

The proposals for NHI developed by the ANC task team since December 2007 seem to ignore the diversity of healthcare already provided in the workplace or negotiated by employers and unions in the workplace. This policy brief sets out what is known about workplace healthcare in South Africa and argues that this should be encouraged, developed and incorporated in a future NHI. Direct payments by firms are roughly of a similar order to the financing flowing through the National Department of Health.

The Medical Schemes Act allows for the creation of restricted membership schemes linked to a union, employer, industry or profession. At the end of 2009 there were 77 restricted membership medical schemes, covering 1.344 million members and their families, a total of 3.253 million beneficiaries. Restricted schemes account for 70.0% of medical schemes but only 38.5% of members and 40.3% of beneficiaries.

Government, as an employer, reversed its decision in 2002 about open schemes and established a new restricted membership scheme, the Government Employees Medical Scheme (GEMS). The fund was registered in January 2005 and became operational in January 2006. At the end of 2009 GEMS had grown to be the second largest scheme with 409,804 members and 1,147,897 beneficiaries. The public sector unions have successfully negotiated unusually large medical scheme subsidies from Government as an employer. To date there has been no reaction from the unions to the NHI proposals. Restricted schemes set up for government workers and state-owned enterprises account for 724,389 members and 1,929,250 beneficiaries, which is 54% of restricted scheme members and 59% of restricted scheme beneficiaries. In addition there are a large number of public sector workers in semi-government enterprises on open medical schemes.

The Low Income Medical Schemes (LIMS) process reported in 2006 and the key target market was set as households earning between R2,500 and R6,000 per month, with at least one member in formal employment. Bargaining Council schemes, established under the Labour Relations Act, are a particularly interesting form of workplace healthcare. It was reported that there were 27 Bargaining Councils that offered benefits, representing over 800,000 employees and close on 50,000 employers. These funds may also provide for a range of other purposes including retirement, sick pay, disability, death, holiday pay, unemployment benefits, housing, maternity and education.

There is extensive legislation governing occupational health issues in the workplace. Workplace-based occupational health services may be engaged in the promotion and maintenance of employee health and provide primary health care services in excess of the statutory occupational health requirements. In some companies, the clinics have been extended to provide services to family members.

The Mine Health and Safety Act compels mines to employ occupational medical practitioners to carry out medical surveillance of miners. The rural isolation of mines meant the development of staff-model healthcare arrangements where the mine owns a hospital or clinics and health professionals are employed. Mining companies are the only private companies permitted to employ their own medical staff and have developed extensive experience of providing healthcare for those without insurance.

The WHO argues for integrating the development of occupational health services into national strategies for reforming the health system and improving its performance. It is surprising that the ANC proposals on NHI make no mention of occupational health, bargaining councils, restricted membership medical schemes or the employer role. The only reference to employers is that there may be payroll taxes (for employees and/or employers).

The thinking by National Treasury on equity in the tax system with regard to health purchased by employees or provided by employers needs to be taken further to consider equity in the financing of the health system. We need to acknowledge the contribution of employers to workplace-based healthcare and recognise the often hard-won agreements between employees and employers in designing bargaining council funds and restricted membership medical schemes. There are no easy answers yet ... but we should be working towards incorporating all these forms of healthcare in our national health system. Not replacing them with an untried and untested single purchaser NHI.

Figure 1 attempts to quantify the number of people already covered by medical schemes, those that could have cover under Bargaining Council funds and those earning above the LIMS threshold (and their insurable families) that still do not have cover.

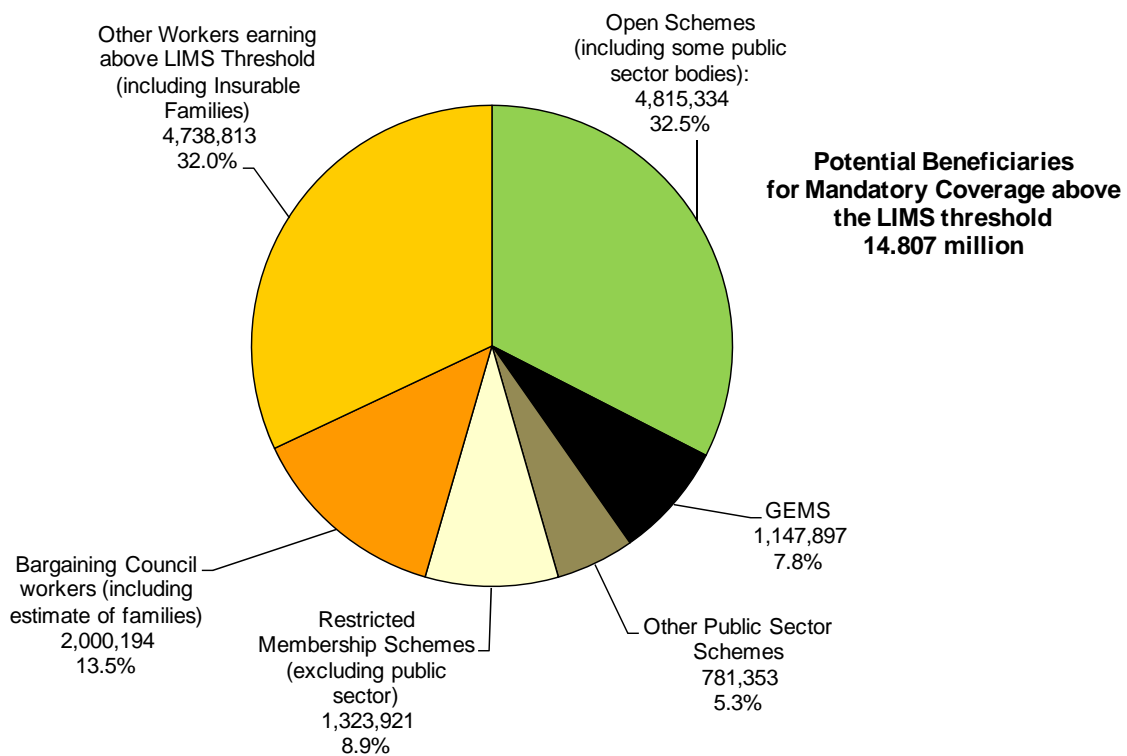


Figure 1: Possible Mandatory Health Insurance linked to Employment, 2009

Summarised for IMSA by **Heather McLeod**
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Further resources on the IMSA NHI web-site

http://www.innovativemedicines.co.za/national_health_insurance.html

- The full policy brief and slides.

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