SOCIAL SECURITY - MEDICARE

1998

17% fees increase short-changes consumers

BD 9/1/98

The Hospital Association of SA is to publish its own set of 'guideline' tariffs after a ruling from the Competition Board allowing it to do so. They are likely to be higher than medical schemes will pay. Alex van den Heever examines the association's reasons for doing this

THE Hospital Association of South Africa (Hasa) has responded to permission by the Competition Board to publish a set of guideline tariffs by setting hospital fees 17% higher for 1998 than they were in 1997.

Aside from the fairly self-serving rationalisations for such a high tariff increase, various interesting and problematic issues arise concerning the nature in which "competition" works in the private health industry and the implications for members of medical schemes.

The publication of a set of hospital fees guidelines arises out of a conflict between the Representative Association of Medical Schemes (Rams) and Hasa. Rams has, until now, been allowed to publish guidelines for hospital fees, provided they are not directly or indirectly enforced, while Hasa could not because this was considered price collusion.

However, not all providers are excluded from setting guidelines. Representative associations of professions can do so: the Medical Association of South Africa (Masa) sets fee guidelines for doctors, for example.

A distinction, however, needs to be made between the amount that a medical scheme chooses as its price for a medical service, and the fee charged by the provider.

Where a difference occurs between the scheme price and the provider price, balance billing can occur. In other words, the patient is billed for the difference.

In the health care market, prices are determined to a large extent by the existence of health insurance — medical schemes.

Because the patient is actually paying either nothing or very little at the point of service, they tend to be indifferent to prices generally, and apathetic about which provider (in this case hospital) to select. This means there is no real competitive market for hospitals within the insurance-funded fee-for-service setting. In addition to price indifference is the power of the provider to determine the level of services needed by a patient.

In hospitals, where detailed telephone-book type itemised bills result, overbilling can be, and has become, a serious problem. This has left the consumer of private health care disempowered. They can neither negotiate prices nor moderate the volume of services provided.

Within this context, per capita medical cost increases faced by medical schemes have gone up by an astounding 7,6% a year in real terms (after inflation has been accounted for) since 1982. Hospital per capita costs have outperformed all others, except for notorious pharmaceuticals (10% a year, after inflation), by going up by 9,6% a year, again in real terms. All this in a period when the SA economy grew at less than 1% a year in real terms and achieved negative per capita growth.

Furthermore, during this period, private hospitals dependant on the fee-for-service environment introduced no efficiency improvements, information systems to assess efficient outcomes or improvements in management.

Allowing hospitals to effectively collude in the setting of prices through Hasa, puts individual consumers of health care at a substantial disadvantage.

The balance billing does not apply to medical schemes. If the recommended fees were to be used as reference prices for negotiations between schemes and providers in setting the reimbursement rates, this would be less of a problem.

However, the moment these are used to determine a "surcharge" over and above medical scheme rates, this must be considered anticompetitive. This is because there is one Hasa and 7-million individual consumers of health care — who cannot shop around for a better deal if all providers have the same price.

Some of the reasons for Hasa's actions need examination. Normally in competitive health care markets an all-inclusive fee is created which increases, at most, at the inflation rate.

To include input costs in the argument is much like saying the gold price should be $500 an ounce because of gold mining input costs.

Demand should determine price and quantity, except where demand is subject to manipulation and price exclusively determined by the supplier.

The reasons given for the "unmanageable" cost increases to hospitals include items like nursing salaries and the rising cost of equipment due to currency devaluation.

Salaries are a negotiation between hospitals and staff for which both parties should accept the risk of any decision made, otherwise private hospitals would have unlimited potential to pass on cost inefficiencies and poor bargaining arrangements to patients.

Currency devaluation has been given as an excuse but it can only have an impact on the capital depreciation portion of hospital costs in any year where costs depend on foreign imports and where purchases cannot be delayed. As it happens the producer price index shows only a 2% change for medical equipment for domestic consumption between December 1995 and October 1997.

There is clearly much to think about within the private health system. The 8% across-the-board increase in tariffs suggested by Rams is, in many senses, generous as it is above the inflation rate. If they gave higher, one would have to question their legitimacy in representing members in fee negotiations. Over the next few years medical schemes are going to push much harder to contain costs.

What appears to be clear is that consumers are being short-changed and that the Competition Board needs to think again.

☐ *Van den Heever is a senior researcher at the centre for health policy at the University of the Witwatersrand.*

Health cover is set up for hawkers

By Saint Molakeng

HAWKERS will from tomorrow be in line for a scheme that will provide them with medical aid, death and disability cover, funeral and accident cover, stokvel savings and personal loans – all in one package for only R160 a month.

These benefits are the brainchild of the African Council of Hawkers and Informal Business (Achib), Medwise and First Bowring insurance company under First National Bank.

The scheme was piloted in Johannesburg late last year and is to take effect around South Africa this month.

Achib will host a meeting at St Mary's Cathedral at corner Pritchard and Small streets in Johannesburg, tomorrow where hawkers will be briefed about the scheme. Application forms will be available for anyone who wants to sign up.

"Hawkers have been in dire need of such schemes as they have not been covered at all for their health, death or accidents," said group scheme marketer for Achib, Thomas Lehana.

In case members do not utilise the medical savings, they will be paid back.

For more information interested people should contact Lehana at (011) 838-2983/4.

Medical aid funds start moving out of intensive care

The future is beginning to look brighter for most medical aid fund members, writes LEIGH ROBERTS

MEMBERS of medical aid funds have endured punishing hikes in contributions for many years, but things are looking better as the industry moves into an improved financial position.

But the industry is not out of the woods — there are still some issues to overcome before it can reward fund members with annual increases which are no higher than the inflation rate.

Most fund members will be hit with a hike in contributions of 12% this year (this is the industry average, but the increases range from 8% to as high as 20%). This average is still way above the inflation rate (about 6%), but it's a great improvement on the 20% plus which was the norm until a few years ago.

This week, independent credit rating agency Duff & Phelps released their annual review of the financial stability of medical aid funds and the state of the industry. The accompanying table reflects the credit rating of 31 "open" funds. An open fund offers membership to any company and its employees (by contrast, a private fund is run on an in-house basis by the company itself).

Not all of the open medical aid funds available in the market agreed to be rated by Duff & Phelps, so 10 funds are not on the list (but see below for the names of three funds on which Duff & Phelps offer words of caution).

A credit rating is an assessment of a fund's ability to pay its members' claims timeously.

The members of the funds listed in the table will be pleased to see that, with the exception of Medilife, their funds received a secure rating — although some funds are in a better state than others. As members of Medilife Medical Scheme know, their fund got into financial trouble last year and is now in liquidation.

The ratings are based on the funds' December 1996 financial figures as well as their interim management reports for 1997.

Dave King, managing director of Duff & Phelps, says the funds that did not agree to be rated were nevertheless assessed on the basis of their publicly available information.

King points out three funds that, in his view, are currently showing solvency and liquidity problems. "There are definite risks in these funds," says King, "and the members should be aware of them."

□ Allcare Medical Aid Scheme — this fund has been making losses,

ST(BT) 18/1/98

If there is a sustained downwards market, this will create solvency and liquidity problems for certain funds'

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despite the heavy increases in contributions it imposed on members. What is particularly disturbing, adds King, is that many members are elderly.

□ East Coast Medical Plan — this fund's financial problems have recently been compounded by its exposure to Care Corp (a managed health care company in the throes of liquidation).

□ Stability Medical Aid Society — the losses of this fund haven't been stemmed and it reflects a highly illiquid position, says King.

The Duff & Phelps survey reveals that the industry as a whole is in much better financial shape than it was four years ago.

In the past, the industry was hard hit by spiralling claims, declining membership, and runaway medical inflation (problems which were abetted by a fair chunk of fraud).

The financial problems of the funds led to their members being whacked with sky-high contribution increases.

Things started to improve after the industry was deregulated in 1994 — a move which enabled the funds to introduce managed health care programmes and other claims cost containment measures, like member savings accounts.

The positive impact of these measures on the industry's financial position can be seen in Duff & Phelps's latest industry review.

The average solvency margin of the industry is up, and medical inflation has been brought back more into line with the overall inflation rate.

Nevertheless, there are some worrying industry trends — not least of which is the weakening state of the stock market.

In the last few years, says King, many funds increased their investment in the stock market and reduced their cash holdings in a bid to raise their investment performance.

"The industry is now much more exposed to the negative impact of a falling stock market. If there is a sustained downwards market, this could create solvency and liquidity problems for certain funds," notes King.

Another negative trend is the ever-increasing operational costs of some funds (this includes administration costs and other operating costs).

"Currently an average 7.4% of the fund's contribution income goes to operational costs, up from 5% three years ago.

"Many funds have implemented new options and cost containment mechanisms in the past few years and this has resulted in a corresponding rise in operational costs.

"Notwithstanding this, the fund administrators must be able to justify any increase in operating costs given the fall in claims costs," says King.

Ironically, industry regulation — the factor which pushed the industry into its current recovery — is now once more a threat to the industry's future.

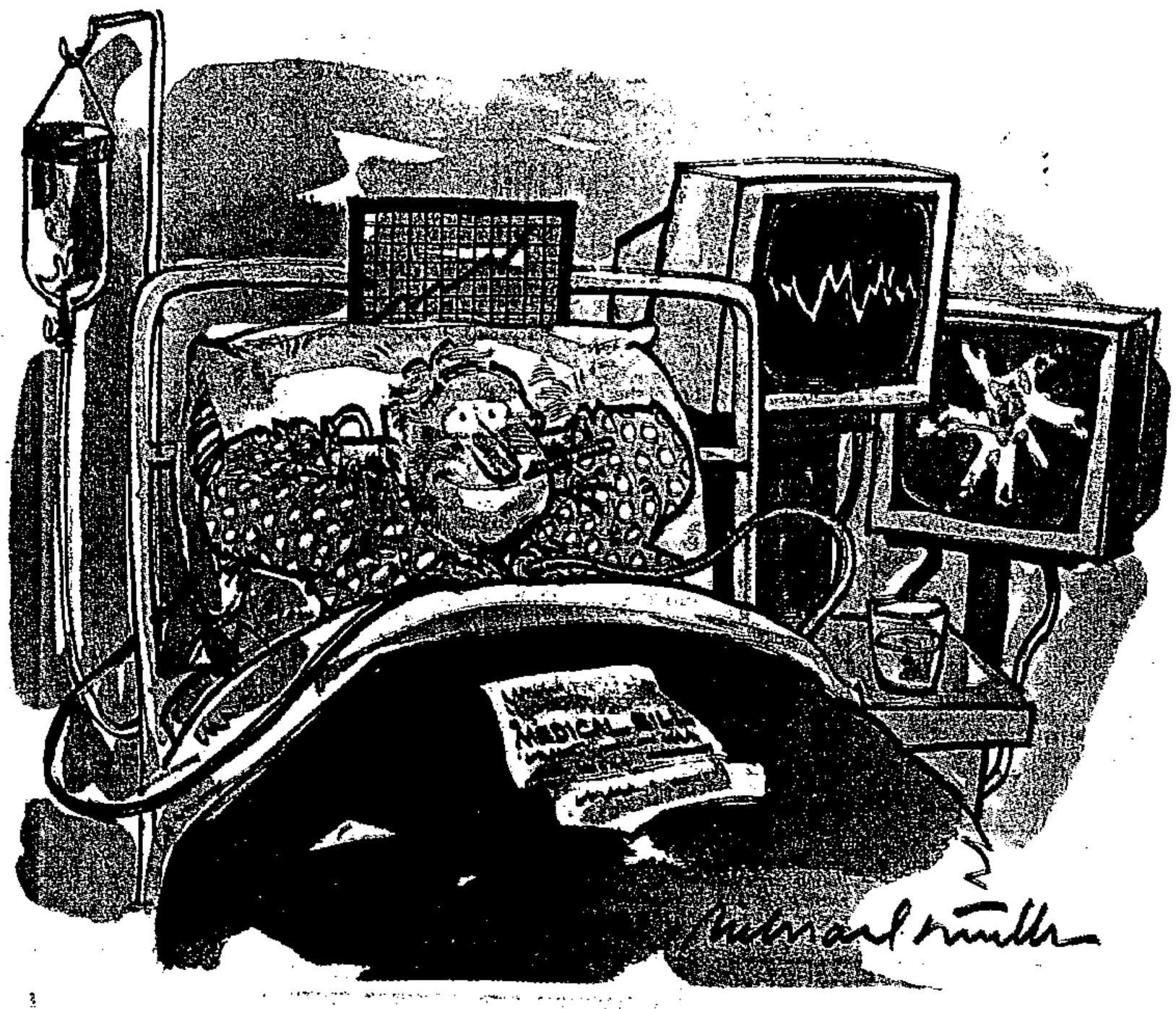
The government white paper on the industry proposes a move back to greater regulation of funds and away from free market principles.

"Any attempt to turn back the clock needs to be seriously considered. In our view, the regulatory environment must encourage free market principles and efficiency, while allowing funds to correctly price for risk and apply cost containment measures," says King.

What will surely be of more immediate concern to many fund members, is a proposal which effectively outlaws no-claim bonuses paid to members, and the popular member saving accounts.

In the past two years, the medical aid funds which have attracted the most new members are the so-called new generation funds, like Momentum Health and Fedsure Health. These funds are structured around a savings account which returns to the member the unused portion of their contributions.

If the draft legislation becomes law, it is King's view that by this time next year, savings accounts will no longer be around.



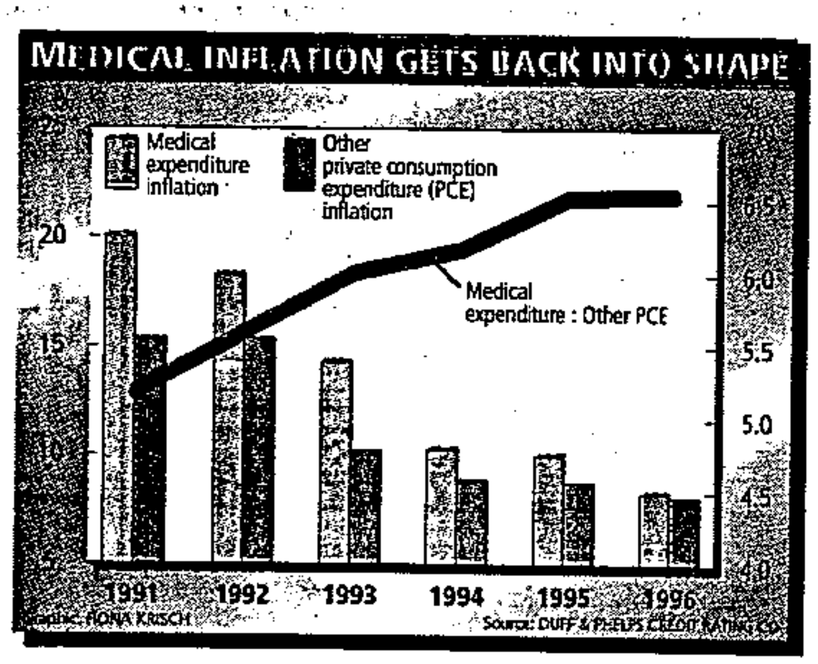
HOW SOUND IS YOUR MEDICAL AID?

Beland	A
Bonitas	AA-
Commercial and Industrial Medical Aid Scheme	A+
Fedsure Health	A+
Premier	A+
SAKAV	A+
Sizwe	A
Southern	A+
Tafelberg	A+
Witbank Coalfields Medical Aid Society	A+

* Now in liquidation
** Rating in progress

KEY
AA is the best rating but any rating of BBB and above means the fund is financially secure

Graphic: FIONA KRUSCH
Source: DUFF & PHELPS CREDIT RATING CO



Lesbian cop asks court to lift medical aid ban on partner

Johannesburg – A lesbian police officer has taken legal action against the SA Police Service seeking a court order allowing her to register her partner on its medical aid scheme, Polmed.

Mazibuko Jara, spokesman for the National Coalition for Gay and Lesbian Equality, said yesterday the court bid would open in the Pretoria High Court on Tuesday.

The applicant, Jolande Langemaat, is based in Johannesburg and has been with the police force since 1982.

Mr Jara said Ms Langemaat sought legal action after her employer last year refused to register her partner of 11 years on the grounds that they were not married. Under South African law, two people of the same sex cannot be married.

Police spokesman Johan Smal confirmed the case would come before court on Tuesday.

He said it was sub judice and he could not comment further.

Mr Jara said in terms of the constitution, lesbian and gay people were assured equality and non-discrimination.

"It's a simple case of discrimination," he said.

Mr Jara said there were several similar cases which his organisation was taking up against employers. The matters were being dealt with by the organisation's lawyers.

He said the coalition, which was formed in 1994 and has 74 affiliates countrywide, successfully took up the case of a lesbian employee of Anglo American Corporation last year.

The case had not reached the courts.

On Tuesday, lesbians and gays would picket outside the police headquarters in Pretoria to highlight the court case, Mr Jara said. – Sapa

Controlling AIDS, TB is Shisana's priority

Josey Ballenger

BD 28/11/98

HEALTH director-general Olive Shisana yesterday announced her department's objectives for the year at a conference in Midrand.

Controlling communicable diseases, continuing to improve access to health services, augmenting the health information system and stepping up antiviolence initiatives would be priorities this year, she said.

At a health care symposium organised by the Institute for International Research, Shisana said the department was drafting the Tobacco Control Bill to "further discourage" tobacco use by children in line with World Health Organisation recommendations.

Shisana said research by the Medical Research Council and the Human Sciences Research Council showed the prevalence of smoking in SA had decreased by 2% in 1996 from the previous year, which meant about 500 000 fewer smokers.

The control of the spread of AIDS, as well as the treatment of sexually transmitted diseases, would be priorities. Government aimed to control the prevalence of tuberculosis and reach an 85% cure rate and would expand its programme in each province. The control and treatment of mosquito-borne diseases, especially in malaria-prone KwaZulu-Natal, Mpumalanga and Northern Province, was also vital.

One of three "key" pieces of legislation to be presented to Parliament this year would be the National Health Bill, which would provide a framework for the policies outlined in the white paper on the transformation of the health system.

She said the controversial Medical Schemes Amendment Bill aimed to contain costs and ensure beneficiaries were "able to obtain a basic package of care that is affordable".

On access to health care, Shisana said measures would be implemented to contain the cost of drugs. These included establishing a new Medicines Control Council and a pricing committee, controlling the theft of drugs from public institutions and the licensing of pharmacies and dispensing doctors.

Strategies to improve the health information system would continue, including the disease surveillance system, and birth and death notification.

Shisana said antiviolence initiatives would be provided including surveillance, referral centres and empowerment and trauma counselling courses for health care personnel.

DP agrees on regulating health care

Josey Ballenger

BD 28/11/98

DEMOCRATIC Party health spokesman Mike Ellis said yesterday he agreed with the health department that the private sector needed regulation to provide affordable and accessible health care for all, but questioned how government proposed doing so.

At a health care symposium in Midrand organised by the Institute for International Research, Ellis said steps needed to be taken to reduce or prevent abuse in regulating the sector.

"If it is to be regulated and legislated against to such an extent that it becomes little more than an effete extension of the public health care sector and cannot operate freely, then I believe we will face the collapse of the entire health service in this country".

He accused Health Minister Nkosazana Zuma of not adequately collaborating with the private sector on health bills last year and said the "pattern" looked set to continue.

Same-sex couple fights police for medical aid

CT 29/1/98 (299)

PRETORIA: In a ground-breaking case, a gay captain in the South African Police Service yesterday took on the medical aid scheme of the South African Police Services (Polmed) to have her lover of more than 11 years registered as a dependant.

Captain Jolande Langemaat, who attended the court proceedings with her lover, Ms Beverley-Ann Myburgh, brought the application against the Minister of Safety and Security, the national Commissioner of the South African Police Services and the chairman of the South African Police Medical Scheme (Polmed).

She said in court papers that she has been a member of Polmed since she joined the police service in 1982. In an application for the registration of a dependant to her medical aid, she described Myburgh as her partner and said they had had a same-sex relationship since 1986. However, she was denied permission to register Myburgh as a dependant.

Langemaat said her lover did not belong to a medical aid. She said that on Myburgh's current salary she was unable to afford to join a medical aid in her private capacity.

Langemaat said in her application: "I am committed to Beverley and to my relationship with her. I believe she should be entitled to the benefits that would be accorded her if she were married to me in a recognised civil marriage.

"I believe that the refusal by the chairman of Polmed to register her as my dependant under their scheme, violates rights to which I am entitled in terms of the Constitution.

"The failure to recognise my relationship constitutes unfair discrimination on the basis of marital status and sexual orientation, within the meaning as described in the Constitution. It also infringes my right to equality in terms of the Constitution."

The fund manager of Polmed, Mr Eduard Otto Boersma, said in an affidavit the Langemaat-Myburgh relationship was "no more and no less" than a love relationship and could not be termed a marriage or a common law marriage.

He said the relationship did not appear to be one of dependency, but one of friendship as a result of a love affair. According to Boersma, Myburgh did not "constitute" a dependant.

He said Langemaat could not seek the protection of the Constitution, because she was not married to Myburgh, either in the legal, strict or natural sense of the word. Judgment was reserved. — Own Correspondent

'DISCRIMINATION': Jolande Langemaat (left) at court yesterday with her partner, Beverley-Ann Myburgh. *PICTURE: PRETORIA NEWS*

Judgment reserved in case on SAPS medical aid

Taryn Lamberti

JUDGMENT was reserved in the Pretoria High Court yesterday in an application brought by a lesbian police officer, who wants the police medical aid scheme to accept her partner of 11 years as a member of her family and to allow her benefits from the medical aid scheme.

Capt Jolanda Langemaat has challenged the constitutional validity of medical aid scheme Polmed's rules and regulations which prohibit her partner, Beverly Myburgh, from being admitted as a member of the scheme.

Langemaat has asked the court to declare Polmed's rules to be in conflict with the constitutionally guaranteed right to equality.

Court papers show that Langemaat's application for the registration of Myburgh as her dependent for the purpose of Polmed's benefits was refused in May 1996.

The Police Act, which allows "dependants" to be admitted to the scheme, defines dependants as "the legal spouse, widow, widower or dependant child of a member".

According to her affidavit, Langemaat and Myburgh have been involved in an intimate relationship since June 1986 and have lived together in a house bought by Langemaat using her subsidy from the SA police service.

They operate joint finances, are financially co-dependent, have commitments to one another and are the listed beneficiaries in each others' policies.

Langemaat's counsel highlighted yesterday the principles laid down in the constitution for the interpretation of the Bill of Rights. "When interpreting the Bill of Rights a court ... must promote the values that underlie an open and democratic society based on human dignity, equality and freedom."

Langemaat's counsel argued: "Unfair discrimination on the ground of sexual orientation displays the same basic features as discrimination on the grounds of race or gender." Langemaat's case also relied on the Labour Relations Act which defines discrimination on the grounds of sexual orientation as an unfair labour practice.

Alternatives proposed to state's healthcare schemes

ET(BR) 2/2/98 (299)

ADELE SHEVEL

Johannesburg — Medical aid schemes were proposing alternatives to the government's focus on flat-community rating and open enrolment to schemes, Adrian Gore, Momentum Health's chief executive officer, said recently.

Proposals had been suggested for guaranteeing access to health cover, such as a high-risk pool that would provide guaranteed coverage for people who were turned away from medical schemes and health insurers, he said.

Although reregulation in the healthcare sector was imminent, he was cautiously optimistic that some of the real concerns with the initial reregulation could be averted. This would mean that the reregulation could be less disruptive than expected.

He highlighted the challenges facing the healthcare industry for the year ahead. "Managed care will start making inroads into the inflation rate of healthcare, but this will take time, and unless individuals are prepared to give up some freedom of choice as to what doctors and hospitals they attend, consumers should not expect a substantial reduction in healthcare costs."

He said the rapid move in managed care and clinical technology would enhance the flow of information within the healthcare sector. This would enable the entire environment to increase the quality of healthcare and bring down the cost.

In order to be competitive, health insurance companies and medical schemes would have to demonstrate that their coverage served the health employers more effectively than other plans, said Gore. There were opportunities in blending the successful medical savings account approach to financing healthcare with emerging managed care models.

Medical savings accounts rely on patients making choices, whereas managed care tends to focus on supply-side control. He said the combination of the two could maximise quality and reduce costs if they were carefully balanced.

Gore said the form of managed care that would work in the South African marketplace would be one based on partnerships between providers and payers.

"The relative undersupply of doctors in the South African marketplace means that dictatorial market-making approaches such as the American market simply will not work.

"While employers are acknowledging the critical need to keep healthcare costs under control, there is growing awareness about the importance of the quality of healthcare and the health status of their staff."

Judge orders medical aid to admit gay partner

Star 5/2/98 (299)

Lesbian police captain's successful court application against Polmed will have wide-ranging effects, say analysts

NAASHON ZALK

Gay-rights victory ... "We ask for nothing more," said Captain Jolande Langemaat (left) after a judge ruled that same-sex relationships deserve equal respect, and that a medical aid's refusal to register her partner, Beverley-Ann Myburgh, as a dependant was unconstitutional.

By Robert Brand and Ryan Cresswell

In a ground-breaking ruling for gay and lesbian couples in South Africa, the Pretoria High Court has found that a lesbian captain in the South African Police Service has the right to register her lover of 11 years as her dependant on her medical-aid scheme.

Judge JP Roux yesterday declared regulations by the South African Police Service's Medical Aid Scheme (Polmed), which exclude the partners of gay and lesbian couples as dependants, unconstitutional.

Judge Roux ordered Polmed to reconsider Captain Jolande Langemaat's application to have her partner, Beverley-Ann Myburgh, registered as a dependant.

This follows an application last month by Langemaat, seeking a court order compelling Polmed to register her partner on the medical-aid scheme.

The ruling could pave the way for the recognition of gay and lesbian marriages, legal analysts said yesterday.

The precedent set by Judge Roux is legally binding only within the jurisdiction of the Transvaal division of the High Court, but would be a persuasive argument in other jurisdictions.

"It is an important decision because it affects not only medical aid," said Professor Gretchen Carpenter of the University of South Africa's law faculty.

Any benefit accruing to an employee or dependant by virtue of his or her marital status may have to be extended to same-sex partners, Carpenter said. This could include pension benefits or other benefits such as free education of spouses or dependants.

Kevan Botha, legal adviser of the National Coalition for Gay and Lesbian Equality, said the ruling had "opened the way for many lesbian and gay people to claim their rights and for our relationships to be recognised".

He said the judgment was a direct challenge to all employers to change their policies and abide by their constitutional and statutory obligations.

Langemaat described the judgment as a victory for the gay and lesbian community.

"We didn't do it just for ourselves. The judge spoke to our hearts when he said both hetero and single-sex relationships deserve equal respect. We ask for nothing more."

In his judgment, Judge Roux said it was time that South African law recognised committed gay and lesbian relationships, which he said were no different from the relationships of married couples.

Roux said the police regulations and Polmed's definition of dependants represented a select group of people and excluded a large number of dependants, including grandparents and brothers and sisters. This was discriminatory.

The constitution forbids unfair discrimination on the grounds of sexual orientation or marital status.

Commissioner George Fivaz – who, together with Polmed and Safety and Security Minister Sydney Mufamadi, opposed the application – said he had taken note of the judgment and would comment once he had studied it.

Declan Brennan, executive director of the Representative Association of Medical Schemes, said copies of the judgment would probably be studied by medical-aid management.

He said some medical-aid schemes already covered brothers, sisters and grandparents if they were proven dependants.

He said there was a problem with the law in that gay marriages were not yet legally recognised in South Africa and schemes needed a marriage contract or a common-law relationship to write up a policy.

Adrian Gore, managing director of Adrian Gore Momentum Health, said his company was already covering gay couples whom it considered "serious partners".

However, Gore said, Judge Roux's "broad definition" of other dependants such as grandparents, brothers and sisters should be considered carefully because the industry had to guard against members being able to put any unhealthy relative on a policy.

High Court ruling paves the way for gay couples

ET 5/2/98 (299)

ROBERT BRAND AND RYAN CRESSWELL

JOHANNESBURG: The Pretoria High Court's landmark ruling in favour of a lesbian police captain who wants to register her partner as a dependant for medical aid could pave the way for the recognition of gay and lesbian marriages, legal analysts said.

Mr Justice J P le Roux set aside a decision by Polmed, the South African Police Service's medical aid scheme, to refuse an application by police Captain Jolande Langemaat to register her partner of 11 years, Ms Beverley-Ann Myburgh.

Constitutional experts said the ruling — recognising same-sex couples should have the same rights as heterosexual couples — could also have implications for other areas of employer/employee relationships.

The precedent set by Judge Roux is legally binding only within the jurisdiction of the Gauteng division of the High Court, but would be a persuasive argument in other jurisdictions.

"It is an important decision because it affects not only medical aid," said Professor Gretchen Carpenter of the University of South Africa's law faculty.

Any benefit accruing to an employee or dependant, by virtue of his or her marital status, may have to be extended to same-sex partners, Carpenter said.

Mr Kevan Botha, legal adviser of the National Coalition for Gay and Lesbian Equality, said the ruling had "opened the way for many lesbian and gay people to claim their rights and for our relationships to be recognised".

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"The judge spoke to our hearts when he said both hetero and single-sex relationships deserve equal respect. We ask for nothing more."

In his judgment, Judge Roux said it was time that SA law recognised committed gay and lesbian relationships, which were no different from marriages.

Roux said police regulations and Polmed's definition of dependants represented a select group of people and excluded a large number of dependants, including grandparents, brothers and sisters.

The regulations governing the registration of Polmed dependants will now have to be rewritten and Langemaat's application to register Myburgh reconsidered.

Commissioner George Fivaz, who with Polmed and Safety and Security Minister Mr Sydney Mufamadi opposed the application, said he would comment after studying the judgment.

Mr Declan Brennan, executive director of the Representative Association of Medical Schemes (RAMS), said there was a problem with the law at the moment as gay marriages were not yet legally recognised in South Africa and schemes demanded a marriage contract or proof of a common law relationship.

But some medical aid concerns are already covering gay couples whom they deem to be serious partners. Mr Adrian Gore, managing director of Adrian Gore Momentum Health, said his company was already doing this for many gay couples.

Medical aid schemes 'in fool's paradise'

BD 5/2/98 (299)

Josey Ballenger

THE days of medical aid schemes living in "a fool's paradise" by ignoring HIV and AIDS were numbered, medical fund administrator Medscheme said this week. It was inevitable the schemes would have to recognise and cover the disease, Medscheme said.

Medscheme director Gary Taylor said: "When AIDS first emerged in the 1980s, many medical aids refused to cover it at all, believing this was a self-inflicted illness.

"Even today, some schemes classify HIV as a sexually transmitted disease, and have very low limits."

However, this approach had been resisted by many doctors who had treated medical aid scheme members without disclosing the AIDS diagnosis on their accounts, Taylor said.

Medscheme administers 57 medical aids serving 2-million people.

"In effect, medical aids were living in a fool's paradise, thinking they were avoiding AIDS but actually paying for it anyway," Taylor said. "Most medical aid schemes now realise that it is unfair to discriminate against AIDS claims when they do pay for treatment of cancer caused by smoking, (which) also can be regarded as self-inflicted."

However, Taylor said, medical aids could not afford to pay for "any and every" account submitted, as it would lead to a sharp, unaffordable rise in premiums. Individual schemes were investigating some "very promising" managed health care programmes geared to address concerns about confidentiality while delivering care at affordable costs.

One such programme was "Aid for AIDS", developed by Medscheme subsidiary Pharmaceutical Benefit Management (PBM) and due for launch in April. This would include counselling, lifestyle management, vaccinations and antiretroviral therapy. Patients would consult the doctor of their choice, and confidentiality would be guaranteed.

PBM executive chairman Dr John Cowlin said Aid for AIDS would be administered by an in-house unit, as opposed to the few medical schemes which provided some sort of HIV/AIDS benefit but did not have management structures in place.

One of the programme's primary objectives would be to combat "the fear and stigma" that accompanies AIDS.

Treatment would involve the use of certain antibiotics to reduce the risk of infection and, when necessary, an antiretroviral therapy cheaper than the "widely publicised triple cocktail" would be administered.

Cowlin said early detection was "vital" as it could lead to preventing an HIV-positive mother, for example, bearing a baby with the same condition. "Statistics reveal that 14% of pregnant women in SA are HIV-positive, but if therapy is started immediately, there is a good chance the baby will be born HIV-free," he said.

Health authorities have estimated that 2,4-million South Africans are HIV-positive.

However, Medscheme said its strategic planners "assume the real figure to be double that because of limited reporting of the disease".

Medscheme projected that 20% of its members could be HIV-positive within 10 years.

Banks to tighten criteria for home loans

BD 5/2/98

Robyn Chalmers

THE number of houses built each year could be reduced by up to 18 000, with the loss of about 40 000 potential jobs, when financial institutions phase in new criteria for granting bonds next month, developers warn.

The more stringent criteria bring SA into line with international lending norms and raised a storm of protest when mooted two years ago.

Employees receiving housing subsidies will be affected by the change, which substantially reduces the size of bond for which they qualify. Public servants make up the bulk of this market.

Council of Southern African Bankers housing GM Lance Edmunds said that with the downsizing of the public service banks believed it prudent to revise lending criteria. Many retrenched employees would not be able to pay their bonds, particularly as the current lending criteria allowed borrowers access to homes they struggled to afford.

Banks calculate the bond amount to be granted by taking 25% of the base salary and adding the housing subsidy. The new method will be to take 25% of the combined salary and subsidy.

This means someone earning R1 600 a month and qualifying for a R63 400 bond previously, will now be offered a bond of about R33 000.

SA Residential Developers' Association executive director Hendrick Kekana said the new criteria would kill the much-needed secondary housing market and have an adverse effect on sectors of the residential market, notably houses priced between R60 000 and R100 000.

Kekana said about 21 250 houses a year were being built for individuals with a subsidy. With the new criteria, it was estimated that only about 15% of these would be built each year.

Building Industries' Federation of SA executive director Ian Robinson said the change would have a negative effect initially on public residential investment, which is about R1,1bn a year. "However, in the longer run it will control consumer spending and debt obligations and there will be less repossessions, which should have a positive effect on the economy."

Edmunds said banks were aware that the new criteria would have a "serious impact" on the amount an individual could borrow, and had attempted to lessen its effect. "We have done what we can by imposing a one-year moratorium on the criteria last year, and we will phase the criteria in over an eight-month period. But ultimately we believe it irresponsible to continue lending as we are."

Lesbian ruling expected to set precedent

BD 5/2/98 (299)

Taryn Lamberti

THE refusal of the police medical aid scheme, Polmed, to allow a lesbian police officer to register a female partner of 11 years as a dependant on her medical aid was declared unconstitutional by the Pretoria High Court yesterday.

An SA Police Service regulation, which defines a dependant as a "legal spouse, widow, widower or dependent child", was struck down by Judge JP Roux on the grounds that it violated a constitutional right to equality.

Roux directed Polmed to reconsider Capt Jolanda Langemaat's request.

Langemaat and Beverley-Anne Myburgh, who had lived together as a married couple since June 1986, had a "committed, exclusive, loyal and continuous relationship". They had joint finances, were financially co-dependent, made joint decisions and were listed beneficiaries of each other's policies, Roux said.

The stability of same-sex relationships was no different from that of married couples and "it was time the law recognised such unions".

Polmed's argument that it feared a flood of unmarried people attempting to register their partners as dependants on the medical aid had no merit.

Josey Ballenger reports that medical scheme administrators believe the case will set a precedent not only for medical aids but also for pension and other funds with beneficiaries.

However, they pointed out that several medical aids already extended benefits to homosexual partners. In those cases a member supplied a legal document verifying the couple's long-term cohabiting status.

Subject to certain conditions, "special dependants" such as parents, grandparents or other relatives were also accommodated.

Alex van den Heever, senior researcher at Wits University Centre for Health Policy, said the case meant medical aids would have to decide how to differentiate between unmarried heterosexual couples and same-sex couples. This could be resolved by a change in law to recognise same-sex marriages, he said.

Key Market Movements — 3/2 to 4/2

Gold		Currencies			
Lon close	Lon PM				

yesterday. At yesterday's closing share ers' Union Investment Company. Continued on Page 2

Banks to tighten criteria for home loans

BD 5/2/98

Robyn Chalmers

THE number of houses built each year could be reduced by up to 18 000, with the loss of about 40 000 potential jobs, when financial institutions phase in new criteria for granting bonds next month, developers warn.

The more stringent criteria bring SA into line with international lending norms and raised a storm of protest when mooted two years ago.

Employees receiving housing subsidies will be affected by the change, which substantially reduces the size of bond for which they qualify. Public servants make up the bulk of this market.

Council of Southern African Bankers housing GM Lance Edmunds said that with the downsizing of the public service banks believed it prudent to revise lending criteria. Many retrenched employees would not be able to pay their bonds, particularly as the current lending criteria allowed borrowers access to homes they struggled to afford.

Banks calculate the bond amount to be granted by taking 25% of the base salary and adding the housing subsidy. The new method will be to take 25% of the combined salary and subsidy.

This means someone earning R1 600 a month and qualifying for a R63 400 bond previously, will now be offered a bond of about R33 000.

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BD 5/2/98 (299) (~~262~~)

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Key Market Movements — 3/2 to 4/2

Gold				Currencies		Europe close DM/$	Europe close R/£	3 month NCD	Stock Markets				
Lon close $/oz	Lon PM $/oz	Lon PM R/oz	Kruger-rand	R per $	$ per R				FTSE 100	Nikkei Index	JSE Ov'all	JSE Gold	JSE Indus
298,45	298,35	1 472,21	1 540,0	4,9345	9,2031	1,8171	8,1360	14,90	5 612,8	17 022,98	6 569,4	860,6	7 716,9
↑	↓	↓	↓	↓	↑	↓	↑	↓	↓	↓	↓	↓	↓
297,35	298,15	1 467,64	1 520,0	4,9225	0,2027	1,8017	8,1016	14,83	5 595,8	16 882,62	6 506,7	829,0	7 654,0

New steps to regulate medical aids

(299)

Bill seeks to provide a safety net for all members

Star 17/2/98

By Jovial Rantao
Political Correspondent

Draft legislation which will contain measures to prevent fraud and corruption in public and private medical aid schemes, saving the Government and the private sector millions of rands, is soon to be tabled in Parliament by Health Minister Dr Nkosazana Zuma.

The Medical Aids Amendment Bill, which is still being refined by state law advisers, is aimed at regulating the multi-million-rand medical aid industry to ensure the schemes provide a safety net for all members irrespective of age.

The legislation also seeks to make it illegal for the schemes to deny members cover by claiming that their cover has been exhausted.

The Government's concern has been that medical aid members who were denied services by the medical schemes always turned to provincial and national hospitals, placing a strain on their resources.

Most medical aid schemes have lost millions of rands from members who, with the connivance of unethical doctors and pharmacists, have used their schemes to buy goods such as sunglasses, clothes, expensive perfumes and groceries.

One of the most corruption-plagued medical aid schemes is Polmed, which serves members of the South African Police Service.

Towards the end of last year, at least 500 cases were being investigated by the SAPS's commercial branch and Polmed detectives against the police, doctors and pharmacists.

Among the cases of fraud that have been brought to court is that of a Pretoria-based doctor who has appeared in court on 13 100 charges of fraud believed to involve close to R1-million.

Dr Nkosazana Zuma

Parliament's portfolio committee on safety and security was told that Polmed was in financial straits and needed R1,5-billion to get through the 1997/98 financial year.

A task team in which the police, Business Against Crime and Polmed were represented has been formed to determine short, medium and long-term solutions for the medical aid scheme.

The Medical Schemes Amendment Bill is expected to contain measures through which medical aid schemes could verify claims and identify fraudulent or corrupt activity.

Zuma's spokesman Vincent Hlongwane would not reveal the anti-fraud measures contained in the bill.

Dr Aslam Dasoo, a spokesman for the Representative Association of Medical Schemes, which has had discussions with the Department of Health about the draft legislation, said the proposals had been received positively in the industry.

"This will enhance the industry's ability to survive and create cover for all members," Dasoo said, adding that schemes were preparing to operate in a regulated environment.

Zuma to shake up med aid

CT 17/2/98 (299)

JOVIAL RANTAO
PARLIAMENTARY BUREAU

DRAFT legislation with measures to prevent fraud and corruption in public and private medical aid schemes, saving the government and the private sector millions of rands, is to be tabled soon in Parliament by Health Minister Dr Nkosazana Zuma.

The Medical Aid Schemes Amendment Bill, which is being refined by state law advisers, also aims to regulate the multi-million-rand medical aid industry to ensure that schemes provide a safety net for all members — irrespective of age.

The legislation also seeks to make it illegal for the schemes to deny cover to members by claiming that their cover has been exhausted.

The government's concern has been that members of medical aids, who were denied services by the schemes, turned to provincial and national hospitals for service, placing a strain on government resources.

EYE ON FRAUD: Nkosazana Zuma

The legislation, which will soon be debated during public hearings in Parliament, is expected to receive a mixed response from doctors and pharmacists.

Most medical aid schemes have lost millions of rands as a result of members, with the connivance of some unethical doctors and pharmacists, using their schemes to buy goods such as sunglasses, clothes, expensive perfumes, two-plate stoves and groceries.

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State will play greater role in regulating medical aids

(299) Star 18/2/98

Parliamentary committee told that new bill will target corruption and seek to revive the social function of schemes

By Jovial Rantao
Political Correspondent

Draft legislation which seeks to re-regulate the medical aid schemes industry was also designed to make it impossible for unscrupulous health insurance brokers and fly-by-night medical aid schemes to operate, Parliament's portfolio committee on health was told yesterday.

Alex van der Heever, a representative for the Wits Health Policy Unit, said provisions in the Medical Aid Schemes Amendment Bill would ensure that the Government, through the registrar of medical aid schemes, had a strong role to play in the industry.

He pointed out that many health insurance brokers operated illegally and often chose products for their clients which would yield a high commission.

Van der Heever said the legislation, scheduled to be tabled soon by Health Minister Dr Nkosazana Zuma, would seek to revive the social function of medical aids, which was slowly being eroded.

"It will stop schemes from cherry-picking the young and healthy in place of the sick and the elderly," he said, adding that there was a need for greater consumer awareness.

Besides strong anti-fraud measures, key provisions in the Medical Aid Schemes Amendment Bill included the reinforcement of community rating in

Minimum benefits proposed

medical scheme contributions and the introduction of a prescribed set of minimum healthcare benefits, he said.

Through the new regulations to be applied to the medical schemes industry, it would be a condition of registration that schemes must offer a prescribed set of minimum benefits, which would include insurance cover for the cost of public hospital care.

This would be done to prevent large numbers of lower- and middle-income employees and their families being "dumped" in public health institutions because their insurance cover had been exhausted.

"The schemes will be forced to structure their cover in such a way that their beneficiaries can be looked after," Van der Heever said.

Savings accounts, which had been used by many companies as a tax evasion measure, would not be outlawed but would be regulated to prevent abuse. Medical aid schemes would have to restructure contribution scales and resubmit them to the registrar of medical schemes.

He said an early-warning system would be introduced to ensure that beneficiaries would not be left in the lurch in case of insolvencies.

Provisions in the legislation were also aimed at protecting female beneficiaries who, despite being contributors to medical aid schemes, would lose their membership once they were divorced.

The re-regulation of the medical schemes industry forms part of government plans to establish a social health insurance system which would ensure that all South Africans had access to health care.

Objectives of the social health insurance scheme include the need to provide an effective mechanism for collecting public hospital fees, by ensuring that all formal sector employees and their dependants are insured for public hospital treatment.

Law to allow govt to oversee medical aid schemes

CT 18/12/98 (299)

JOVIAL RANTAO

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Mr Alex van der Heever, a representative for the Wits Centre Health Policy Unit, told the committee that provisions in the Medical Aid Schemes Amendment Bill would ensure that the government, through the Registrar of Medical Aid Schemes, had a strong oversight role to play in the industry.

He pointed out that many health insurance brokers operated illegally and often chose products for their clients which would yield a high commission.

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Freedom of choice in medical aid membership has its perils

BD 20/2/98 (299)

Janyne Simon-Meyer

UNLESS it is a condition of employment, nothing compels South Africans to take out private medical cover. But this freedom can also be a peril: right now, an individual or small company outside the private medical aid/insurance system has only one hope of getting into it, and that is for all applicants to be young and moderately healthy.

The likelihood of getting cover plummets for anyone of more than 55, or who is younger but has a condition like insulin-dependent diabetes, asthma, hypertension, depression, a history of back surgery, cancer, heart disease, HIV, epilepsy and stroke.

Chronic conditions like Crohn's also will not be covered, unless there have been no symptoms for 10 years. In addition, new members will under no circumstances be covered for pregnancy.

Entry to individual based schemes is almost exclusively risk rated for age and health, says Jonathan Behr of Duff & Phelps Credit Rating.

Momentum Health uses a localised version of small group health care underwriting criteria drawn up by US health-care underwriters. Fedsure works on specific criteria and scheme rules and evaluates pre-existing conditions according to whether they are controlled and the client is compliant.

"If risks are unacceptable, the condition may be excluded or the application declined," says Fiona Mostert, underwriting supervisor.

Contrary to popular belief, traditional medical schemes are as tough on their underwriting, though their medical boards are probably more open to persuasion. GEB Administrators, for example, turn down between 15% and 20% of all applications. "If someone already has a chronic disease, we do not want them," says director Murray Tonathy.

The bottom line, says Carol Eder, of Ceder Medical Aid Consultants, is that it is becoming increasingly difficult to find cover for individuals or groups of less than five if there is a pre-existing condition.

Prevailing industry sentiment is that the private medical system has to protect the interests of those already inside, and cannot afford cover for the old or ill who come without a clutch of healthy colleagues to help pay for their problems.

The only protection a scheme has is to risk-rate when a member joins, because once in the system, a member has guaranteed renewable membership, says Barry Swartzberg, chief operations officer of Momentum Health. He says only a small percentage of people will be affected, and the moderately ill will find cover at 20% to 30% above general rates.

Few of the 60 commercial schemes operate solely in the individuals market as individual-based schemes are higher risk and typically more expensive to administer than a groups-based scheme. The young and healthy can and do change schemes frequently, searching for the best benefit at the lowest price, says Behr. An individual-based scheme often finds it has spent considerable financial and administrative resources to sign up the member, only for the member to leave after a year.

Only some schemes sell direct to the public — others use brokers. There are a host of these health-care intermediaries being advertised in the Yellow Pages.

Some are elected and accredited by the administrators, are knowledgeable and professional, effectively negotiate the house rules and compare products.

However, the broker you choose may not be selling the product best suited to your needs.

Attempts to set up an association of health benefit advisers with a national code of ethics failed, but the Institute of Life and Pension Advisers (Ilpa) has been holding examinations in health care for the past three years, and has 50 registered fellows in the field. The focus has been strongly corporate planning, but fellows are on top of technical and ethical issues, says Ilpa executive director Ben Rossouw.

The only way to tell what you need is to analyse your situation, looking at previous illnesses, chronic medication, injury, and long-term treatment like orthodontics. Cost, financial stability of the company and structure of benefits are the deciding factors, says Rossouw.

Ballpark figures for comprehensive cover from either traditional products or new-generation schemes are about R500 to R700 for singles, R800 up to R1 400 for couples, and R1 200 to R1 700 for families of four, says Merrik Meek, GM of Medical Aid Advisory Services. The crucial difference between the two kinds of plans is the structure and extent of the benefit package, and when you will be required to pick up a shortfall.

Of course, premiums vary with health. Eder cites a recent case of 11 members applying for a medical savings-based plan, where one had a cholesterol problem. He was offered membership at twice the premium. Asking an individual to shoulder the cost of their own age and ill health is allowed by current legislation. The law of interchangeability forces schemes to accept — without exclusions, waiting periods or penalties — members who are joining, because it is a condition of new employment and because they have been a member of a medical fund for at least two years prior to that.

However, it allows schemes to impose exclusions, limitations or waiting periods on individuals whose membership is not conditional to employment, says Danie Kolver Registrar of Medical Schemes.

Similarly, the law of continuity gives a member (and his or her dependants) who leaves employment due to old age, disability or ill health, a legal right to continued cover providing he or she has five years of unbroken membership. That principle does not extend to individuals who resign for other reasons, but who may have difficulty in finding cover from an individual scheme because they have pre-existing medical conditions.

This will change with the advent of the Medical Schemes Bill, due before the cabinet in the next few weeks, which will force schemes to accept all applicants, no matter what their state of health. To protect schemes, it will force anyone who has been outside the system to pay an age-related penalty to a medical scheme, based on the period he or she has been without cover, says Kolver.

That is not enough, says the industry. The cost of reinsuring for high risk members will push premiums through the roof. "Only a system with mandatory membership can afford to cover the unhealthy," says Howard Walker, joint MD of Alexander Forbes Healthcare Consultants. "The regulations will kill health insurance for everyone but large companies."

Comparison of Selected Medical Aids

Cost/Member	Cost/Member and three dependants	Benefit Doctors & Specialists	Benefits — medicines — acute and chronic	Benefits — Hospital stay
Momentum Classic Comprehensive *				
R658 R333 risk; R325 savings	R1 461 R919 risk; R541 savings	100% of cost from savings; thereafter at RAMS; no limit	Acute: from savings then at tariff; no limit. Chronic illness benefit — no limit	100% of cost; no limit
Fedsure Health - Plus option at guideline savings level **				
R732 R377 risk; R355 savings; T/H R5 000	R1 330 R830 risk; R500 savings T/H R10 100	100% of MASA cost from savings; accumulate at MASA tariff; 100% of MASA after T/H reached	Acute 100% from savings; thereafter from threshold cover at cost. Chronic: Full cost for approved chronic diseases, no limit	100% of cost; no limits, R500 penalty from savings account if no pre-notification for non-emergencies. HIV/Aids R10 000 per family pa
Premier Premier Plan				
R1 020 >R4 000 pm	R1 745 R4 000 pm	GP — 100% of tariff. M limit R900; M+3 limit: R2 200; Specialists — 100% tariff; unlimited	Acute: 100% of cost less 20% levy per script to max of R3 000 (M) or R7 400 (M+3). Chronic: subject to approval; 100% of cost to R10 000 (M) or R20 000 (M+3)	100% of tariff for general ward expenses; no limit
GEB Option B				
R560	R868	100% of tariff, 13 consultations per person	Acute medication: R1 450 pp. Chronic: no limit once accepted	24-hour advance notification or pay 80% otherwise 100% of RAMS tariff
Nat Independent Medical Aid Society (Nimas) Policy 1 * **				
R836	R1 428	100% of tariff to R630 (M) and R1 870 (M+3) for GPs; specialists unlimited	100% of tariff, R15 levy to R1 600 (M) and R3 850 (M+3) for acute; R4 000 pp pa for chronic	100% of tariff limited to 180 days per case
Protea Plan 2 ** **				
R1 088	R1 800	80% of tariff up to R550 (M) or R1 850 (M+3)	Acute: 80% up to R3 300 (M) or R7 600 (M+3). Unlimited diabetes, other chronic included in acute limit	100% of tariff; R500 levy if no pre-authorisation; R6 000 limit on prosthesis, psychiatric 14 days only
Premier — PremSav *** **				
R726 — savings R3 600 pa	R1 642 — savings R12 000 pa	Paid at cost from savings, no limit	100% of cost, paid from savings account	100% of cost at general HASA ward rates; no limit
Northern Medical Society Jade Managed Care				
R608 income >R8 000	R1 084 income >R8 000	100% of RAMS tariff; no	Acute: 100% up to R1 100	100% of tariff to limit of

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savings 20/2/98	savings	ings; thereafter at RAMS; no limit	at tariff; no limit. Chronic illness benefit — no limit	100% of cost; no limit
Fedsure Health - Plus option at guideline savings level **				
R732 R377 risk; R355 savings; T/H R5 000 (219)	R1 330 R830 risk; R500 savings T/H R10 100	100% of MASA cost from savings; accumulate at MASA tariff; 100% of MASA after T/H reached	Acute 100% from savings; thereafter from threshold cover at cost. Chronic: Full cost for approved chronic diseases, no limit	100% of cost; no limits, R500 penalty from savings account if no pre-notification for non-emergencies. HIV/Aids R10 000 per family pa
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Northern Medical Society Jade Managed Care				
R608 income >R8 000	R1 084 income >R8 000	100% of RAMS tariff; no limit at society approved providers' network	Acute: 100% up to R1 100 (single member); R3 000 (members and three dependants) at approved price only. No benefit if other pharmacies are used. Chronic: 100 of cost unlimited, through Medi-scor only	100% of tariff to limit of R70 000 with option to buy additional cover. R500 levy for failure to pre-authorise. Provincial, private and day clinics.

* Savings accumulates at RAMS tariff, shortfall likely

** Guideline payment falls short of threshold

***Wait 36 months for full benefits for major disease/surgery

****Most benefits subject to initial excess deduction of R30 per service rendered

*****No cover once savings are depleted

None of these medical schemes will accept new members older than 55.

Managed health care in SA 'nothing to fear'

(35) (299) M 26/2/98

Josey Ballenger

GRAHAM Anderson did not accept an easy job when he took the reins as CEO of Southern HealthCare last November. He took the position after the relatively comfortable, uncontroversial job of executive director of Clinic Holdings, at a time of uncertainty for managed care.

The health care industry, analysts and the media have criticised the joint venture — and the few other SA practitioners of "managed care" — as trying to "plop down" a US system on a country not yet ready to deal with all its complexities.

Anderson is convinced that scenario has changed with the management switch late last year from US partner United HealthCare, which has a 20% stake in the venture, to SA experts. Anglo American and Southern Life each have a 40% interest.

"There was resistance at first to the Americans, but now we are run by South Africans for South Africans," he says. Negotiations between the US managers and local doctors were so acrimonious at times that the former were dubbed the Minnesota mafia.

There are legitimate grievances about applying US managed care to SA without major adjustments — particularly as the local industry was not initially familiar with the concept. For starters, SA does not have the "overabundance" of doctors the US does. In the Eastern Cape, for example, health MEC Trudy Thomas estimates some areas have doctor-to-patient ratios of 1:30 000. The island of Manhattan alone has 25 000 doctors — more than the total number of doctors in private practice in SA, Anderson says.

The US and SA have at least one thing in common: runaway medical prices, and a desire by consumers and medical aid administrators to stem these costs. SA's fee-for-service system, where fund administrators do not question procedures, medication and length of care, has led to abuse, waste, overservicing and a medical inflation rate 12 percentage points higher than the inflation rate.

Southern HealthCare was born out of Anglo and Southern no longer being able to cope, Anderson says. Managed care requires the medical aid administrator to grant permission, or "pre-authorisation", to doctors before they administer a prescription or service — from diagnosis to post-operative recovery — short of emergency.

Fears abound that the pendulum will swing the other way under managed care to underservicing, overregulation and diminished patient privacy.

US managed care groups such as Columbia HCA and Kaiser Permanente have come under fire for cutting back services and facilities "too much" in the name of profit. Columbia had to scale back its operations and underwent an internal revenue service investigation for alleged fraud, and Kaiser was fined $1m last year for negligence, including denying emergency treatment for a patient in diabetic shock.

Anderson believes the "difference" between United HealthCare and others is "quality" — and that is what the local industry needs to be convinced of.

He has identified information as the driving force behind managing health care — not only of patient's profiles but also of providers' practices in order to establish protocols — and says this is the missing link to making managed care "fully integrated" in SA.

Anderson says Southern HealthCare uses the World Health Organisation-designed diagnostic coding, which enables the company to compare a doctor's practices to those of his or her peers.

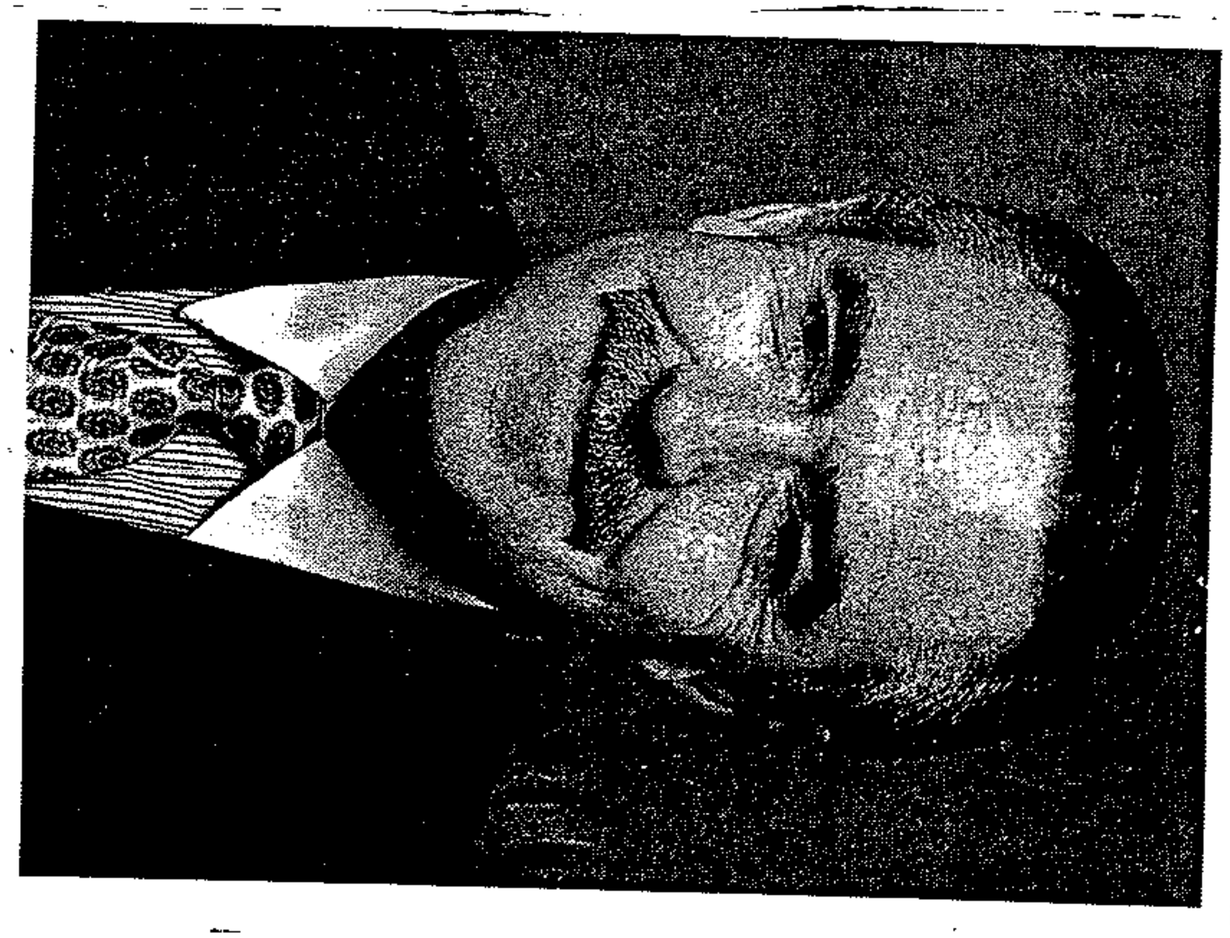
The database is nowhere near complete, but Anderson believes "a year's worth of imperfect data is better than no data. It is a gradual process."

He says Southern HealthCare is the only SA managed care provider with a disease management component. Its competitors, he says, embrace only the pre-authorisation and case management elements of managed care.

Managed care has "without a doubt" been slower to take off in SA than expected, but Anderson believes it is poised for growth as consumers and employers grow wary of paying escalating fee-for-service premiums.

The onus is on managed care providers to prove they are better at containing costs on a sustained basis, and without sacrificing quality. Last year Southern HealthCare saved 2% to 3% through decreased hospital admissions and length of stays, and 10% cost savings overall — which analysts believe is slightly below its competitors' performances, but still better than the average medical scheme.

Anderson warns that pharmacy costs are a key target as they take up 25% of overall health care expenditure, whereas in the US they make up only 12% to 13%.



ANDERSON

Medical aids urge hospitals to code patients' accounts

CT (POR) 26/2/98 (299)

ADELE SHEVEL

Johannesburg — Medical aid groups were putting pressure on hospital groups to code patients' accounts, Stuart Ramsden, the business development manager of 3M Health Care South Africa, said yesterday.

Classification and coding had been taking place in the US for several years, he said, and the local healthcare industry would find it easier to manage costs using data collection.

Data collection started to take place locally about two years ago. This would enable the industry to reduce costs and improve outcomes, said Ramsden. "South Africa is lagging in terms of data collection."

3M said yesterday it had bought two Health Market International software products: CODExpert is a program for coding patient records using ICD-10 diagnosis codes, and Medicus I is a computer-based clinically orientated training tool for coders.

CODExpert software is used by hospital health information management and medical records staff to assign diagnosis and procedure codes to individual patient records, utilising the ICD-10 diagnosis coding system and procedure coding systems.

3M Health Information Systems is headquartered in Utah and Health Market is in Michigan, also in the US.

Ramsden said 3M was probably the only company in South Africa which would now offer a total product in which procedure and diagnosis systems were provided in a single product, made available through this acquisition. The CODExpert program would target the hospital and managed care companies.

3M also had a product called Codefinder, a more complex software program that included only procedures coding. It would include diagnosis when it became available in the near future.

This would be used by the more sophisticated end of the market, because South Africa was one of only a few countries using the ICD-10 coding system, said Ramsden. The US is not using that system but will be working towards ICD-10 in the near future. Ramsden said the new technology would target hospitals and medical aids.

South African customers will receive support through a distribution agreement with South Africa's Value Health Services company as well as from the 3M South Africa healthcare group.

3M will market the software to HMI's users in South Africa. Health Market International has been a leader in international healthcare consulting for over six years. During this time, HMI has performed consulting and software services in over 25 countries and been responsible for deliverables to more than 500 healthcare organisations around the world.

(299)

REVAMPING MEDICAL AID

Association set for fracture

Bill splits aid schemes

FM 27/2/98

The powerful Representative Association of Medical Schemes (Rams) and its dominant member, Medscheme, face an internal revolt over their handling of proposed legislation to reregulate the medical aid industry.

Rams represents 90% of medical schemes and wields enormous industry power. Mounting resentment by large insurance-based and open schemes (as opposed to employer-based schemes) against Rams burst into the open this week, with certain administrators comparing Rams to the SA Rugby Football Union, likening Medscheme to the Gauteng Lions and portraying Rams chairman Keith Hollis as the Louis Luyt of the medical aid industry. Detractors say Rams has behaved arrogantly, ignoring member concerns.

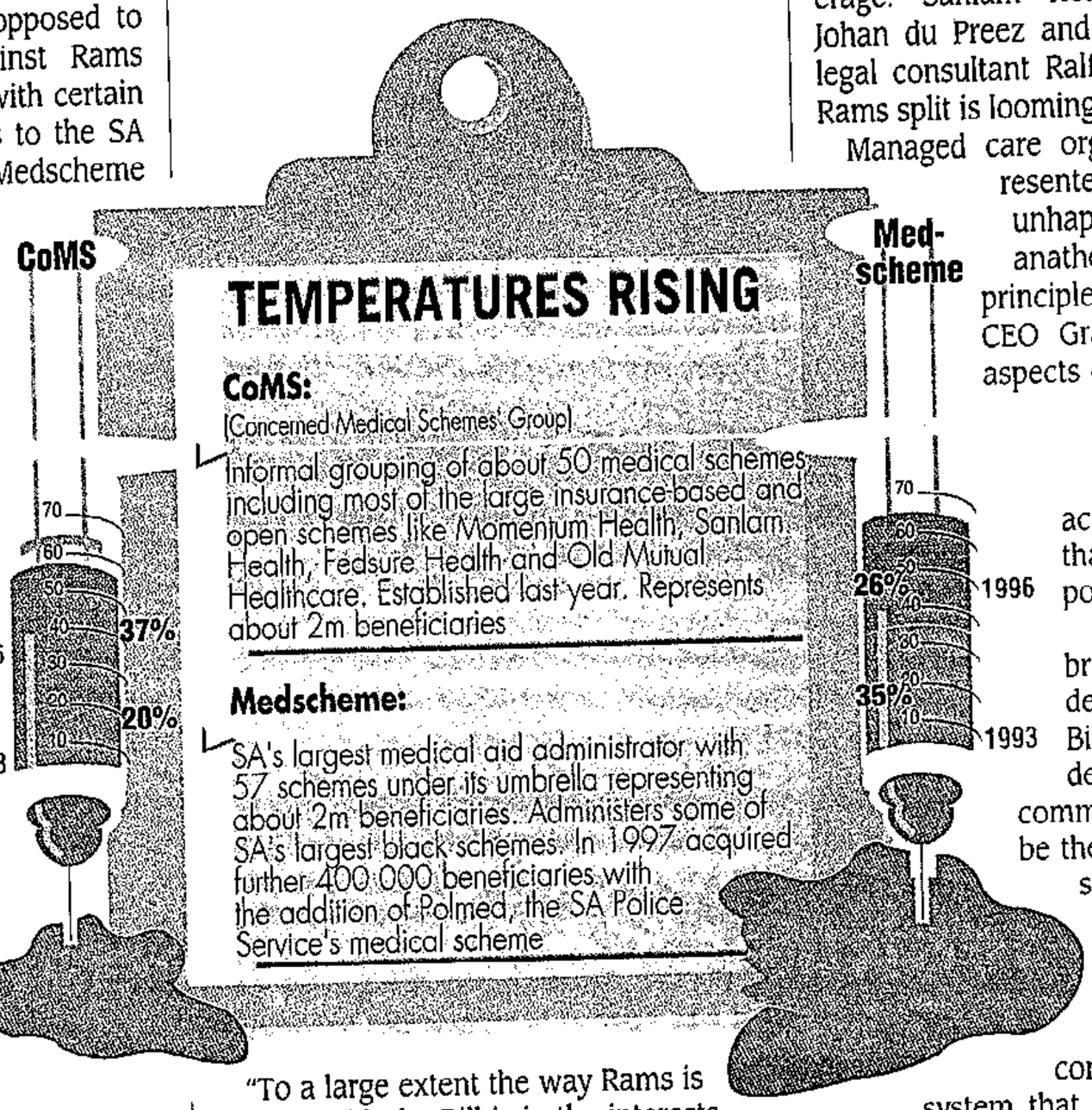
The furore centres on the Medical Schemes Amendment Bill, which would reverse the industry deregulation of 1989 by returning to flat community rating, in which everyone pays a flat contribution rate to a scheme irrespective of their age or health. Open schemes would have to enrol all applicants. The proposal aims to ensure that medical aid remains affordable, and that the State is not burdened with the costs of caring for the aged and sick.

The Concerned Medical Schemes Group (CoMs) is fielding the strongest resistance to the Bill. It says the legislation will be self-defeating, since young and healthy members will opt out, causing premiums to rise and making private medical care less affordable to all. CoMs is a faction within Rams that represents nearly 2m beneficiaries from about 50 schemes, including the majority of large insurance-based and open schemes like Momentum Health, Sanlam Health, Fedsure Health and Old Mutual Healthcare. CoMs was formed last year because some schemes felt that Rams was not representing its members' interests in private discussions on the Bill with the Department of Health.

With the final legislation soon to be released, tensions are rising and Rams is in danger of splitting. Many of the large open schemes are threatening to bolt and set up a new body around CoMs. Traditional schemes would remain in Rams.

Hollis has been democratically elected Rams' chairman for three consecutive years. He is also chairman of Medscheme, SA's largest medical aid administrator, which groups 57 schemes and 2m beneficiaries under its umbrella. It turned over R7bn in claims last year.

A number of medical aid executives say Medscheme is too dominant in Rams, and that Hollis is using his position as chairman of both to pursue Medscheme's interests.



"To a large extent the way Rams is dealing with the Bill is in the interests of Medscheme rather than all Rams members," says Fedsure Health executive chairman Dave Avnit.

Momentum Health CEO and CoMs spokesman Adrian Gore says: "The irony is that the department is trying to do the right things and is amenable to suggestions, but the whole thing is being hampered by commercial interests." Gore accuses Rams' leadership of supporting the Bill in order to stifle competition from CoMs members, who are largely open schemes that will be more adversely affected by the legislation.

CoMs schemes doubled their membership between 1993 and 1996 at the expense of traditional medical aids. Taking advantage of deregulation, they led the way with innovations such as medical savings accounts, which were banned in early drafts of the Bill but have since been restored.

"There is no doubt that we are taking business from the traditional players," says Gore. "You can't do that and go unnoticed. It raises cries of foul play from some of our colleagues." He also accuses Rams and Medscheme of wanting to garner favour with the Department of Health by not opposing reregulation. CoMs, on the other hand, has spent R1m analysing the impact of the Bill and devising alternative solutions that, Gore claims, will meet the department's objectives of allowing people guaranteed access to schemes and lifetime coverage. Sanlam Health senior manager Johan du Preez and Old Mutual principal legal consultant Ralf Metz confirm that a Rams split is looming.

Managed care organisations, also represented by Rams, are also unhappy. They say the Bill is anathema to managed-care principles. Southern Healthcare CEO Graham Anderson finds aspects of the Bill "unpalatable and potentially dangerous".

Hollis rejects all the accusations, saying, "all that Rams is doing is supporting State policy".

He says that Rams broadly accepts the underlying principles of the Bill and agrees with the department that flat community rating appears to be the only way that medical schemes can provide affordable cradle-to-grave coverage.

"We support a social solidarity, community-rated medical system that has operated in SA for 100 years. It's of deep concern that the methods used by some insurers are resulting in pensioners being dumped on to the State," says Hollis. He further questions why CoMs members have failed to stand for election at Rams.

Rams has scheduled a March 12 meeting to canvas members' views and obtain a proper mandate to respond to the Bill. If the organisation splits, it could speed passage of the Bill; Health DG Olive Shisana has warned the industry to speak with one voice unless it wants government to pursue the proposals it deems best. **Claire Bisseker**

BUDGET PREVIEW

Tighter medical scheme controls on cards

CT(BR) 3/3/98 (299)

NEVILLE KOOPOWITZ

In the 1997 Budget, Trevor Manuel, the finance minister, first indicated that control and regulation of medical savings accounts would be tightened up. His comments extended to interest earned on account balances, as well as funds withdrawn on retiring from a medical scheme.

Subsequently, in the Katz Commission's sixth interim report recommendations, more detailed recommendations were made with regard to the tax treatment of medical scheme contributions and medical savings accounts.

The commission recommended that employers could only claim a deduction on a "rand for rand" basis, which means that for every R1 contributed by employees, the

Trevor Manuel

employer would be entitled to contribute another R1 and claim it as a deduction from taxable income.

This will only affect employees where the employer contributes more than 50 percent of the total; any amount over 50 percent will be taxed as a fringe benefit in the employee's hands. This proposal will affect all medical schemes equally and could hit the take-home pay of individual members, particularly in the higher income categories.

Katz recommended that self-employed people would be entitled to deduct 50 percent of their contributions.

This is a change from the current allowance of amounts exceeding the greater of R1 000 and 5 percent of taxable income (after certain deductions), effectively levelling the playing field.

Previously, self-employed individuals were potentially at a disadvantage to the corporate sector. The proposal will encourage more self-employed individuals to enter the health insurance market.

The commission also proposed that withholding tax be imposed on interest credited to medical savings accounts, in line with the Budget. This is relatively minor and will not affect the value or effectiveness of medical savings accounts.

Finally, the Katz commission suggested bonuses paid to reward members of medical schemes for no or low claims be subjected to the same tax regime as "cash withdrawals" from medical savings accounts.

Momentum Health, while encouraging maximum participation of the public in medical schemes, supports rigorous controls and legislation to curb abuse and fraud within medical schemes, and welcomes the proposals being made.

☐ *Neville Koopowitz is the managing director of Momentum Health Marketing*

MINDING THE TILL... *Ajith Haripaul is now financial controller at South African Breweries' Rosslyn Brewery.*

HANDS ON... *Tlhabeli Ralebitso has been appointed capacity engineer – at South African Breweries' Rosslyn Brewery.*

Aid for Aids sufferers

IN THE PAST, medical schemes would not pay for HIV/Aids. Now Bonitas Medical Fund offers a solution by way of the Aid for Aids programme, which provides benefits for the treatment of HIV/Aids.

Benefits include counselling, vaccinations, medication, hospitalisation, consultations and tests.

Bonitas deputy chairman Aubrey Dube says if you have HIV you can join the Aid for Aids programme, where their medical team is especially trained to help.

"Instead of keeping your disease a secret, tell the mecial staff in the Aid for Aids unit about it. No one outside the unit, except your doctor, will know about your condition – not your employer, not even your medical scheme," he says.

Dube added that the programme is also open to pregnant women and all members of a family.

Medical schemes are also welcome to contact the unit for help.

The Aid for Aids unit can be reached at (021) 658-6555, or fax (021) 685-2283. Write to PO Box 23286, Claremont 7735.

CP 8/3/98

Taxman tackles perks – medical schemes hit

ARG 11/3/98

(299)

Perks paid to employees will be taxed more heavily in the Budget presented to Parliament by Finance Minister Trevor Manuel.

The Government has stopped short of implementing the Katz Commission's recommendations on the taxation of employer contributions to medical aid schemes.

The Katz Commission suggested that for every R1 contributed by employees, the employer could contribute R1 and claim that R1 as a deduction from taxable income.

But concerns from Parliament's Finance Committee and the Department of Health that this might discourage lower wage earners from medical aid membership, as well as practical difficulties, prompted the Government to tone it down slightly.

Mr Manuel said today that where the employer's contribution to a medical aid scheme exceeded two-thirds of total contributions, the balance would be taxed as an employee fringe benefit from April.

EMPLOYMENT PERKS

Other perks which have attracted the taxman's attention are travel allowances, where employees will now be taxed on 50% of the allowance instead of 40%, a change which is expected to yield R150-million in additional funds for the state's coffers.

A scheme announced last year to combat abuse of tax provisions on residential accommodation provided by employers to employees will be changed. The scheme provided for taxing employees on the cost to the employer where the accommodation was not owned by the employer or an institution associated with the employer. It had been found the scheme could hit some lower-income groups, prompting its revision.

A new formula, worked out in co-operation with business and supported by the National Union of Mineworkers, will take effect in April next year.

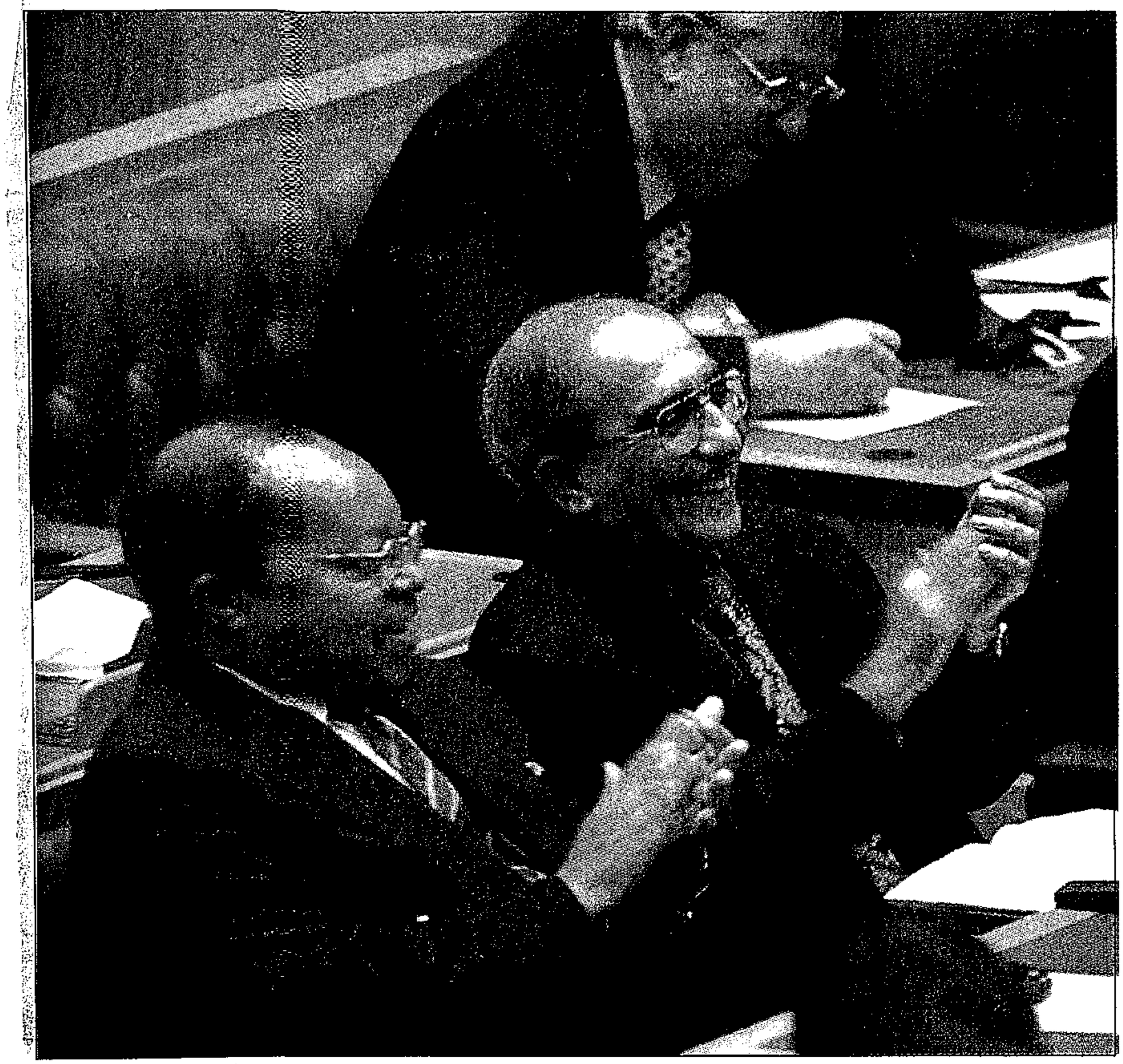
TAX: UNDER-65s

Taxable income	1999 rates	1998 rates	Difference
17 000	0	15	15
18 000	0	205	205
19 000	95	395	300
20 000	285	585	300
21 000	475	775	300
22 000	665	965	300
23 000	855	1 155	300
24 000	1045	1 345	300
25 000	1235	1 535	300
26 000	1425	1 725	300
27 000	1615	1 915	300
28 000	1805	2 105	300
29 000	1995	2 295	300
30 000	2185	2 485	300
35 000	3575	3 985	410
40 000	5075	5 585	510
45 000	6575	7 185	610
50 000	8435	9 235	800
55 000	10385	11 285	900
60 000	12335	13 335	1000
65 000	14485	15 485	1000
70 000	16635	17 635	1000
80 000	21035	22 035	1000
90 000	25435	26 435	1000
100 000	29835	30 835	1000
120 000	38635	39 835	1000
150 000	52135	53 335	1200
200 000	74635	75 835	1200
300 000	119635	120 835	1200
400 000	164635	165 835	1200
500 000	209635	210 835	1200

TAX: OVER-65s

Taxable income	1999 rates	1998 rates	Difference
28000	0	0	0
29 000	0	0	0
30 000	0	0	0
35000	915	1485	570
40 000	2415	3085	670
45 000	3915	4585	770
50 000	5775	6735	960
55 000	7725	8785	1060
60 000	9675	10 835	1160
65 000	11825	12 985	1160
70 000	13975	15 135	1160
80 000	18375	19 535	1160
90 000	22775	23 935	1160
100 000	27175	28 335	1160
120 000	35975	37 335	1360
150 000	49475	50 835	1360
200 000	71975	73 335	1360
300 000	116975	118 335	1360
400 000	164694	163 335	1360
500 000	206975	208335	1360

all figures in rands



WHERE THERE'S SMOKE: Sibusiso Bengu and Kader Asmal applaud Trevor Manuel's decision to slap a hefty tax on tobacco products. Asmal is well-known for his fondness for a puff or two. Behind them Jannie Momberg pays attention. ***PICTURE: BENNY GOOL***

Medical aid tax can raise R700m

299 (280) CT 12/3/98

JUDITH SOAL
HEALTH WRITER

WHAT difference does R700 million make, asked medical aid schemes yesterday after Finance Minister Trevor Manuel said he hoped to increase revenue by R700m by taxing certain contributions as fringe benefits.

Manuel said employees would be taxed extra if their employer paid more than two-thirds of their contributions.

"The provision of health care should not be seen as a fringe benefit," said Mr John Human of D&E Health Benefits. He said the tax would make people opt out of private health care and put extra pressure on state health services.

But Mr John Pugsley of medical aid administrators Medscheme disagreed.

"We don't know yet at what rate that extra amount will be taxed, but it won't make that much difference to people's salaries," he said. "It is mainly people in higher income brackets who get all or most of their contributions paid by their company.

"Say you are paying R1 200 for a good medical scheme, and your employer pays it all, you will be taxed on R400, which is the amount above the allowed two-thirds. Even if this is taxed at 45%, you will pay an extra R180 a month in tax. For someone in this income bracket, earning perhaps R20 000 to 30 000 a month, that won't be a problem."

He said that if lower income earners were having their contributions covered by employers, their tax would be lower because they would be paying a lower marginal rate. "If you are in a lower income bracket, your rate is 17%, so you could pay an extra R34 a month."

Pugsley said these increases would not scare people away, but he still did not agree with the taxation method.

"We suggested that the government revert to the old way of taxation, where employees could claim back for their contributions to medical aids.

"This would surely suit the ultimate goal of the state, which is to encourage people to join medical aid schemes and to reduce the burden on the state health sector.

"I can't see why they don't drop these taxes. After all, what difference does R700m make?"

High court order against Rams succeeds

BD 13/3/98 (299)

Pat Sidley

A HIGH court interdict yesterday stopped a meeting called by the Representative Association of Medical Schemes (Rams) from gaining a mandate to discuss the proposed new medical schemes legislation with the health department.

The interdict was brought by Momentum Health and a group of medical schemes within Rams, and was based on the constitutionality of the meeting.

The proposed medical schemes legislation contains principles which many medical schemes are opposed to, such as the minimum package of benefits which must offered to members and the fact that schemes may be compelled to admit people who are now excluded because they are too old or too ill.

The proposals are being scrutinised by provincial MECs and will be presented to the cabinet within the next few weeks.

The principles in the bill have so far been discussed only with select interest groups and changes affecting the schemes will therefore be tabled before schemes have had the opportunity to comment.

Momentum Health MD Adrian Gore asked Rams for a postponement of the meeting to deal with various issues such as the way of voting, which according to him "failed to take into account the fact that there may be divergent views within the community of medical schemes".

He had earlier asked for the agenda to reflect the input of all members; for the meeting to permit any scheme to put forward its views and raise questions (which was not to be allowed at the meeting); to change the voting method; and to "make provision for addressing who takes the issues forward and how they will be addressed with the government".

Rams chairman Keith Hollis, said: "We went in good faith to members to get a mandate to discuss issues with the government. Because of a technical flaw in the Rams constitution — we

Continued on Page 2

Key Market Move

Gold

Lon close $/oz	Lon PM $/oz	Lon PM R/oz	Kruger rand
294,55	294,10	1 465,79	1 466,
↓	↓	↓	NO MOV
293,95	293,85	1 464,40	1 466,

Rams

(299) BD 13/3/98

Continued from Page 1

had no authority to call a meeting of members — we find ourselves totally and utterly hamstrung."

Dave Avnit, MD of Fedsure Health, and a member of the Concerned Medical Schemes, a dissenting voice within Rams, said he believed Rams would consider the events of the day as a vote of no confidence. The Concerned Medical Schemes group would discuss its position and formulate a strategy.

Speaking in his private capacity Dr Brian Brink, senior medical consultant to Anglo American, said one of the important issues was that a mandate was being sought to discuss the proposed medical schemes bill, but it had not yet been published.

An additional worry was that much of the contentious and difficult areas of running medical schemes would not be in the law itself but in the regulations which had apparently not yet been drawn up.

"This is a contentious piece of proposed legislation. The process of drawing it up has not been extremely transparent and this was tested at Rams," Brink said.

Medical aid tax 'will deter new entrants'

CT (BR) 16/3/98 (299)

ADELE SHEVEL

Johannesburg — The fringe benefit tax placed on medical aid contributions would deter employed people who were not part of medical aid schemes from entering private sector schemes, Ian Kadish, the director of managed care at Netcare, said last week.

The government has committed itself to reforming the healthcare environment, and through various policy papers has indicated an increasing role for the private sector to finance and deliver healthcare. This would enable the public sector to focus on those who cannot afford private sector care.

But Adrian Baskir, an actuary at Old Mutual Healthcare, said lower-income workers would be the worst affected with the medical schemes tax, even negating any benefit they would otherwise have derived from budgetary measures to cut personal tax through reducing fiscal drag.

Kadish said there were more astute ways of increasing the medical coverage net, without it costing the government more. He said people at the lower end of the income stream should be subsidised with regard to getting healthcare coverage.

The sixth report of the Katz Commission recommended that employer contributions to medical schemes be limited on a rand-for-rand basis to the amount contributed by the employee

"The 1998 Budget proposes that the amount by which the employer's contribution to a medical scheme for an employee exceeds two-thirds of the total contributions be taxed as an employee fringe benefit from April this year," said Baskir.

"Put differently, the new tax will impact those being subsidised by more than two-thirds of their contributions, and those who are fully subsidised by the employer will be especially hard hit.

"Subsidisation relates to the employer paying a part or all of the contribution as part of a package or on a salary sacrifice basis."

Older medical scheme members with dependants will be harder hit than young, single members. Baskir says this is because the former generally pay higher contributions and are likely to have more comprehensive medical cover.

"Employers may be pressurised into increasing salaries to compensate for the impact of the new tax on net take-home pay."

Medical aid group warns against 'solvency crisis'

(299) BD 17/3/98

Vuyo Mvoko

CAPE TOWN — In a last-ditch attempt to influence the legislative process, a body claiming to represent almost half of SA's medical aid schemes said yesterday the schemes would face a "solvency crisis" if proposals contained in the white paper for the transformation of the health system in SA were to be implemented.

The Concerned Medical Schemes group said the proposals would lead to an increase in the costs of cover and to a decrease in the number of people covered, so jeopardising the old and sick and dumping more people onto the state.

Addressing Parliament's health portfolio committee on behalf of the group yesterday, Momentum Health MD Adrian Gore said a solvency crisis would hamper the ability of medical schemes to include sectors of the population previously denied access to cover.

Gore told the committee that the group disagreed that regulatory mechanisms were required to reverse the recent deregulation of private health insurance which had resulted in serious instability, increasing costs and reduced coverage. The most recent statistics were showing "positive trends emerging", he said.

The white paper calls for "open enrolment" which stipulates that medical aid schemes may not exclude an individual on the basis of health risk. It also calls for "flat community rating", which states that contributions for full of benefits would be set according to income and number of dependants.

"Open enrolment increases costs by incentivising the healthy to delay joining and therefore accentuates the penalty on those currently uncovered."

Flat community rating would see the young and the healthy opting out and result in an increase in the costs of cover and fewer people covered.

In the long term, medical schemes would be left vulnerable as they depended on a flow of new, young members.

The group suggested a "more flexible" alternative to the one suggested in the white paper,

Schemes should be allowed to screen applicants "to some extent", and once in a scheme, a member would be fully covered, he said.

For those who were not members of a medical aid scheme and were too sick to join, an industry subsidy system could be devised, he said.

The Chamber of Mines, in its submission, said a unified national health system could only be achieved within a framework of "voluntary co-operation, goodwill and a market orientated economy".

As the private health sector was an integral part of the health system, the solution should be mutually beneficial, representative Lettie la Grange said.

COST STRUCTURE 'A MESS'

No blame accepted for higher health bills

CT 17/3/98 (299)

WHY ARE OUR medical bills so high? Health Writer **JUDITH SOAL** asked hospitals, doctors, medical aids and policy-makers who was to blame for escalating health costs.

THE cost of private health care in South Africa is increasing by about 25% a year — way above the inflation rate — and experts agree that the industry's pricing structure is in disarray.

The *Cape Times* recently exposed the practice of "confidential discounts" whereby private hospitals can make profits of between 30 and 60% on all equipment — from bandages and cotton wool to prostheses and pacemakers — used in the hospitals, although they often do not handle the equipment or add value to it.

But hospitals have defended this practice, saying they have to make money in some areas — such as equipment and drugs — to cross-subsidise the losses they make on other areas — such as ward fees.

"Hospitals are on thin ice if you look at our profit margins," said Dr Anette van der Merwe, the executive director of the Hospital Association of South Africa, which represents private hospitals. "You can't just look at the mark-up in isolation unless you examine the whole pricing structure."

Predictably, hospitals, medical aids and doctors can't agree on who is to blame for escalating costs, but they do agree that the cost structure of private health care is "a mess".

"The problem is that the health care industry doesn't operate like a normal business," said Dr Jocelyne Kane-Berman, chief director of health administration in the Western Cape. "The normal principles of supply and demand don't apply because it is the provider who decides what should be purchased.

"Patients don't know whether or not they need an operation, or expensive tests, or how long they have to be in hospital. They have to rely on the doctors and hospitals, and there are 'perverse incentives' for over-use of medical services.

"Also, unlike other businesses, the prices aren't set by market forces or even the provider, they are set by an outside body, the Representative Association of Medical Schemes (Rams)."

A factor that seems to complicate an already convoluted price structure is the oversupply of private health services in Cape Town.

"There is no doubt about it, the city bowl and southern suburbs are over-bedded," said Dr Richard Friedland, the chief operating officer of hospital group Netcare, which owns City Park, among other hospitals.

Hospital occupancy rates are confidential, but insiders suggest that private hospitals are only just maintaining the 60 to 65% occupancy they need to remain in business. Treatment costs are based on 65% occupancy, so patients are already subsidising empty beds.

The same applies to operating theatres.

'Hospitals are on thin ice if you look at our profit margins' — Dr Anette van der Merwe

Ten years ago there were 17 private operating theatres in Cape Town. Now there are almost 50, with more planned to open soon.

"It can cost millions to equip a theatre and consulting rooms," said Van der Merwe. "Just a microscope can cost about R8 000."

Hospitals have spent a lot of money equipping theatres that aren't being fully used, and those costs are being passed on to patients and medical aids.

Because of the structure of medical aid tariffs, certain procedures are more profitable to hospitals than others, so some services are provided at the expense of others.

This is particularly noticeable in the field of mental health, which does not receive much compensation from medical aids, so few private psychiatric hospital services are available.

Surgery, on the other hand, can be very profitable, hence the surfeit of theatres. But this can also be costly as hospitals fight for operations.

"If you have so many beds and theatres but only five orthopaedic surgeons, they will be wooed and given incentives by all the hospitals. There are many ways that it is done, but in the end it increases the price of health care," said Van der Merwe.

Because of this excess capacity, there are rumours that at least one private hospital in Cape Town will close in the next year or two, although this has been strongly denied by the hospitals.

Whatever happens, it is clear that all is not well in the health sector. Sixty-two percent of all the money spent on health care is spent in the private sector, which services only 20% of the population.

The other 80% of South Africa's people receive less that 40% of health care funds. Paradoxically, as the costs of private health care rise, less people are able to afford it, forcing more people to rely on over-burdened state services and further increasing the costs of private health care.

UNHEALTHY DISTRIBUTION: State hospitals such as Red C... they need to remain in business.

They all vow to keep costs dow...

PRIVATE HOSPITALS:

- Say private health care costs are not too high when compared with other countries.
- Point out it costs "millions" to equip hospitals with the latest equipment.
- Claim medical aids waste money on administration costs.
- Stress that contributions to medical aids have consistently gone up at a higher rate than medical aid tariffs.
- Say the medical aid tariff structure is "obscenely" skewed and forces them to make large profits in some areas to recoup losses in others.
- Point out that the share prices of most hospital groups are dropping on the JSE.
- Stress the costs of theft, breakages and bad debts.
- Vow they are doing everything possible to keep costs down.

DOCTORS:

- Feel they are being exploited by hospitals, who often make more out of an operation than the surgeon does.
- Say medical aid rates are far too low and point out that a specialist who has trained for 14 years will be paid less per hour than a plumber.
- Emphasise that no ethical doctor would purposely "over-service" patients to make money.
- Say there are too many medical aids and managed health care schemes, which add to administration costs.
- Point out that many doctors are leaving the country because of low earning potential.
- Claim some patients are guilty of seeking health care unnecessarily because they are paying medical aid subscriptions.
- Vow they are doing everything possible to keep costs down.

MEDICAL AIDS:

- Say they are pay... hospitals than ever ...
- Stress medical aids profit organisa... administration cost... five percent of ... and the rest paid ...
- Claim hospitals ... tors with incentives to wards and equipm... can lead to over-serv...
- Say doctors can inf... "bumping" patients ... sive care units wi... performing unnece... dures or carrying out non-essential tests.
- Cite cases where ... have billed for ... haven't been performed ing re-used equipment ...
- Ask why "mist... patients' bills favour ...
- Vow they are doing ... possible to keep costs ...

ale hospitals such as Red Cross Children's Hospital (above) are bursting at the seams while private hospitals struggle to achieve the 65% bed occupancy

FILE PICTURE

osts down

MEDICAL AIDS:

- **Say they are paying more to hospitals than ever before.**
- **Stress medical aids are non-profit organisations, with administration costs fixed at five percent of contributions and the rest paid to settle claims.**
- **Claim hospitals provide doctors with incentives to use their wards and equipment, which can lead to over-servicing.**
- **Say doctors can inflate bills by "jumping" patients up to intensive care units without reason, performing unnecessary procedures or carrying out expensive, non-essential tests.**
- **Cite cases where hospitals have billed for procedures that haven't been performed and selling re-used equipment as new.**
- **Ask why "mistakes" on patients' bills favour hospitals.**
- **Vow they are doing everything possible to keep costs down.**

1-1/03/98

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Plan is unhealthy, say medical aids

Star 17/3/98 / 299

Cape Town – Medical aid schemes yesterday rejected government plans to force them to accept all prospective members, regardless of health risk, and urged that they be allowed to screen new applicants "to some extent".

In a presentation to the National Assembly's health committee, which is holding public hearings on the 1997 white paper on transformation in health, they said there was no evidence to support claims that medical schemes were becoming more expensive, or that the total number of beneficiaries was shrinking.

The Concerned Medical Schemes Group and other schemes, which said they represented more than 2,6 million beneficiaries, said that if the proposals in the white paper were implemented "simplistically and literally", they would achieve the opposite of what was intended.

They said that if schemes were not allowed to exclude individuals on the basis of health risk, people would defer joining until they were sick, which would increase the cost of cover and decrease the number of people covered.

Instead, schemes should be allowed to screen to some extent, "thereby incentivising the young and healthy to join".

They said the Government should allow flexibility such as rating bands. – Sapa

failed to give legislative effect to facilitate the reduc-

Government warned on regulation

(299)

CAPE TOWN — Government would be acting extremely irresponsibly if it re-regulated medical aid schemes on the grounds that deregulation had been unsuccessful, a representative of the Actuarial Society of SA, Prof George Marx, said yesterday.

He told parliamentary hearings on the white paper on transformation in health that this claim was not substantiated.

The white paper proposes that schemes should not be allowed to exclude anyone on the basis of health risk, and that contribution rates for a full package of benefits should be set according to income and number of dependants.

Director of policy for the Representative Association of Medical Schemes (Rams) Dr Aslam Dasoo told the hearing that schemes should be regulated in a way responsive to the interests of all South Africans instead of a few.

Meanwhile, the launch of a new, unified doctors' professional body has been set for June this year, co-ordinator of unity talks Dr Percy Mahlati said yesterday.

The new body — to be called the SA Medical Association — will unite seven professional associations divided largely on racial lines.

BD 18/3/98

Warning on med aid plans

ET 18/3/98 (299)

THE government would be acting extremely irresponsibly if it re-regulated medical aid schemes on the grounds that deregulation had been unsuccessful, a representative of the Actuarial Society of South Africa, George Marx, said yesterday.

He was commenting at parliamentary hearings on proposals in the White Paper to set up "regulatory mechanisms", to reverse serious instability, increasing costs and reduced coverage in the industry.

Policy director for the Representative Association of Medical Schemes Aslam Dasoo told the hearing that schemes should be regulated in a way responsive to the interests of all South Africans, and that Rams supported a private sector delivery system for affordable, appropriate lifetime coverage.

Sapa, Parliamentary Bureau

POLITICS

Expert slams plan to change medical aids

(299) Star 18/2/98

Cape Town – The Government would be acting extremely irresponsibly if it re-regulated medical aid schemes on the grounds that deregulation had been unsuccessful, a representative of the Actuarial Society of South Africa, Professor George Marx, said yesterday.

He told parliamentary hearings on the white paper on transformation in health that this claim in the document was not substantiated.

The society believed schemes that had moved towards responsible risk rating and sound risk management had succeeded in holding back the hyper-escalation in contributions.

"They have also succeeded in providing better access and showing improved financial positions," said Marx, who is a member of the society's healthcare committee.

He was commenting on proposals in the white paper to set up "regulatory mechanisms" to reverse – according to the document – serious instability, increasing costs and reduced coverage in the industry.

The white paper proposes that schemes should not be allowed to exclude anyone on the basis of health risk, and that contribution rates for a full package of benefits should be set according to income and number of dependants.

It also says schemes should be obliged to continue providing benefits to pensioners and widows or widowers, as well as to individuals, for a limited period after they become unemployed.

The director of policy for the Representative Association of Medical Schemes, Dr Aslam Dasoo, told the hearing that schemes should be regulated in a way responsive to the interests of all instead of a few.

"We are also aware of the centrality of the economic power of medical schemes and the responsibilities which that fact confers on the leadership of this industry," he said.

One of those responsibilities was to ensure that people who were covered by medical schemes were able to afford that cover. Another was to ensure cover was adequate, and that having people run out of benefits and being transferred to public sector health facilities would be the exception rather than the rule. – Sapa

MEDICAL SCHEMES (299)

Bewitched by Zuma? FM 20/3/98

The rift in the medical aid industry widened last week when warring power blocs within the industry body, the Representative Association of Medical Schemes (Rams), locked horns in court.

But a bigger clash is coming between Health Minister Nkosazana Zuma and the private health sector.

The rift in Rams is caused by the fact that most large, open insurance-based schemes oppose the draft Medical Schemes Amendment Bill, while the Rams Council broadly supports it (*Current Affairs* February 27).

The draft Bill aims to re-regulate the industry to give people guaranteed access to schemes and lifetime coverage.

The largest open schemes worry that the proposals threaten their financial viability. Together they represent about half of the medical aid industry, including heavyweights such as Old Mutual, Fedsure Health, Sanlam Health, Momentum Health, Liberty Life and D&E Health Benefits.

Rams represents 98% of all schemes and wields enormous power in the industry. But cracks have been appearing in its edifice, centring on the leadership of its chairman of six years, Keith Hollis.

Hollis and members of the Council have held closed discussions with the Health Department on the draft Bill over almost a year without a broad mandate from Rams members.

When the Council called a meeting last week to obtain a retrospective mandate for its position on the draft Bill, the dissenting group took the unprecedented step of court action.

Momentum Health CEO Adrian Gore says the group feared that contrived voting arrangements would turn the meeting into a "rubber stamp" for the Council's position.

D&E Health Benefits director Errol Benvie finds it remarkable that "as Rams members we had to resort to a court interdict to be heard by our association".

Rams lost the court case. A confrontational meeting of about 200 medical scheme representatives followed.

At its conclusion, members resolved to write individually to Zuma to inform her that the input she had received on the draft Bill from Rams was not a mandated position.

Gore says:. "We've stopped this runaway train of Rams and created an opening for a richer debate in the private sector." Rams spokesman Aslam Dasoo accuses the dissenting faction of frustrating progress. "There are issues of commercial interest at stake and these will relegate public interest to the background."

But the dissenting faction has previously accused Hollis of supporting the draft Bill to further the commercial interests of SA's largest medical aid administrator, Medscheme, where Hollis is also chairman.

"If there's anything the Minister loves it's internal division in an organisation because then she can come in and decide on its behalf," says an opposition MP on the portfolio health committee.

Claire Bisseker

Syndicate fleeces medaid schemes of millions

Star 21/3/96

By CHARLENE SMITH

At least nine medical aid schemes have lost tens of millions of rands to an elaborate fraud syndicate with international links and involving senior officials in universities, hospitals, the accounting profession and the telecommunications industry.

Police are investigating fraud charges against the superintendent of a Northern Province hospital, a senior medical officer at Chris Hani Baragwanath Hospital (whose medical credentials are also in question), and a consultant with one of the world's top consultancies, among others. Two journalists who worked for SABC's Channel Africa disappeared after initial arrests.

Bail refused

At the Magistrate's Court in Johannesburg on Thursday, bail was refused to Amiri Abdullah Musisi, a Ugandan who carries a South African identity document and who is one of the alleged masterminds behind the scam. Two alleged accomplices, University of the Witwatersrand civil engineering lecturer Meds Kwesiga and Dr Dan Kibuuka, a lecturer in veterinarian infectious diseases at Medunsa near Pretoria, have pleaded guilty to charges of R90 000 and R93 000 worth of fraud respectively.

They are both in custody pending their sentencing on April 7.

The medical aid schemes targeted by syndicate include the University of the Witwatersrand medical aid, SABC medical aid, Bonitas (which most government employees belong to), Fedhealth, Chartered Accountants medical aid fund, Medihealth, Bestmed, Medscheme and Sanlam medical aid (Sanmed).

It is believed that several more schemes may have been affected, but a failure by medical aids to share information has made it difficult to determine this.

The scam was picked up when Medscheme, using its high-tech Data Warehouse computer system in a routine check of cheques issued for more than R30 000, found that several claims from different members who said they had received treatment at different hospitals across Africa and the United States were all payable to the same post office box number in Johannesburg.

Gary Taylor of Medscheme said the accounts submitted to his company appeared genuine and ranged from $12 000 to $21 000 (about R60 000 to R104 000) for refund to members. Taylor said foreign bills have increased in recent years as more foreigners live and work in SA, and South Africans travel abroad more often.

"The arrangement with one of the South African-based ringleaders of the syndicate was apparently for a 50/50 split in the proceeds," Taylor said. One member admitted to defrauding the scheme of R500 000.

Medscheme involved its own fraud unit in investigations and they in turn brought in a team of outside investigators, Pharmaceutical Investigators under Dave van Heerden, who in turn found Medscheme was not alone in being defrauded.

> *'Slip was to have several big claims paid to same box number'*

Van Heerden said: "In one instance, a member claimed for his spouse who allegedly spent 20 days in an intensive care unit at the fictitious Arusha clinic in Tanzania, and which the medical aid concerned refunded the member R256 564,37.

"We found that the people involved in the fraud syndicate were having rubber stamps for the supposed hospitals made at a shop in Auckland Park. The accounts appear to have been done with the help of doctors, because they are very credible.

"We also discovered that a number of those concerned are carrying false SA identity documents and have false university degrees."

Kibuuka, who has pleaded guilty, as a further example lodged a claim of $12 047 (about R60 000) in March last year which was paid out by Bonitas medical aid for bogus treatment for cerebral malaria, severe migraines and acute gastro-intestinal bleeding at the fictional Gallex hospital in Mombasa, Kenya.

Just five months later he claimed a further $15 623 (about R78 000), saying he had been hospitalised after a severe accident in Lubumbashi in the former Zaire.

There are a further three cases due to be heard before the courts in Pretoria, a further six before the Cape Town courts and six further cases in Johannesburg.

Taylor said Medscheme was "thrilled that we have got to the point of prosecuting".

"Normally it is very difficult to get enough evidence. We have a computer system which allows us to process information from 2 million claims a month. It allows us to look at data in all sorts of ways and track suspicious claims.

"After that we bring in independent investigators, who get to work." Taylor said the medical aid societies did share information, but only after prosecutions were complete.

"Not all fraud is as big as this syndicate. We deal with little things often that are borderline fraud like a home nurse who claimed she made 40 calls a day. Or a hospital that charged a patient, who had a circumcision, for 150 metres of bandage – they said they had erred and it should have been 1,5 metres, which frankly is still considerable."

Stopper

Nick du Preez, an independent consultant with Sanmed, said they had picked up around R800 000 of fraudulent claims in the Musisi investigation.

"We had only paid out R500 000. I got a tipoff that it was happening from someone who said I must watch out for this. I placed a stopper on all foreign accounts. I picked up two, and then went to the records and picked up another five.

"The accounts are very professionally prepared on hospital letterheads with receipts. We had one from the US and others from African countries.

"They date back to 1994. Most of those we have picked up were from members in Gauteng, although some are teachers in North West Province," Du Preez said.

He added that no foreign bill gets paid by Sanmed now unless he sees it first. "Medical aid societies should only pay foreign accounts if there is an emergency, and then they must have someone with a knowledge of these to inspect each."

Bafana Nkosi, principal officer of Bonitas medical aid, which has 180 000 members with 500 000 dependants, said they had a team of full-time staff going through claims looking for foreign fraud.

"We are lucky we have found only R300 000 so far, from five members, all except one of whom were doctors in senior positions at state hospitals. It was clearly a growing syndicate and we believe we will unearth more fraud.

"We see the arrests so far as a breakthrough. It is not the amount we have lost that is as important as stopping these syndicates and prosecuting them," Nkosi said.

Police and private investigators expect to make further arrests.

Gay couple to take medical aid to court

ARG 4/4/98

(299) (~~SEP~~)

ADELE BALETA

A Cape Town City Council employee plans to take the municipality's medical aid to court for discriminating against him because he and his lover are gay.

This week the Local Authorities Medical Aid Fund told Johan Fourie, 50, that an application to register his lover Theunis Rautenbach as his dependant had failed.

An angry Mr Fourie accused the fund of "blatant discrimination" and said he was prepared to do battle with the fund's managers in the Cape High Court and the Constitutional Court.

The National Coalition for Gay and Lesbian Equality has criticised the municipality for taking a "huge step backwards", especially in view of the Johannesburg City Council's decision to extend benefits to same-sex partners.

Mr Fourie's application to the fund followed the landmark Pretoria High Court judgment earlier this year that ruled in favour of lesbian police captain Jolande Langemaat, allowing her to register her partner Beverly-Ann Myburgh on her medical aid.

The police services medical aid, Polmed, has given notice of its intention to appeal against the court's ruling, which is legally binding only within the jurisdiction of the Gauteng division of the High Court.

In a letter to Mr Fourie, Melt Louw, the municipal pension fund's general manager, said Mr Fourie's application had been turned down in accordance with the Medical Schemes Act of 1967 and the Rules of the Fund.

OBED ZILWA

Turned down: Johan Fourie and his lover of 18 years, Theunis Rautenbach

However, he said the fund would consider accepting Mr Rautenbach as an "extraordinary member", which would mean increased premiums.

Mr Louw told Saturday Argus that he did not want to comment further as the matter was between the Mr Fourie and the fund's managers.

The Act requires that prospective dependants not be on any other registered medical aid and that they be legally married to the existing member of the fund.

Declan Brennan, executive director of the Representative Association of Medical Schemes, said that most member medical schemes demanded a marriage contract or proof of a common-law relationship. Because marriages between men were unlawful, that would preclude them from registering dependants.

But he added that medical aids could determine whether they recognised homosexual relationships. He said the Pretoria ruling was likely to make an impact on other medical aids.

Mr Fourie, who has lived with Mr Rautenbach for 18 years, said: "Because we are men, and cannot be legally married, we can't get benefits that married couples get." Although Mr Rautenbach, 51, has a job in the clothing industry, he cannot afford his own medical aid.

In a complaint to the SA Human Rights Commission, the men said they were in a committed and exclusive relationship, had a joint will and were financially co-dependent.

Faranaaz Veriava, the Human Rights Commission's legal and education officer, was "disappointed" with the medical aid fund's decision.

"We would have liked them to take the initiative in developing a human-rights culture based on the principles of non-discrimination, by revising the definition of dependency."

Mazibuko Jara, of the National Coalition for Gay and Lesbian Equality, said the municipality's decision was a "gross violation" of the Constitution and the Labour Relations Act, which states that, when it came to benefits, no one should be discriminated against on the basis of marital status or sexual orientation.

Mr Jara said the fund's decision also went against the spirit and the letter of the Employment Equity Bill, which outlawed discrimination in the workplace.

He said the Polmed judgment had paved the way for same-sex partners to claim their rights. He confirmed that marriage between same-sex partners was illegal in terms of the common law, but that the matter was part of the South African Law Commission's review process.

Need for more inclusiveness in medical schemes

debate

The debate about new legislation relating to medical schemes seems so far to have been limited to those with some financial stake, writes Alex van den Heever

(299) BD 7/4/98

THE health department is proposing new legislation to protect access to medical schemes for the general public.

These proposals have resulted in heated attacks on the department from certain commercial interest groups, and support from others. As this bill goes through Parliament, much will be said and written about this new environment and the "draconian" measures to be introduced.

That this debate happens, and happens fully in the public domain, is of great importance to the public interest.

Very few people know what is happening to their access to cover through medical schemes, and the proprietary interests central to these shifts.

Some trends the department finds to be a problem are: pensioners are having premiums hiked up despite having contributed to their medical schemes their entire lives; some pensioners are finding their employer contribution is withdrawn; and open schemes are denying access to applicants with a pre-existing condition, or if they are over the age of 55, or are a member of a high risk group.

Despite these trends occurring in a range of different health funding environments, what is often not appreciated is the interrelatedness of these seemingly disconnected trends.

Despite the not-for-profit nature of medical schemes, only the very naive believe that their behaviour and choices are not substantially influenced by the commercial administration companies that manage the claims processing, or set up the scheme (in the case of open schemes).

So, the question must be asked, why are certain commercial interests in the market hot under the collar about these reforms?

The answer is that they propose to eliminate discrimination on the basis of health status.

This is to be achieved by a combination of mechanisms: community rated premiums (that is, premiums can be varied only on the basis of income and number of dependants as prior to 1989); open enrolment; and a requirement that all schemes provide a set of prescribed minimum benefits.

Open enrolment which is directed at open schemes, as closed schemes will be exempt, will prevent schemes from being able to deny cover to any applicant willing to pay the community rate of the scheme.

The minimum benefit requirement will limit the extent to which indirect discrimination against certain groups can be created in schemes through benefit manipulation. These proposals indirectly affect the profitability of setting up new "commercial" schemes in that their chief means for the rapid capture of market share is no longer available.

It is correctly argued by the Concerned Medical Schemes Group (a lobby group representing particular commercial interests brought together to challenge government's proposals) that this combination of reforms will result in a disincentive for the young and healthy to join.

In other words, people will only join schemes when old and sick — raising the average cost of medical schemes. As this trend continues, premiums will rise, not because of medical costs, but because the covered group is on average less healthy. So, they argue, health-related cross-subsidies will be driven from schemes. Their example for this is Australia.

However the only similarity between the countries is the use of the term community rating. Australia has a national health insurance system with a free high quality public hospital system. Neither of which exists in SA.

Australia largely maintains its community rating system for consumer protection, and not for health systems reasons. In fact, if community rating were removed, it is unlikely many young people would join, as catastrophic cover, which they favour, is already provided by good state facilities.

Yet the question remains as to what the health department proposes to do to counter the "inexorable collapse" induced by its diabolical bid at social engineering.

The answer coming from the proposals is fairly simple. The problem that within a voluntary environment the healthy will only choose cover when unhealthy is acknowledged, a problem traditionally termed adverse selection.

However, the department is proposing that adverse selection be dealt with by specific regulations aimed at preventing people from joining schemes only when their risk status changes or when an immediate medical crisis strikes. The focus is specifically on those people who are seeking unfair cross-subsidisation.

However, those who join early and remain in cover their entire lives clearly do not represent an adverse selection problem. In fact they are more likely to be victims of it if not protected. The department argues you do not risk rate (that is, treat people differently because of their health status) to solve an adverse selection problem in health care.

To this end the department has made it clear that people who join medical schemes for the first time later in life will be treated differently to those who have been members for most of their lives. Those who join for the first time with a pre-existing condition, will not be covered for that condition for a specified period of time.

The department has also indicated its willingness to be flexible on these regulations to ensure schemes are effectively protected.

Consequently, the contradiction in the "concerned" group's proposals, according to the department, is that, rather than eliminating adverse selection, they would seek to reinforce it by not rewarding people for remaining in schemes their whole lives.

If government withdrew its proposed legislation, many, if not most, young people today who are opting for limited cross-subsidisation, will find themselves, perhaps deservedly, without insurance cover late in life.

Also, many current recipients of cross-subsidies would undeservedly lose their cover in the future. This is the likely outcome of a market rewarding adverse selection rather than punishing it.

Given the important implications of such an outcome, it is maybe prudent to have the public interest represented by parties less tainted by pursuit of immediate financial reward taking part in this debate.

A group unluckily notable by their absence thus far.

□ *Van den Heever is a senior researcher with Wits University's Centre for Health Policy.*

MEDICAL AID COSTS

(299)

Applying the brakes to medical inflation

FM 1/5/98

Rise in costs slows as managed health care takes hold

Managed care and medical savings accounts are reigning in medical inflation and boosting the growth and financial soundness of the medical aid industry.

And medical schemes' expenditure on all health categories is slowing considerably, according to the latest medical aid industry figures (see table).

The most dramatic reduction is on members' treatment in private hospitals — down to an annual increase of 16% in 1996, a considerable improvement in the annual price hikes in excess of 30% during the early Nineties.

Independent managed care consultant Dr Henriette Potgieter, executive director of Access Health SA, says the results show managed care is taking hold in SA.

With medical inflation having outstripped the CPI since the late Eighties, medical schemes are turning to managed health care to contain costs.

Managed care is a US cost containment strategy which requires the medical scheme to monitor and manage the cost, amount and quality of care of every member to ensure that the treatment dispensed by doctors and hospitals is cost effective and necessary. If in the medical scheme's opinion it is not, it may refuse to pay.

Managed care requires medical schemes to institute better control and information systems. The results show that the industry's investment in this area has translated into better risk and financial management, says Potgieter.

She believes the introduction of benefit limits and medical savings accounts (where the member manages day-to-day medical expenses out of a personalised savings account) have also helped cut costs.

These cuts mean lower contribution increases for the consumer. The average contribution increase per member has fallen from a high of 34% in 1991 to 14,2% in 1996 to about 12% last year.

At the same time schemes are becoming more solvent. The accumulated funds per member improved by 27% between 1995 and 1996 with half the industry coming in just below the reserve requirement of 25% (the industry average was 24,3% compared to 23,2% the previous year).

Schemes also increased membership by about 2%, bringing total medical membership to a record high of R6,8m.

"The challenge is to make cover more affordable, cover more people and run more solvently and we are starting to achieve this," says Momentum Health CEO Adrian Gore. Complete managed care has the potential to reduce monthly medical aid premiums significantly — Potgieter says by as much as 20%.

However, as only 15%-20% of the medical aid industry has introduced the basic elements of managed care, industry averages can be expected to fall even further as more schemes go this route. "The results show that managed care is beginning to take effect and we expect the 1997 figures to show even better results," says Representative Association of Medical Schemes (Rams) chairman Keith Hollis. **Claire Bisseker**

TRENDS IN MEDICAL COSTS
Growth in medical costs (per member)

	% growth in annual medical costs					
	1990 %	1991 %	1992 %	1993 %	1994 %	1995 %
General Practitioners	24	8	5	11	14	11
Specialists	37	35	16	18	19	10
Dentists	28	28	6	5	17	7
Private Hospitals	22	33	33	32	30	16
Provincial Hospitals	24	14	(2)	(10)	(25)	(13)
Medicine	37	45	19	6	14	11
Other	19	33	12	9	27	13
TOTAL	29	31	15	11	18	11

SOURCE: RAMS (REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES)

PROPERTY

Don't be too clever by half

There's such a thing as trying to be too clever in avoiding tax. This is a lesson that has to be learnt over and over again. One deep trap lurks when the buyer of residential property hopes to avoid transfer duty by purchasing shares in a company owning the property — or an interest in a property-owning close corporation or trust.

In a recent issue of *Tax Planning*, tax practitioner Robin Lockhart-Ross points out the severity of the risk. Suppose the company or other entity had been registered as a vendor for Vat purposes.

Though the letting of residential property is generally exempt from Vat, the need to register could have arisen in certain circumstances. Thus, the use of the property for short-term letting — say as a boarding house — would have constituted the conduct of a commercial or residential rental establishment and so would have been subject to Vat. More commonly, the premises may have been used in part to conduct the practice of a doctor, dentist or other professional.

When the purchaser takes up residence in the property, the enterprise will have ceased for Vat purposes. Then the deregistration procedures (Section 8 (2) of the Vat Act) will apply. The vendor is deemed for Vat purposes to have supplied its remaining assets at the lower of their cost or open market value. This triggers the obligation to account for Vat at 14%, payable by the purchaser — against transfer duty at a maximum rate of 8% on a transfer to an individual. A bad bargain indeed.

Worse still, in many cases the purchaser "will blow the whistle on himself". The new owner of the property may receive a Vat return in the name of the previous enterprise which he innocently returns to the Receiver, explaining that he now lives at the property and no longer wants the company or other entity to remain registered. This triggers the demand for Vat on the purchase price.

The first line of defence is for the purchaser to inquire thoroughly into the Vat history of the entity before signing up. Secondly, he should always insist on the inclusion in the agreement of sale of a warranty that the entity has never been a Vat vendor and that the seller indemnifies the purchaser against any Vat arising if the warranty is incorrect.

Robin Friedland

Govt to curb health costs

(299)

By Ido Lekota

THE Government is to introduce legislation aimed at addressing the rocketing costs in medical aid which has seen more people unable to afford a visit to the doctor.

Addressing Parliament during a debate on the 1998-99 health budget yesterday, Health Minister Nkosazana Zuma said her Ministry would soon introduce the Medical Aids Bill aimed at addressing the ever-increasing medical aid costs.

"There is a real crisis in the medical aid industry," she said.

Zuma ascribed the rise in medical aid costs to, among others, the inappropriate use of expensive technology as well as incorrect diagnosis by doctors.

The Government would also develop a comprehensive social security system which would help the poor, Zuma announced.

She revealed that also soon to be presented to Parliament were tobacco laws aimed at preventing children from starting to smoke, protecting the rights of non-smokers and helping smokers who want to stop smoking.

Zuma also called on politicians to join the fight against HIV-Aids and mobilise all South Africans to take precautions to prevent its spread.

"Please educate people about the dangers of this disease. Please remind them not to discriminate against people with HIV-Aids," she said.

Zuma said it was estimated that 1 500 people were infected daily and 2 million South Africans were already infected.

"Most of them are poor and cannot afford the cocktail anti-retroviral treatments that are in the market," she said.

Medlife relations 'incestuous'

BD 6/5/98 (299)

MARITZBURG — An incestuous relationship had existed between the Medlife Medical Scheme and its administration company, Medilife Administrators, an Insolvency Act inquiry heard in Maritzburg yesterday.

Medical Schemes registrar Danie Kolver told the inquiry the incest was manifested by virtually the same people running the medical and the administration company.

The administrating company had made large illegal and unsecured borrowings from the medical scheme to the detriment of the scheme's creditors and its members, he said.

Kolver said the permissible norm of medical scheme administration costs was about 10% of the contribution income, while the average for most medical schemes was 6% or 7% of contribution income. There had been many irregularities perpetrated by Medilife Administrators in its administration of the scheme, he said.

Medilife's total administration costs for 1995 were 28% of contribution income — more than three times the norm and four times the average.

The medical scheme was liquidated last year, leaving debts of about R30m.

Liquidator Andries Geyser said brokers who had received illegal commission for recruiting members for Medlife were paying back the commissions.

So far, R570 000 of the R4,4m paid out in illegal commissions had been recovered. Geyser said that he had issued summonses against former directors and executives demanding repayment of all debts, totalling about R30m. — Sapa.

Union and Eskom at odds over Esmed medical aid scheme

Robyn Chalmers

THE National Union of Metalworkers of SA (Numsa) has lashed out at Eskom over the handling of the crisis at its medical aid scheme, Esmed.

Steve Nhlapo, Numsa Eskom sector co-ordinator, said yesterday Eskom was trying to force employees to become members of the ailing medical aid scheme. The scheme has been losing millions of rand each month and Eskom was recently forced to call in a firm of auditors to help with reconciliations.

"Eskom is trying to make it a condition of employment that workers belong to Esmed, but we are suspicious of this. Do they wish to boost Esmed's cash flow?" he said.

An Eskom spokesman denied the electricity utility had made it a condition of employment to belong to a single medical aid overseen by Eskom. The spokesman said that since the early 1980s, when the medical aid scheme was opened to all employees, there was a choice between the Eskom medical aid or three external schemes.

"This situation has not changed — many employees have opted to belong to external schemes and we have never tried to stop them," he said.

Nhlapo said Eskom had made inroads into the employers' contribution. Eskom used to pay 100% of medical aid costs but, after previously disadvantaged people were allowed into the scheme, this was downgraded, he said.

"The trade unions are not even represented on the Esmed board of trustees, so we have no say over how the medical aid scheme is being restructured. There is a crisis in this scheme .... we wish to participate," he said.

However, the Eskom spokesman said the parastatal had never contributed 100% to medical aid costs, but had always combined employer and employee contributions in a 60:40 ratio.

The spokesman said Eskom had set up a semiautonomous body to oversee its medical aid scheme.

A board of trustees had been appointed to manage the medical aid scheme and deal with its problems.

The board had called on all members to participate in Esmed's restructuring, and this included the trade unions, so they could become involved should they wish to do so, he said.

MEDICAL AID

BREAK WITH TRADITION

But new generation products do not suit all medical scheme members

(299) FM 22/5/98

Do you still trust your medical aid? Don't you just loathe the fact that your surplus contributions are used to fund other, sicker members of the scheme? But you are afraid of jettisoning your medical aid entirely and wary of self-insurance?

If you are 30-something, in middle management, healthy and have answered "yes" to any of the above questions, you should be looking at a new generation medical scheme.

With medical aid premiums rising faster than inflation, yuppies with small, healthy families are opting out of traditional medical schemes where they are in effect overcharged.

Those who perceive that their traditional medical aid offers poor value for money usually consider insuring themselves, take out comprehensive hospital insurance or join a new generation scheme.

The products of such schemes differ from traditional medical aid in that they divert some of the member's monthly contribution into a personal medical savings account which the member can control.

The new schemes typically provide comprehensive hospital and chronic illness cover as well as a savings account to cover small, everyday medical expenses like GP consultations.

At least 60% of a new generation member's monthly contribution is paid into a common risk pool run on normal insurance lines to cover major health expenses.

The remaining 40% is paid into the member's savings account. Funds not used up in the savings account in any year can be rolled over into the next, allowing members to reduce monthly premiums.

Momentum Health Marketing MD Neville Koopowitz says new generation products are cheaper than traditional ones and allow the member to generate savings.

Momentum Health — which in 1993 was the first insurer to bring a new generation product to the market and now turns over R1bn a year across the board — reports that last year 60% of its principal members rolled over funds in their savings accounts.

The average rollover among these 54 000 members was R2 000. Under a traditional medical aid system this R110m saving would have been lost to these members. Traditional medical aid members have no incentive to curb costs because whatever they fail to spend in any year disappears into the common risk pool.

This use-it-or-lose-it mentality has been a significant contributor to spiralling medical aid costs in SA. New generation products, though, give members a cash incentive to limit their medical expenses and so bring costs down.

However, the Health Department will soon release the Medical Aid Amendment Bill, which many fear will reduce contribution rates to savings accounts to as little as 15% of total premiums. This could render some new generation schemes unviable.

The department feels cheaper savings account-based products are not in the national interest because they are poaching low-risk members from traditional schemes.

Traditional schemes are being left with an increasing number of high-risk members and are being forced to raise premiums, resulting in pensioners and those who can no longer afford their cover being dumped on the collapsing public hospital system.

Most large insurance-based open schemes, run by the likes of Momentum Health, Fedsure Health, Sanlam and Old Mutual, are fighting hard to retain medical savings accounts.

About 1m South Africans have opted for savings account-based plans since 1993. The 1997 Old Mutual Actuaries & Consultants (OMAC) health benefits survey found that 76% of large employers surveyed were considering, or had already introduced, a new generation product to their work force.

OMAC's preliminary indications for 1998 are that new generation schemes have increased their annual premiums by about 10% on average, compared to about 15% by traditional schemes.

NMA Medical Fund Managers reports that its top traditional schemes increased their premiums by 13% this year, while its top new generation products increased premiums by only 7,5%.

Because new schemes induce members to change their behaviour, they spend less on health care and the overall costs to the scheme go down, so the scheme can reduce its annual premium increase.

But are new generation products good for everybody?

NEW GENERATION

Pros

- Member has ability to control everyday health-care expenditure.
- Accumulated funds in savings account can be used for future health-care expenses and retirement funding.
- Members have incentive to use funds sparingly and therefore make less use of health-care services.
- Members have incentives to become more educated consumers of health-care products.
- Provide people who don't require extensive cover for out-of-hospital benefits with cheaper alternative to traditional medical aid.
- Accumulated funds can be transferred to another scheme.

Cons

- Assumes that member knows when circumstances are serious enough to justify seeking medical attention.
- Member might deliberately forgo necessary treatment, including preventative care, in order to obtain the maximum savings benefit.
- No preferential treatment of accumulated savings in the event of a medical scheme having to be liquidated.
- No certainty regarding future of product.

WELL-KNOWN NEW GENERATION PRODUCTS

- Momentum Discovery
- Fedhealth Medicine Chest
- NMA Crystal Range

WELL-KNOWN TRADITIONAL PRODUCTS

- Bonitas Medical Fund
- Southern Health Medical Scheme
- NMA Jewel Range

Fedsure medical aid scheme 'world first'

(299)

David Greybe BD 25/5/98

CAPE TOWN — Fedsure will launch SA's first medical aid scheme for complementary health care at the end of the month.

Andrew McDonald, designer of the scheme and MD of Eco Health Projects, said at the weekend the scheme was considered "unique in the world because it focuses primarily on complementary health principles and will operate as a stand alone option".

Fedsure's complementary scheme was different, he said, from "mainstream" allopathic schemes focusing on western medicine and those which cover traditional medicine like that offered by sangomas.

A number of medical aid companies in the US had already expressed an interest in the principles of the scheme, he said. In SA, it would be operated by Fedsure Health, a member of the Fedsure group.

Complementary treatments to be covered under the scheme included aromatherapy, homeopathy, chiropractic services, ayurvedic treatments, naturopathy, reflexology, remedial yoga and acupuncture.

"The aim of the scheme is to effectively integrate complementary and alternative medical treatments into a structured option for people who follow the principles of alternative health care," he said.

Because the risk pool was subject to a healthier target market, the premiums would "express the wellness of the group" and were therefore expected to be lower than those for existing allopathic (ordinary) medical aid packages, McDonald said.

The scheme's preamble said it adopted the principle of preventative health care, rather than the curative treatment of disease.

"It adopts the notion that the prescriber of health care becomes an intimate participant in the life of the patient, thereby stimulating a more personalised wellness approach to health," it said. As a result, "this option's focus is toward complementary-alternative health benefits as opposed to allopathic benefits which will be limited within this option".

The initial marketing of the scheme will be done mainly through SA's complementary associations, the health broking firm Eco Health Projects and the Natural Health Directory.

Doctors help to defraud medical aid schemes

(299)

CP 3/15/98

By PHALANE MOTALE

MILLIONS of rands are being stolen from medical aid schemes by people who use their medical aid cards to buy clothes, food and other goods and even to obtain cash advances from doctors involved in the scam.

Most of those involved in this systematic fraud are recently graduated medical doctors who risk their careers to maintain high lifestyles.

A City Press investigation has discovered that despite previous warnings by the Interim National Medical and Dental Council of South Africa and the police, several doctors are still cashing in on medical aid schemes by giving patients cash advances on the strength of their medical aid cards. Some medical aid scheme members have been buying groceries from shops apparently owned by relatives of doctors allegedly involved in the scam.

After cash and goods have changed hands, doctors send claims to the medical aid scheme as if the patients were treated.

Another common practice is double billing. Doctors bill the client – and then bill the medical aid for the same amount.

In December last year, Pretoria medical practitioner, Dr Beria Matshivha (31), was convicted of defrauding the police medical aid fund – Polmed – of nearly R50 000.

Matshivha admitted stealing R46 186 from the fund during a 17-month period, and was fined R15 000, or 15 months' imprisonment by the Pretoria Regional Court. He was also ordered to repay the money to Polmed.

The court heard that between 1995 and 1996, Matshivha deliberately submitted claims to Polmed for services not rendered.

Convicted Pretoria psychiatrist, Dr Omar Sabadia, will soon also face multiple charges of defrauding Polmed of several hundred thousand rands in a similar manner.

Spokesman for the Interim National Medical and Dental Council of South Africa, Louise Emerton, says medical aid fraud is "fairly widespread" in South Africa.

Emerton says complaints received concerning fraud or abuse of medical aid schemes normally involved claims for services not rendered, over-servicing, a "pattern" of claiming for expensive medication, claiming for expensive procedures and patients signing blank claim forms.

She says 20 professional conduct inquiries were held during 1994 and 1995 pertaining to fraud concerning medical schemes. Five members were stricken from the register, two cautioned, 10 suspended for a period between six and 12 months and three fined between R1 000 and R10 000.

Emerton says the council can only take action against its members after they have been found guilty in a court of law or if someone has lodged a formal complaint with the council.

☐ This week, City Press accompanied a senior government clerk to a doctor in Soshanguve, north of Pretoria, who made him sign blank letterheads before he was given R200. According to the clerk, the doctor would in turn claim from the medical aid double what the "patient" was given – R400 – and keep the balance for himself.

In another case, a factory worker bought toiletries and perfumes from a chemist after a doctor had arranged with a pharmacist for a R250 "buying slip" prescription.

An investigator in the police's Commercial Crime Unit says the case load of investigators dealing with medical aid fraud has increased "incredibly" over the past few months. Sums involved range from R1 000 to hundreds of thousands of rands.

☐ An international expert on fraud warned late last year that the problem of medical aid fraud had just started in South Africa – with the worst yet to come.

Speaking at the first seminar in South Africa on medical aid fraud investigation, attended by investigators police fraud units, the Computer Crime Investigation Unit, the Syndicate Fraud Unit, the Commercial Crime Unit and the Money Laundering Forum, Dr Alex Peros of the Association of Fraud Examiners in America said medical aid fraud had amounted to R4 billion in 1993 in the US – and had increased to R4,5 billion in 1994. It has been a growth enterprise since then.

☐ Representative Association of Medical Schemes (Rams) spokesman, John Pugsley, confirms that medical aid fraud is on the increase countrywide. He says Rams' Fraud Committee has made several breakthroughs in recent months, which will be made public soon.

Pugsley warns that medical aid members caught defrauding their schemes will be barred from joining any fund in future.

Decision due soon on contentious Medical Schemes Bill

BD 19/6/98 (85) (299)

Pat Sidley

THE cabinet is set make a decision soon on the final draft of the Medical Schemes Bill which seeks to ensure that more people have access to medical schemes — particularly those who are frequently excluded because they are chronically sick or elderly.

The bill proposes to do this with a variety of mechanisms which have been under discussion for several years, such as "community rating" and the banning of various types of exclusion of members which the proposed law would view as discriminatory.

To prevent prospective members selecting certain schemes over others because of the benefits, to the detriment of those schemes, mechanisms have been created to try and prevent what is known in the industry as "adverse selection". Mechanisms have also been created to discourage people from joining schemes for the first time late in life when they begin to feel they need the benefits. However some of these are to be contained in regulations which are not part of the main bill.

The bill also provides for the health minister to compel schemes to provide minimum benefits for all members which would roughly conform to the kind of service they would receive at state health care facilities.

A long-running debate has raged between the health department planners of the legislation, the medical schemes industry and the life assurers who sell medical scheme-like products with elements of the medical schemes industry and the insurers implacably opposed to the community rating proposals.

The provisions would compel schemes to allow more cross subsidisation between sick and healthy and young and old within each scheme.

Some schemes and insurers claim it would make the industry unprofitable, cause prices to rise and force younger and healthier members out. The department's planners, however, contest this assertion and are committed to broadening access to medical schemes.

The community rating clauses, by far the most contentious, ensure that contributions and benefits cannot be changed on the basis of age, gender, past or present state of health or the frequency of past claims. This clause refers to regulations to prevent adverse selection. A clause allows the minister to prescribe benefits to avoid discrimination or to stop a scheme thwarting the intention of the bill.

The bill will severely limit the ability of schemes to impose new waiting periods, cancel memberships and refuse to continue cover between schemes.

Members who have been with schemes for more than two years and who wish to change schemes, will have their right entrenched not to have new waiting periods introduced.

Membership of a medical aid can only be cancelled for a failure on the member's part — not because of a high claims experience, the size of the family or a disability, for example.

In circumstances where principal members lose their jobs, or die, schemes will be obliged to retain the principal member and dependants for a limited period until the dependants are on other schemes.

The Bill proposes to change the definition of a medical scheme to ensure that anybody offering what looks like health insurance, a medical scheme or a medical benefit fund will have to register as a medical scheme in terms of the bill. The registrar for medical schemes, his council and his office will report to the health minister. This, too, has been an area of contest with insurers hoping some of their products can continue to be regulated through the Financial Services Board by virtue of being a long term insurance product.

Other clauses will allow for medical savings accounts — but limit them; place restrictions on schemes offering different benefit options, stop pre-funding for future membership fees, curtail broker activities and introduce an ability to declare a practice harmful and stop it.

No perfect way to pre-fund medical aid contributions

CT (PR) 23/6/98 (299)

There were currently no perfect ways in which to pre-fund medical scheme contribution liabilities of pensioners who were former employees of a company, Graham Turnbull, managing director of Specialised Retirement Fund Services, told the Institute of Retirement Funds annual conference.

He added that the option of a separate pension or provident fund to house pre-funding for medical aid contributions at retirement seemed to be most widely supported.

However, this would require changes to the Income Tax Act as well as amendments to the Pension Funds Act.

A number of pre-funding vehicles had been considered by the National Retirement Consultative Forum committee dealing with post-retirement health care. These were:

A Special Reserve Fund within a Medical Scheme.

Advantages of this option included:

☐ Accumulated funds would be used to pay medical aid contributions;

☐ If benefits were over-funded, the employer could redress the situation as the cash would not be in the hands of pensioners;

☐ Funds would be available only to members and dependants who were continuation members of the medical scheme; and

☐ The fund rules could allow for transfer of funds to another medical scheme.

The disadvantages included:

☐ The Medical Schemes Act would need significant amendment to deal with supervision of these additional activities in a medical scheme;

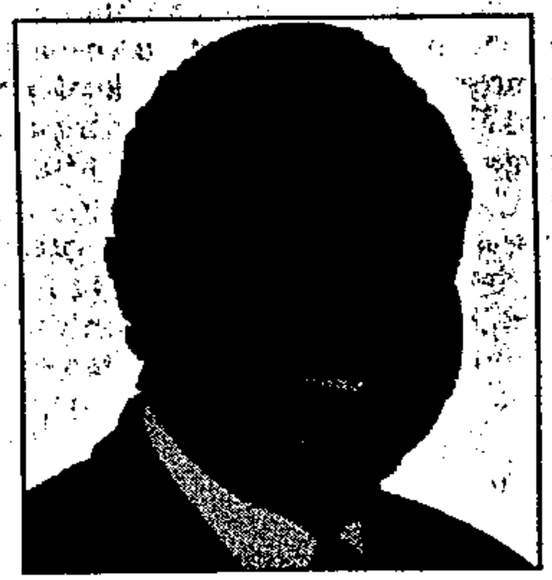
☐ The control of funds inside a public/multi-employer scheme would be tricky;

☐ Currently there was no mechanism available to protect these funds inside a medical scheme in the event of insolvency; and

☐ A medical scheme was effectively a pay-as-you-go setup.

This option was not strongly supported by the forum's health care committee.

Using an Existing Pension or Provident Fund.



GRAHAM TURNBULL, *MD of Specialised Retirement Fund Services*

Turnbull said this was an attractive option especially when there is a large surplus in the fund and the employer wanted the fund to take over its obligation for funding pensioners' medical aid contributions.

The problem for this option was that the nature and method of determining the actuarial liability relating to the payment of post-retirement medical aid contributions and the liability relating to the funding of pensions were not the same. The result was employers would have to run two funds within one, with the consequence that, over the long term, provisions could become blurred, resulting in inadequate provision being created for each risk.

A Separate Pension or Provident Fund.

Advantages included:

☐ A separate fund could be set up specifically to cater for medical aid pre-funding under the current regulatory framework;

☐ There was a high degree of security for member's benefits and the financial condition of the medical aid did not put member's savings at risk;

☐ Member's vesting rights and transferability of funds to another scheme could be easily accommodated;

☐ Contributions could be tax deductible; and

☐ The regulators of retirement funds (the Financial Services Board) would consider transferring the surplus from a pension fund to a pre-funding health care fund under certain conditions.

The disadvantages included:

☐ Pensioners could not be forced to use the pension generated from a special pension or provident fund to pay medical aid contributions as legislation does not specifically make provision for these types of funds;

☐ Should the new tax proposals for retirement funding of the Katz Commission be implemented, it could be difficult to determine up front how much tax would be due at retirement on a pensioner's benefit; and

☐ Currently, the system is not tax neutral for retirees under the age of 65.

Medical aids see growth in private users

(299)

SHIRLEY JONES

KWAZULU-NATAL EDITOR

CT (BA) 29/6/98

Durban — Individual or private membership of medical aids was growing in the wake of shrinking employment, Jerry Bryant, the principal member of National Independent Medical Aid Society (Nimas), said yesterday.

Although Nimas catered for large, medium and small employer groups, almost all new members were individuals. Nimas had only opened to private membership a few years ago, but between 15 percent and 20 percent of its membership comprised individuals.

He said this was a response not only to the shrinking corporate workforce, but the tendency for larger companies to contract out, thus saving on providing benefits, which were a major expense.

Bryant said the trend towards individual membership was becoming so popular that public sector employers were also encouraging employees to choose their own medical aids and offering to subsidise their membership. This would probably escalate to the point where it would create a whole new division within the medical aid industry aimed specifically at the individual.

This would have positive spinoffs. Large employers only had to give three months' notice before withdrawing, which had devastating implications for medium-sized medical schemes. Bryant said individuals were less likely to withdraw and more likely to remain loyal.

Bryant's comments were made after the release of Nimas's results for the year to December 31. These reflected revenue of R106,6 million (R103,1 million the year before), expenditure of R104,6 million (R100 million) and reserves of R26,8 million (R20,3 million).

He said managed care and constant monitoring had proved successful in capping expenditure. "Private healthcare is expensive without the cost being driven upwards through overservicing, incorrect prescribing and inappropriate treatment."

Although overprescribing had been brought under control by most medical aids, fraudulent use of medical aid benefits to acquire products other than medicines from pharmacies still had to be addressed, he said.

Bryant said the new Medical Scheme Act, due to be introduced this year, was also a cause for concern. It threatened to plunge medical aids back into the crisis of three years ago and undermine the financial stability they had struggled to achieve, he believed.

CT(BR) 3/7/98

Zuma rejects proposal on registrar's office

(299)

ADELE SHEVEL

Johannesburg — Nkosazana Zuma, the health minister, had rejected the proposal put forward by the finance department that the Financial Services Board take over the office of the registrar, a healthcare source said yesterday.

The issue is expected to be clarified in the Medical Schemes Bill, due before Cabinet shortly.

Jeff Slome, the managing director of medical fund managers NMA, said some participants in the industry were probably "not overly unhappy with the office where it was" because they would have tighter financial restrictions if placed within the parameters of the finance department.

Sources have said the finance department proposed that the office of the registrar be shifted so that it can be afforded more corporate dispensation. The office administers the conduct of medical schemes under the act. The main function is to administer medical schemes and ensure that they comply with the act.

Medical schemes are regulated through this office but commercial insurance products report to the Financial Services Board, which has the equivalent role of the office of the registrar but falls under the finance department.

Danie Kolver, the registrar of medical schemes and an official of the health department, said about 200 medical schemes were registered with and accountable to this office.

He said the department was working on the Medical Schemes Bill, which industry sources say could be presented to cabinet as soon as next Wednesday.

The bill is supported by the memorandum of objects that covers the main features in the proposed legislation, including the issue of the registrar's office.

An industry source said the health department was intent on having the principles of the bill passed in the forthcoming cabinet meeting.

Medical aid law 'bad for the industry'

Sello Mabotja

PROPOSED amendments to the Medical Schemes Act had stringent and burdensome conditions which could cripple the medical insurance industry, Howard Walker, a joint managing director at Alexander Forbes Health Care Consultants, said yesterday.

Walker said clauses which allowed for a community rating system and the guaranteed issue of medical care on demand could hurt the industry severely.

The clauses are contained in a bill before Parliament now.

In terms of the proposed amendments, there will be a community rating system to control medical schemes to accept members' contribution by using only income and the number of dependants as criteria for membership.

The guaranteed issue clause prohibits the use of age and a potential member's health as determining factors for membership.

Walker said of the two clauses: "Separately they are okay but together they are a problem."

He was speaking at a media briefing on the health care industry in Sandton yesterday.

Walker said the medical insurance industry supported the department's "good objectives" of boosting access to affordable, quality health care and promoting a financially viable private health insurance market.

However, the department's implementation strategy was flawed.

This strategy, he said, posed serious problems which could devastate the industry.

Walker also expressed concern over the proposed 15% restriction on the contribution made to members' savings accounts products.

Walker also lashed out at the department for attempting to practise "tax arbitrage" through the proposed restrictions on the grounds that it was seeking to curb tax abuse and to retain the cross subsidisation of members.

"The issue can be easily addressed and should not form the basis for tax arbitrage," he said.

The department of health was unavailable for comment.

Sello Mabotja (299)

Schemes 'ill prepared' for HIV epidemic

SA's medical insurance schemes were ill-prepared to deal with the calamity which could be unleashed by HIV-related deaths once the disease reached epidemic proportions, the latest Alexander Forbes Survey of In-House Medical Schemes has found.

Of the country's largest 52 in-house and commercial or open medical schemes surveyed, only 33% had conducted an AIDS impact assessment on insurance and medical cover claims.

Although the country had one of the highest incidences of HIV/AIDS in the world, only 46% of the medical schemes provided cover for the disease.

"Pretending that HIV/AIDS does not exist will not make it go away," said Howard Walker, the group's health care division MD.

"Our research has shown that only 46% of the company schemes surveyed have a formal HIV/AIDS policy in place, while an equal number do not.

"The balance have a decentralised policy where some parts of a group have a policy and others do not."

The research found that one in 10 firms had taken no steps to address the AIDS problem, while 10% had contingency reserves to meet potential claims which could arise as result of the epidemic.

Other findings were that 29% of the participating companies covered AIDS-related diseases, while 23% also provided case management for members who suffered from the disease.

The companies which participated in the survey included IBM SA, Engen, Anglo American, Toyota and Metropolitan Life.

BD 9/7/98

Medical aid schemes show financial vigour

ADELE SHEVEL

Johannesburg — Most medical aid schemes had improved their financial position, according to the first survey of in-house medical aids conducted by Alexander Forbes's healthcare consultant division.

Managed care and savings schemes were recognised as effective cost-containment measures in the survey of 52 closed medical schemes.

Closed schemes are those where membership consists only of employees of a particular organisation.

The consultancy said 172 open and closed medical schemes were surveyed.

Managed care and savings schemes help to contain costs, survey reveals

From 1995 to 1996, the operating profit for companies surveyed rose from 38 percent to 60 percent, while operating loss declined from 62 percent to 40 percent.

Net increases in funds' free reserves rose from 70 percent to 85 percent, while net decreases dropped from 30 percent to 15 percent, the survey showed.

Howard Walker the joint managing director of the company, said the survey also showed that managed care interventions were used by most of the schemes.

Of the companies surveyed, 63 percent said they intended to increase the use of managed care techniques.

Within the profile, 27 percent of the schemes offered savings accounts, 33 percent intended to introduce savings accounts and 21 percent intended to offer a full-managed care plan.

But there were areas of concern.

While the recommended ratio of free reserves to income was 25 percent, 52 percent of these had accumulated a funds ratio lower than 25 percent, and 42 percent had fewer than 2 500 members, even though the recommended number was 6 000 members a scheme.

The medical schemes registrar said it was expected that this recommendation would become mandatory.

(299) CT(BR) 9/7/98

Most medical aids refuse HIV treatment

(299) (~~82~~)

BUSINESS EDITOR

ARG 9/7/98

Fewer than one in three private medical schemes offer cover for HIV or AIDS, a survey has found.

The survey of 51 of the biggest in-house medical schemes also found that most employers had not adopted a clear policy to deal with the disease.

Less than half of the companies contributing to the schemes surveyed had a formal HIV-AIDS policy, said Howard Walker, joint managing director of Alexander Forbes Health Care Consultants, which did the survey.

Only one third had done a study of the impact of HIV-AIDS on their staff, Mr Walker said. This meant that most private medical schemes did not even know how many members were affected.

This was disturbing in a country with one of the highest incidences of HIV and AIDS in the world.

"Pretending that HIV-AIDS does not exist will not make it go away," Mr Walker warned. "It is disappointing that only 10% of companies have set aside reserves within their medical scheme to deal with the problem."

Members of medical aid schemes should check the rules of their funds to make sure they were covered against HIV-AIDS, he said.

Transnet workers sick of medical aid scheme

(299) ~~(298)~~ (299)

NCABA HLOPHE

ET (BR) 15/7/98

Johannesburg — More than 14 000 Transnet employees have threatened to pull out of the Transnet Medical Aid Fund (Transmed) to protest against its failure to honour medical bills.

France Marumo, the chairman of the Gauteng branch of the South African Rail and Harbours Workers' Union, said yesterday members wanted to withdraw from Transmed.

He called for an option to engage other independent medical aid administrators.

Transmed, like the Transnet Pension Fund, is mired in a deficit morass that has improved slightly, from R96 million in 1996 to R54 million this year.

The fund still carries a 40 000-strong risk pool of pensioners inherited from the former South African Transport Services when it was commercialised into Transnet in 1990.

Marumo said Transmed had become useless to most union members, who were being turned away by doctors because the scheme did not pay their medical bills.

Petrus Wassermann, Transmed's principal officer, said members' disappointment with the fund was valid and steps had been taken to improve its operations.

He said the fund had already been restructured into a "new-generation scheme" which stipulated a fixed benefit into members' "savings accounts".

"It's not true that we do not pay the medical bills," Wassermann said. "Members use everything in their accounts and face bounced medical bills ... Transmed cannot afford more than the limit," he explained.

☐ **Business Watch, Page 2**

Medical Schemes Bill aims to end risk rating

Josey Ballenger BD 7/8/98 (299)

DRAFT legislation intended to stop medical aid schemes from discriminating against potential members on the basis of age, sex or state of health would have regulations to protect the schemes against opportunistic behaviour which could bankrupt the system, a health department consultant said yesterday.

The Medical Schemes Bill, which state law advisors are expected to certify for publication within two weeks, will outlaw discrimination on the basis of age, sex, past or present state of health, or claims experience other than in special circumstances.

Department consultant Patrick Masobe told a Johannesburg forum that this would remove "risk rating", whereby medical schemes charged different premiums based on age, gender and health status. The bill would impose "community rating" where the only premium criterion would be income.

Exceptions would be provided for in regulations to protect medical aid schemes "against opportunistic behaviour" where people joined schemes only once they became ill or developed a condition. The protections would include a waiting period for pre-existing conditions and premium penalties within defined bands for late joiners.

A list of minimum benefits related to essential and cost-effective cover, a focus on hospital services and full cover for public hospital services, would be outlined in rules to be drafted by a working committee.

Gerald Sweidan, the MD of Pharos Medical Plan who hosted the forum, said the bill's objectives were "very noble" but that the industry would have been more supportive if the bill had been part of a social health insurance bill, as originally envisioned.

Sweidan said the bill got "top marks" for governance because of its proposed requirements for trustees and accredited administrators, an independent audit committee, a council with "more teeth" to augment the current registrar and offences and penalties for fraud.

Small business 'a poor cousin'

Patrick Wadula BD 7/8/98

LARGE corporations and some banking institutions are still hesitant about identifying the small business sector as a potential business opportunity, Eskom small business development officer Jenny Rogers said yesterday.

Speaking at the opening of Eskom's second Small Business Exhibition at Nasrec, Rogers said it was difficult to entice established businesses to showcase their products and services.

Big companies saw the small business sector as being unable to contribute substantially to their bottomline profits.

The exhibition, housing 80 exhibitors, runs until tomorrow and is aimed at providing opportunities for black entrepreneurs to find affordable business ideas and solutions. It also caters for unemployed people who want to start their own businesses.

The exhibition focuses on manufacturing business, agrobusiness and franchising as inroads for small business development.

HEALTH CONSULTANTS

ROUND ONE GOES TO THE BROKERS

(299)

FM 7/8/98

Health Department backs away from ban

Powerful lobbying by the country's major health consultancies and medical aid administrators has caused the Department of Health to rethink its proposed blanket ban on the payment of commission to health brokers.

It's a rare victory for the private sector, which has won very few rounds against Health Minister Nkosazana Zuma.

The department's change of heart on this aspect of the Medical Aid Amendment Bill is largely thanks to a joint submission made by SA's three major health consultancies: Alexander Forbes Health Care Consultants, Aon Consulting and Ginsberg Malan & Carsons.

The trio provides independent advice to Wooltru, Nissan, Volkswagen, Delta, MultiChoice, Nampak and other large employers faced with choosing medical cover from a complex array of options.

The role of the intermediary has expanded over the past 10 years to cover some of the duties of the medical aid administrator, including membership updates, billing and claims handling.

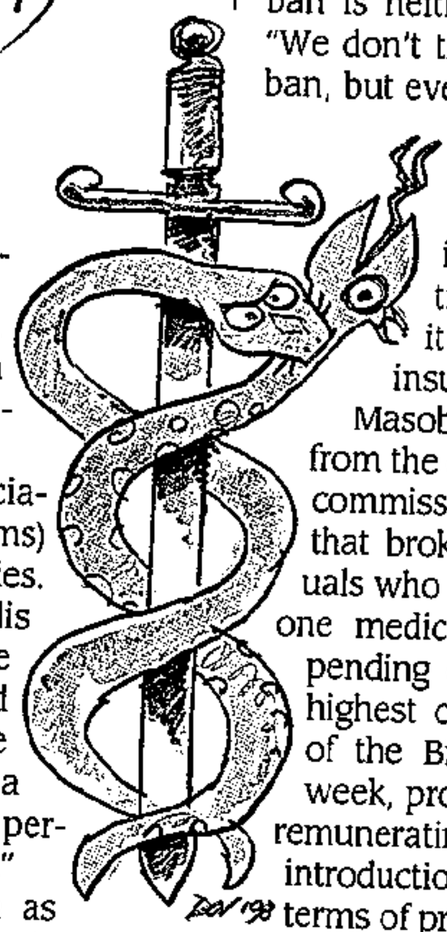
Medical aid administrators generally pay commission to intermediaries of between 2% and 3% of their contribution income, compared to a maximum of 20% in the short-term insurance industry. As many as 30% of open schemes' members are obtained through intermediaries.

The Representative Association of Medical Schemes (Rams) has backed the intermediaries. Rams chairman Keith Hollis says: "Rams has engaged the Department of Health and stated categorically that the payment of commission is a normal practice that should be permitted but should be regulated."

Practised in countries such as Hong Kong and the US, commission payment is unregulated in SA. This has allowed some opportunistic brokers to fleece the public by charging exorbitant fees.

Joint MD of Alexander Forbes Health Care Consultants Howard Walker argues that a blanket ban on commission would harm legitimate businesses. Nor would it be in the consumer's interest since in the absence of independent intermediaries, schemes would undertake their own marketing and members would shift to schemes with good marketing strategies.

Special consultant to the Health Department, Patrick Masobe, who is organising the legislation, agrees that such a ban is neither enforceable nor desirable. "We don't think we can enforce a blanket ban, but even if we could, it will not allow competitive neutrality between schemes." This is because a ban will favour medical insurance products above traditional medical schemes, as it is legal to pay commission on insurance products.



Masobe's thinking is light years away from the department's original view that commissions fuel medical inflation, and that brokers are unscrupulous individuals who shift unwitting employers from one medical scheme to the other, depending on which one pays them the highest commission. The final version of the Bill as passed by Cabinet last week, prohibits a medical scheme from remunerating an intermediary for the introduction of new members, "except in terms of prescribed regulations".

Masobe says the department is establishing a technical team to draft regulations that will probably stipulate maximum levels of commission and require schemes to disclose such payments.

This is in line with the recommendations made by the trio in its submission to the department. They also recommend that the Bill require intermediaries to be accredited to an independent body and that an industry ombudsman be established.

There will be lobbying of the health committee this session of parliament to ensure politicians do not circumvent Masobe's good intentions.

Claire Bisseker

CAPE PULSE *From left, Elaine Clarke of DFPA, Grant Newton, the director of Real Health and Dr Deon Smit of CPC at the launch of the new healthcare company yesterday* PHOTO: ANDREW BROWN

Norwich joins doctors to launch Real Health

CT (BDR) 14/8/98 (299)

VERA VON LIERES

Cape Town — Norwich Healthcare, the managed care company, had united with the Independent Practitioners' Associations (IPAs) to form Real Health, a new company aimed at providing affordable medical cover to low-income earners, the groups announced yesterday.

The partnership between Norwich Healthcare and the IPAs, which represent nearly 80 percent of medical practitioners in the Western Cape (about 800 doctors), is the first of its kind in the province.

The IPAs are made up of the Cape Flats-based Dispensing Family Practitioners' Association (DFPA) Healthcare and Cape Primary Care (CPC).

Grant Newton, the director of Real Health and Norwich Healthcare, said the joint venture planned to provide a product developed with doctors that gave maximum benefits to patients: "It is also aimed at maintaining good doctor-patient relationships and eliminating tensions between providers and funders," he said.

Sulaiman Moosa, an executive member of DFPA Healthcare, said access to affordable healthcare for low earners would have a major impact on health services in the community.

Real Health targets low-income employees who earn a minimum of R1 500 a month in the formal employment sector. Workers have the option to join as individual members or as part of a subsidised employee group medical aid scheme. Monthly medical aid premiums are determined on salary. On average for all income brackets, Real Health's rates were 20 to 30 percent lower than the industry average.

Moosa said employees from typical Western Cape industries would benefit from participating in a formal medical aid scheme.

MEDICAL AID AMENDMENT BILL

FM 14/8/98

PRICING FIX AS ZUMA FLATTENS THE HEALTH CURVE

(299)

People won't be charged more because of their age or health risk

The medical aid industry is gearing up for tough negotiations on the long-awaited Medical Schemes Bill which will fundamentally reform the industry.

The Bill, which should be passed by parliament before the end of the year, aims to reverse the industry deregulation of 1989 by returning to flat community rating. This will prevent schemes from charging people more because of their age or health risk.

The aim is to ensure medical aid remains affordable so the State is not burdened with the aged and sick.

But schemes will also have to enrol all who apply, leaving them (medical aids) little room to design products that are both affordable to the member and financially viable. If they fail to rise to the challenge, the prognosis for the industry is dire.

"While these principles are noble in intent, many of the proposals could spell disaster for the medical benefits industry, which will be obliged to admit and cover members regardless of the downstream impact on their basic business viability and profitability," says Private Health Administrators MD Gerald Sweidan. "Employers will be expected to bear most of the costs. Many may not be in a position to do so. The burden on the State and the public will then be even greater than it is now."

The Bill leaves the key issues to be resolved by way of regulations that are not subject to parliamentary oversight — Health Minister Nkosazana Zuma's preferred way of legislating. However, the department has shown its willingness to consult the private sector by convening a forum on the regulations, which meets for the first time this week.

Key players agree the department has softened on the Bill since the publication of the first draft about a year ago. At the time Momentum Health CEO, Adrian Gore, predicted average premium increases of 30% across the industry if the Bill was enacted. Now, he says: "There's a glimmer of hope that we can work with the department to draft regulations that are flexible enough to enable us to price products attractively."

This is because the department has recognised the problem of antiselection (opting-out) inherent in a system that relies on the voluntary cross-subsidisation of the elderly by the young, and will introduce regulations to minimise this problem.

About 1m South Africans have opted for cheaper new generation products since their emergence in 1993. They differ from traditional medical aid in that they divert about 40% of the member's monthly contribution into a medical savings account to cover small everyday medical expenses. Funds not used up in the savings account in any year can be rolled over into the next, giving members a cash incentive to curb their medical expenses.

Traditional medical aid members have no incentive to curb costs because whatever they fail to spend disappears into the common risk pool to cross-subsidise the sick and old. This use-it-or-lose-it mentality has been a significant contributor to SA's spiralling medical inflation.

However, the department feels the new generation medical schemes are not in the national interest as they poach low-risk members from traditional medical aids, threatening the inherently unstable edifice of cross-subsidisation on which the industry has always relied (see table).

Then the Bill will curtail the use of savings accounts by putting a cap on the percentage of contributions that can be devoted to them. The actual percentage is left to the regulations but the industry expects it to be between 15% and 30%. It must be over 35% for savings accounts to incentivise members to contain expenses.

"A 15% ceiling would sound the death knell of new generation medical insurance products which have played such a critical role in bringing down medical costs in recent years," says NMA Medical Fund Managers MD Jeff Slome "To leave legislation to regulation potentially places enormous power in the hands of the Minister and creates an untenable level of uncertainty within an industry."

Also left to the Health Minister's discretion is the package of minimum benefits which every scheme must offer. The department says it will relate to essential and cost-effective cover only, including full cover for public hospital services, but the industry has no idea of what the cost implications of this key provision will be, says Representative Association of Medical Schemes (Rams) chairman Keith Hollis.

However, the Bill will improve the governance, solvency and financial reporting requirements of schemes.

Claire Bisseker

THE MAJOR SHORTFALL

The medical aid industry's R44bn cross-subsidisation bill

Average monthly medical scheme contribution per pensioner	R280
Average monthly cost to scheme of pensioner	R980
Shortfall that must be cross-subsidised by the young & healthy	R700
Total industry shortfall in 1998	R44bn
Total net assets of medical schemes industry in 1998	R5,3bn

SOURCE: MOMENTUM HEALTH

New medical schemes bill should do you good

(299) ARG 15/8/98

The controversial Medical Schemes bill, to be passed by parliament this year, should give you better protection, though at some cost. ESANN DE KOCK reports on what the bill means for you.

As an individual on private medical aid you will probably benefit more than you will suffer if the new Medical Schemes bill is passed by parliament and becomes law.

Essentially, the bill aims to offer you greater protection.

THE GOOD NEWS

No exclusions

If you apply to become a private medical scheme member, no scheme that you apply to will be allowed to turn you away – providing you can pay your contribution.

At the moment, medical schemes can turn your application down on the basis that you may already be ill and therefore a risk to them, or they may decide that you are too old and will therefore have a high claims ratio.

This is probably the most fundamental change to the bill.

Patrick Masobe, a consultant with the Department of Health and co-author of the bill, says the change is an attempt to build in more protection for you as a medical scheme member and to discourage opportunistic behaviour by schemes that are currently allowed to cherry pick their members.

Not surprisingly, the industry is opposed to this.

In response to their concerns, Masobe says it may be possible to build in certain control mechanisms, such as periods where people with serious health problems will have to pay contributions to the scheme for a period before they can claim medical expenses.

Or, he says, it might also be possible to encourage people to join medical schemes when they are young by instituting penalties for joining late in life.

Better supervision

The overall capacity of the Department of Health to oversee your medical scheme will be strengthened by the establishment of the Council for Medical Schemes as a corporate body accountable to the Minister of Health. The council will be given the power to charge your medical scheme a levy to fund its activities.

You should feel safer as a member of a financially sound medical scheme because your scheme will have certain solvency and reporting requirements. The council will be given the power to monitor a minimum reserve requirement and will be able to suspend the operations of unsound schemes.

Elected trustees

Your interests should be better served in that your medical scheme will have to establish a board of trustees with at least half member representation. Trustees will have to qualify as fit and proper according to a set of criteria and the board will have access to, for instance, accounting, legal and business skills. In addition, the administrators of your scheme will have to be accredited according to objective criteria.

Minimum benefits

Your private medical scheme will have to provide a certain set of minimum benefits which relate to essential cover and cost-effective cover. Masobe says there is some concern over the power that the minister has to prescribe these benefits. He says a technical working team has been instructed to come up with proposals on which types of benefits would be appropriate.

THE BAD NEWS

You'll pay more

You will probably end up paying more for your medical scheme membership. This is because the bill proposes that medical schemes should not be allowed to exclude anyone that applies for membership – whether they are 70-years-old, are HIV positive or have a family history of serious disease.

A medical scheme with a heavy loading of sick and elderly people will face more claims and will have to spend more money. This means its members will probably have to pay higher membership fees to cover these expenses.

Limits on saving

The "new generation" schemes which allow you to save by limiting your day to day medical expenses will have to place a limit on these savings accounts and will have to ensure that, if you want to withdraw money from them, it should only be for health purposes. The limit on savings accounts has to be defined in regulations.

Masobe says the Department of Health is discussing the bill with the medical schemes industry before finalising these regulations.

DEFINITIONS

New generation medical schemes recognise that there are two reasons why you join a medical scheme: To have some form of long-term medical insurance and to have an account for day-to-day medical expenses. A new generation scheme offers you both. In other words, a portion of your monthly medical premium goes towards funding for expensive medical treatment, such as surgery and being admitted to hospital. The other part is paid into a savings account which you use to pay for day-to-day medical expenses such as a visit to your general practitioner when you have flu. The idea behind this is that you have some control over how you spend the money in your savings account. The money in these accounts attracts interest and some schemes allow you to withdraw your unspent contributions. This means they are often an attractive option to encourage you to moderate your claims.

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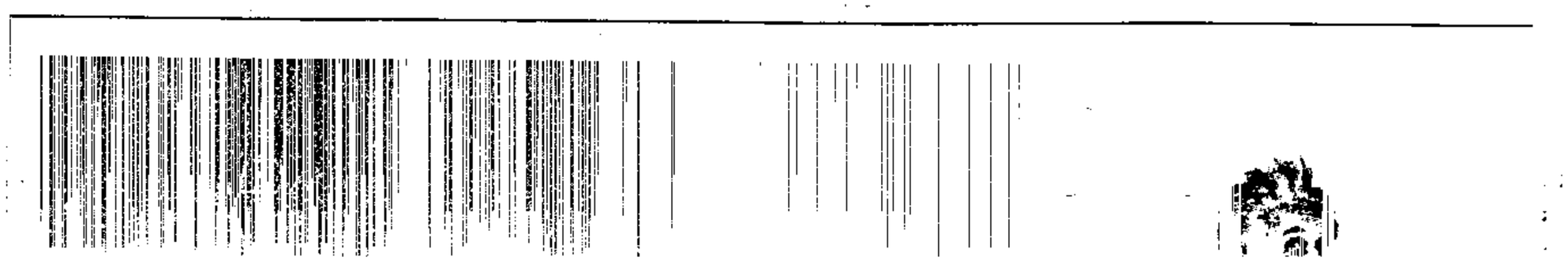

Industry player says new medical aid bill simply won't stick

(299) ARLT 15/8/98

You may be impressed with what the Medical Schemes bill will offer you but not everyone in the medical industry likes it.

While many medical schemes support the noble objective of the bill to bring quality and affordable healthcare to everyone, some say the Department of Health has "selectively leaked" the bill to gauge opinion.

Patrick Masobe, a consultant with the Department of Health, says he is satisfied that the department consulted widely with key players in the industry, including the Financial Services Board and the Representative Association for Medical Aids (Rams).

But one of those who believe the opposite is Jeff Slome, the managing director of NMA Medical Fund Managers and a member of Rams.

Slome says the impact of the bill will be important to both individuals and business but few people outside the industry have any idea of what is being proposed and are therefore unable to comment properly on it.

He is concerned that the bill will be rushed through parliament.

He is also worried that some key issues will be left to be determined by regulation, such as the maximum and minimum benefits that can be offered to you by your medical scheme, and the percentage of premium that can be devoted to members' savings accounts.

"To leave legislation to regulation is, in my opinion, a rather dangerous policy.

"Regulations, as we all know, do not have to go before parliament for debate and the minister or Council for Medical Schemes could impose unsatisfactory regulations at will.

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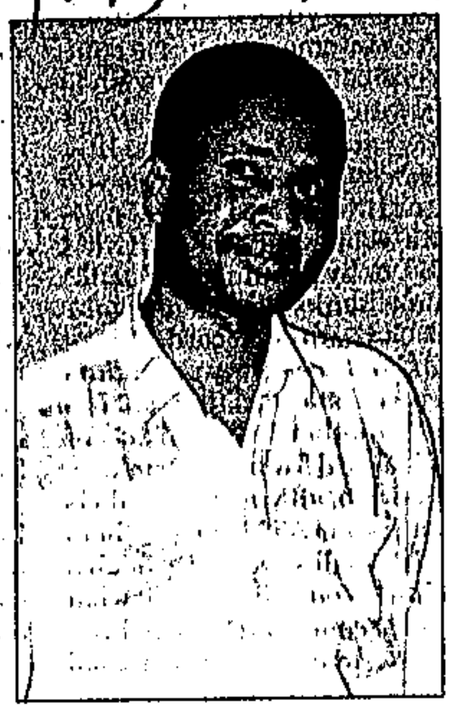

Patrick Thokwa Masobe

Leaving fundamental issues to be determined by regulation, says Slome, will not promote stability in the industry. He says indications are that the government favours a system where the percentage of contributions which may be used for a savings account will be regulated.

"We hear figures of between 15 and 30 percent being bandied about, when we know that the medical savings account percentage has to be 35 percent or higher to work as intended – ie to incentivise members to contain expenditure."

Slome says a 15 percent ceiling on savings accounts would sound the death knell for the new generation medical insurance products, which have played an important role in bringing down medical costs in recent years.

A further problem, he says, is the proposal to limit the registration of new schemes, unless they have more than 6 000 members.

"This is, in effect, a restriction on the free market. While I understand that some basic protections ought to be in place, this is not one of them."

Slome says he has clear evidence that schemes with fewer than 1 000 members are working and that they are financially viable.

"The Department of Health is barking up the wrong tree. If they are truly concerned about the viability of medical schemes, the emphasis should, for example, be on who promotes the scheme and what administrative capacity the company has, and whether a company has a business plan which includes a financial forecast."

Slome says the solutions to these problems include wider consultation by the minister and the publication of a medical schemes amendment bill, along with a clear timetable for implementing a new healthcare act.

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"Instead of bringing out an act which gives overwhelming powers to the minister and which is overly protectionist, give us an act which leaves us the freedom to move."

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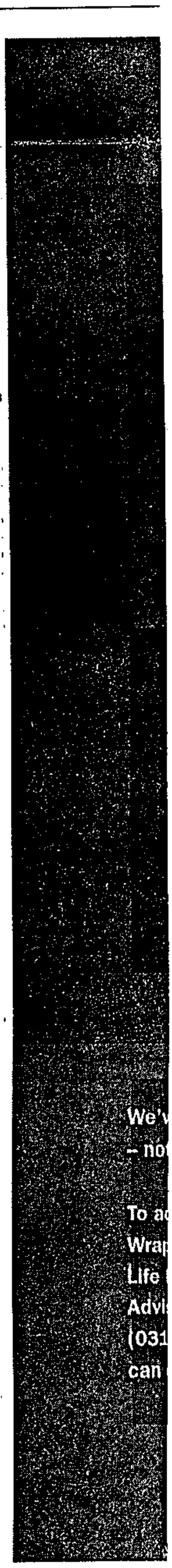

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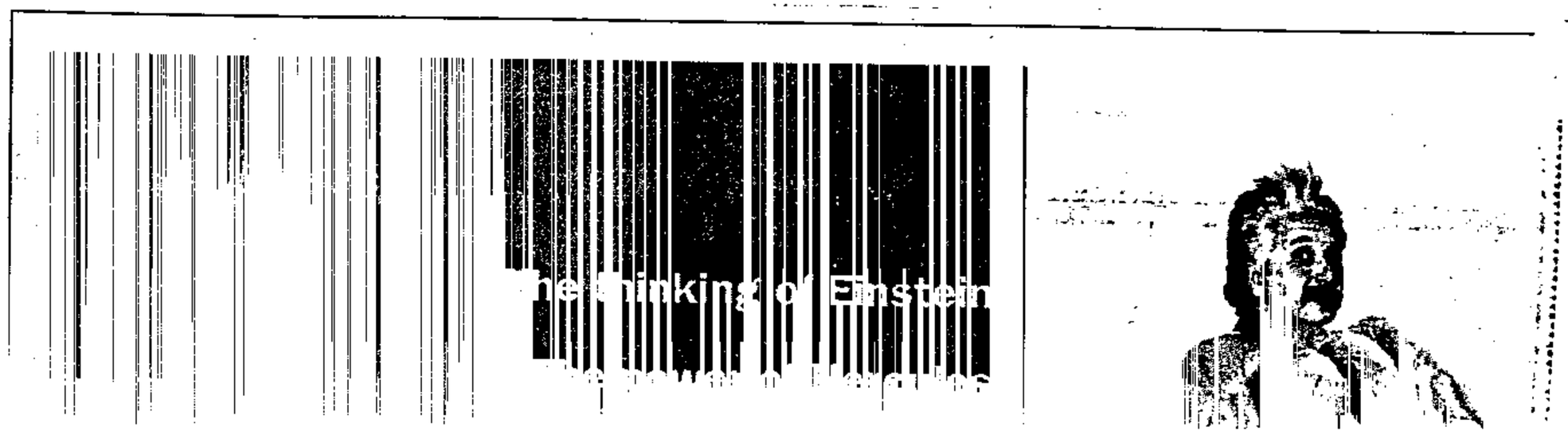

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Medical aid proposals enough to cause heart failure

ST(BT)16/8/98

Higher fund contributions could be in store for members, writes TERRY BETTY

(299)

OH NO! Now Dr Zuma has her eyes on your medical aid fund. The new Medical Schemes Amendment Bill will result in higher medical aid premiums and worse, could even send the industry back into the financial mess of 10 years ago.

Health Minister Nkosazana Zuma has taken the unusual — and some say sneaky — step of presenting the highly controversial Bill to cabinet for a rubber stamping before putting it through the standard parliamentary procedure.

The Bill is expected to be passed by Parliament and be legislated in October this year.

In an undemocratic vein, the Bill has not been released to the public for comment. Only a few industry insiders have gleaned its secret contents.

Broadly, it's expected that the Bill will reintroduce principles which have long been passed over by the industry in favour of more efficient and cost-saving methods.

The contents of the Bill are expected to include:

□ **Everyone will pay the same premium regardless of age or health.** Dan Pienaar, managing director of Liberty HealthCare, says this means an 80-year-old member with cancer will pay the same monthly premium as a healthy 20-year-old member.

Members currently pay premiums in line with their individual risk.

□ **Guaranteed acceptance into a medical aid.** No one will be turned away from joining a fund. "This means an applicant with a chronic disease can join the scheme at any time and will pay the same premium as a long-standing member," says Pienaar.

□ **The scope for using medical savings accounts may be reduced.** Introduced in 1994, the popular medical savings accounts are considered to be the main reason medical aid premium increases have been contained — by reducing fraud and giving members an incentive to cut back on medical costs.

□ **The term "dependants" could be widened to cover anyone who is financially dependent on the fund member and living under the same roof.** The exact number of dependants will be difficult for the medical schemes to verify.

Many in the industry say the proposals could reverse the industry into the rampant medical inflation of 30% plus experienced in the 80s and early 90s. Specifically, the effects of the Bill are likely to be:

A dramatic reduction in medical aid membership

Pienaar says research and overseas experience has shown that the above principles will result in a mass exodus of young and healthy members from medical aids, who will re-enter the system only when they are sick.

(A meeting was held in Pretoria this week with the health ministry and medical aid industry to find ways to prevent "anti-selection".)

Premiums will rise dramatically

Adrian Gore, chief executive of Momentum Health, says: "The exodus of young, healthy members means those remaining will on average be older and sicker, necessitating a rise in average premiums."

The restricted use of medical savings accounts could see increased spending and fraud. Also, there will have to be premium increases to meet the cost of treating HIV-positive members.

Medical aids may be financially vulnerable

Claim costs will rise, and member premiums will not be able to compensate by taking account of risk factors such as age.

Gore says that for the medical aid industry to survive, it needs to keep attracting young, healthy people.

Gore points out another fact that is deeply disturbing: the Bill makes broad statements but with no detail of how these objectives are to be achieved. The detail has been left to regulation, which the Health Minister publishes by way of government gazette.

This means Zuma has retained control and the regulations could change at her whim, providing little protection or certainty for the industry or fund members.

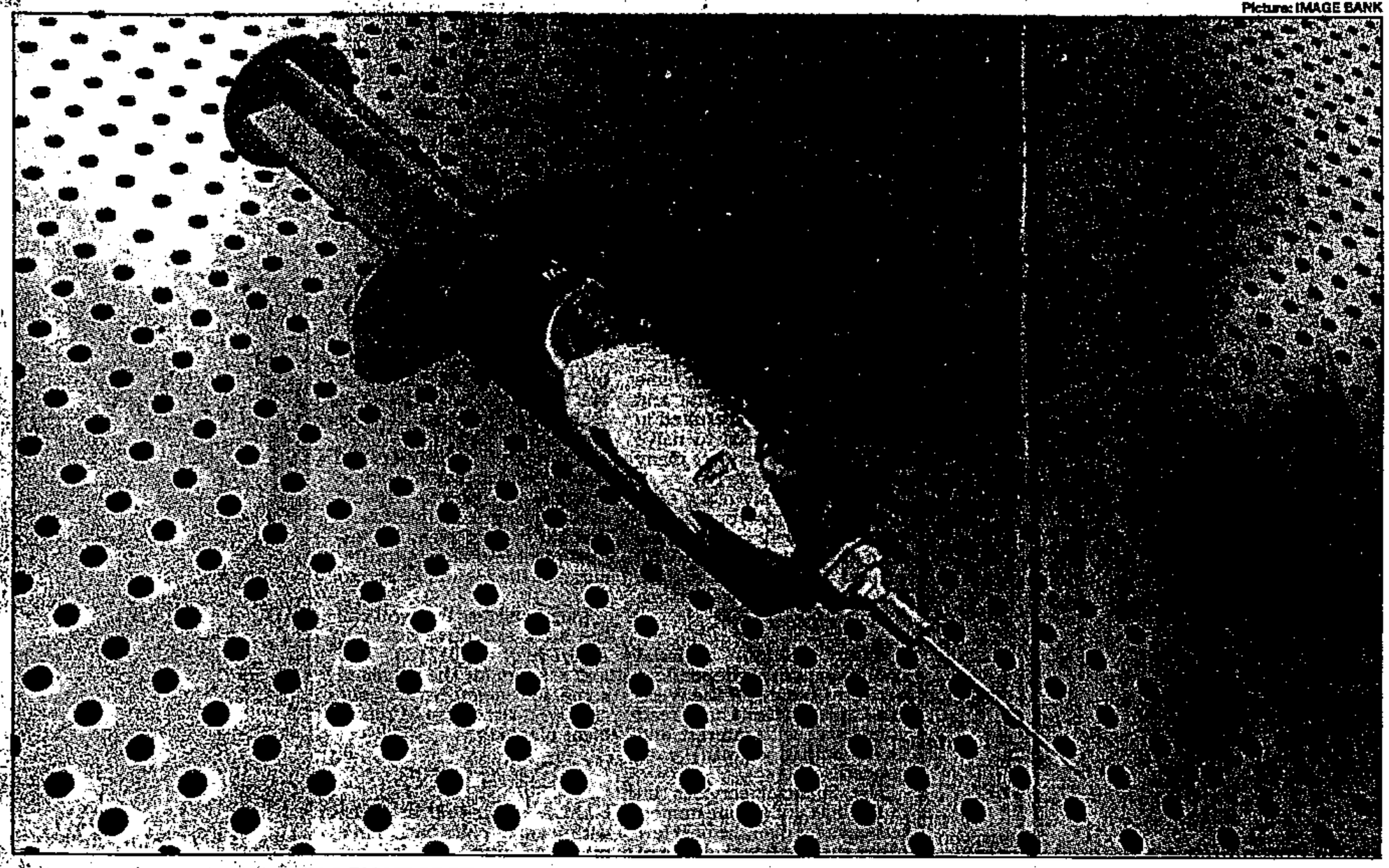
Many within the industry are perplexed about why the Bill is needed in the first place — after all, the medical aid industry is in a healthier position than it ever has been.

Over the past five years premium increases have halved, net assets have doubled and membership is increasing at a faster rate.

So why is this Bill being pushed through Parliament in such a rush before the detail has been finalised, before the financial implications have been analysed, and with proven models being ignored?

Industry critics say it's because of next year's general election — the government has to demonstrate it has delivered on its 1994 election promise. And health is the only social card they have to play.

Picture: IMAGE BANK



IN A TIGHT SPOT ... medical aid members could be in for some harsh changes

ON THE BLUE COLLAR ROUTE

Managed care is gaining acceptance among black doctors as a way of making medical cover accessible to the 12m who have jobs but cannot afford traditional medical aid.

The medical aid industry is working feverishly to design low-cost medical aid products aimed at the emerging market, its largest potential growth area (see graph).

Norwich Healthcare has taken the plunge by establishing a new company — Real Health — to form joint ventures with key independent and black doctors around SA by the end of the year.

Many managed care companies have signed contracts with doctors, but Norwich Healthcare is the first to make them shareholders in a specially created joint venture company aimed at providing medical aid to the masses.

So far Real Health's partners include the Soweto Independent Practitioners' Association (Soipa), Clinicross — which represents 290 doctors on the East Rand, the KwaZulu-Natal Managed Care Coalition and 80% of doctors in the Western Cape.

The Western Cape partners are the Dispensing Family Practitioners' Association (DFPA) — which represents most of the GPs on the Cape Flats — and Cape Primary Care, which represents a further 560 GPs.

Real Health — funded by Norwich Healthcare and the Erica Medical Aid Society — will market, administer and fund a medical aid product which is priced at 20%-30% below the industry average (across all income groups) and is targeted at workers who earn at least R1 500 a month.

It offers a wide spectrum of benefits, including full hospital cover but excluding specialised dentistry and optometry.

The product is priced affordably because doctors share some of the financial risk of caring for each patient and members may only visit these doctors.

They are paid a fixed annual fee (a capitation fee) per patient irrespective of how many times the patient is treated. This gives the doctor an incentive to manage the patient's health in the most cost-effective manner possible.

Doctors also have to subject their practice habits and clinical decisions to peer review. In exchange, they are paid upfront and share in any savings achieved by the scheme (90% of the savings go to the doctor and 10% used to build the scheme's reserves).

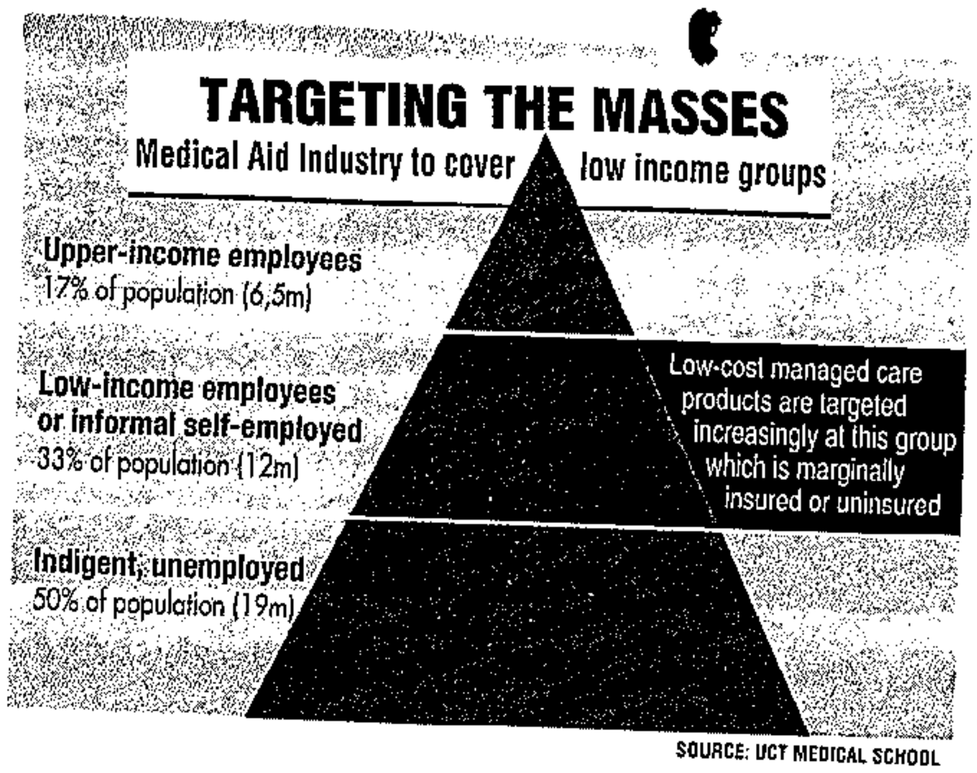
Costs are also cut on medicine due to doctor groups' bulk buying power and by eliminating some of the profittaking in the pharmaceutical supply chain.

For township doctors, who charge — on average — R68 or less per consultation, the remuneration tariff they have negotiated with Real Health represents at least a 40% increase. They may also sell Real Health's medical aid product to their patients, meaning that they will be able to convert cash-paying patients into medical aid members for a minimum monthly contribution of R185.

"Access to affordable health care for low income earners will have a major impact on health services in the community," says DFPA executive member Dr Sulaiman Moosa.

However, previous capitation schemes run by the Care Corp and Medimo have been spectacular failures. "Real Health is different in that the medical scheme and the doctor share in any savings the scheme makes, denying the administrator the ability to skim the profits off the top as has happened in previous models," explains Real Health director Grant Newton. By the end of the year, Real Health aims to have established more than 10 joint operating companies with the key doctor groups in each province.

Claire Bisseker



SOURCE: UCT MEDICAL SCHOOL

Bill is a bold move to regulate a politically sensitive sector

Health Minister Nkosazana Zuma faces a dilemma, as do most health ministers, in trying to design a health system which effectively integrates the public and private sectors.

The Medical Schemes Bill is a bold move to regulate an important industry, and not a disaster, argues **Gary Taylor**

(299) BD 16/9/98

THE long-awaited Medical Schemes Bill, published for comment last week, is significant in that it repeals the original act of 1967 and all eight subsequent amendments.

As with most post-apartheid laws dealing with the workplace, the prelegislation process has been fraught with controversy — something with which the minister of health is by now familiar.

Its most vociferous critics have orchestrated a strong campaign against the draft bill that has leaked to stakeholders and press in a process frustrating to all. The insurance antilobby has polarised itself against the more accommodating medical aid schemes, and the debate is complicated by personalities and vested interests.

The advent of the bill comes as no surprise to the industry, which got a foretaste in 1995 with the report of the commission of inquiry into a national health insurance system. Ironically, in view of the controversial nature of such compulsory cover, the system is unlikely to see the light of day until well after the elections.

Health Minister Nkosazana Zuma faces a dilemma, as do most health ministers, in trying to design a health system that effectively integrates the public and private sectors. Most of the private sector would prefer to regulate their own affairs, and have the minister sort out the seriously deteriorating situation in public hospitals.

The reality is that the two sectors cannot be separated, and both policy and resources need to be aligned in the face of efficiency and hugely powerful multinational interests. Health care is a multimillion-dollar global industry that is not easily re-engineered, as First Lady Hillary Clinton learned in her first year in the White House.

Our country spends 8,5% of gross national product on health care, and most agree that the quantum is correct, but not the system. The time has come for a shakeout of an act dating back to 1967, and Zuma has never been afraid of pursuing her goals.

Her logic behind the bill is clear. If the department of health cannot get additional money to do what she needs to, the next best thing is to use her existing budget on fewer patients. Not only does the private sector spend as much as she does on less than half the patients, but she complains that they have been dumping their high-risk uninsurables on state facilities.

Some insurers would deny this, but their opposition to the new open enrolment provisions in the bill reveals their fear of a return to the private sector of those uninsurable patients who can no longer afford private care.

This clause allows anyone entry into an open or multi-employer medical aid. On its own, this right would appear to open the floodgates for the old and sick to re-enter medical aids to which they have not contributed. The fear also exists that the young and healthy (who usually cross-subsidise the higher claimers) will leave medical aids now for cheaper insurance products, only to return when they want to claim.

Exclusions

These fears are exaggerated for a number of reasons. Firstly, the bill states that people can join an open scheme (as individuals) only if they have been members of another scheme for two years. In addition, they can do so only within three months of changing employment. Outside of these provisions, waiting periods and exclusions can be imposed to prevent antiselection.

Larger employers who have an in-house medical scheme are exempt from the open enrolment rights of individuals, as theirs is classified as a "restricted membership" scheme. Some groups might want to take advantage of restricted status, which is available to definable trades, professions, industries, and unions.

Industrial relations practitioners who fear the centralised bargaining implications of a union-only scheme can draw some comfort from the fact that the required R5m financial guarantees will make union-based schemes unlikely to materialise in great numbers.

Somewhat lost in the lobbying have been the very welcome regulations on governance, which now place fiduciary duties on medical aid trustees in the league of the Pension Funds Act amendments and the King report.

The disasters of fly-by-night schemes and the effect of subsequent unpaid bills on ordinary families have made these amendments most appropriate. The spectre of a fine and five years' imprisonment as penalties under the bill will make even management-appointed trustees reconsider their roles as trustees.

Employer liability for medical aids has been of growing concern, with several listed companies conforming to the AC305 guideline and making provision in financial statements for millions of rands. The new bill firstly requires that at least 50% of trustees must be elected by members, and then states that a registered scheme becomes a body corporate which must "assume liability for and guarantee the benefits of its members".

This clause clearly shifts the focus on to the human resources department to determine whether the employer has created a liability by promising a benefit. If no such benefit is guaranteed, the employer cannot be held liable for the funding in the scheme itself.

Employers will need to make some pragmatic decisions when it comes to subsidising dependants on their employees' medical aids. In addition to listing the spouse and children, the bill includes as a dependant "any other member of the immediate family who resides with the member, who is not self-supporting and who is dependant on the member for family care".

In addition, the prohibition (similar to the Labour Relations Act) against unfair discrimination extends to "race, gender, marital status, ethnic or social origin, sexual orientation, disability and state of health".

The reference to "marital status" now means that a partner — gay or heterosexual — who chooses not to marry, cannot be denied rights of being a dependant.

For those who feared the inclusion of traditional healers in Zuma's new dispensation, the bill firmly restricts payments only to practitioners registered under the law. For some while come, this will exclude from medical aid bene traditional healers and other "fringe" forms of ternative medicine.

A relief for many who have gone the "new g eration" design path is that personal savings counts are here to stay, although their scop likely to be curtailed in regulation. There is cl evidence that savings accounts have enjoyed p ular support from members and led to short-te cost reductions. At the same time, the medi profession has expressed concerns that memb are making "clinical" decisions to avoid sh term preventative costs (such as breast prostate examinations) only to exacerbate lo term curative costs (such as cancer).

If your employee benefits broker/consulta criticises the bill, you can understand why. . though outlawed, it is widespread practice for t consultant involved in placing your company w a scheme, to receive 2% of the premium ev month. The department is loath to see million health care rands being clandestinely paid in turn for scarce membership in a declining m ket. The bill plans to regulate this aspect of t market, which it is unlikely to wish away.

Comfort can also be drawn from the accre itation of medical aid administrators by t Council for Medical Schemes. With the demise Medilife, Medimo, Hippocrates and the Care C poration in one year, the prudence of outsourci this function was under question. Several oth administrations are in trouble, and the accre itation system will certainly give greater assu ance to consumers.

In summary, the bill is a bold move to regula an industry, which enjoys substantial tax reli and which deals with the politically sensitive i sue of health and wellbeing.

Several questions are still unanswered b cause of impending regulations, but the bill is n the disaster predicted by the prophets of doom.

□ *Taylor is Medscheme's director: human r sources and public affairs.*

New legislation promises...

Health and justice for all

Alex van den Heever defends the new Medical Schemes Amendment Bill

(299) BD 18/9/98

THE Medical Schemes Amendment Bill, currently before Parliament, proposes to significantly improve access, oversight and governance for medical schemes. Many changes have occurred in this environment over the past 10 years, most of them harmful to continuous coverage and protections for vulnerable groups.

The essential features of the proposed Bill are:

☐ To expand access to medical schemes, especially for the elderly and sickly who currently tend to be excluded — often despite the fact that they have contributed all their lives to a medical scheme. This is to be achieved by means of reinforcing a system of community rating and nonexclusion (also termed open enrolment or sometimes, incorrectly, guaranteed issue);

☐ Community rating will require that contributions be differentiated only on the basis of income and number of dependants. This will remove the current ability of schemes to charge older members substantially higher contribution rates;

☐ The policy of nonexclusion reinforces community rating by requiring that medical schemes cannot exclude applicants who are able to pay the average contribution. This limitation will apply to both restricted membership schemes (employer/profession-based schemes) and open schemes, albeit in a different manner;

☐ For open enrolment schemes, the bill provides for appropriate protection to be placed in regulation to deal with the tendency within a voluntary environment, where there is some form of open enrolment, for people to deliberately apply for membership of medical schemes and be admitted only when sick or at an advanced age (often termed adverse selection). This is intended to protect other members and medical schemes against unfair and opportunistic behaviour;

☐ To protect against the tendency for medical schemes to limit or diminish cover for catastrophic medical costs and needs, the bill provides for prescribed minimum benefits. This is intended to protect members from suddenly finding that they no longer have cover for major medical events, and prevents inappropriate cost-shifting onto the public health system. It will also prevent medical schemes from being able to discriminate against certain members or groups by manipulatively designing benefits;

☐ The minimum benefits and other protections are regarded as important to cater for the emerging environment, where genetic testing will be used by the insurance industry to underwrite and/or exclude certain people from cover on the basis of inherited disorders. In most societies such practices are regarded as abhorrent and curtailed by legislation. This is because no-one should be discriminated against on the basis of something over which they have no control;

Access to schemes will not be reserved simply for the young and fit

☐ Continuation cover for limited periods for those who lose their jobs, or after the death of the principal member, is provided for. It also regulates the transferability of membership between medical schemes. The latter limits the application of waiting periods or conditions to be applied to transferring members where they have been a member, or a dependant member, for a period of two years;

☐ With respect to dependants, the bill expands the definition to include "any minor child who resides with the member, who is not self-supporting and in respect of whom the member is legally liable for family care", and "any other member of the immediate family of the member who resides with the member, who is not self-supporting and who is dependent on the member for family care"; and

☐ To protect medical schemes from undue manipulation by administration companies, 50% of the board of trustees (formerly management committees) will now have to be made up by elected scheme members. This provision will apply to open and closed schemes.

In addition to the above, the bill provides for a strengthening of the Office of the Registrar and the Council of Medical Schemes, the accreditation of administrators, greater powers given to the office and council to deal with undesirable business practices, prohibitions on the reimbursement of brokers from the funds of a medical scheme, and stricter provisions relating to solvency and other financial soundness requirements.

The bill obviously treads on many toes, and represents a clear threat to many unwholesome practices that are the norm within the market. If it did not, it would not be of much use. Attacks on the bill typically suggest that costs will increase as the young and healthy drop out of cover — assertions that are clearly exaggerated. Nevertheless, those schemes where expansion has been rapid due to cream skimming (allowing only the young and healthy to join) and cost-shifting onto community rated schemes or the state, will now have to compete on more even terms for members: they will have to accept a broader range of risks. In fact, for the first time, many commercial schemes will have to face the prospect of competing on the basis of cutting medical service costs, something they are not relishing. After all, it is so much easier just to keep reducing the cross-subsidies.

However, it should be clear the latter only avoids dealing with the central problem facing cover in the private sector: that of cost increases driven by retrospective fee-for-service reimbursement. Ultimately there are only a limited number of groups to discriminate against before the exercise becomes blatantly self-defeating. If one continues with discriminatory practice as a cost-cutting measure there will be fewer people, but continuing costs. Worse still, those doing the discriminating will inevitably become the victims of a lack of cross-subsidisation at a future date — when they become older and sicker and need it most.

This bill represents a fundamental step towards creating a fair health system where access is improved, discrimination removed, and where for the first time consumers are given effective protection.

☐ *Alex van den Heever is a member of the health department's working group on the Medical Schemes Act.*

Rushed, dubious bill augurs slow death for medical schemes

BD 21/9/98

(299)

Dr Brian Brink warns that the new Medical Schemes Bill is fundamentally flawed

BUSINESS Day's recent editorial and analysis in support of the Medical Schemes Bill is fundamentally flawed in failing to recognise the possible adverse consequences of the contentious concepts contained in the proposed legislation.

Your oversight is aggravated by failing to comment on the manner in which this bill is being bulldozed through Parliament without proper consultation.

The policy changes proposed by the minister are so radically different to the present dispensation that an entirely new act is required to replace the existing legislation, which is 31 years old and has been amended eight times. The fact that there have been so many amendments points to the difficulty in properly regulating this complex and emotive field.

The National Assembly has a duty to facilitate public involvement in its legislative processes, yet interested parties, which must include all employers, unions and members of medical schemes, have been given less than three weeks to assimilate and understand this complex piece of legislation. Even more astonishing, the portfolio committee on health has set aside just two days (one a significant religious holiday) to hear oral evidence regarding the new bill. The closing date for all submissions is 21st September 1998.

Why the indecent haste to rush this legislation past an unsuspecting public into the statute books? Where is the open and transparent political process that we have been promised by government? Perhaps it is that the measures proposed would not withstand proper public scrutiny.

The main problem with this bill is that, under the guise of "social solidarity", it prescribes a triple cocktail of measures, which may prove lethal to private health care insurance. We all recognise and support the health minister's best intentions to improve access to medical scheme membership for the sick and the elderly at an affordable price. Yet these noble intentions stand a good chance of being defeated by a combination of bad ideas, which will drive medical scheme costs beyond the reach of the average employee — and, importantly, the average employer.

There are three concepts that give rise to the greatest problems:

The inclusion of all immediate family members living in the same household as ordinary dependants will significantly increase the costs of the scheme without an appropriate and corresponding increase in contributions to be paid by the member concerned.

The bill does not allow for differentiation between adult and child dependants in the determination of contributions, or differentiation on the basis of age. High cost individuals such as females of child-bearing age and grandparents will be entitled to membership at the same rate as all other dependants – normally children.

The average cost of dependant membership will increase dramatically for all members. The winners will be those with extended families; the losers with small families will presumably leave the medical scheme when they realise that the cross-subsidy they are required to pay is too onerous. In time, the winners will also become losers.

The concept of community rating as intended by the bill (but not properly worded as such) is that medical scheme contributions may only be raised on the basis of family size and income.

This "pay as you go" funding philosophy relies on a large cross-subsidy from young to old. The concept can only work if it is underpinned by a constant influx of young members, who are prepared to contribute substantially more than they claim.

Such community rating usually requires a compulsory membership environment to ensure that there is an adequate supply of young members. However, the bill specifically provides for voluntary membership (open enrolment) coupled with guaranteed access, regardless of state of health, for all individuals applying to join a medical scheme.

The likely outcome of this regulation is that young members will withdraw from medical schemes because of the high cost and only rejoin when they anticipate high medical expenditure, knowing that they must be accepted. While there may be some protection in measures designed to reduce anti-selection, such as waiting periods, these are unlikely to contain the inevitable rise in costs to the remaining membership.

The cost spiral so created will drive more low claiming members out of medical schemes, thus defeating the object of expanding access to private health care cover for more people.

Most employer-based medical schemes have seen progressive ageing of their membership over several years. This means that those members, who over-contribute when they are young, will find that there are fewer young members to pay for them when they are old.

Unless the medical scheme has adequately reserved for ageing of the membership (and none of them have), the unfortunate member will end up paying twice for the increased (and predictable) health care costs of old age.

This was the main reason for the collapse of the Mines Benefit Society, which was community rated in the same way as is being proposed in the Medical Schemes Bill. Experience has shown that this form of community rating is unsustainable in the long term.

A further concern is that enforced community rating will aggravate the situation with regard to unfunded post-retirement liabilities. New accounting standards require employers to declare these unfunded liabilities on their balance sheets. The amounts of money involved are staggering. Any employer that has promised to pay a proportion of the medical scheme contribution will be exposed to increased and unmanageable cross-subsidy liability for post-retirement medical costs as a result of enforced community rating.

The provision for minimum benefits being not less than benefits provided for by public hospitals will undoubtedly increase costs for many schemes serving low-income earners. Low-cost schemes will typically have to remove any limits they might have on hospital benefits. Then they will no longer be low cost schemes.

What is more disturbing is that the bill provides that no limitation will apply to the payment of any relevant health service obtained by a member from a public hospital.

This in effect legislates guaranteed payment for any service rendered by a public hospital at whatever price the state chooses to charge. It can be expected that public hospitals will exploit this provision to raise additional revenue outside of their normal budgetary constraints.

Members will always have a mechanism to bypass any limits that may have been imposed on services obtained from private health care providers.

The combination of the above three factors is bound to raise the cost of medical scheme membership beyond affordable levels for employers and for average employees. The inevitable result will be that employers will change their basis of funding healthcare from a defined benefit promise towards a defined contribution, which will only escalate at the rate of salary increases.

Hence employees, including the millions of trade union members, will bear the major brunt of the increased costs.

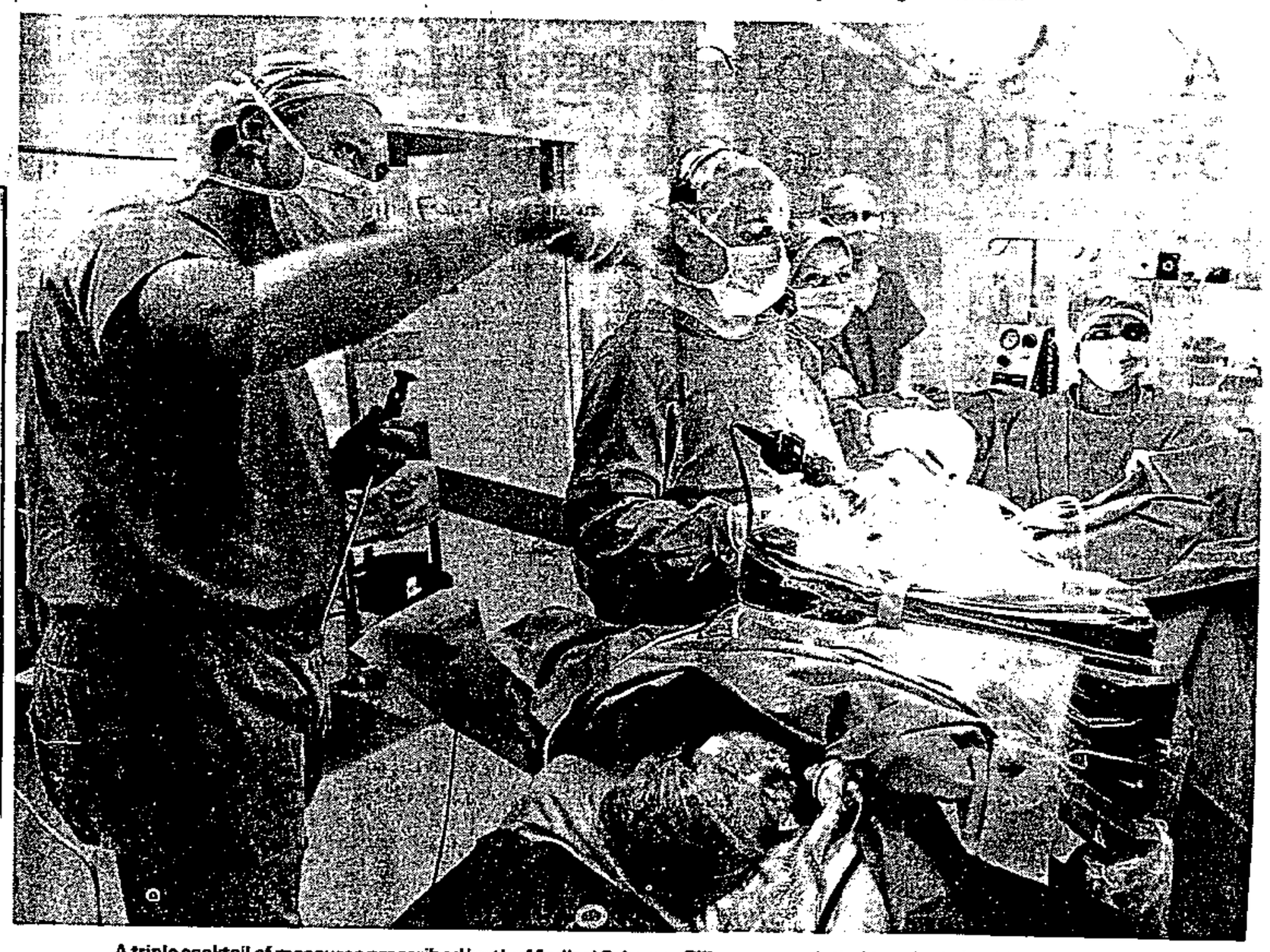
Has the department of health carried out an independent analysis of the economic impact of the proposals, let alone an actuarial evaluation of the long-term sustainability of medical scheme funding in the new environment?

Certainly any business, which made proposals such as these, without taking such basic financial evaluative steps, would be liable for legal, and shareholder action and would rapidly become bankrupt.

The promise of expanding access to medical schemes for the sick and the elderly, at contributions less than the actual cost, is a political winner, and hence the indecent haste to get the bill through Parliament before anybody asks any questions. But as is always the case, somebody will have to pay – and as always it will not be the wealthier members of society who are hardest hit.

The minister of health must delay the introduction of this legislation until employers and members of medical schemes have been properly consulted. During this process, all the parties involved must seek a solution to the legitimate concerns of government in a way which will not cause the funding of medical schemes to become financially unsustainable.

□ Brink is senior medical consultant at Anglo American.



A triple cocktail of measures prescribed by the Medical Schemes Bill may prove lethal to private health care insurance.

Call for withdrawal of Bill from Parliament

(299)

THE Medical Schemes Bill should be withdrawn from Parliament and referred to the National Economic Development and Labour Council (Nedlac) because employers have not had enough time to debate it, Business South Africa (BSA) told the health portfolio committee on Friday.

BSA spokeswoman Dr Lettie la Grange told the committee that this was in fact compulsory in terms of the Nedlac Act because of the significant impact the Bill could have on business.

It should have gone there before it went to Parliament, she said.

The committee held two days of hearings on the Bill which introduced a system of community rating and non-exclusion from medical schemes.

Community rating means contributions can be based only on income and the number of dependents, not on age or health status.

BSA said in a written submission to the committee that the Bill should be subjected to independent economic analysis to establish its effect on the private health sector.

It was far too prescriptive, and members and employers should be allowed discretion to agree on appropriate and affordable benefits.

La Grange, who is a health adviser to the Chamber of Mines, said BSA refuted claims that its members dumped old and poor patients on the state.

The Actuarial Society of South Africa said in a submission that its analysis showed that the Bill would not increase the number of people covered, or reduce the cost of coverage.

Community rating would result in a spiral of increasing contributions as healthier members left schemes, while guaranteed membership, combined with the hike in contributions, meant younger people would not buy cover and that the number of individuals covered would drop by 11,5 percent.

Partners must be included in medical plans

(299)

THE definition of "dependant" in the Medical Schemes Bill should be expanded to include partners in customary marriages and same sex relationships, as well as unmarried couples, the parliamentary portfolio committee on health was told yesterday.

The Human Rights Commission said in a written submission to the committee hearings on the bill that it had received several complaints of unfair discrimination in medical aid schemes. BD 22/9/98

This discrimination had taken place despite the provisions of the constitution, and the schemes had promised the commission they would review their rules.

"However, the commission has perceived an absence of commitment and urgency on the part of the schemes to... bring the rules and regulations into line with the constitution."

At present, the definition in the bill includes a spouse, minor children and other immediate family members who are not self-supporting.

The commission said the High Court had recently ruled that exclusion of a same-sex partner from medical scheme benefits was unacceptable.

The bill seeks to place schemes under the authority of a statutory council.

It also aims to expand access to the medical schemes, especially for the elderly and sickly, and to make it easier for schemes to contain costs.

Congress of South African Trade Unions deputy president Connie September told the committee that regulations promulgated without advanced publication and comment should be valid for only a limited time, during which public comment could take place.

If regulations were then not promulgated again, they should lapse.

— Sapa.

Cosatu wants workers who lose jobs to be able to continue on medical aid

(299)

By Jovial Rantao
Political Correspondent

Cape Town – Cosatu has expressed strong support for the Medical Schemes Bill but has called for the bill to be amended to allow workers who lose their jobs to be covered until they find new employment or they enroll in another scheme.

In a submission to Parliament's Portfolio Committee on Health, Cosatu said an amendment to the Labour Relations Act should be crafted so that it did not prevent a bargaining council from establishing a medical scheme.

The Medical Schemes Bill will, once it becomes law, introduce a community rating system which will prohibit schemes from charging different rates based on age and health status, ensuring that there is cross-subsidisation of the older and the sick.

Medical schemes will also be required to accept that they will be able to pay a community rate, regardless of age and health status.

The legislation will also grant the minister of health authority to regulate personal savings account programmes by prohibiting schemes from penalising members for seeking primary care services.

Cosatu has also supported provisions in the bill which authorise the minister to prescribe a minimum package of benefits that will be provided in public hospitals.

The Human Rights Commission called for an amendment on the inclusion of same-sex couples and unmarried heterosexual couples by including the word "partner" in the definition of a dependant. The commission recommended the inclusion of treatment relating to contraception into the definition of "relevant health service". The National Coalition for Gay and Lesbian Equality made a similar submission.

The South African Association of Medical Schemes, which represents 57 registered medical schemes with more than 700 000 members, expressed its support for the bill but called for provisions to be made to protect medical schemes from the disadvantages of community rating.

Business South Africa said the bill should be withdrawn from Parliament and referred to the National Economic Development and Labour Council for further debate.

The Actuarial Society of South Africa said its analysis showed the bill would not increase the number of people covered, or reduce cost of coverage.

Eskom medical aid on life support

ET(BR)25/9/98(299)

NCABA HLOPHE

Johannesburg — Eskom, the state electricity utility, was expected to pump R40 million to R60 million annually into Esmed, its medical aid scheme, a top Eskom source said yesterday. Esmed was not expected to break even in the next four years.

The source said a recent internal report prepared by the trustees had said the scheme would never break even in the short term, contrary to statements by Esmed senior executives who said in June that a break-even was possible by the end of the year.

The scheme lost 7 000 members between January and June this year. Eskom pumped R29 million into the scheme last February, but funding has dried up and Esmed is expected to approach Eskom for another lifeboat.

Peter Adams, Eskom's media liaison officer, confirmed that Esmed had approached the management board on Tuesday for more funding. The board did not accede to the request but instructed Esmed to conduct more investigations on the matter.

"Eskom cannot afford to close down the scheme even though ... it is beyond repair, because there are 8 000 pensioners who rely on this scheme," another Eskom source said.

"Instead of these short-term rescue packages, Eskom must settle for a long-term funding strategy to restructure it."

The sources said electricity consumers could shoulder increased tariffs to subsidise Esmed. The problems in the scheme surfaced after Jerrold Bernstein, who served in Esmed's crisis committee last year, said, among other things, that money had been misappropriated.

Bernstein said the financial department had generated unreliable figures and the information system was poor, resulting in duplicate payments to some doctors.

The scheme lost R64 million and recorded an accumulated deficit of R26 million last year. Sources said Bernstein's recommendations were implemented too late to salvage the scheme.

Bernstein, who was subsequently elected by the scheme members as a trustee, has refused to comment about Esmed's latest crisis.

Nomonde Mapetla, the deputy director-general of the department of public enterprises, which is responsible for Eskom, said the ministry was unlikely to intervene.

Submit bill to Nedlac, health department told

Dustin Chick

BD 6/10/98 (299)

BUSINESS SA has threatened legal action against the national health department if it fails to take the proposed Medical Schemes Bill through the National Economic Development and Labour Council (Nedlac) process before submitting it to Parliament.

Business SA chairman Dorian Wharton-Hood, in a letter to Health Minister Nkosazana Zuma last month, said Business SA had been advised by senior counsel that the introduction of the bill into Parliament before being submitted to Nedlac amounted to the "omission of a serious step in the legislative process", and that any bill adopted under those circumstances would hold no force of application.

Wharton-Hood said Business SA had consistently maintained the bill's impact on employment conditions and employment costs brought it into the ambit of legislation required to be submitted to Nedlac.

In terms of the Nedlac Act, consensus on matters relating to social and economic policy as well as all labour legislation relating to labour market policy must be reached before a bill can be introduced to Parliament.

Wharton-Hood said social and economic policy would be "fundamentally affected" by the introduction of the bill, leading to "severe financial pressure" in the sector as a whole.

He said Business SA and its members — represented at Nedlac — regarded the bill as representing sufficient change to social and economic policy to warrant consideration by the council.

The health department could not be reached for comment yesterday.

MEDICAL AIDS

'Access for all' may leave employees out in the cold

(299) CT (BR) 7/10/98

ADELE SHEVEL

Johannesburg — Just as the era of receiving a gold watch for extended service has ended, so too might the days of expecting a new job to provide medical benefits be about to enter the realms of business history.

New employees might find themselves having to cover their own medical costs as employers consider refusing this additional employee cost.

Medical cover industry operators expect this to happen if medical aid premiums rise significantly, and many anticipate this increase in the face of healthcare's new legislative domain.

Bernie Clark, a senior director at Alexander Forbes healthcare consultants, said the changes were not expected to take place immediately, and put the timeframe within the next three years.

"Companies will reach a stage when the cumulative effects of healthcare costs will be too expensive for them to bear any longer," he said. He did not expect existing employees to be affected by the changes because labour laws would hinder this.

Gerald Sweidan, the managing director of Sweidan Trust, the administrators to Pharos medical plan, said a number of employers were already talking about modifying employment contracts to exclude medical coverage.

The government has had to shoulder a large portion of hyperinflation, and resources have been strained. It plans for the private sector to take on more responsibility to service the medical market. The department of health has stated the need for new legislation to extend access to medical schemes.

The Medical Schemes Bill is a controversial piece of legislation that was accepted by Cabinet in late August and released for public comment.

Lobby groups had about three weeks to put forward submissions after about three years of negotiation, fierce opposition and breakaway lobby groups. Some industry players, including Adrian Gore, the chief executive of Momentum Health, said the industry did not have enough time to offer fair comment.

The terrain is complex and scheme operators vary in their attitudes to the bill. Opposition centres on a directive in the bill for implementation of open enrolment (non-exclusion) and community rating, among others.

Community rating is proposed as a way of ensuring cross-subsidisation within a scheme (that the young and healthy cover the more extreme costs of the infirm and elderly). The bill requires that scheme rules may not base contributions on age, gender, past or present state of health or claims experience. This means contributions may be based on income and/or family size only.

Up to now, schemes could charge premiums according to a flat rate on income rates, or based on age and risk-rating.

The level of opposition to the bill varies according the type of products offered by companies.

Schemes span the spectrum from traditional to more innovative new-generation products. The latter are more prejudiced by the bill than traditional operators, as the latter already operate largely with income as a basis for premiums, while new-generation schemes — mainly insurance companies — base payment on age, risk and experience.

They contend the new legislation will be self-defeating since the young and the healthy will choose to leave the system, causing premiums to rise and making private care less affordable. They cite research and overseas experience to back up this perspective.

The implementation of open enrolment means that schemes have to take the old and sickly into the loop and will not be able to reject an applicant. The government has said, however, that penalties will be incurred for those who join late in life.

Traditional as well as new-generation operators are opposed to open enrolment. Sweidan says medical scheme operators will be hamstrung in their ability to manage their business schemes because of it.

A number of industry players agree from a social perspective, the bill is noble and does facilitate access. From a business point of view, however, it will be more difficult for schemes to be economically sound.

Alec Abraham, the healthcare analyst at SG Frankel Pollak Securities, questioned the profitability of the new system and its sustainability, while Jonathan Behr, an analyst at Duff & Phelps Credit Ratings, said: "In terms of financial stability of medical schemes it could mean a regression."

Others are more positive about the bill. Aslam Dasoo, the director of policy at the Representative Association of Medical Schemes (Rams), says the bill salvaged the medical system because the new-generation schemes created volatility in the traditional market.

This "would have resulted in a number of traditional schemes experiencing market failure and increased dumping on the state". He said new-generation products already had close to 30 percent of the medical scheme market after only a few years of operation.

Another and interesting opposition voice to the bill is that of the Federation of Unions of South Africa (Fedusa).

The federation said the bill threatens the very existence of medical schemes if passed in its current form. It said Nkosazana Zuma, the health minister, should recognise that 6 million people belong to medical schemes, and any health plan should take cognisance of what is already working. Over the past five years, premium increases have declined after years of dramatic medical inflation.

One insider said it was all very well providing access to more people, but what if the schemes were not able to be sustained — where did that leave the consumer? The government is seeking to extend medical aid coverage to the entire employed population and beyond.

With the possibility of employees having to take on more of their own coverage and then at increased premiums, the bill and its implications might turn out to be more of a band-aid than anything else.

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ADELE SHEVEL

Johannesburg — Just as the era of receiving a gold watch for extended service has ended, so too might the days of expecting a new job to provide medical benefits be about to enter the realms of business history.

New employees might find themselves having to cover their own medical costs as employers consider refusing this additional employee cost.

Medical cover industry operators expect this to happen if medical aid premiums rise significantly, and many anticipate this increase in the face of healthcare's new legislative domain.

Bernie Clark, a senior director at Alexander Forbes healthcare consultants, said the changes were not expected to take place immediately, and put the timeframe within the next three years.

"Companies will reach a stage when the cumulative effects of healthcare costs will be too expensive for them to bear any longer," he said. He did not expect existing employees to be affected by the changes because labour laws would hinder this.

Gerald Sweidan, the managing director of Sweidan Trust, the administrators to Pharos medical plan, said a number of employers were already talking about modifying employment contracts to exclude medical coverage.

The government has had to shoulder a large portion of hyperinflation, and resources have been strained. It plans for the private sector to take on more responsibility to service the medical market. The department of health has stated the need for new legislation to extend access to medical schemes.

The Medical Schemes Bill is a controversial piece of legislation that was accepted by Cabinet in late August and released for public comment.

Lobby groups had about three weeks to put forward submissions after about three years of negotiation, fierce opposition and breakaway lobby groups. Some industry players, including Adrian Gore, the chief executive of Momentum Health, said the industry did not have enough time to offer fair comment.

The terrain is complex and scheme operators vary in their attitudes to the bill. Opposition centres on a directive in the bill for implementation of open enrolment (non-exclusion) and community rating, among others.

Community rating is proposed as a way of ensuring cross-subsidisation within a scheme (that the young and healthy cover the more extreme costs of the infirm and elderly). The bill requires that scheme rules may not base contributions on age, gender, past or present state of health or claims experience. This means contributions may be based on income and/or family size only.

Up to now, schemes could charge premiums according to a flat rate on income rates, or based on age and risk-rating.

The level of opposition to the bill varies according the type of products offered by companies.

Schemes span the spectrum from traditional to more innovative new-generation products. The latter are more prejudiced by the bill than traditional operators, as the latter already operate largely with income as a basis for premiums, while new-generation schemes — mainly insurance companies — base payment on age, risk and experience.

They contend the new legislation will be self-defeating since the young and the healthy will choose to leave the system, causing premiums to rise and making private care less affordable. They cite research and overseas experience to back up this perspective.

The implementation of open enrolment means that schemes have to take the old and sickly into the loop and will not be able to reject an applicant. The government has said, however, that penalties will be incurred for those who join late in life.

Traditional as well as new-generation operators are opposed to open enrolment. Sweidan says medical scheme operators will be hamstrung in their ability to manage their business schemes because of it.

A number of industry players agree from a social perspective, the bill is noble and does facilitate access. From a business point of view, however, it will be more difficult for schemes to be economically sound.

Alec Abraham, the healthcare analyst at SG Frankel Pollak Securities, questioned the profitability of the new system and its sustainability, while Jonathan Behr, an analyst at Duff & Phelps Credit Ratings, said: "In terms of financial stability of medical schemes it could mean a regression."

Others are more positive about the bill. Aslam Dasoo, the director of policy at the Representative Association of Medical Schemes (Rams), says the bill salvaged the medical system because the new-generation schemes created volatility in the traditional market.

This "would have resulted in a number of traditional schemes experiencing market failure and increased dumping on the state".

He said new-generation products already had close to 30 percent of the medical scheme market after only a few years of operation.

Another and interesting opposition voice to the bill is that of the Federation of Unions of South Africa (Fedusa).

The federation said the bill threatens the very existence of medical schemes if passed in its current form. It said Nkosazana Zuma, the health minister, should recognise that 6 million people belong to medical schemes, and any health plan should take cognisance of what is already working. Over the past five years, premium increases have declined after years of dramatic medical inflation.

One insider said it was all very well providing access to more people, but what if the schemes were not able to be sustained — where did that leave the consumer? The government is seeking to extend medical aid coverage to the entire employed population and beyond.

With the possibility of employees having to take on more of their own coverage and then at increased premiums, the bill and its implications might turn out to be more of a band-aid than anything else.

Business seeks medical bill interdict

BD 9/10/98 (299)

Primarashni Pillay

BUSINESS SA (BSA) yesterday applied for an interdict in the Cape Town High Court against Health Minister Nkosazana Zuma and Parliament's health portfolio committee to prevent them from continuing with the Medical Schemes Bill until the National Economic Development and Labour Council (Nedlac) had considered it.

BSA's health task-group convenor, Lettie La Grange, said yesterday that her organisation had requested several meetings with health officials to discuss the impact of the bill on the employer and other issues, but such meetings had been denied.

The bill entails open enrolment, which means that anyone who wants to join a medical aid scheme can do so and it proposes flat rate payments along the lines of a forced community rating as opposed to differentiated payments based on aspects such as age. The definition of dependants would also allow more people to join a scheme.

La Grange explained that legislation had previously allowed for risk rating of members, as well as a "business-like approach to address post retirement health-care benefits".

The bill could result in schemes becoming extremely expensive — to the point that employers could opt out of a health care system of this nature.

"The bill amounts to employees bringing on people who could be elderly parents. Health costs for the elderly are expensive and young people would then cross subsidise them.

"However, if young people opt out of medical aid schemes it will result in increased costs with less people joining," she warned.

She said medical scheme membership in SA was almost exclusively employment based and contributions by employers and employees constituted about 17% of formal-sector salaries.

BSA had repeatedly appealed for independent and objective actuarial and economic analyses of the bill, particularly in order to assess the effects of the development of future demand and the costs of services. Such analyses had not been undertaken.

"BSA believes that the introduction of the Medical Schemes Bill to Parliament, in absence of its prior submission to Nedlac amounts to the omission of a necessary step in the legislative process," she said.

Health ministry spokesman Vincent Hlongwane said that BSA had a democratic right to seek recourse in the law, but the ministry believed it had "not done anything that warranted the intervention of the courts".

Zuma to defend new Bill

(299)
Sowetan 13/10/98

By Khangale Makhado

HEALTH Minister Dr Nkosazana Zuma will defend an application by Business South Africa (BSA) to have the Medical Schemes Bill removed from discussion in Parliament and referred back to the National Economic Development and Labour Council (Nedlac).

The BSA served papers on Zuma last week in which they asked the court for an interdict preventing her from having the Bill discussed in Parliament.

BSA spokesman, Mr Vic van Vuuren told *Sowetan* there was insufficient consultation over the Bill's contents.

Van Vuuren said the Bill should have been referred to Nedlac.

The BSA argues that the provisions of the Bill are likely to place severe financial pressure on existing medical schemes and will undermine the sector's sustainability.

Speaking to *Sowetan* at the weekend, newly appointed director-general of health Dr Ayanda Ntsaluba said the ministry had already briefed lawyers who were working on the matter.

According to Ntsaluba the intention of the Bill is to create a just and fair health system and to promote access to medical aid schemes.

He said his department had until October 20 to respond and hoped the portfolio committee on health would have had enough time to deliberate on the Bill.

"If the Bill is made law it will prohibit exclusion of applicants from medical schemes on the basis of their age, sex or past and present state of health," said Ntsaluba.

Both trade unions and the South African Medical and Dental Practitioners Association support the Bill.

Medical aid split is forecast

ET (BR) 19/10/98 (299)

ADELE SHEVEL

Johannesburg — Senior health sources said the Representative Association of Medical Schemes (Rams) would split this week as the South African Association of Medical Schemes (Saams), one of the three associations within it, was expected to break away.

Rams represents 95 percent of all registered medical aid schemes. The companies under its domain are expected to provide medical coverage to the value of R25 billion this year. This compares with the health department's budget of R21 billion for the year.

The split comes after months of uncertainty and discontent about the body. Earlier this year member companies levelled an interdict at Rams, preventing it from presenting issues to the government on behalf of the medical schemes operators. The basis for the interdict was that Rams had not adequately expressed the concerns of the full spectrum of the industry.

Industry sources said Keith Hollis, the chairman of Rams and Saams, had handed in his resignation, and that of his association, from Rams. However, he intended to announce it only after the forthcoming Rams council and annual general meeting to be held today and tomorrow, the sources said.

Aslam Dasoo, the policy director at Rams, said nothing had been sealed yet, but confirmed that tensions had been mounting in the industry over the process of transformation and how the industry would be funded, as well as medical schemes legislation.

Dasoo said the situation was "still fluid" and anything was possible, but he did not discount that the body could split. "The electorate must decide what they want to do with the industry".

Hollis, also the chairman of Medscheme, South Africa's largest medical aid scheme administrator, declined to comment, saying he had stated previously he would not seek re-election of Rams chairmanship.

Saams covers about 25 percent of the representative body's members. The other two associations in Rams are the Advisory Association of Medical Schemes and the Federation of Health Funders and Managers. Direct membership of Rams is also an option.

An industry insider said it would be wrong for Hollis to withdraw his association, and the action would be difficult to understand.

BSA gets tough on Medical Schemes Bill

ET (BR) 19/10/98 (299)

ADELE SHEVEL

Johannesburg — Business South Africa (BSA) would take the Medical Schemes Bill beyond the National Economic Development and Labour Council (Nedlac) to the finance minister and deputy president if it was not changed substantially to suit the requirements of employers and employees, Dorian Wharton-Hood, the chairman of BSA and vice-chairman of Liberty Life, said last week.

The High Court will decide today whether the bill will be required to go through the Nedlac process.

BSA levelled an interdict against the health department last week to prevent the bill from continuing its process, on the basis that the bill had significant implications for labour, the government, business and society at large, but Nedlac had not considered it.

According to the Nedlac Act, any legislation that affects labour, government and society has to go through the Nedlac process.

BSA said the act fell within the association's ambit.

But Aslam Dasoo, the policy director for the Representative Association of Medical Schemes, questioned the motives behind business's decision to challenge the legislation.

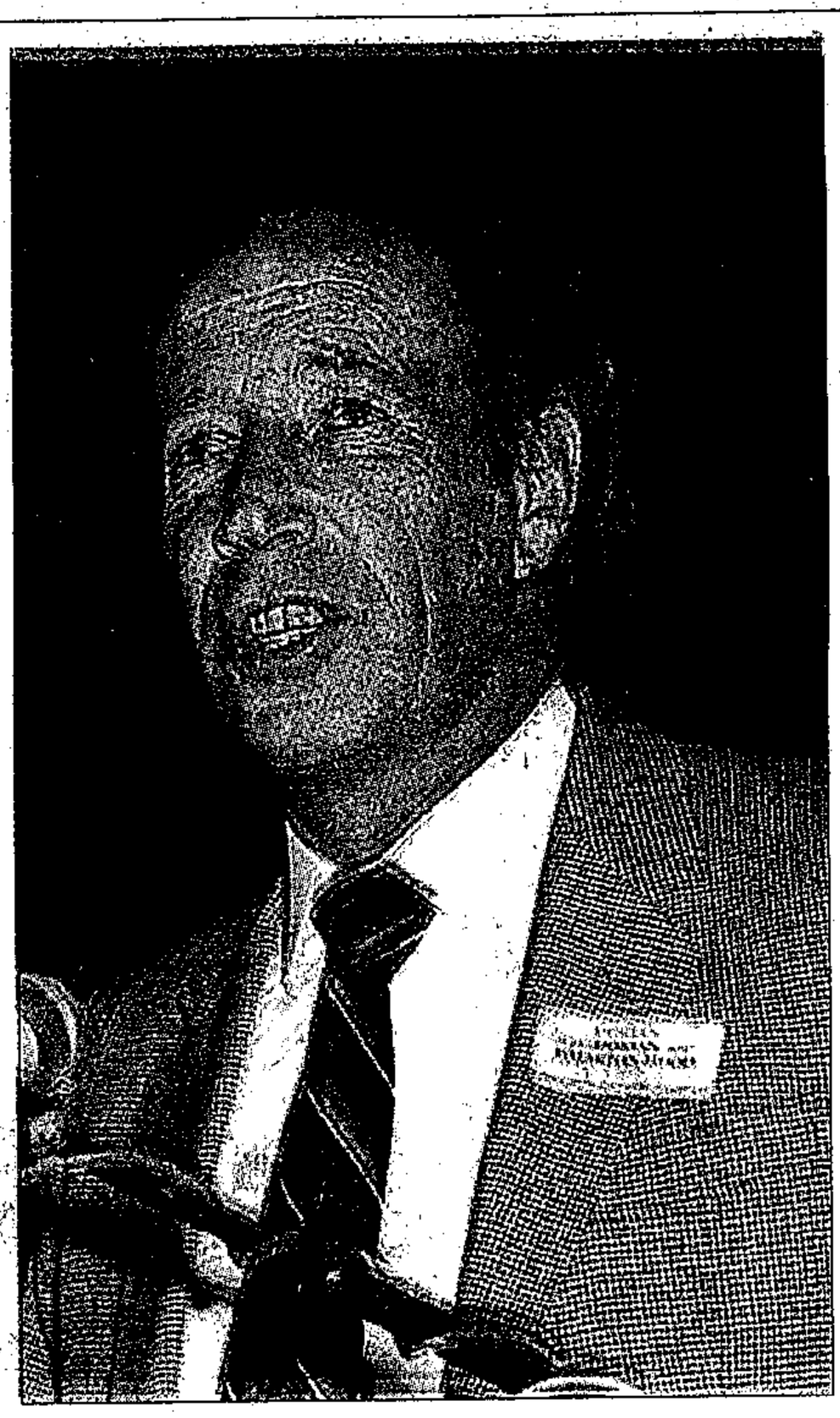
He said in his statement to the parliamentary portfolio committee on health: "There is either a breathtaking naivete or an act of desperation at play here.

"It is my firm belief that employers are not as concerned with any alleged deleterious effects of this bill as we have been led to believe."

Wharton-Hood said the association had the mandate from business to proceed with the interdict.

BSA hoped to improve "dramatically" the bill because experts said it was "nonsense", but this had not been taken into consideration by Nkosazana Zuma, the health minister .

"The bill will have a devastating effect on medical aids and employees and is a terribly important issue for South Africa," said Wharton-Hood.



NO QUARTER *Dorian Wharton-Hood, the chairman of BSA and vice-chairman of Liberty Life, says the bill will have a devastating effect on medical aids.*

(299) Star

Bid to derail Zuma

Court actions against key reform measures proposed by the health minister will undermine her reform programme, critics warn

juggernaut

v. 19/10/98

BY CHARLENE SMITH AND MATTHEW BURBIDGE

Three crucial bills aimed at transforming the healthcare system have been stopped in their tracks as Health Minister Nkosazana Zuma's policies face an unprecedented wave of legal challenges and protest this week.

The Medicines and Related Substances Control Amendment Bill has already been interdicted by pharmaceutical manufacturers; the Tobacco Products Control Amendment Bill has been interdicted by the tobacco industry; and the Medical Schemes Bill is now threatened with a similar fate.

To add to Zuma's woes, about 350 foreign-qualified doctors – many of them South African citizens – met in Johannesburg at the weekend to protest at the withdrawal of work permits and their working conditions. The foreign doctors are threatening major court action.

But Health Department spokesperson Khangelani Hlongwane said Zuma valued the foreign doctors and had no plans to "bundle them onto the next aircraft".

He said there was a perception in the department that there were deliberate attempts to frustrate the passage of legislation: "There are those with sinister motives who seem to be frustrating the passage of legislation that is aimed at transforming healthcare delivery."

Hlongwane said Zuma was not obliged to attend any of the public hearings on the tobacco amendment bill this week.

The Freedom of Commercial Speech Trust umbrella body, which represents the tobacco industry, handed a letter to the portfolio committee on health last week announcing that it was withdrawing from the parliamentary process surrounding the bill and would be instituting legal action against the Government.

Trust chairperson Neil Jacobsohn said the Health Department's behaviour in introducing the bill was a manipulation of the accepted principles of consultation and of the legislative process: "We have been denied our constitutional right to consultation, to the extent that the department has resorted to misrepresentation of the facts in official documentation."

According to observers, if tomorrow's application succeeds, it is likely that the bill could be tied up legally for at least two more years, delaying the introduction of Social Health Insurance, aimed at revolutionising the medical aid industry.

Also tomorrow, Business South Africa will challenge in the Cape Town High Court the passing of the Medical Schemes Bill, aimed at regulating medical aid schemes. BSA has applied for an interdict against Zuma and the chairperson of Parliament's portfolio committee on health, Dr Abe Nkomo, saying the bill impacts on employment conditions and costs.

CAPE ARGUS, **MONDAY**, OCTOBER 19, 1998

Cape court hears bid to halt medical aid bill

ARG 19/10/98 (299)

Employers fear effects on schemes

JENNY VIALL
HEALTH REPORTER

Business South Africa is to seek an interdict in the Cape High Court tomorrow preventing Health Minister Nkosazana Zuma and the parliamentary health committee from going ahead with the Medical Schemes Amendment Bill.

Business SA, which represents a large number of employers, says that by the introduction of the Medical Schemes Bill in Parliament before submitting it to the National Economic Development and Labour Council (Nedlac), a necessary step in the legislative process has been omitted.

It will ask theHigh Court to order that the council consider the bill before the process continues.

This is the third health bill to be challenged in court. The Medicines Control Bill has been challenged by the pharmaceutical industry and the case will go to court next year.

Last month the tobacco industry asked for a court order compelling Dr Zuma to produce the information on which she based anti-smoking legislation in the Tobacco Amendment Bill.

The application was dismissed in the Cape High Court.

Business SA contends that the Medical Schemes Bill falls within the category of legislation which needs to be submitted to the council, as it will have an impact on employment conditions and costs.

Medical scheme membership was almost exclusively employment-based, said Lettie le Grange of Business SA.

Contributions to medical schemes by employers and employees made up about 17% of formal sector salaries. The bill would have a profound impact on Business SA members and on employees and would amend the regulatory framework of the private health sector radically.

The bill provides for open enrolment, where no one can be refused admission to a medical aid scheme, forced community rating where everyone pays an equal contribution regardless of age or health, and guaranteed post-retirement membership without actuarial supervision.

Dr Le Grange said the combination of these provisions would lead to severe financial pressure on medical schemes and ultimately undermine the sustainability of the sector.

Business SA had appealed repeatedly for independent and objective actuarial and economic analysis of the bill but this had not happened.

Opponents bid to halt Zuma's juggernaut

(299)

ARG 19/10/98

ARGUS CORRESPONDENT

Johannesburg – Three crucial bills aimed at transforming the health-care system have been stopped in their tracks as Health Minister Nkosazana Zuma's policies face a wave of protest and other action this week.

The Medicines and Related Substances Control Amendment Bill has already been interdicted by pharmaceutical manufacturers, the Tobacco Control Amendment Bill has been interdicted by the tobacco industry and the Medical Schemes Bill is now threatened with a similar fate.

And about 350 foreign-qualified doctors – many of them South African citizens – met in Johannesburg at the weekend to protest at the withdrawal of work permits and about their working conditions.

Business seeks to stop medical aid bill
Page 4

The doctors said they were forced to work 80 hours overtime a month.

But Health Department spokesman Khangelani Hlongwane said Dr Zuma valued the foreign doctors and had no plans to "bundle them them on to the next aircraft".

Mr Hlongwane said there was a perception in the department that there were deliberate attempts to frustrate the passage of legislation.

Mr Hlongwane said Dr Zuma was not obliged to attend any of this week's hearings on the Tobacco Amendment Control Bill.

The Freedom of Commercial Speech

To page 3

Opponents move to halt Zuma revolution

ARG 19/10/98

(299)

From page 1

Trust umbrella body, which represents the tobacco industry, handed a letter to the portfolio standing committee on health last week announcing that it was withdrawing from the parliamentary process surrounding the bill and would be instituting legal action against the Government.

The trust's chairman, Neil Jacobsohn, said the Health Department's behaviour in introducing the bill was a manipulation of the accepted principles of consultation and of the legislative process.

Mr Hlongwane said the department had met the trust. "No door has been closed, people can raise concerns and make suggested improvements.

"Perhaps they are are playing to gallery, or they understand consultation in a different way."

According to observers, if tomorrow's application succeeds, it is likely that the bill could be tied up legally for at least two more years, delaying the introduction of social health insurance, aimed at revolutionising the medical aid industry.

Speculation about a conspiracy is enhanced by the fact that the Representative Association of Medical Schemes (Rams), which represents 95% of the medical schemes industry, was interdicted in March this year so that it could not secure a mandate to represent its members on the bill.

According to the Rams director of policy, Aslam Dasoo, at least 70% of the industry would have supported the measures, which would have been sufficient to propel the legislation through parliament.

Tomorrow, Business South Africa will challenge in the Cape Town High Court the passing of the Medical Schemes Bill, aimed at regulating medical aid schemes.

BSA says the bill will have an impact on employment conditions and costs, and thus it should have been submitted to Nedlac.

Medical body denies imminent split

Taryn Lambert (299) BD 21/10/98

REPRESENTATIVE Association of Medical Schemes (Rams) executive director Declan Brennan yesterday denied reports of an imminent split in the organisation and rejected claims that the SA Association of Medical Schemes was set to break away from the umbrella body.

Brennan said the alleged split was not on the agenda for discussion at a two-day Rams conference which started in Midrand yesterday, nor was the resignation of both associations' chairman, Keith Hollis.

Brennan said there was no discussion within the organisation about a possible restructuring and declined to comment on the accuracy of media reports to the contrary. However, there had been discussion over a possible "transformation" of Rams, which represents 95% of registered medical aids.

The Rams council had appointed a transformation task team mandated to examine transformation and a programme for its implementation.

Bid to stop medical aid bill thrown out by court

Employers lose

JENNY VIALL
HEALTH REPORTER (299) ARG 22/10/98

Business South Africa's attempt to stop Health Minister Nkosazana Zuma going ahead with the Medical Schemes Amendment Bill failed in the High Court today.

Business South Africa asked for an urgent interdict to stop the bill proceeding, and for Dr Zuma to be ordered to refer it to the National Economic Development and Labour Council (Nedlac).

Business South Africa is a large employer organisation and, with organised labour and the Government, a partner in Nedlac.

It claimed that the bill would have an impact on employment conditions and costs, and therefore was within the ambit of legislation required to be submitted to Nedlac.

Mr Justice Deon Van Zyl said in his judgment that Dr Zuma had at no stage been obliged to refer the bill to Nedlac.

He was unable to find the slightest indication in the Nedlac Act that implied such an obligation.

The proper procedure to be followed by Business South Africa as a leading member of Nedlac was to ensure the matter was fully debated by the council during various phases of the bill's development, said Judge Van Zyl.

Its concerns could then have been addressed, and it could have persuaded Nedlac to prepare a report.

As it was, Business South Africa drew up a report of its concerns about the bill for the portfolio committee on health, and had been given a chance to air its views.

The application was dismissed with costs.

SPEAKOUT ISSUES

And they huff and they puff to blow Zuma's bill down

(a99)

But where there's smoke, there's money...

AKG 22/10/98

INSIDE STORY

Parliament is asked to weigh the cost in lives against the cost in rands of Dr Zuma's bid to curb smoking, writes **JOVIAL RANTAO** of our Parliamentary Bureau

It's almost like the biblical battle between David and Goliath, only this time it is not clear whether David will emerge as the victor.

The often robust debate on whether tobacco advertising and smoking in public places should be banned – brought on by the tabling in Parliament of the Tobacco Products Control Amendment Bill – has pitted the health sector (David) against the might of the tobacco, marketing and media industries.

At the public hearings hosted by Parliament's Health Committee, academics, some from the same institutions, squared up. They looked at the same statistics and research, and interpreted them differently.

Allegations of deceptions, cover-ups, smokescreens, suppression of information and of Cosatu-affiliated trade union leaders being flown by tobacco companies to oppose legislation by an African National Congress Cabinet minister flew thick and fast.

It was pointed out that, after losing the battle in Europe and elsewhere in the world, international tobacco conglomerates were now targeting South Africa and other poorer countries to keep their industry alive.

In Parliament this week, the tobacco industry employed the best legal minds money can buy. They were ably assisted by experts in designer suits and foreign accents from all over the world, armed with reams and reams of research from the United States, Australia, the United Kingdom and Canada.

For nearly 40 hours parliamentarians were bombarded with a flood of statistics on how many millions would be lost to the economy and how many jobs would be lost, and what kind of a threat Dr Nkosazana Zuma's legislation would be to the tourism industry.

The tobacco industry said that, if approved, the legislation would lead to losses running into millions in the industry, and to job losses in, among others, the tourism industry. The Tobacco Products Control Amendment Bill, they strongly argued, would make it illegal for the national rugby team to use the name, "Springbok", because it was also a tobacco trademark.

It would lead to the end of the multi-million rand Rothmans Cup, one of the most prestigious competitions in soccer – the No1 sport in South Africa.

Coastal cities such as Durban could stand to lose R800-million a year from the loss of events such as the popular Gunston 500 surfing competition.

US hamburger giant McDonald's would be prevented from using its trademark, which was also registered in South Africa as the trademark of a Canadian tobacco company.

The Food and Allied Workers' Union, the Cosatu affiliate that has emerged as an unlikely force against Dr Zuma, claimed a total ban on tobacco advertising would lead to a huge loss of jobs.

The Tobacco Institute of Southern Africa (TISA), one of the strongest opponents to Dr Zuma's legislation, claimed the Bill and the process of consultation was seriously flawed.

TISA asked the committee to consider whether a total ban on all communication on tobacco, even between members of the tobacco trade and adult consumers, was constitutional, and whether the total ban on smoking in all public places was constitutional, reasonable, practical and enforceable.

In response, the health and anti-tobacco lobby tabled spine-chilling statistics and heart-rending stories about how tobacco would kill as many people as the AIDS pandemic.

Yusuf Saloojee, executive director of the Council Against Smoking, warned that, unless smoking behaviour changed, worldwide deaths from tobacco every year would increase from the current 3,5-million to 10-million by 2025, "with 70% of these future deaths occurring in the poor nations of the world, where the already over-burdened health services are unprepared for this coming epidemic".

"The World Health Organisation estimates that by 2025, that is over the next 27 years, about 500-million people worldwide will die of tobacco-related diseases. That is a numbing figure. It's too large to take in ...

"That is the death toll from World War 2 every three years for 27 years. That is Bophal every two hours for 27 years. That is *Titanic* every 43 minutes for 27 years. That is a Sharpeville for every minute for 27 years. Bophal and the *Titanic* were accidents. Tobacco deaths are not," Dr Saloojee added.

There was silence in the Old Assembly Chamber in Parliament when 57 year-old Masi Mbasa, who is dying from lung cancer, told the committee that he was, as a 17-year-old, attracted to smoking by an advertisement that portrayed a smoker as a strong man.

"I began to smoke 'Boxer' because I wanted to be as strong as the man in the advertisement and my picture will be in the newspapers. When I discovered that I wasn't becoming strong I tried to stop, but could not," Mr Mbasa, a bread-winner from Khayelitsha in Cape Town said.

Twenty-four hours earlier, former Johannesburg bus driver Dennis Woest, who has lost his voice because of his addiction to cigarettes, delivered a heart-rending tale.

He communicates by pushing air from his mouth into his oesophagus, then bringing it up again, like a burp. "You could say I have to burp up speech," he explained.

> *'Over the next 27 years, about 500-million people will die of tobacco-related diseases'*

On October 27, 1989 when he was 49, Mr Woest was diagnosed as having cancer in his vocal chords. He had smoked between 20 and 30 cigarettes a day for 33 years.

He had to have a laryngectomy.

So emotional has the exchange been and so strongly did the parties feel about their respective positions that the Zuma legislation was compared with the extreme and obsessive laws enacted by Hitler in Nazi Germany.

Representatives from the tobacco industry were repeatedly asked whether profits took precedence over the health of children.

At the heart of the exchange between Government and the tobacco companies is the survival of the R10-billion-a-year industry the companies and tobacco farmers fear will be annihilated.

An economist has warned that the ban would lead to a loss of 15 000 jobs, and R6-billion a year in government revenue.

On the second and last day of public hearings on the Tobacco Products Amendment Bill, P Black, from the Corporation for Economic Research, told Parliament's Health Committee that studies showed that the tobacco industry's total annual contribution to the GDP was more than R10-billion.

Professor Black said his impact analysis of the tobacco industry on the South African economy showed that the number of jobs created and supported by the tobacco industry increased from 86 754 in 1995 to 99 489 in 1997.

"Tobacco farming and manufacturing supported by far the highest proportion of total jobs (78%). It is worth noting that some 25% of the total was created in the expenditure-induced sector in 1997," he said.

And, according to the Print Media Association, which represents publishers of at least 600 titles, banning advertising of tobacco products would be a contravention of the constitutional freedom to conduct business within a market driven economy. The organisation said the bill was not about smoking but about freedom of expression.

"The loss of income from tobacco advertising will result in a considerable reduction of income into the Tobacco Advertising Research Foundation which is a qualitative research study assisting the whole of the marketing communicating industry in ensuring that the rands spend on advertising are 'bulls-eyed' and not wasted.

"Such research would have to be curtailed, the information dramatically reduced and the end result could be wasteful advertising rands," said Graham Langmead, executive director of the PMASA.

He said the PMASA was concerned that a domino effect is going to dramatically affect the publishing industry and print media in South Africa.

While it has remained unclear whether the two opposing factions will ultimately agree on the bill, it has become increasingly clear that its passage, like that of two other bills piloted' by Dr Zuma, will be delayed by court action by the tobacco industry.

It would seem that no matter how many stones David has in his sling, the tobacco industry Goliath will take time and a lot of money to fell, if at all.

LEGISLATION *Zuma 'not obliged to put bill before Nedlac'*

BSA bid fails to block Medical Schemes Bill

(299) CT (BR) 23/10/98

RONNIE MORRIS

Cape Town — A Cape High Court bid by Business South Africa (BSA) to block the passage through parliament of the Medical Schemes Bill was dismissed with costs yesterday.

However, Justice Deon van Zyl granted BSA leave to appeal against the decision.

BSA, which represents 20 employer and business organisations, had brought an urgent application for a declaratory order that Nedlac be required to consider the bill before it is implemented or introduced into parliament.

The issues to which BSA objected were the extension of the membership of medical aid schemes to any other member of the immediate family (who is without an income and who lives with a member of a medical aid scheme); a system of community rating which prohibits a variation of contributions and provision for a minimum; and benefits payable by a medical aid scheme, provided these are not less favourable than those provided for by public hospitals.

An order was also sought directing Nkosazana Zuma, the health minister, to refer the bill to Nedlac and restraining Abe Nkomo, the chairperson of the parliamentary portfolio committee on health, from implementing or introducing the bill into parliament.

FULL SPEED AHEAD *Nkosazana Zuma, the minister of health*

BSA had argued that Zuma was obliged by law to send the bill to Nedlac first.

However, Justice van Zyl said there was no such obligation on Zuma to place the bill before Nedlac.

He said in view of the lengthy period which had elapsed since the first steps were taken to bring the proposed medical schemes legislation to fruition, it was questionable whether BSA's application should have been brought on an urgent basis.

Judge van Zyl agreed that the envisaged legislation would have important socio-economic consequences and could indeed be described as "proposed labour legislation relating to labour market policy".

It would give rise to "significant changes" in social and economic policy, he said.

Sapa reports that Khangelani Hlongwane, Zuma's spokesman, said afterwards that the ministry welcomed the judgment and hoped that the parliamentary process would continue unimpeded.

Nkomo said: "We have always had confidence in the processes that we followed.

"We are strengthened and reinforced by the judgment, upholding as it does the principles of a constitutional democracy."

The portfolio committee met yesterday morning to begin a clause-by-clause discussion of the bill. It is scheduled to vote on it today.

Court rejects attempt by big business to mothball Medical Bill

(299) CT 23/10/98

JOVIAL RANTAO

HEALTH MINISTER Nkosazana Zuma, facing a flood of court actions aimed at blocking the passage of her transformatory bills, received a morale-boosting victory over big business yesterday in the Cape High Court.

The court threw out an attempt by Business South Africa (BSA) to block the passage of the Medical Schemes Bill through Parliament.

BSA had filed an urgent application demanding that the bill, which will dramatically change the face of the medical aid industry in favour of lower-income families, be referred to the National Economic Development and Labour Council (Nedlac) before being considered by Parliament.

Judge Deon van Zyl said there was nothing in law that specifically obliged Zuma to submit such legislation to Nedlac.

His ruling has been welcomed by Zuma and Abe Nkomo, chairperson of Parliament's health committee.

BSA said yesterday it was "considering all its options", including a possible appeal.

Labour director-general and government's Nedlac convener Sipho Pityana said: "The court saw through the ill-conceived attempts by business to use Nedlac as a mechanism to forestall and obstruction transformation."

The health committee, which discussed the bill informally yesterday, is to vote on the proposed legislation today.

Court bid to refer bill to Nedlac fails

BD 23/10/98 (299)

Wyndham Hartley

CAPE TOWN — Business South Africa's (BSA's) attempt to force Health Minister Nkosazana Zuma's Medical Schemes Bill into the National Economic, Development and Labour Council (Nedlac) before Parliament votes it into law was dismissed in the Cape High Court yesterday, but BSA has promised to appeal the decision.

Parliament's health portfolio committee is poised to approve the Medical Schemes Bill and the Tobacco Product Control Amendment Bill this morning. They will then be debated in the National Assembly.

MPs were not sure how an application for leave to appeal would affect the passage of the medical bill.

Confusion surrounded the status of the bill yesterday morning as the health committee of the National Assembly began work using the old bill as a reference, even before the court had ruled on whether it should be referred to Nedlac.

Ironically, while it was doing this, health portfolio committee chairman Abe Nkomo ruled that health director-general Ayanda Ntsaluba did not have to answer a question put by Inkatha Freedom Party MP Ruth Rabinowitz because it was "sub judice".

Judge Deon van Zyl ruled that BSA had failed to show that Zuma should have sent the bill to Nedlac first. He said that while the bill would have a significant effect there was nothing specifically in the law that compelled Zuma to consult Nedlac.

There was another setback for the bill, however, in that it had to be amended in order for it to be constitutional. A new bill was tabled with all the finance references excised, because only the finance minister is allowed to introduce money bills.

Rabinowitz and Democratic Party MP Mike Ellis said during the tea break that they did not know why the committee was discussing a bill that was before the courts. Rabinowitz said it made a mockery of both processes — that taking place in Parliament and that in the High Court.

BSA spokesman Vic van Vuuren said BSA would appeal against the decision. He said he was unable to comment in depth on the judgment.

Sapa reports that Nkomo said: "We have always had confidence in the processes that we have followed.

"We are strengthened and reinforced by the judgment — upholding, as it does, the principles of a constitutional democracy."

The committee spent the day going through the bill clause by clause.

BSA chairman says the move is 'essential'

Nedlac has to see new medical bill

ET (BR) 24/10/98 (299)

ADELE SHEVEL

Johannesburg — Dorian Wharton-Hood, the chairman of Business South Africa (BSA), said it was now essential that the "allegedly revised" Medical Schemes Bill go through the National Economic Development and Labour Council (Nedlac) after yesterday's court ruling.

This comes after the court's refusal to grant BSA the right to appeal Thursday's decision not to enforce the bill's passage through Nedlac as obligatory.

Wharton-Hood said the decision was "absolutely bizarre". In a letter to Nkosazana Zuma, the health minister, he said "any revised bill that will address any constitutional shortcomings in that bill is clearly one that must be considered by Nedlac before its introduction into parliament".

He said by claiming it to be a new bill, there was no way the government could now duck the Nedlac process.

The health ministry said BSA would "hopefully" realise there was "nothing to be gained by attempting to frustrate the democratic legislative process. We encourage them to participate in the legitimate consultative processes available to them and everyone else."

Jayendra Naidoo, the executive director of Nedlac, last night said the bill should have been dealt with in Nedlac as it fell within council's ambit and had BSA adopted the right procedure it would have been assessed by the body. Naidoo said BSA could have taken the bill directly to Nedlac. It was most unlikely that Nedlac would now cover the bill as it was within the parliamentary process and there was no precedent for withdrawing a bill at this stage. He would however look at the letter addressed to Nedlac from BSA regarding this issue.

Parliament had instructed the portfolio committee on health this week to prepare a new bill replacing the Medical Schemes Bill so as to exclude the money provisions.

But contrary to reports that allege the Medical Schemes Bill was thrown out and replaced with a new one, a number of medical aid experts say the only difference is that the revised bill places the imposition of taxes or levies under the domain of the finance department rather than the health department. The two monetary clauses at issue would be introduced through a separate bill by Trevor Manuel, the finance minister.

However, Wharton-Hood and several key industry players have said there was almost no difference between the present and previous bills. Wharton-Hood said he would consult with BSA's legal team at the weekend regarding further action. Vic van Vuuren, the BSA spokesman, said he was astounded by the decision and would assess other options such as petitioning.

The new bill is scheduled to come before the National Assembly on November 5 and the National Council of Provinces on November 12 and was yesterday before the portfolio committee on health. Players expected it to be passed largely in its current form.

Business to appeal court's ruling on medical bill

(299) ARG 26/10/98

STAFF REPORTER

Business South Africa will today apply for leave to appeal against a Cape High Court decision which dismissed an application to stop Health Minister Nkosazana Zuma from proceeding with the Medical Schemes Amendment Bill.

Business SA had asked for an urgent interdict to stop the bill from proceeding through the legislative process and asked that Dr Zuma be ordered to refer the Bill to the National Economic Development and Labour Council (Nedlac).

Business SA is a large employer organisation and a partner in Nedlac, along with organised labour and the government. It claimed the Bill would impact on employment conditions and costs and as such was within the ambit of legislation required to be submitted to Nedlac.

In his judgment Mr Justice Deon van Zyl said Dr Zuma had no stage been obliged to refer the bill to Nedlac.

He said he was unable to find even the slightest indication in the Nedlac Act which created such an obligation.

He dismissed the application with costs.

His decision was welcomed by Dr Zuma, who said she hoped Business SA would respect it, and would work with the government in ensuring that the legislative process continued unhindered.

Inkatha's spokesman on health, Dr R Rabinowitz, said there was nothing in the bill that provided an incentive to medical schemes. The Bill would result in fewer people seeking private medical cover and a greater burden on the State.

He said his party proposed an amendment that would give an incentive to young and healthy people to join medical schemes.

It wanted to see a "high risk pool" for the severely ill, a government health scheme as an option offering a low-priced basic package, and a mechanism for young people to pay towards health cover at retirement.

Compulsory medical aid for all spreads risk

(299) BD 27/10/98

COMPANIES that do not require employees to belong to a medical aid scheme but offer them optional ad hoc medical cover could end up leaving many individuals without cover.

This could arise as medaid schemes implement strict underwriting criteria when deciding to accept or reject individual applicants with poor health, such as those suffering from diabetes or heart disease, to ensure a scheme's survival, says Grant Jamieson, an administrator for Spectramed medical aid.

"Companies and institutions need to make medical cover compulsory, at least from a certain salary level, in order to avoid anti-selection against the scheme."

It is a question of risk management. If the entire group of employees is taken on by a medaid the risk is spread, allowing for cover of individuals with chronic problems.

If the company offers employees medical cover on an ad hoc basis, applications by people with major health problems are then underwritten as a separate risk.

"People are astounded when individual medaid policies are declined, but the same risk management principles are at work as those to determine life assurance," says Jamieson.

"No one is surprised when the recipient of a triple bypass cannot obtain life assurance."

Anti-selection can create problems when senior employees are promised medaid cover as part of their package. If membership applications are then rejected, either individuals find themselves dependent on state facilities or the company could lose the services of valuable senior executives.

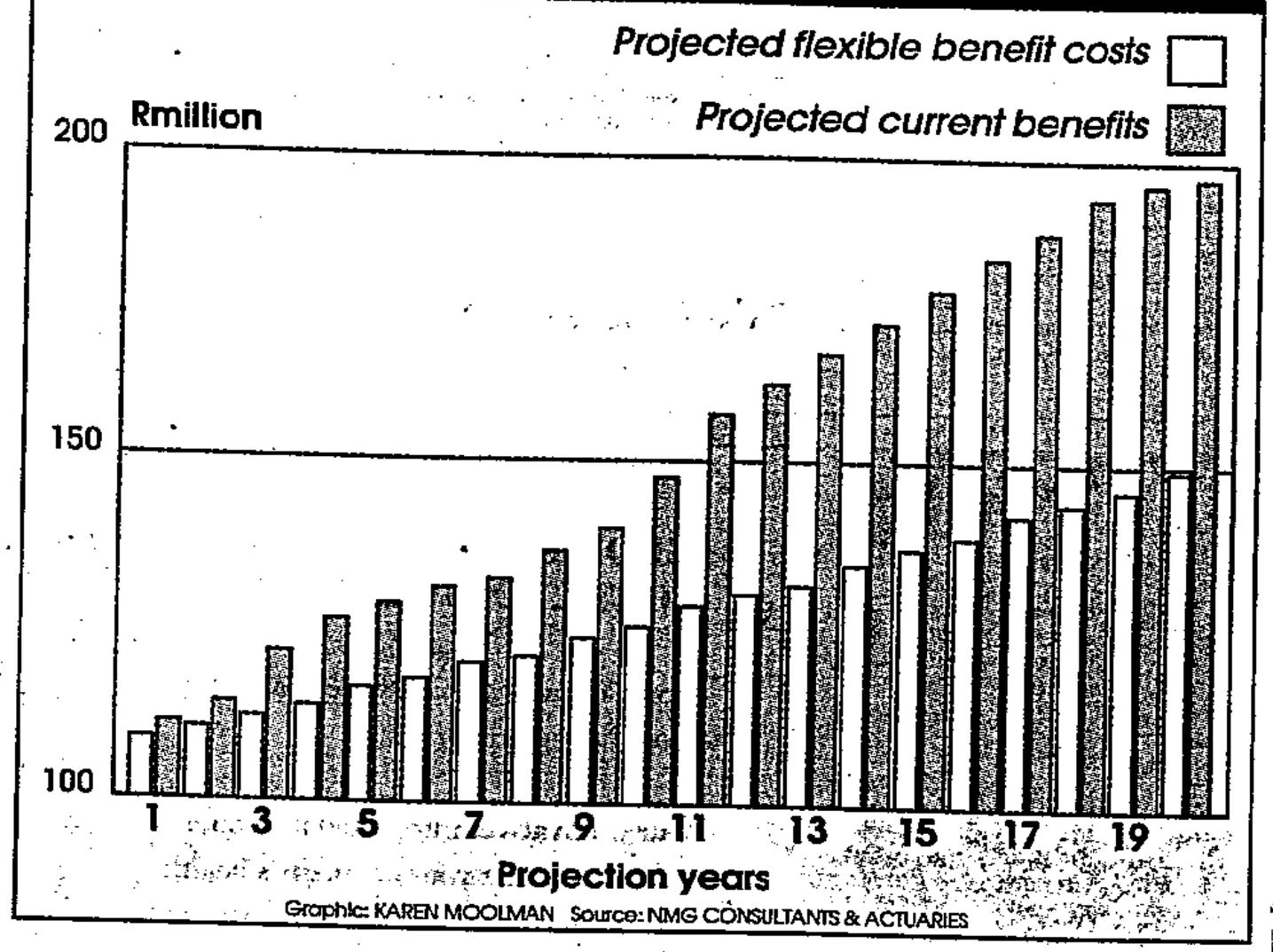
In addition, schemes are forced to re-rate companies with adverse claims profiles and load the contributions of members on the scheme. This may result in contributions becoming unaffordable, which would again force employees to seek employment elsewhere or rely on state facilities.

Jamieson says the increased number of formal sector employees without private health-care cover is a problem government hopes to address through the new Medical Schemes Amendment Bill, which will make business responsible for the health care of its employees.

To ensure the continued survival of private care for employed individuals in SA, the bill needs to enforce cover for all employees to protect the industry from the crippling effects of non-compulsory individual cover. If not, the recent gains made by the industry in curtailing costs by implementing managed-care principles will be negated.

"The bill proposes the reintroduction of community rating. However, this will only be successful if a broad spectrum of individuals, young and old, are included in the mix," says Jamieson. "Otherwise, the cost of caring for the sick and the elderly will cause medical aid premiums to soar and lead to the potential collapse of private medical cover in SA."

Dramatic effect of controlling benefit costs



Graphic: KAREN MOOLMAN Source: NMG CONSULTANTS & ACTUARIES

Deadly diseases can be managed

EFFECTIVE medical care in the form of chronic disease management programmes is being offered to employers or separately to employees considered to be patients at risk.

Henriette Potgieter, a disease management specialist, says chronic disease management programmes can be added to existing medical aid cover or purchased as stand-alone products by employers.

Potgieter, executive director of Access Health SA, says chronic conditions such as asthma, diabetes and heart disease afflict an estimated 12% to 15% of members of South African medical aids and possibly the country's population at large.

Although they fall into the "most feared diseases" category, these conditions can be managed through:

☐ Frequent and regular monitoring by care-givers; and

☐ The empowerment of patients through information to reduce the risk of complications developing.

"After extensive local and overseas development, Access Health is now launching its diabetes management programme.

"Asthma and pregnancy management programmes will follow before the end of the year," says Potgieter.

"Next year we will be introducing programmes to manage cardiac disease, depression and HIV/AIDS."

Potgieter says she sees great benefit in having a full range of disease management programmes under one roof.

"In many cases there is significant disease overlap, for example diabetes and asthma are very commonly co-diagnosed in SA. We therefore strongly believe that if you fragment disease management you stand the risk of losing its effectiveness," she says.

"For instance, we see the cardiac suite — namely high cholesterol, hypertension, angina and heart failure — as a single package."

The company's chronic disease management programme revolves around highly trained case managers making regular and frequent phone calls to each patient according to an individualised, management programme.

This ensures that the patient not only understands his or her condition, Potgieter says, but that the patient:

☐ Understands all the implications of the particular condition; and

☐ Adheres to the treatment plan provided by the patient's doctor.

The case managers are supported by a medical director and have computerised and comprehensive information about each patient's medical condition at their fingertips.

Patients are encouraged to phone their case managers whenever they need advice or emotional back-up via a toll-free hotline that operates 24 hours a day, 365 days a year, because the more a patient knows about the measures that can be taken to prevent complications, the better.

Patients are given information about healthy lifestyles, diets and alternative treatments that are available.

Potgieter says the chronic disease management programme does not interfere with, or replace, a patient's relationship with his or her own doctor, but it does provide support between visits to the doctor without intruding on the doctor-patient relationship.

"We do not tell patients what to do, but help them to decide," Potgieter says.

"Our programmes are the next logical step in managed health care, empowering patients to understand the costs and medical implications of each treatment and what their doctors are trying to achieve."

Potgieter says the company's statistics show that for every rand spent on its programmes, two rands can be saved in terms of potential costs of hospitalisation, emergency medical services, sick leave and reduced productivity.

More emphasis on flexibility

FLEXIBLE benefits programmes are increasing in popularity as more people learn how these exert greater control over benefit inflation increases, improve benefits and raise awareness of benefit structures.

Roz Hollins, executive consultant at NMG Consultants & Actuaries, says flexible benefits used to be perceived as providing tax benefits for the upper echelons of an organisation.

Only a few organisations implemented a similar system down to middle-management level.

Recent developments show a different approach, with flexible benefits being implemented throughout organisations and groups, says Hollins.

"Many organisations have recognised that current benefit structures in place are in conflict with individual needs and interests. This is particularly true in light of the general emphasis being placed on individual needs and on the value of individual choice."

Factors resulting in human resources executives reviewing current remuneration and benefit policies are:

☐ Rising employee costs;

☐ Changing demographics in the workplace accompanied by varying needs of employees; and

☐ A worldwide move from defined benefit to defined contribution systems.

With a flexible benefit, an employee is remunerated in a total package format, and offered a benefit structure consisting of a minimum set of core (compulsory) and optional benefits.

They can choose benefits that are appropriate for their own lifestyle and finance them from the total package.

Hollins says the plus side is the employee's freedom to select appropriate benefits and amount spent on them, an increased understanding of the benefits available, and tax efficiency.

The reasons for the change to such programmes are mostly:

☐ The ability to control the total cost of employment. Previously, control of employee costs was limited by the fact that benefit inflation increases are outside the control of the employer

☐ Employees appreciate benefits more when they become aware of the high cost of providing benefits; and

☐ As the flexible benefit concept is increasing in SA, so employees are coming to understand and question their benefit structures and expect choice and total package valuations.

Medical Schemes Bill is 'catastrophic'

CT (BR) 29/10/98 (299)

ADELE SHEVEL

Johannesburg — Nico Czypionka, the chief executive of Economic Dynamics, called on the private sector yesterday to vigorously resist and prevent the "catastrophic damage of the economy" expected to follow the implementation of the Medical Schemes Bill.

Czypionka, the former chief economist at Standard Bank, said legislation in areas such as healthcare and labour would be an obstacle to attracting crucial foreign investment to aid South Africa's economic growth.

Czypionka said foreign markets were apprehensive about the 1999 elections. They feared that the Growth, Employment and Redistribution programme would be replaced by new labour and health legislation.

He said hard choices and trade-offs would be required between economic and social objectives.

"Decisions in the health area need to be carefully weighed, to contribute to South Africa's efficiency and competitiveness, but not to unduly burden the productive element of the economy."

The orthodox socialist agenda was still being pushed in areas such as healthcare, irrespective of the potential damage to private sector costs and competitiveness.

"The Medical Schemes Bill is very damaging and burdens some of the First World components of the economy. It puts political principles over economic ones".

Czypionka said the health insurance scheme was ultimately a socialist dream and "clearly inappropriate in a developing country".

It would greatly increase costs and act as an equivalent of extra tax on those currently insured. It would also make risk management difficult, he warned.

Influential members of medical body out

BD 3/11/98 (299)

Pat Sidley

MEDSCHEME chairman Keith Hollis has been ousted, along with two colleagues from the Representative Association of Medical Schemes, after 12 years as an influential member of the body's council. The move is likely to have an effect on how the organisation negotiates with government over the contentious Medical Schemes Bill.

Members of the body voted in three new faces, all prominent in the medical schemes lobby opposed to the new bill, which seeks to prevent medical schemes from discriminating against potential clients on the basis of age or prior medical condition.

The three are Dave Avnit of Fedsure Health, Adrian Gore of Discovery Health and Brian Brink of Anglo American's medical scheme.

Although they constitute a small group among the organisation's 16 council members, the writing is on the wall for changes to the organisation, which has been wracked by dissension among its members and staff for several months.

The organisation was successfully stopped by the courts from representing the industry on the bill by a group known as Coms — Concerned Medical Schemes.

The group is largely made up of insurers with medical scheme products who bitterly opposed the coming changes to the law. Brink has identified himself closely with this group at times.

Until 1994 the Representative Association of Medical Schemes was a statutory organisation responsible for the negotiation and setting of the fees for medical schemes known as the scale of benefits. It is now a voluntary organisation which sets some tariffs.

Hollis, who had served as the organisation's chairman, said yesterday the three new council members should have always been part of the council and that the move was overdue. The main issue he said, was one of transformation of the health sector.

On the one hand there were those who were concerned largely with commercial interests, while on the other there were those who shared the "social solidarity" views of the government, Hollis said.

Brink believed that the organisation's work should be complimentary to the government.

He said the department of health had created working groups to discuss regulations in three difficult areas.

These are minimum benefits to be offered by schemes; savings accounts and how they would be limited; and mechanisms to stop "adverse selection", whereby prospective members select schemes which suit their particular age or disease profile.

He believed, however, that the Representative Association of Medical Schemes should be consulted.

Zuma keeps her gloves on (299)

BD 5/11/98 (198)

Having won the fight to pass the tobacco bill, Zuma engages in battle over medical aid

Wyndham Hartley

CAPE TOWN — The African National Congress, aided by one member of the African Christian Democratic Party, approved the tobacco bill yesterday despite strenuous objections from the remainder of the opposition.

As the Tobacco Products Control Amendment Bill was being approved by the National Assembly, the first salvos in the battle over Health Minister Nkosazana Zuma's second piece of legislation, the Medical Schemes Bill, were fired.

The Medical Schemes Bill was opposed by most opposition parties during a parliamentary debate last night. The opposition charged that the bill was unconstitutional.

Zuma went from the euphoria of a victory of 213 votes to 106 for the bill that will eventually ban all tobacco advertising, tobacco related sports sponsorships and smoking in public places, to another battle in the National Assembly over the bill that seeks to fundamentally transform the way in which medical schemes operate in SA.

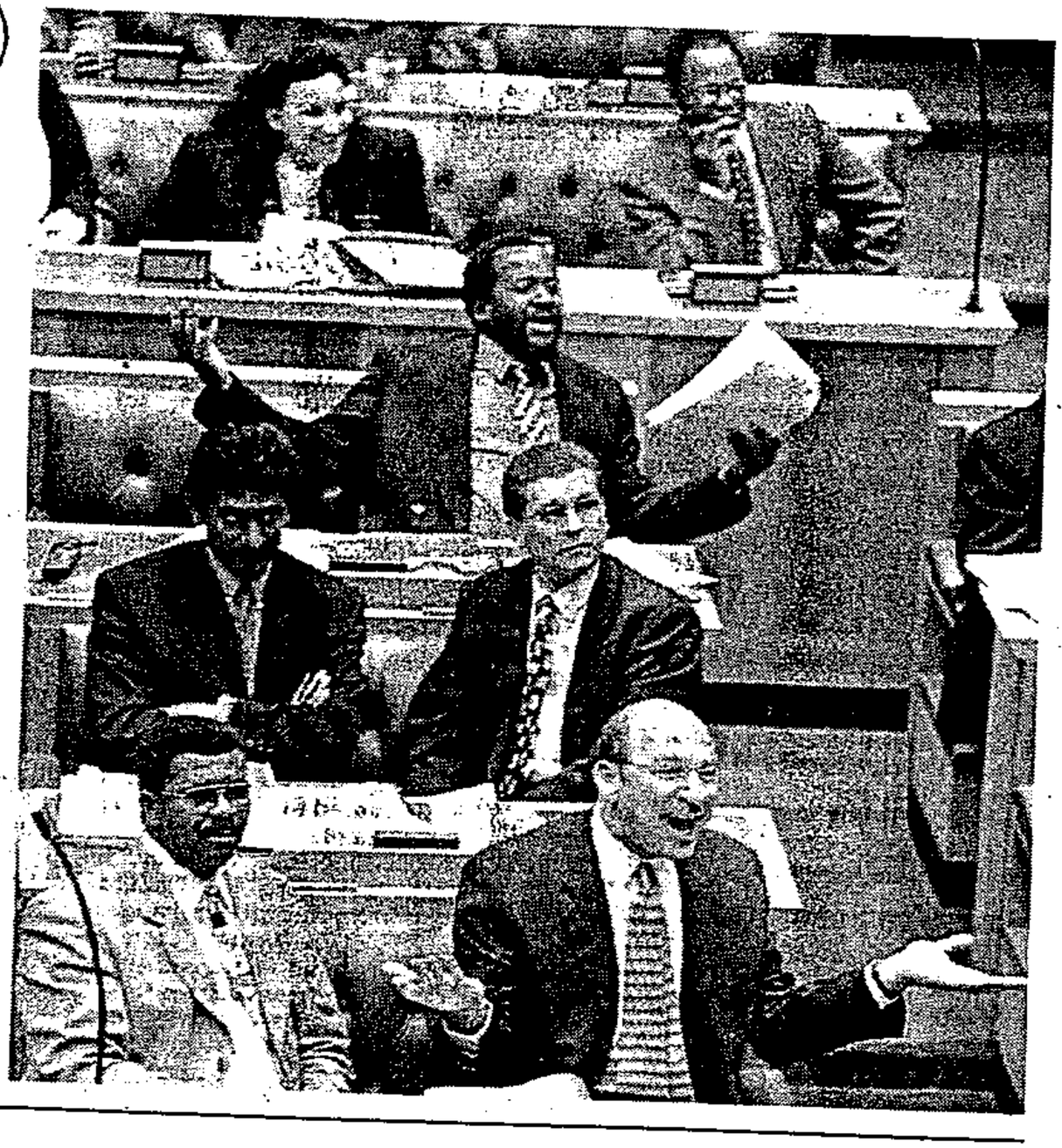
Zuma said the bill was one of the most important to be brought to Parliament by her ministry in that it provided for people to pay for health insurance according to their means. She said the present system discriminated against people on the basis of age and health status and this was forbidden in many places in the world.

Kobus Gous of the National Party questioned the way in which the department of health had ignored predictions from the Actuarial Society that the country could not afford this bill and that it would have the opposite effect to its stated intention of boosting access to health care for more people. Gous said it would drive schemes out of business and effectively give care to fewer people.

Parliamentary health committee chairman Abe Nkomo said the actuarial model used against the bill had been discredited. He said: "Don't confuse me with facts; I have made up my mind".

Freedom Front MP Piet Grobbelaar said his party would oppose the legislation because of the financial strain it would place on existing schemes. He said it would force large increases in tariffs and make medical aid unaffordable to average South Africans.

Inkatha Freedom Party MP Ruth Rabinowitz said creative suggestions from her party and from the industry had been ignored. She said there would be fewer young and healthy people in the schemes and the cost to the state would increase. She also challenged the powers granted to the state in the legislation.



Finance Minister Trevor Manuel, right, gesticulates during a parliamentary debate in the National Assembly yesterday. Next to him is Labour Minister Shepherd Mdladlana.
Picture: TYRONE ARTHUR

Privatised Sasria a step closer

BD 5/11/98

Linda Ensor

CAPE TOWN — The privatisation of the SA Special Risks Insurance Association (Sasria) would have a strong

vatisation of Sasria in the bill as committee members felt that flexibility was required to maximise returns.

However, the bill did compel the minister of finance to dispose of the

introduced by Sasria which mandated Manuel to consult with the industry during the implementation of the bill. Originally Sasria vociferously opposed the appropriation of its ex-

'Unite parastatal medical aids'

CT(BR) 5/11/98 (299)

ADELE SHEVEL

Johannesburg — Transmed, the medical aid scheme of Transnet, had proposed consolidating the medical aid schemes of parastatals, a top-level industry insider confirmed yesterday.

This move follows the request by the department of state enterprises for all organisations under its jurisdiction to achieve efficiencies.

This would mean pooling membership bases in the face of increased commercial pressure and would cover the four largest parastatals: Transnet, Telkom, Eskom and Denel.

It is recognised in the healthcare industry that medical inflation costs have significantly outstripped contributions.

Esmed, the independent medical aid scheme of Eskom, the state electricity utility, has experienced dire financial problems over the past six to seven years and relied on Eskom to bail it out.

Esmed lost 7 000 members between January and June this year. Eskom pumped R29 million into the scheme this February.

Funding has subsequently dried up and Esmed has approached the management board for another financial lifeboat.

Market talk is that Eskom has already injected more than R100 million into the scheme.

Esmed was looking at sourcing between R40 million and R60 million for this year, said Kay Darbourn, the chief executive of Esmed.

Jac Messerschmidt, an executive director of Eskom, said the board had not made a decision as to how Esmed would be restructured, but a number of alternatives were being explored.

Apart from combining forces with other parastatal medical schemes, these options included using defined contributions.

Charles Harebottle, a business consultant, said companies were willing to contribute to medical costs but this had to be done in relation to the total wage bill.

He expected that medical funding would be increasingly approached in the same manner as pensions, as a defined contribution, but the problem was that "having lower earnings does not necessarily mean having lower medical costs".

Messerschmidt said another option would be to rectify what was wrong with Esmed.

Medscheme, the country's largest medical scheme administrator, is to take over the administration of Esmed from the first of next year.

Harebottle said Eskom was evaluating its options to obtain fixed-cost and risk-free contributions. One method would be to contract out to a managed healthcare company.

He said Southern JV and HMH had been identified as potential implementors of managed care or defined contributions, but Discovery had put itself forward as a prospective suitor in the latter regard.

"Business simply cannot afford to carry the risk," said Harebottle.

Crunch day for new medical schemes move

(299)

Health-care not a commodity that can be left to unfettered market forces, says minister about her pioneering legislation

Star 5/11/98

SAPA
Cape Town

Health-care was not a commodity that could be left to unfettered market forces, Health Minister Dr Nkosazana Zuma said yesterday in a spirited defence of a bill that will change the face of the medical-schemes industry.

The National Assembly will vote on her Medical Schemes Bill today.

The bill aims to ensure more people are covered by medical-aid schemes by preventing schemes from barring the sick and the elderly, or making it prohibitively expensive for certain people to belong to them.

"Health-care has to be according to need and not according to wealth," Zuma said after opposition parties repeated claims that the bill would ultimately reduce the membership of medical schemes and make them unaffordable for most people.

"The situation where people are refused cover or forced out of cover because of their health status is clearly untenable," she said.

Meeting needs ... Health Minister Nkosazana Zuma.

Inkatha Freedom Party health spokesperson, Dr Ruth Rabinowitz, said the bill would allow women to join when they were already pregnant, and other people when illness threatened or was diagnosed, at no different cost to when they were not pregnant, or not ill.

She said this would increase costs to those that were already members.

"All of these factors will contribute to a negative spiral in health care," she added.

National Party health spokesperson Dr Kobus Gous said the bill gave Zuma unacceptably wide discretionary powers, allowing her to rule by regulation. The bill would have catastrophic consequences, he warned.

Zuma last month came out on top after a court challenge by Business South Africa, which wanted the bill referred to Nedlac before it went through Parliament.

The measure will enforce open enrolment, meaning that anyone who wishes to join a medical-aid scheme will be able to do so.

It proposes flat-rate payments, as opposed to differentiated payments based on the age or state of health of a potential member.

A broad definition of dependents will also allow more people to join a scheme.

Medical Schemes Bill is passed

(299) Star 6/11/98

Cape Town – A bill which will change the face of the medical scheme industry was approved by the National Assembly yesterday.

The Medical Schemes Bill aims to ensure more people are covered by medical aids by stopping schemes from barring the sick and the elderly, or making membership prohibitively expensive.

The bill, which has been subjected to a court challenge by Business South Africa, was opposed by all the major opposition parties, which claim it will ultimately reduce schemes' membership and make them unaffordable for most people.

Defending the measure, Health Minister Nkosazana Zuma said healthcare had to be available according to need and not wealth. "The situation where people are refused cover or forced out of cover because of their health status is clearly untenable," she said.

The bill will enforce open enrolment, meaning anyone who wants to join a scheme can do so. A broad definition of dependants will also allow more people to join a scheme. – Sapa

Gray implicated in suspected Mpumalanga medical-rescue scam

(299)

Star 10/11/98

By Justin Arenstein

Nelspruit – Hundreds of Mpumalanga residents claimed yesterday they had been sold invalid memberships to an emergency response scheme with a medical rescue company set up by Mpumalanga's suspended parks board chief Alan Gray.

The company, Life Crisis, sold memberships to the international Euro Care scheme without a licence or mandate from the scheme's owner and operator, Europ Assistance.

Mpumalanga, Swaziland and Mozambique-based clients paid their scheme membership fees to Life Crisis in Nelspruit.

The money was, however, never transferred to Europ Assistance or any of its agents, said Europ Assistance spokesperson Leon Venter.

He said yesterday that Europ Assistance had never had any formal agreements or relationship with Life Crisis. The international company was, however, approached to buy Life Crisis several months ago.

"We met Life Crisis at their request and spoke to them about a buyout, but decided against any association after studying the situation," said Venter.

Life Crisis has since closed its office and gone into liquidation. Venter added that Europ Assistance realised Life Crisis had been selling invalid memberships using the Euro Care scheme only when disgruntled members asked whether their membership would be transferred to Europ Assistance.

> **"They at no stage had a mandate to sell our product"**

"We explained that we have no records of membership and that Life Crisis at no stage had a mandate to sell our product," Venter said.

Life Crisis is one of several struggling companies set up by Gray as part of an alleged business network designed to boost the ANC's 1999 election coffers.

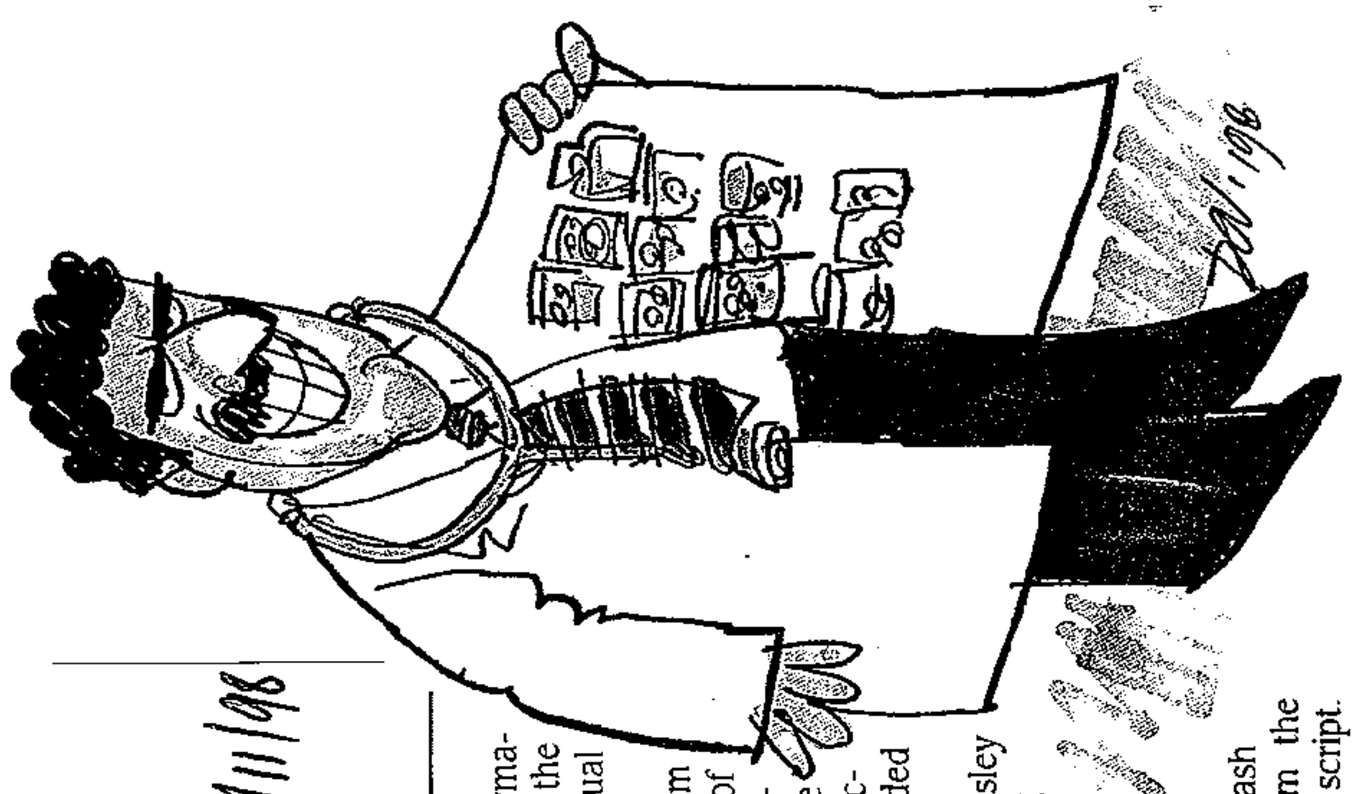
He admitted the company relied on its core client base of government officials for business and has refused to comment on why Life Crisis defaulted on a R1,5-million official contract with a water development agency in Swaziland.

Provincial government officials working with agencies such as the parks board were obliged to take out membership with Life Crisis. The auditor-general has repeatedly criticised the practice as a conflict of interests. Neither Gray nor Life Crisis could be reached for comment yesterday. – African Eye News Service

MEDICAL AID FRAUD

CLOSING RANKS AGAINST A WIDESPREAD SCOURGE

Industry losing R4bn a year



The nine provincial attorneys-general have closed ranks on medical aid fraud, agreeing to centralise future national prosecutions and to appoint experienced prosecutors to these cases.

Professional bodies like the Representative Association of Medical Schemes (Rams) and the Interim National Medical & Dental Council have also agreed to take a tougher stance against this scourge, which costs the medical aid industry up to R4,2bn each year – about 17% of all claims.

The medical aid industry is beginning to uncover significant levels of fraud that previously went undetected, thanks to a huge investment in sophisticated information technology.

The new, imported managed care IT systems produce detailed costing information, enabling schemes to pinpoint which doctors, hospitals and pharmacies charge or dispense more than the norm, and to drive down to individual transactions.

Southern Healthcare CEO Graham Anderson says common types of abuse involve pharmacies that submit duplicate claims or increase the prescribed dose on a claim, and doctors who greatly exceed recommended drug dosages.

Rams financial director John Pugsley says the association is investigating 90 fraud cases, 45% of which involve dispensing doctors and 22%, pharmacies. Many involve a card-for-cash scam in which the doctor gives the patient cash and claims back the amount from the medical aid through a fictitious script.

Often, syndicates of doctors, patients and pharmacies are involved. Fictitious prescriptions are made out and used by the patient to buy cosmetics and other pharmacy items to half the value of the script, with the balance being shared by the doctor and pharmacist.

Among the cases being investigated by Rams is a Mitchells Plain pharmacist who is allegedly giving children narcotics in exchange for doctors' prescriptions.

Pretoria deputy attorney-general Adv John Welch says medical aid fraud has flourished because medical schemes have failed to co-ordinate their anti-fraud activities. It is common for perpetrators to operate across several provinces and schemes, but until now neither the schemes nor the provincial authorities regularly shared this type of information.

Amazingly, a provision in law that allows the Justice Minister to centralise a national case under the attorney-general in the province most affected has never been used to fight medical aid fraud. It soon will be. Rams is co-ordinating its first national case and will request that it be centralised and a senior prosecutor appointed – a move the prosecuting authority welcomes.

Professional councils representing medical practitioners have also reaffirmed their willingness to strike convicted members off their rolls. The problem is that though some schemes do turn to the courts, many take only disciplinary steps or merely allow the perpetrator to pay back the stolen funds.

"If medical schemes expect fraudulent behaviour to stop, they will have to decide whether to utilise the courts. In other words, they must take crime seriously," says Welch.

Adv Koot Myburgh, a Rams council member who heads its fraud task team, agrees. "No economy can afford business to become a facilitator for fraud, dishonesty and other criminal behaviour merely because it has become convenient not to bring the culprits to justice.

"By pooling resources into sustainable strategic alliances consisting of investigators, defrauded schemes, the prosecuting authority and motivated police fraud units, it is still possible to get to grips with this scourge."

Claire Bisseker

»Common types of abuse involve pharmacies that submit duplicate claims or increase the prescribed dose on a claim, and doctors who greatly exceed recommended drug dosages«
Graham Anderson

Medical aid bill gets the nod

CLIVE SAWYER (299)
POLITICAL CORRESPONDENT
ARG 13/11/98

Parliament has approved reform legislation on medical aid schemes amid a row about whether a broadening of the definition of dependents will bring financial ruin to schemes.

The Medical Schemes Bill was approved by the National Council of Provinces yesterday.

Neels Ackermann of the NP said the new bill would bring medical aid schemes to their knees by making medical aid prohibitively expensive.

Health Minister Nkosazana Zuma said it made no sense to limit dependents only to the immediate family of scheme members.

New head, same problems at Rams

LT (PR) 20/11/98 (1299)

ADELE SHEVEL

Johannesburg — The internal dissent that has plagued the Representative Association of Medical Schemes Association (Rams) over the past year continues in the face of the election of a new chairman as part of the association's transformation process.

Arnold Fair, the chairman of NMA Medical Fund Managers, was elected on Wednesday as Rams' chairman with effect from January 1 next year.

Fair replaces Keith Hollis, the chairman of Medscheme, who was ousted from the executive and council after 12 years' service.

Rams has been burdened by dispute, especially over the controversial Medical Schemes Bill, which was recently passed in the national assembly. Earlier this year a breakaway group that included representatives from the insurance industry issued an interdict to prevent Rams from representing the industry because they said it did not adequately convey their concerns with the bill. Certain of these insurers were recently elected to the Rams council for the first time.

But Gerald Bester, the chairman of Pro Sano medical aid, said there was concern the newly elected executives might take over Rams and manage the association to their benefit. "Those insurance giants might not necessarily serve the needs of the membership schemes," he said.

Pro Sano Medical Scheme, one of the largest black medical aid schemes in South Africa, has called for the disbanding of Rams.

Bester said Rams was required to undergo not a transformation but a metamorphosis. "In its current guise it will not be acceptable to the majority of South Africans".

Its "81 percent white composition — with only one female and three blacks — is incapable of transforming the healthcare sector to reflect the demographics of South Africa", he said.

Bester has referred to the "lily-white Rams" and appealed to form a completely new organisation "truly reflective of the composition and needs of our country".

Rams represents most of the country's185 medical schemes.

By Adrienne Roberts

NO REMEDY FOR MEDICAL AID INFLATION (299)

It has overtaken the CPI

FM 27/11/98

Medical aid inflation has been outstripping the consumer price index (CPI) since the late Eighties; employers now spend 8,7% of payroll on health-care costs compared with 5,3% four years ago.

Medical schemes have turned to managed health care, medical savings accounts and benefit limits to contain costs. As a result, the average annual contribution increase per member has fallen from a high of 34% in 1991 to 14,2% in 1996 and 12% this year.

But medical inflation shows every sign of heating up again. Contribution increases for 1999 could range from 13% to 20% — bad news for employers.

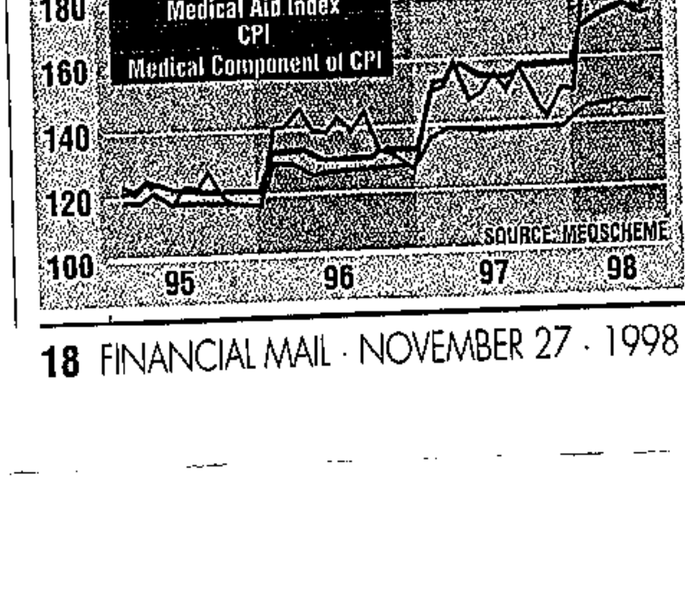
A weak rand, the health-care demands of SA's rapidly ageing population, not to mention the impact of Aids, malaria and TB, will continue to fuel medical price increases.

Unhealthy lifestyles also push up costs, says Medscheme director Gary Taylor. The effects range from respiratory diseases caused by coal smoke in townships to the burgeoning demand for Prozac from stressed-out Sandton yuppies. One administrator spent almost R20m on Prozac last year and expects Viagra to cost the scheme twice as much.

Two of the biggest cost-drivers are pharmaceuticals and diagnostic equipment. "Because pharmaceuticals and medical equipment are almost entirely imported, the fall in the rand has had a huge impact on these costs and this will continue to affect us next year," says Taylor.

Discovery Health CEO Adrian Gore agrees the industry is beginning to feel the effects of the weak rand. "Going forward, I'm concerned about private hospital costs and drug prices. Going back, we've had a bad flu epidemic. Put the two together and you've got a strong inflationary trend. Our best view of medical inflation for 1999 is 14%."

He also blames poor pricing and management strategies by medical aids who discounted their rates too heavily this year in the mistaken expectation that managed care would deliver huge savings. They are now having to raise their 1999 rates to recover this year's losses. **Claire Bisseker**



Medical scheme association fragmented by walk-out

ET (10R) 3/12/98 (299)

ADELE SHEVEL

Johannesburg — The medical scheme industry faced fragmentation following this week's decision by the SA Association of Medical Schemes (Saams) to withdraw from the Representative Association of Medical Schemes (Rams), industry insiders have said.

The sources did not discount the possible withdrawal of other members from Rams or the replacement of Rams by a new body.

Saams, the second largest member of Rams, decided 60 to one to withdraw from the 25-year-old unified body. The decision means Rams no longer fully represents the industry.

Parties within Saams claim Rams is incapable of, or unwilling to, transform the healthcare arena. At present Rams represents most of the country's 185 medical schemes, while Saams represents about 27 percent of the industry.

Declan Brennan, the chief executive of Rams, said yesterday that he had not received the official notification about Saams's withdrawal but that he "would hate to see the industry split".

An insider said the letter of withdrawal was expected to be received today or tomorrow.

Brennan said membership of Rams and Saams was not mutually exclusive. Arnold Fair, the incoming chairman of Rams, said he encouraged schemes to belong directly to Rams.

Concern was expressed that Rams would not function at the current level of subscription, as the walk-out is expected to cost it about R2,5 million in yearly levies.

Saams comprises mainly Medscheme's client schemes. Keith Hollis, the outgoing chairman of Rams, is the chairman of both Medscheme and Saams. He declined to comment, saying it was "inappropriate".

Over the past year Rams has been burdened by dispute. The industry has battled with the recently passed Medical Schemes Bill. Earlier this year a breakaway lobby group was formed within Rams, but said it would never withdraw from the body because it would not benefit the industry.

MEDICAL AID

(299) FM 4/12/98

EMPLOYERS RUN FOR COVER AS HEALTH COSTS TENSE TO SPRING

Rocketing contributions could spur shift to managed care

More and more companies are being forced to consider slashing their expenditure on health benefits in the new year as medical schemes warn of premium increases of up to 38%.

Health-care costs have risen to 8,7% from 5,3% of payrolls in the past four years. Despite the promise that managed health care will bring down costs, salary increases will again fail to keep pace with medical-aid inflation.

Projections for medical inflation in 1999 range between 13% and 15%, which is double some Consumer Price Index projections. The rekindling of medical inflation comes at a time when the industry is trying to reduce costs to make private care accessible to more people.

Medical schemes will raise their premiums by 8%-38% next year, with the bulk being about 15%-20%.

The medical aid industry blames the high increases on higher prices and increased use of health care during the year. Six administrators canvassed by the *FM* say the biggest cost-drivers are private-hospital costs, the flu epidemic, and rising costs of medicine and medical equipment because of the fall in the rand.

They are adamant that managed care is working, and that without this cost-containment strategy the damage would have been worse. They reject the suggestion that the real culprit is the high administrative burden imposed by managed care.

Instead, they blame the historic lack of managed-care principles in health care for rampant inflation. They say the savings achieved through managed-care programmes already outweigh the costs, sometimes by as much as seven to one, and argue that, given more time, they will bring even bigger savings.

But employers say they cannot afford to absorb further costs.

"For the first time there is a strong move among employers to reconsider what they are spending on health care and to look at the bare essentials of what a health plan should offer," says Aon Consulting SA MD Aubrey Sonnenberg. "Compared to the US, our medical aids offer rich benefits and companies are beginning to look at what is realistically affordable in the current business climate."

He says that though terms of employment may require an employer to provide medical aid, they seldom stipulate what level of benefits must be provided. Employees, also feeling the pinch, may even be grateful for the opportunity to reduce their medical aid contributions, as most pay 50% of these costs.

Alusaf's Bayside and Hillside smelters took the plunge about three years ago, giving employees cash in lieu of health benefits. Staff can choose a plan to suit their health needs as long as it offers certain minimum benefits. The company awards contribution increases in line with those of average new-generation schemes.

Howard Walker, joint MD of Alexander Forbes Health Care Consultants, is aware of employers who are considering giving staff cash instead of providing medical aid next year. But they are constrained by the fear that some staff may not be accepted by new schemes because of poor health, and that the cost to individuals of joining a scheme may be higher than as a group.

Whatever course of action they take, it is clear that more companies are seriously considering ways to cut their health costs.

This is bad news for high-end, or "Rolls Royce", schemes that offer excellent benefits, like Southern Healthcare's managed-care plan. Though managed care has brought the company savings of 7%-10% this year, its 1999 premium increases range from 8%-38%, with the average being around 20%.

Southern CEO Graham Anderson says it will take "some time" for managed care to make an impact on medical inflation, as was the case in the US, but he has "no

COMPANIES SQUEEZED

Medical aids' looming crisis

- Medical schemes plan to raise premiums 8%-38% next year, averaging 15%-20%.
- Medical inflation projected to rise 13%-15% in 1999, exceeding salary increases.
- Health costs have risen to 8,7% of payroll from 5,3% in the past four years.
- Companies say they are no longer prepared to keep pace with rising medical aid costs.

Cont.

4/12/98

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doubt" that the medical data Southern is now retrieving from members and practitioners will enable it to curb cost increases in the months ahead.

NMA Group spokesman Tommy Edmond concedes that managed-care companies haven't been as successful as they could have been in curbing costs, mainly because of a lack of member education and a refusal by all categories of health-care players to accept accountability for high costs.

"Managed care is still in its infancy in SA. The average consumer is still remarkably ill-informed and therefore often resistant to the concept of managed care," he says.

Edmond says the NMA Group's biggest cost-drivers are the impact of new technology, HIV/Aids, trauma, neonatal services, resistant infections acquired in hospital, inappropriate levels of care, the flu epidemic and the crash in the rand.

"HIV/Aids is starting to cut into schemes' costs at an alarming rate, and trauma as a result of motor-vehicle accidents and violent crime has also had a big impact on hospital costs," says Edmond.

Complications arising from infections acquired by members once in hospital cost NMA about R144 000/case and are increasing. It has reports of 14 such cases across nine hospitals in two consecutive months. The crash of the rand, Edmond says, has increased the cost of hospital consumables and drugs by more than 20% because of their high imported content.

As a result of these factors, NMA's hospital costs increased by a staggering 20%-46% across various schemes in 1998. The average annual contribution increase across the group is 19,5% but schemes with relatively well-educated members and strong managed-care programmes averaged increases of as little as 9%.

Like other managed-care companies, Medscheme's managed-care programmes concentrate on curbing medicine and hospital costs. They achieved total savings of 2%-3% in 1998. Since the introduction of Pharmaceutical Benefit Management (PBM), a Medscheme subsidiary promoting the cost-effective and judicious use of medicine, Medscheme's spending on medicine has slowed.

"Managed care is definitely working and, in the case of PBM, is saving at least R3 and in some cases as much as R7,80 for every R1 spent," says PBM pharmacy director Ashley Smart.

Medscheme kept medicine cost increases to below medical inflation in 1996 and 1997 but costs have escalated by 27% this year — a major factor in its 1999 contribution increases of 8%-18%.

Other schemes report similar medicine cost hikes and the Representative Association of Medical Schemes (Rams) warns that medicine prices could climb 25% next year because of the weak rand.

The flu epidemic also hit some schemes hard, with Northern Medical Society notching up a flu bill of R23m for the year.

In July the number of hospital admissions at Southern was up almost 10% compared to the same time last year because of the seriousness of the epidemic, but thanks to managed-care initiatives to ensure that no member enters hospital unless it's medically necessary, or stays longer than is medically indicated, the number of hospital days fell 4% and the average length of hospitalisation fell 8,5%.

This may be the reason the number of Caesarean births among Southern members fell by 7% during the year. And a 19% fall in appendectomies shows that managed care is also bringing GPs into line.

NMA has more than halved its Caesarean rate and denied more than 40% of all requests for hospitalisation for dental and psychiatric care as these cases could be handled on an outpatient basis or in the dentist's chair.

The new-generation schemes usually achieve contribution increases below those of traditional schemes, mainly because they use medical savings accounts that reduce their costs, their membership base tends to be younger and healthier, and they risk-rate members more accurately. Discovery Health's contribution increases range from 13,8% to 14,8% while the other main new-generation player, Fedsure Health, has a slightly disappointing 16%.

"Though the cost of managed care has been high, the savings we've achieved have been higher," says Discovery Health GM Alan Pollard. "We believe that had it not been for managed care our hospital cost increases (which were 10% per member per month) would likely have been three to five percentage points higher."

Sanlam Health failed to supply the *FM* with its 1999 contribution increases but at least it didn't try to hide the damage from the collapse of its claims-processing system during the year, which lost it thousands of members to rival schemes.

The industry recognises that medical-scheme contributions are becoming unaffordable and that managed care must be intensified next year if costs are to be contained. This means medical practitioners and hospitals will come under severe pressure from medical administrators to control their costs. If they don't, employers will have little choice but to cut back on medical aid and the entire health-care industry will lose.

Claire Bisseker

ELECTION 1999

VOTING RIGHTS ROW

It sounds iniquitous, if not unconstitutional. While SA diplomats serving abroad will be able to vote "within the confines" of our foreign embassies or High Commissions, the same right — or privilege — will be denied to other citizens who are out of the country during next year's general election.

"SA citizens deployed in diplomatic missions abroad, and their families, will be able to vote," says Michael Overmeyer, media relations director of the Independent Electoral Commission. This is in terms of the Electoral Act, "which should be in synch with the Constitution"..

Embassy polling booths were open to all citizens in the 1994 election. This was a "special case", and, since only 20 000 turned up, it seems laying on the facilities is deemed not to be worth the cost involved.

Amarnath Singh

MEDICAL AID COVER

ADVERTISING FEATURE

Aims of the Medical Schemes Bill

Sowetan 4/12/98 (299)

THE Medical Schemes Bill is intended to replace the Medical Schemes Act (Act 72 of 1967) and its subsequent amendments. Legislation, as it stands, does not reflect the Government's current health policy.

The Bill has hence been introduced with the following intentions:

- To promote access to medical scheme coverage through a system of community rating and non-exclusion (open enrolment).
- To protect medical schemes from members selecting against them by delaying joining until sick or elderly, within the open enrolment environment mentioned above.
- To prescribe a minimum level of benefits, both to ensure that members are adequately covered, and to avoid shifting the costs of caring for members with insufficient benefits to public hospitals.
- To appropriately define the business of medical schemes and that of other sickness insurance products offered under the Insurance Acts.
- To improve the regulatory supervision of medical schemes, as well as their governance and administration.

All in all, these changes are intended to provide incentives for cost containment and improve access to medical schemes.

Application of the Bill

Either the Constitution or any Act expressly amending the Bill may only override any conflict relating to matters dealt with in the Bill. The Bill will also apply to medical schemes established by the State.

An attempt has been made to ensure that the Bill is constitutional by stating that a scheme may 'not unfairly discriminate directly or indirectly against any person on one or more grounds including race, gender, marital status, ethnic or social origin, sexual orientation, disability and state of health'.

This not only extends the protection offered to applicants for membership, but also prevents exclusions in respect of state of health to give effect to the open enrolment policy.

While discrimination on the grounds of marital status and sexual orientation is disallowed, the definition of dependant does not explicitly allow for same-sex partners.

It is also implied that fair discrimination is permissible.

Admission of a member

Section 30.1 (n) reads: The terms and conditions stated in the rules may not provide for the determination of contributions or benefits, on one or more grounds including age, sex, past or present state.

A medical scheme will not be allowed to provide in its rules for the exclusion of any applicant or a dependant of an applicant from membership, unless it is a restricted membership scheme.

The exclusion of any applicant or a dependant of an applicant will not be allowed, if the person is otherwise eligible for membership.

The implication of these clauses is the so-called "open access" ruling that has recently received extensive media coverage. Members' age and existing health profiles may not disqualify them from medical cover under any approved scheme.

It is expected that large employers will move their employees to in-house schemes, in order to benefit from the more lenient prescriptions regarding the admission of members that apply to restricted membership schemes.

Combined, open access and community rating will lead to all approved open medical schemes being required to accept virtually any applicant providing they are able to pay the contributions.

The minimum prescribed benefit

The minimum benefits that a scheme provides shall not be less than the benefits provided by public hospitals. Furthermore no limitation shall apply to the payment of any relevant health service obtained by a member from a public hospital.

Under the current legislation, the minimum benefits a scheme must offer are not prescribed.

The prescription of minimum benefits will not effect a major change, as most schemes are currently offering at least the benefits provided by public hospitals.

Business of a medical scheme

The Bill states that no person shall carry on the business of a medical scheme unless that person is registered as a medical scheme. The business of a medical scheme is defined as "the business of undertaking liability in return for a premium or contribution

a) to make provision for the obtaining of any relevant health service;

b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and

c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with or in terms of an agreement with a medical scheme."

The Act as it currently stands states that the business of a medical scheme is to defray medical expenses.

Changing this definition to include organisations that undertake liability in return for a contribution will impact significantly on a number of organisations currently in operation.

These include Independent Practitioner Associations working on a capitation basis, managed health care companies, insurers, as well as any other organisations that enter into risk-sharing arrangements.

When these organisations become subject to registration, meeting the required provisions such as providing prescribed minimum benefits may prove too onerous for the organisations to continue in existence.

It is, however, within the powers of the Council of Medical Schemes to exempt medical schemes from certain provisions.

The result of this change will be that all medical 'schemes' will fall under one regulatory body. Organisations that previously reported to the Financial Services Board, or were subject only to the provisions of the Companies Act, will now fall under the supervision of the Registrar of Medical Schemes.

This should hopefully increase member security, as well as having the effect of levelling the playing fields.

Rules of Medical Schemes

The Registrar of Medical Schemes will not register a scheme if the rules fail to make certain provisions. The rules of a medical scheme must provide for:

- the governance of the scheme
- the admission of a member
- the minimum prescribed benefits
- continuation cover and transferability
- the cancellation of membership
- the non exclusion of applicants
- general provisions
- and the procedure for the amendment of the rules.

Medical schemes industry body splits

(299)

Many are wondering who is considering the members' interests, writes **Pat Sidley**

BD 4/12/98

THE medical schemes industry body has split — and the recent Medical Schemes legislation is the reason.

Rams, the Representative Association of Medical Schemes, has been the body which "fixed" tariffs in the industry, negotiated with government on behalf of several million scheme members, and purported to speak with one voice on the controversial new law.

This week, a major component of the industry body, known as the SA Association of Medical Schemes (Saams) withdrew from Rams to represent its own interests. Saams claims to have a department of health sanction for their go-it-alone move.

However, the department's medical schemes expert, Patrick Masobe, said he believed the move was unfortunate.

Although millions of medical scheme members do not feature in the squabble, their interests are likely to be prejudiced by the move, which according to one industry commentator, is a clash of differing commercial interests.

The move is also likely to cost Rams a great deal of money. Saams represents about 27% of the membership of Rams and contributes about R2,5m a year to Rams. Although it is bound for another year to this amount, it is thought that Saams may disband to get out of its obligation to Rams.

The split has followed a series of squabbles within the industry which resulted in an interdict being granted to stop Rams from purporting to represent its own members.

The interdict had been applied for by a group of medical schemes which called itself the Concerned Medical Schemes (Coms) and included a group of insurance company-based medical schemes.

An election to the Rams governing council which followed the interdict saw Saams losing three of seven members on a 16-member council to the Coms group. The divisions turned out to be irreparable — and the Saams grouping announced this week it was leaving.

Fallout from the split is likely to affect more than just the Medical Schemes Act negotiations. Increasing medical costs and the effect of AIDS are among the issues which are likely to miss the spotlight in a divided industry.

However, that is not how Saams is seeing the issue. It is largely formed out of traditional medical schemes claiming to accept the notion of community rating which is fundamental to the Medical Schemes Act.

This forces schemes to quit charging premiums based on the health and age of members and forces them to accept older and more sick members and to charge only according to the income and size of a family.

Although the traditional-style medical schemes — which technically do not operate for profit, but out of whom administrators make a huge profit — claim to support community rating, the reality is that they all do "risk rating" the same way as insurance companies do.

According to Reg Magennis of Medscheme (part of Saams) they have been forced to join the insurers in "risk rating" to stop the flow of younger and healthier members into schemes which woo them with lower rates.

Magennis points to the complications of the setting of tariffs by Rams and believes if necessary Saams will do their own negotiating with health care providers.

Brian Brink, who represents Anglo American's health care division and becomes a Rams council member next year, said the breakaway was unfortunate. The community rating issue, he said, was now a thing of the past. The law had been passed and everyone would work with it. He believed the industry's interests would be served best by a united front dealing with such things as ever-spiralling medical costs and AIDS.

Ironically, one of the "new" groupings within Rams believes the competition between two industry bodies may be useful precisely to force more efficiency into the system.

However, for Alex van den Heever, who helped draft the Medical Schemes Act and has been a member of the statutory medical schemes council, the fight is simply about money. He believes members' interests are not taken into account anywhere in the squabble.

MEDICAL AID INDUSTRY

(299) FM 11/12/98

LESS PRINCIPLE THAN REVENGE OF A WOUNDED OLD LION

Hollis breakaway deprives the industry of a single voice

The medical-aid industry has split and so is opinion on why Keith Hollis, the long-standing chairman of the Representative Association of Medical Schemes (Rams), has defected with a third of its members and R2,5m in annual levies.

It is either the petulant revenge of a wounded old lion or the principled stand of a man who commands respect for leading the industry as chairman of Rams for five consecutive terms.

The 61 member schemes of his breakaway faction, the SA Association of Medical Schemes (Saam), are convinced it is the latter, but some of his oldest colleagues and Rams councillors say "it's just sour grapes" because he has lost all influence in Rams.

As chairman of SA's largest medical aid administrator, Medscheme, which covers about 2m people, Hollis is used to wielding power in an industry of which he is a founder member.

Saam is his traditional support base. It represents about 27% of the industry and is made up almost entirely of Medscheme's client schemes.

The upshot of Saam's defection is that the medical aid industry no longer speaks with one voice.

Rams, which had substantial clout because it represented 97% of all schemes and set industry tariffs, is weakened, but not irreparably.

"I think it's sad for the industry," says Rams council member and NMA Medical Fund Managers MD Jeff Slome. "It's been done with a lot of self-interest on the part of Hollis and without careful thought and consideration."

Saam says it has left Rams "so that it may more effectively represent the specific interests of its medical schemes and proactively participate in the legislative changes which are shaping the medical aid industry."

Saam says its breakaway is motivated by the new mindset that will be demanded of medical schemes under the recently passed Medical Schemes Amendment Act. "Our approach is one of co-operation and support, not confrontation," says Saam vice-chairman Berman Mofekeng.

>> Rams, which had substantial clout because it represented 97% of all schemes and set industry tariffs, is weakened, but not irreparably <<

Saam fears Rams is being hijacked by the insurance industry as Hollis and two Saam councillors lost their seats on Rams in October to a new generation of leaders, among them Discovery Health CEO Adrian Gore and Fedsure Health chairman Dave Avnit. Their schemes have lured thousands of young and healthy members away from traditional schemes, like those run by Saam, by offering members personalised medical savings accounts.

The insurance-based schemes vigorously opposed the Act, which will hamstring their schemes, while Rams, under the chairmanship of Hollis, endorsed it. But the legislation has been passed and all that remains is for an industry/government forum to draft the regulations, as it is doing quite amicably.

Rams chairman-elect Arnold Fair is devastated by Saam's breakaway and feels Hollis has failed to give his members the full story.

Gore and Avnit are merely two members of a 16-member council (most of which remains unchanged) that is committed to working with government and representing the interests of all its members.

The new Rams council unanimously endorsed a transformation document submitted by Saam just before its departure, giving the lie to accusations that Rams is opposed to transformation.

As more than one Rams councillor remarks: "If Rams is such a bad organisation, why didn't Hollis do something about it? After all, he was the chairman for five years."

Fair also plans to change the Rams constitution to give the regions and smaller schemes a greater say in its affairs. He will be approaching all Saam's schemes to give Rams' viewpoint and to offer them direct membership of the organisation.

Last month Gore, Avnit and another new councillor, Anglo American's Brian Brink, wrote a letter to Saam urging it not to split the industry.

"Now, more than ever, the members of medical schemes need a strong and unified voice to represent their interests. Fragmentation and division will be exploited to the detriment of all members," they said.

It's a myth that the fragmentation of Rams is in the best interests of some members, that commercial interests are incompatible with social objectives or that the three new council members have hijacked the process or are opposed to transformation, says Gore.

"We want to put the political squabbling behind us and concentrate on the real issues like medical inflation and Aids."

Hollis is angry about accusations that he has acted in a fit of pique but does not wish to comment.

Claire Bisseker

SOCIAL SECURITY-MEDICARE

1999

Pharmacists issue ultimatum

Amanda Vermeulen

TWO thirds of SA's pharmacies have threatened medical schemes that if they do not agree by March 1 to guarantee payment of prescription claims, scheme members will have to pay for their drugs and then claim from the schemes.

United SA Pharmacies (Usap), which represents two thirds of the 2 600 retail pharmacies nationally, has been battling with medical schemes and the claims processing offices for about more than two years over rejection of claims.

Usap chairman Julian Solomon said yesterday all the schemes — about 180 — and the claims processing offices had been sent letters, giving them until March 1 to come up with a mechanism to guarantee that claims would be covered, or Usap member pharmacies would withdraw credit facilities to the schemes.

Usap says its members cannot check the validity of customers' scheme membership with many medical aids as they do not have accurate or current information on their membership base. Claims are rejected by the medical schemes when a member has resigned or exceeded his benefit scale.

The pharmacy is then often forced to carry the loss. It is believed that the rejection rate is about 10%.

Solomon said a major problem was lack of co-operation from employers in providing information.

Usap has called a meeting with some of the major players for next week.

Medical schemes upbeat about payment deadline

BD 11/1/99(299)

Amanda Vermeulen

SA MEDICAL schemes and their clearing houses say they should be able to meet a deadline to guarantee payment to pharmacies after they threatened to withdraw their credit facilities.

United SA Pharmacies (Usap) said last week that unless SA's about 180 medical schemes came up with a solution to guarantee them payment by March 1, scheme members would have to pay for dispensed drugs themselves, and later claim back from their schemes.

Medical aid administrator MD Andrew Jackson said: "Medscheme's Medpharm system has the necessary technological sophistication to meet the Usap requirements. Usap chairman Julian Solomon has confirmed this to us."

Medscheme appreciated the cash flow problems of pharmacists dealing with medical aids that do not have such high-tech systems.

Clearing house MediKredit said it would comply with the Usap request. CEO Wimpie du Plessis said this was conditional on employers and schemes providing the claims processing office with the correct information. MediKredit has an on-line claims processing system.

Interpharm, which is implementing its own systems, said it would wait for a meeting called by Usap for this week before commenting, while Mediscor was not available for comment.

Usap said one of the critical problems which led to the two-and-a-half year long running battle between the pharmacies and the schemes was the employers' failure to inform their schemes in time of changes in the details of their staff.

About 10% of claims sent by pharmacies to schemes and clearing houses are rejected due to memberships having been terminated or benefit limits being exceeded. Last year, a pharmacy suffered a R13m loss due to rejected claims.

Currently, pharmacies fill out prescriptions and claim the cost of the medicines from the schemes. Usap's argument is that its members cannot check the validity of customers' scheme membership with many of the medical aids as they do not have accurate or current information on their membership base.

If Usap members, who represent about two thirds of SA's 2 600 retail pharmacies, carry through their threat, members of some schemes will be forced to pay for their drugs.

According to statistics from Medscheme, the average cost per prescription rose 13,9% last year, compared with 1997, with the number of scripts per family increasing by 4,2%.

The compounding effect of the devalued rand means that total medicine costs in medical aids have risen 18,6% per family from R183,98 per month in 1997 to R218,25 per month last year.

Medicines represent 25% to 30% of total medical aid costs on drugs, more than the 12%-15% in the US, Europe and Zimbabwe.

New medical body to challenge Rams

(299) CT(JHB) 14/1/99

ADELE SHEVEL

Johannesburg — A new organisation to rival the Representative Association of Medical Schemes (Rams) is being established, initially with the membership base of the South African Association of Medical Schemes (Saams), it emerged yesterday.

This is the first time in the 25-year history of the representative body that an umbrella association will counter Rams. Saams, the second largest member of Rams, withdrew from Rams at the end of last year, but other medical schemes will be able to join the new body.

"Things are changing quite considerably, and I think the new body could more adequately represent the industry," said Keith Hollis, the chairman of Saams. The name of the new group is yet to be finalised, but a meeting scheduled for later this month is expected to shed more light on the name and the group's agenda.

Medical schemes spend more than R25 billion a year in payments for services to 6,9 million members in the private sector.

Hollis said that changing arrangements with regard to reimbursement by schemes is expected to entrench itself to a greater extent. "We are of the view that Rams may not be adequate to transform to the schemes' evolving requirements," he said.

Aslam Dasoo, Rams' director of policy, said the interest of the industry was best served by a single voice, but the call for an alternative voice implied that Rams needed to assess why a new association may be necessary.

MEDICAL SCHEMES ASSOCIATION

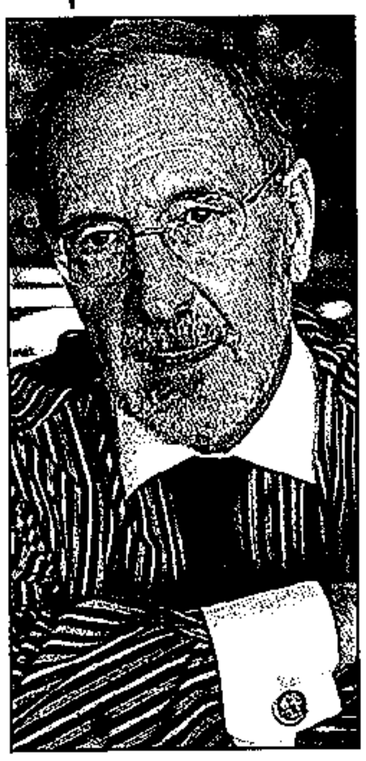
RAMS RECLAIMS LOST LAMB?

Medscheme chairman Keith Hollis, who split SA's medical aid industry association, Rams, late last year by walking out with a third of its members — could be back in the fold soon.

Hollis, who served five successive years as chairman of the Representative Association of Medical Schemes (Rams), failed to be re-elected to the Rams council in the October AGM, amid differences within the organisation about how the industry should respond to Health Minister Nkosazana Zuma's medical aid reforms.

Two Rams council posts held by members of the SA Association of Medical Schemes (Saam) — Hollis's traditional support base — went to a new generation of leaders who had vociferously opposed Zuma's reforms. Under Hollis, Rams had shown support for Zuma's moves, which reflected Hollis's and Medscheme's good relationship with the Minister.

After failing to be elected, Hollis and Saam duly quit Rams, splitting an astounded medical aid industry and depriving Rams of R2,5m in annual levies. Their departure left four Rams council vacancies, which its constitution says must be filled by those who received the next-highest number of votes at the AGM.



Keith Hollis

All four in line are Saam members, one of them Hollis.

Rams chairman Arnold Fair is hopeful Hollis will take the opportunity to reunite the association. "The feeling is Medscheme's senior management don't want to become embroiled in industry politics, they want to run their business, and that they may welcome this opportunity," he says. "I hope they encourage Keith to come back to the council."

Hollis says he hasn't yet decided whether to accept the offer.

Claire Bisseker

Medical aid funds are healthier but relapse is possible (299)

An independent report shows the industry has recovered from its weak position five years ago, but there are problems on the horizon, writes LEIGH ROBERTS

ST (BT) 14/1/99

THE 4-million members of medical aid funds in the private sector can sleep more soundly at night. A survey shows most medical aid funds are financially stronger than they were a few years ago.

But there are still some issues of concern for fund members, which could lead to sharply higher contributions in the future.

Independent credit rating agency Duff & Phelps this week released its 1998 report on the medical funds industry. The report covers 31 "open" medical funds in the private sector, making up 90% of the industry. The "open" classification means their membership is open to any company and its employees.

The accompanying table shows the credit rating awarded to each fund. A credit rating is an assessment of a fund's financial ability to pay its members' claims timeously. The ratings are based on the fund's 1997 financial statements and available 1998 management accounts.

The members of these 31 funds can take heart that all funds achieved a secure credit rating, although one fund, the Allcare Medical Aid Scheme, is at the bottom of the secure rating.

Discovery Health achieved the highest rating out of the 31 funds, but it is still two notches short of Duff & Phelps' premier risk-free rating of AAA.

The report reflects the improved conditions in the industry. Just five years ago the industry was battling against spiralling cost claims and the exodus of younger members embittered by sky-high contribution hikes.

Vice-president of Duff & Phelps, Jonathan Bear, attributes the industry's improved position to the high contribution increases imposed on members and to the cost containment measures introduced in the past few years. These cost containment measures, designed to cut the number and size of claims, resulted in a below-average claims increase of 8% in 1997; well down from the 15% and 10% jumps in the previous two years.

The industry was also helped along by members returning to the funds. In 1997, membership rose by almost 5%; a far cry from the shrinkage of 13% in 1992.

Higher delivery costs must be countered with membership growth and lower claims — a luxury not all funds have

But the industry is not out of trouble. There are some serious hurdles on the horizon.

First is the trend of steeply rising medical inflation, which pushes up the cost of servicing members' claims.

Since the early 1990s medical costs have risen faster than general inflation. The gap widened in 1997 with medical inflation at one and a half times the consumer price index (8.6%).

Secondly, the cost of delivering services to members, mainly administration and managed healthcare expenses, is taking an ever-bigger slice of the funds' income. Only three of the 31 funds — Natalmed, Bankmed and Discovery Health — did not increase their delivery costs relative to their contribution income in 1997.

Higher delivery costs must be countered with membership growth and lower claims — and that's a luxury not all funds have.

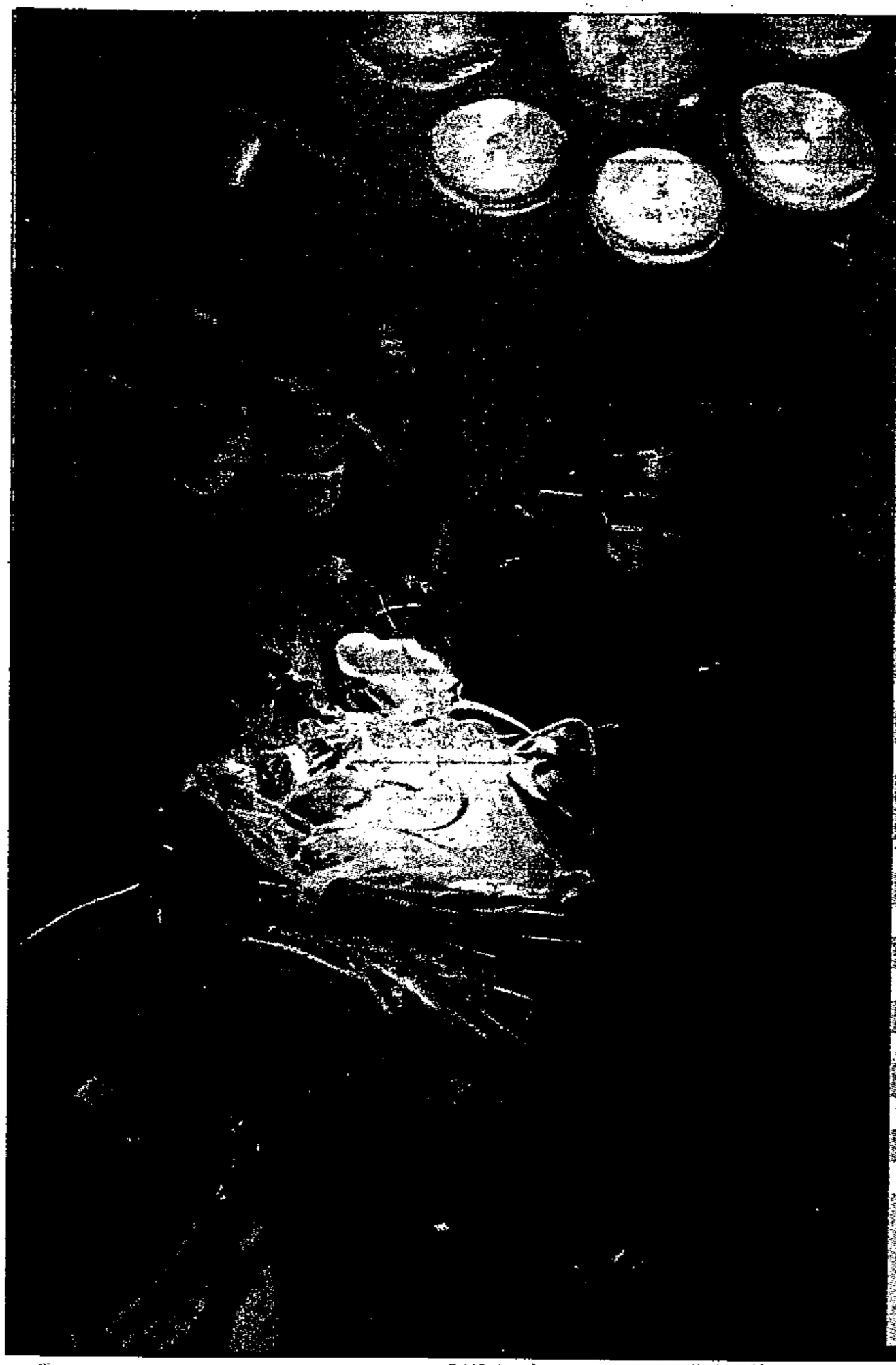
The third hurdle for the industry is to comply with the 25% minimum solvency level recommended by the registrar of medical schemes. Almost half of the funds currently fall short of this level. The lower the solvency ratio, the lower the fund's financial reserves.

The solvency position could be weakened further, notes Bear, because the funds' final figures for 1998 will reflect the tumultuous events of the year. Notably, the flu epidemic and the weaker rand, which increased costs, and the stock market crash, which knocked the funds' investments.

Bear expects these conditions to result in sharply higher contributions this year: increases in the 15% to 25% range.

The final hurdle for the industry — and undoubtedly its biggest — is the new Medical Schemes Bill. The Bill's far-reaching changes, if implemented in their entirety, could weaken the financial health of many funds by pushing up claims costs.

Under this scenario, there will once again be an exodus of younger, healthier members from the funds as they opt for cheaper alternatives.



HOW SOUND IS YOUR MEDICAL AID?

Allcare Medical Aid	BBB-
Bankmed	AA
Beland Medical Aid Society	A
Bestmed	A
Bonitas	AA-
Cape Medical Plan	A+
Commercial and Industrial Medical Aid Society	A+
Compcare Medical Scheme	A
Fedsure Health	A+
Firmed	BBB+
Lifemed Medical Scheme	A-
Medcent Medical Scheme	A+
Medical Expenses Distribution Society	A+
Medical Services Plan	A
Medihelp	A+
Medshield Medical Scheme	A
Discovery Health	AA
Munimed	A+
Natalmed	A
National Independent Medical Aid Society	A
National Medical Plan	A+
NBC	A
Northern Medical Society	A+
Polfa Medical Scheme	A
Premier Medical Plan	A-
Sasay Medical Aid Fund	A
Sanitas Benefit Scheme	A-
Stywe Medical Fund	A+
Southern Health	A-
Spectramed	A
Tafelberg Medical Aid	A-

Prosano and Sanmed are currently being rated or reviewed.

KEY

AAA is the best rating but any rating of BBB and above means the fund is financially secure in the short to medium term

Graphic: FIONA IDISON

SOURCE: DUFF & PHELPS CREDIT RATING CO

Access to medical aid demonstrates inequity

BD 28/11/99 (299)

Stephané Bothma

LESS than one-fifth of SA's population belonged to a medical aid scheme and yet this small group had access to 85% of pharmacists and 60% of medical specialists in the country, according to the SA Health Review for last year.

The annual review, published by the independent Health Systems Trust yesterday, said the greatest inequity in SA's health system last year remained the difference between those who predominantly used private health care and those who did not.

Members of medical aid schemes spent about four times more on health care than people who did not belong to the schemes.

Provincial health budgets indicated that progress had been made in the years 1995/96 and 1996/97 in the provision of public health care, with most budgets coming closer to the national average.

"However, since that time progress has stagnated, with the gap between expenditure per person in the North West, Mpumalanga and Northern provinces and the national average remaining a cause for concern."

The review said that comparisons of spending patterns within provinces showed that disparities were greater than those between provinces.

In the Potchefstroom and Grahamstown districts, for example, for every R4 spent on health services in the public sector, R1 was spent in the Odi and Mount Frere districts.

With regard to the distribution of health sector personnel, disparities tended to occur between the more urbanised and historically better funded provinces and the predominantly rural provinces.

The Western Cape had 40 nurses per 10 000 population while in the Northern Cape and Mpumalanga the figure was 20.

Gauteng had 2 000 people to every pharmacist while the comparable figure in the Northern Province was 16 000. In 1997, slightly fewer than 2 000 nurses and 1 000 doctors graduated.

The trust said there were few African students at most of the country's medical universities.

At end-1997, a total of 27 354 medical practitioners were on the register of the Interim Medical and Dental Council. There were 1 296 new registrations in 1997, with 909 registrations from SA's eight medical schools. About 30% of all new registrations were foreign doctors.

Sowetan 8/1/99 (299)

Zuma wins battle against BSA

THE Supreme Court of Appeal in Bloemfontein has refused an application by Business South Africa for leave to appeal against the dismissal of its urgent application for the Medical Schemes Bill to be referred to the National Economic Development and Labour Council (Nedlac).

BSA had contended that Minister of Health Dr Nkosazana Zuma and Dr A Nkomo, chairman of the parliamentary portfolio committee on health, were required to refer the Bill to Nedlac.

It contended that they should be restrained from proceeding with the processes for its introduction to Parliament or its implementation before Nedlac had produced a report on the issue.

In the Cape Town High Court on October 22 1998 Judge DH van Zyl held that before BSA could claim the relief it sought it had to persuade the court that the minister had an obligation to place envisaged legislation before Nedlac.

The only ministers mentioned in the Nedlac Act were the minister of labour and the minister without portfolio in the Office of the President. Their obligations were mainly related to appointment of certain members to Nedlac.

The judge said the proper procedure for BSA to have followed, in its capacity as a member of Nedlac, was to ensure the matter was fully debated by Nedlac.

Throughout it had had the fullest right to convene a meeting of Nedlac members and to place the matter on the agenda for discussion and debate.

There was no question that Nedlac had any right or even expectation that the health minister should refer the Bill or any other document relating to socio-economic policy to it. The minister was not obliged to do so. *Sapa*

Medical aid industry to take its medicine by restructuring

(299) CT(BR) 2/2/99

ADELE SHEVEL

Johannesburg — The multi-billion-rand medical aid industry was on the verge of massive change with the expected reformation of the Representative Association of Medical Schemes (Rams), the industry's 25-year-old representative body, Aslam Dasoo, the association's policy director, said this week.

Dasoo will head the task team to restructure the organisation to become more relevant to the times, its membership and other stakeholders. He said the organisation was poised to take on a new nature, form, content and name.

The new body would incorporate the interests of healthcare financing entities, in addition to medical schemes, and would include managed care, healthcare administrators and facilitators.

It would ensure its long-term interests would be preserved and better able to plan for the future while also enjoying input from participants previously excluded.

Self-regulation of this industry is "hopelessly inadequate", Dasoo said. The new body would minimise the need for government to intervene as there would be one interface with the state.

At an Institute for International Research conference held last week, Dasoo maintained: "If transformation did not take place, ruination will follow."

The body has grappled with transformation over the past year. This led to the formation of a breakaway group during 1998 and culminated in a walkout of the South African Association of Medical Schemes.

This organisation represents about 30 percent of the industry under its chief executive and the former head of Rams, Keith Hollis.

Last week, the group that broke away from Rams under Hollis dissolved. It was reconstituted as the South African Medical Schemes Association under Dan Krige, and will be a rival representative body to Rams.

Medical Schemes Act promulgated 'early'

New law is too soon, say medical aids

CT(BR)8/2/99 (299)

ADELE SHEVEL

Johannesburg — The medical aid industry was stunned this week to discover that the Medical Schemes Act had been promulgated sooner than expected, with the effective date of implementation the first day of this month.

"I hereby determine 1 February 1999 as the date on which the said Act shall come into operation," it was proclaimed in the Government Gazette on Friday, signed by President Nelson Mandela and Health Minister Nkosazana Zuma.

Arnold Fair, the chairman of the Representative Association of Medical Schemes (Rams), said the early proclamation had taken them by surprise.

"The regulations which are an integral part of the act haven't yet been finalised. The new act has some fundamental changes which the medical schemes industry will have to become accustomed to.

"We need time to readjust. We normally review subscription rates and benefit structures in the last quarter of every year, and to change this would be impractical."

But Aslam Dasoo, the director of policy at Rams, said the matter was "of little concern" and was not an attempt to undermine the industry, but the government faced time constraints.

"Once the election date is announced parliament has to go electioneering. The concern in the industry is unwarranted."

Dasoo said he was in close contact with the health department.

"Though the act was promulgated on February 1, transitional clauses stipulate that it will only be effective six months after the date of promulgation.

"For the ensuing six months the status quo will remain, so no scheme need be concerned that it is in contravention of any statute until August 1."

Regulations which have financial implications for schemes could only come into effect by January 1 2000, he said.

The early promulgation is set to be raised at meeting of the Council for Medical Schemes, a statutory body that regulates the industry and advises the health ministry.

Certain draft regulations to govern the act are expected to be announced by the end of this month.

Task teams of industry members have been working on the three key areas covering minimum benefits, anti-selection and savings accounts, which were contentious during the promulgation process.

There are at least 30 items that have yet to be regulated but are still in draft form.

Concern has been raised that the regulations could be changed by the health minister without any legal obligation to refer back to parliament.

The legislation has been through a turbulent process, opposed by a significant proportion of the industry. The government has said its aim was to increase access to medical coverage, but some industry members have claimed that it would achieve the exact opposite.

President Mandela had referred the act to his legal advisers to ensure it did not infringe constitutional principles.

MEDICAL AID (299)

PARTS OF NEW ACT IN EFFECT

Schemes not illegal, yet

17/12/99

The medical aid industry was in a froth last week when the Health Department promulgated the Medical Schemes Amendment Act with immediate effect.

The industry was expecting a 12-month honeymoon period before it would have to comply with the Act, which will force many schemes to restructure their contribution tables, rules and benefits. This is because schemes will no longer be allowed to charge the sick and elderly higher rates and will have to enrol all who apply.

The most contentious issues in the Act are contained in regulations that are being negotiated with the industry. For government to promulgate the Act at this time seems impractical and injudicious.

"I'm stunned," said Anglo American medical consultant Brian Brink on hearing the news. Discovery Health CEO Adrian Gore refuses to read any deeper message into the department's actions, saying, "I think it's ridiculous but it must be a mistake. I'm quite sure it wasn't done intentionally."

Representative Association of Medical Schemes (Rams) chairman Arnold Fair says since it is "technically impossible" for the industry to comply with the Act immediately, the entire industry is being forced to operate illegally.

But the department's director of health financing, Patrick Masobe, assures schemes that, despite anything their lawyers have told them to the contrary, they still have until January 2000 to comply with the core aspects of the Act (any aspect that will affect contribution tables and benefit design), as the department appreciates that schemes operate on a calendar year.

"Schemes are not operating illegally now," he says, explaining that the Act was promulgated intentionally so that the provisions relating to noncore issues, like scheme governance, could be implemented as soon as possible. He says schemes have six months to comply with these and other noncore aspects of the Act and may apply to the Council for Medical Schemes for a three-month extension if they need more time.

"I've had a lot of calls from schemes who are worried about this," says Masobe, "Maybe we should have issued a press statement."

Claire Bisseker

MEDICAL AID INDUSTRY (299) FM 19/2/99

MUTUAL DESIRE TO FORGE A NEW UNIFIED BODY

Personality differences being put aside for industry's good

Bruised after its high profile split last year, the medical aid industry looks set to bury the hatchet and reunite under a brand new representative association.

This is good news for an industry which has been riven by internal politics, while at the same time having to cope with the pressures of the new Medical Schemes Act.

It is an attempt to put the good of the industry ahead of personal mistrust, and both sides are cautiously optimistic this can be achieved.

The advantage to the industry of speaking with one voice is that it has more weight in negotiating annual tariffs with service providers such as doctors and hospitals.

Last week, councillors from the Representative Association of Medical Schemes (Rams) and the breakaway grouping, the SA Medical Schemes' Association (Samsa), broke new ground in exploratory talks on reunification.

Representing Rams was its chairman, Arnold Fair, and councillor, Anglo American health consultant Brian Brink. Across the table were those who led the breakaway: former Rams chairman Keith Hollis and former Rams councillor, Dan Krige, who is now Samsa's chairman.

The parties' joint proposals on the formation of a new, more broadly representative association will be put to the full councils of both organisations early this week. If accepted, Rams will have to call an extraordinary general meeting to discuss its dissolution.

The main reason for Samsa's defection late last year was the failure of Hollis and Krige, who supported Health Minister Nkosazana Zuma's medical aid reforms, to make it on to the Rams council while those opposed to the legislation — Discovery Health CEO Adrian Gore, Fedsure executive chairman Dave Avnit and Brink — were voted on to the council for the first time.

As Samsa is mostly black and Rams mostly white, the issue quickly became politicised. Rams and its new council were portrayed as being opposed to transformation. Samsa (then called Saams) broke away, representing a third of Rams' members and R2,5m in annual levy income.

But Rams' new chairman, Fair, didn't waste any time shaking things up at Rams. From the outset, Fair was determined to make Rams more transparent and inclusive and to depoliticise key appointments. The new council began a complete reappraisal of everything that Rams did and it is this open attitude that has paved the way for the reunification of the industry.

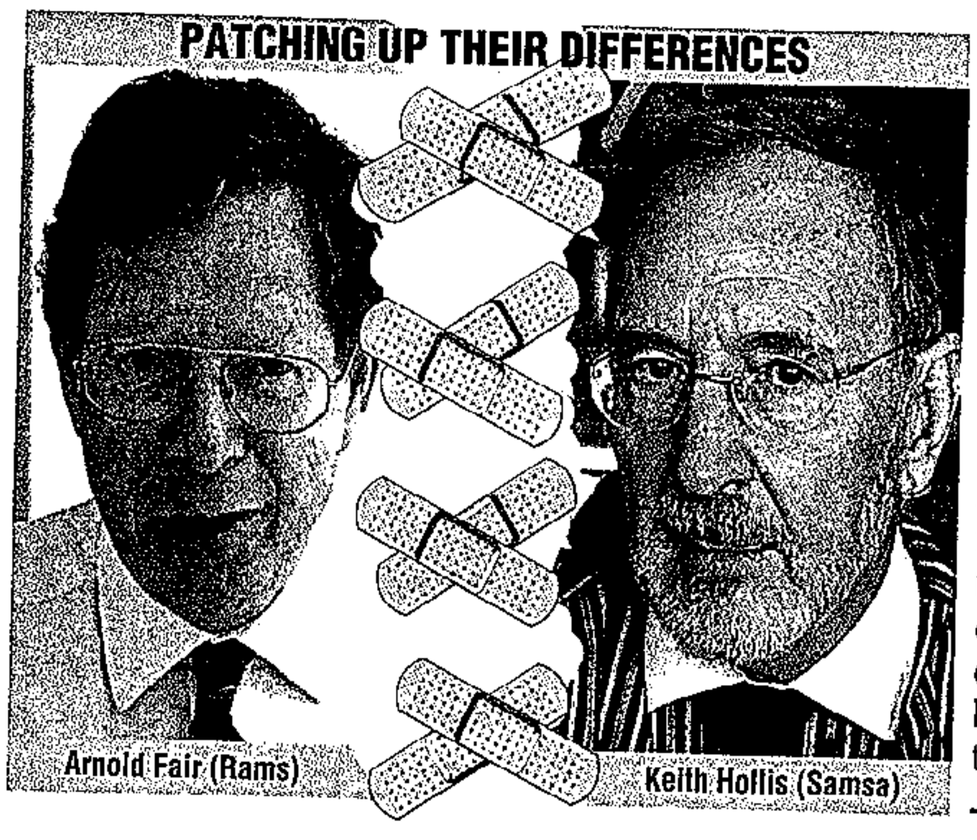
Fair says no single individual is driving the process. Rather, the desire to forge a new unified body is mutual.

"We're enthusiastic about the idea," says Samsa chairman Krige. "Everyone seems to realise we need to move towards the same goal of a unified, transparent, democratic organisation which represents the whole private health-care financing industry."

Hollis did not wish to comment but he is known to support the idea, though he is unlikely to make himself available to chair such a body.

Gore and Brink are also in favour of a new body, provided personal mistrust between the key players can be overcome and that it doesn't make the same mistakes as Rams, which was dominated by medical aid administrators and a few strong personalities.

"People don't want to fight," says Brink, "but I have my doubts, when push comes to shove, whether it will work because the reasons which led to the fracture are all still there. It will require a fundamental change to the old structures to accommodate the differences of opinion. It will be a challenge to get that to happen." **Claire Bisseker**



New unified body for medical schemes industry

ET (BR) 2/3/99 (299)

ADÉLE SHEVEL

Johannesburg — The two bodies representing the South African medical schemes industry have established a joint process to unify the sector under a new representative body.

At a meeting last weekend, the negotiating parties paved the way for the launch of a unified body in the first half of this year, said Aslam Dasoo, the newly appointed chief executive of the Representative Association of Medical Schemes (Rams). A name has yet to be agreed.

Rams had been the sole representative body of the medical schemes industry for 25 years. At the end of last year the South African Association of Medical Schemes (Saam) split from the umbrella body, taking with it about 30 percent of medical schemes. Saam then reformulated itself into the South African Medical Schemes Association (Samsa) as a counter body to Rams.

Arnold Fair, the chairman of Rams, said what was important was that Rams and Samsa had met to discuss common interests.

The joint committee met at the weekend to discuss the industry, which has been bruised by disputes over effective industry representation within Rams, policy formulation and internal dissent.

The Medical Schemes Bill exposed instability within Rams, leading to the resignation of Saam. Saam cited Rams' inability to represent its interests and to transform its structure as reasons for its departure.

'Fired' Bonitas boss wants unions' help

(299) CP 21/3/99

Medical aid boss Nkosi says Dube's claims are hogwash

By CHRIS HLONGWA

IN an intriguing corporate row at Bonitas, the largest medical aid scheme in the country, a founder member is now calling for civil service unions to fight his expulsion from the company.

If they do not fight with him, he says, thousands of state employees who are members of the fund stand to lose benefits when they are forced into early retirement by the government's drive to make the civil service smaller.

This warning comes from Aubrey Dube, a former national vice-chairperson of the Bonitas council and a founder member.

Dube says he has, after a long-running row with another executive, been expelled from the company because he did not let things pass unquestioned.

Hinting at alleged irregularities, he queried "the payment of a multi-million rand loan to the administrator of which R8,7m was still outstanding in August 1998 when this should have been paid finally in February 1998."

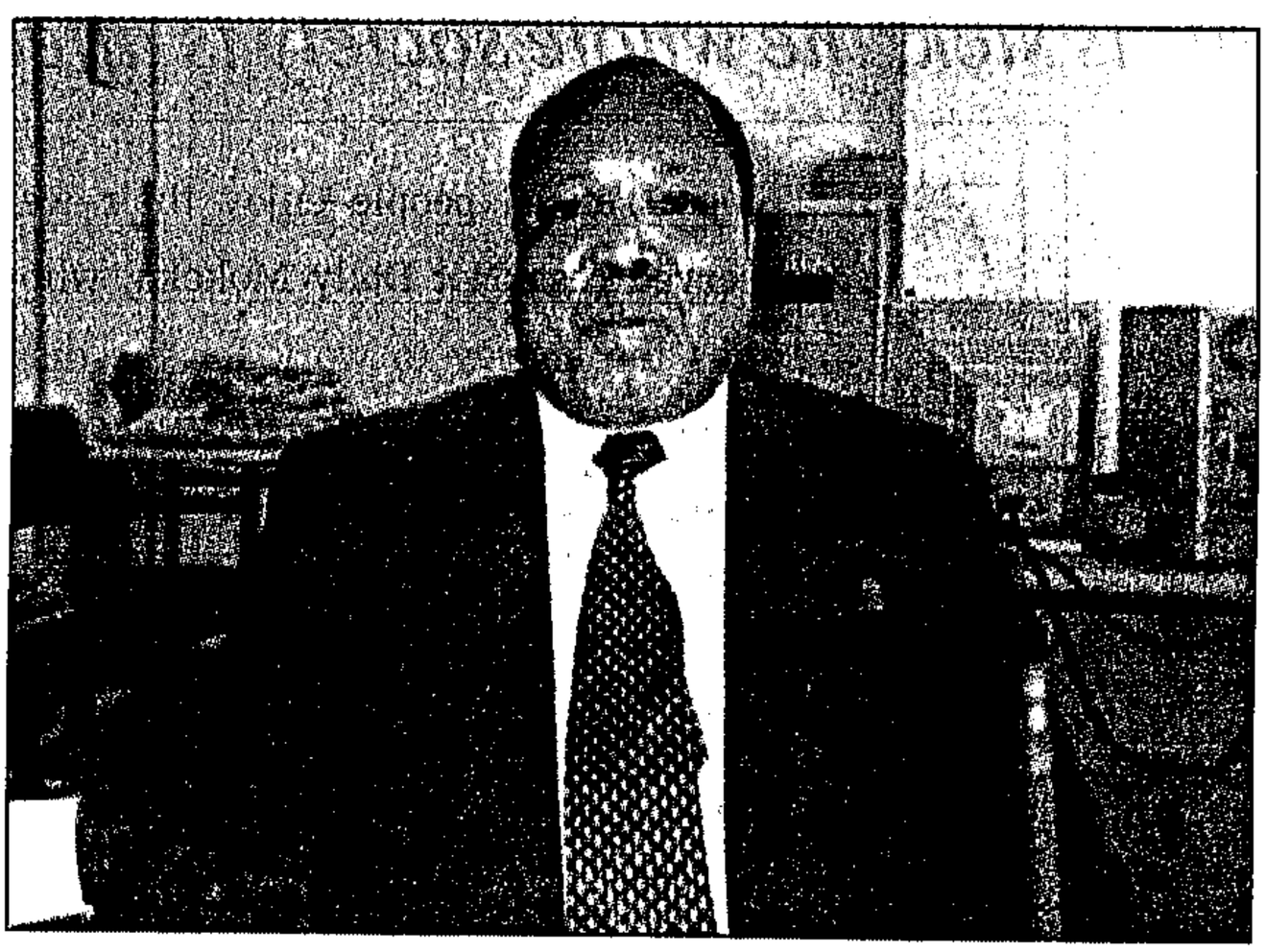
Another reason for his expulsion, says Dube, is that he had also queried directors' fees.

He claims that he will unfairly forfeit the benefits of an early retiree, even though the company has a scheme that provides for early retirement.

If not challenged, this will affect many civil servants who are facing the government axe and those who have opted for early retirement, says Dube (51).

Bonitas executive principal officer Bafana Nkosi vehemently disputed Dube's allegations, dismissing them as "hogwash".

He says Dube was not expelled but had "his membership terminated because of non-payment of contributions".



DIRE STRAITS... *Aubrey Dube, founder member and former vice-chairman of Bonitas.*

Regarding the multi-million rand loan, Nkosi says Dube has misunderstood the issue.

"A legally binding loan agreement was entered into between Bonitas and Medscheme in terms of which Bonitas was to loan Medscheme an amount of R15 million at Nedbank's call rate plus two percent, the final repayment being February 1999.

"The loan was paid off in December 1998, two months earlier than in terms of the loan agreement," said Nkosi.

Regarding the directors' fees, Nkosi said: " Dube served as councillor/trustee of Bonitas until 1998 when, in democratic elections by the members of the fund, he was not re-elected as a councillor.

"Bonitas has investments in various companies and some trustees serve as directors in those companies. Some of these companies pay directors' fees which, in terms of corporate practice, should be kept by the directors concerned.

"It was, however, agreed by the council of Bonitas at the time when Dube was still a councillor to rather pool these fees and share them amongst all the trustees, including Dube. The current position is that Dube is no longer a councillor of Bonitas and therefore does not get director's fees anymore."

Regarding Dube's early retirement, Nkosi said: "People who have an option of early retirement consider all facts, including medical aid, before they opt for early retirement, because this is part of retirement planning. A majority of our members have planned their retirement such that they are still entitled to a subsidy from the State even after early retirement.

"Dube complicated matters by changing from a reasonably cheaper option to a much more expensive option, with a view that he was going to be granted pensioner status."

Dube, however, is adamant: "I call upon all unions to stand up and be counted, and on all early retired state employees to support me in the fight against the denial of our rights which we strived for in the bargaining chamber in Pretoria in 1995."

Shifting the medical burden

(299) M+G 26/3-1/4/99

The Medical Schemes Act was amended last month to spread medical risks and costs. **Kathryn Strachan** *reports*

Medical aid schemes are gearing up for a complete overhaul of their operations, with newly introduced legislation opening up new avenues and ending discrimination against the patient.

Up to now medical aids have shared risk with the patient, but the amendment to the Medical Schemes Act, passed last month, is designed to spread the load.

What the new legislation signals is that the focus on securing "low-risk" members to allow medical schemes to engineer lower premiums will shift to managing health care costs together with the health care providers. Essentially, medical schemes have to shift the burden of risk from patients to doctors, hospitals, pharmacists and managed health care organisations.

It legislates that people can no longer be discriminated against on the basis of their age, sex, health status — or their HIV status. Medical aid schemes have to provide lifetime coverage of all essential services, and the only factors on which contributions can be based are income and number of dependents.

The Act reintroduces the concept of minimum benefits, but exactly what these benefits will be still has to be worked out. At the very least, it means medical aids will have to fully fund all essential services — which can be described as the range of services that could be obtained from a public hospital. There can be no limit to cover. If, for example, a patient is in intensive care, the medical aid scheme would now have to fully fund his bills to the end of the treatment period, regardless of the cost.

What led to the new Act was that the medical aid industry found itself close to collapse when it covered the full risk. With medical prices rocketing, and members resisting sharp increases in their premium contributions, the medical schemes could not be sustained. This brought in the concept of sharing risk with members — a plan that made those at higher risk (the elderly and the sick) pay more than the young and healthy. It cut out poorer people and led to widespread instability in the industry.

It meant that an elderly patient who had made contributions for 30 years could no longer afford the new premiums and fell off the medical scheme. This patient had to rely on the public health service, with all its inconveniences.

Another problem was that the private health sector had been receiving the patient's premiums for 30 years, but it was now the public health sector, which had not received a cent of this, which had to provide for the influx of people who fell out of the medical aid net.

Reg Magennis, director of Medscheme's managed care division, says other trends arising from the new legislation are that people will not be able to join medical schemes when they need cover, and leave once they have paid their bills; there will be severe penalties for not joining and staying with a medical scheme; and employees will have greater reason to join medical schemes in future, and could be penalised for electing to join later in life when they have a greater risk of needing health care.

The challenge to medical aids, doctors and hospitals is to make it work. "The new health Act signals an end of an era," says Representative Association of Medical Schemes (Rams) CEO Aslam Dassoo. The year ahead will see the introduction of various regulations emanating from the Act, which will mean the full impact of the Act will only be felt on January 1 2000, he says.

But the Act has left in its wake a fragmented industry, with a third of medical schemes deserting Rams, arguing that it no longer represents their interests. The task is to heal the divide, says Dassoo, adding that he expects a new association to be established within the next few months.

Esme Prins, head of health policy and economics at the South African Medical Association, which represents doctors, has her reservations about the legislation. The health care environment is not ready for such an advanced concept as sharing risk with the provider, she says, and she does not believe medical aids will be able to make use of this mechanism in the short term.

Medical aid schemes have not tried to control their costs in the past, she says, but acted merely as claims processors. Many still did not have systems which were sophisticated enough to manage utilisation and costs.

The best known model for risk sharing is the "capitation arrangement" where the doctor receives a fixed pre-payment for a group of patients per month to provide certain agreed-upon health care services. This effectively means that the patient can access the doctor's services as often as she wishes without the risk of any additional payment.

It is then the doctor's responsibility to manage the care in such a way that the patient does not need to access the services that often. If the capitation amount is calculated incorrectly, insolvency could await either the doctor or the medical aid, says Prins. To calculate an appropriate capitation amount, accurate data is required, and this data is seriously lacking in South Africa — a fact that makes risk-sharing arrangements premature, she says.

Dassoo says the new legislation requires a whole new mindset on the part of health care providers, and adds that medical schemes are trying to go about the steps of risk-sharing in a consultative way. "We need to join forces to do it," he says.

The new Act still retains the principles of managed health care which were introduced four years ago. Managed care brought in a series of tools to manage costs which included plans such as preferred provider arrangements, where a hospital or doctor gave discounts to a medical scheme in return for their referring patients on to them, and getting authorisation from the medical scheme before an elective operation or treatment.

Regulations would soon be published which required managed care organisations and administration companies to be accredited, said Magennis. Under an Act that significantly extended the powers of the minister, their activities would become subject to audit, and levels of supervision and control would increase, he said.

The solution, said Magennis, was to be found in information technology. Managed care companies were developing information and "tools" for identifying and managing costs in collaboration with health care providers, and he expected that through information technology this would be an ever-growing segment of the private health care market.

He said this legislation brought health care closer to the health ministry's plan for new social health insurance legislation which would make it mandatory for everyone in formal employment to enjoy cover for minimum benefits in the future.

Two medical associations agree to eliminate all 'perverse' profits

Amanda Vermeulen (299)

THE Representative Association of Medical Schemes (Rams) has concluded a joint monitoring plan with the Hospital Association of SA (Hasa) to ensure there are no perverse profits on pharmaceuticals sold through the hospitals.

Rams chairman Arnold Fair, who has been guiding the association through difficult times recently, said at the weekend that the basis for the new hospital tariff, introduced last year, was that it should deliver a profit neutral situation when it came to the dispensing drugs by the hospitals. Hospitals previously had been allowed to mark up prices.

Fair said Rams and Hasa were not entirely sure if this plan was delivering the right result, leading to the formation of a monitoring process to ensure that the profits accruing to the hospitals were not larger than envisioned.

Fair said if the schemes were paying too much to the hospitals, this would have an effect on members.

"We need to find an equitable solution," he said.

In the past few months Rams has been troubled by internal political squabbling. Fair, since taking over from former chairman Keith Hollis, has been working to eradicate this.

Hollis formed a splinter grouping outside the Rams structure called the SA Medical Schemes Association (Samsa) after failing to be re-elected in the Rams elections late last year. Hollis has subsequently given his support to the reunification of the two bodies, leading to the joint initiative to unify the industry.

Fair said that Rams and Samsa had formed a joint working committee to discuss a number of issues, including the formulation of a new constitution.

This committee, in a novel move by Rams, had included members of the affected trade unions, representatives from the Council for Medical Schemes, former health department officials, and others representing employers and employees in the schemes industry.

BD 6/4/99

Bills to cover medical aid brokers

Pat Sidley (B8) (299)

BROKERS selling medical scheme memberships are likely to be regulated through the Financial Advisers Bill that is now being circulated for comment, and certain aspects of their work could be regulated through the Medical Schemes Act.

It is also likely that limits will be placed on the commission they earn. The health department has suggested a ceiling of about 3% of premium income.

This information emerged yesterday in a discussion on the remuneration of health-care brokers at the Institute of Life and Pension Advisers (Ilpa) annual conference, held in Sandton.

Commission for medical scheme brokers is technically not allowed, but this rule is often ignored. As a result there has been abuse of commission payments.

The new Medical Schemes Act seeks to regulate sales of scheme membership and the recently released financial advisers bill makes provision for the regulation of brokers selling health-care products.

Patrick Masobe of the health department welcomed the draft Financial Advisers Bill, saying he believed its provisions could be used to regulate medical scheme sales remuneration. He said it went further than he had expected, but believed certain aspects of medical scheme sales still would have to be regulated by the Medical Schemes Act.

Task groups were working out aspects of the regulations to be applied to the Medical Schemes Act, which was passed by Parliament last year.

In his address to the conference, Masobe outlined provisions under the Medical Schemes Act that would apply to these sales staff. Among the key points would be the need for sales staff to be accredited and licensed.

Full disclosure would be necessary, including disclosure of remuneration and a full written contract with a scheme member specifying the nature of the services.

A code of ethics could also be devised to which all sales staff would have to subscribe.

Masobe said that the health department believed the maximum commission paid should be 3% of contributions.

However, an alternative would be for medical schemes to use a portion of their marketing expenses to pay sales staff.

SA NEWS DIGEST

MEDICAL SCHEMES (299)

Agreement reached to transform industry's representative body

An agreement had been reached to form a new association in the medical schemes industry, Aslam Dasoo, the chief executive of the Representative Association of Medical Schemes (Rams), said yesterday. This would lead to the demise of Rams and the South African Medical Schemes Association and "a great leap away from recrimination and division", Dasoo said. The association would be named at the end of the month.

"The challenge facing this industry is its transformation from an industry confining itself to providing healthcare to an affluent elite to one that can act in complete harmony and synergy with the public healthcare system," Dasoo said.

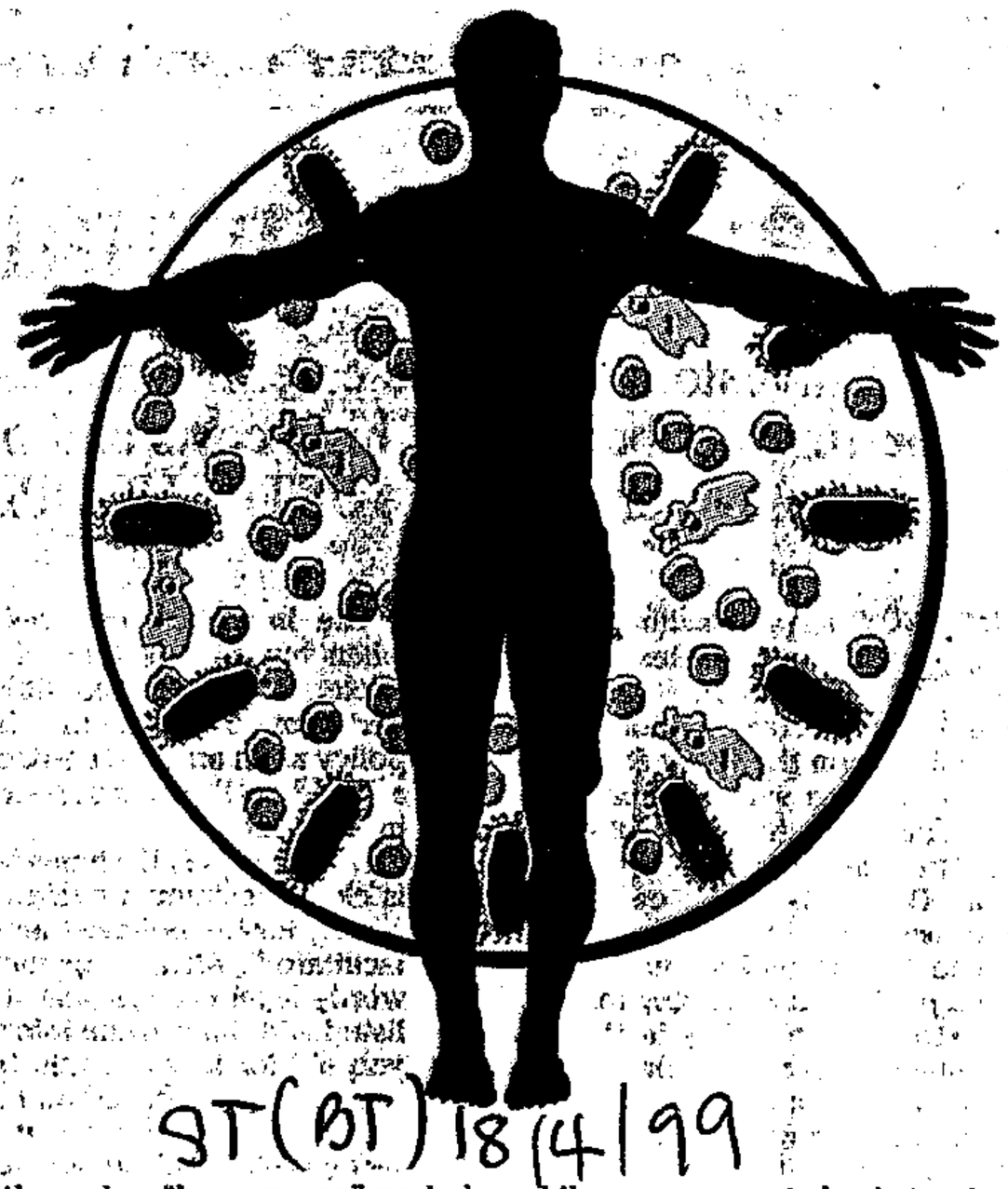
For the first time a black chairman has been named for the representative body. The medical aid industry provides healthcare cover to about 7 million South Africans and spends about R25 billion a year on services rendered to those beneficiaries. – *Adele Shevel, Johannesburg* CT(BR) 16/4/99

Sunday Times Business Times
April 18 1999

Medical fund fees to rocket as AIDS bites

(292) (299)

Healthy members will be forced to bear the costs unless measures are taken, writes DINA SEEGER



ST(BT) 18/4/99

MEDICAL aid premiums could soar in the next few years if health insurers and medical aid funds don't prepare for the impact of AIDS.

Currently, one out of five South Africans between the ages of 20 and 40 are HIV positive, and the disease is spreading with phenomenal speed. More and more sufferers will begin to depend on medical schemes for the cost of treatment.

And if Health Minister Nkosazana Zuma's medical schemes Bill is passed, no medical aid fund will be able to turn away new applicants no matter what disease they have.

This could cause enormous financial pressure on health schemes. Healthy members will be forced to subsidise the costs of those who need ongoing HIV medical treatment and eventual hospitalisation.

Dr Clive Evian, HIV consultant in association with Alexander Forbes, spoke this week at the Institute of Life and Pension Advisers annual conference on how medical schemes can look at keeping the epidemic under control.

Although about 20% of SA adults are already infected, the effects have not yet been seen, says Evian. We will see increasing consequences of the disease (illness and death) from next year onwards.

Evian advocates managed HIV/AIDS care to keep infected members healthy in an effort to avoid high medical expenses or delay them for as long as possible.

He says this can be done by providing ongoing ante-retroviral therapy, which prevents the decline in immune status and delays the onset of AIDS.

Although this treatment can cost between R600 and R4 000 a month for each HIV-positive member, it may still be cheaper than providing for serious illness and hospitalisation once the disease has progressed.

Evian further argues that medical schemes can save themselves money by preventing the further spread of HIV. For example, many health insurers do not allow for the treatment of sexually transmitted diseases (STDs). Leaving such cases untreated increases the chances of contracting HIV by 10 to 15 times.

He advocates that medical schemes allow pregnant women who are infected to claim for the drug AZT. The drug can prevent the disease from being passed on to the woman's child and so avoid the cost of treating an HIV-infected child as well.

He also believes medical schemes should be educating their members and providing free condoms.

Evian says medical premiums will definitely rise as a result of the AIDS epidemic.

Because the epidemic hasn't yet developed into the major symptomatic phase, the schemes have been going through a "honeymoon" period during which claims have not been too severe, he says.

Money contacted several of the major health insurers this week to find out some of the measures they are taking against the disease.

Southern Healthcare provides a computer programme to member companies. The educational programme is loaded on to the company's computer system so employees can log onto any PC and learn about the disease.

Barry Swartzberg, chief operating officer at Discovery Health, says the company offers a disease management programme. Infected staff members are sent on regular visits to a general practitioner and an HIV specialist, and are given ongoing drug treatment. Discovery encourages HIV-infected members to register with it.

"The problem is that whatever we offer today, we will have to be able to offer sustainably into the future. And we cannot predict how many people will be infected in the future," he says.

Swartzberg explains that while everyone gets basic treatment, employee schemes will have to pay more if they choose to insure for full HIV cover.

According to Discovery, approximately one out of 20 members are HIV positive. And for each member who claims R4 000 worth of treatment in one month, the other 19 members pay approximately R150 each towards this.

Dr Laubi Walters, CE of managed healthcare company Pharmaceutical Benefits Management, says benefits are available to HIV-infected members.

"We're facilitating health management now so that we can keep members away from hospitals for as long as possible."

He says all contributions go into one fund "pool". Healthy members continue to subsidise non-healthy members, he says.

"But if we ask our healthy members to continue to subsidise HIV-infected members, they will leave the scheme," he says. "Only through early detection and appropriate treatment can we provide benefits without increasing premiums."

New rules for medical plans

(299)

BD 26/4/99

Benefits, taxation and AIDS care under spotlight

Pat Sidley

RULES governing medical aid schemes' minimum benefits, regulations on medical savings accounts and measures against "adverse selection" are being finalised by the health department.

The department's advisers met yesterday to discuss the measures, which will give effect to the new Medical Schemes Act. They propose, among other things, to:

- Force all schemes to cover HIV/AIDS conditions and heart or liver transplants conducted in state-designated facilities;
- Limit the scope of medical scheme savings accounts and tax withdrawals in members' hands; and
- Institute severe penalties (including waiting periods and exclusions for specific conditions) for "late joiners" — but an "amnesty" of six months will allow late joiners or sickly people to join a scheme for the first time without penalties.

During lengthy negotiations, the medical scheme industry was strongly opposed to critical elements of the act, including the concept of "community rating" — which would stop the practice of setting different premiums for people based on risk.

This, combined with "open enrolment" (which would prevent schemes excluding or penalising certain members), means some schemes would face members joining only when sick, old or pregnant.

To prevent this the regulations, which will be in force by January, are likely to incorporate a general waiting period of up to three months. Pregnancy will be covered only if the member has belonged to the scheme for a year.

Failure to disclose a condition could mean termination of membership.

Late joiners — those aged 40 and older — could be penalised with premiums of up to 1,75 times the standard rate, according to their age.

Medical savings schemes would be limited to 25% of contributions.

The regulations will state that "for every R3 paid into the general pooled funds of the scheme, R1 may be paid into a member's individual savings account".

However, this could accumulate only for two years and be used only to pay for services that are not part of the compulsory package of benefits provided by each scheme.

If a member changed schemes, the funds could be transferred, but if the member withdrew, the funds accrued in a saving scheme would be taxed.

The minimum benefits package is likely to draw criticism within the medical schemes community.

Costing has been done from the basis of a mine hospital stay — not on normal private health care costs.

The department has also rejected the Actuarial Society's costing projections on care for AIDS and HIV patients.

The intention of the compulsory package is to ensure that members do not lose their cover during the year and then land up being dumped on state hospitals.

The minimum package would have to cover HIV and AIDS care as well as organ transplants. Primary care could be excluded as it is offered free by the state.

The health planners have recommended that the package should cost about R800 a year. Had the Actuarial Society's projections been used the cost would have been about 85% higher.

Limited cover for people with terminal illnesses proposed

Star 6/5/99 (299)

By Cathy Powers

Regulations of the Medical Schemes Act, due to be released today, will provide limited cover for people living with HIV and Aids and other terminal illnesses.

According to health economist Alex van den Heever, the prescribed minimum benefits contained in the regulations will mean full cover for specific conditions. But people living with HIV and cancer, for instance, will receive cover limited in terms of the efficacy of the treatment.

"When the treatment can restore health, the patient will be covered," said Van den Heever.

The regulations on the Medical Schemes Act, signed by Health Minister Nkosazana Zuma yesterday, mark the culmination of months of controversy and debate.

However, Dr Aslam Dasoo, chief executive of the Board of Healthcare Funders, said he did not expect any major surprises.

On a cursory examination of the regulations, Dasoo said the regulations reflected "pretty much what had been discussed" by the technical task team, consisting of the Government and industry players.

The regulations give effect to clauses in the act, due to come into effect in August, which establish how medical schemes will be regulated.

Dasoo said the three areas the regulations will govern are:

- The prescribed minimum benefits which all medical schemes will have to provide complete funding for.
- Medical savings accounts and the level of contributions that can be transferred to these accounts.
- Open enrolment. According to the act, anyone able to afford medical scheme premiums should be given access to the scheme. The only differentials in premiums placed on members are income and number of dependants.

One argument against this provision was that if a voluntary medical schemes environment was opened up, people would not join until they were ill.

Van den Heever said there would be penalties for people who had opted out of joining a scheme until older age.

Dasoo said a change from a voluntary to a mandatory medical schemes environment would oblige all employed people to contribute to a scheme, along the lines of social health insurance.

Zuma has invited comment within the next three months.

Plea to tell communities of known paedophiles

By Gill Gifford
Crime Reporter

Child rights activists have reacted with consternation following the lengthy interview with a self-confessed paedophile which was broadcast on national television on Tuesday night.

A 30-minute piece, entitled "Confessions of a Sadistic Paedophile" and screened on SABC3's *Special Assignment* on Tuesday night, showed a large man, named only as John, describing in vivid detail how he picked up children and abused them in Pretoria.

Miranda Friedman of Women Against Child Abuse (WACA) said that while she was not shocked by the documentary, she was glad it had been broadcast and hoped it would prompt strong reaction from people in power.

"About two years ago police knew of 20 paedophiles in Gauteng alone. We feel that, even though these offenders have served their time, the community has a right to know who they are," she said.

She said WACA was lobbying for Megan's Law – a piece of US legislation requiring that a community be notified when a known paedophile moves into their area – to be introduced in South Africa.

"Megan's Law, which has been endorsed by (US President Bill) Clinton, was devised by the parents of a little girl who was murdered. It basically entails paedophiles being registered, and their location made known to people," said Friedman.

Friedman said it was unfortunate that a paedophile could confess his actions on television, while police were unable to arrest him. Superintendent Anneke Pienaar, national head of child protection, said that while actions related to paedophilia constituted a crime, claims to have hurt children did not.

(298) Star 6/5/99

BD 6/5/99

Medical aids to scrutinise draft act regulations

Pat Sidley (299)

THE draft regulations giving effect to the Medical Schemes Act are likely to be gazetted this week.

The regulations are to be circulated for comment for three months before a final version will be gazetted.

The timing gives the medical schemes industry its first opportunity to act together in shaping opinion and law since it was united and reformed last week as the Board of Healthcare Funders.

The new grouping represents almost all medical schemes and unites the previously divided industry.

The divisions previously coincided largely with industry views of the Medical Schemes Act, but the new body's CEO, Aslam Dasoo, says the industry will be able to achieve consensus and present a united view to government. Discussion within the industry and with the government are to begin almost immediately.

Dasoo says there will be few surprises in the draft regulations. However, he expects dissent and discussion on the basis on which the minimum benefits have been costed. Industry estimates are far higher than those worked out by the health department.

Some contentious issues, says Dasoo, will prove to be less contentious when properly studied. For instance, the minimum benefits package (the services all schemes will have to provide for members) covers HIV/AIDS. This does not mean, however, that schemes will be obliged to cover expensive drug treatments like AZT. It will be mandatory to cover "surgical treatment of opportunistic infections and localised malignancies", which Dasoo says most schemes do already.

CAPE TIMES
THURSDAY, MAY 6, 1999

SCHEMES TO BE REGULATED

Limited medical cover for terminal diseases

CT 6/5/99

JOHANNESBURG: Regulations on the Medical Schemes Act provides limited cover for HIV, Aids and other terminal illnesses. **CATHY POWERS** reports.

(299)

REGULATIONS on the Medical Schemes Act, due to be released today, will provide limited cover for people living with HIV and Aids and other terminal illnesses.

According to health economist Alex van den Heever, the prescribed minimum benefits contained in the regulations will mean full cover for specific conditions. But people living with HIV and cancer, for instance, will receive cover limited in terms of the efficacy of the treatment. "When the treatment can restore health, the patient will be covered," said Van den Heever.

The regulations on the Medical Schemes Act, signed by Health Minister Nkosazana Zuma yesterday, mark the culmination of months of controversy and debate.

However, chief executive of the Board of Healthcare Funders (BHF) Dr Aslam Dasoo said he did not expect any major surprises.

Zuma has invited comment within the next three months. The regulations will be made available to the press today, and will be gazetted tomorrow, according to the Health Department.

On a cursory examination of the regulations, Dasoo said the regulations reflected "pretty much what had been discussed" by the technical task team, consisting of government and industry players.

The regulations give effect to clauses in the act, due to come into effect in August, which establish how medical schemes will be regulated. The aim of the act is to ensure just and fair access to medical schemes, said Van den Heever.

Dasoo said the three areas the regulations will govern are:

- The prescribed minimum benefits which all medical schemes will have to provide complete funding for.
- Medical savings accounts and the level of contributions that can be transferred to these accounts.
- Open enrolment. According to the act, anyone able to afford medical scheme premiums should be given access to the scheme. The only differentials in premiums placed on members are income and number of dependants, unlike the previous legislation which limited the members according to age and health records, said Dasoo.

One argument against this provision was that if a voluntary medical schemes environment was opened up, people would not join until they were ill. "This could create financial havoc," Dasoo said. "It's clear that while voluntary schemes exist, there is a need for protection against this opportunistic behaviour."

Van den Heever said there would be penalties for people who had opted out of joining a scheme until they were older. "The clock starts running at 30," he said.

These protection measures could introduce further barriers, Dasoo said, but they were necessary to maintain financial stability.

A change from a voluntary to a mandatory medical schemes environment would oblige all employed people to contribute to a scheme, along the lines of social health insurance, Dasoo said. Protection in this case would be unnecessary.

Managed care scheme urges SA doctors to test patients for HIV

(299)

JUDITH SOAL
HEALTH WRITER

CT 6/5/99

THE next time you visit your GP you might be encouraged to take an HIV test — even if you think you are not at risk of contracting the disease.

Over the next two months SA's 7 000 doctors in private practice will be visited by representatives of a managed care scheme and asked to urge their patients to be tested for the virus. They will also be told about benefits and treatments available for people with HIV.

"Most people — including many GPs — think there is no treatment for HIV or that if treatments exist they are too expensive and not covered by medical aid," said Laubi Walters of Pharmaceutical Benefits Management. "But this is not true."

Medical aids have started to realise that it is cheaper to keep HIV-positive members healthy than to pay for their hospitalisation when they are ill. Although there is no cure, proper care can allow people with the virus to live productive, healthy lives.

"Medical schemes are paying for Aids-related illness anyway, they just don't always know it."

Walter's company has developed a medical aid benefit programme for HIV, known as Aid for Aids. Members of this programme have confidential access to a range of benefits — from counselling and education to advanced drugs like AZT. Anyone belonging to a medical aid that subscribes to the Aid for Aids is able to join without paying extra.

"About 15 medical aids have signed up since we began a year ago, and we expect 20 more by the end of the year," said Walters.

Given the national HIV rate of 22,8%, he believes at least 10% of those people are HIV-positive. "That means we should have about 36 000 members of Aid for Aids, but only about 1 000 people have joined."

The company believes people aren't joining either because they don't know they are HIV-positive; they are worried their status will be revealed or they aren't aware of the benefits. "This is why we have decided to target GPs, who are probably in the best position to inform their patients about the service," Walters said.

Doctors will be advised to encourage all patients who have had unprotected sex and are members of participating medical schemes to be tested for HIV.

Dr Andrew Clark, who specialises in caring for people with HIV, yesterday welcomed the campaign. "Many doctors send their (HIV-positive) patients away and tell them to come back when they are sick," he said. "Too many doctors don't even know where to start when it comes to treating people with HIV. Even with limited resources, there is a lot that can be done."

Although about 75% of South Africans do not have medical aids and so will not benefit from this scheme, Clark said there would be advantages for the public sector. "It will show that cost-effective treatment for HIV is possible," he said, "and it will provide protocols for this treatment." He said an increase in the volume of drugs used in SA would bring down their price.

● Participating medical aids: ABI Medical Scheme; Barlow Medical Scheme; BMW Medical Scheme; Bonitas Medical Scheme; Finmed Medical Scheme; Independent Newspapers Medical Aid Society; Meddent Medical Scheme; Medical Services Plan; Medshield Medical Scheme; Midmed Benefit Plan; Phila Medical Scheme; SA Breweries Medical Aids Society; SAB Castellion Medical Scheme; Stocksmed, and Wits University Medical Aid Fund.

Sasolmed and Oilmed will join from June 1.

Draft regulations greeted with relief

(299)

Medical Schemes Act now 'reasonable', writes **Pat Sidley**

THE medical schemes industry is breathing a sigh of relief — although with some red faces — with the release of draft regulations for the Medical Schemes Act.

It was only a few months ago that Business SA (BSA) tried to stop the act seeing the light of day by interdicting the process. The court action itself was ill-conceived, found groundless, and BSA had to pay costs and was not given the opportunity to appeal.

To make matters worse, the expected "draconian" regulations, which would usher in an era of the worst of socialist health systems and stamp out any entrepreneurial spirit, seem almost reasonable.

"Reasonable", "workable" and similar concepts were how the regulations were greeted by some of the act's more vigorous opponents, including Discovery Health and Fedsure Health.

The draft regulations, published today will give effect to the act which was passed last year.

The act was designed to ensure more people had access to medical aids and were protected from landing up using scarce state resources when catastrophe struck and schemes stopped paying.

Schemes would be obliged to accept people who could afford to pay, without penalising them for being too old or sick. The regulations — about 70 pages of them — set out how this is to be done, and crucially, how to protect schemes from some of the adverse effects the new law will have on them.

Some of the measures include restrictions on medical savings accounts, the details of the minimum package of benefits which each medical aid (with some exemptions) will have to supply to all members, and protection against adverse selection (measures to protect schemes from people joining only when they have become sick or are old and have refused to belong).

Schemes will have to cover HIV/AIDS until the CD4 count (an indicator of the extent to which the immune system has been compromised) is below 100. At that point the immune system is so low that death is likely from an opportunistic infection.

Adrian Gore, Discovery Health CEO, is generally positive about the regulations, but points to specific areas which will need further attention. These include the amnesty period (during which people can join schemes without penalties for age), savings accounts and protection against people switching schemes for better benefits.

He bears out the optimism of Dr Aslam Dasoo, the CEO of Board of Healthcare Funders, which represents almost all schemes, that some consensus in the industry is likely to be found — and these regulations are an important test for the new representative body.

Gore believes there have been compromises in the drawing up of the regulations. He is not unhappy at the minimum package of benefits which all schemes will have to provide, and would have liked to have seen medical savings accounts less restricted, but believes the regulations, after further discussion, will be workable.

The minimum benefits package may be a problem for schemes offering a low cost package for low income earners, he says. However, the regulations provide an exemption for these schemes for a certain period. They must demonstrate that the average premium is R1 000 or less per year.

Fedsure Health's Mel Rom is uncomfortable about the medical savings account limits. His company had wanted to offer accounts which would consist of 50% of member's premiums. The regulation limit is 25% — but the health department originally threatened to ban them altogether. He says: "On the whole there is still a lot of opportunity for us," a feeling echoed by Gore. "Schemes which are innovative and creative will survive," he says. The environment also means there will be significant attempts to use managed care devices to cut costs.

DD 7/5/99

Get in on the new Medical Schemes act

(299) ~~BMS~~ ARG 8/5/99

ESANN DE KOCK

You have three months to have your say on regulations in the Medical Schemes act.

The new regulations, signed by Health Minister Nkosazana Zuma this week, are set to introduce significant and possibly controversial changes to the way your medical scheme is run.

The overall aim of the regulations is to ensure fair access to medical schemes – many of which currently exclude members on the basis of their health and age.

The act proposes that everyone able to afford the premiums should be able to join a scheme, and that premiums should differ only depending on your income and your number of dependants.

But the regulations also specify that there should be penalties for people who opt out of their medical schemes until they are older and need more care.

The reasoning behind this is that people should not be allowed to get away with opportunistic behaviour, by joining a medical scheme only when they get sick.

This type of behaviour, it is said, has had financially disastrous effects on medical schemes, many of which are battling to contain premiums, which have been soaring, due to increased medical costs and rising medical claims.

Older and sick people who are being excluded from medical schemes, and lower income earners who have chosen not to join medical schemes, are relying on the State for their health care.

This has placed an additional burden on scarce government resources and funding. It also means that those who have remained members of medical schemes have been left with increased costs, as the pool of contributors shrinks.

Government now wants to ensure that medical scheme members have access to necessary care, and that costs are not unfairly shifted to public hospitals.

Another important change to the regulations which will govern medical schemes is a provision that all schemes should offer a set of prescribed minimum benefits to their members, for which they should provide full funding.

People with HIV and Aids are likely to receive limited cover under the new regulations. Many medical schemes currently exclude cover for these conditions.

The Department of Health believes administration of medical aids will be enhanced by ensuring that they set aside adequate funds to ensure their solvency. And it hopes to improve the supervision of medical aids through the Council for Medical Schemes and the office of the Registrar of Medical Schemes.

It believes these measures will, cumulatively, provide incentives for medical schemes to contain costs without sacrificing access to healthcare for all their members – young and old.

A spoonful of sugar sweetens Zuma's medicine

If the draft regulations of the new Medical Schemes Act are passed, you will pay for your high-risk years in advance, writes DINA SEEGER

DR NKOSAZANA Zuma's new draft regulations of the Medical Schemes Act have all the elements of a classic movie — some good, some bad and some downright ugly.

The good news is that if you have a chronic disease or are a retiree, you will at last be allowed to join a medical aid scheme at an affordable monthly contribution.

But if you are young and healthy, expect your medical scheme to slap you with a fat increase in contributions in order to fund the regulations.

And if you earn a good income, be prepared to subsidise your fellow citizens by paying an even steeper contribution.

After a long wait, the draft regulations for the controversial Medical Schemes Act were published in the Government Gazette on Friday.

The regulations, some of which could be implemented as soon as September, impose guaranteed acceptance in a medical scheme and a minimum benefits package.

Also guaranteed is a standard-rate contribution that ignores a members' age or risk (with a chronic disease like AIDS, for example). But medical schemes will be allowed to make adjustments to members' contributions according to their income and number of dependants.

Zuma's regulations put a dampener on the popular medical savings accounts (which give you cash back for any unspent contributions). If you have a medical aid savings account you will now be restricted to putting only 25% of your monthly contribution into your savings account. Currently, members' savings average 40% of their contributions.

Lynda Fussell, director of consultancy Alexander Forbes Health Care, says the contribution increases will be justified — in the long run.

The Act, she says, aims to reverse the present system in which young and healthy members pay lower contributions than high-risk members who are often retired and can't afford costly health cover.

Currently, these high-risk individuals pay up to four times more in contributions than healthy members. Under the new Act, you will effectively pay for your high-risk years in advance.

Fussell believes that over the next two years our medical contributions will be disproportionately high. During this time, medical schemes will be finding their feet in the new system before coming up with cost-effective health packages.

Alex van den Heever, consultant to the Health Department, says if contributions rise as a result of the Act, they will only be a better reflection of the true cost of lifetime medical care.

He says medical schemes will have to find new methods of keeping contributions affordable. "There's a lot of fat in the schemes right now. They will have to look at this very carefully."

You will pay more early in life but should reap the rewards when you get older

Van den Heever adds that there is a trend towards enhanced competition among medical providers (doctors and hospitals), and this could help keep contributions down.

But he admits the medical schemes have big changes coming once the regulations are implemented.

Strangely enough, the medical schemes industry doesn't appear overly concerned about the new regulations. Perhaps the reason for this is that there has been much compromise by the Health Department following close negotiations with the industry.

Shaun Matisonn, risk management actuary for Discovery Health, says: "We've come a long way since Zuma's original proposals for the Act." In essence, the regulations contain sufficient protection for the medical schemes to stay financially viable, he says.

Although the principles of guaranteed acceptance and a standard rating are now entrenched in the Act, Matisonn is happy the industry is "safe".

Medical schemes will no longer be allowed to turn away new members in terms of guaranteed acceptance, but they can still impose penalties and exclusions for late joiners and new members who have pre-existing medical conditions.

This is to discourage people from joining medical schemes only when they really need to — when chronically ill or old.

Late joiners can be penalised with up to 75% higher contributions than the flat rate charged to other members. And people are incentivised to join a scheme early because the penalty clock starts running on your 40th birthday.

And if you join a medical scheme with a pre-existing condition, your contract could exclude cover for your condition for the first 12 months.

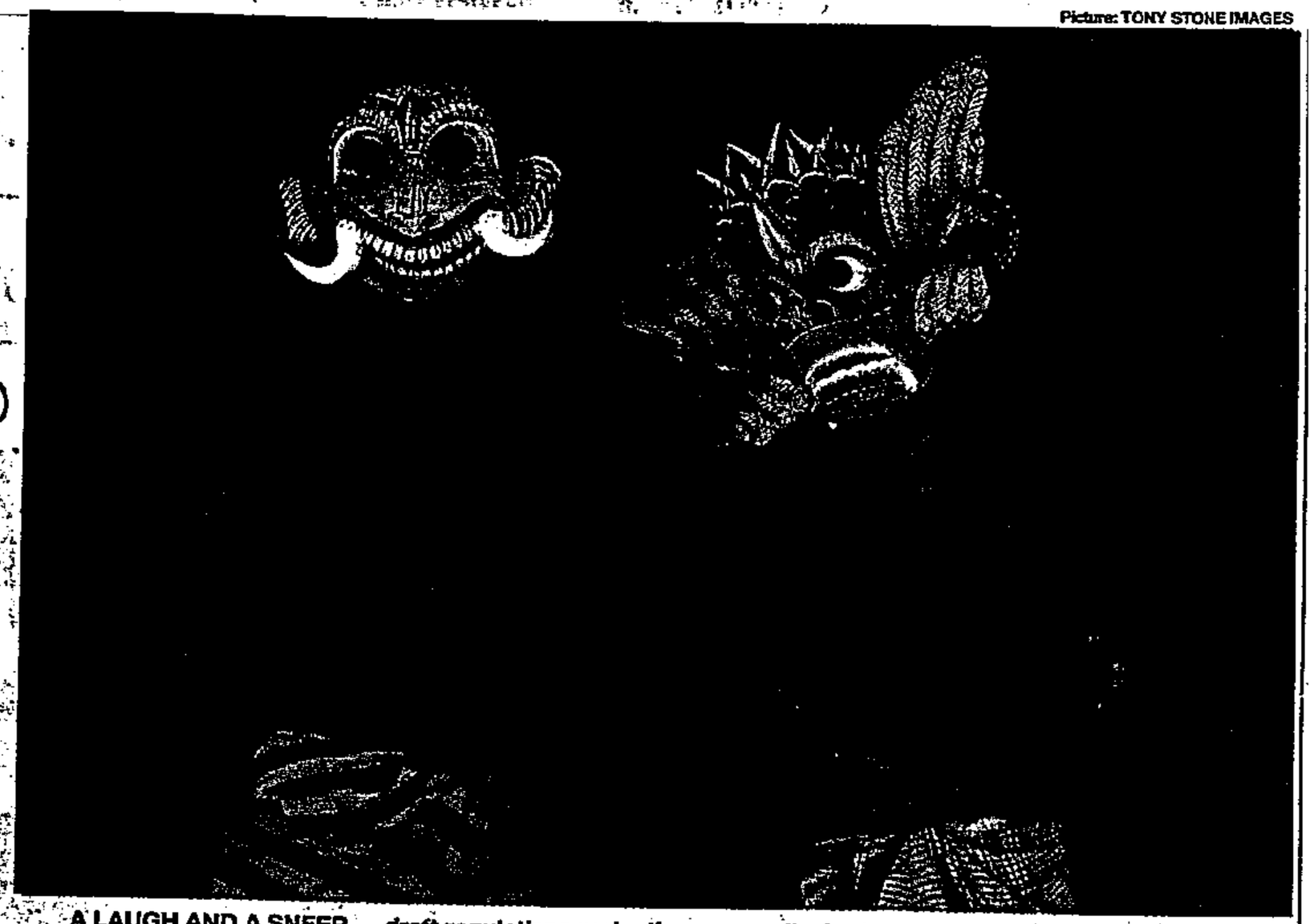
Further, Matisonn does not expect the much-feared flood of extended families joining medical schemes. Schemes will charge additional fees for each dependant, he says.

Matisonn's major gripe with the regulations is the restriction on medical savings accounts. He says the Health Department's concern is that members will not seek health care if they can increase their own savings. "But this isn't happening. People are just spending more efficiently."

Like them or not, the draft regulations are unlikely to change. Medical fund members will pay more in the early stages of life but they should reap the rewards in the later stages — provided their medical scheme is still around to foot the bill.

The industry is in for a shake-up and the schemes will have to do some nifty financial footwork.

Picture: TONY STONE IMAGES



A LAUGH AND A SNEER ... draft regulations make the new medical schemes law more balanced for all

Medical schemes call for greater flexibility

BD 13/5/99

Pat Sidley (299)

MEDSCHEME, one of SA's largest medical scheme administrators, has called for new investment regulations to be more flexible.

It is concerned about the implications of an amnesty period in the regulations which would allow older and sicker people who had never been members of schemes to join without penalties.

Regulations covering the activities of medical schemes to go with the new Medical Schemes Act, which was passed last year, are being circulated for comment over the next three months.

According to Medscheme's financial director, Anton Roux, the investment of reserves of schemes would be better regulated if they were bound by the same rules as pension funds, which, he said at a seminar yesterday allowed more flexibility.

He singled out the risk attached to bonds as needing particular attention.

"In an attempt to reduce risk exposure for a scheme, the opposite will be achieved. The risk relating to bonds has been ignored," he said.

Medscheme's analysis showed there were greater restrictions for medical schemes than for pension funds. For instance, medical schemes could have only 20% of their assets in cash whereas pension funds could have 100%. However both schemes and pension funds could hold 100% bonds. The risk in bonds, he said, was in municipal bonds.

He said schemes could have only 30% of their assets in equity portfolios, whereas pensions could have 75% in equities. Property and fixed assets differed too, with schemes allowed 10% and 30% respectively while pension funds were allowed 25% property and up to 10% fixed assets.

Analysing the effects of the regulations on the compulsory package of benefits that all schemes will have to apply, Prof Alan Rothberg, also of Medscheme, said the attempts by government to stop private patients being "dumped" on state hospitals would create "a different dumping possibility".

He used the regulation around the treatment of HIV/AIDS as an example. Medical schemes would have to cover the costs of treatment of HIV/AIDS patients until the CD-4 count (a measure of the strength of the immune system) fell below 100.

A patient in hospital with a CD-4 count of 101, would have treatment costs paid for by his scheme. But when his count fell to 99, this would stop.

Rothberg believed government had listened to the medical schemes industry and that there had been a clear attempt to accommodate its problems.

Willie van Staden, MD Medscheme consulting division, was concerned about the implications of the six-month amnesty period which would allow people who had never joined a scheme to join without penalty.

He believed that people who had tried to join, but had been kept out of the system because of pre-existing conditions or very high premiums, should be able to benefit from an amnesty, but not those who had simply chosen not to belong to a medical scheme.

Future of defined benefit schemes 'hangs in balance'

(299) CT(BR) 13/5/99

FROM SAPA

Johannesburg – The future of defined benefit retirement funds appeared to hang in the balance as a growing body of equity legislation redefined the environment in which these funds operated, Kerry Horsley of Old Mutual Actuaries and Consultants, said yesterday.

Horsley said: "Defined benefit arrangements still have a place in our society and members' interests in these funds should be protected.

"However, the benefits, practices and procedures of defined benefit funds are frequently being tested by our courts and Professor John Murphy, the pensions fund adjudicator, as aggrieved members bring claims of unfair discrimination against their funds."

The issue of equity in retirement funds has received significant media coverage in recent months. Members have challenged unfair discriminatory practices and procedures in their funds, which has lead to ground breaking determinations by Murphy.

Section 9 of the constitution, for example, which outlaws gender and lifestyle discrimination, has given rise to a number of questions.

Paul Spencer, an actuary, said some of the constitutional questions raised were whether the needs of legally married members were any different to the needs of those who were not, or whether the needs of heterosexual marriages differed from the those in homosexual marriages.

It is also questioned whether it was fair that a spouse's benefit was reduced based on the age difference between the spouse and the member.

Another problem was that changes to the level of benefits and the assumptions could result in significant changes to the required employer contribution rate.

"Actuaries are concerned that levelling up benefits to meet the needs of all members' dependents, irrespective of their marital status or age, could increase employers' required contribution rates to the extent that funds could go insolvent," said Spencer.

Horsley said retirement fund lawyers had to ensure the institutions they represented complied with the constitution's requirements.

He said retirement funds ran the risk of litigation by aggrieved members, employees and their dependents based on the constitution.

This view, he said, was reinforced by the fact that Murphy had a backlog of about 1500 cases where members claimed they were treated "inappropriately" by their retirement funds.

Murphy has the same powers as the High Court in terms of the Pensions Fund Act and can award damages to claimants unfairly discriminated against. He is able to set aside rules, practices and procedures that discriminate unfairly.

"Although the possibility of retrospective damages cannot be ruled out, Murphy has made it clear that it is not his intention to pass rulings that would financially cripple funds and employers," said Horsley.

Horsley said that, according to Murphy, the constitution required a remapping of the law which would require an insertion of new values into society.

"What may be required is a legislative intervention to entrench the nature of benefits currently being provided by these funds in respect of past service in order that they can remain viable into the future," he said.

MEDICAL SCHEMES (299) PM 14/5/99

THE ART OF COMPROMISE

Zuma sticks to her principles

The medical schemes industry can live with government's new medical scheme regulations. But though they're not as harsh as expected, they still leave room for improvement.

Industry representatives say the regulations reflect the compromises reached during months of technical talks with the Health Department, and strike a balance between the Ministry's ideological aims and the concerns of private administrators. This must be a new experience for Health Minister Nkosazana Zuma.

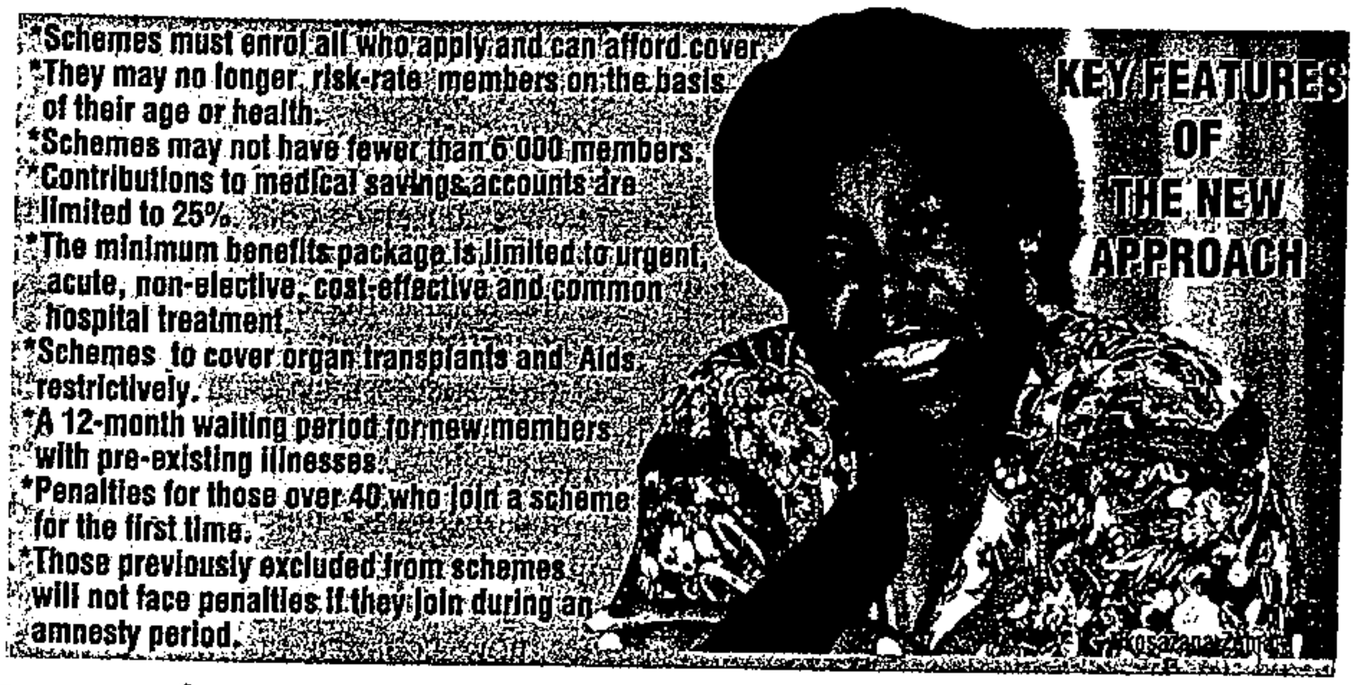
The initial hue and cry with which most of the industry greeted the Medical Schemes Amendment Act was partly because of the private health sector's fundamental mistrust of Zuma and the fact that the most contentious aspects were left to regulations that are not subject to parliamentary scrutiny. But when it finally came to thrashing out the regulations, the two sides found each other to be fairly reasonable.

"Initially there were many concerns but there was a lot of co-operation from the department, compromise on both sides and a huge amount of analysis," says Fedsure Managed Care MD Mel Rom. "It was an excellent experience and opportunity, but at the same time everything hasn't been addressed 100%."

These feelings are shared by Discovery Health CEO Adrian Gore who is relatively optimistic about the regulations. "The department hasn't moved at all on matters of principle but has accommodated us on some technical aspects."

However, many schemes are unhappy that the regulations impose a limit of 25% on contributions to medical savings accounts (compared to the current norm of 40%-50%) as this will reduce their effectiveness in curbing unnecessary health expenditure.

"Consumers will lose out," says Rom. "Savings accounts have been an effective tool, reducing members' annual contribution increases to 2%-5% compared to about 15% across the industry as a whole."



Commentators agree that 25% is completely unjustified, especially as the industry feels it has disproved all the department's concerns. But at least the department no longer wants to impose a 13% limit and is prepared to debate the matter further.

Industry negotiators are impressed with the scientific and broadly consultative approach the department adopted in designing the minimum benefits package.

In future all schemes will have to offer at least these basic hospital benefits. The aim is to prevent schemes from setting their hospital benefits so low that members fall back on to public hospitals. Schemes that will have to raise their hospital benefit limits to comply with the regulations will probably have to raise their contribution levels.

The package covers about 60% of the usual hospital benefits, including most common acute conditions like heart attacks, strokes, and trauma. It is limited to urgent, acute, non-elective, cost-effective and common hospital treatment and in some cases limits the benefit to treatment that will be clearly beneficial. For instance, schemes will only have to pay for renal dialysis and organ transplants performed according to the stringent criteria adopted by public hospitals that perform these services only as a last resort to those who have a good chance of responding to the treatment. And though schemes will have to pay for a member's first Aids-related hospitalisation, they only have to pay for subsequent hospital visits if the member's health is relatively strong (their CD4-count exceeds 100).

Schemes may also specify that treatment be received in a public rather than a private hospital, thus reducing their cost exposure.

"They've met their objective narrowly on this issue while giving schemes flexibility so they don't have to institute radical change," says Discovery Health risk management actuary Shaun Mattison.

The principal architect of the package is private health-care consultant Neil Soderlund, formerly of the Wits health policy unit and now a manager at Abt Associates.

The Act forces schemes to enrol all who apply and can afford cover, but they may no longer risk-rate members on the basis of their age or health. To protect schemes against the potentially adverse effects of this system, they will be allowed to impose a 12-month waiting period on new members with pre-existing illnesses and may load the premiums of those over 40 who join for the first time. These penalties won't apply if the treatment falls within the minimum benefits package or during the six-month amnesty period from January 2000.

Though these measures are not as generous as the industry would have liked, Rom and Gore are hopeful they will provide schemes with enough protection.

Old Mutual Healthcare MD Riaan Jordaan says the bottom line is the Act will make private health cover more expensive. Employers could react to this by providing their employees with the minimum benefits package (estimated at R200 to R300/family/month), rather than providing comprehensive cover to just a few.

From a legal perspective, the regulations have attracted criticism. Old Mutual's principal legal consultant Ralf Metz says they "are badly drafted, full of inconsistencies and wide open to interpretation".

The industry will press hard for further concessions during the three months allowed for debate on the regulations.

Claire Bisseker

Acceptance of 'Zuma's revenge'

(299)

Medscheme chief believes industry can, to a large degree, live with the proposed new regulations

Star 17/5/99

By Anso Thom
Health Reporter

It has earlier been slammed as "Zuma's revenge" and a "disaster for medical schemes", but the muted response by the industry following the publication of the regulations of the Medical Schemes Act illustrates a large degree of acceptance.

Keith Hollis, chairman of Medscheme, the largest medical scheme administrator in South Africa, said although they identified some problems, they believed that the regulations would be accepted to a large degree by the industry.

The regulations published in the Government Gazette gave effect to clauses in the Act, due to come into effect in August, which established how medical schemes would be regulated.

The aim of the Act was to ensure just and fair access to medical schemes.

"There is nothing really that we haven't expected," Willie van Staden, managing director of Medscheme's consulting division, told their members at a workshop in Randburg last week.

He said government had attempted to soften the blow of open enrolment with general waiting periods.

"If we have to take any applicant it will put up the cost dramatically, and it is clear that the department of health would like to get as many people covered as possible," he said.

General waiting periods were:

- up to three months for a new member before entitlement to benefits;
- nine months for pregnancy benefits not prescribed in the minimum benefits package;
- no general waiting period for the applicant who was a beneficiary of another scheme for a period of two years or more, and applied within three months, after leaving the other scheme.

There was also provision in the regulations for penalties for late joiners older than 30 years.

Schedule has 262 conditions

The prescribed minimum benefits schedule in the regulation contained 262 conditions with diagnosis and likely treatment. Those worth noting included:

- cardiac transplant (subject to acceptance onto state hospital waiting list);
- induced abortion;
- only incubating a premature baby which weighs more than 1000 grams;
- pregnancy/obstetric care;
- HIV/Aids only for patients where the CD4 count is greater than 100. The treatment is medical and surgical treatment for opportunistic infections and localised malignancies;
- sexually transmitted diseases;
- mental illness. There are 10 categories for illnesses including alcoholism, substance abuse, anorexia, schizophrenia, suicide attempts, depression and stress disorders. Limits are set in terms of treatment time, varying from three days to three weeks.

Dr Alan Rothberg, Clinical director at Medscheme, said Aids activists were certain to challenge the HIV benefits which effectively excluded hospitalisation for those whose immunodeficiency levels were low. It also excluded any form of anti-retroviral therapy such as AZT.

Rothberg said there was also practical problems as the lack of resources in the public sector often prevented patients from actually getting treatment.

Chief executive of the Board of Healthcare Funders (BHF), Dr Aslam Dasoo, said recently that on a cursory examination of the regulations, it reflected "pretty much what had been discussed" by the technical task team, consisting of the Ggovernment and industry players.

"We will, however, subject the proposed regulations to careful consideration in order to issue a meaningful and representative response on behalf of the industry" he said.

Health Minister Nkosazana Zuma has invited comment within the next three months.

We need to change schemes' priorities

(299)

WHILE medical aid schemes still deny infertile patients treatment, some groups and individuals are not taking the matter lightly.

Sue Ivins, founder member of Fusion, says the organisation is aimed at lobbying Government and medical aid schemes for financial assistance with fertility treatment. This is happening worldwide.

Ivins, who waited 10 years before she could have a child, says Fusion's objectives include holding specific awareness drives to get fertile men and women to donate sperm and eggs.

"This association is not going to be a sob session for infertile women but a place where we can talk about issues such as how to cope with infertility and how it can affect your sex life and marriage," says Ivins.

According to the report: *From Words to Action: Sexual and Reproductive Rights, Health Policies and Programming in South Africa 1994 to 1998* by the Women's Health Project and the Centre for Health Policy in the health ministry, infertility diagnosis and its management are frequently perceived as a luxury medical service and are threatened by rationalisation and budget cuts to contain health and service cuts.

"In general infertility is not viewed as a priority concern area. There is no training dealing with the subject," reads the document.

Senior Sister Anne Hacking, from Dr Mervyn Jacobson of the Linksfield Fertility Clinic, says fertility is a human rights issue and not a privilege, as most medical aids would like to believe.

"It is every woman's or couple's right to have a child and family. That's how society sees us, as a natural progression of a relationship.

"Fertility is not life-threatening but what about the emotional and psychological effects. The medical aids will pay for those when they could have been avoided by paying for just one attempt."

Hacking says a couple has to worry about infertility after they have been trying for at least a year without any use of contraceptives.

And in order for them to determine the problem they have to go for a full investigation. During investigation, says Hacking, the male's sperms and the female's eggs and pathway are checked.

The initial investigations can cost up to R1 500. This excludes the routine tests like Hepatitis B, HIV, German measles and Pap smear.

When the problem is determined and a procedure has to be performed – like artificial insemination (a hole is drawn in the egg and a sperm is inserted so that conception can occur) – this costs about R2 200 with medication.

When the problem is hormonal, the medication used for growing eggs costs between R2 000 and R8 000, depending on the dosage and length of treatment.

In 1990 the average cost of one in vitro attempt was R2 500 at a Government hospital and between R4 000 and R6 000 at a private clinic.

NEW HEALTH ACT

Age no longer an issue for medical aid schemes

ET 31/5/99 (299)

THE MEDICAL Schemes Act represents a quantum change in how medical aids will operate, the new organisation that represents the industry said on Friday. **JUDITH SOAL** reports.

IF you do not belong to a medical aid society, now is the time to sign up. The new Medical Schemes Act, which is expected to come into operation in August, will stop medical schemes charging higher rates as you get older — unless you have not been a member in the past.

Under the act you will be required to pay more than other members if you have been without medical aid coverage for two years or longer.

"This is to protect medical schemes from people who don't pay contributions when they are young and healthy but then want to join when they are older and need more coverage," said Aslam Dasoo, the chief executive officer of the Board of Health Care Funders, which represents medical schemes.

"Under the new law, medical schemes can't ask for higher contributions from older members as they did in this past, though this leaves them open to opportunistic behaviour. Penalties for late joiners protect schemes from this."

In the legislation, which was passed in May, Health Minister Nkosazana Zuma has allowed an amnesty period between 1 January and 30 June 2000 for non-members to join medical aids without paying the penalty.

The Board of Health Care Funders has asked that this period be reduced.

"Basically we support the legislation, which is intended to give more people access to medical aids," said Dasoo, "but there are certain aspects we would like changed."

The board wants the amnesty period to be reduced to three months and the late joiner penalties to start at a younger age.

The current scenario is:

- If you join between the ages of 40 and 49 you will pay 1,25 times the normal rate.
- Between ages 50 and 59, you will pay 1,5 times the standard rate.
- Over 60 you will pay 1,75 times more than the standard rate.

The medical schemes suggest the following:

- If you join between 30 and 39, you will pay 1,25 times the normal rate.
- Between 40 and 49, you will pay 1,5 times the standard rate.
- Between 50 and 59, you will pay 1,75 times the standard rate.
- Over 60 you will pay double the standard rate.

On Friday, members of the Board of Health Care Funders, which was recently formed to replace Rams (the Representative Association of Medical Schemes) and Samsa (South African Medical Scheme Society), came to Cape Town to discuss proposed amendments to the legislation with its members.

Other key aspects of the new law are to broaden the definition of "dependants" and to set minimum benefits that schemes have to provide for certain medical conditions, including HIV.

"The legislation appropriately moves away from a Western paradigm to allow for the African reality when it defines dependents," said Dasoo. "But we feel schemes may need some protection against risk because this definition is too wide." Dasoo said the Board of Health Care Funders had been involved in drawing up the list and accepted that it would need changes. "The first attempt at defining medical conditions and their treatment is obviously going to be flawed," he said.

The board will finalise its suggestions in the next month and report back to the Department of Health at the end of June.

"This is a quantum change in the way medical schemes work," said Dasoo. "It is important that we are involved in the process."

Medical schemes placed under curatorship

(299)

Sowetan 4/6/99

By Bhungani Mzolo
Health Reporter

THE controversial Regional Medical Aid Scheme, which is administered by Insurance and Finance Marketing, has been placed under curatorship after reports in *Sowetan* about its financial troubles.

Sharing its fate is the KwaZulu-Natal Medical Scheme.

The IFM-controlled scheme was placed under provisional curatorship by the Johannesburg High Court last week after a number of doctors and patients complained that they had not been paid for several months.

A KwaZulu-Natal doctor, who was owed more than R50 000, staged a sit-in for a day at the company's Johannesburg offices last week until he was paid.

Mr Danie Kolver, registrar of medical schemes, launched the application for a curator to manage the two schemes because they had become aware of "certain administrative an other apparent irregularities, whic required investigation by independer management".

Kolver said the appointment of curator did not indicate that th schemes were financially unsound an about to be placed under liquidation He said the curator would assess th financial position of the schemes anc their administration and report to the High Court soon. Members and interested parties would be kept informed.

The High Court appointed attorney Mr Hans Klopper of Hans Klopper Inc to manage the two schemes.

People who have been affected by the latest developments regarding the schemes can call (011) 332-7495 for more information.

A source said a large number of people would be affected as both schemes had thousands of clients as they offered loans and funeral cover at reasonable premiums.

MEDICAL AID

RACE UNDER WAY TO DEVELOP BLUE COLLAR COVER

(299) FM 4/6/99

Managed care providers face challenge of risky emerging market

Imagine going to your doctor with earache who, after looking you over, keys your symptoms into a desktop computer, which then suggests a diagnosis and prescription.

These are the lengths the medical aid industry is going to, to curtail rising medical inflation and make private health care affordable to the emerging market.

The race is on to design low-cost medical aid plans for this market — those 6m-14m blue collar workers, secretaries, clerks and the self-employed who have jobs but no medical aid.

The emerging market is the only significant source of new members for an industry that has priced itself out of the reach of the man in the street.

But designing managed care plans for this unknown market is notoriously risky and requires a big investment in IT.

"SA's health-care scene is littered with managed care executives with holes in their pockets and stakes in their hearts," says Old Mutual Health Care marketing manager Lindsay Walker.

But then the rewards can be great for those who get it right.

SA's largest medical aid administrator, Medscheme, manages a high percentage of low-income members and has its sights firmly set on this market to drive the future growth of the company.

Others, like Metropolitan Health, have limited their involvement in the emerging market to one or two tailor-made plans.

Many, like Fedsure Health and Discovery Health, are cautious about covering a population whose health needs they know so little about, but are working on emerging market products.

New legislation that forces all schemes to provide a prescribed minimum benefits package will make it even harder for schemes to enter this market. As the package includes benefits for Aids, organ transplants and other hospital events that are excluded by most emerging market plans, (it is priced at R300/life/month by the private sector), it will also raise the cost of existing plans, some of which may no longer be feasible.

Emerging-market products typically follow a model in which the scheme contracts at a discount with a general practitioner network, or group of primary healthcare clinics that provide GP services, dentistry, radiology, pathology and other out-of-hospital services. Members may consult only these providers. They are paid a fixed monthly fee per patient (a capitated fee) rather than a fee per consultation, and are incentivised not to overservice patients. In most cases, doctors are bound to practise medicine according to very strict guidelines to ensure only necessary, cost-effective and appropriate care is dispensed.

»SA's health-care scene is littered with managed care executives with holes in their pockets and stakes in their hearts «

Old Mutual Health Care's Lindsay Walker

Established in January, Impilo Health Plan Organisation (a subsidiary of African Life) is one of the first companies established purely to provide medical aid to the emerging market. (Norwich Health Care was the first with the launch last year of Real Health.)

Impilo has contracts with the Prime Cure and Carewell clinic groups. Administration and managed care are done in-house using an American IT system customised for SA by the clinics themselves. It tells the doctor what the standard treatment protocols are for the hundreds of common ailments seen at primary care level. So if a member complains of a sore ear, the computer will list common diagnoses and cost-effective drugs which the doctor must adhere to unless he or she can motivate otherwise.

"About 95% of all GP consultations are for standard things. The other 5% are left to the discretion of the doctor," says Impilo director Dr Peter Botha.

He says that in this way Impilo is able to price its health plan at R215/month/member, which includes unlimited primary care plus R80 000 private hospital and specialist cover per annum.

Apart from being costly and complex to implement, this model also impinges on the discretion of the doctor and removes patient choice as the member may see only a contracted-in provider. Some capitated schemes have gone under because patient volumes were too low, the risk was inadequately assessed, or because profits were stripped out by a management company.

But health consultants say this model is recognised as an effective way to contain costs and will be used more often, not only in the emerging market.

Another way of expanding access is for medical schemes to lease wards in public hospitals where private doctors can practise in a less costly setting. This scheme has worked well in Uitenhage and is being piloted elsewhere in SA, but has been circumscribed by the health authorities' mistrust of the private sector.

Health Minister Nkosazana Zuma prefers the idea of a national social health insurance system to which every employer will contribute 2%-4% of its payroll to cover its workers' use of the public hospital system. The revenue generated will improve the quality of public hospitals.

This policy has been placed on the backburner for the past year while government has considered the broader question of a national social security system, but it is high on the ANC's agenda and is expected to be implemented by 2001. **Claire Bisseker**

***Low income patients** . . . waiting for affordable care*

Medical aid plan brokers form new body

BD 11/6/99 (p99)

Pat Sidley

BROKERS selling medical aid plans have formed an industry body to lobby for their interests in the light of the new Medical Schemes Act and the regulations to follow.

The new body, the Association of Health Benefit Advisers, will operate in an environment in which thousands of brokers are selling healthcare plans with little or no regulation.

Medical schemes have until now not been allowed to pay commission to brokers. The previous law prohibited using members' funds to pay commissions. The industry, as a result, devised "underground" methods of using and paying brokers, but the outcome was an unregulated, clandestine industry worth millions of rands a year.

The new Medical Schemes Act seeks to limit commission to about 3% of premiums and seeks an accreditation system to ensure that only qualified and knowledgeable brokers sell healthcare plans.

The association seeks to be officially recognised in the regulation and accreditation of brokers — and will lobby on behalf of their interests, seen as being different from those of the schemes themselves.

Chairman Yekani Tenza says the association intends to persuade government that its limits on commission are too low.

The association supports the idea of disclosure, and hopes to take part in accreditation and regulation functions. It hopes to be the regulatory body, with government recognising the principle of self-regulation.

Tenza says association members are all "independent" — many on the committee belong to large organisations like banks or international brokerages with ties to financial services firms — and adhere to a code of conduct.

Those members transgressing the code will be expelled from membership. If the body were recognised by government, then in terms of the law those barred from membership would not be able to practice as healthcare brokers.

Numbers of brokers in the healthcare field are hard to estimate. According to one industry source, there are about 200 or 300 brokers specialising in healthcare plans.

However, one insurer uses the services of about 3 000 brokers who sell financial services products and include some healthcare planning in their range of products. So there are several thousand people selling healthcare financing products with minimal regulation.

Health benefit commission slated

(299) ET (BR) 11/6/99

ADELE SHEVEL

Johannesburg – The 3 percent commission proposed to be paid to health benefit providers was not viable and "ignores the complexity of the industry", Yekani Tenza, the chairman of the Association for Health Benefit Advisers, said yesterday.

The proposed regulations, open for comment until the end of next month, comprise the details that govern the Medical Schemes Act, which was passed by parliament at the end of last year.

Tenza was speaking at the launch of the association, formed to address issues in the health industry, mainly the regulations that govern the Medical Schemes Act. The association consists of intermediaries and advisers in the healthcare industry.

Tenza said the regulations would create an imbalance in the healthcare industry, especially with regard to advisers. "No new person will become a healthcare consultant," he said. Proposals required consultants to have a three-year tertiary qualification and a year's experience, or at least four years' experience.

"Who will invest three years in an institution to earn a commission of 3 percent?" asked Tenza, who predicted this would lead to job losses. He said the association was planning a mentor programme through which advisers could be trained.

HEALTH CARE

RUNAWAY MEDICINE PRICES FORCE SCHEMES TO ACT

Incentives to over-service patients must be eliminated

The prices of some of the most heavily used medicines in SA have increased by up to 20% over the past year, forcing medical schemes to use survival tactics.

Schemes can no longer afford these annual hikes and are looking at ways to collaborate with pharmaceutical companies, doctors, pharmacists and managed care companies to change the way medicine prices are determined in SA.

It will be an uphill battle because every sector of the health-care industry is at fault, even the schemes, managed-care companies and administrators, for failing to tackle medicine prices effectively.

In SA, out-of-hospital drugs constitute 24%-29% of schemes' annual claims expenditure, compared to about 12%-15% internationally, making them the single biggest contributor to claims' costs.

>>There is nothing inherently wrong with the rebate system provided the discount is passed on to the patient, but most of the time it isn't, resulting in margins of up to 360%<<

According to official pharmaceutical industry figures, the average increase in medicine prices was 15% last year — not bad given that the rand fell by about 18%.

But Pharmaceutical Benefit Management (PBM) CEO Laubi Walters says this is only half the picture. The official figure does not reflect the cost-push effects of expensive new drugs that came on to the market during that time, nor does it take account of utilisation patterns. When these factors are included, total payouts are much higher.

For instance, medicine expenditure by SA's largest medical aid administrator, Medscheme, increased by 22% in 1995-1996, 17% in 1996-1997 and 20% in 1997-1998. But the pure price increases quoted by the pharmaceutical industry were 14%, 13% and 15%.

"As a general rule, drugs with higher market shares go up much faster than those with low market shares, especially in the case of patent-protected drugs where there is little competition," says Walters, who claims that the prices of some of the most heavily used medicines, like respiratory drugs, have increased by about 20% over the past year (see graph).

The reasons for runaway medicine prices are many and complex.

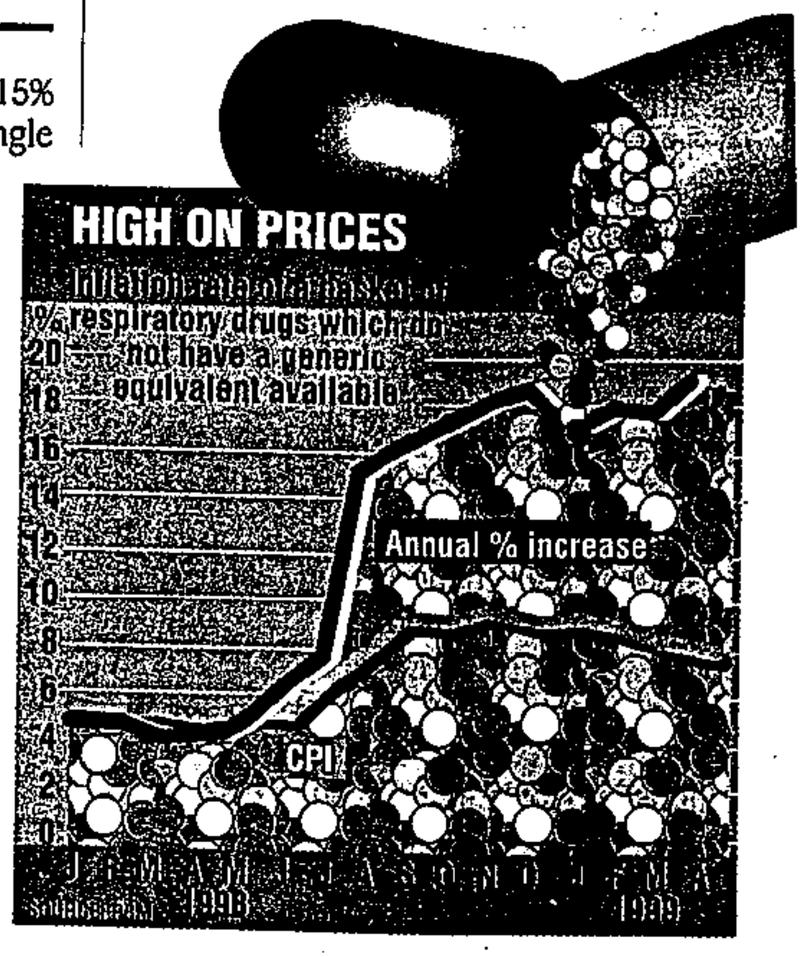
First, there is the percentage price mark-up system, which affords wholesalers and pharmacists gross margins of 21% and 50% respectively.

But for those with bulk buying power, like groups of dispensing doctors, pharmacies, hospitals and medical aid administrators, it is possible to beat the manufacturer down below the published ex-factory price.

The greater the buyer's proven sale volumes, the bigger the discount. There is nothing inherently wrong with this rebate system provided the discount is passed on to the patient, but most of the time it isn't, resulting in margins of up to 360% for some players in this market.

QualSA HealthCare CEO Sally Velzeboer also blames the poor dispensing habits of doctors, saying that unless doctors are held accountable and share risk for every pathology test, X-ray and drug dispensed, they will never prescribe cost-effectively.

"There has been a huge shift away from older, simpler drugs that may be slightly less effective but do the job in most cases, towards fancy new drugs that are much more expensive and are often used inappropriately as a first-line treatment," she says, citing the example of an expensive new drug, Klacid, which is sometimes wrongly prescribed to treat viral upper respiratory problems.



Some doctor groups have created prescribed drug lists (formularies) to cut their drug costs and can be quite brutal, forcing manufacturers to offer them large rebates or face exclusion from the formulary.

The problem, says Walters, is that the biggest rebates are offered on the big-ticket items, resulting in formularies that are skewed towards the most expensive and most frequently utilised drugs, thus fuelling the upward cost spiral.

PBM executive director Ashley Smart says the increasing use of below-the-line rebates has caused an upward shift in the base price on which all players then add their mark-ups.

PBM has embarked on a pilot project in a Gauteng town where it is attempting to subvert the current system to save a small, in-house scheme from going under. The town's 35 doctors have abandoned their inflationary formulary for one that is scientifically sound and cost-effective. In exchange, PBM offers guaranteed and prompt payment for drugs on its formulary.

"The message to the doctors is that they can make money in a morally defensible way while reducing the cost to the patient. The two aren't mutually exclusive," says Smart, who plans to expand the project through a series of nationwide meetings with select providers. While he concedes that success on a national scale will be much more difficult, he says PBM is being approached by doctors and pharmacists who know the current system is not sustainable and are looking for solutions.

"This is the start of a battle," says Walters. "It will take years. Everyone must be partners in it and fight the problem, not each other."

The Medicines & Related Substances Control Act (which is in limbo pending a court challenge) seeks to reduce drug prices by, among other things, curtailing dispensing by doctors and making generic substitution mandatory. It also legislates an end to the rebate system. The problem is how it will be enforced in practice.

The Representative Association of Medical Schemes has long tried to introduce a fixed professional fee for pharmacists to replace retail price mark-ups, but this initiative has failed to get off the ground.

In the end, SA must eliminate any perverse incentives; including the profit motive, that induce those who prescribe or dispense drugs to over-service patients. A radical solution perhaps, but one the health-care sector has backed itself into.

Claire Bisseker

INNOVATION (299) FM 18/6/99

STAYING AHEAD OF THE PACK

Adapting to legislative change

The medical schemes industry is not renowned for its ability to innovate. But the persistence of high medical inflation coupled with the tough new legal requirements laid down by the Medical Schemes Act, has galvanised the industry into action.

"Suddenly, we've been jarred on to a treadmill of rapid innovation," says Discovery Health CEO Adrian Gore. "It's now one of the key things that drives a healthcare company."

The current phase of rapid innovation started with the arrival of new generation companies whose hallmark product was the medical savings account.

The question is whether there is life after medical savings accounts and how schemes are adapting their products to cope in the new environment created by the Act?

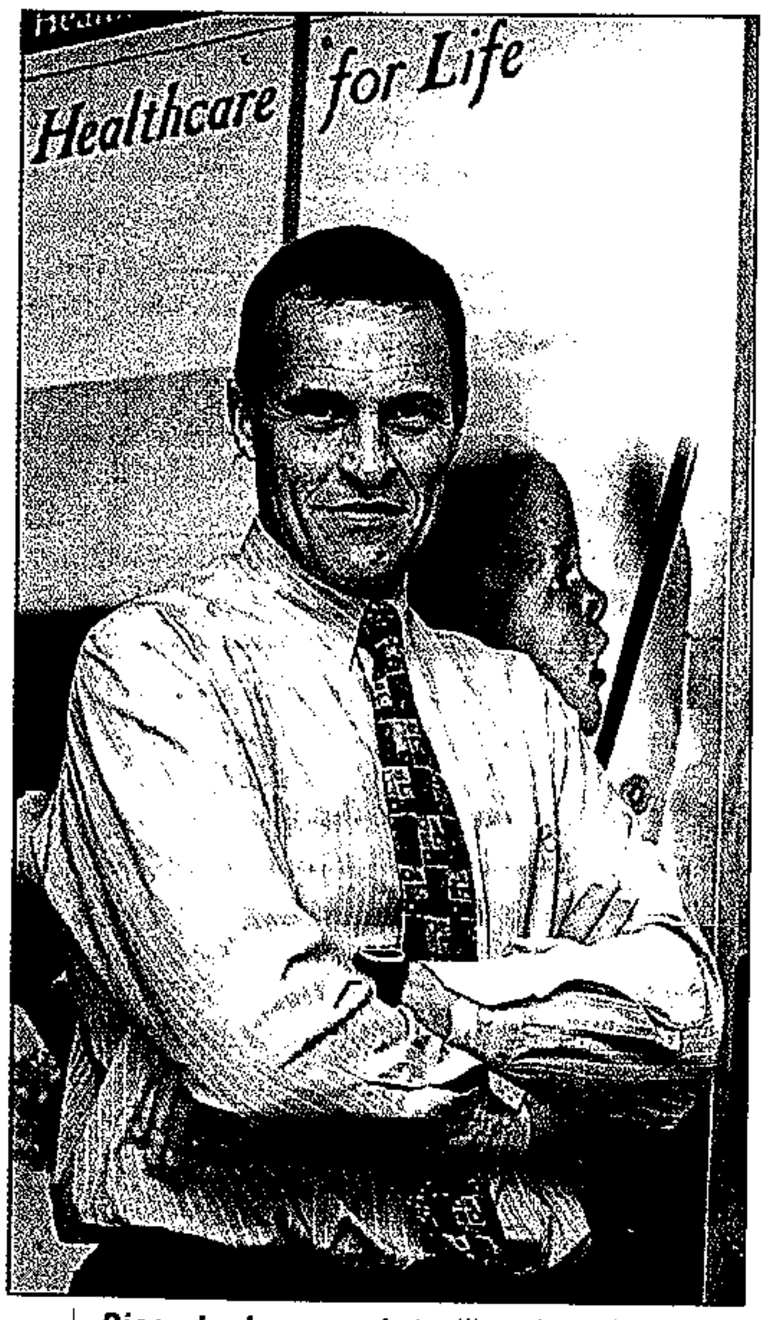
The Act forces schemes to enrol all who apply and can afford cover, but they may no longer risk-rate members on the basis of their age or health.

Old Mutual Healthcare MD Riaan Jordaan says the bottom line is the Act will make private health cover more expensive.

He expects the young and healthy to continue to opt out of medical schemes as contribution rates climb. He also predicts that there will be a virtually unchecked movement of people to schemes that offer comprehensive benefits but to which they previously couldn't gain admittance because they posed too great a risk.

"This environment certainly favours companies with years of experience in risk management and access to good data. It will be those who understand risk and can manage it that will do well," he says.

Jordaan also expects employers to react to the increasing cost of medical scheme cover by moving away from luxury schemes. Some may choose to provide all their employees with the new legislated minimum benefits package (costed by government at R200/family/month), rather than continue providing comprehensive cover to only part of the work force.



***Riaan Jordaan** . . . Act will make private health cover more expensive*

"Soon health costs will be the biggest portion of employers' costs after wages," says Jordaan. "In some companies they already exceed retirement funding.

"Old Mutual gets about three calls a week from employers who can't accommodate this liability any more, especially with Aids and rising medical inflation, and are looking for a less costly alternative. We will certainly soon be launching a product based on the minimum benefits package."

QualSA HealthCare MD Sally Velzeboer feels the only way for schemes to deal with the return to community rating is to reduce or eliminate all the waste in the present system and to manage the care of the elderly, who consume far more than they contribute.

"Managed health care aims to improve the efficiency of health-care delivery and some of the more innovative managed care companies have introduced chronic care or longevity programmes that target the care of members older than 60 through a focused programme of health advice and health care and lifestyle management," she says.

Gore feels that though the Act changes the rules of the game, the winners will still be the ones who are best at it. "It's like a rule change in soccer which says the goalie is no longer allowed to pick up the ball," he says. "But the winner is still the team that can kick the ball into the net."

Discovery Health is developing three new products for launching later this year that supersede medical savings accounts and are driven by the main trends that are behind the current cycle of furious innovation by medical schemes.

"The first trend is patient power: people are becoming more informed and taking ownership of their health care. Another trend is the coalescing of traditional health insurance with financial services. The old-style medical schemes can't cover all your health needs anymore. And thirdly, people want to build assets."

Gore feels that funders are going to need increasingly broader instruments to cover these trends and that the survival of schemes will depend ultimately on their ability to be innovative and meet customers' needs.

"Innovation," he says, "is what I lose sleep over." ■

Reports by Claire Bisseker

Medical aid sector players bring R75m fight to court

Tim Cohen (299)

CAPE TOWN — SA biggest medical aid administrators MedScheme and ProSano, a medical aid company serving mainly Western Cape public servants, have decided to take their R75m dispute to court.

The case follows the lodging of a claim in the Cape High Court last week by ProSano for R75m in arrear member contributions and overpaid claims between 1992 and 1997.

Medscheme notified the court on Friday it would defend the claim, ending hopes that it would be settled amicably by the two firms, which remain major shareholders in new medical aid administrators Sigma.

Sigma, established after the dispute arose, is 37% owned by Medscheme and 56% owned by ProSano which has about 48 000 members with 150 000 dependents, mainly education department, Telkom and SA Post Office employees.

The dispute will not endanger the schemes of these employees as ProSano now has a healthy balance sheet, with R207m in financial reserves constituting more than 42% of its annual contributions.

The dispute arose after months of investigation by auditors Ernst & Young, which according to ProSano, disclosed material irregularities in the way MedScheme had administered members' contributions.

"Since MedScheme's administration fees of about R17m a year were also based on membership numbers, later found to be incorrect, ProSano is also reclaiming a pro rata sum of administration fees," said ProSano chairman Vernon Pitt.

MedScheme CEO and chairman Keith Hollis said he regretted ProSano had resorted to legal action after ties dating back to 1978. "We have no option but to defend that action. I am hopeful common sense will prevail and the claim will be withdrawn."

BD 21/6/99

Workers fight medical aid benefit cuts

BD 6/7/99 (299)

Employers are reassessing their obligations, writes **Peter le Roux**

SOARING medical costs, the opening of medical aid benefits to more employees and new accounting standards have set the scene for a confrontation in the workplace as employers clamp down on medical aid benefits and disgruntled employees fight back. This is reflected in three recent decisions which challenged employers who had reduced the value or valuable benefits of medical aid schemes.

Until relatively recently many employers, as a matter of course, undertook to subsidise their employees' contributions to medical aid schemes. It was also not unusual for employers to agree, either explicitly or implicitly, to continue to subsidise medical aid contributions after retirement.

However, with rising costs and new accounting standards which require employers to disclose their liabilities, employers are reassessing medical aid schemes.

Various strategies are being adopted. The first has been to formulate obligations more specifically. Given the value of the benefits of subsidised medical aid contributions to employees and the obligations that this may impose on employers, it is surprising how few contracts of employment spell out the employer's obligations in detail.

This is rapidly changing and more detailed provisions regulating this benefit are now increasingly being added to employment contracts.

It is not unusual for employers to limit their obligations to new employees by, for example, stating that they would not be entitled to post-employment subsidies of medical aid contributions. Limiting an employer's obligations in terms of new employees is relatively easy. This is not necessarily so in the case of existing employees or pensioners.

Should an employer attempt to reduce these benefits unilaterally, there is a distinct possibility that an employee or pensioner may allege that this constitutes a breach of contract or an unfair labour practice.

To overcome this problem employers have adopted two main approaches. The first has been to attempt to shift the burden of financing post-retirement obligations by introducing prefunding arrangements (by agreement) or by using pension fund surpluses. The other has been to try to reduce costs by reducing the benefits employees and retirees are entitled to.

Understandably employees and particularly pensioners are reluctant to lose their benefits or see them diminished and this has resulted in three recent court cases.

In SA Association of Retired Persons & others v Transnet Ltd & others, the rules of the Transnet medical fund had been amended to significantly reduce certain benefits. The pensioners argued that the amendments should be set aside on the basis that the alterations had severely prejudiced their interests and that they had not been given an opportunity to state their case prior to the amendments being made.

The court found that the pensioners were not entitled to be heard prior to the amendments being made and these were upheld.

In Consolidated Employers Medical Aid Society v Leveton, the Supreme Court of Appeal also had to consider the validity of a decision taken in terms of a medical aid society's rules. In this case the management committee of the society had transferred the pensioner concerned to another scheme.

He appealed to the medical aid society's dispute committee, which disagreed with the decision and recommended that the management committee rescind its decision. The management committee refused to do so. The high court found that the decision was binding on the medical aid society and ordered it to readmit the pensioner as a member. The decision was upheld on appeal.

The third decision is that of a senior commissioner of the Commission for Conciliation, Mediation and Arbitration in Postal and Telekom Association of SA v SA Post Office.

The post office has traditionally subsidised its employees' medical aid contributions to the extent of 66% of the total contribution. In an effort to limit costs associated with medical aid it established its own scheme over which it had control.

It initially proposed that all post office employees should belong to its scheme. However, after representation and protests from employees it agreed that employees would retain the freedom to belong to other schemes of their choice.

At a later date, however, the post office decided to "cap" its contribution to medical aid schemes other than its own. The applicant union argued that this constituted a unilateral change to the terms and conditions of employment and that the post office had committed an unfair labour practice.

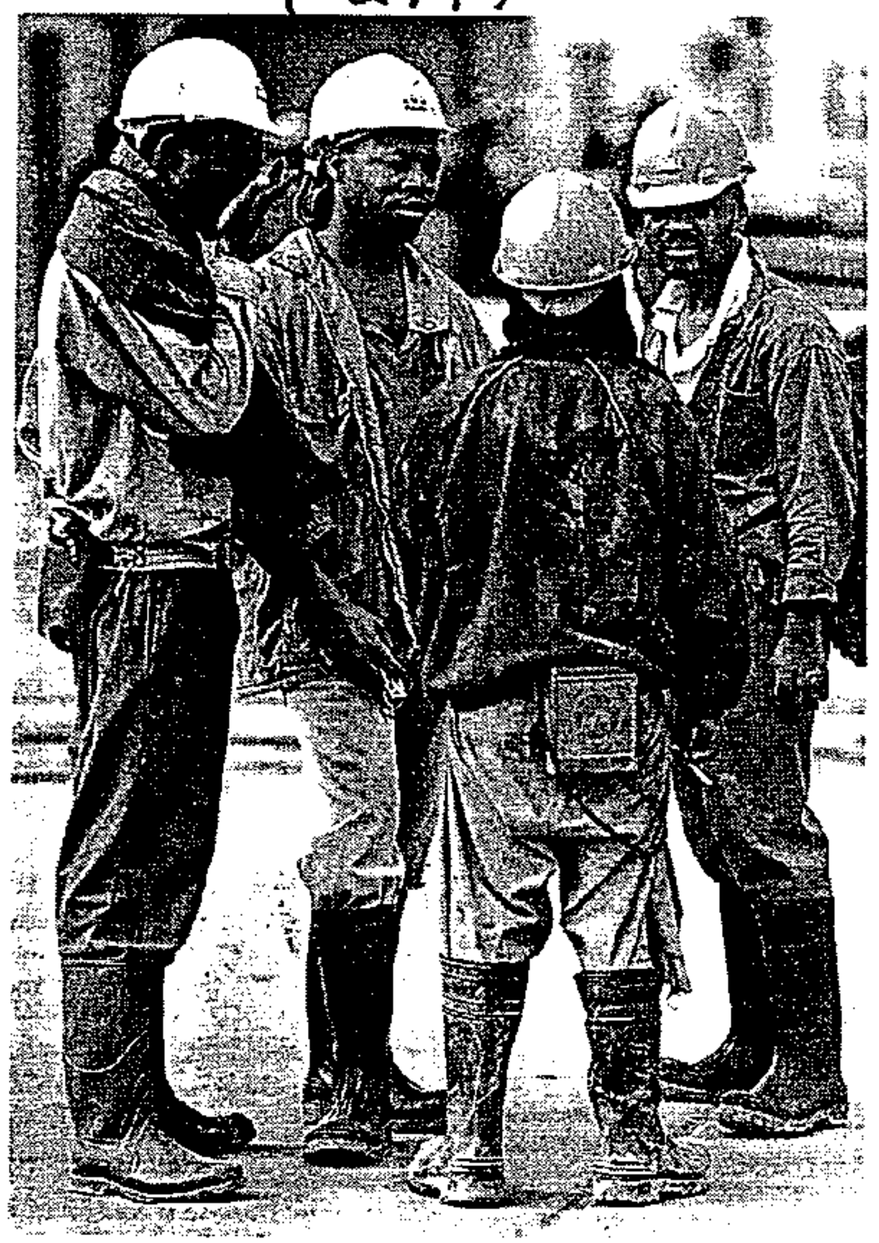
The commissioner found that the employer had not committed an unfair labour practice as there was a commercial reason justifying the change.

The post office had also negotiated with the union prior to introducing the change and adequate notice had been given to employees.

Whether these initial skirmishes will result in a long battle over the issue remains to be seen. Of special relevance here is the complaints and appeals procedure found in chapter 10 of the new Medical Schemes Act of 1998. The term "complaint" and the procedures to be followed to resolve complaints bear some resemblance to the corresponding provisions in the Pension Funds Act, regulating the powers and functions of the pension fund adjudicator. The office of the adjudicator is finding it increasingly difficult to cope with a growing number of complaints.

It will be interesting to see whether the provisions of chapter 10 of the act will also be seen by members of medical aid funds as an attractive option to enforce their rights in terms of the rules of a fund.

Le Roux is a partner at Brink Cohen Le Roux & Roodt and a member of the mediation and arbitration panels of the Independent Mediation Service of SA.



The scene has been set for a confrontation in the workplace between employers and employees over medical aid benefits

Eskom to close medical scheme Esmed

BD 7/7/99 (55) (299)

Robyn Chalmers and Sapa

ESKOM is to close down its main medical aid scheme, Esmed, after struggling for almost three years to stabilise the troubled entity, which is running at a loss of about R60m a year.

Eskom has issued a statement to the suppliers of medical services to its members saying there is no cause for concern. The fund has more than 18 000 members.

Eskom has undertaken to make good Esmed's shortfalls until the end of the year. All legitimate medical services within members' limits will be honoured until January 1.

Eskom's management had to step in to stabilise the scheme in 1997 after its surplus plummeted. Management ended its contract with administrator Medimo last year and called in auditors when it discovered financial chaos and unreconciled accounts.

Eskom and Esmed will now investigate medical aid schemes to find a long-term solution for Esmed's members.

Esmed's difficulties are understood to have arisen from two main causes: the high rate of medical inflation and the increasing ratio of pensioners to employees.

A viable scheme needs at least four active members for each pensioner-member. Esmed has two active members for each pensioner, mainly because of early retirements and voluntary transfers.

Officials close to the process said this factor and rising medical fees meant Esmed could not retain the prescribed 25% reserve fund. Conditions were unworkable and unlikely to improve soon, the officials said.

Danie Kolver, registrar of the Council of Medical Schemes, said Esmed's problems were reported to the council some time ago. He said the council conditionally accepted Eskom's assurances that Esmed would be kept going while its future was being considered.

The Mineworkers' Union expressed concern earlier about its members who belong to Esmed and urged Eskom to allow them to join a plan the union intended setting up.

Eskom officials said the union's request had to be considered carefully. "Losing more active members will weaken the fund and aggravate the situation. Whatever the case, we will find a solution before the end of the year."

Medical aid schemes have a heart

Full coverage for transplant patients, who battle with huge expenses after surgery

(299) ARG 10/7/99

ON THE ROAD AGAIN: Tom Sales with his wife Donna after his heart transplant Picture: HANNES THIART

TWEET GAINSBOROUGH-WARING

There's light at the end of the tunnel for heart and other transplant patients who battle with huge medical bills after surgery.

Cape Town heart transplant surgeon Willie Koen said that for some patients, like heart recipient Tom Sales of Table View, the three or four months after surgery were the most traumatic as they often coincided with negotiations with the medical aids to accept medical expenses.

But now leading medical aid schemes have indicated that organ transplants will soon be fully covered.

Kobus White, an exco member for Sanlam Health, said: "Sanlam has changed its benefits from July 1 to provide unlimited benefits for organ transplants, provided the patient has been given authorisation."

He said other leading schemes were expected to follow suit.

Dr Koen said transplants were becoming a recognised form of treatment and were no longer seen as experimental procedures.

Based at City Park Hospital, where nine heart transplants have already been carried out this year, Dr Koen said most medical schemes were changing their benefits to include the costs of transplant surgery.

At present some medical aids are paying limited benefits to transplant patients.

Groote Schuur is the only state hospital that does transplants in South Africa. The hospital's Phillipa Johnson said there was a shift towards transplants being carried out at private hospitals.

"Budget constraints and the lack of donors have seen the number of transplants drop," she said.

This year Groote Schuur has carried out only five heart transplants, compared with City Park's nine.

Mr Sales, South Africa's youngest open-heart patient in 1966, was 45 when he got his new heart three months ago.

The operation has changed his life in more ways than one. Like other organ transplant patients, he has a new lease on life, but he has been bogged down by thousands of rands worth of medical expenses.

"Cyclosporin, the drug necessary to prevent rejection, costs R5 000 for a month's supply and I will be on it for the rest of my life," he said.

His wife Donna has increasingly shouldered the financial burdens of the family. The Sales couple have two children, Tonia, 20 and Wayne, 19.

Wayne, who matriculated last year, has put his plans to study theology on hold because of financial constraints.

Mrs Sales told Saturday Argus that she and her husband moved from Gauteng when they were told he would need a transplant.

The deeply religious Mrs Sales said her faith had given her the strength to make the move and support her husband, while leaving her son behind to finish school.

With her husband in and out of hospital throughout their married life, Mrs Sales has drawn on that faith many times.

In 1989, before Mr Sales had a valve replacement, he came close to death. "I refused to accept him going," she said with quiet conviction.

She described how her husband's heart problems had at times made him so listless and tired he could not even lift an arm.

"At times he did not have the energy or will to get up in the morning," she said.

Since having open-heart surgery in 1966, Mr Sales's condition has fluctuated and he has had two valve replacements.

At the time of the transplant, his own heart was 18% functional.

The family were informed at 11.40pm on April 11 that a heart was available.

"Getting that call is the biggest shock to the system," said Mrs Sales, who described how she had experienced a whole spectrum of emotions after she was told to bring her husband to the hospital for a heart transplant.

"The next day my thoughts were for the family of the donor," she said.

Family pictures taken of Mr Sales after the transplant show him holding his own heart, calcified and eaten away by disease.

Dr Koen said Mr Sales's transplant had been a success, a lot of which he attributed to Mr Sales for his commitment to losing weight.

"You can't use a small heart in a big man so it is essential for these patients to diet and bring down their body size," he said.

Despite the sacrifices, Mr Sales's recovery has made the operation more than worth it for his family.

Stability medical scheme liquidated after 31 years

(299)

ADELE SHEVEL ET(BR) 26/7/99

Johannesburg – Stability, a medical scheme that has been in existence for 31 years, had applied to the high court to be liquidated, Danie Kolver, the registrar of medical schemes, confirmed last week.

After the granting of this provisional order, a final liquidation was expected to be granted tomorrow.

Tim van Staaden, the managing director of Medwise, the administrator of the scheme, said attempts were being made for members to be taken on by other medical schemes.

"The new Medical Schemes Act is beneficial in that it allows any member who has been covered by a scheme for two years to join another without being rejected, so long as the member is able to pay the contributions."

The Stability medical scheme covers 1 800 members. Some have been contributing to the scheme for decades.

Van Staaden said the scheme went insolvent because liabilities exceeded assets. "The collections of debtors became problematic and, in conjunction with the claims ratio, put strain on the cash flows."

Van Staaden said about 44 percent of the membership was pensioners, far above the industry norm. He said it was one of the last schemes to offer subsidies to pensioners.

The younger members had moved to risk-rated, new-generation schemes, where premiums for the younger were lower than that expected to be paid by those in the more traditional schemes. The more traditional schemes were heavily weighted with the elderly and more sickly.

Composite

Medical aids get more time for compliance

(E99) CT(BE) 12/8/99

ADELE SHEVEL

Johannesburg — The registrar of medical schemes has granted an extension to medical schemes to comply with the regulations that govern the Medical Schemes Act, promulgated in February this year.

According to legal process, regulations have to be implemented within six months of promulgation of the act. The promulgation of the act in February astonished the industry. Many said it was premature, and concern was raised about the regulations, which had not yet been tabled.

Medical schemes technically had until the end of July to comply with regulations. This has now been extended to the end of October; a further extension is expected to be granted until the end of the year, with complete compliance expected on January 1 next year.

The deadline for submissions from the industry was the beginning of this month, exactly three months after they had been published in the Government Gazette. That meant compliance would have been due at about the same time as submissions were due.

The health department will consider industry comments. Changes to the regulations will be implemented before being approved by the health minister and published in the Government Gazette, probably at the end of the month.

Industry participants were concerned that the act and its associated regulations could result in some medical schemes facing liquidation.

The regulations will provide the teeth for the act, though some of its provisions are already in operation.

Danie Kolver, the registrar of medical schemes, said the industry accepted most of the act's provisions. These included financial issues, patient protection, governance, regulatory oversight and financial sustainability.

Aslam Dasoo, the chief executive of the Board of Healthcare Funders, the representative body for the medical schemes industry, said the degree of cooperation between the industry and the government was encouraging.

Cost of providing health care rising

(299)

Survey finds top strategic issues for employers are cost control, AIDS and prefunding for pensioners

BD 2/9/99

Pat Sidley

THE cost of providing health care to employees continues to rise at well above the general inflation rate, according to Old Mutual Healthcare's 1999 survey on health care.

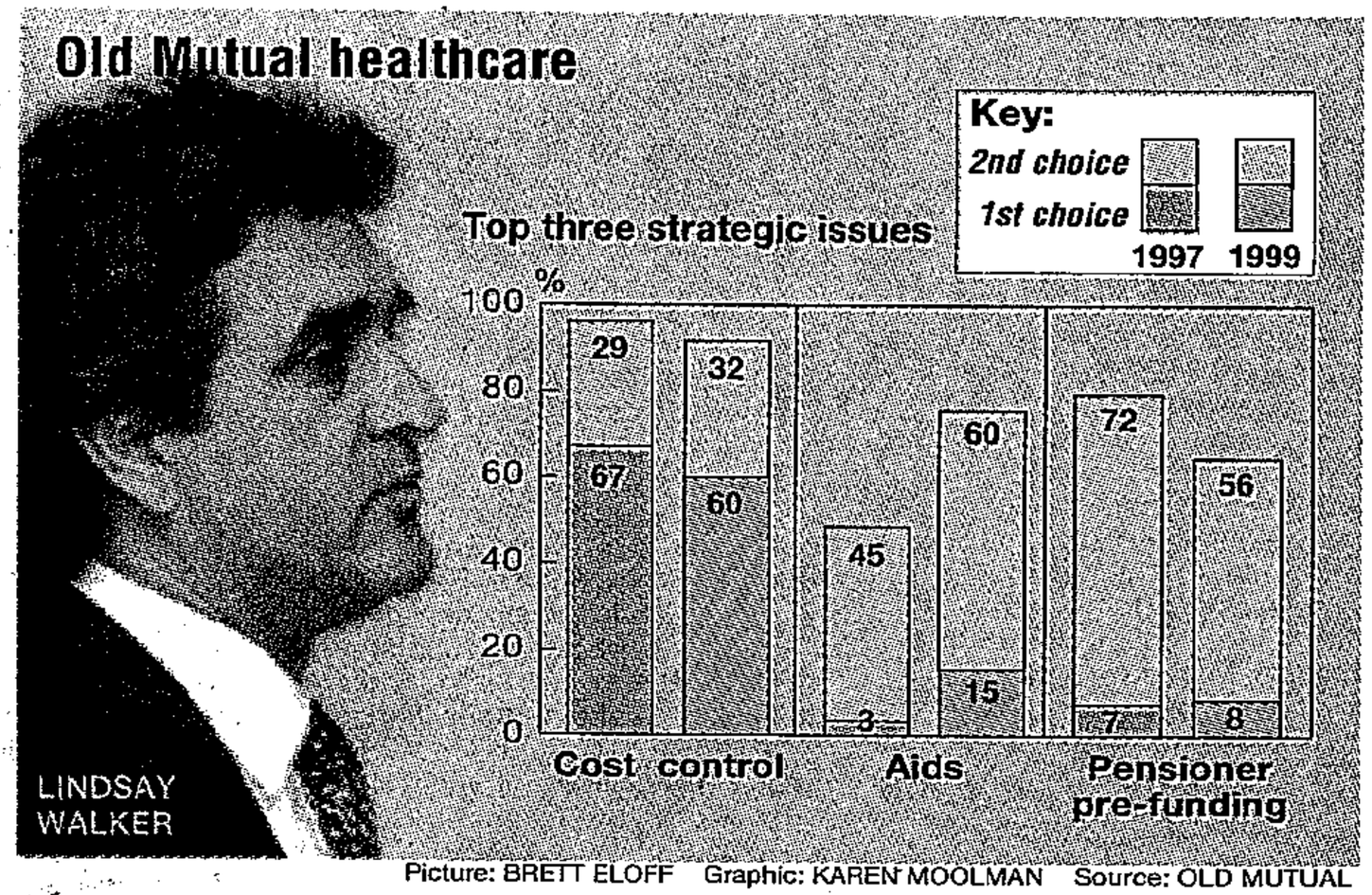
More than 1 000 large employers were "identified" among private and parastatal employers and across all sectors of employment and geographical areas. About 56 employers were eventually surveyed in detail. Employees were not surveyed.

Costs of contribution to medical schemes have increased between 12% and 16%, despite cost control measures apparently undertaken by schemes. The top three strategic issues for employers when planning to provide health care to their employees were cost control, AIDS and prefunding for pensioners.

In 1997, more employers viewed cost control as the most important strategic issue — about 67% — while this year, 60% viewed it as most important. On the other hand, AIDS took more prominence in employer minds, with 15% viewing it this year as the most important strategic issue against only 3% in 1997.

Many employers however listed AIDS as their second choice for important strategic issues. Pensioner prefunding was the third most important strategic issue.

Few employers (30%) have a documented corporate health care strategy, however. The survey notes that this lack of strategy is a "key employment issue" and a growing liability as "75% of employers are paying a fixed percentage of contributions".



Picture: BRETT ELOFF Graphic: KAREN MOOLMAN Source: OLD MUTUAL

"As long as medical inflation continues to outstrip salary inflation, this cost as a percentage of payroll will continue to rise," the survey says.

Cost control has largely been implemented by restructuring benefits to employees using the medical savings accounts so that employees are taking the risk on a major portion of their own health care costs. More than 70% of the schemes have some form of savings scheme.

Most of these schemes, however, will have to change their savings schemes when the new Medical Schemes Act is implemented as it is likely to impose a limit of 25% of premium income to be used in the savings accounts.

A large majority of employers (79%) viewed AIDS as a disease which would affect the future costs of providing health care to employees. Notwithstanding this, close to a quarter of employers are doing nothing about this.

Pensioners face the toughest changes in the environment. Around 15% of employers are "planning to offer pensioners enhanced pensions in lieu of subsidising their post-retirement health care benefits".

But almost half the employers will not offer any retirement health care benefits for new employees.

Overdose of fraud pumps up the cost of cover

ST (BT) 5/9/99 (299)

Contributors to medical aid funds are paying for abused services, writes DINA SEEGER

FRAUDULENT medical aid claims are running into millions of rands a year: a cost that ends up in the monthly contributions of the honest fund members.

It's estimated that 30% of medical aid claims are either fraudulent or spent on wasteful and unnecessary services.

The high cost to the industry has contributed to the spiralling costs incurred by medical aid funds. Last year, the funds suffered medical inflation of 16% compared with general consumer inflation of 9%.

The big medical aid fund administrators are investing in multimillion rand projects to wage a war against fraudsters.

Their battle plans encompass sophisticated anti-fraud software programs, "swat" teams manned by professional investigators, and computerised data warehouses to store every scrap of medical information submitted by fund members.

Administrator Discovery Health launched their anti-fraud swat team at the end of 1997 and have since recovered R11.4-million in fraudulent claims.

Medical schemes have been an easy target for fraud because of the volume of claims processed, according to Johan van Rooyen, head of provider networks at Discovery Health.

Discovery estimates that between 5% to 10% of the claims paid out by them are fraudulent — although Van Rooyen suspects the real figure to be much higher.

A spokesperson of another administrator estimates that fraud makes up 25% of the total money paid out. This figure, he says, is not unique to SA — people cheat their medical aid funds all over the world.

For instance, the US government has estimated its national medical aid fund, American Medicaid, loses 10% of its funds through fraud.

The compulsory Hippocratic Oath, a pledge to be ethical by medical professionals, obviously doesn't extend as far as financial ethics because some medical practitioners are a part of the fraud problem. One of many scams is for a doctor to claim more money from the medical aid than necessary.

For example, the doctor sends off a R500 bill to your medical aid for extra tests which he didn't do. And have you ever wondered whether you needed all those fillings in your teeth?

As members, we may not care because it's not our money that is being misspent. But actually it is. Fund contributions have spiralled with medical inflation over the last few years, and the main cause is the increased costs from fraud and abuse.

The 1999 Old Mutual Healthcare survey, released this week, shows that employees currently pay an average of 6% of their net annual income on medical aid contributions. Old Mutual predicts that by 2008 14% of your salary could go to medical aid. The forecast rise is based on continuing high inflation, the impact of HIV/AIDS on medical schemes, and the new medical aid regulations.

Discovery Health's "zero-tolerance" strategy against fraud includes: a code of conduct for doctors, a fraud unit, and a tip-off phone line for the public to warn Discovery of suspected fraud. (If you warn Discovery and they successfully catch the crook you get 10% of the recovery as bounty.)

Discovery will also press criminal charges against offenders — something many administrators have avoided because of legal expenses and the difficulty of gathering evidence.

Medscheme, SA's biggest administrator, has also pumped resources into eliminating fraud. They have invested in computer software which will pick out suspicious claim patterns and strange claims.

Medscheme director, Gary Taylor, says every claim is input into the system and stored. This prevents medical practitioners from claiming for obviously fraudulent services.

Medscheme recovered R8.2-million from fraudulent transactions last year. "We're getting smarter but we're not there yet," he says.

Taylor agrees that about 25% of medical aid claims may be fraudulent. "But if you include the amount of wasteful healthcare costs with the fraudulent ones, you may find that 30% or 40% are unnecessary," he says. Medscheme also has a tip-off hotline and a team of full-time anti-fraud investigators.

One of the methods Fedsure Health is using to stop abuse is the establishment of a network of pharmacies linked to each other online. With this system, members cannot fill a prescription numerous times by visiting different pharmacies (to procure medicine and then either sell it or abuse it).

In June this year, Fedsure launched a risk control department which focuses on uncovering fraudulent claims.

But consumer attitudes about fraud and wastage are improving, according to Old Mutual Healthcare's operations manager, Dave Jones. He says more medical aid members are notifying their schemes when they feel they've been ripped off by a medical practitioner.

This attitude can be attributed to two factors, says Jones. With medical savings accounts, members are in charge of their expenditure. And with spiralling medical aid inflation, members are just as eager to cut costs as the administrators.

Jones says that to fight fraud the medical aid industry needs to get together and co-ordinate their efforts.

"We need a central body to help us correlate information on suspicious claims patterns," says Jones.

Jones says medical aid administrators have, in the past, spoken of getting this kind of body together but the plan has never materialised.

CRAZY CASES OF MEDICAL AID FRAUD

- Medical aids regularly deal with claims from 'pregnant' men. This is because members lend their medical aid cards to relatives and friends.
- Some dentists are happy to fill the cavity in their patient's front tooth with a diamond. The dentist claims from medical aid and both dentist and patient are smiling.
- Medscheme received a phone call from a member whose membership was cancelled because he was dead - according to their records. The member explained that he lent his medical aid card to his sister who was hospitalised and passed away.
- Discovery Health sent a team of undercover agents to a selection of opticians to test if they would sell them sunglasses on their medical aid. Eight out of 10 happily obliged - after all it's money in their pockets.
- A dentist submitted a claim for putting fillings in his patient's false teeth.
- Rumour has it that you can buy sound equipment, appliances and bulk meat from a doctor in central Johannesburg - on your medical, aid of course.

Picture: TONY STONE IMAGES

PUTTING ON THE BITE: Fraudulent and unnecessary claims cost consumers dear

MEDICAL AID

(299) rm 10/9/99

THE LOAD SHIFTS

Old Mutual's health-care survey shows employees are being squeezed as costs rise

In an effort to avoid the steady rise of medical aid contributions, employers are shifting health-care costs on to employees. According to Old Mutual Healthcare's 1999 Health Benefits survey, the US approach to managed care has been spectacularly unsuccessful in curbing medical inflation in SA and next year's medical aid contribution increases are set to be worse than ever.

Over the past two years, average medical aid contribution increases have been between 12% and 16%. Old Mutual Healthcare warns members that contribution increases could exceed 16% next year, more than double the inflation rate.

Since 1994, health-care costs to employers have risen from 5,3% of payroll costs to just under 9%.

The 56 randomly selected employers surveyed by Old Mutual all cited cost containment as the most important strategic issue facing them in the area of employee health-care benefits. But, whereas in the past most employers saw managed care as the way to cut costs, most now aim to make the employee pay more.

According to the survey, employers are moving away from giving employees a fixed percentage of an ever-increasing medical aid contribution to one that is linked to salary increases, as a fixed percentage of payroll. But with medical inflation vastly outstripping inflation and therefore salary increases, such a strategy will likely shift an increasing portion of health-care costs on to the employee.

Old Mutual Healthcare marketing manager Lindsay Walker says this strategy could reduce an employer's liability for health-care costs by 40% over a 10-year period, raising the cost to the employee from 6% to 10% or even 14% of gross salary over this period.

Almost all employers recognise they have a liability towards their current pensioners. More than 90% of those surveyed have quantified this liability and 60% of these (double the number in 1997) have acknowledged this on their balance sheets.

Almost all are setting aside some form of funding to fully or partly offset this liability into the future.

But when it comes to new employees, almost half of those surveyed (43%) refuse to offer post-retirement health-care benefits — taken for granted in the past. This means many employees will have to insure themselves for this costly eventuality.

After cost containment, Aids has emerged as the second-biggest area of concern to employers, many of whom are starting to feel its impact on their medical schemes.

Old Mutual Healthcare actuary Adrian Baskir conservatively estimates that 6%-10% of total medical scheme costs are HIV/Aids-related now and that this will grow to just under 40% within 10 years.

"This will mean a cost of about R23bn/year within 10 years," he says. But though 77% of employers have embarked on Aids awareness campaigns, not many are actively preparing to manage the disease and its impact on their medical schemes — even though it could severely affect the future costs of providing health care to their employees.

Astoundingly, about 23% of employers are doing nothing about Aids.

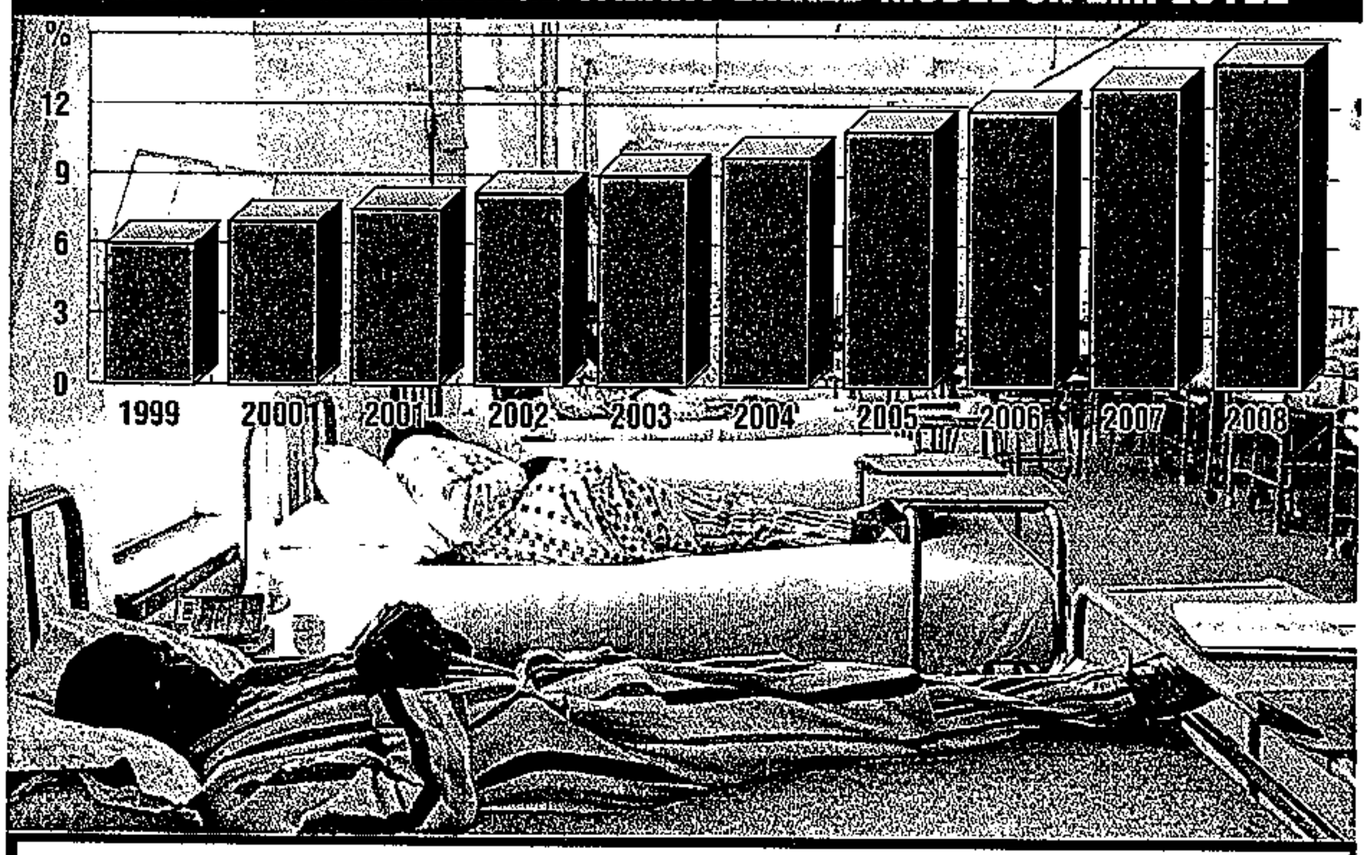
Overall, the survey strikes a gloomy note on the state of private health-care financing. It expresses concern that all the savings from the move to new-generation schemes (those based on medical savings accounts) have been gleaned and that costs have again started to rise.

"What is needed," says Old Mutual Healthcare's medical affairs manager, Dr Paul Theron, "is a new, inspired idea that will help employers manage health-care costs more effectively. Such an idea will almost certainly be built around the mobilisation of health-care providers to a level where they can effectively take and manage the risk. This is the only sustainable mechanism for long-term cost control."

The market is moving in this direction, with 16% of schemes having adopted risk-sharing arrangements already. They must be expanded. Funders and providers must put aside vested interests and work together to keep medical aid affordable. If they don't, everyone will be poorer.

Claire Bisseker

IMPACT OF PERCENTAGE SALARY-LINKED MODEL ON EMPLOYEE



This graph shows a significant impact on employees' net pay, as it raises the cost of their health care from 6% to 14% of their gross salary over a ten-year period. But it significantly reduces the employer's relative liability and cost.

SOURCE: OLD MUTUAL HEALTHCARE FUNDING MODEL

More people get access to medical aid

(299)

Regulations will give flesh to law that prohibits discrimination against the sick or the elderly

BD 6/10/99

Pat Sidley

THOUSANDS of South Africans will have greater access to medical insurance in terms of the regulations to be signed this week, giving flesh to the Medical Schemes Act.

The act prevents schemes from discriminating against the sick or elderly in terms of higher premiums or by excluding them from schemes altogether.

The regulations provide mechanisms to prevent schemes from suffering from the consequences of being overwhelmed by riskier, sick and elderly patients. These mechanisms will include stiff penalties for those who have chosen to remain out of schemes until they need them.

Between now and December, medical schemes will have to redesign their products, benefits and rules to conform to the regulations and have them approved by the registrar for medical schemes. From the beginning of next year a six-month amnesty period will allow people who have previously not joined schemes to become members without the "late-joining" penalties.

The medical scheme industry believes that to conform to the law and regulations some schemes will go out of business and others will have to charge much higher premiums to all their members.

The law's planners believe the scene has been set for innovation and competition among scheme operators and health care insurers. This should ideally keep premiums from escalating — ensuring that members do not leave and that new young and healthy members are recruited to avoid the late-joining penalties.

The regulations provide for the accreditation and training as well as a new transparency for brokers, whose activities will be monitored by the health department. Brokers, previously not legally recognised, will have their commission strictly regulated (up to 3% of premiums) and may not be paid for any other administrative tasks.

Managed care, a technique imported from the US to manage spiralling health care costs, will be controlled in the regulations for the first time.

All schemes will have to offer a basic package of benefits but can offer extra on top of this.

Among the changes is an extension of the period in which schemes must accumulate high reserves. Initially the regulations demanded there be a three-year period in which reserves of 25% must be accumulated, but this has been extended to five years.

The essence of the law and regulations has been to stop schemes and health insurers from "risk rating" (picking the young and healthy for membership and rejecting others).

However, to avoid this without jeopardising the schemes themselves, the schemes will have to have a minimum of 6 000 members each to ensure a larger spread of the risk.

A contentious issue for many schemes has been the health department's desire to limit medical savings accounts (initially they hoped to eliminate them altogether). These have been allowed with a maximum of 25% of premiums payable into them. The money in the accounts will be owned by members (not the scheme), can be accumulated for two years and can be transferred to other schemes. The money will be taxed if withdrawn.

Other changes between the last draft and the one to be signed into law this week include the way in which reserves can be invested.

This has partially addressed the industry's concerns that insufficient flexibility was allowed.

Septem

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John Dlu

Patients are a virtue ... and pay the price

(299)

It is the last round for medical schemes' talks with hospitals, writes **Pat Sidley**

THE last round has been called for an annual health-care ritual between the medical schemes industry and a prominent group of providers: private hospitals.

Disturbed by allegations that they may be behaving as though they are "colluding horizontally", the Hospital Association of SA (Hasa) got permission from the Competition Board to negotiate with the medical schemes' body, now called the Board of Healthcare Funders (BHF), on behalf of about 98% of private hospitals in the country.

Negotiations were to be with the body which represents medical schemes and, so, the appearance was given of "equal monopolies" fighting each other.

The outcome was swift and nasty. Schemes said they were willing to pay an increase on hospital tariffs of 4,5%; hospitals said they would charge 9,5% more. The logical outcome is that consumers would foot the rest of the bill.

Not only that, in the custom built up over the years, this would be paid by patients on admission to hospital.

Both hospitals and funders claim that their main concern is the welfare of patients. One may, however, want to look beyond the rhetoric.

The legislative environment has changed for medical schemes, which will force them to compete and negotiate with providers on behalf of members in a way previously foreign to them. It will also compel the use at times of public hospitals.

Schemes have six months in which to alter their products to conform to the new law. Thousands more members will have access to schemes. Membership has been largely static for several years. The new members may mean extra revenue, but may add to the risks and costs the schemes face in the long run.

Despite the static membership, costs to schemes have risen dramatically and these have been borne by members. Hasa's executive director, Dr Annette van der Merwe, was adamant this week — in a statistically backed-up presentation on private hospitals' point of view — that hospital costs have been carefully monitored. She said that schemes had the opportunity — unused — to check the monitoring procedure and that hospitals are not the reason for added costs at the medical scheme end.

Instead hospitals believe that, among other things, the costs to schemes of installing managed-care equipment and protocols have cost too much and outweigh the benefits they were to bring with them.

Van der Merwe alleges that the schemes' need to meet legal obligations compelled them to charge members more than real costs may have indicated.

Schemes challenge this, citing actual costs they have had to meet. Dr Aslam Dasoo, executive director of BHF, believes the increase to reimbursements will be in line with inflation.

Behind the scenes, however, is a larger unfolding story. Private hospital beds have increased and occupancy has dropped. Old tariff structures for the private health-care industry have revolved around what is known as "fee for service", which has provided an incentive to overservicing in the industry.

Providers, like pharmaceutical firms are notoriously opaque when costs are questioned.

The only certainty in the future of medical schemes is that their negotiations with providers will be more robust. Risks will have to be shared between providers and funders, managed-care principles will be more strictly implemented and more scrutiny and competitive behaviour will govern negotiations with providers.

By the same token, providers will be similarly challenged. There is no reason why hospitals cannot strike individual deals with schemes and they too will place their providers under more pressure. Which ever way this skirmish ends, it will herald a new era in health care in SA.

BD 8/10/99

Broader access to coverage on the cards

New Medical Schemes Act to be gazetted

CT (BR) 13/10/99 (299)

ADELE SHEVEL

Johannesburg – The regulations governing the Medical Schemes Act were signed off this week by Manto Tshabalala-Msimang, the health minister, and are expected to be published in the Government Gazette on Friday.

The regulations provide the teeth to enforce the act, intended to allow more people greater access to medical scheme coverage.

Aslam Dasoo, the chief executive of the Board of Healthcare Funders, the representative body of the medical scheme industry, said the health department had accommodated the concerns of the industry and was ready to move forward.

The principles of the regulations had been communicated to the market and regulatory sources said there were no changes in policy direction.

All schemes would have to comply with the regulations by January 1, which meant they would have to redesign products and benefits and have them approved by the medical schemes registrar.

Schemes had been working on the regulations since May and new product lines were expected to be announced soon.

The new regulations also introduced barriers to entry, in that new medical aid schemes would require a membership base of 6 000 and financial reserves of 10 percent in the first year of operation and 25 percent within five years.

Changes were effected so that no discrimination against members would take place on the basis of race, age, sex or state of health. Schemes could only differentiate on the basis of income and/or number of dependents.

Everyone had to be allowed on to a scheme, provided they could pay contributions, and all members would have access to the same basic minimum set of benefits.

There would also be an amnesty period whereby, in principle, no prospective member could be rejected for the first six months of next year.

Govt warns Discovery Health

Pat Sidley

Planners say the scheme contravenes both letter and spirit of new law

BD 20/10/99 (299)

THE health department has warned that it plans to stop Discovery Health marketing a new range of medical scheme products, if necessary by taking it to court or changing the law.

The department is concerned that Discovery's new medical aid will discriminate against older and sicker applicants for membership. The department's medical scheme planners insist that the scheme contravenes both the letter and the spirit of the new Medical Schemes Act.

Discovery, which is a FirstRand subsidiary formerly called Momentum Health, is due to list on the Johannesburg Stock Exchange tomorrow.

The company believes its product falls within the ambit of the new law and will be properly regulated by both the health department and the Financial Services Board.

The dispute arises from a "top-up" hospital plan and chronic medication benefit plan which will be sold separately from the medical scheme itself. This top-up element will be sold as an insurance product and can therefore exclude people considered to be a high risk. These members' needs would be met by the basic medical scheme, but they would not be eligible for the benefits offered by the insurance products.

The insurance product will also enable Discovery's brokers to earn more commission than regulations under the new act allow, by ensuring them a separate commission.

A basic principle of the new law is that medical schemes are barred from declining the sick and elderly, or charging them higher premiums. Schemes must also provide a basic minimum package of benefits. Broker commissions are capped at 3% of premiums.

The registrar of medical schemes, Danie Kolver, would not comment on the looming dispute but said Discovery's rules were not yet registered.

Adrian Gore, Discovery's CEO, said the new medical scheme not only met the minimum requirements but exceeded them. "It offers more comprehensive benefits than most schemes."

Gore said the dispute centred on an addition to the basic plan. The issue was one of "demarcation" — who would regulate which elements of the product and whether "they can live side by side". He said he had taken top legal advice while planning the product, which contained many other aspects aside from the scheme itself. "If the product does not meet the requirement of the law, we'll change it."

One health department official who helped plan and write the law said the top-up insurance products would have to be registered with the registrar of medical schemes.

"Our main point is that we will not let anybody float a product like this on to the market, as they will be contravening the Act. We are prepared to take whatever measures are necessary including court or looking at changing the legislation," he said.

Gore was "disappointed" that he had received no formal notice from the health department of their problems. He had discussed the plan with Kolver earlier, and held one "informal" discussion this week which had alerted him to the possibility of a problem.

HEALTHCARE *Differentiation between insurance and medical aid comes under focus*

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Medical scheme industry to set up code of conduct

(299) CT (BR) 27/10/99

ADELE SHEVEL

Johannesburg – The Board of Healthcare Funders, the representative body of the medical scheme industry, has been tasked with setting up a code of conduct for medical schemes following last week's conflict after the launch of Discovery Health's new product range.

Discovery Health last week became the first health insurer to list on the JSE.

The department of health indicated it was unhappy with certain elements of Discovery's new products, the first to be launched subsequent to the recent release of the regulations that govern the Medical Schemes Act. The department said the products did not meet the spirit of the law.

Incorporated within Discovery's offer was the additional option of an insurance element to top up the medical scheme, which Adrian Gore, Discovery Health's chief executive, said was appropriate insurance business. He said the debate revolved around a demarcation between the insurance industry and the medical schemes industry.

APT OPTIONS *Adrian Gore says Discovery's addition of an insurance element in its medical scheme is appropriate and the debate about the demarcation of the industry is purely intellectual*

The expectation is that the act would be tried and tested through various interpretations. "We will never do anything illegal," Gore said.

At the board's meeting last week, certain parties called for the resignation of Gore and Dave Avnit, the chief executive of Fedsure Health. Fedsure Health is also among the foremost healthcare companies affiliated with the insurance industry. But it was decided this was not the right forum.

Sources said the government would take the medical schemes companies to court using insurance elements, if not change the act itself. Others said it was the first of a healthy debate about interpretations of the act.

Fedsure launches its product line today. Avnit said at the weekend the company had not amended the product line subsequent to the controversy, adding it had been confident the range met the letter and spirit of the law.

The ultimate outrage — state to peck your pension

(300) ST(BT)3/10/99

Analysts aghast at plan to pay out pension-fund money to everyone, writes DINA SEEGER

WE'RE already taxed to the hilt — now there's a new plan that could see government dipping into our personal retirement savings!

A plan to create a national retirement fund is under way. The parties involved are working on a proposal which will be presented to Finance Minister Trevor Manuel and Welfare Minister Zola Skweyiya.

The idea behind the proposal is that all citizens contribute a portion of their income to the national retirement fund during their working years.

All citizens would be entitled to withdraw a minimum pension from the fund at a set retirement age whether they contributed to the fund or not.

But contributors to the fund will receive more: their total contributions plus any growth on investment.

Known as compulsory retirement provision, the scheme is being spearheaded by the Financial Services Board (FSB) with input from the finance and welfare departments.

Contributions will be made by those in formal employment as well as freelancers, contractors, the self-employed and people in the informal sector.

If you are already a pension fund member, a portion of your current contributions would be allocated to the state fund.

If the proposal is approved, a white paper will be submitted to Parliament for approval.

The blueprint for the fund is far from complete, but Dube Tshidi, head of pension funds at the FSB, says they are looking at a contribution of about 3% of annual pre-tax salary.

You would be allowed to access your money only at a set retirement age (probably 62). You would then get a lump sum to the value of your previous contributions plus any growth.

The fund is likely to be administered by the private sector and management decisions will be taken by trustees representing all interested parties.

In the initial discussions there were questions about whether the Constitution would allow government to peck at an individual's retirement savings. Tshidi says: "According to the Constitution your rights on what to do with your money can be limited as long as this is reasonable and justifiable within the democracy."

Tshidi says the majority of South Africans are not making sufficient provision for their own retirement.

Speaking in her personal capacity, Giselle Gould, executive director of the Institute of Retirement Funds, an industry association of pension and provident funds, says the rationale for compulsory retirement provision is that the majority of pension fund members withdraw their funds and "blow it" during their working years. "Then they turn to the state for an old-age grant."

Gould says compulsory retirement provision would help ensure you have some form of guaranteed pension tucked away.

But perhaps the real rationale is that a national fund would lift much of the financial burden off the state in providing pensioners with old-age grants. It's a looming problem for countries around the world as they battle to come to grips with an ageing population and to find ways to fund the huge cost of state pensions.

The SA proposal has, not surprisingly, drawn sharp criticism from the private sector.

First, doubt exists whether a national retirement fund is viable in the long term. Similar funds have failed, or are on their last legs in Zimbabwe, Zambia and Canada. New Zealand tried to implement compulsory retirement provision in 1997, but its citizens voted strongly against it in a referendum.

However, Germany and Chile have successfully imposed national retirement funds. Tshidi confirms that our national fund is likely to follow the model used in Chile.

Independent financial analyst Dave Crawford says the scheme is likely to fail because the benefits paid out will almost certainly exceed the contributions paid in. "Employed people contribute to the fund but everybody is entitled to withdraw from it — a recipe for running out of money!"

Crawford points out other pitfalls. "A national fund has to be cautious when making its investments and so the fund will not give you good growth on your contributions."

And running this type of fund will be costly. A large part of your contribution is likely to go to hiring bureaucrats. "The state is trying to figure out ways to tax us more to achieve a redistribution of income. It can't raise taxes, but that's essentially what this is — another tax," says Crawford.

Chris Newell, an Old Mutual consultant and actuary, wants to know how the government is going to make sure that people in the informal sector contribute to the fund. "You can't tell people to save when they're on the breadline."

Newell says the scheme is an attempt to use the working population's pension assets so that the state can provide better old-age grants to the poor. "But in the process those people who have contributed to the fund for their own pension will end up getting less than they would have through their private pension funds because of the cross-subsidy," says Newell.

If the scheme's creators expect the finance ministry to approve their retirement fund proposal, they'll have to come up with a model that will be economically sustainable in the long term, adds Newell.

Johann Grobler, MD of Absa Consultants and Actuaries, emphasises that there is a need to establish a policy for retirement provision. "Government has to find a way to provide a pension for those who are unemployed or in the informal sector." However, Grobler says 75% of people in formal employment already contribute to a retirement fund. He suggests that if such a fund comes into place you should be exempt from making contributions if you are already covered by your employer's fund.

Only one in every ten South Africans saves enough to afford a comfy retirement.

But a scheme such as this goes against the individual's right of choice. It's a witless bid to get the private sector to fund the government's burgeoning cost of providing state pensions.

THE PROPOSED NATIONAL RETIREMENT FUND

The Financial Services Board is proposing compulsory retirement provision where you'll be forced to contribute to the state's national retirement fund. If you already contribute to your employer's fund a portion of your contributions will be allocated to the state fund. Even if you never contributed to the fund you can still draw a minimum pension. But the plan is bad news - and can be seen as a down-right cheek - to those who contribute to a private retirement fund. The proposal is currently being drawn up - once complete it will be submitted to the finance ministry.

ALL FOR ONE: There won't be enough to share among everyone if a proposed state retirement fund is approved

COMPANIES STAND TO BENEFIT

R80bn pension funds at stake

CT 11/10/99 (300)

COMPANIES appear poised to benefit significantly from huge pension fund surpluses while retrenched and transferred pension fund members and pensioners are left short, **GUSTAV THIEL** reports.

MANY pension funds have created huge surpluses as a result of the method used to transfer members to the new defined contribution pension and provident funds, a consultant in the industry, Roger Wellsted, told the *Cape Times* yesterday.

Wellsted said pension funds created these surpluses by defining the value transferred to the new pension schemes as an amount less than the total amount originally reserved for members. This practice is illegal under British law.

Companies have already begun claiming these surpluses for their own use ahead of legislation to control distribution of these funds.

The chief actuary of the Financial Services Board, Jeremy Andrew, said government is in the process of drafting legislation which will govern the use of the surplus, which is estimated to be R80 billion. The bill will go out for comment within the next month.

Companies stand to benefit significantly from the new bill while retrenched and transferred pension fund members and pensioners would be left short. Much will depend on the controls of the new legislation, including provision for remedying past practice.

The massive surpluses have been realised over a relatively short period of time, Wellsted said. The Sentrachem Group Pension Fund was a case in point.

"In 1995, the R650m Sentrachem Pension Fund had a shortfall in budgeted investment returns of some R57m. By March 1998, the fund had moved to a R408m surplus. During this period, many members had either been transferred out of the fund or retrenched. Executives, on the other hand, were granted additional pension benefits amounting to more than R40m.

"As with the Sentrachem Fund, many members have been transferred out of traditional defined benefit pension funds, leaving behind the investment reserve portion of their actuarial reserves.

"Many actuaries argue that the investment reserve applies to the pension fund as a whole and cannot be allocated to individual members. In many cases, this has resulted in up to 40% of the reserve value being left behind in the fund, later to be declared as surplus," said Wellsted.

Former Sentrachem executive, Basil Kransdorff, who was unhappy with the transfer value of his pension, lodged a complaint with the Pension Funds Adjudicator.

The adjudicator dismissed Kransdorff's application, claiming that in terms of South African practice, the transfer value was fair. The case has been referred to the High Court on appeal.

The South African Chemical Workers' Union has also challenged the Sentrachem Pension Fund transfer value, claiming that the "investment reserve" portion of the actuarial reserve should have been included in the transfer. The case is pending.

Peter Theunissen, an actuary

❑ Turn to Page 3

Pension funds

CT 11/10/99 (300)

❑ From Page 1

and consultant at Sanlam Employee Benefits who assisted with Kransdorff's appeal, said this "investment reserve" should be transferred with members to ensure their benefits are equally protected in the new fund.

In actuarial methodology, explained Theunissen, if the stock market value of assets is inflated above what the actuary considers realistic, a higher market value of assets is set aside to fund a member's benefits. Should the assets revert to a more prudent level, there will still be sufficient funds available to meet the benefit expectations of the member.

According to Wellsted, British law requires transfer values to take into account the market value of assets, thus protecting the interests of members.

"In other words, British practice requires the investment reserve to be transferred with the member. South African law should provide the same level of protection to members and we would avoid the battle over who owns these newly created windfall profits," he said.

Baby blues as UIF fails moms

Getting pay-outs from the Unemployment Insurance Fund has become a nightmare for many women, writes **Khadija Magardie**

(301) M+G 29/10—4/11/99

South Africa has legislation that ensures relative job security to women whose work is temporarily or permanently interrupted by motherhood. This is extended to cover not only childbirth, but cases of miscarriage, stillbirth and even adoption.

According to the Basic Conditions of Employment Act, women on maternity leave are entitled to 45% of their basic salary. This is provided that they have been engaged in employment as a contributor to the Unemployment Insurance Fund (UIF), or have been in employment for at least 13 of the 52 weeks preceding confinement.

But for many South African women who pass through the Department of Labour offices, getting their pay-outs on time has become a bureaucratic nightmare.

Frustrations such as broken printers, misplaced documents and endless queues mean that some women are receiving their cheques up to three months after handing in the required documentation.

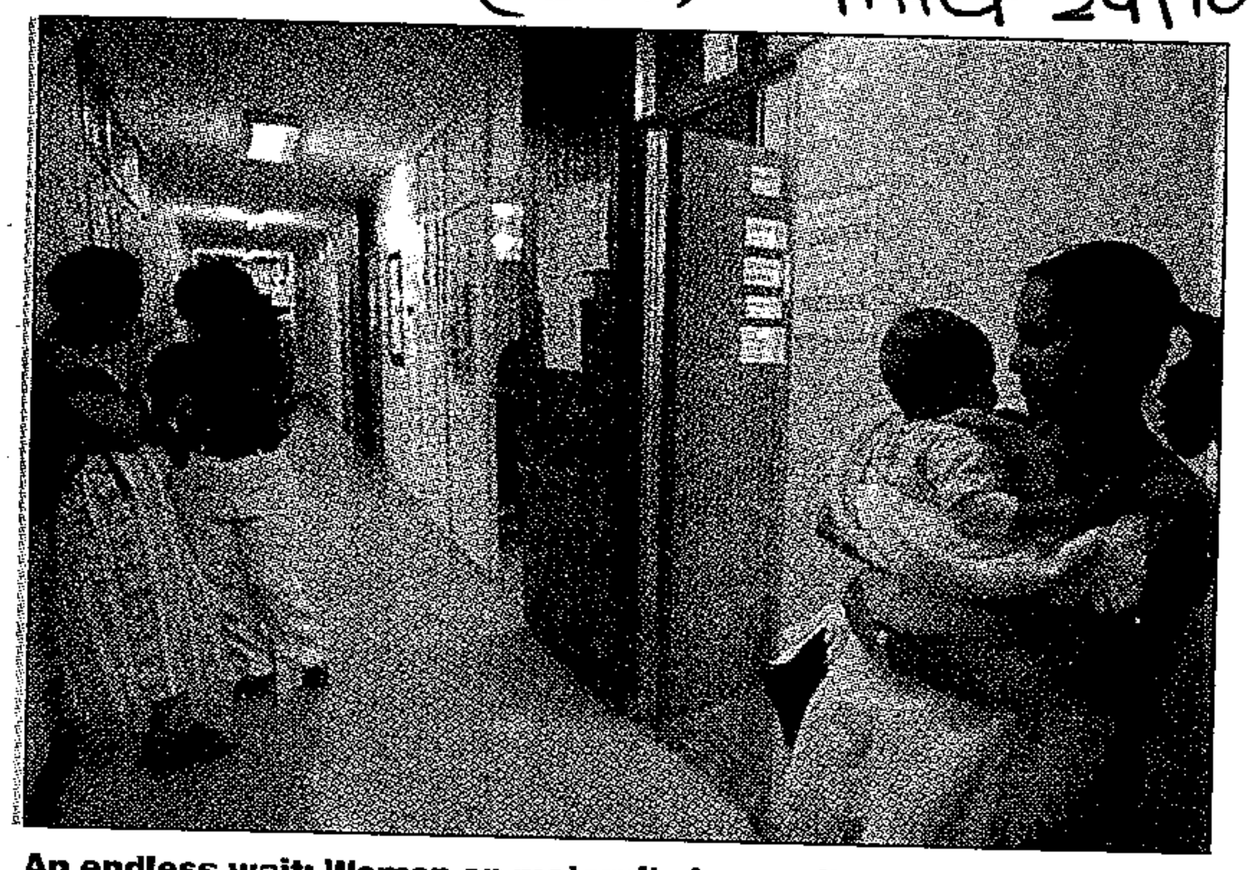
Na'eema Adams, a 25-year-old administrator, handed in her documentation to the UIF offices in June, two weeks after the birth of her daughter. She received her first cheque in September.

Adams, who returns to work in November, finds it "ironic" that she will only receive the money, which she needed to cover the expenses for her baby, when she is back at work, and theoretically able to support herself.

Numerous women sitting on the benches at the UIF offices in downtown Johannesburg have similar stories of having to "scrape together money" to survive between cheques, which are supposed to be issued at 20-day intervals.

One woman, who did not want to be named, said she had to spend money she often did not have to phone the UIF offices, as well as on taxi fares to make the trip from Isando to Johannesburg. And more often than not she was told her cheque was not ready.

Despite the Department of Labour offices having a separate section for maternity pay-outs, women bringing in their forms have to sit in the main hall in endless queues. Most are carrying their infants, and have to feed and change them while sitting patiently on the narrow benches.



An endless wait: Women on maternity leave often receive their UIF cheques only when they are back at work. PHOTO: NADINE HUTTON

Adams says there should be mechanisms in place to ensure that women are not left in virtual economic suspension because the department does not process the documentation on time. These measures should also be broadened to include banks, which confound delays. Bank policy dictates that crossed cheques can only be drawn after a minimum of one working week. "If they can clear salary cheques across the counter, why not our UIF cheques?"

It has also been suggested that the time frame for payment be changed. This can be solved if women bring in the documentation, excluding medical certificates, on their last working day, to allow the department ample time to process the application. Upon presentation of a medical certificate, as soon after the birth as possible, the cheque should be immediately issued.

According to many of the women, the UIF officials never offer an explanation for the delay, and are often rude when answering telephonic inquiries.

The Department of Labour says it has to deal with thousands of applications, and that delays are often inevitable. But the cause of the problem is seldom rectified.

A department representative called the numerous mishaps "the exception rather than the rule", and said that women should hand in their documentation on time to prevent unnecessary delays.

He also said that it was not a necessary prerequisite that women deliver, in order to be paid out. The department is also currently testing new measures, such as the electronic payment directly into bank accounts, to ease the burden on the UIF offices.

Adams dismisses the department's explanation that the printing of cheques takes time. One of her cheques, she says, was dated less than three days after she handed in her forms. Despite this, she waited more than a month to receive it.

A substantial portion of South African women in paid employment are sole income earners. As a result, the delay impacts significantly on their entire household.

While the UIF provides protection for women in the event of suspension of their employment, the "spanners in its works" are making it decidedly difficult for these very women.

'Apartheid killers abuse fund'

(301)

By PHALANE MOTALE

THOUSANDS of apartheid-era human rights violators are allegedly milking the Workmen's Compensation Fund of millions.

City Press is in possession of an application wherein a former member of the security forces claims from the fund for the HIV-virus he contracted "while in the line of duty in Congo".

The Compensation for Occupational Injuries and Diseases Act is designed to help "all employees" injured at work. And for an employee to qualify he or she must have been injured at work, and the compensation is awarded "according to the severity" of the injuries.

A source within the department of labour told City Press that the applications of former members of the notorious Koevoet, 32 Battalion and Vlakplaas units were allegedly also receiving preferential treatment, by being marked "urgent" and awarded "higher than usual" payments.

The thousands of former security force members are apparently all claiming to be suffering from post-traumatic stress, and most of their applications are being handled by "the same psychiatrists and lawyers" who have "apparent connections" at Compensation House – the headquarters of the fund in Pretoria, according to the source. He said the same security members who were desperately waiting for amnesty application results from the Truth and Reconciliation Commission (TRC), were now waiting patiently for the fund to compensate them for their involvement in the deaths of political activists in South Africa and neighbouring countries.

Some of the former Vlakplaas operatives had publicly admitted to the TRC's amnesty committee that they had continued to act against known political activists long after the unbanning of the African National Congress (ANC).

Operatives sergeant Hendrik Hanekom and constable Johannes "Blackie" Swart, who told the TRC that ANC activist, Tiisetso Leballo sat and drank beer with them before being shot and his body destroyed with 25 kg of military explosives at Penge mine on March 26, 1992, were among those compensated by the fund.

Former policeman Deon Gouws, who with Stephanus Oosthuizen, Jacque Hechter and Joe Mamasela shot dead nine young Mamelodi activists, were also compensated by the fund.

In a written reply, departmental spokesperson, James Moche said statistics regarding the amount paid to former security force members was not available.

"Statistics are compiled at the end of the financial year, in conjuction with the department of finance," he said.

But between March and September this year, more than R800 million had already been paid to employees in general.

Moche said if the HIV virus was proven to have been contracted in the course of employees' duty, a claim would be accepted and submitted for payment.

He denied that security members were receiving preferential treatment from the fund.

New steps to control Polmed costs

ART 4/11/99

CLIVE SAWYER
POLITICAL CORRESPONDENT

Police have admitted to Parliament that spending on medical scheme Polmed is all but out of control, but say new steps including membership fees and limitations on treatment are being introduced to rein it in.

Top police suspect that, in turn, the hike in spending may be because members have embarked on an eleventh-hour spree of no-cost medical treatment.

At the same time, finance committee members are frustrated about cuts in the police crime prevention budget.

Yesterday police deputy national commissioner Morgan Chetty led a delegation summoned by the committee to discuss concerns about the transfer of more than R300-million to cover expenses mainly related to Polmed, while the budget for crime prevention was cut by more than R200-million because of a reduction in the number of police.

Another concern was the cost of transferring information technology functions to the new State Information Technology Agency. (299)

CAPE TIMES
THURSDAY, NOVEMBER 4, 1999

Finance committee comes to rescue of Legal Aid Board and police medical scheme

ANDRÉ KOOPMAN
POLITICAL CORRESPONDENT

PARLIAMENT'S finance portfolio committee yesterday approved R107 million to bail out the nearly bankrupt and problem-prone Legal Aid Board, and has allowed police to move R300m allocated to fighting crime, to the ailing police medical scheme Polmed.

Judge Mohamed Navsa, the recently appointed chairperson of the Legal Aid Board, said steps were being taken to address the "chaos and maladministration" he had discovered on being appointed.

He said the funds requested fell far short of the R290m needed to keep the fund afloat.

Navsa ascribed problems to the failure to apply means tests to applicants for legal aid, the exorbitant fees paid to lawyers acting for the state, as well as huge backlogs in account payments.

As a result, fees were almost halved, which led to howls of protest from lawyers.

A new system had also been introduced to speed up payments.

Rates paid to lawyers for appearances in the High Court had been reduced to R750 a day, from a high of up to R3 000 previously paid to senior counsel.

A means test had been introduced to ensure that only those who qualified for legal representation received it, Navsa said

Since there had been no means test before, people who could afford to pay for their legal costs had claimed from the board, while the poorest of the poor had not received assistance, he said.

Navsa added that a financial business plan expected to be finalised this week to map the way forward, would be submitted to Parliament soon.

Amounts approved by the committee have to be approved by Parliament.

Committee chairperson Barbara Hogan expressed doubts about the board's future and whether additional funds would help it survive.

"Is it not just a case of treading water?" she asked a delegation from the board.

The right to state funding for legal costs in courts is guaranteed in the Constitution's Bill of Rights.

Navsa said the board had debts totalling R428m. While there had been a marked improvement in the processing of claims since he had been appointed, there was still a huge backlog.

Hogan congratulated Navsa and his staff for their hard work in trying to cope with the processing of the hundreds of thousands of claims.

Meanwhile, the committee was also asked to divert sorely needed crime fighting funds to the police medical aid scheme Polmed.

Morgan Chetty, the deputy national police commissioner, told the committee permission had been requested to transfer more than R300m from crime prevention to Polmed, to keep it afloat until next year.

The medical scheme has a history of corruption and fraudulent claims.

From January next year Polmed would be registered as a private medical scheme, and would charge membership fees based on salary and number of dependents.

It would limit certain treatments.

Less money was needed for crime prevention programmes because the number of police officers employed had been reduced by 2 400, Chetty said.

(252) (299) CT 4/11/99

Why your private healthcare world is changing

(299)

ARG 13/11/99

The government wants every South African to have access to quality, affordable healthcare.

But the public healthcare system faces huge financial challenges, for apart from battling to provide quality healthcare to the poor, it is also burdened with providing healthcare to people who can afford to pay for private medical cover, by joining a medical scheme, or buying health insurance products.

Private medicine, too, has been battling with rising costs, inefficient financial management of medical schemes, inefficient cost control measures, dwindling numbers of people who join schemes, high consumption volumes and high expectations from consumers.

This is the background to the recently released rules which govern the new Medical Schemes Act, via which the government hopes to introduce constructive changes to your private healthcare world.

The regulations, along with the act, are the reasons why many medical schemes and health insurers are now scrutinising their benefits, structures and premiums.

They have to get in line with the requirements of the act and the regulations before January 1, 2000.

And they have to do it in a financially sustainable way.

The rules contained in the act and regulations include:

◆ Incentives for people who can afford it, to join private medical schemes by, for instance, allowing schemes to impose a late-joiner penalty on people who only decide to join schemes when they are older or sicker;

◆ Equal access for everyone to medical schemes – regardless of whether you are sick or old. Schemes can no longer discriminate on the basis of your health or age. Your income and the number of dependents you want covered by the scheme are the only factors affecting the premium you pay;

◆ Minimum levels of benefits to be provided by all schemes;

◆ A provision that no more than 25 percent of your total contributions to your medical scheme can be held in your medical savings account; and

◆ A provision that if you want to join a scheme and are not in good health, schemes can impose waiting periods on you and can exclude you, for a period of time, from getting cover for certain pre-existing conditions.

Medical benefits tossed out

You may be out of pocket as schemes react to pressures in new legislation

ST ARG 13/11/99 (299)

ESANN DE KOCK

More medical schemes are cutting back your benefits – probably to protect themselves against the effects of the new legislation. But the Department of Health is ready to take them on.

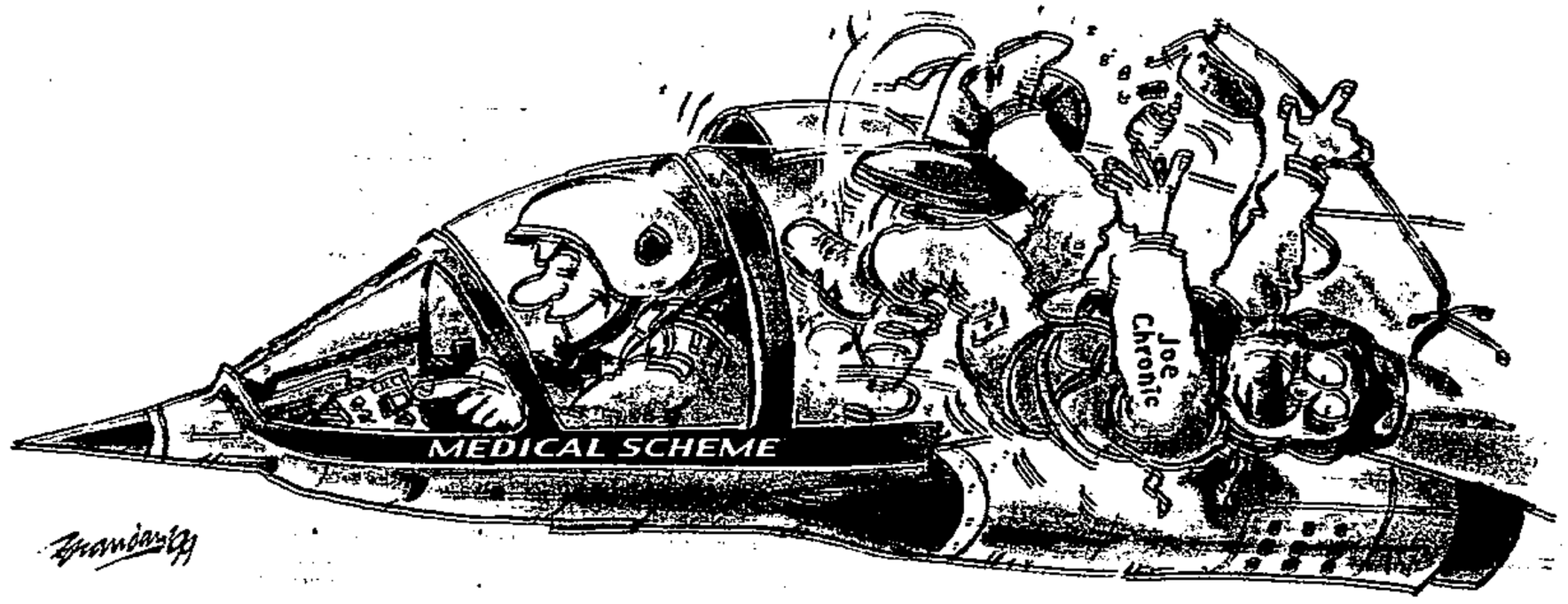
Discovery Health has already locked horns with the department on the issue. Now Fedsure Health seems to be following a similar route and Cape Medical Plan has slashed chronic medication benefits.

Fifty-four-year old Mrs X, who has been a member of the plan for the past six years, told Personal Finance that the reduction in her chronic medication benefits has left her wondering whether her membership of the scheme is still worthwhile.

Mrs X says Cape Medical Plan used to pay all her chronic medication costs to a maximum of 70 percent of the retail price – limited to R20 000 a year. She also enjoyed the benefits of a savings account which enabled her to control her spending and carry unused funds over from one financial year to the next.

However, recent changes resulted in a R100 drop in her monthly contribution to the medical scheme and a sharp reduction in chronic medicine benefits to R2 400 a year.

Johan Wiese, Cape Medical Plan marketing manager, says while chronic benefits have been reduced, allowances for specialist care have been increased significantly. He says this was part of the annual review of benefits and does not necessarily have anything to do with the new Medical Schemes Act requirements.



The Act stipulates that medical schemes can no longer exclude the sick or the elderly or expect them to pay higher premiums than younger, healthier members. The new rules state that only differences in income and in number of dependents can justify differences in premiums. This is likely to mean higher costs for many schemes.

Some schemes, like Discovery, are finding ways to tackle the cost danger by transferring chronic medication benefits and hospital benefits out of the scheme and into an insurance product. Insurance products are governed by different laws and insurance companies can load the premiums of sicker or older people.

Discovery's medical scheme still offers hospital benefits, but the way it has been restructured essentially encourages you to buy the additional insurance product – or pay out of your own pocket the first R500 of your daily hospitalisation costs or the first R1 500 of your daily costs in intensive care.

Patrick Masobe, of the Department of Health, says informal discussions with Fedsure Health have revealed that this company's restructured medical scheme product, while continuing to offer you chronic medication benefits, also excludes a list of hospital costs which you can cover through an insurance option.

"We don't see a huge difference between what Discovery Health and Fedsure Health are doing.

"In the case of Discovery Health, we believe the insurance product is doing the business of a medical scheme. We will not keep quiet about it and we have told Discovery so."

Masobe says the idea behind writing a requirement into the Medical Schemes Act that all medical schemes should offer a certain minimum benefits did not imply that other benefits can be stripped out of the schemes.

He says the department hopes to resolve the matter with Discovery and Fedsure and it "absolutely will not register schemes that do not comply with the Act".

Discussions with the two companies have "hardened" the department's position, he says. If the products remain unchanged, Masobe says, the department expects the Medical Schemes Council to take appropriate action.

He says the Act allows the council to force companies to register a product as a medical scheme or to stop it doing business.

Discovery and Fedsure are, however, standing firm that their products do comply with the Act.

Alan Pollard, general manager of research and development at Discovery Health, says the matter of when an insurance product does the business of a medical scheme has become an industry issue.

Pollard points out that existing Discovery members retain all their benefits – including chronic and hospitalisation benefits in the insurance plan – at no extra cost.

Not all medical schemes have gone the insurance route.

MediHelp, one of the largest medical schemes in South Africa, says because the law is aimed at making comprehensive medical cover available to people who have been excluded in the past, it will not move benefits that traditionally belong in medical schemes into insurance products.

Anton Rijnen, MediHelp chief, says although this route holds certain benefits for the scheme, it offers very little for the consumer, since products which fall under the Insurance Acts have very little or no tax advantages. He says taking up these options can also affect your subsidy as an employee, because employers are not allowed to subsidise insurance policies.

◆ Choosing a medical scheme, pages 2 and 3

Talks deadlock could force prepayment at hospitals

(299) BD 19/11/99

Pat Sidley

MEDICAL Scheme members may find themselves forking out huge sums to hospitals before being admitted as negotiations once again deadlocked between the Board of Healthcare Funders (BHF), which represents medical schemes, and the Hospitals Association of SA (Hasa) which represent private hospitals.

Talks yesterday ended acrimoniously with BHF CEO, Dr Aslam Dasoo, calling on members of schemes to tell hospitals their views. The BHF has offered an increase in hospital tariffs of 4,5%. Hospitals demand 9,5%.

Among the offers made and rejected yesterday was one from the BHF offering an added management fee of what would have amounted to 2%, if hospitals accepted the certain managed care principals.

This would have meant hospitals sharing some of the risk with schemes and patients. Hospitals, on the other hand, according to Hasa CEO Dr Annette van der Merwe, had made an offer, which she could not disclose, which had been rejected by BHF.

Van der Merwe said hospitals were talking to certain schemes individually in the hope of persuading them not to force members to pay the full fee upfront.

NEWS

Hospitals, medical aids hit tariff talks impasse

ET (BR) 19/11/99 (299)

ADELE SHEVEL

Johannesburg – Talks collapsed yesterday between the Hospital Association of South Africa and the Board of Healthcare Funders (BHF) after an urgent meeting failed to resolve the impasse over tariff negotiations for 2000.

Earlier BHF had received a unanimous mandate from all medical schemes to award a 4,5 percent increase to private hospitals for the year 2000.

Private hospitals rejected this offer, demanding 9,6 percent. BHF said its offer was based on inflation projections and national wage adjustments expected next year.

BHF said it was the reasonable expectation of medical aid members to pay increases for medical scheme contributions consistent with other cost of living increases.

The board said the private hospital industry insisted it would demand upfront payment on admission from members should medical schemes reimburse them instead of paying the hospitals directly.

"BHF finds this an outrageous and irresponsible proposition in that it will unfairly and unjustifiably place further financial burden on medical scheme members," BHF said.

A general meeting of the members of BHF held last week mandated negotiations around an additional fee to be reimbursed for certain value-added and cost efficient services from private hospitals. This would roughly equate to a further 2 percent increase in real terms to the reimbursement award.

No agreement was reached between the hospital association and the BHF. The BHF said it was disappointed at the lack of foresight demonstrated by the private hospital industry.

BHF said a new reimbursement model was urgently required. "BHF services notice that such a model shall be developed next year with or without the co-operation of the private hospital industry. We hope that this will not be necessary."

Shock for medical aid patients

Five percent of bills at private hospitals will have to be paid upfront

(299) ST 21/11/99

LAURICE TAITZ

MEDICAL aid patients admitted to private hospitals after January 1 will be forced to pay five percent of their bill upfront following a breakdown of talks between medical aid schemes and the Hospital Association of South Africa this week.

For minor procedures patients could pay a few hundred rands, but for complex operations, such as heart surgery, the amount could be as much as R4 000.

Dr Aslam Dasoo, chairman of the Board of Healthcare Funders — representing 170 medical aids with seven million members — said on Friday that annual negotiations to determine next year's tariff adjustment deadlocked this week when the association — representing about 98 percent of private hospitals — refused to budge on their demand for a 9,5 percent tariff increase.

Dasoo said the board's mandate was to offer a 4,5 percent tariff increase to private hospitals based on projected inflation and salary adjustments for next year. "It means they are going to charge the difference to the member upfront. They can say pay up, or we won't admit you."

Dasoo slammed private hospitals, saying: "The private hospital sector is notoriously inefficient. There are 200 private hospitals and they run at 58 percent capacity. However, they still manage to post massive headline earnings because they just raise tariffs to ensure shareholder value.

"Historically tariffs have been based on the demand of suppliers. Medical aids simply raised contributions to the scheme to stay solvent. Under the new Medical Schemes Act we cannot do that. In line with that we agree that there is no reason for providers to get an increase above the normal cost-of-living increase."

But Norman Weltman, chairman of the association, hit back, saying: "The board made a unilateral decision on the tariff increase without taking our circumstances into account. There was no consultation and no negotiation."

Weltman said the increase was, in actual fact, seven percent, with another 2,5 percent payable because of the increase in labour costs. "A hospital is not like any other business. It's open 24 hours a day, seven days a week. Previously, hospitals had a dispensation from the Department of Labour. Now we are subjected to the basic Conditions of Employment Act which affects our labour costs on public holidays and Sundays."

He said costs had also risen because the hospitals were buying equipment overseas at poor exchange rates. "We have gone out of our way to ensure costs are restrained. We are prepared to make concessions, but it's a two-way street."

Weltman said: "They have threatened us with paying claims directly to the member instead of the hospital. If this happens we will need to ask patients for an [additional] deposit upfront for the full procedure to ensure we don't incur bad debts."

Sore point for medical aid patients

(299)
CHARMAINE PILLAY. ET 22/11/99

DURBAN: Medical aid schemes and the Hospital Association of South Africa are still at loggerheads over next year's tariff adjustments — but no matter what the outcome, the patient will be the loser.

The annual negotiations deadlocked last week when the Board of Healthcare Funders, representing 170 medical aids with seven million members, refused to give in to the Hospital Association's demand for a 9,5% tariff increase.

The board was mandated by medical aid schemes to offer 4,5%.

Neil Lewis, communications manager for the board, said that if it accepted the association's demands, medical aid schemes would have to increase members' contributions.

The Hospital Association, which represents 200 private hospitals, has threatened to make patients pay the five percent difference as an advance deposit to ensure that they don't incur bad debts.

This means that if a complex medical procedure is likely to cost R60 000, a patient will have to fork out R5 000 before being admitted to a private hospital.

"Our offer was based on a projected inflation and salary adjustment," Lewis said.

"We made a further 2% offer, provided the Hospital Association proved to us that it would not stretch out the medical care. For example, if a patient can be discharged after two days, that patient should not be kept at the hospital for five days. The association rejected the offer.

"The hospitals are running at 58% capacity. From their demands it seems as if they are expecting the medical schemes to subsidise the remaining 42% of their beds."

Lewis said the Board of Healthcare Funders would not move from the mandate given to it, but its door remained open for further talks with the association.

The chairperson of the association, Norman Weltman, could not be reached for comment.

Brokers wrestle with Medical Schemes Act

(299) BD 26/11/99

BROKERS are slightly confused at the moment. With little clarity in the market of exactly what is likely to be acceptable to the Registrar of Medical Schemes by way of products, brokers are finding it hard to work out what to sell.

And many of them have problems with the law and regulations.

A broker, wishing to remain anonymous, gave a useful insight into working as an agent for a large insurer.

His most important point, for consumers, is that "best advice" as contained in the regulations cannot work.

Many brokers and agents are tied to particular insurers or schemes, and obliged to sell those products only — whether or not they are as good, better or worse than other products.

The broker faces particular difficulty with the impasse in the registrar's office. His insurance product, like several others, has gone to ground while he is waiting for a determination on whether or not certain insurance products can be sold at the same time as schemes.

This means that when employer groups ask him for information, or for a description of the variety of products which may be on the market, he is not able to give it.

He has problems, too, with the 3% sliding scale for commission.

More importantly, however, he sees no reason to comply with one regulation which says he has to state to customers exactly what his commission is.

"I don't ask my stockbroker what he earns," he says. "But I do expect him to tell me the cost of the transaction on the Johannesburg Stock Exchange."

He is prepared to explain the cost to consumers and the benefits they will get — but feels it an invasion of his privacy to have to declare the value to them of each transaction.

Despite his disapproval of the regulations surrounding brokers, he believes in the essence of the Medical Schemes Act.

Health care, he says, is a basic human right and the act attempts to ensure that more people have access to health care.

He believes one of the unintended effects of the regulations will be to encourage some brokers to drum up work to ensure a good living on the low commission rate.

He thinks accreditation is the best thing about the regulations and is "long overdue".

He points out though, that there is as yet no industry standard for accreditation.

He says that his company has gone the route of educating its brokers on the products and not on any broader aspects.

Asked if he understood and could inform employer groups and employees about the ins and outs of how the different products (medical schemes and insurance) are treated tax-wise, he says that he does not fully understand them.

In addition, employers are dismissive and do not want to know, and employees do not ask.

He sells other insurance products aside from health, but says about 20% of his gross income comes from selling hospital plans.

It means, with the low commissions on schemes, he will not be pushing medical schemes particularly hard. That will affect the access some employers and employees have to information about products.

THE MEDICAL SCHEMES ACT

Medical schemes vs health insurance

(299) BD 26/11/99

Department and insurers at loggerheads over interpretation

WHAT is the big fuss about between the health department and the health insurers, led by Discovery Health and Fedsure?

The answer to those baffled by the question lies in the premium rates published alongside. The insurers have looked at two sets of legislation and designed products which use both laws.

They have produced a medical scheme which will cover, among other items, the basic minimum package of benefits as laid down in the regulations. Both insurers, however, also offer extra coverage to fill the gaps left in the medical scheme. They offer different types of "gap" cover, and both have chosen to take out of their basic package certain items which members may want to cover.

Discovery, for instance, took out a chronic medication benefit (although it offers coverage of medication through its scheme). Fedsure elected not to cover in full certain medical procedures. Members would be required to fork out substantial sums or buy extra coverage. Hospital coverage is also limited on the basic scheme, but can be topped up.

The big problem for the health department is that it would be far less expensive for members who are young and healthy to plug all those gaps by buying an insurance product — which both insurers conveniently offer. Those who are older or who have riskier claims profiles may find it too expensive to buy the insurance product or may be excluded altogether.

In the end, what it does is to allow healthier and younger members of schemes to buy cover for less money than others will pay.

To other insurers waiting in the wings, the fate of these products will determine their own ability to market products they have designed but have quietly put back on the shelf for the time being.

For the more traditional schemes, if the insurers are allowed to market their products, they will join the party too.

In the end that will mean once again that the younger and healthier members are cherry-picked and get their coverage cheaper, while older and less healthy members will pay dearly for their cover, or will not be able to afford it at all. That was why government decided to redesign the Medical Schemes Act in the first place.

Discovery Health recently listed on the Johannesburg Stock Exchange. The share price has continued a steady rise since the listing, largely, it would seem, because of shareholder confidence in CEO Adrian Gore. The company basically has only one product — its medical coverage plan — which is under scrutiny by the health department, which has stated emphatically it will not register the product in its present form.

Both Fedsure and Discovery believed their products were legal.

One portion of the scheme was legal in terms of the Medical Schemes Act: the insurance portion legalised by the Long Term Insurance Act, passed last year. At the time of finalisation of both bills the Financial Services Board and the health department formalised an agreement covering which types of products would be covered by the Medical Schemes Act and which by the Insurance Act.

The insurance industry, led by Discovery and Fedsure (the others having put their plans on hold for the time being), opted to use an insurance policy to be sold alongside the medical scheme. The more traditional medical schemes drew up plans based on the Medical Schemes Act.

Exaggerating the problem for the health department is the fact that both the tax treatment and the commission rates are different in the two types of products. Most of the premium of a medical scheme comes from pre-tax money and only a small portion of the premium is taxed. The insurance policies would be paid for by post-tax income in the hands of the employee.

Commission to brokers is much more on insurance products than medical scheme products.

Quite naturally the insurance products will be pushed more than the gap cover, which has not been underwritten and its risks rated according to insurance principles.

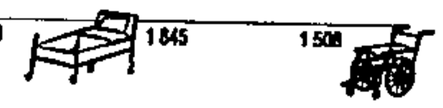
An example of this is the fact that Discovery has very few people over 65 years old on its scheme. According to Allan Pollard of Discovery, it will not be paying commission to brokers who recruit people over 65.

Gore, however, is working with the health department to find a way of putting its product on the market in a manner which will be acceptable to the Medical Schemes Council. Fedsure has a similar stance but the belief in the industry is that its product may be slightly less problematic.

The major flaw in the Discovery product from the department's side was that it made its chronic medication plan an insurance product, thus ensuring that older and sicker people who will need it, may have less access to it.

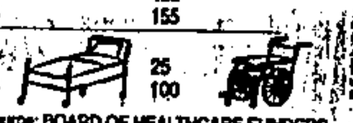
How insurance would affect premiums

	Ultima 300 (Budget)	Ultima 200 (Hospital)	Prime 200 (100% Medical)	Optima 200 (Medicross)
Member aged 30	402	286	680	464
Member aged 60	490	374	768	552
Member aged 40 Spouse aged 37	769	521	1 269	890
Member aged 70 Spouse aged 67	1 225	977	1 725	1 346
Member aged 50 Spouse aged 47 1 Child	963	671	1 597	1 239
Member aged 40 Spouse aged 37 2 Children	1 077	741	1 845	1 508



Fedsure Health – Medical Scheme (no insurance) Monthly contributions - 1 January 2000

Plan	Series	Member rate	Adult dependant rate	Child dependant rate
Core benefits				
Ultima	300	322	253	104
	200	206	121	60
	100 (Salary <= R3	113	90	90
	100)	306	241	99
	True Health			
Prima	300	886	704	352
	200	600	475	238
	100	421	332	166
Optima	Medicross 300			
	Medicross 200	552	393	220
	Medicross 100	469	329	183
Optima	Medinet (Salary <	406	282	156
	R3 500)	178	155	155
Add-on benefits				
Xtracare Top-up		40	35	25
Hospital Gap Cover		350	325	100



MATTHYS MOSS Source: BOARD OF HEALTHCARE FUNDERS

Fedsure Health – Insurance Plans

Monthly contributions - 1 January 2000

Age range	Hospital Comprehensive	Hospital Basic
0 – 30	80	80
31 – 35	88	88
36 – 40	97	97
41 – 45	105	105
46 – 50	117	117
51 – 55	138	138
56 – 60	168	168
61 – 65	235	235
66 – 70	325	325
71 – 75	425	425
> 75	568	568
Child rate	50	50

MATTHYS MOSS Source: BOARD OF HEALTHCARE FUNDERS

Health brokers now in the fold

BD 26/11/99

(299)

Medical Schemes Act recognises their legal standing in an attempt to regulate the industry

BROKERS (or intermediaries), previously illegal in the healthcare field, have now been deemed legal. Their recognition in the Medical Schemes Act was effectively the recognition and control of a "necessary evil".

While previously they technically did not exist, huge amounts of money were spent paying commissions to intermediaries to bring business to schemes. The past law reflected the notion that members' funds should not be used on commission.

An entire "underground" system grew up around the remuneration of intermediaries and as they were not officially in existence their behaviour has been largely unregulated.

The new laws will place many brokers in an odd position.

Many of the thousands of brokers sell other forms of financial services products — such as life assurance, which is regulated in a different way by a different body.

These other forms of broker activity will be regulated soon by new rules and laws being formulated through the Financial Services Board.

For many brokers who plod the streets door to door selling small products to small people, the new law may mean hardship.

For consumers the immediate benefits of having a better educated, well regulated and transparent sales person are obvious — but may mean specific hardships as well.

For instance, if smaller brokers cannot earn an adequate living on the door-to-door beat, they may stop servicing individual consumers or very small businesses.

And as the new medical schemes environment demands knowledge of healthcare financing never before needed, this may make it difficult, if not impossible, for prospective members to make informed and adequate choices.

The new law allows intermediaries to operate in the field — but heavily circumscribes what they do, how they do it and what they earn.

Naturally this has met with some reservations from brokers themselves.

Brokers fear that certain administrators will use the regulations to steer business in a particular way — and while generally the market is trying to regulate broker behaviour, brokers do believe that part of the industry will behave unethically too.

The law now says brokers can be paid up to 3% (of premium income) in commission. That is the upper end of a very short sliding scale.

They have to be accredited with the Medical Schemes Council and they have to disclose various details in the interests of members.

The moves have spawned a new lobby group of brokers; as broker interests are not necessarily the same as schemes, members or regulators, this organisation is the Association of Health Benefits Advisors.

The association represents the interests of thousands of brokers who may be selling one small policy at a time, or who may be selling large schemes to large employers.

While the law takes effect on January 1 next year, there is as yet no accreditation scheme in place and many schemes and insurance companies are devising education programmes on their own.

The association is looking at the issue in detail.

Brokers have to either have adequate accreditation or be apprenticed.

They have to have written agreements with schemes for which they are acting and have to show these to prospective members.

Other requirements include:

- Disclosure to the member of the amount of commission being earned;
- The provisions of "best advice" to the prospective member; and
- An undertaking not to receive any other payment or any other type of compensation for the job.

The 3% commission is the maximum amount payable in a year for the introduction of members to a scheme. The sliding scale, according to the regulations, should relate to the size of the group being introduced.

If a scheme's rules do not allow for brokers to be paid, they cannot be paid.

If brokers are paid for more than a year, the services must be specified. They must have an agreement with a scheme for this and it has to be indicated separately to the Registrar of Medical Schemes.

Applications for registration are to be in by December 1 this year. Accreditation will imply minimum educational levels — but do not specify exactly what the broker should be studying.

Brokers will have to renew their licenses periodically.

Clampdown on medical aid age practices (299)

Pat Sidley BD 6/12/99

THE health department is to issue its first declaration of an "undesirable business practice" in terms of the new Medical Schemes Act this week.

The declaration deals with the splitting of employer groups previously on one medical scheme, and placing lower-risk members (usually the young and healthy) with one scheme, and either dumping the higher-risk members (often older, sicklier pensioners) on another scheme or leaving them on their original scheme.

Complaints of such practices by two health insurers with medical schemes — Discovery and Fedsure, which have themselves frequently been accused of market behaviour of which the health department does not approve — have been made to the registrar.

The statement giving notice of the gazetting of the undesirable practice says that in terms of the act, "when an employer group leaves one medical scheme to move to another, the new scheme must accept the whole group, including continuation members and dependants of deceased members".

This is the first move against practices that may be seen to be thwarting the intention of the act. It signifies an intention to close loopholes in law and regulations.

Old Mutual is said to have been a victim of such a practice. When a large employer group was split, its younger and healthier members were offered a lower-cost product with Discovery Health and those posing a higher risk were "dumped" on Caremed, Old Mutual's medical scheme.

Discovery CEO Adrian Gore says his company subscribes fully to the principles of the act and its regulations and agrees with points made in the undesirable business practice notice. Discovery, however, pays no commission on pensioner members recruited.

Hospital tariff row to end soon

CT(BR) 9/12/99 (299)

ADELE SHEVEL

Johannesburg – The impasse between hospitals and medical aids over hospital tariffs could be settled by the end of this week, Norman Weltman, the chairman of the Hospital Association of South Africa (Hasa), said yesterday.

Hasa and the Board of Healthcare Funders (BHF), the medical aid representative body, have been at loggerheads over what tariff to charge for hospital beds in the private sector.

BHF said earlier it had received a unanimous mandate from all medical schemes to award a 4,5 percent increase to private hospitals for 2000.

The BHF said its offer was based on inflation projections and national wage adjustments expected next year. Private hospitals rejected this offer, demanding a 9,5 percent increase.

Weltman said it was likely that a 4,5 percent basic increase would be agreed as a basic payment with an extra levy to cover additional costs of managed care practices.

The levy has yet to be determined.

The BHF said a few weeks ago it was the reasonable expectation of medical aid members to pay increases for medical scheme contributions consistent with other increases in the cost of living.

It said the private hospital industry insisted it would demand upfront payment from patients before admission to make up the shortfall, if medical schemes reimbursed their members instead of directly paying hospitals.

Healthcare funders and hospital group battle over costs of private sector care

Govt warns on medical schemes

(299)

Sowetan 16/12/99

By Bhungani Mzolo
Health Reporter

THE Department of Health has issued a warning to all members of medical aid schemes and employers to exercise "extreme caution" before signing any contract.

A statement from the department said it was aware of complaints from the public that certain medical aid schemes were selling policies that were not registered.

director of health, finance and economics Mr Pat Masobe said: "The department of health is worried about the rights of various parties entering into contractual agreements at this time, particularly those that offer incomplete and incorrect information – to scheme members, intermediaries and employers – concerning the nature and official status of the products presented to them."

Masobe said the department strongly opposed unfair practices by medical schemes and would take all the necessary action, in terms of the Medical Schemes Act, to ensure that the rights of relevant parties are protected.

The new Medical Schemes Act is intended to ensure that all South Africans are treated fairly when they go for treatment in the private sector. It forbids any unfair discrimination against any person based on age or health status.

Masobe said the department would like to make the following clear:

- That to date no health insurance products have been approved, whether existing or new;
- It has no intention of permitting the registration of so-called hybrid schemes;
- The medical schemes business involves undertaking liability in return for a contribution or premium to make provision for or to defray expenses incurred in connection with obtaining or rendering of any relevant health services, as defined in the Act; and
- The Medical Schemes Act applies to all products, including products that may need registration in terms of the Long-term Insurance Act or the Short-term Insurance Act.

"The department of health currently finds the behaviour of certain administrators and schemes unacceptable," the director said.

"Consequently, it wishes to reassure the public that all actions in contravention of the Act will be pursued to the full extent of the law."

Talks on hospital tariffs deadlocked

Pat Sidley (299) BD 17/12/99

PRIVATE hospitals and medical schemes have once again failed to reach agreement on tariff increases for next year.

Although new offers and structures were proposed and discussed since the two parties deadlocked two months ago, the same impasse was reached once again.

This makes it likely that after January 1 medical scheme members may be asked for cash deposits before being admitted to hospitals, while many will be asked for the difference between what their schemes will pay and what the hospital charges.

State hospitals — which are in the process of beefing up their billing systems and plans to retain their earnings — are waiting in the wings to take in private patients whose medical schemes will, from January 1, be obliged to cover state hospital expenses.

Private hospitals, says Alex van den Heever of Gauteng's health department, have "got themselves into a financial pickle" with overcapacity, of what he estimates is about 40%.

"During this difficult period public hospitals will look at developing contracts with medical schemes to provide reasonable care with guaranteed beds, adequate standards and quality of care," says Van den Heever.

Brian Brink, who chairs the tariff committee of the Board of Healthcare Funders, says that next year patients' schemes and hospitals will be "testing the water" on the issues.

Schemes simply could not afford to push prices up beyond the original 4,5% increase offered by the board. Neither members nor employers subsidising premiums could afford the extra costs, Brink said. Hospitals wanted 9,5% more and will charge this to patients.

He was especially concerned about lower-income members of schemes who were not able to afford large cash payments for hospital treatment.

The board had tried to introduce "bridging" systems for the next year prior to introducing a system similar to that used widely in the US in which certain groups of diagnoses would be reimbursed at a flat rate.

It would mean changing the economic incentive that hospitals have at present from overservicing to curtailing the service to fit the capitated fee.

One of the points of contention was the amounts charged for maternity costs and gases (like oxygen) in hospitals.