Chapter 6

The private health care sector
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6.1 Introducing private health care

The health care system in South Africa is divided into two components – the public sector that was described in Chapter 4, and the private sector. The private sector includes:

- All private health service providers (such as doctors and nurses).
- The institutions that represent health professionals.
- Private health facilities (e.g., hospitals, laboratories).
- The funding mechanisms of private health services (e.g., medical schemes, life and short-term insurance, out-of-pocket payments).
- Traditional health practitioners. (A special focus on this area of the private sector is contained in Chapter 7.)

Unfortunately, the reality of this divided health system is that only the employed and better off can afford access to many aspects of private health care. Prohibitive costs have made private health care too expensive for most people.

High costs have a number of causes, including anti-competitive pricing of medicines, laboratory services and specialist services, collusion among hospital groups and laboratory service providers, and the rising premiums of medical schemes. This chapter explains the laws and policies that are meant to address these problems.

The high cost of using the private health sector is one deterrent. The distribution of private health facilities, mainly in urban and affluent areas, is another. This leaves people in large parts of the country with access only to the public sector. This geographic inequality is also reflected in a comparison between the percentages of people covered by medical schemes in urban and rural provinces. For example, according to the Council for Medical Schemes, 37.3% of medical scheme members reside in Gauteng, as compared to 2.2% in the Northern Cape.

Inequalities in access to health care services

Therefore, although apartheid ended in 1994, there is still a massive structural inequality in access to health care services, as reflected in the table on the opposite page:
The high cost of private health care creates inequalities even between those who are members of medical schemes. Thus, lower-income earners contribute disproportionately to medical schemes.

Example: Unequal payments
- For people with a low monthly income of R2 000, almost 40% goes to paying the premiums of a medical scheme.
- For people earning over R15 000 a month, less than 10% goes to premiums.

Most of the private companies that offer health care services regard these services as a commodity to be sold for a profit. By contrast, the government has a duty to provide access to health care because it is a right in our Constitution. As with private access to care, the health care services provided by the government must be paid for by individuals and by the government – but here the aim is to improve access, equity, quality and sustainability of care, rather than profits.

Against the background of this historical inequality, the government’s constitutional duty to protect and fulfil the right of access to health care services means that it should:
- address problems in the public sector; and
- regulate the private sector with the aim of bringing to an end the inequitable and unaffordable distribution of health care services.

This chapter will describe the structure of the private health care sector, its impact on health care, the legislative and policy related steps that the government has taken to address some of the problems, and changes that still need to be made in order to achieve an equitable system. While the characteristics of the private sector hinder the pursuit of equitable access to
health care services, this need not be so. Regulating the sector in a manner that reduces inefficiencies and utilises wasted resources to the benefit of the uninsured will provide an important boost to the public sector. The private sector is an inextricable component of the health system and has an integral role to play in increasing access to health care services.

6.2 The evolution of the system of private health care in South Africa

For many people, the term private health care paints a picture of high quality services, personal attention to patients and “state of the art” facilities. In contrast, public health care often conveys an image of overcrowded waiting rooms and hospitals, and sub-standard health care services.

This picture, although understandable, is not totally accurate. Although private health care is always expensive, it is not always of a high quality – and although public health care is under-funded and dilapidated, public health policies are often more rational and its staff more community-orientated.

However, there are now many indicators that demonstrate that the quality difference between these two systems is so great that the Government needs to intervene. This is further required by the fact that during the final years of apartheid, the National Party government deliberately fostered an environment encouraging the growth of private health care at the expense of the public sector.

Chapter 1 showed how, under apartheid, the public health system generally offered a high standard of care for white people, but denied care to black people. But during the 20th century, there was a steady drift of white people to a growing private health sector that they could afford. Thus by 1960, 80% of whites had medical scheme cover. At the same time, 95% of black people were reliant on the public sector.

Perhaps as a reflection of this trend in the late-1960s, the apartheid state began to introduce legislation to regulate medical schemes – initially with the aim of protecting the white health user. The Medical Schemes Act 72 of 1967 prescribed:

- Minimum benefits.
- Reasonable rates of reimbursement to medical providers by the schemes.
- Outlawing the use of “risk-rating”, that is, excluding people known to have poor health or at risk of poor health from membership, or by increased premiums.
However, in the dying years of apartheid, the government introduced two significant Acts to deregulate health care in the private sector. In 1989, an amendment to the Regulations of the Medical Schemes Act removed the prohibition against risk-rating, thus increasing the contribution costs of vulnerable groups (mainly the sick and elderly at this time). In 1994, a further amendment removed the statutory requirement of minimum benefits. As a result, the medical schemes were allowed to provide health care services and run their own health facilities without state intervention.

These “reforms” encouraged a drift towards selling health services for a profit. They further entrenched the inequalities in health care generated by apartheid.

Profiting from health care

Between 1974 and 1990, the membership of medical schemes grew from 2.5 million to nearly 6 million people. So did their potential profitability. This led to the growing use of outsourced service providers, known as “administrators”, to manage the logistics of processing member claims and contributions. The administrators were, in turn, a further cause of increasing costs.

By law, medical schemes are supposed to be not-for-profit entities. But their administration by companies that are profit-driven has driven up costs – and the possibilities for making profits from health.

Linked to these changes were changes in the structure of medical schemes themselves. Historically, medical schemes were “closed”, with membership restricted to a certain group of people – employees in a company, for example. However, from around the mid-1990s, there was a growth in the number of “open schemes”, with membership open to anyone who could afford to pay the premiums. In this context, schemes took advantage of their new rights to “risk rate” and increasingly discriminated in admitting members.

Example: Medical scheme exclusions

- By 1999, no open scheme enrolled individuals over the age of 55.
- Throughout the 1990s, most medical schemes refused membership to people with HIV – or drastically limited their benefits.

Another significant development during this time was the entry of profit-seeking insurance companies into the market for health services. They took advantage of the fact that the legal requirements for operating insurance companies were not as strict as the requirements for medical schemes.
Companies began to see a market for clients who were interested in health insurance that would cover their specific condition. In other words, none of the usual benefits of the medical schemes were needed, such as coverage for doctor consultations, or purchase of medicines. For example, a person at risk of heart disease could receive a lump sum payment upon having a heart attack and being hospitalised. These are sometimes called “stand-alone” insurance products.

This gave rise to a further group of intermediaries – health brokers. Health brokers are in the business of selling medical insurance, either through medical schemes or insurance products. Since brokers are now not allowed to earn a commission on increasing the membership of a medical scheme (as a result of Medical Schemes Act regulations), there are incentives for health brokers to sell health insurance products instead.

Thus the consequence of the 1989 and 1994 deregulation was the growing exclusion of the sick, the elderly, the poor, women and people with chronic conditions from inadequate health care, a decrease in benefits, higher premiums and an upward spiral in non-medical expenditure.

Examples: Results of deregulation

- Between 1992 and 1998, there was a 243.5% real increase in non-health expenditure (the cost of brokers and administrators) by medical schemes, with only a 6.5% increase in beneficiaries.
- In 2003, the cost of scheme administration fees was R4.5 billion.
- Brokers’ fees increased by 64% from R354 million in 2002 to R581 million in 2003.

Ironically, all these trends reinforced and deepened apartheid in health care – even though the apartheid system had formally ended.

Private health sector and its dependency on the public health system

Some people argue that rising costs and the growing exclusivity of private health care are the result of a free market and cannot be challenged. They feel that people have a right to choose and buy better health care if they can afford it. But this argument overlooks the various ways in which private health care is subsidised by the Government.

Although there appears to be a clear separation between public and private care, the reality is that the private and public sectors influence each other.
Key Points: Overlaps between private and public health

Government subsidises private medical schemes through tax benefits to companies. High-income earners benefit the most from this arrangement since the more expensive the product, the greater the subsidy.

The private sector employs medical practitioners, who were originally trained at the public expense. As a result, the public sector loses its investment in training health professionals.

Public servants receive contributions to the medical scheme of their choice. However, only higher-income public servants can afford this benefit. As a result, about 50% of public servants and their families do not benefit. Nevertheless, currently, public servants and their dependants make up 25% of all members of medical schemes.

The Government often contracts with private organisations to provide hospital care and the use of private facilities. It also contracts private health professionals to provide periodic service in the public sector ("sessional" doctors).

Public sector health workers often "moonlight" in the private sector in order to supplement their income.

When private patients are referred to the public sector for treatment, the medical scheme must pay the full cost of the service. This is one of the few ways in which the public sector can benefit from private sector financing – except that most medical schemes use only private hospital facilities.

Because the public and private sectors are part of a single system, when there is an imbalance that favours the private sector, it necessarily has a negative impact on the public sector.

The flow of resources (both financial and human resources) between the public and private sectors is very skewed. More public resources flow into the private sector than the other way around. In order for the Government to fulfil its duty to ensure that “everyone [who] has a right of access to health care services” does in fact gain that access, it is necessary to address this inequality. This means the Government has a duty to introduce legislative and policy measures to redistribute resources and reduce the parasitic nature of the private sector.
6.3 The Government’s constitutional duty to create equity in access to health care services

The 1997 White Paper for the Transformation of the Health System in South Africa says that one of the aims of health policy in the new South Africa is “promoting equity by developing a single, unified health system”. It also explains that the health policy aims to:

“integrate the activities of the public and private health sectors, including NGOs and traditional healers, in a way which maximises the effectiveness and efficiency of all available health care resources”; and to “establish health care financing policies to promote greater equity between people living in rural and urban areas, and between people served by the public and private health sectors”.

Key Point: Meaning of equity in health care
Essential health services and goods should be made available to all people according to their need, and people should not be disadvantaged by their class, race, gender or where they live.

The World Health Organisation defines equity as:

“The absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically; thus, health inequities involve more than inequality – whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health – but also a failure to avoid or overcome such inequality that infringes human rights norms or is otherwise unfair.”

The main purpose of trying to achieve equity therefore is to reduce differences in health status and access to health services between groups of people. In South Africa, this means addressing the health needs of the most disadvantaged groups as a priority. It also means that health differences that are avoidable or clearly unfair must be dealt with as soon as possible. This principle is embodied in the right of all people to “an essential package of health care services”, as articulated in the National Health Act.

For a more detailed explanation of the National Health Act, see Chapter 4.
Fortunately, this is not just a moral duty. The Government’s firmest obligations to achieving equity by regulating private health care flow from sections 27 and 9 of the Constitution. Section 27(1) states that “Everyone has the right to have access to … health care services, including reproductive health care”. It instructs the state to “take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights”.

The right to equality

However, when trying to make sense of the meaning of these duties, it is also important to take note of what the Constitution says about the right to equality. Section 9, known as the “equality clause”, states that everyone is equal before the law. But the most important part of the clause says that:

(2) “Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.” (Emphasis added.)

If we read sections 27(1) and 9 together, it is clear that protecting and fulfilling the right of access to health care services requires the Government to take steps to tackle inequality. The Constitutional Court has recognised the key role of the equality right in addressing socio-economic disadvantage and the duty that rests on the whole of society. In Minister of Finance v Van Heerden 2004 (6) SA 121 (CC) the Court stated:

“When our Constitution took root a decade ago our society was deeply divided, vastly unequal and uncaring of human worth. Many of these stark social and economic disparities will persist for long to come. In effect the commitment of the Preamble is to restore and protect the equal worth of everyone; to heal the divisions of the past and to establish a caring and socially just society. In explicit terms the Constitution commits our society to ‘improve the quality of life of all citizens and free the potential of each person’.” (paragraph 23)

In Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs 2004 (4) SA 490 (CC) the Constitutional Court stated:

“Our Constitution recognises that decades of systematic racial discrimination entrenched by the apartheid legal order cannot be eliminated without positive action being taken to achieve that result ... The effects of
discrimination may continue indefinitely unless there is a commitment to end it.” (paragraph 74)

The interpretation of the right to equality by our courts gives force to the notion of substantive equality – that is, that the right to equality does not mean treating everyone identically for to do so, would further entrench socio-economic, race and gender inequalities that already exist. We cannot treat everyone as equal because they are not. Inequality pervades our society and cannot be tackled by the state alone. Section 8 of the Constitution provides that the “Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state”. It goes on to provide in subsection (2) that “[a] provision of the Bill of Rights binds a natural or juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of the duty imposed by the right”.

Of all rights, the nature of the right to equality is such that it cannot be seriously addressed without the participation of society as a whole, and especially by drivers of inequality. It is therefore arguable that it is constitutionally mandated and appropriate that the private sector should be regulated in order to reduce inequality.

Since 1994, there have been many changes to the law that aim to reduce public-private inequities. These are explained later in this chapter. But before we do that, it is necessary to describe the institutional framework of the private sector.

### KEY PRIVATE HEALTH SERVICE ORGANISATIONS

**The Hospital Association of South Africa (HASA)**
HASA has a membership of 183 hospitals (private groups and independent hospitals) and clinics. It is the official representative of the private hospital sector.

**The Board of Healthcare Funders (BHF)**
The BHF is a not-for-profit association that represents more than 95% of all medical schemes in South Africa, Namibia, Botswana and Zimbabwe. In South Africa, these schemes have approximately seven million beneficiaries. The BHF used to set tariffs for health care services as a “guideline” to its members. It has a Forensic Management Unit to address fraud and inappropriate behaviour by its members.

**The National Association of Pharmaceutical Manufacturers (NAPM)**
In South Africa, generic manufacturers are represented by a separate organisation known as the National Association of Pharmaceutical Manufacturers (NAPM).
6.4 The structure of private health care – providers and funders

In South Africa, the system of private care can be divided between:
- providers – those who provide health care services and the institutions that represent them; and
- funders – the systems and organisations that finance people using private health care.

As we examine this framework, we should realise that, although most of the users of private health care are well off, there are also many poor people who access the system. They do this largely because of the failures of public health. This adds to the duty on the state to regulate private care and prevent abuses.

Providers of private health services

As with public health care, private health care providers supply the full range of care from diagnosis by an appropriate medical practitioner (eg general practitioners, traditional healers, specialist physicians, neurologists, cardiologists), pathology services, to pharmacies, treatment options, surgery and the maintenance of health. But unlike the public health system, the institutions that offer these services are often independent of each other, sometimes in competition, and most of them aim to make profits from their services.

The Pharmaceutical Society of South Africa (PSSA)
The PSSA represents pharmacists. The PSSA was a party to the litigation against the Minister of Health regarding the validity of the medicine pricing regulations.

See pages 182-183 of this chapter and Chapter 14 on access to medicines.

The South African Medical Association (SAMA)
SAMA is a voluntary association that represents medical doctors. SAMA is also a registered trade union affiliated to the Congress of South African Trade Unions (COSATU). According to SAMA, about 70% of all doctors are members.

The National Pathology Group (NPG)
The NPG is an official subcommittee of SAMA. Most private pathologists are members of the NPG. The NPG sets tariff and fee billing structures in closed negotiations with the BHF.
Private hospitals, for example, are run by large corporate groups such as Netcare, Afrox, and Medi-clinic that aim to make a profit. In addition, there is a smaller number of for-profit independent hospitals, as well as a number of private health services contracted to the public sector (e.g. LifeCare).

All health professionals are subject to regulatory authorities, regardless of whether they work in the public or private sector. But in addition, in the private sector there are a number of associations responsible for representing and self-regulating their members.

Most of these voluntary organisations have codes of ethics and internal disciplinary and investigation procedures. However, they also play a major part in lobbying around health policy and law – usually trying to preserve the vested interests of their members. These interests do not always coincide with public health policy.

From 1994 to 2006, several of these organisations were directly involved in litigation against the government to try to maintain the situation inherited from apartheid. For example, in 1997, 40 multinational drug companies under the PMA launched legal action to try to stop the government from introducing legislation to make generic medicines more readily available.

The Competition Commission has investigated several of these institutions, including HASA, the BHF and SAMA, for engaging in anti-competitive practices. The investigation confirmed that their role is more to represent the financial interests of their members than to ensure their conduct is in line with legislation, the Constitution and ethics.

In 2005–2006, the NPG was under investigation by the Competition Commission. Because there is no statutory regulatory authority governing pathologists, the outcome of this investigation will be important.

For more on how competition law governs the conduct of private health organisations, see pages 189–191 of this chapter.

**Mechanisms that fund access to private health services**

Private health care is expensive and people have access to it through:

- membership of medical schemes and other forms of health insurance
- out-of-pocket expenditure
- access at their workplace
- non-profit organisations and NGOs.
In 2003, 47% of all health expenditure was via medical schemes. Another 14% was out-of-pocket – meaning that 61% of all health spending is paid for privately, and spent on private services.

We look briefly at each of these funding mechanisms.

**Medical schemes**

Contributions to medical aid schemes are the key source of financing in the private sector. Since 1994, the operation of medical aid schemes has been the subject of major reforms that we explain in more detail in this chapter.

**Health insurance**

South Africa is following the trend of countries like the USA, where there is a growing number of commercial health products sold by insurance companies. The range of benefits available varies. For example, an individual can purchase a “hospital plan” which will not cover the cost of day-to-day consultations with health professionals or treatment. However, if a person needed hospitalisation, all costs would be covered.

Health insurance is sold by brokers, who earn a commission from sales. These brokers often have little or no understanding of health or medicine.

It is important to be aware of the difference between health insurance and medical aid. They differ in the periods of cover they offer, the manner in which they select members and the rules that govern their products.

Examples: Differences between medical aid and health insurance

- Health insurance aims to be profitable by attracting people with lower risks of ill health as members (the "young and affluent").
- Medical schemes are not supposed to be in the business of making profit and may not "risk rate" in this way.
- Medical schemes must cover their members against all conditions and provide prescribed minimum benefits (PMBs).
- Health insurance may cover you only for a specific medical event.

Before 1998, health insurance was not regulated in the same way as medical schemes. However, the Medical Schemes Act of 1998, the Long Term Insurance Act of 1998 and the Short Term Insurance Act of 1998 drew a clear legal distinction between health insurance and medical aid. This aimed to prevent the insurance industry from “cherry-picking” the young and healthy, thereby increasing the cost of medical schemes. Today, the Council for Medical
Schemes (CMS) exercises control over which products are registered as medical schemes and which as insurance products.

**Out-of-pocket contributions**

A significant amount of spending on private health is through the direct purchase of health services or medicines – what we call *out-of-pocket expenditure*. In 2001, this accounted for 22.1% of private health expenditure, up from 19.7% in 1997.

Out-of-pocket expenditure usually refers to:

- Individual cash payments to health care providers.
- Co-payments (where the medical scheme member pays a percentage of the cost of the health service).
- Paying for over-the-counter medications.

Those who pay for health services in this way tend to be the lower-income earners who cannot afford medical scheme cover, or other vulnerable groups who have no or inadequate cover. The government has a duty to protect these groups from rising costs.

**Workplace programmes**

In the past, many companies, particularly in the agricultural and mining sectors, provided health care services directly to employees. These services took the form of on-site clinics or mobile clinics, or off-site through an agreement with a doctor or health facility. As with medical schemes, private health companies contracted to provide health services and facilities dominate workplace programmes.

However, except in the mining sector where health services included hospitalisation, workplace programmes typically provided no more than primary health care. They were also usually available only to employees and not their dependants.

The main reason for the emergence of workplace programmes was the drive by the trade unions in the 1980s to improve access to health services for workers – something not otherwise possible for black people under apartheid. Employers also provided health care in order to respond to occupational health and safety issues, as well as to prevent a reduction in productivity as a result of workers having to travel long distances to access basic health services.

However, as the number of open medical schemes grew, many employers transferred their responsibility for employee health to medical schemes that
were paid for as an employee benefit. Thus, with the exception of the mining sector, there has been a significant decline in access to health through workplace programmes.

Predictably, with the cost of medical schemes, it is lower-income earners who suffered. In 1998, the percentage of the workforce with access to workplace programmes was under 50%. Large factories employed the majority of these workers in the wealthier, industrial provinces such as the Western Cape and Gauteng. Thus the inequities between urban and rural areas evident in other areas of the health system were felt equally in workplace programmes.

Key Points: Joint responsibility of business and government

- Providing health care and promoting health should be seen as a duty of employers – a shared responsibility with the state. Workplace health programmes can reduce the burden on the public sector by providing basic health services to employees as well as their dependants.
- In the 1990s and 2000s, the growth of the HIV/AIDS epidemic led to increasing pressure on businesses to offer HIV care and treatment to employees. This was particularly important in support of the eventual national treatment plan for the rollout of antiretroviral medicines (ARVs).

**NGOs and charitable organisations**

For some people, access to private health care can be obtained through not-for-profit companies and faith-based and charitable organisations. These organisations have often arisen to fill a particular gap in providing health care, or to target populations who otherwise have limited access to health care services.

Examples: Service organisations

- The TAC Treatment Project is a Section 21 Company that was established by the Treatment Action Campaign (TAC) to begin to make ARVs available to people living with HIV/AIDS in South Africa.
- The private international humanitarian organisation, Médecins Sans Frontières (MSF), provides emergency medical aid to people who need it in over 80 countries. It also works together with local personnel to strengthen health systems and train local health care workers.
6.5 Legislative reform and regulation of private health care since 1994

According to the White Paper, the principle governing the integration of public and private health is that:

“the activities of the public and private health sectors should be integrated in a manner that makes optimal use of all available health care resources. The public-private mix of health care should promote equity in service provision”.

This statement is significant. It means that, while the Government recognises the existence of the private sector, it believes that its activity should work to assist rather than undermine the public sector, and that the two should work in a complementary fashion.

In this part, we deal with legislative measures the Government has taken to increase regulation of the private sector in order to make access to health care more equitable.

The Medical Schemes Act

In 1995, the National Health Insurance Committee of Inquiry made an assessment of the health system and recommendations for reform. The policy direction that the Department of Health has followed subsequently is largely based on the findings of this Committee. The most immediate result of the policy shift was an overhaul of legislation and the passing of the Medical Schemes Act of 1998 and its related Regulations that came into full effect in 2000.

The 1998 Medical Schemes Act re-regulated medical schemes in the face of tremendous opposition from the insurance companies that underwrite medical aid schemes. The new Act reintroduced mechanisms that aimed to make access to health services more equitable.

The new Act aimed to:

- Provide for registering and controlling some activities of medical schemes.
- Co-ordinate schemes.
- Protect the interests of members of medical schemes.
- Establish a Council of Medical Schemes.

The new Act also aimed to bring about change in the medical scheme industry through the use of open enrolment – this requires medical schemes to accept all eligible applicants. It also introduced community rating – this means that
schemes may not discriminate on the basis of health status, but allows differentiation based on income and the number of dependants of an applicant. For example, a person cannot be denied admission to a scheme because she is black, or old, or a woman, or has a chronic illness.

In addition, the Act says schemes must provide a package of prescribed minimum benefits (PMBs). These are a detailed set of treatment and care protocols covering the most common medical conditions that members are entitled to, regardless of their level of cover. From January 2005, this included ARV treatment.

The Act allows fair discrimination but prohibits unfair discrimination. For example, schemes are allowed to set an exclusion period of between 3 months to a year for people who have never had medical aid before. They can ask people to pay higher premiums if they are older and therefore more likely to need medical care.

Key Point: Broader definition of “dependant”

The Act broadens the definition of “dependant”:

“the spouse or partner, dependent children or other members of the member’s immediate family in respect of whom the member is liable for family care and support; or any other person who, under the rules of the scheme, is recognised as a dependant of a member”.

This definition moves away from the traditional idea of a nuclear family, and it means that a person can register a niece, for example, as a dependant if she is under his or her care. It also means that gay and lesbian partners cannot be discriminated against in access to schemes.

The Council for Medical Schemes

In order to address the historical imbalances in the private sector, the Act strengthens regulatory requirements and aims to improve governance and accountability of the schemes.

The Council for Medical Schemes (CMS) is the main body tasked with monitoring medical schemes. It has up to 15 members with varying skills, such as expertise in law, accounting and economics. The Registrar is the executive officer of the CMS and manages its affairs. The functions of the Council are to:

- Protect the interests of beneficiaries of schemes.
- Control and co-ordinate the functioning of medical schemes.
- Advise and make recommendations to the Minister of Health on issues that relate to medical schemes, including quality of health services.
Investigate complaints and settle disputes.
Disseminate information relating to private health care.

The Act recognises that controlling the rising costs of members’ premiums is an issue of governance. Certain of its sections attempt to address the problem of the rising costs of non-health expenditure as a proportion of the total expenditure of schemes – costs which are often carried by members through increased contributions, but without any improvements in benefits. For example, the Act says that:

- All administrators (such as Medscheme) must be accredited by the CMS.
- Brokers must be accredited by the CMS.
- The Minister of Health can determine the amount of compensation paid to a broker.
- A statement of account must be supplied to all members.
- The CMS must oversee reinsurance agreements, taking into account the best interests of the members.

The Act also allows the Registrar of Medical Schemes, with the agreement of the Council and the Minister, to declare certain business practices undesirable.

Example: Controlling prices

Before the Medical Schemes Act was passed, the BHF and SAMA set tariffs for health services. This meant that doctors and other health service providers would use the tariff list and charge the scheme a set tariff for services provided to a user. Now, the set tariff is no longer permissible because it contravened the Competition Act.

Instead, as an interim arrangement, the CMS is administering a National Price Reference List. This means that all providers have to negotiate independently with the CMS and agree on reasonable tariffs. The health provider may still require less than the stated tariff if he/she chooses.

Remaining problems with costs

The 1998 amendments to the Medical Schemes Act have brought about important changes to the principles by which medical schemes operate, but they have not stopped rising costs. There are several obvious reasons for this.

Firstly, the firms that administrate medical schemes operate for profit even though the scheme itself is not for profit. In 2002, administration fees accounted for about two-thirds of non-health expenditure. The Act gives the CMS a regulatory role over administrators, but this has not prevented non-health expenditure from continuing to increase.
Reinsurance
Secondly, in order to protect against unexpectedly high claims, medical schemes insure themselves with other insurers. This is called reinsurance. Reinsurance is a private contract from which the external insurer expects to make some profit.

There are legitimate reasons for reinsuring. For example, small schemes may not have a wide enough membership to provide adequate risk-sharing, for example where there is a large pool of members, and the younger and healthier subsidise the old and sick.

But it has also been recognised that this process has been open to abuse by administrators. For example, some companies may have a business relationship with the external insurer, both the administrator and the insurer may be owned by the same parent company, or they may have a profit-sharing agreement.

In other words, reinsurance became a loophole that allowed administrators to channel money out of a scheme to another companies’ shareholders – rather than back to the scheme’s members.

Key Point: Controlling reinsurance
In recent years steps have been taken by the CMS to control this practice so as to remove profit-making arrangements. All reinsurance agreements now have to be submitted to the CMS for approval.

Some of the reforms currently being considered by the Government will hopefully address these problems.

Lack of competition
In addition, the market for various health services (such as hospital and pathology services) is concentrated, which means that there is less competition among the providers of these services, which ordinarily drives down prices.

The next section of this chapter deals with the role of competition in the health sector.

The Medicines and Related Substances Control Act
Historically, the Medicines and Related Substances Control Act 101 of 1965 (the Medicines Act) was meant to ensure the safety, efficacy and quality of medicines. However, the rising price of medicines, together with the constitutional duty on the government to make health care more accessible, meant that a vehicle was needed to regulate medicine prices as well. In 1997,
Parliament amended the Medicines Act in order to increase access to affordable medicines, by introducing the Medicines and Related Substances Control Amendment Act 90 of 1997.

For more about the controversial history of this Act, see Chapter 14.

In 2004, after the Act had eventually been brought into effect, the Government promulgated new regulations governing medicine pricing (Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances). These regulations have also been controversial.

**Medicine Pricing Regulations**

The regulations require that there should be a “single exit price” (SEP) for each medicine. This means that the price of a medicine is known from the moment it leaves the manufacturer, and cannot be arbitrarily increased by pharmacies or dispensing doctors. The SEP must include the cost of the medicine’s manufacture, distribution and value-added tax (VAT).

The coming into effect of the SEP in 2005 also eliminated the system of bonuses, rebates and discount practices that had previously affected the cost of medicines. However, it does not require transparency in the determination of prices by the manufacturer.

**Dispensing Regulations**

These regulations provide for a maximum dispensing fee to be charged by pharmacists:

- Initially, this fee was set at 16% of the SEP of a non-prescription medicine that costs less than R100, and R16 for those that cost R100 or more.
- For prescription medication, the fee is 26% of the SEP for medicines less than R100, and R26 for those that are R100 or more.

For more on the scheduling of medicines, see Chapter 14.

The aim of these regulations was to end the practice of percentage-based mark-ups that meant that the higher the cost of a medicine, the higher the mark-up would be.

In 2004 and 2005, the regulations governing dispensing fees were the subject of litigation between pharmacies and the Minister of Health. The pharmacies challenged the constitutionality of the regulations. They questioned whether the regulations would lower the price of medicines, and argued that the dispensing fee had been set arbitrarily and was so inappropriate that it would drive smaller community pharmacies out of business.
The pharmacies succeeded at the Supreme Court of Appeal, and the Minister of Health appealed to the Constitutional Court. Eventually, in September 2005, the Constitutional Court ruled that the dispensing fee was inappropriate and ordered that the fee should be referred back to the Pricing Committee. This was another blow for the Minister of Health, but what was equally important was that the Court declared that it:

“unanimously accepted the validity of a single exit price being established for medicines sold in SA, and the validity of the regulatory structure put in place for its realisation.” (paragraph 14)

The Treatment Action campaign intervened in this litigation as an amicus curiae before both the Supreme Court of Appeal and the Constitutional Court. The argument of the TAC sought to provide a via media between the profit concerns of the pharmacies on the one side and the regulatory concerns of the government on the other. A key issue for the TAC was that the regulations did not distinguish between different types of pharmacies. For example, pharmacies that service rural areas are not corporate-owned and do not have large front-shops (where items such as cosmetics and even swimming pool cleaning aids are sold) to supplement their pharmacy practice. Their main function is to dispense medicines. The dispensing fee therefore affected their economic viability and if they were to close, this would seriously restrict access to medicines in outlying areas. In other words, while the regulations were motivated by the need to increase affordability of medicines, this might result in restricting the availability of medicines.

The revised dispensing fee was announced in October 2006, and can be accessed at www.doh.gov.za.

In December 2006 a group of pharmacist associations filed an urgent application in the Pretoria High Court challenging the appropriateness of the dispensing fee, which is meant to come into operation in January 2007.

See Chapter 14 for more on the dispensing fee regulations.

Dispensing doctors

Another area in which questionable practices had developed over time concerned the dispensing of medicines directly by doctors, rather than by pharmacists. In addition, because private doctors are reimbursed by medical schemes for the services they provide (“fee-for-service” reimbursement), there is an incentive to provide services that are not necessary.

Doctors are able to do this because most people do not understand medicine. They do not have sufficient knowledge to question the interventions that the
Doctor undertakes. There is an unequal power relationship and generally a patient will put his or her trust in a professional to do whatever is necessary for the patient’s good health.

Doctors are also flooded by marketing incentives by pharmaceutical companies that have an army of salespeople touting medicines and encouraging their use in return for free or cheaper medicines. Importantly, in rural and peri-urban areas, it is necessary for doctors to dispense medicine since there are few pharmacies available and the distance to travel may be a hardship for the patient.

To overcome these problems, the dispensing regulations required that all doctors apply for a dispensing licence if they wanted to continue to dispense medicines. This too led to a court challenge.

In 2004, the regulations requiring doctors to apply for a dispensing licence were challenged in the Constitutional Court. In 2005, the Court ruled unanimously that most of the regulations were valid, finding that the Medicines Act gave the Minister power to make regulations necessary to ensure the safety, quality and efficacy of medicines.

The Medical, Dental and Supplementary Health Services Amendment Act

The Medical, Dental and Supplementary Health Services Amendment Act 89 of 1997 introduced the requirement of two years of community service by newly qualified health practitioners. This enables health professionals to experience a broader range of services than they would normally have in a university setting. It also provides for interaction between the private and public sectors.

The Pharmacy Amendment Acts

The Pharmacy Amendment Act 88 of 1997 allowed for ownership of pharmacies by non-pharmacists. This aimed to improve the distribution of pharmacy services in rural and outlying areas. The Pharmacy Amendment Act of 2002 extended the community service required of doctors to pharmacists. [Author: Is “2002” correct? Should it not be Act 1 of 2000?]

These amendments to legislation have had some positive effects on the private health care industry and on access to health care generally. However, many problems still remain. Unfortunately, the changes seem not to have succeeded in altering the basic structure of inequality in the South African health system.
6.6 Competition law and the private health system – the Competition Act

In the introduction to this chapter, we explained how the private health sector is primarily driven to make profit, rather than to provide equitable quality care. Because it is essentially a collection of companies, it is subject to the same market trends and behaviours as companies working in other sectors, such as the manufacture of cars.

Most private companies are in competition with each other. But in order to make profits stronger, companies sometimes collude unfairly to strengthen their position. This is often to the disadvantage of the consumer, whether it is a person who needs a car or a medicine. The difference though is that a person who cannot afford a car will take a bus or taxi. A person who cannot afford health care will possibly die.

Recognising these facts of life and their negative effects on individuals and the economy as a whole, led the government to introduce a new Competition Act 89 of 1998. This Act has already demonstrated that it can have a major impact on regulating private health care. But before we look at its impact on health, it is necessary to sketch a bit of background to competition law.

Introducing competition law

In any capitalist economy like South Africa, the market involves free trade between people in goods and services. People’s needs for certain goods determine what is manufactured, how resources are going to be allocated in the production process and to whom those goods are going to be distributed or sold.

The price of goods and services will be determined by changes in the relationship between the supply of a product and the demand for it. For example, the greater the supply of a product and less the demand, the less the price of the product will be. Alternatively, a great demand but limited supply, perhaps because there is only one supplier, will also cause high prices.

But in modern markets supply and demand can be manipulated to influence price. Companies in competition with each other try to take legal (and sometimes illegal) steps to influence supply and demand. They also take advantage of inequalities in the market, for example:

- The ignorance of consumers in respect of products such as medicines that are complex and scientific.
The vulnerability of people depending on the advice of intermediaries, such as doctors, about what to buy.

On the supply side, there may be a situation where there is just one supplier of a product. This is called a *monopoly*. That supplier is then able to set the price of the product as high as possible to ensure greater profitability. If the demand for that product is driven by an essential need, such as to eat or be healthy, then high prices will exclude the poor and create fundamental inequalities.

There are also situations where just a few suppliers of a product, such as modern hospitals, dominate an industry. This is called an *oligopoly*.

Where there is no competition or imperfect competition, then the dominant firms can affect other producers and consumers adversely. This often means that people have less choice about what they buy and must pay higher prices.

**Key Points: Aim of our competition law**

- Competition law in South Africa and internationally aims to structure and control the market so as to increase and protect competition. The value of competition should be that it enhances consumer welfare by making goods and services more accessible and affordable.
- Our Competition Act recognises this by including the objectives of providing consumers with “competitive prices and product choices” and the “advancement of the social and economic welfare of South Africans”.
- In relation to health care, it specifically links the functioning of the economy to the Bill of Rights in the Constitution.

**The Competition Commission and Tribunal**

The Competition Act created the Competition Commission as the statutory body responsible for investigating anti-competitive practices in the economy. The Commission is an independent and impartial body that has a range of functions, including the investigation of allegations of prohibited practices made by the public or other stakeholders in the market.

After an investigation, the Commission may refer complaints to the Competition Tribunal for adjudication. The Tribunal may determine whether a prohibited practice has occurred and may impose a remedy under the Act. It may also determine whether a merger between companies should be approved or not. If a party is dissatisfied with the decision of the Tribunal, it may appeal to the Competition Appeal Court.
Prohibited practices

The Competition Act declares that “restrictive horizontal practices”, “restrictive vertical practices”, and “the abuse of a dominant position” are prohibited:

- A restrictive horizontal practice is where companies in a horizontal relationship (e.g., two competing pathology laboratories) agree, directly or indirectly, to fix the price of a product or service in the market. The complaint against the pathology sector, referred to in more detail below, is an example of this.

- A restrictive vertical practice refers to the situation where companies in a vertical relationship, say a manufacturer and a wholesaler, collude against other companies. An example of a restrictive vertical practice is when a drug manufacturer and wholesaler agree that the wholesaler will buy products exclusively from the manufacturer, thereby preventing competition with other companies that may be able to offer lower prices or better goods.

- Abuse of a dominant position describes the conduct of a big company when it aims to unfairly prevent smaller companies from competing with it. Or it may involve a situation where a company uses its dominance to set prices that adversely affect consumers, but which they have to pay because there is no competition.

CASE STUDY: COMPLAINT ABOUT THE CONDUCT OF THE NATIONAL PATHOLOGY GROUP

Three private companies (Lancet Laboratories, Ampath Laboratories and Pathcare Laboratories) make up about 80% of the private pathology industry. Each of these companies is also a member of the NPG. In 2005, the pricing practices of this sector were under investigation by the Commission after a complaint was lodged by the AIDS Law Project on behalf of the TAC in 2004.

The TAC complaint alleged:

- Price-fixing by the NPG amongst its competitors.
- The use of expensive diagnostic and monitoring tools where cheaper alternative technologies exist.
- Collusion between private hospitals and laboratories (especially where the hospital companies have investment interests in the laboratory) to exclude competitor laboratories from the hospital premises. This limits consumer choice and increases prices.

At the time of publication, the Commission had decided not to refer the complaint to the Tribunal. However, as a result of the complaint and the Competition Commission investigation into private health practices the NPG was required to submit information about costs and prices.
Another way the Competition Act controls the market is by regulating mergers and acquisitions of firms – which may further concentrate a market. The Act says that the Competition Commission must be notified of proposed mergers so that it may examine whether it will substantially prevent or lessen competition – and if it does, whether there is any justification.

Among other factors, the Commission will consider public interest grounds in approving a merger or not. The bigger the merger, the more closely it will be examined. Recently, for example, the Competition Tribunal prohibited a merger between two health care companies on the grounds that it could prejudice access to affordable medical care in the lower-income market. In its judgment, the Tribunal stated that:

“We are, to state the obvious, dealing with a transaction in a market that is central to the interests of the state, to the private sector and ordinary consumers.”

*Medicare Healthcare Group v Prime Care Holdings*, Case No 11/LM/March 2005, paragraph 72

On the position of the private sector in the health system, in the same case, the Tribunal stated the following:

“The reality – and possibly the only agreed certainty in the fraught debate surrounding the provision of healthcare in South Africa – is that the private healthcare system, and notably, although not exclusively, the private hospital network, is characterised by significant excess capacity, while the public healthcare system is simultaneously resource-constrained and increasingly unable to cope with the demands made of it.” (paragraph 53)
A merger or acquisition by a big company of a small company may also be cause for concern – especially if a trend can be shown of the bigger company acquiring smaller competitors. The immediate harm may not be felt, but in time it may result in the reduction of competitors in that market. This is sometimes referred to as “creeping mergers”.

**Impact of Competition Act**

What impact has the Competition Act had on the private health sector? The use of the competition framework to address anti-competitive practices in the health sector is still fairly new in South Africa. But this kind of regulation has taken place in other countries such as Canada, the United Kingdom and the United States.

However, in a few South African cases, the private health sector has come under the spotlight of the Competition Commission.

The investigations described above and their outcomes show that the competition framework is a useful mechanism to improve access to medicines and health care services. But the competition authorities need to do more to prioritise the private health industry in their investigations and deliberations. The need to prioritise basic services has been recognised by the Chairperson of the Competition Tribunal:

“It seems to me that the competition authorities need to have on their roll at any point in time a case that responds to spontaneous consumer dissatisfaction at the pricing of a basic commodity.”

Dave Lewis, Role of Civil Society in Co-operating with National Competition Authorities, INSCOC Workshop, January 2004

**CASE STUDY: COMPLAINT AGAINST GLAXOSMITHKLINE AND BOEHRINGER INGELHEIM**

In September 2002, the AIDS Law Project lodged a complaint before the Competition Commission on behalf of the Treatment Action Campaign (TAC), people living with HIV/AIDS, health care workers and various trade unions. The complaint was against GlaxoSmithKline and Boehringer Ingelheim, two multi-national drug companies, for charging excessive prices for a number of patented antiretroviral medicines (ARVs).

The complaint led to an investigation and a decision by the Commission to refer the complaint to the Tribunal. However, at this point the companies negotiated a settlement agreement to grant voluntary licences to generic manufacturers of ARVs. This has resulted in greater access to ARVs and competition amongst manufacturers in South Africa.

For details about this complaint, see Chapter 14.
Key Points: Stopping collusion between hospital groups and private laboratories

The annual report of the CMS for 2004–2005 stated that private hospitals and pathology laboratories are cost drivers in the private sector and have caused an increase in medical aid contributions:

- Three big cartels, Netcare, Medi-clinic and Afrox Health (Ahealth), control more than 80% of the private hospital market.
- This concentration of ownership creates a risk of collusion over the cost and type of service that will be offered.
- As recommended by the CMS, these facts deserve to be investigated by the Competition Commission.

According to the Council for Medical Schemes, hospitals account for about one-third of expenditure by medical schemes. This is partly explained by the fact that the cost of health care provided inside private hospitals has grown enormously.

The Council for Medical Schemes 2005 Annual Report shows that, since 1997, total hospital expenditure has increased by 103%. Including:

- ward fees – increased by 85%
- medicines – increased by 122%
- theatre fees – increased by 172%

These increasing costs have a negative impact on the cost of medical schemes that have increased membership contributions, in spite of regulations that are intended to decrease costs for consumers.

The growth in the number of private hospitals has serious consequences. It has depleted the resource flow to the public sector. It has created an overcapacity of hospital beds and a further concentration of health care services in urban areas (approximately 90%). In 2003, almost no benefits paid by medical schemes went to public hospitals – compared with 33.8% to private hospitals. This means that people who can afford to use private hospitals do this because of the poor condition of public hospitals, but this ends up depriving public hospitals of their much-needed resources.

As a result, in 2006 the DoH indicated that it was considering introducing legislation to limit the fees that hospitals may charge. Yet hospital groups argue that they owe it to their shareholders to operate profitably. This illustrates
two very different approaches to providing health care services – one that is based on health care as a business like any other, and the other with a social duty to ensure access to affordable health care.

**CASE STUDY: INVESTIGATION OF BHF, HASA AND SAMA**

In 2004, the Commission carried out an investigation into the health care sector. As a result, it concluded that evidence indicated that the BHF, HASA and SAMA were acting in contravention of the Competition Act by colluding to fix prices of health care services by setting tariff guidelines. This practice also prevented new service providers from entering the market as competitors.

The Commission decided to refer the case to the Tribunal. In response to this, a settlement was reached between the Commission, HASA and SAMA. In the settlements, administrative penalties of R4.5 million and R900 000 were levied against HASA and SAMA respectively. The BHF refused to agree to a settlement, and the Commission decided to refer the case to the Tribunal. However, the BHF responded by agreeing to settle, but without admitting guilt.

In the settlement agreement, the BHF agreed to:
- Stop its practice of setting tariffs.
- Inform its members (medical schemes) of this change.
- Discourage medical schemes from engaging in collusive activity.
- Commission an independent study on the range of charges and other factors to be considered in determining the cost of providing health care services.

### 6.7 Current and future health reform initiatives

Despite the legislative changes mentioned, the number of people that can afford to access medical schemes did not increase between 1994 and 2005. This means that the public sector is still the main provider of health services, but is denied the necessary financial and human resources.

The Government admits that it has underfunded the public sector. But this problem is made worse by the behaviour of the private sector. Both factors are contributing to the growing inaccessibility of private care. Thus, in 2006 the main obstacles to equality, equity and access remain:
- the rising cost of and declining benefits offered by private care; and
- the poor geographic distribution of health services.
In its Strategic Priorities for the National Health System 2004–2009, the Ministry of Health lists some of its main priorities as being to:

- Improve governance and management of the national health system.
- Contribute towards human dignity by improving quality of care.
- Strengthen primary health care, emergency medical services and hospital service delivery systems.
- Strengthen support services.
- Improve human resource planning, development and management.
- Tighten up planning, budgeting, monitoring and evaluation.

In these priorities, there is little direct reference to the need for further regulation of the private sector, despite the fact that success with these priorities is dependent on resolving the current imbalance between public and private.

Nevertheless, opportunities do exist in a number of other policy and legislative initiatives. These processes, which were incomplete at the time of writing, are described in the remainder of this chapter.

The Health Charter

In 2005, the DoH published two drafts of the proposed Health Charter (the Charter). The Charter aims to bring about further transformation of health services through a voluntary agreement between all the stakeholders (but mainly private sector) in South Africa involved in providing, financing and using health care. The stated objectives of the Charter are to increase equity, access and quality of health care services, and to increase black economic empowerment.

In July 2005, the Minister of Health, Dr Tshabalala-Msimang, presented the first draft of the Charter and said that its adoption would:

“commit us all to move towards a coherent, unified health system offering financial protection for all the population in accessing a nationally affordable package of health care at the time of need and to improve access to health care services in general”.

However, the early drafts of the Charter are concerned in the main with black economic empowerment rather than the pursuit of equity, access and quality. Civil society and union representatives argued that transforming the ownership of capital would not increase access to health care services, and that there is therefore a misplaced emphasis on this in the Charter.
The Charter process requires that all sectors sign on to the Charter in order for it to come into operation. The failure to reach consensus resulted in the disbanding of the Charter drafting committee, and the creation of a new Health Charter Steering Committee, which is made up of 40 people representing the private sector, public sector, labour and civil society. 25 of the 40 members represented the private sector, so the negotiations were weighted in favour of the private sector. In the middle of 2006, the Committee was still negotiating the text of the Charter. A key demand of civil society is to include a commitment by the private sector to assist in servicing an essential package of health care services. The detailed definition of the essential package is still to be determined.

The Health Charter is an important vehicle to engage the private sector in increasing access to health care services for the poor and uninsured. Outside of this however, it is within the government’s mandate to legislate a role for the private sector in the delivery of these services.

Towards Social Health Insurance

This chapter has demonstrated how medical aid remains unaffordable for the poor. In attempting to remedy this, the centrepiece of the policy framework on the funding of health care remains the DoH’s policy to introduce a system of Social Health Insurance (SHI). This was first proposed in 1995 by the Committee of Inquiry into a System of National Health Insurance and was reinforced in the recommendations of the 2002 Committee of Inquiry into a Comprehensive System of Social Security.

Key Points: The meaning of Social Health Insurance in South Africa

- It will become mandatory for all employers to make a contribution into a national fund that will pay for the cost of medical care for all employees.
- The aim is that more people will have access to medical care (either through public or private facilities), but that less people will be solely funded by the state.
However, this kind of SHI approach is criticised by organisations like COSATU that argue it will increase the cost of employing labour and result in further unemployment.

By 2006, this policy had not been fully implemented, although the DoH is in the process of introducing a number of reforms that are based on this broad vision. Important steps include:

- The requirement that medical schemes provide members with a set of prescribed minimum benefits (PMBs) that came into effect in 1998.
- The creation of a Government Employee Medical Scheme (GEMS).
- The setting up of a Risk Equalisation Fund (REF).
- Proposals for reform to tax subsidies for medical aid.

For more on PMBs, see pages 175 and 179 of this chapter and Chapter 8.

The Government Employee Medical Scheme (GEMS)

The government employs an estimated 550 000 people. But although all public servants get a medical benefit, in 2005 it was estimated that 380 000 of them earned salaries that were too low to afford to belong to a medical scheme. Those that could afford it belonged to one or other of more than 60 different schemes.

In order to change this, in January 2005 the Government registered a new medical aid scheme with the CMS that aims to become a single scheme for all public servants – the Government Employee Medical Scheme (GEMS).

In January 2006, this scheme officially came into operation and it is now mandatory for any new public service employee to be a member. However, although the vision is to have a single public service medical scheme, at this point civil servants who are members of other schemes are not being forced to join GEMS.

One problem with the GEMS is that it will not be open to municipal workers because they are employed by local municipalities – not national or provincial government. So, for example, street cleaners would be excluded from membership.

The GEMS is an independent scheme, subject to the same rules as all other schemes. But the Government hopes that its size (a potential one million members) and affordability will greatly extend access to private care, while at the same time creating more competition and lower prices in the private sector.
The private health care sector

The Risk Equalisation Fund (REF)

The introduction of PMBs meant that all schemes are legally required to provide their members with certain benefits. However, this requirement is likely to fall more heavily on schemes that have more members of people who are old or ill. This could affect their financial sustainability and thus the access of poorer and sicker people to medical care if schemes go bankrupt.

Therefore, to achieve greater fairness among schemes after the implementation of the PMBs, the government intends to introduce a Risk Equalisation Fund (REF) in 2007.

Key Points: How the REF will work

- Medical schemes with a younger and "healthier" membership profile (with less "risk") will contribute financially to an REF that will be administered by the Council for Medical Schemes.
- The REF will pay amounts to those schemes with an older or more "unhealthy" membership profile (those with greater "risk").
- The formula to determine contributions to and payments from the REF still has to be worked out.

South Africa will not be unique in using this type of mechanism. It is intended to level the playing field with regard to the risk profile of all schemes. Theoretically, the introduction of an REF should mean that schemes will have to compete on the delivery quality care at lower costs thus reducing their community rating, rather than relying on their membership profile.

Tax reforms relating to medical schemes contributions and medical expenses

Another policy issue that aims to create a better balance between the public and private sectors involves reform to the system of tax subsidies for medical aid.

At present, if an employer contributes to an employee’s medical aid as part of a salary package, the employer can do this without being taxed on the amount, as long as the employee pays for up to one-third of the medical scheme cost. If the employer pays more than two-thirds, then the employee must pay tax on the additional amount.
As this formula covers a percentage of the cost, rather than setting a cap, it has meant that the more expensive the schemes are, the higher the subsidies. This means that better paid people get bigger subsidies, and it also means that the tax rebate is effectively paying for these services, as most medical aid schemes use private health services. This further benefits the private sector and disadvantages the public sector.

The 2002 Taylor Committee of Inquiry reported that this tax subsidy to medical schemes was R7.8 billion or R1000 a member. This is more than the total annual health expenditure for each person in the public sector.

In October 2005, the Government published its proposals for tax reforms and invited comment from the public. Amongst its recommendations was a proposal that the 2/3:1/3 system should be done away with and replaced with a monetary cap. At the time of writing, the Treasury had not published its final proposals, but these are likely to be enacted in 2006.

Low Income Medical Scheme (LIMS)

In 2005, a consultative process began (between private sector and the government) to investigate the possibility of creating a Low Income Medical Scheme (LIMS). The investigation was driven by the private sector according to terms of reference that were drafted by a Ministerial Task Team. In April 2006, the consultants produced a final report, in which recommendations were made for the structure and design of the LIMS. The proposed income threshold for LIMS is R6 500, adjusted annually for inflation. The scheme would be open to formally and informally employed people and their beneficiaries. The scheme would fund a defined minimum package of benefits, that would be distinct from the PMBs, mainly in that the LIMS minimum package would focus exclusively on out of hospital benefits.

The recommendations of the consultants have been referred to the Council for Medical Schemes. The implementation of LIMS will require amendments to the legislative and regulatory framework, and as at October 2006 this process had not yet begun.

A Human Resources for Health (HRH) Plan

One of the areas in which the imbalance between public and private health care has the most negative consequences is in relation to the distribution of health professionals.
Over the last decade, there has been a growing human resource crisis, caused by factors such as:

- poor working conditions in the public sector
- better working conditions in the private sector
- the unattractiveness of rural areas (e.g., perceived lower quality of life, shortage of medical equipment and supplies)
- the high salaries and opportunities being offered in certain countries abroad.

This combination of "push and pull" factors has led to a drastic imbalance and a shortage of even the most essential health workers, such as pharmacists and dentists, in the public sector.

Example: Imbalances

- Rural provinces have far fewer personnel than the urban provinces. For example, in North West there are 11.7 doctors for each 100,000 people in the public sector. By contrast, the number is 31.9 per 100,000 in the Western Cape.
- There are insufficient pharmacists in the public sector generally and in rural areas in particular. Of the total number of registered pharmacists, only 11% practise in the public sector. There are three times more pharmacists in the Western Cape than in the North West.

The problem is not only an absolute shortage of certain categories of health professional, but also the fact that many health workers choose not to work in the public health service. For example, in Mpumalanga more than two-thirds of public sector posts were vacant in 2004. Overall in South Africa, one-third of posts was vacant in 2003. Yet, at the same time, 10% of Canada’s hospital-based physicians and 6% of the total health workforce in the United Kingdom are South African.

The development of a Human Resources for Health (HRH) Plan was identified as a priority in the ANC’s National Health Plan in 1994 and in the White Paper. There have also been several commissions looking at issues of human resources. However, it was not until August 2005 that the Government published a draft Strategic Framework for Human Resources for Health Plan.

Unfortunately, this document was extremely weak and lacked firm proposals and plans to address the crisis. In early 2006, the DoH released the final version of this plan. However, its substance had not changed much since its earlier drafts.
Most importantly, it fails to provide an accurate assessment of the human resource needs of the health system. The document takes issue with staffing ratios as a benchmark for assessing capacity, but provides no interim mechanism. Instead, this critical issue is left for further research beyond the national HRH plan. It is questionable whether there can be rational planning for HRH in the absence of data as to the needs and current capacity of the health system as a whole.

Human resource needs, as with health care needs, ought to be determined with reference to disease burden in the country. Yet the national draft HR plan does not mention HIV/AIDS or TB, let alone consider their impact on the health needs of people and on the health system.

6.8 Conclusion

This chapter has illustrated that reform of the private health sector through legislation and policy has been very slow. The Constitution requires that the large differences in access to health services in the public and private sector should decrease in the medium-term and be completely eradicated in the long-term. This has not yet started to happen.

In the second decade of South Africa’s democracy, the challenge of making South Africa’s two health systems work together will be one of the greatest tests of the Government’s commitment to the poor.

Some important measures may be taken in order to fulfil the right of access to health care services. These include:

- Providing definition to an essential package of health care services, that should eventually be accessible to everyone regardless of ability to pay. All sectors will have to work together in order to ensure the delivery of this package of services.
- Tackling the human resources crisis in the health sector.
- Addressing the lack of competition and inefficient use of resources by the private sector.
- Unifying public and private health services with the aim of creating an integrated national health system.
The legislative framework for achieving greater access to health care is already in place. What is lacking is a speedy, transparent and accountable implementation of those enabling laws. The key driver in this endeavour has to be the national Department of Health. The primary constitutional obligation rests on the state. The constitutional requirement that reasonable legislative and other measures must be taken to realise the right to health progressively, means that there are steps that can and must be taken in the short term. These measures will have to include a regulation of the private sector, as well as a greater commitment of financial and other resources to the public sector.

The longer the delay in implementing legislative and other measures, the longer the denial of access to health care by those who cannot afford it. This not only results in an infringement of the right to health care, but also of rights to dignity, life and indeed every right that cannot be exercised because a person is too ill to do so.