheme. The transfer is to be backdated to September 3.

It was estimated Medilife could have had up to 15 000 members, many of them public servants.

Body opposes dispensing fee

Jacob Dlamini

CAPE TOWN — The Interim Pharmacy Council of SA would not support the introduction of a fixed dispensing fee as proposed in Medicines and Related Substances Amendment Bill, council registrar Jan du Toit said yesterday.

Du Toit said a fixed dispensing fee would not be in the public interest and may keep the price of drugs high.

The bill is one of three pieces of legislation designed to improve access to health care by lowering the price of drugs, encouraging the use of generic drugs and parallel importing medicines from cheaper sources. But Du Toit said he welcomed provisions in the bill which would give the council powers to determine the procedure to be followed by pharmacists when they charged dispensing fees.

Du Toit said the council also supported mechanisms that would guarantee the safety, quality and efficiency of medicines offered by pharmacists.

BD 16/9/97

Eskom guarantees medical aid payments

(299)

Robyn Chalmers

BD 16/9/97

ESKOM has issued a letter to suppliers and service providers to the ailing Esmed medical aid scheme guaranteeing payment for all valid claims submitted by Esmed members.

A copy of the letter, issued by the Mineworkers' Union to its members, said administrative and financial difficulties being experienced by the scheme were of "extreme concern". Eskom executive director Jac Messerschmidt said it was Eskom's intention to ensure that services by suppliers to Eskom employees should continue on credit as before, without suppliers demanding cash for services rendered.

"To the above end, Eskom guarantees payment to suppliers for all valid claims in respect of services rendered to all beneficiaries of Esmed under the scheme," he said.

Mineworkers' Union general secretary Flip Buys said the union had alerted its members to the possibility that Esmed was heading for bankruptcy, and action was needed urgently.

Buys said a union bulletin had "shaken" Eskom and Esmed to the extent that Eskom CE Allen Morgan had offered to put an executive director on Esmed to sort out its problems. Messerschmidt had subsequently taken over management of the scheme. The scheme, which caters for about 40 000 employees, would continue as normal.

Messerschmidt said at the weekend the medical aid fund's surplus had dropped dramatically since the beginning of the year and cash flow projections were not rosy. "It's losing several million rands a month," he said.

Esmed began operating in January after the demise of the Eskom Medical Aid Society. More than 75% of 40 000 employees had opted for or defaulted to Esmed's managed care option.

Proposed medical aid changes stir debate

(299) BD 26/9/97

Pat Sidley

HOW hard will medical aid members be hit in the pocket if proposed changes to the laws governing medical aids become law? This question is at the centre of a debate between groups of medical schemes and insurers — and it is the weapon of choice in a propaganda war which hopes, on one hand, to see little or no change and, on the other, to ensure changes that meet government's policy needs.

The designers of the proposed policy changes would like to see "community rating" — a system in which members' age and existing health profiles will neither disqualify them for medical aid cover nor make them pay punitive premiums. This proposal suits medical schemes that do not use risk rating and underwriting principles when admitting members. It relies on the belief that the risk should be spread over as wide a base as possible, so that the older, or less healthy, members are not penalised.

A group calling itself the Concerned Medical Schemes Group (CMSG) believes the community rating system will produce a dangerous cure for health woes. CMSG insurers often sell their memberships at rates lower than the other medical schemes, but apply insurance underwriting principles to their membership bases. This is done by having pools of largely young and healthy members who do not pose costly health risks.

If these schemes are forced to apply the suggested community rating system, they say premiums will have to rise and the young and healthy will opt out of their schemes. This in turn will put more pressure on premiums and they will rise further.

> The CMSG points to a US study that purported to show that if a similar system of mandatory community rating was introduced into New York state's insurers, 500 000 members would drop their insurance and premiums would go through the ceiling.

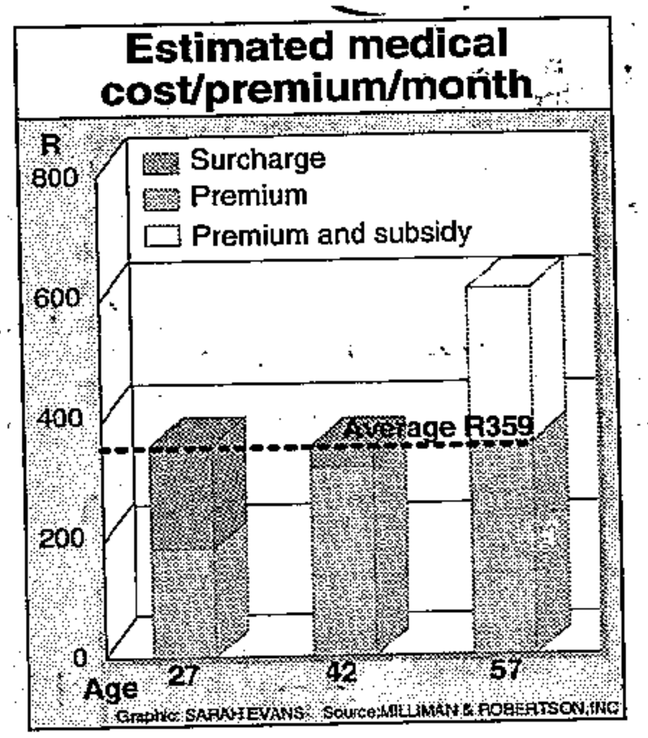
The CMSG has approached the same firm of US actuaries, Milliman & Robertson, to produce local figures and scenarios.

Much doubt has been cast on the original study — the firm even admitted some of its information was not accurate. The study's authors also failed to disclose they were backed financially by insurers which bitterly opposed the New York reforms. One of the authors, Mark Litow is an associate member of the trade organisation which backs these insurers. He is also the author of the study and figures commissioned locally, some of which is reproduced in Business Day. The CMSG did not inform Business Day of Litow's tie-ups in much the same way as Milliman & Robertson failed to do so in the US.

The figures nevertheless provide a picture of the effect that flat community rating by age may have on premium rates in SA based on certain assumptions.

In the study, Litow says that "premium surcharges and subsidies by age group can cause people to drop their insurance coverage due to affordability, subsequently creating an upward cost spiral".

However, for groups of members, such as those found in firms with 1 000 or more employees, provided the employer pays a substantial portion of the premium, the cost spiral would be less likely to develop.



Three age bands are used in the study: 20-34; 35-49; and 50-64. The calculations use average ages of 27, 42 and 57 with 1 000 people in each group. No differentiation is made for sex and current premiums are assumed to be R188, R323, and R565 a month in each group respectively. It is also assumed that members pay for their own insurance.

The study then assumes the reforms will introduce an average monthly premium of R359. This rate would imply a 91% rate increase for the youngest group, an 11% increase for the 35-49 group and a 36% decrease for the oldest group. The actuaries then assume 80% of the youngest group drop their coverage, as do 10% of the next group, while the 50-64 group attracts a 20% increase in enrolment. This pushes the average premium up to R438 a month — or 22% higher on average. But this is a 133% increase for the 20-34 age group which may force others to drop their coverage. The actuaries assume a further 100, 300 and 100 members drop their coverage in the respective age groups, pushing the average premium to R463.

Illustrative premium effect of flat community rating

	Current system		Proposed reform					
			Year 1			Year 2		
Age group	Premium charged	People	Premium charged	Premium change	People	Premium Charged	Premium change	People
20-34	R188	1 000	R359	91%	200	R438	R133	100
35-49	R323	1 000	R359	11	900	R438	36	600
50-64	R565	1 000	R359	(36)	1 200	R438	(22)	1 100
Average/ Total	R359	3 000	R359		2 300	R438		1 800
Required Premium			R438			R463		

* New premium based on change in distribution of people by age and actual cost consistent with premiums charged in current system

Source: MILLIMAN & ROBERTSON, INC

The study does not involve people older than 64 — for a reason. This group of insurers claims very high premiums for elderly members — and thus has few older members.

One of the prominent groups in the CMSG is Momentum Health. Its memberships are sold by brokers who then claim 3,5% of the gross premium income as their fee. There is no commission on memberships sold to people older than 65 "to keep the premiums down". There is thus no incentive to encourage older people to buy coverage. Only 2,5% of Momentum's members are older than 65. Across other schemes 5,5%-6% of members are older than 65.

Health network faces action

BD 30/9/97 (299)

Samantha Sharpe

CAPE TOWN — Medical fund administrator Sanlam Health's newly launched health care provider network is under threat from legal action, court papers submitted in the Witwatersrand High Court show.

Sanlam Health and medical practitioner association, SA Managed Care Co-operative, launched the as yet unnamed company earlier this month in a bid to create an independent, self-regulated provider network.

According to the court papers, Johannesburg businessman Stanley Eiser is seeking an interdict to stop Sanlam and others from conducting managed health care businesses that involve the creation of doctor-owned health care networks.

The legal action follows a wrangle between Eiser and Vuna Health Care (formerly Thebe Health Care), and Sanlam Health Care over a partnership between Vuna and Sanlam.

Eiser and Vuna originally owned 50% of managed health care service provider Integrated Health Services (IHS) which was later courted by Sanlam as a possible partner in a new deal.

Sanlam broke off talks with IHS, only to notify Vuna that it wanted to pursue a deal excluding IHS and Eiser, according to the court documents.

A joint venture company, SA Health Alliance, was formed by Sanlam and Vuna in July 1997.

Eiser claims Vuna had a fiduciary duty to promote the interests of IHS and its business and was not entitled to compete either directly or indirectly with IHS.

The creation of SA Health Alliance breached that responsibility, with Sanlam Health Care "utilising for the benefit of its business confidential information" belonging to IHS.

"The third defendant (Sanlam Health) knew that the plaintiff (Eiser) and the first defendant (Vuna Health) were co-shareholders and partners in IHS and ... intended to induce the first defendant to breach its obligations."

Sanlam Health has twenty-one days to respond to the claim.

Bill aims to put end to exclusive medical aids

ST 30/9/97 (299)

JOHANNESBURG: Medical aid schemes should not be allowed to prevent members joining on the basis of age or state of their health, proposals contained in the Medical Schemes Amendment Bill state.

Speaking at the Representative Association of Medical Schemes' (Rams) annual conference in Durban yesterday, financial adviser to the Department of Health Mr Pat Masube said the bill was moving away from the present system whereby the elderly, the sick and the poor were excluded from medical aid schemes.

Masube said medical aid schemes should be required to provide a "minimum benefit package" focusing on hospital-type services.

The bill also contains an "open enrolment" policy.

This policy, he said, did not mean that anybody could join at any time. Rather, the department had proposed that open enrolment should be limited to two weeks, once every two years and that people who joined medical schemes late in life should be penalised.

But Dr Brian Brink of the Anglo-American Corporation said the medical aid industry believed that the proposals could lead to soaring medical aid premiums and an exodus of members from schemes.

An "open enrolment" policy which would prevent schemes from excluding people on the basis of their health risk could cause costs to increase, Brink said.

This would in turn result in younger, healthier members — who were not prepared to pay the high rates — leaving the schemes.

— Own Correspondent

Company medical schemes slow to face up to AIDS

ARG 2/10/97 (299)

BUSINESS REPORTER

Only a quarter of companies have restructured their medical schemes and benefits to allow for HIV and AIDS-related diseases, says the latest Old Mutual Survey.

Ant Lester, managing director of Old Mutual Actuaries and Consultants, said although 86% of the surveyed companies were aware of the impact AIDS could have on the health benefits industry, it was seldom seen as the main strategic issue facing medical aid schemes.

But, according to the survey, control of spiralling health-care costs remained the key issue for employers (as in previous surveys), and pre-pension funding of medical benefits ran a close second.

Mr Lester said it was heartening to see a significant increase in AIDS awareness in the workplace, and in the education campaigns initiated.

Since 1994 the percentage of companies conducting such campaigns had risen from only 40% to 83%.

The survey also noted that 21% of companies surveyed restricted benefits to Aids-related conditions, and 5% ruled against HIV-positive employees joining their schemes.

'It was heartening to see a significant increase in AIDS awareness in the workplace'

"These measures may contravene the prohibition of unfair discrimination in the Labour Relations Act, and could be specifically prevented in terms of proposals from the Department of Health, making it essential for these companies to rethink their current policies," Mr Lester said.

In the survey, managed care emerged as the leading means cited for curbing medical benefit costs, but other strategies, including cost-sharing and employee health education, were frequently mentioned.

"The drive to cap contributions is not surprising, given that the cost of medical benefits has increased from 3% of a company's payroll in the 1970s to between 8% and 11% today," Mr Lester said.

He said he was surprised to find that 45% of respondents surveyed were already setting aside advance funding for future pensioner medical benefit liabilities.

"But perhaps more telling is the fact that only 14% of respondents believed that they had set aside enough to cover the full liability."

Shock findings on medical aid plans

2/10/97 (299)

Survey finds 40% of employees don't have coverage

LLEWELLYN JONES
BUSINESS REPORTER

Two employees in every five are not covered by medical aid and many employers have no plans to improve the situation.

This is one of the shock findings of a health benefits survey conducted by Old Mutual Actuaries and consultants.

The survey is conducted once every two years, and attempts to identify trends and developments in the turbulent medical benefits industry.

While about 90% of all employees in this year's surveyed companies were eligible for medical aid, more than 40% do not currently belong to employer sponsored schemes.

"The gap between potential coverage and actual coverage is probably because many lower-paid workers cannot afford to join company schemes, or are unwilling to join them while acceptable low- or no-cost cover is available in the public sector," said Ant Lester, the managing director of Old Mutual Actuaries and Consultants.

But this has important implications for both employees and employers in the light of government proposals that basic private sector healthcare cover should be made compulsory for everyone in formal employment – a measure to remove the burden on the state. "In the light of these proposals, the attitude of respondents to employees currently not covered by medical schemes was interesting," Mr Lester said.

While 32% of respondents said they were investigating a cheaper option for these employees, almost half the respondents were either doing nothing or expected the state to take responsibility.

On the other side of the spectrum,

'Almost half the respondents were either doing nothing or expected the state to take responsibility'

nearly half the companies surveyed offered their employees more than one medical scheme option, and most of those gave their employees the option to switch options every year.

"Although this is in line with the trend to greater member flexibility, we question whether employers understand the implications of allowing staff to switch options so frequently," Mr Lester said. "There is an obvious opportunity for employees whose health deteriorates during a year to switch to an option which gives them the most financial assistance and protection – in the longer term, this could severely affect the financial viability of these schemes."

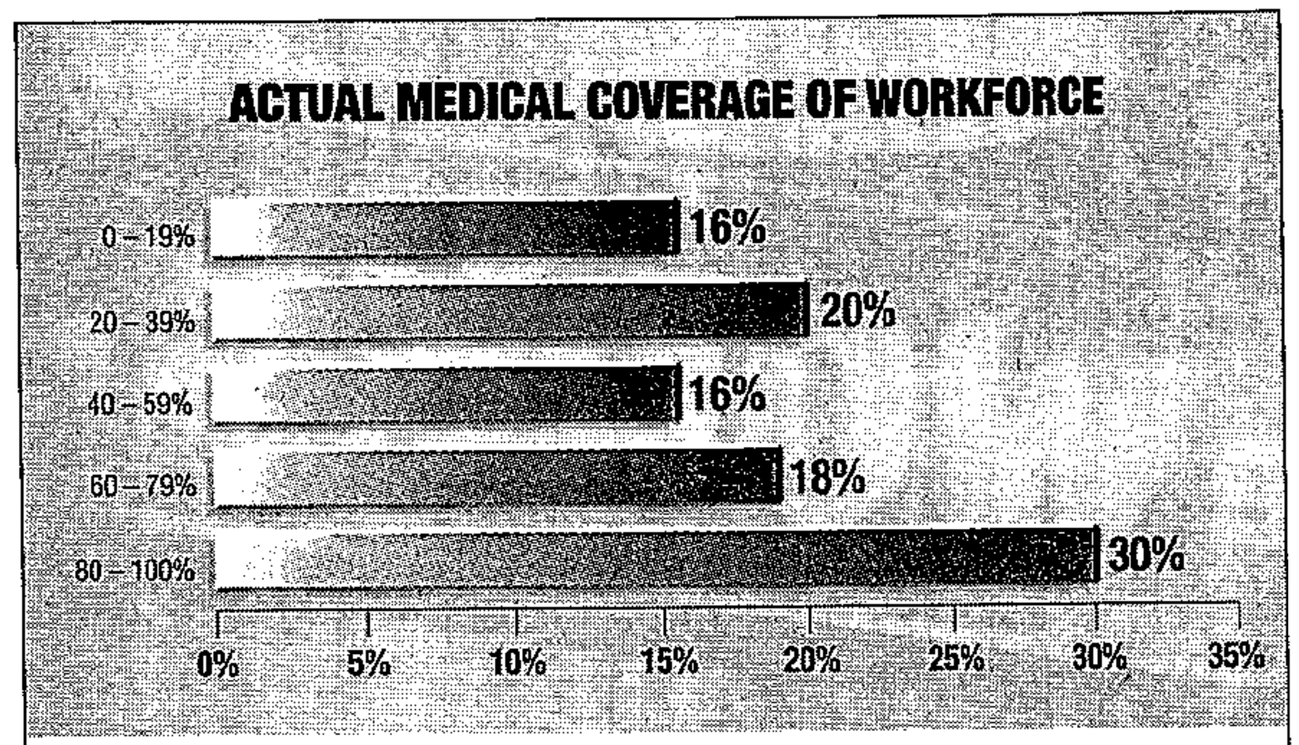
Mr Lester said an increasingly popular option was "new generation" schemes which offered employees savings accounts. Members meet the cost of day-to-day benefits out of the savings account, while other major medical expenses are still provided for on a pooled basis.

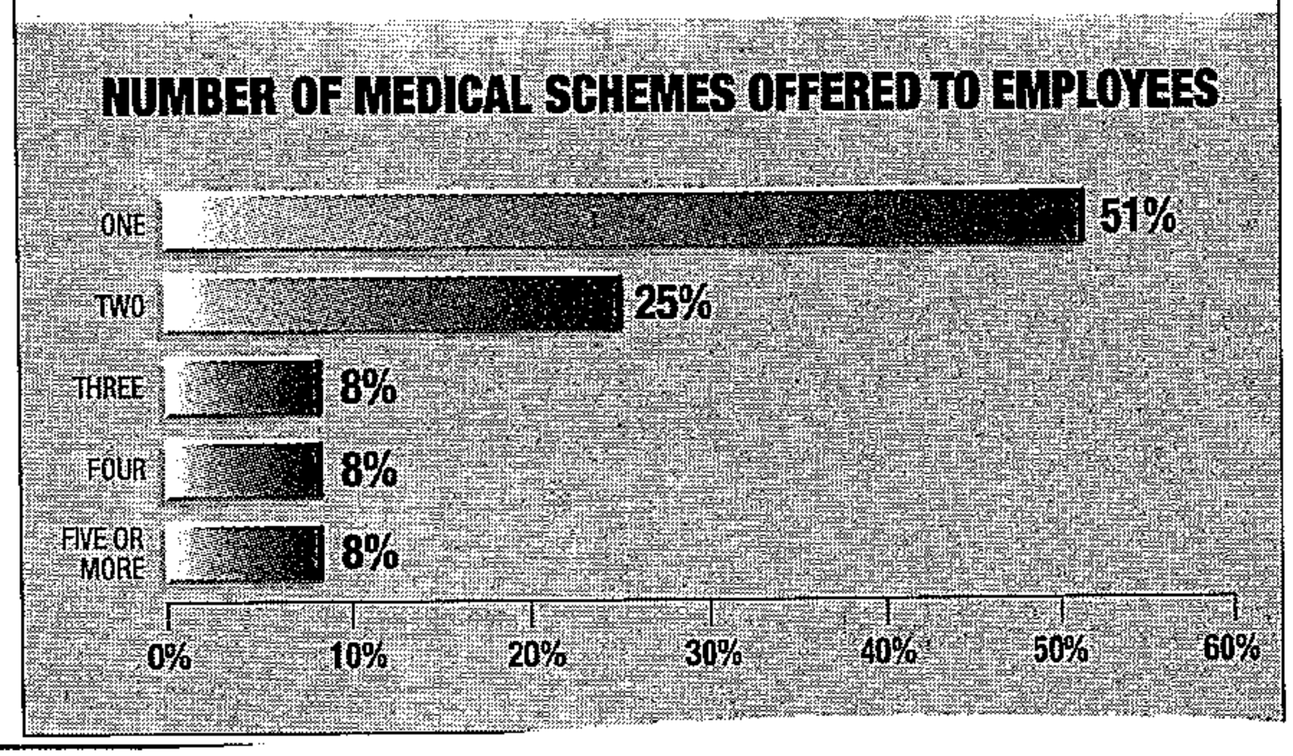
More than 76% of the companies surveyed were either considering, or had already introduced such schemes.

"For the employer, these schemes allow part of the financial risk to be transferred to the individual member. Younger and healthier employees, who are less likely to benefit from pooling which operates in traditional schemes, are likely to see the advantages, as are higher income employees who can afford to contribute sufficient funds to the savings accounts.

"But lower income groups, where larger families are more common, may be unable to contribute enough to cover their medical expenses, and may come to resist these schemes."

He added that there was a further risk to these schemes from the Department of Health's apparent opposition to savings arrangements within medical schemes.





Health sector challenged by rapid change

ESANN DE KOCK

GRAPPLING WITH CHANGE: Ant Lester, MD of OMAC, says although the survey shows that employers and medical schemes are grappling with change, he does not believe members have begun to adapt in terms of what is going to happen in the future.

The reality of the turmoil in South Africa's health benefits industry has started to dawn on employers, medical schemes and their members who are grabbing at options to cut costs, retain good benefits and plan for an uncertain future.

The latest Health Benefits Survey by Old Mutual Actuaries and Consultants (OMAC) shows that a significant re-think is taking place in terms of cross subsidisation policies; funding for pensioner medical aid costs; the structure of medical aid schemes in terms of benefits offered; the advantages of managed care; and the introduction of personal savings accounts.

Ant Lester, managing director of OMAC, says that this survey is by far the most quantitative of the three surveys OMAC has so far undertaken.

To realise the growing importance of effective medical aid management, you need to look no further than the 1970s, where health care costs made up about three percent of an employer's payroll. Today it makes up about eight percent.

The uncertainty surrounding government plans to restructure the healthcare industry and the financial predicament in which many medical schemes instances, encouraging employees, medical schemes and their members to adopt a wait-and-see approach.

Lester says although this is understandable, considering the environment of uncertainty, it also poses the risk that companies will eventually be overtaken by events and find themselves unprepared to deal with changes in the industry.

This is particularly the case for the 20 percent of respondents in the survey who indicated that they were not fully informed about the development of a national health policy. On the other hand, many employers have begun re-thinking policies and medical schemes, have begun implementing aspects of the managed care philosophy pioneered in the United States.

Lester says the results of the survey confirm that there is a great degree of turbulence and rapid change in the healthcare environment. The industry is pessimistic about the prospect of a more hostile, regulatory environment and medical scheme members are generally concerned and confused about where things are headed.

"You are dealing with the infancy of change. I don't believe members have begun to adapt in terms of what [illegible]

Symptoms of an ailing industry manifest in medical scheme survey

(299)

ESANN DE KOCK

New government initiatives, spiralling healthcare costs, the possibility of tax changes and the Aids epidemic have all contributed to the state of upheaval in South Africa's healthcare industry.

These key findings affecting companies, medical aid schemes and members have emerged from the survey:

◆ Medical schemes are offering members an extremely wide choice of medical aid options and most allow members to switch options every year. This poses a financial risk for schemes.

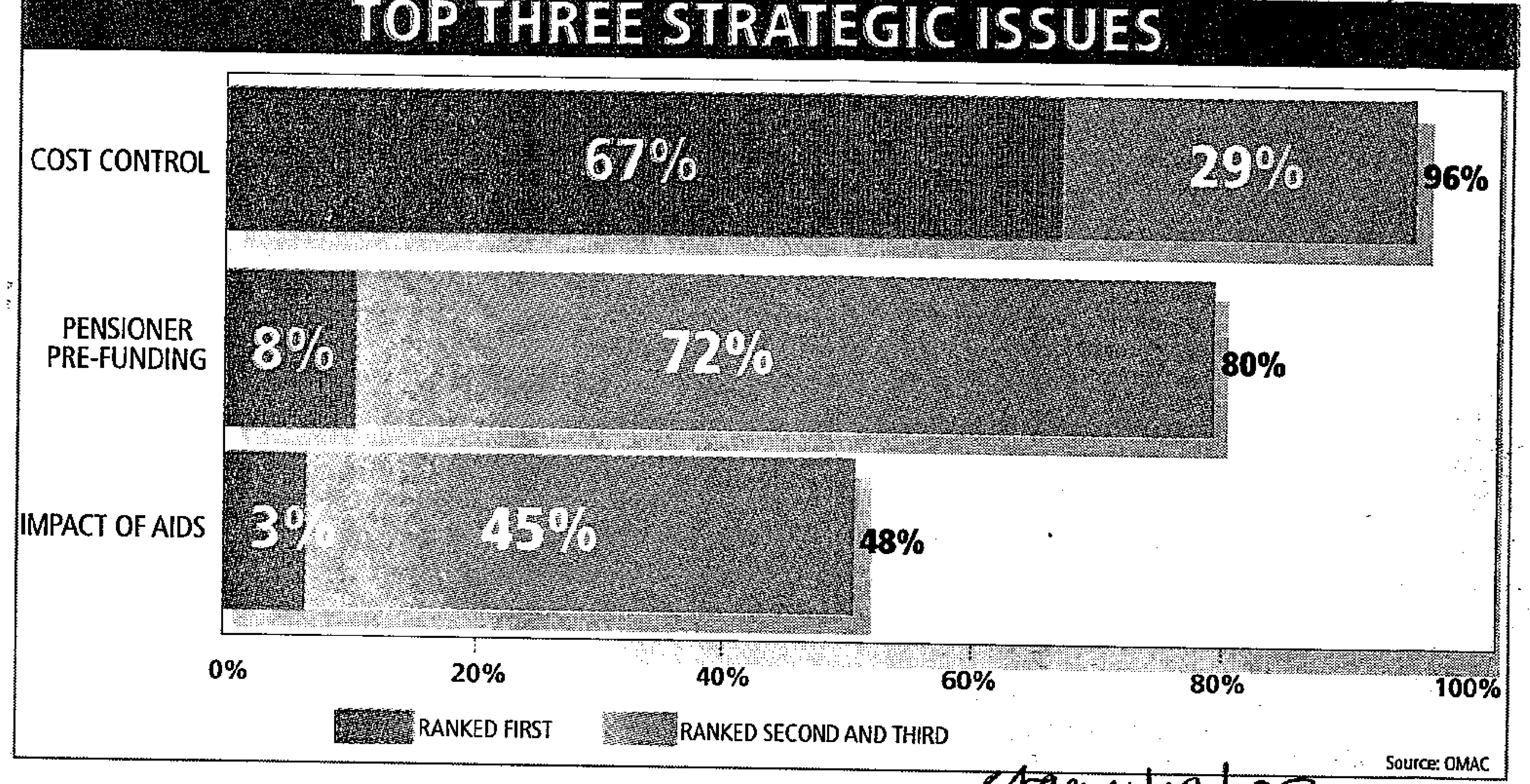
OMAC senior consultant Geetesh Solanki says it means that members whose health needs change can abuse the system by switching from one option to the next to get maximum financial assistance. In the long term, this could severely affect the financial viability of these schemes which, in turn will have serious implications for members;

◆ About 76 percent of companies have introduced, or are considering some form of individual savings account in their schemes for day-to-day medical expenses. The dramatic rise in so-called "new generation" medical schemes have gone hand-in-hand with these types of savings accounts.

For employers, these schemes allow part of the financial risk to be transferred to the individual member.

Solanki says if you're young and healthy you are likely to benefit from a savings scheme because there's less chance that you'll gain personally from the pooling of funds in a traditional scheme. It will also benefit high-income employees who can afford to contribute sufficient funds to savings accounts.

On the other hand, he says, lower income groups may be unable to contribute enough to cover their medical expenses and may resist these schemes;



Star 4/10/97

◆ Less than half the schemes surveyed have employee representation on their management structures which could lead to conflict in the future – particularly if medical scheme coverage is extended to more highly unionised sectors of companies' workforce;

◆ While 32 percent of respondents said they were investigating cheaper options for employees who choose not to belong to medical schemes, almost half are doing nothing or expect the State to take responsibility for this sector;

◆ At least 80 percent of the companies surveyed allowed at least some employees to make contributions to their medical aid on a salary sacrifice basis (ie employee contributions are effectively paid out of pre-tax income). These companies may be forced to re-negotiate conditions of service if the Katz Commission's recommendations that contributions be treated on an after tax basis, are implemented;

◆ Cost control was rated the most important issue facing medical aid schemes and managed care was the leading means cited for curbing costs.

Most companies said they were

sition from both employees and health-care providers as a significant obstacle to managed care initiatives;

◆ Only 14 percent of the employers surveyed believe they have set aside enough funds to cover full pensioner medical liability. Although most companies recognised this obligation, more than 40 percent said they would not recognise the liability in their financial statements until compelled to do so;

◆ About a quarter of the companies restrict benefits for AIDS-related conditions, or even prevent employees with HIV from joining medical schemes. This discourages members from admitting their HIV positive status and it could result in schemes unknowingly funding medical costs of HIV positive members with no symptoms of full-blown AIDS for years. OMAC believes it cou[illegible]

HOW THE SURVEY WAS DONE

OMAC identified 700 large South African employers, both private and parastatal, each with more than 1 000 employees, for the survey.

It used a stratified random sampling procedure to target employers, using the criteria of workforce size, economic sector, geographic location and market capitalisation.

The survey drew responses from 60 employers. The respondent rate was over 80 percent.

Sixty percent of the participants had a company medical scheme. The other 40 percent participated in commercial schemes.

OMAC also held group discussions with ordinary medical scheme members to canvas their views on the issues examined in the survey.

Pro Sano shows increase in reserves

(299) BD 6/10/97

Business Day Reporter

PRO Sano, a Cape based medical scheme catering for black, Indian and coloured public servants, showed a net surplus last year for the first time since 1993, according to a 1996 audit which showed a 48% increase in net reserves to more than R42m.

Chairman Shu'ayb Patel said yesterday that the audit, although qualified, showed the scheme had achieved a net surplus of R17,3m following a shortfall in the previous two financial years.

In January, the Cape Town Supreme Court ordered a full inquiry into the medical scheme following an attempt by the registrar of medical schemes the previous month to have it placed under provisional judicial management. Accounting firm Deloitte & Touche, assisted by an independent consulting actuary, were appointed to undertake the investigation and submit a report to the registrar by December 31.

The registrar, Daniel Kolver, had argued that the scheme was in a precarious financial position having lost 89% of its accumulated funds in just more than two and a half years. He said there was a danger that members could lose their benefits but Patel at the time said the scheme was financially sound.

Yesterday Patel said the situation for 1997 looked positive with current financial statements for the first eight months of the year showing net reserves were already at R84,7m. He attributed the jump to a 17% increase in subscriptions in March plus a healthy showing by the scheme's investments, mostly short-term and cash investments.

He said steps had been taken in the past few months to deal with administrative inadequacies pointed to by the scheme's auditors Ernst & Young. Patel said Pro Sano recently had appointed Coopers & Lybrand to correct the membership records to reflect accurately what a member had paid, whether a member was in arrears, how much benefit had been used and what benefits remained available.

He said that a meeting had been called with Pro Sano's administrators Medscheme for an explanation as to why the auditors had had difficulty in getting complete and accurate membership records from which to audit contribution income, outstanding contributions, provision for doubtful debt and refundable contributions.

He said that Pro Sano would take whatever steps necessary to ensure its affairs were "lily white" before the December 31 deadline for Deloitte & Touche to present its assessment of the scheme's soundness to the registrar.

Pensioners dumped by Transnet medical aid fund

Restructuring means members pay more

JEAN LE MAY

Many Transnet pensioners are being dumped by Transmed, the parastatal's in-house medical aid scheme, as part of the restructuring of the debt-ridden pension and medical aid funds.

Some pensioners have been told they must transfer to a private scheme which offers fewer benefits. Others have been told that in future they will be expected to pay part of their own medical expenses, although on retirement they were led to expect free lifelong cover.

Ron Foxcroft, secretary of the Transmed board of trustees, said the restructuring was absolutely necessary because medical expenses were out-running the amount of money the fund could disburse.

The pension and medical aid fund deficit of R2,1-billion wiped out Transnet's increased operating profit of R1,9-billion last year, according to financial director Gloria Serobe.

At one time, SA Railways and Harbours (now part of Transnet) was the biggest employer in the country.

Former Spoornet employee William Loots is one of about 1 500 employees who took packages four years ago, when Transnet started reducing staff. "I had 29 years' service as a railwayman and I was under 50 years old," he said.

"As a senior official, the package I got was respectable, but nothing as big as the packages teachers are getting these days. I am very angry with Transnet for breaking the agreement which we reached with them about medical aid.

Mr Loots said the monthly payment for cover for him and his wife had increased steadily over the four years and was now R945.

"That covered everything, or so I thought. A few months ago I broke my hip and was hospitalised. To my surprise a woman from an insurance company came to the hospital and said that if expenses exceeded R22 000 I would have to pay the difference. To this day, I have never discovered how she became involved.

"Soon afterwards I got a letter from Transmed saying they no longer wanted me as a member and that I was being transferred to another company, Northern Medical Aid. My contribution is now R650 a month but I get fewer benefits – nothing for dental or eye care or day-to-day medical expenses.

"If I visit a doctor I have to pay for it myself. In effect, the new scheme - to which I have been transferred without consultation is a hospital plan only.

"I feel that I am being discriminated against. I would like other people in the same boat to call me at 021 591 4946 so we can get together and make representations about the discrimination," said Mr Loots.

Another former Spoornet employee, who asked not to be named, said he retired in 1982 after 42 years' service. "We still get free hospital care but we now have to pay for dental and eye care and for medicines, except for chronic-condition medicines for which we pay 20%," he said.

"We contribute R160 a month to the fund but other medical expenses amount up to a further R200 a month. The total of R360 a month is a big bite out of my pension."

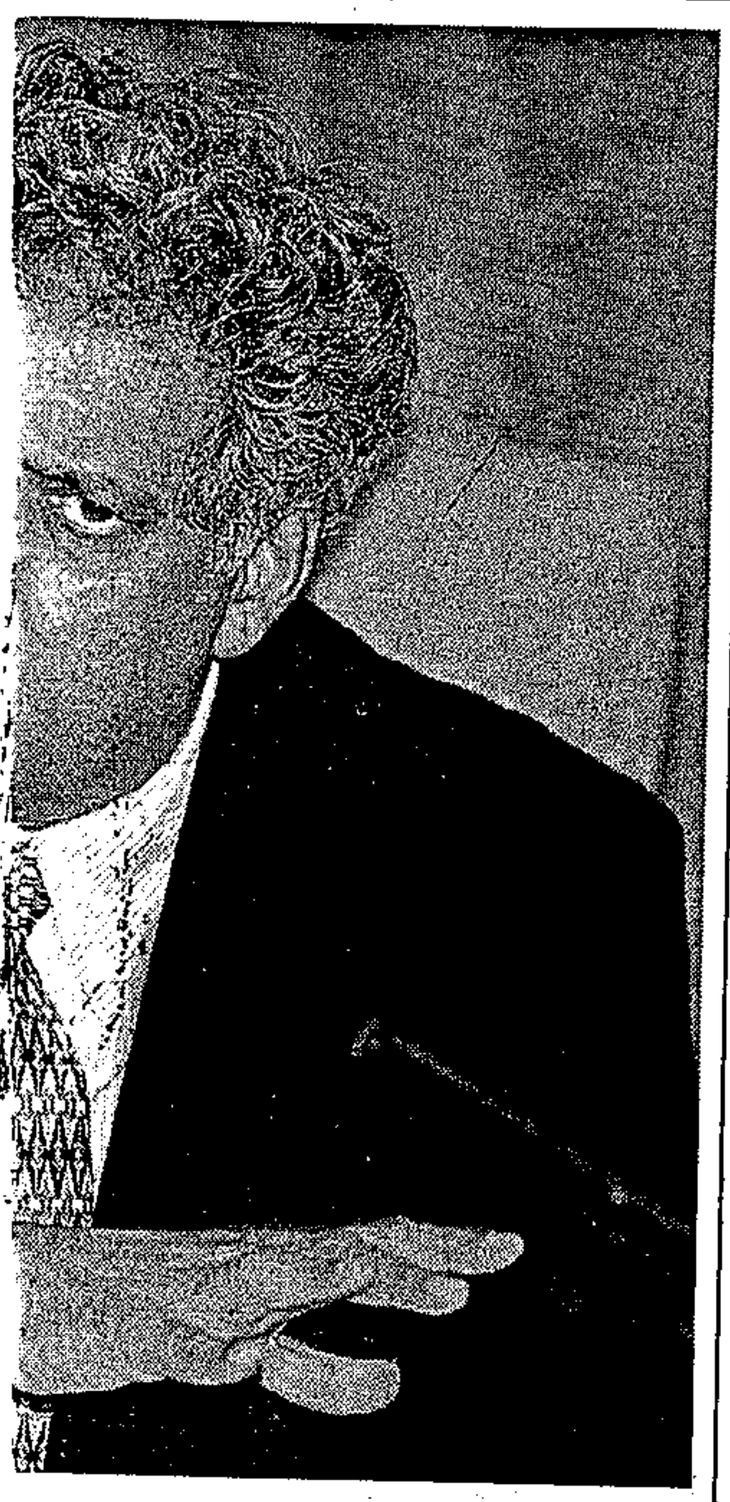
Mr Foxcroft said Transmed had 150 000 members and, with beneficiaries, it meant it was responsible for medical expenses for 330 000 people.

Actuarially, there were three "risk pools", consisting of so-called private members, Transnet employees and pensioners and SA Transport Services pensioners, he said.

The private members were the people who took packages before reaching retirement age, such as Mr Loots. They accepted packages with market-related contributions to the fund, but the pool was getting smaller and was no longer economically viable for Transmed. The pool had built up a deficit of R3-million and had been transferred to the Northern Medical Aid Society.

Mr Foxcroft said there had also been widespread fraud and abuse of the medical aid scheme. There had been cases where members had sold their membership cards to other families who were not Transnet employees, thus defrauding the scheme. Doctors had also been involved in scams in which thousands of rands were claimed unlawfully.

Asked if any doctor or Transmed member had been charged with fraud, Mr Foxcroft said: "We usually settle out of court."



President Thabo Mbeki's office, addresses
on government's plans to replace the SA
eamlined body, the Government Commu-

Picture: TREVOR SAMSON

nelands 'not possible'

financial positions for the 1993/94 and 1994/95 financial years, a statement released yesterday said.

Northern Province provincial auditor Steve Lekutle said "the financial management of the territory (Gazankulu) is regarded as being doubtful".

More than R1,541bn in unauthorised spending for the 1992/93, 1993/94 and 1994/95 financial years had also been reported for Lebowa. — Sapa.

Body subpoenas Meiring over army medical scheme

~~354~~ (299) BD 15/10/97

THE Human Rights Commission has subpoenaed SA National Defence Force (SANDF) chief Gen Georg Meiring to appear before it to explain why medical benefits allegedly discriminate against married women army members.

The subpoena, served in Pretoria on Monday, summoned Meiring to appear next Monday, the commission said yesterday.

The subpoena requires Meiring to appear in connection with an investigation into the admission of the dependants of married female members of the army to the army's medical system.

Meiring is required to produce any documentation in his possession relevant to the commission's investigation from an earlier investigation ordered by the minister's committee on the improvement of conditions of service.

The commission's senior legal officer Liesl Gernholtz said any person failing to comply with such a subpoena committed an offence and was liable for a fine or six months in jail.

The subpoena arises from a complaint lodged by Penny James, an employee of the SA Navy in Simonstown, who asked the commission to request amendments of the army's regulations to permit dependants of married women members to use the army's medical facilities on the same basis as dependants of male members.

James, who is married and has one child, wanted to have her child placed on her medical aid, but was informed that as a married woman she was not entitled to receive any medical benefits for her husband and child, the commission said.

The commission is investigating discrimination on the grounds of gender and marital status, in violation of the constitutional right of equality.

"Although the SANDF is aware that the regulations were inconsistent with provisions of the constitution, it has failed to amend them."

The commission said Brig FW Fieldhouse, of the army's legal section, indicated after meeting the commission on July 23 that the army was investigating the complaint.

Fieldhouse had said the findings of the investigation were expected to be released by September 30, the commission said.

Last week the commission subpoenaed Health Minister Nkososana Zuma on an allegation of discrimination against three unmarried women who wanted to undergo artificial insemination. — Sapa.

Body subpoenas Meiring over army medical scheme

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Health department backs tax proposals

Linda Ensor

CAPE TOWN — The health department has come out strongly in support of a Katz commission proposal not to extend the tax deductibility of medical aid contributions to nonindemnity, risk-rated medical insurance products offered by life insurance companies.

It also endorsed the commission's recommendation that contributions to registered medical aid schemes continue to enjoy tax deductibility.

Deputy director-general Ayanda Ntsaluba highlighted severe distortions within the medical aid industry in a submission to Parliament's standing committee on finance yesterday. The committee has been hearing submissions on the sixth interim report of the commission on medical aid and benefit funds and friendly societies.

"The health department is of the view that the tax subsidy on contribution to medical care should be applied only where its application best serves the broader interests of health policy. Such tax concession should not be extended to medical insurance products that are simply age and risk rated."

Since 1989 when legislative amendments abolished compulsory community rating of medical schemes, medical insurance policies which charged highly competitive premiums specific to the policyholder's age, gender and claims patterns, had emerged.

These risk-rated, nonindemnity

Continued on Page 2

Health

Continued from Page 1

products had "cream-skimmed" young and healthy people out of medical aid schemes while excluding the sick and elderly from membership. This had fractured the cross-subsidisation of the elderly and chronically ill.

As a result, medical aid schemes had been burdened by higher claims and had to increase premiums.

Ntsaluba said the department wished to revert to the pre-1989 situation and had proposed steps to reinforce community rating and cross-subsidisation. "Medical schemes would be obliged to offer cover to all those who seek it and could use only income and/or number of dependants as the basis for determining rates."

It agreed with the principle of avoiding salary sacrifice, but was concerned that the proposed "rand for rand" regime might result in reduced cover or benefits as many schemes operated on a two-thirds to one-third basis.

The department supported the view that existing retirement vehicles and not medical schemes were the appropriate vehicles for prefunding post-retirement medical schemes contributions. The 22,5% deductibility limit for the retirement industry was adequate.

The department agreed with the commission's recommendation that tax advantages of benefit funds should be abolished.

MIDWEEK
PERSONAL FINANCE

Wide criticism for Katz Commission proposals to close tax loopholes

Medical schemes in firing line

BT (BR) 15/10/97 (299)

ESANN DE KOCK

The Katz Commission has come under fire from the private sector, Cosatu and other institutions for some of its proposals aimed at closing tax loopholes where medical benefit funds are concerned.

Parliamentary hearings took place this week on the commission's sixth interim report on benefit funds such as medical aid schemes, medical insurance and friendly societies.

There were clear gaps of understanding, though, between health care experts, tax experts who want to see a levelling of the playing fields as far as regulated and unregulated medical benefit funds are concerned, and private sector players who want to see the delivery of affordable health care to a broad range of the population in an environment where they have freedom of choice.

The Department of Health supported many of the Katz recommendations. It cautioned, however, that there should be no deductibility for medical insurance products that are simply age and risk related.

The commission faced particularly strong opposition to the proposal to abolish the tax benefits of largely unsupervised paragraph (c) benefit funds that often provide cheaper medical benefits to lower income employees.

Parliament's finance committee heard that about 20 000 of these funds exist. The Life Offices' Association said this was proof enough that there was a need for them.

The commission stood firm in its view that paragraph (c) funds should not be allowed to be largely unsupervised and that they should not be allowed to enjoy a favourable tax situation.

The funds are currently exempt from tax as is investment income derived from them.

Katz commissioner Jan de Villiers Graaff said while the commission recommended the elimination of the paragraph (c) category, it did not suggest the elimination of the benefit funds as such.

These funds can and are often used to create tax shelters and salary sacrifice schemes whereby you accept a lower salary in return for your employer paying the same amount to a benefit fund so your tax is lower.

The commission has proposed that employer contributions to medical schemes be limited to a rand-for-rand basis – a move which should reduce the attractiveness of salary sacrifice schemes.

In addition, it has said that self-employed taxpayers should be able to deduct 50 percent of their contributions. It wants to see tax charged on interest and withdrawals from medical savings accounts as well as on cash bonuses paid for low medical claims.

A strong argument in favour of retaining paragraph (c) benefit funds came from Medwise, a private company specialising in the restructuring and re-engineering of medical financing.

Medwise director Marilyn Gottlieb said the elimination of these funds would adversely affect lower paid employees who are unable to afford membership of traditional medical schemes.

It would discourage them from making any provision for healthcare costs.

Yet, Graaff, said lower income employees are often not severely affected by changes to the income tax system.

Cosatu spokesman Neil Coleman argued that insufficient research had been done into paragraph (c) benefit funds.

Cosatu was concerned that the report did not take into account the impact of other government proposals concerning the restructuring of the health insurance system.

'Collapse of medical aids was avoidable'

(299) CT(BR) 16/10/97

RICHARD STOVIN-BRADFORD

Johannesburg — If greater actuarial and financial disciplines had been exercised in the healthcare market, the recent collapses of certain medical aid schemes could have been avoided, Howard Walker, the joint managing director of Alexander Forbes' Healthcare Consulting division, said this week.

The industry needed to operate with stricter controls. Walker said he would like to see the department of health implement the 1994 Melamet report's recommendations that medical aid contribution rate tables be certified as financially sound by actuaries.

"Various proposals by the department of health regarding the regulation of a private health insurance market have been under discussion for some months now.

"Although (health) minister [Nkosazana] Zuma's proposals for the pharmaceutical industry have met with criticism from concerned parties, and despite various rounds of consultation, the bill appears headed for parliament with only a few minor amendments having been made to the original proposal," he said.

He said the stated objective of the government proposals was to reinforce community-rated "pay as you go" medical schemes. The proposals aimed to revert to the situation that existed prior to the enhancements made to the Medical Schemes Act in 1989 and 1994, with all its shortcomings.

"Concerned Medical Schemes Group's (Coms) argument is that the proposals will cause the opposite of what is intended, namely raise the price of health care cover and decrease its availability," said Walker.

Another debate centres on the department of health's targeting of the so-called "savings account" or "new generation" products, which have gained popularity in recent years. Included in the government's initial proposals on private health care funding is the potential prohibition of this kind of product. It is estimated that more than 1 million South Africans are already covered under this type of product.

Coms wants the product abolished.

Katz's medical aids plan starts row

(299) CT(BR) 21/10/97

RICHARD STOVIN-BRADFORD

Johannesburg — Proposals on new regulations for medical aids made by the Katz commission were drawing strong reaction from both the insurance and medical scheme businesses, Richard Rowe, the chief executive of NBC Administrators, said last week.

Rowe took issue with an article in Business Report last Thursday in which Howard Walker, the joint managing director of Alexander Forbes' healthcare consulting division, said the collapse of certain medical aid schemes could have been avoided.

Rowe said the comments in the article "raised the temperature of many medical aid schemes".

"The question of stricter controls on the financing of medical schemes is certainly required to safeguard the interest of members who might otherwise be financially prejudiced due to inappropriate funding, which very often arises out of the motivation to price for market share. This motivation aims to secure members and is a dangerous practice."

The biggest problem facing the medical aid industry was the established behavioural pattern exhibited by the vast majority of medical scheme members, said Rowe.

"This pattern has been nurtured over a number of years and has led to an almost blatant disregard for the consequences of undisciplined demands on the benefits provided by a medical scheme."

According to Rowe, attempts to change this behaviour, through the introduction of certain healthcare plans which sought to strike an equitable balance between cost and benefit, had met with fierce resistance.

"It would appear that the individual requires to get as much as he or she can and pay as little as possible," he said.

Email: fmcurrents@tmi.co.za

SOCIAL HEALTH INSURANCE

New wage tax could squeeze work force

Legislation is on the drawing board for a 2%-4% tax on companies' payrolls to fund hospital care for uninsured workers

Companies are up in arms over the Health Department's plan to introduce a dedicated payroll tax of 2%-4% to provide public hospital care to workers who don't have medical aid.

"We believe off-Budget levies of this kind stand to have a serious effect on job creation, especially in smaller businesses," says the SA Chamber of Business (Sacob), which is fundamentally opposed to any dedicated payroll tax engineered to escape fiscal controls or discipline.

Details of government's social health insurance plan are outlined in a detailed discussion document that is being circulated within the Health Department and trade union movement ahead of the drafting of legislation later this year.

According to the plan, the business levy will be fixed at 2%-4% of payroll. This will cover the R3bn in annual costs to provide public hospital care to 2,2m workers — that portion of the work force which pays tax but does not have medical aid.

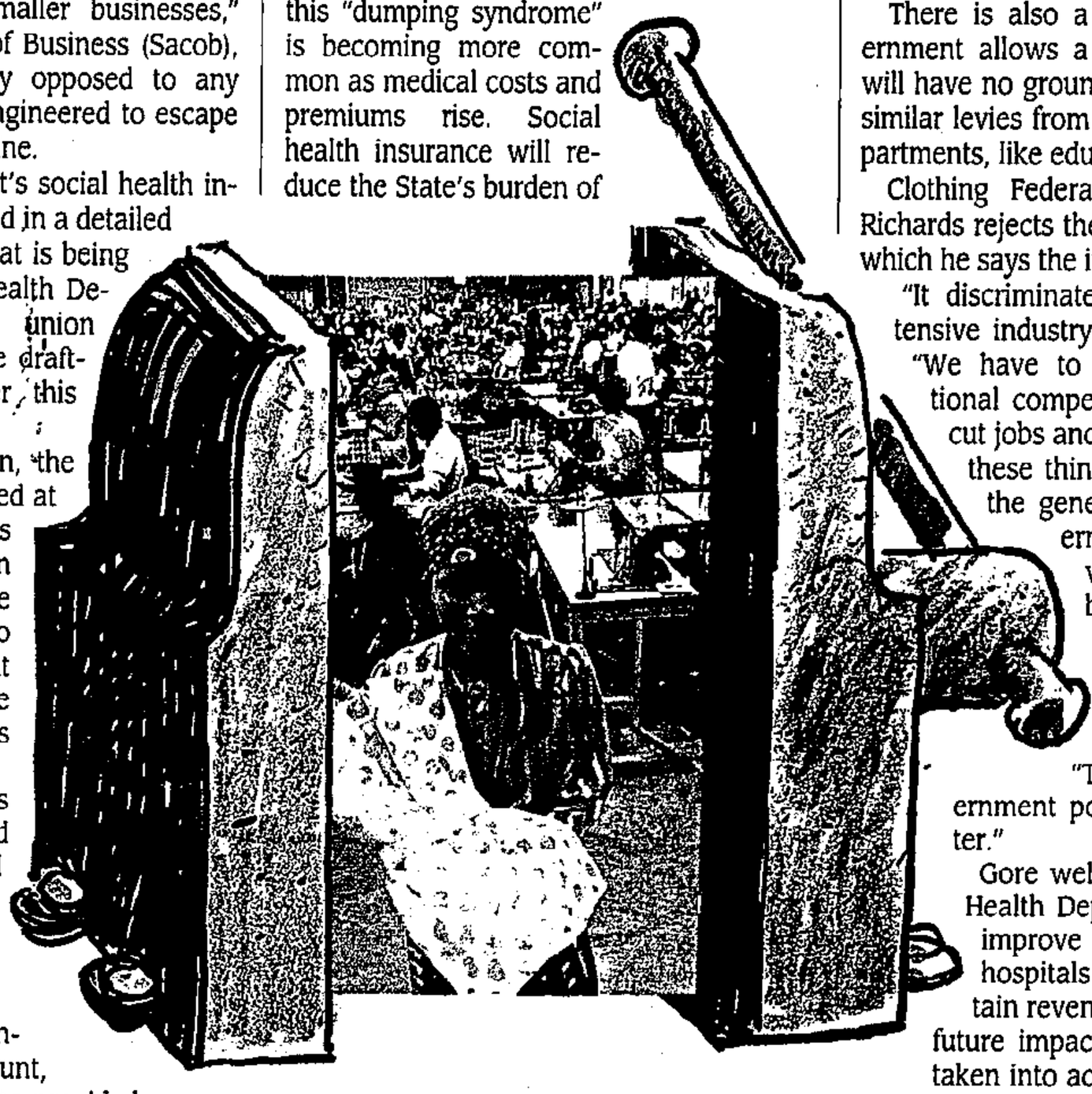
Annual contributions of between R600 and R1 200 per worker will be shared by employers and employees depending on whether the tax is set at 2% or 4% of payroll. Taking beneficiaries into account, about 6,9m people will be provided with health insurance for the first time (see table on page 36).

In addition to this group, anyone will be able to obtain social health insurance to cover basic public hospital care.

Until now public hospitals have provided virtually free care to uninsured patients, but the department says this is no longer sustainable.

Public hospitals are in the grip of a funding crisis. Resources are being diverted towards primary health care at a time when demand for hospital services is increasing, as those who have exhausted their benefits or can no longer afford medical aid turn to the State.

The department says this "dumping syndrome" is becoming more common as medical costs and premiums rise. Social health insurance will reduce the State's burden of paying medical costs for the old, the poor and those the private sector finds unprofitable to insure.



The department estimates that social health insurance could raise up to R4bn in desperately needed funds for the public health service.

It says State hospitals are losing out on about R1bn in fee revenue from patients each year, either because they fail to reveal that they have insurance and so are charged minimal fees, or because of inefficiencies in hospital fee collection.

To remedy the situation, government is proposing that medical schemes pay R1bn up front to State hospitals to cover their members' possible use of the hospital system during the year — this in addition to the payroll tax.

The medical schemes may, however, choose the option of paying only when their members actually make use of State hospitals. They will be charged more than schemes which pay up front. But this option will probably appeal to groups with a large proportion of high-income earners who are unlikely to use public facilities.

"It is really a dedicated tax to provide revenue for the public hospitals and it will add to the cost of employment," says Momentum Health CEO Adrian Gore.

There is also a danger that once government allows a dedicated health tax it will have no grounds to resist demands for similar levies from other cash-strapped departments, like education.

Clothing Federation president Bernard Richards rejects the notion of a payroll tax, which he says the industry cannot afford.

"It discriminates against a labour intensive industry like clothing," he says. "We have to compete with international competition. We have already cut jobs and have no money to fund these things. It must come out of the general revenue fund. Government has said it doesn't want to increase the tax bite."

Finance Minister Trevor Manuel chose not to elaborate on the issue, saying only: "There is no national government position yet on this matter."

Gore welcomes the fact that the Health Department is planning to improve fee collection at State hospitals and allow them to retain revenue. But he fears that the future impact of Aids has not been taken into account in calculating the cost of the scheme.

Ginsburg Malan & Carsons director Gavin Watkins also disputes aspects of the scheme's costing. "Employers' costs will rise," he says, "but they need to see the payroll increase in relation to a possible increase of 10%-15%, which is what it would cost to provide full private cover to these employees.

"If I were an employer I would be happy to accept it. But of course the unions and

P.T.O.

ARG 3/11/97 (299)

Schemes will have to spread load

CAROL CAMPBELL
STAFF REPORTER

Health Minister Nkosazana Zuma is planning legislation to stop medical aid schemes from having only young and "healthy" members in order to keep payouts low.

Her view is there should be "cross-subsidisation" between members of a medical scheme, so that the contributions of healthy members are used for the sick and elderly.

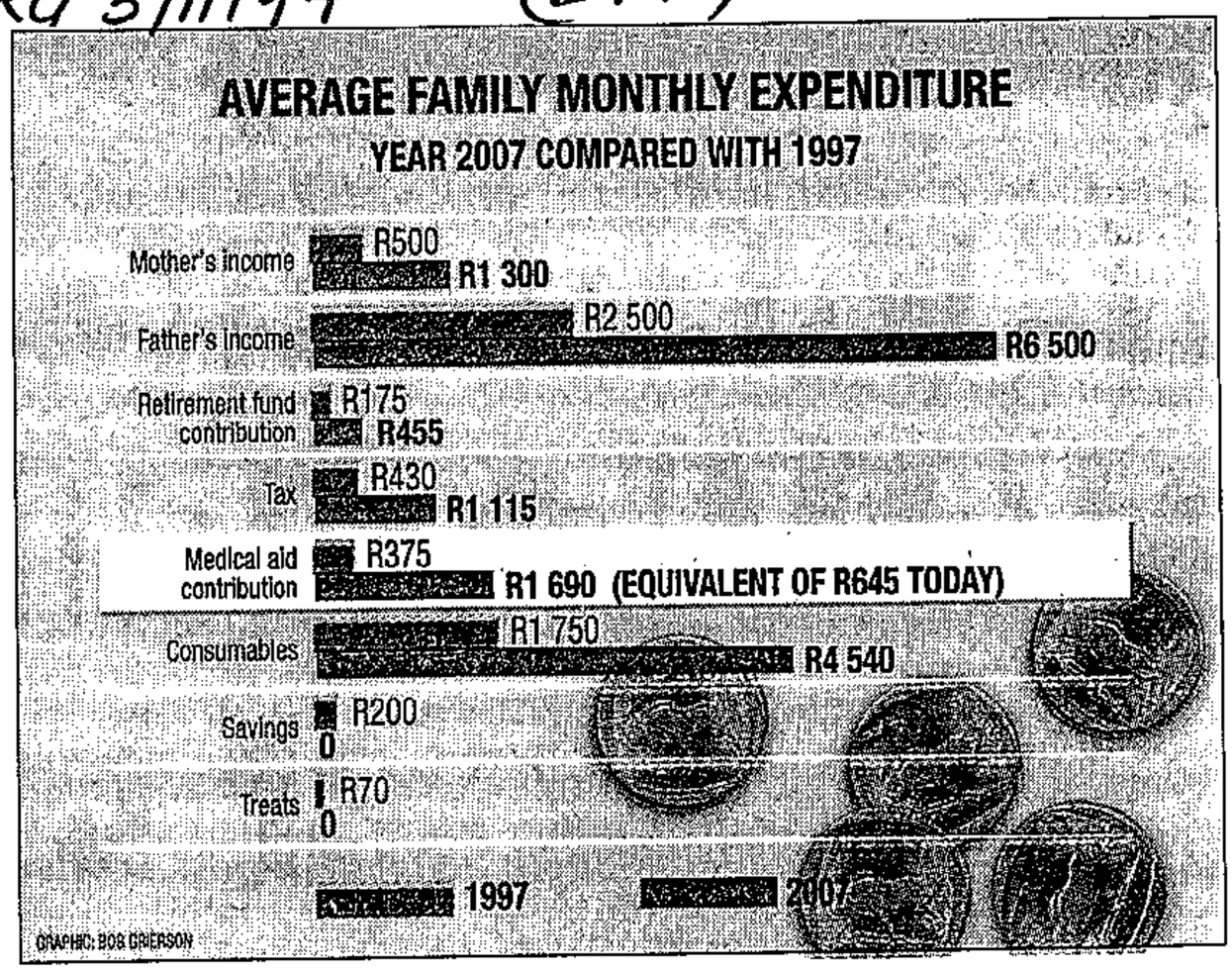
Often patients who think they are covered by a medical aid scheme end up in the public health sector because they are inadequately covered when they became sick – this is what Dr Zuma wants to avoid.

Vincent Hlongwane, her spokesman, said the new medical scheme laws would be put to Parliament, after stringent debate, next year.

"The minister wants people who make the necessary contribution to medical aid schemes to be guaranteed access to health care. It is not fair that patients are dumped in the middle of nowhere without support when a medical aid refuses to pay."

He said the minister was aware that many medical aid schemes had "gone under" and she wanted to work with them to find a viable solution to providing cost-effective and accessible health care to people in the private sector. Public health resources had to be used for the very poor and the unemployed.

Aids activist Monty Berman said he supported Dr Zuma's proposed legislation "wholeheartedly".



The future: medical aid and retirement fund contributions will skyrocket to cross-subsidize people with AIDS. Figures in this graphic were supplied by actuary Janina Slawski

Big medical aid gets clean bill of health

Audit probe clears Pro Sano

(299) ARG 3/11/97

BUSINESS REPORTER

Pro Sano, the Cape-based medical aid scheme catering mainly for black public servants, which is one of South Africa's largest, has been given a clean bill of health by auditors Deloitte & Touche.

This follows an intensive eight-month investigation of the medical aid scheme by Deloitte & Touche ordered by the High Court, after the Registrar of Medical Schemes failed in his bid to have it placed in judicial management at the end of last year.

The application alleged that Pro Sano had lost millions of rands and was basically insolvent.

Pro Sano's members are drawn mainly from the public service, including teachers, the Post Office, local government and Telkom.

Pro Sano chairman Shu'ayb Patel said the registrar had responded positively to the Deloitte & Touche report, and to the medical aid's assurance of "a more proactive and transparent relationship".

Mr Patel said the registrar had been satisfied that the scheme had put structures in place to deal with the advisory comments made in relation to arrears contributions and member records.

The administrator, Medscheme, has been given notice that its contract will end next year, and the scheme will be self-administered by October next year.

"The registrar has given us the green light and Medscheme will assist in every way to smooth the transition to Pro Sano's own administration, including transferring member data on a month-for-month basis," Mr Patel said.

"In addition, we have appointed Coopers & Lybrand to ensure database accuracy."

He said restructured packages and increased benefits to members were being actuarially evaluated and could be implemented as early as January next year.

Medical aid scheme Pro Sano declared solvent

BD 3/11/97 (299)

Taryn Lamberti

PRO Sano, a Cape-based medical aid scheme for public servants, has been declared solvent after an intensive eight-month investigation by auditing firm Deloitte and Touche.

In January the Cape Town High Court ordered a full inquiry into the medical scheme following an attempt by the registrar of medical schemes the previous month to have it placed under provisional judicial management.

Deloitte and Touche, assisted by an independent consulting actuary, were appointed to undertake the investigation and submit a report to the registrar by December 31.

The registrar, Daniel Kolver, had argued that the scheme was in a precarious financial position, having lost 89% of its accumulated funds in just more than two and a half years. He said there was a danger that members could lose their benefits, but Pro Sano chairman Shu'ayb Patel said at the time the scheme was financially sound.

On Friday Patel said Deloitte and Touche submitted a report to the High Court last week and the registrar of medical schemes declaring the scheme was solvent.

Patel said the registrar had responded positively to the report and had been satisfied the scheme had put structures in place to deal with arrears contributions and member records.

Pro Sano's administrator Medscheme had been given notice that its contract would end next year and Pro Sano would be self-administered by October 1998.

"The registrar has given us the green light and Medscheme will assist in every way in the smooth transition to Pro Sano's own administration," Patel said.

He said Pro Sano had learnt important lessons from the registrar's High Court application to have the scheme placed under judicial management and every effort had been made to ensure its affairs were "lily white".

'Cost of medical schemes to skyrocket'

Star 4/11/97 (299)

A decade from now employees will be paying five times more for cover because of Aids, says expert

OWN CORRESPONDENT
Cape Town

The cost of Aids to the South African public is set to rocket as medical aid schemes increase tariffs to meet the demand for financial assistance from Aids-sick members.

By 2007 about 20% of the members of medical aid schemes will be HIV positive, Southern Life actuary and Aids risk consultant Janina Slawski has warned.

Slawski has travelled throughout Africa to assess the impact of the epidemic on Third World economies and her projections are now being used by companies like Anglo American and Mondi Paper.

The pressure on medical aid schemes to pay medical bills will be so great in the new century that employees will be paying five times more for medical cover than they are paying now, she said.

This means that if you are paying R375 into a medical scheme now, in 10 years you will pay R1 690.

"There is no way medical aid schemes will offer the same benefits in future because too many people will be sick and need help," Slawski said.

The only way a medical scheme could stay afloat and help Aids-sick members would be to "manage" the amount it paid out for treatment, said Gary Taylor, the director of human resources for Medscheme.

"We asked a doctor to give us a figure on how much it would cost to treat an HIV positive person from diagnosis to death. He estimated between R150 000 and R300 000."

If a fifth of medical scheme members were HIV positive, which Medscheme also predicted would happen within 10 years, and payouts continued unconditionally, the schemes would be "decimated", he said.

"It's very hard to say how big the problem is now because doctors don't tell us when patients are HIV positive."

Some medical schemes had in the past refused to pay for treatment for Aids-sick patients, believing it to be a lifestyle disease which could be avoided.

The only way out was for all parties – medical schemes, the doctor and the patient – to cooperate and find a way around

> **"There has to be cross subsidisation between members"**

the problem. "There is a move to managed health care schemes which will demand a full diagnosis before a patient's bills are paid."

At the same time medical schemes should be upfront with a doctor on exactly how much a patient could afford for medical treatment. Medical scheme resources were not limitless and all members had to be considered.

There is legislation coming which will stop medical schemes from limiting their membership to only healthy people to keep premiums low.

"Health minister Dr Nkosazana Zuma doesn't want a situation where the sick have no cover and the public health system has to care for them.

"There has to be cross subsidisation between members of medical schemes," Taylor said. Life insurance and disability benefits were also areas which companies were beginning to reassess in anticipation of the full blast of the Aids epidemic, she said.

"Instead of group life policies paying out four times an employee's annual salary on death, they are reducing benefits to make sure the premiums do not radically increase with Aids claims."

Dr Aslam Dasoo, spokesman for the Representative Association on Medical Schemes (Rams), said schemes had to completely reassess the way they operated to survive the Aids epidemic.

"There has been a lot of abuse of medical aid schemes by patients and the medical profession and we have to find innovative ways to get this under control. We have to cut the fat."

Rams was developing a policy document to advise member schemes how to deal with the epidemic.

Slawski's projections are supported in a research document released by the Kenyan Health Ministry last year which estimated that since the onset of Aids in the late '80s the disposable income of families declined by 1% a year.

Over the past decade the epidemic has left thousands of families impoverished as breadwinners died or became ill and the surviving family spent the little cash they had on medicines and doctors.

Deal signed to create national health-care provider network

BDS/11/97 (299) (85)

Josey Ballenger

MEDICAL fund-administrator Sanlam Health and independent medical-practitioner association SA Managed Care Co-operative (SAMCC) have signed a deal outlined in September to create an independent, self-regulated, national health-care provider network.

The private company African Health Synergies (AHS) aims to provide the means to develop independent practitioners associations or doctor groups and enable them to provide cost-effective, quality health care "to as much of the population as possible", CEO Martyn Schickerling said.

It promises to invest in community programmes focusing on quality of life and well-being, to support initiatives of government's national health plan and to assist in developing community-oriented health care delivery systems.

At the same time, "we must sustain and expand private practice ... and be adequately rewarded for quality value-added services," SAMCC chairman Dennis Dyer said.

The private sector initiative was "bigger than any individual company or political group" and aimed to "make a contribution towards bringing solutions to our country's health care dilemmas" and to "unlock the synergies between funders and providers", Sanlam Health medical director Herc Hoffman said.

Sanlam Health had provided the initial R2m capital plus a further R1,5m loan, while the SAMCC was contributing resources to the 50-50 joint venture, said Schickerling, who is also MD of Clinic Cross. The full board of directors would be appointed by February, at which time 30-million shares would be offered to "all legally established" funders at R1 each and on a proportional basis to provider groups at 1c a share.

Schickerling said AHS would be a for-profit company only to the extent that it would financially support its member practitioners associations. The SAMCC had 4 300 members, while the SA Medical and Dental Practitioners had 2 000 members.

Schickerling said a court case hanging over Sanlam's head regarding another managed care company, SA Health Alliance, would have no bearing on AHS as the two companies would not be competitors.

Rehabilitation centre boasts globally linked assessment system

Josey Ballenger

BD 11/11/97

THE FIRST specialised physical rehabilitation unit in SA using an "internationally accepted" assessment system which allows domestic cases to be compared to a database of more than 3-million patient records worldwide was opened formally last night at Johannesburg's Brenthurst Clinic.

The unit is affiliated to 1 200 rehabilitation hospitals in 18 countries. The assessment system, licensed in SA to the Physical Rehab Group, aims to quantify financial and legal implications for employers and insurers and medical aid and lifestyle changes for patients and their families.

The unit assesses a patient's functional ability before treatment using 18 different measurements and predicts the optimum degree of improvement in areas such as self-care, mobility and mental abilities, as well as the cost and duration of treatment.

The service was "invaluable to insurers and medical aid schemes," said Prof Stephen Louw, head of the group's SA academic base at the University of Cape Town.

Louw said although physical medicine and rehabilitation was relatively undeveloped in SA, it was well established overseas. Physical rehabilitation patients are those disabled by strokes, sports, motor or work-related accidents, crime attacks or any activity that brings injury to the brain or spinal cord.

Dr Nilesh Patel, director of clinical services, said the group planned to open more units in Gauteng, Cape Town and Durban, but that it was not financially viable to operate in areas where patients did not have medical aid. The Brenthurst unit, which has been operating for about a month, has treated some 20 patients so far.

Physical Rehab Group is a joint venture between hospitals group Afrox Healthcare and medical aid and clinics group Specialised Healthcare Services.

Medical schemes face scrutiny

CT(BR) 11/11/97 (299)

ROY COKAYNE

Pretoria — The Competition Board has launched a formal investigation to determine whether several actions and activities of the Representative Association of Medical Schemes (Rams) constitute a restrictive practice, Pierre Brooks, the chairman of the board, said yesterday.

"There are a number of problems in the industry, and there is a need for the Competition Board to give some perspective on them," he said.

Brooks said the medical health industry was undergoing dramatic changes, "with everybody trying to contain costs and interest groups springing up".

It had become opportune to look at the situation and devise concrete proposals and guidelines for the industry rather than dealing with all complaints and matters referred to the board on an ad hoc basis, Brooks said.

He said some medical schemes had only decided to deal with certain service providers and had excluded others in a bid to limit costs.

He said while this might have led to increased efficiency, it had the effect of limiting the choices of consumers.

ALL SET *Pierre Brooks, chairman of the Competition Board, will probe medical schemes*

However, from a competition viewpoint the board had to try and ensure as much choice as possible for consumers, he said.

The board also tried to distinguish between ethical issues, which had to be considered by the Medical and Dental Council, and competition issues, which the board considered.

However, he said these issues sometimes overlapped. He instanced the board's recent investigation into a scheme which had lured anaesthetists into buying shares in anaesthetic product importer Pulseline.

According to a notice published in the Government Gazette on Friday, the Competition Board investigation has been launched to determine whether any of the following constituted restrictive practices:

☐ The scale of benefits laid down by Rams;

☐ Any agreement, arrangement or understanding existing between two or more medical schemes which adhered to the maximum laid down in the scale of benefits determined by Rams;

☐ Any situation arising out of the activities of any medical scheme or group of medical schemes whereby the medical scheme or groups of medical schemes refused to entertain claims submitted by service providers on any basis whatsoever where such claims exceeded the particular scale of benefits;

☐ The use of the direct payment mechanism to force compliance with the scale of benefits; and

☐ An unjustifiable refusal to deal with a service provider in the healthcare industry on the grounds that other service providers had been contracted to deliver the service.

Medical schemes must be sure of confidentiality

(299)

Pat Sidley

MEDICAL Scheme (Medscheme) members are notoriously disinterested in their schemes for all issues but whether or not the bill has been paid to the provider.

Over the years, this has permitted a variety of abuses by providers, like overservicing and outright fraud.

It has also, however, led to problems for particular members which most members do not see and perhaps ought to be looking at. With the possibility looming that Medscheme's boards will have to have an equal number of member representatives on them, and administrators will have to become less obvious in the running of schemes, members may want to look to some of these issues earlier rather than later.

Among the thornier issues are those relating to the privacy of the member. A recent case in BDFM of a breach of a member's right to privacy has forced Medscheme to re-examine the issue, and audit its procedures.

The member had objected to having her medical information conveyed by the medical scheme (in this case, Finmed) to the company. The company was unperturbed about it, and Medscheme, the administrators, did little about it. Such procedures (and disclosures) appear to be routine matters for the medical scheme and the employer.

But the issue turned out to be, as Medscheme's Gary Taylor confirmed, a serious breach of her privacy.

It was done routinely to ensure that information in the scheme was kept up to date, but the method of doing this involved chasing the missing information through the employer, disclosing details of it at the same time.

Taylor says this kind of breach, aside from the moral issue, is illegal. The constitution provides for a right to privacy, in addition to which there are circumstances in which such disclosures can lead to a breach of labour law. One such case he cites had an employer unfairly dismiss an employee who was Human Immunovirus (HIV) positive after the information had been supplied to him by the medical scheme.

Despite this, Medscheme obliges its own employees to sign confidentiality agreements to prevent them abusing any information they come across in the course of their work.

Employers frequently require disclosure of information when recruiting new employees — for purposes of medical scheme or pension fund membership. Much of this is plainly illegal, but it takes a tough prospective employee (with other employment prospects) to fight this before signing on.

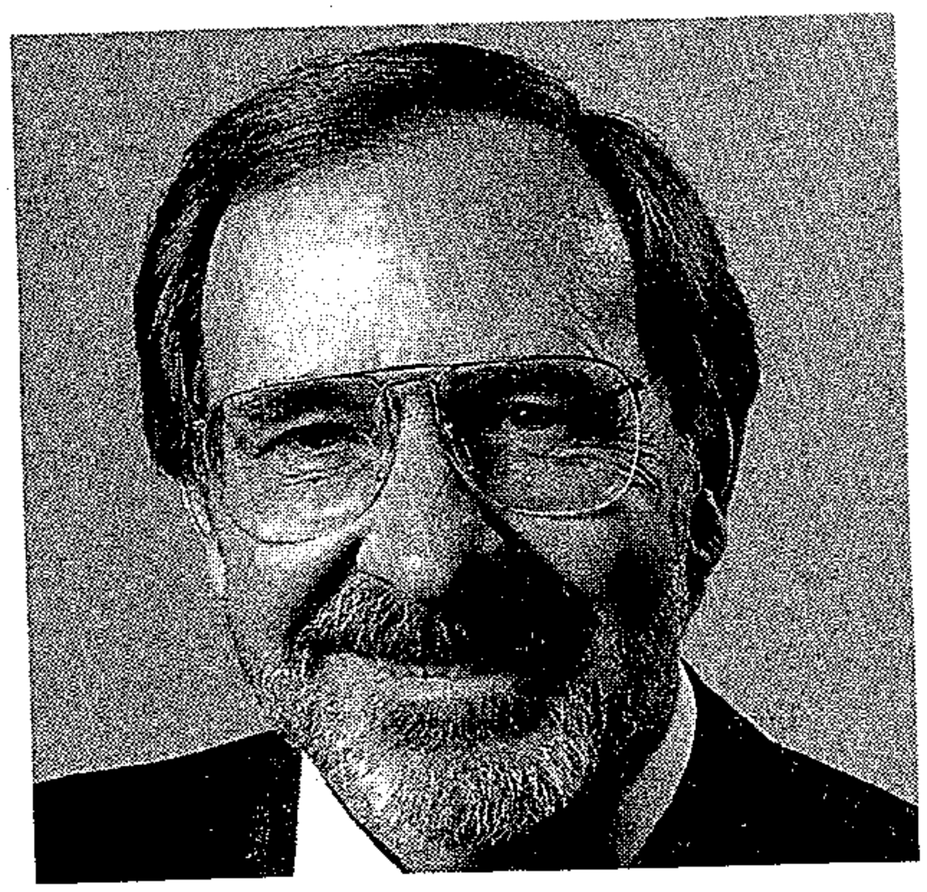
Taylor cites the Labour Relations Act in a discussion document on confidentiality as it applies to the granting of ex-gratia payments from a medical scheme to an employee member.

"The Labour Relations Act promulgated into law in November 1996 provides further details regarding protection of confidentiality in the face of the general tendency towards disclosure of information. Section 89 states that the employer should not disclose information that is confidential and, if disclosed, may cause substantial harm to an employee or the employer, or private personal information relating to an employee, unless that employee consents to the disclosure.

The document expresses concern about information which may be gathered on both the medical and the financial status of the employee and considers it inappropriate to make the names of individual applicants for payments known.

It also notes that human resources practitioners might be exposed to civil suits if they disclose private information.

It ends with the warning: "... we believe that the trustees of medical schemes should ensure that they do not place themselves in a position to potentially contravene such important legislative protection".



Medscheme chairman Keith Hollis

Local authorities' fund raps pharmacy body over negotiations

Medical aid charges row

CT (PTA) 24/11/97 (299)

VERA VON LIERES

Cape Town — The Local Authorities Medical Aid Fund (Lamaf), the national medical aid scheme catering for local authority employees, at the weekend slated United South African Pharmacies (Usap) for its alleged refusal to negotiate on the issue of guaranteed payment for prescribed medicines.

But Julian Solomon, the chairman of Usap, hit back, saying the association, which represents 1 803 pharmacies nationwide and provides credit and services to medical schemes, had in fact attempted to find solutions with Lamaf "over many months".

Solomon said: "The discounts demanded (by Lamaf) are unsustainable and not viable for normal pharmacies, 120 of which have already gone insolvent this year alone."

Michael Schultz, the chairman of Lamaf, said the medical aid scheme guaranteed payment to pharmacies on a preferred provider network for prescribed medicines in exchange for discounts on acute and chronic medicines, in line with a number of other medical schemes.

"Usap is now advocating that these discounts be drastically reduced, but that the guaranteed payment should continue," claimed Schultz.

Although Lamaf was willing to negotiate on the issues, Usap had advised its pharmacy members to withdraw credit facilities to members of a number of medical schemes, including Lamaf, Schultz said.

But in response Solomon said the statement that credit facilities from members had been withdrawn was "untrue and misleading".

"Only credit facilities to the fund have been withdrawn. Members will still continue to receive the usual high standard of service," he said.

Solomon noted that, as a provider of credit, Usap was entitled to know that it would be paid.

"Lamaf has refused to sign a contract with us regulating trading conditions. But three other major medical aid groupings, representing more than half of all schemes, have had no problems in accepting these terms," he added.

The three medical aid groupings were Interpharm, Mediscor and Medscheme.

deductions (2)

Finance committee backs Katz's proposals on medical aid

ARG 26/11/97

Cape Town – The Katz Commission on Taxation's proposals to limit the amount employers may claim as tax deductions for staff medical aid has received the backing of Parliament's finance committee.

The commission has proposed that employers' tax deductions for staff medical aid contributions should be limited to an amount equal to that contributed by employees.

The committee, in its report on the commission's interim findings on medical aid schemes and benefit funds, said, it wanted more thought given to the possibility of such a move discouraging lower wage earners from joining medical aids.

The report, drawn up by the committee's tax sub-committee, was adopted at a meeting yesterday.

The proposals to clamp down on the salary sacrifice scheme drew criticism from several interest groups.

The committee in principle also supported the commission's proposal that self-employed people be entitled to deduct 50% of their medical aid contributions. – Sapa

Payouts to traditional healers to end

BD 27/11/97

THE Registrar of Medical Schemes would early next year stop medical aid schemes which had been paying out benefits to traditional healers, the registrar announced at a benefits conference in Johannesburg on Tuesday.

Medscheme Groups spokesman Gary Taylor said yesterday the move was in response to the Medical Scheme Act which stated that medical aid schemes should not pay unregistered health care providers. Taylor said those medical schemes which had been doing so were contravening the law.

While traditional healers had been proposing that their treatment be included in medical aid benefits, it was only recently that support for the proposal was received from union sources and certain academic and political circles, said Taylor.

"The onus is now on traditional healers to lobby government to give them legal status." He said there were strong arguments for and against traditional healers being brought into the medical aid system because "many inappropriate treatments have had serious consequences for the patient". Western preparations also had harmful effects, Taylor said.

"We administer 57 schemes, serving 2-million patients.

"Half of these patients are black and for many years we have had discussions with various associations representing traditional healers." There were 200 000 healers in SA.

He said there was a way of bringing healers into the formal medical aid system if all parties involved were prepared to adopt a sensible approach. The body, mind and soul approach adopted by traditional healers was increasingly being followed by Western doctors, as well as the use of herbs and other organic substances, said Taylor. —Sapa.

Saccawu launches its own medical aid fund

Sowetan 3/12/97 (299)

By Abdul Milazi

THE South African Commercial Catering and Allied Workers Union (Saccawu) launched a medical aid fund yesterday which the union said would be used as a springboard for the establishment of its own medical aid scheme.

Saccawu assistant general secretary Herbet Mkhize said the fund would operate under Medscheme's Meddent Medical Scheme for about nine months while the union conducted further research into establishing its own medical aid scheme.

Mkhize said trade unions were no longer only competing with one another but also with legal firms that were now offering their services to workers.

"Now a trade union has to convince potential members that it offers the best services," Mkhize said.

"When you try to recruit a member, they would like to know what they will get out of it. You tell them about getting legal representation when they are unfairly dismissed and they tell you that they are members of Legalwise.

"If you do not offer more than just representation, then you have lost those members," he said.

Mkhize said just as banks were now under threat from retail outlets which were now offering banking facilities, unions were under pressure to improve their benefits for members and also broaden the scope of benefits.

The new fund was put together by Medscheme's Negotiated Benefits Unit (NBU) and follows three years of research by Saccawu.

NBU head John Eagles said the fund was unique in that it enabled members to register parents as dependents and that it had a range of benefit options.

Medical aids 'not tackling AIDS problem'

BD 4/12/97 (Pg 2) (299

Samantha Sharpe

CAPE TOWN — SA medical aid schemes are not addressing the AIDS problem effectively and need to devise cost-effective disease management schemes accommodating HIV-positive members, Old Mutual Actuaries & Consultants says.

Geetesh Solanki, the company's practice partner on health issues, said recent Old Mutual health benefits surveys showed medical schemes were responding in an ad hoc way to the AIDS problem, which was understandable given the ignorance and uncertainty surrounding the spread of the epidemic among medical scheme members.

"However, in the light of the rapid increase of the epidemic in SA and the threat that it poses, there is an urgent need for schemes to devise a coherent framework for cost-effective disease management."

Solanki said this would have to include the flexibility to cope with the likely increase in the prevalence of HIV cases. What could clearly not be allowed to continue was the existence of exclusion clauses for members that were or became HIV positive, a situation prevalent among 5% of the schemes Old Mutual had surveyed.

"To address this dilemma we believe it is crucial for schemes to adopt a nondiscriminatory philosophy that regards HIV and AIDS in the same way as comparable life-threatening illnesses.

"This means incorporating HIV and AIDS into the scheme's overall framework for chronic disease management."