

NHI and Workplace Healthcare

The purpose of this series of policy briefs on National Health Insurance (NHI) and the related IMSA web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This includes tools for costing NHI and evidence on where savings could be achieved in moving to a future mandatory system with universal coverage.

The proposals for NHI developed by the ANC task team since December 2007¹⁻³ have envisaged a single pool and single purchaser for healthcare. The September 2010 proposals, like the earlier drafts, 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, rather than replaced by a monolithic single purchaser NHI.

1. Overview of Workplace Healthcare in South Africa

One of the flows in purchasing healthcare in South Africa is direct payments by firms. McIntyre and Thiede⁴, using 2005 data, showed that this is a small amount relative to the total expenditure on health, but in Rand terms may still be significant. It is roughly of a similar order to the financing flowing through the National Department of Health, at less than 1% of the total of R108 billion⁵. The financing intermediaries were found to be (in 2005 Rand terms^a):

- National Department of Health: R1 billion
- Local Departments of Health: R 1 billion
- Provincial Departments of Health: R45.5 billion
- Households out-of-pocket: R16.5 billion (although the authors think this is underestimated)
- Medical schemes: R54.2 billion
- Firms' direct payments: under R1 billion.

There is relatively little written about workplace provision of healthcare in South Africa. One of the few sources is a chapter written for the South African Health Review in 2007 (SAHR 2007) by Adams, Morar, Kolbe-Alexander and Jeebhay⁶. The authors said: 'This chapter focuses on the health status of the South African workforce and health care provision in the workplace. ... Health care provision and financing aimed at the workforce is described in terms of the relevant legislative framework; models of employer-subsidisation and workplace-based models of health care service provision; and provision for social security and disability care.'

"Despite the active role of the private sector in health care provision in the workplace, sourcing of data proved problematic as it was neither available nor accessible. Consequently, most of the data were sourced from government departments, policy documents, company reports or through personal communication." This lack of visibility means that few people thinking of the structure of a future NHI have considered how these initiatives can be harnessed. This policy brief thus aims to open up this question and ensure that workplace health is logically incorporated in a future NHI.

^a The totals quoted in the graphic add up to more than R118 billion, rather than R108 billion quoted in the text of the SHIELD report.

2. Restricted Membership Medical Schemes

The Medical Schemes Act, No. 131 of 1998, allows for the creation of restricted membership schemes. The criteria for establishing a restricted scheme include:

- employment in a profession, trade, industry or calling;
- employment or former employment by particular employer, class of employers; and
- membership or former membership of profession, professional association or union.

All other schemes are classed as open schemes and they must admit any member who applies. 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. The graph below illustrates the proportion of total schemes and beneficiaries. Restricted schemes account for 70.0% of medical schemes but only 38.5% of members and 40.3% of beneficiaries^b.

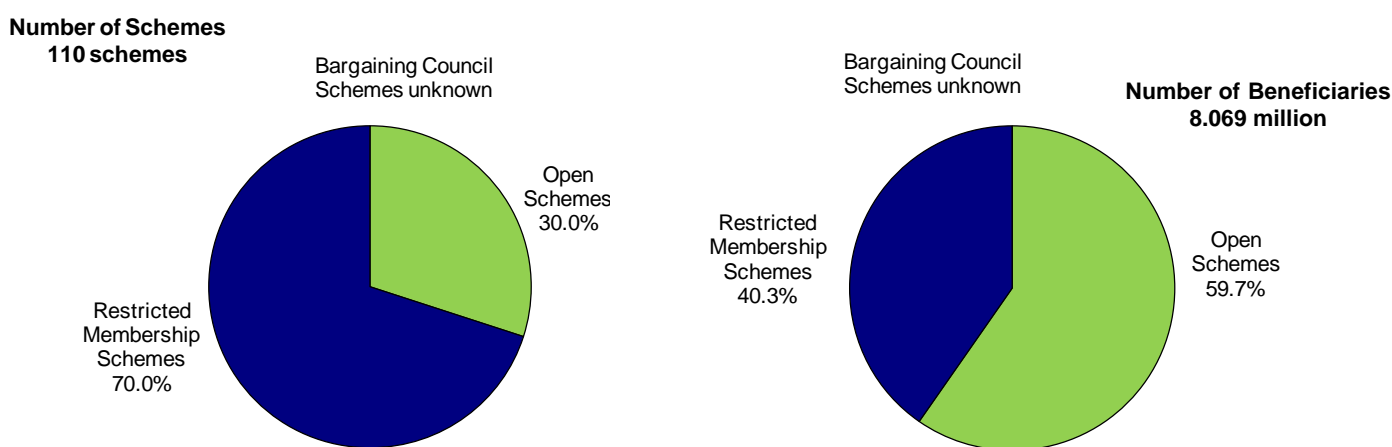


Figure 1: Open and Restricted Medical Schemes and Beneficiaries, as at December 2009

Open schemes and restricted schemes each had some 50% of total beneficiaries in the early 1990s. Brokers began to operate in the market from about 1993 as the major insurers became involved in healthcare and brought insurance-selling models into the environment. Brokers were unregulated until the revised Medical Schemes Act of 1998 and this period saw a dramatic increase in open scheme membership relative to restricted schemes. This was exacerbated by a policy in Government in the 1990s that public servants would get a medical scheme subsidy that could be used in any scheme. By 1999, open schemes had become the dominant model with some 70% of total beneficiaries, reaching a peak of 71.8% of beneficiaries in 2005, as illustrated in Figure 2.

McLeod & Ramjee recorded the history of the change in thinking in the public sector about the use of restricted membership schemes⁷. "The restructuring of medical scheme subsidies in the public sector was placed on the agenda in December 1999. The 1999 Remuneration Policy Review had identified major shortcomings, including inequality in access to medical scheme cover, affordability concerns, lack of value for money, spending inefficiencies and little integration with public sector health care. Despite a relatively generous medical scheme subsidy^c, there were only some 450 000 people, half of the one million employees, using the subsidy."

^b Average family size in restricted medical schemes is slightly larger than in open schemes. At December 2009 there were 2.42 beneficiaries per member in restricted medical schemes.

^c Government paid two-thirds of any medical scheme contribution, to a maximum of R1 014 per month per employee. This was generous by industry standards where 50% was a common subsidy.

“In 2002, Cabinet approved a framework policy for a restricted medical scheme, only for public sector employees, centred on the principles of:

- **equity**, where employees have equal access to the most extensive set of equal basic benefits under equitable remuneration structures, subject to affordability;
- **efficiency** in respect of costs and delivery of benefits; and
- **differentiation**, where employees opting for more extensive cover have equal access to such higher benefits subject to their needs.”

Government, as an employer, thus reversed its decision 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. “Government has used the lure of a higher medical scheme subsidy within GEMS^d, as well as insisting that all new employees may only join GEMS. Within 18 months GEMS became the largest restricted scheme and the third largest medical scheme in South Africa. As at the end of 2009⁸ GEMS was the second largest scheme, with 409,804 members and 1,147,897 beneficiaries, compared to Discovery Health with 2,041,908 beneficiaries.

The graph below illustrates the growth and stabilisation in open scheme membership and the rapid growth since 2006 in restricted scheme membership.

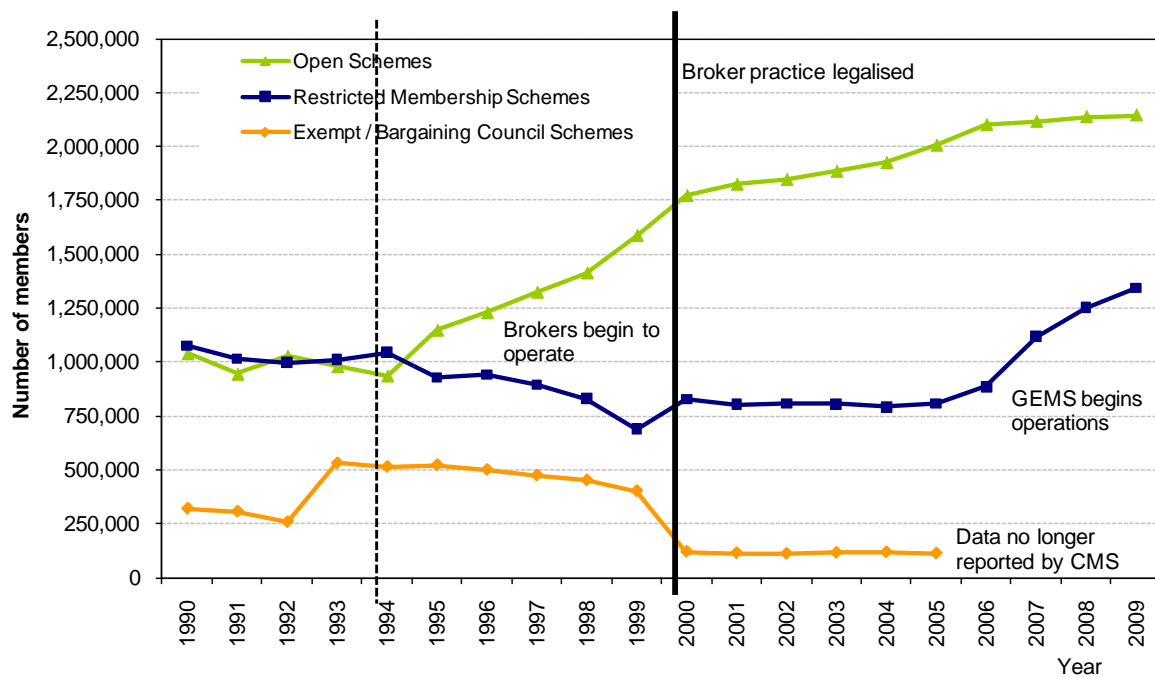


Figure 2: Historic Membership by Type of Medical Scheme

^d A revised and improved employer subsidy regime was negotiated and implemented from 1 July 2006. A 75% subsidy of monthly contributions was provided, capped at R1 900 per month per employee. Workers on the lowest salary bands (earning less than about R60 000 a year) received a 100% subsidy capped at R1 900. Those remaining on open schemes received the lower original subsidy of up to two-thirds of contributions, capped at R1 014 per month. The issue formed part of acrimonious bargaining during the June 2007 public sector strike. There were calls by labour for the subsidy to be used across other schemes. A revised subsidy of R2 020 per month was offered by Government, still restricted for use in GEMS. As at October 2009 the maximum subsidy was R2,319 per month. In the 2010 wage negotiations it was agreed that the issue of equalising the subsidies for membership of GEMS and other medical schemes would be investigated by end 2010.

McLeod & Ramjee explained the rapid growth in GEMS⁷: “The combination of high subsidies for low income workers, income-related contribution tables and the bargaining power of the new scheme have been significant. A low-wage earning civil servant and family was able to join the lowest cost option, Sapphire, without making an out-of-pocket contribution. There are some 325 000 people eligible for the 100% subsidy, 191 000 (nearly 60%) of whom were not previously medical scheme members. It is estimated that the Sapphire option alone could bring about 600 000 new lives into the medical scheme market and that GEMS may ultimately see the enrolment of an additional 1 million medical scheme beneficiaries (an increase of some 14% from current industry levels).”

“The implementation of GEMS sets an example to other employers by demonstrating that it is possible to develop packages of benefits that can be made affordable to all employees. Initial vociferous concerns by open schemes that they might lose up to 25% of their collective membership have become muted. However, there are specific schemes that had very high proportions of public service employees that might need to amalgamate with GEMS or close as their risk pools reduce in size. GEMS provide an important role model for large employers in its design of subsidies and the benefits of returning to a restricted scheme for all its workers. GEMS is also a role model for other medical schemes in terms of benefit design.”

The unions have successfully negotiated unusually large medical scheme subsidies from Government as an employer. To date there has been no reaction from the public sector unions to the NHI proposals. Their reaction and the bargaining that ensues will be an indication of whether it is at all feasible to see restricted membership schemes replaced by a single purchaser NHI, as currently envisaged by the ANC³. The major issue for the unions is likely to be the issue of paying for NHI and simultaneously needing to pay for being a member of a medical scheme. The currently adverse perceptions of the quality of care in the public system will need to be substantially altered before the unions agree to leaving GEMS and other open medical schemes in favour of NHI.

It should also be noted that all parliamentary members and their families are members of a medical scheme, Parmed. This scheme had 5,619 beneficiaries at the end of 2009⁸. The scheme has unusually generous benefits with few restrictions or managed care tools being used, with the average contribution being R2,066.90 pbpm in 2009, compared to the average for all restricted schemes of R816.00 pbpm. Parmed has thus far resisted being combined with GEMS and the Parmed member reaction to NHI will also be worth watching.

Other restricted medical schemes for public sector workers are SAMWUMed^e (municipal and local government workers); LA Health Medical Scheme (for local authority workers); SABC Medical Aid Scheme (for the public broadcaster); POLMED (South African Police Service Medical Scheme); Medipos (for post office workers) and Transmed (for workers and pensioners of Transnet and the old SATS). The table and graph below show the size of these schemes at the end of 2009.

Table 1: Restricted Medical Schemes for Public Sector, 31 December 2009

As at 31 December 2009	Members	Beneficiaries
GEMS	409,804	1,147,897
LA-Health Medical Scheme	24,605	52,862
Medipos	10,702	23,131
Parmed	2,304	5,619
Polmed	168,576	472,313
SABC Medical Aid Scheme	4,604	10,058
SAMWUMED	30,271	73,084
Transmed	73,523	144,286
Total	724,389	1,929,250

^e <http://www.samwumed.org>

“SAMWUMed was started by workers for workers in 1952. The Scheme has a proud history of providing for the specific healthcare needs of its members.”

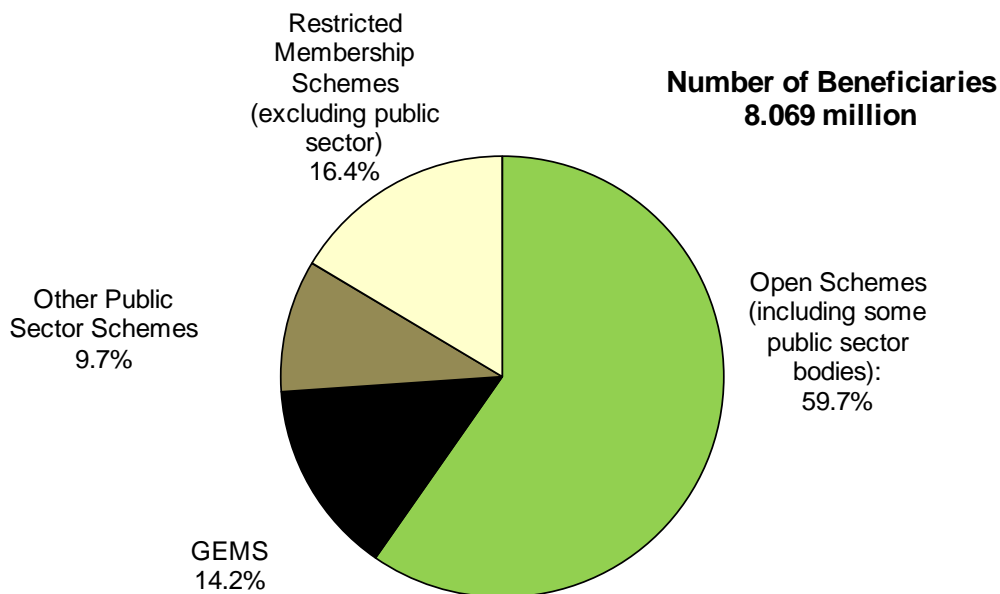


Figure 3: Medical Scheme Beneficiaries end 2009

Together with GEMS and Parmed, these restricted schemes account for 724,389 members and 1,929,250 beneficiaries. Public sector workers account for 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 that belong to open medical schemes^f. Members of statutory bodies, including the Council for Medical Schemes, are typically members of open medical schemes.

3. Low Income Workers and Medical Schemes

The Low Income Medical Schemes (LIMS) process reported in 2006⁹ under the leadership of Dr Jonny Broomberg. Key conclusions of the LIMS Household Survey with respect to employment and workplace healthcare were:

- “There are approximately 5.1 million non-rural households with gross monthly income of R6,000 or less. These households comprise 21.9 million individuals. In the ‘target population’ for LIMS, namely a monthly household income of R2,500 – R6,000, the survey estimates that there are 2.5 million households, comprising 11.5 million individuals.
- There is a relatively strong link between these households and the formal employment sector. In the target population, 86% of households had one or more members working in the formal sector. This suggests that formal employment will be a critical channel for the extension of medical scheme cover to the currently uncovered”.
- The main barriers to entry into insurance coverage appear to be lack of employment by household members, and where one or more household members are employed, the main barriers appear to be absence of medical scheme subsidies/benefits from employers and affordability.”

^f A prime example is TeleMed Medical Scheme which was previously a restricted scheme for Telkom employees but became an open scheme, accepting other members, some years ago. It was merged with BESTmed Medical Scheme and from 1 January 2010 is known as BESTmed Medical Scheme.

The key target market for LIMS schemes was set as households earning between R2,500 and R6,000 per month, with at least one member in formal employment.

The LIMS report⁹ considered that with employment being important, “the needs and attitudes of South Africa’s employers are obviously also critical to the outcomes of the LIMS process.” LIMS commissioned Markinor to conduct interviews with senior executives at 40 employers⁹. “The sample of employers was selected to as to ensure appropriate distribution between large, medium and small employers, as well as geographical representivity.” Some of the key conclusions of this employer survey can be summarised from the report⁹ as follows:

- 8 companies (20% of those surveyed) indicated that 100% of their low income employees were covered. However coverage patterns varied widely in the other companies, with half of the sample indicating that less than 50% of their low income workforce was currently covered^h.
- The majority of companies (83%) indicated that they do offer medical scheme benefits to all employees. The balance have some of their workforce on medical schemes, and some on bargaining council arrangements and/or in-house provision of medical services to low income employees.
- All companies that do not provide a medical scheme benefit do offer low income employees the full range of standard employee benefits, including pension/provident fund, funeral and disability benefits, group life cover, housing subsidies etc. These companies indicated that medical scheme cover does not appear to be highest priority for either employees or trade unions at this stage. Lack of affordability was a key reason for this low priority.
- With one exception, all companies that do offer medical scheme benefits to low income employees do so on a voluntary basis [emphasis added].
- 36 of the 40 companies in the survey indicate that they provide a subsidy to employees who wish to take up a medical scheme benefit. The nature of the subsidy varied between employers, but 58% indicated that they offer a 50% subsidy on the cost of the medical scheme contribution. 22% offered a ‘two thirds’ subsidy in line with then offered tax subsidies for medical scheme premiums, while the balance had a range of different subsidy arrangements. The four companies which did not provide subsidies indicated that they provide the medical scheme benefit on a ‘cost to company’ basis.
- The majority of respondents indicated that they provided subsidies for employees as well as dependents, with most allowing up to three dependents, and some allowing more. Some companies reported that employees tend to cover dependents, and attribute this to the generous employer subsidy. Others indicate that employees find it increasingly difficult to maintain cover for all of their dependents due to high cost of premiums, and that this results in removal of dependents from time to time, and/or to patterns in which children are removed from cover once they are older.
- When asked for views on the maximum premiums affordable by low income employees, most respondents suggested that premiums should not exceed R150-R200 per employee per month, and should be below 10%-15% of the employees’ income.

⁹ An excellent source of historical information on employer views of healthcare was the Old Mutual Healthcare Surveys which were published in 1994, 1995, 1997, 1999, 2001, 2003 and 2005.

^h The 2005 Old Mutual Survey found that out of the total sample of 100 employers interviewed, some 84% of the workforce enjoys cover on company associated medical schemes. Some 13% of employees have no medical cover that employers are aware of, and the balance of 3% of employees are covered by schemes not associated with the company for which they work. These would mainly be in respect of employees covered on their spouses’ schemes.

- The majority of respondents believed strongly that increased take up of medical scheme cover by low income employees would be of benefit to the company, due to some combination of:
 - Higher employee satisfaction and peace of mind.
 - Better employee health, leading to increased productivity and reduced absenteeism.
 - Reduction in requests for loans to fund medical expenses.

4. Bargaining Council Schemes

Bargaining Council schemes are a particularly interesting form of workplace healthcare. They are established under the Labour Relations Act (Act 66 of 1995) which⁶ “allows for the establishment of bargaining councils that have the right to establish and administer pension, provident funds, sick pay and medical aids for the benefit of the members.”

Budlender & Sadeck¹⁰ produced a report on the Bargaining Council benefits for National Treasury “to inform their planning in respect of a possible major reform of work-related social security arrangements.” The paper is one of the only sources of information on this large section of the workforce and provides an understanding of the scope of coverage, as shown below.

Table 2: Number of Employees and Employers covered by Bargaining Councils with Funds
(Source: Budlender & Sadeck¹⁰)

Bargaining council	Employees	Employers
Building Industry (Bloemfontein)	2200	160
Building Industry (East London)	1500	100
Building Industry (Kimberley)	2700	90
Building Industry (North and West Boland)	3678	235
Building Industry (Southern & Eastern Cape)	10000	1000
Building Industry Bargaining Council (Cape of Good Hope)	34000	1000
Clothing Manufacturing Industry National	74456	1048
Canvas Goods Industry (Witwatersrand & Pretoria)	1000	40
Contract Cleaning Industry (Natal)	12000	235
Diamond Cutting Industry (SA)	2165	49
Electrical Industry of SA (National)	15365	3342
Furniture Greater Northern	17261	1289
Furniture Manufacturing Industry (Eastern Cape)	667	65
Furniture Manufacturing Industry KwaZulu-Natal	7000	250
Furniture Manufacturing Industry Western Cape	5000	230
Hairdressing & Cosmetology (KwaZulu-Natal)	700	200
Hairdressing and Cosmetology Services – Semi National	4351	1617
Hairdressing Trade, Cape Peninsula	1800	550
Jewellery & Precious Metal Industry (Cape)	-	64
Laundry Cleaning and Dyeing Industry (Cape)	1405	22
Laundry, Cleaning and Dyeing Industry	850	86
Leather Industry of South Africa	17256	278
Meat Trade Gauteng	3697	861
Metal & Engineering Industries	300000	9500
Motor Industry Bargaining Council (National)	200000	18000
Restaurant Catering and Allied Trades	26200	5500
Road Freight Industry (National)	60000	3000
Total	805251	48811

Budlender & Sadeck found there were 27 **Bargaining Councils** with funds and that these represented “a total of over 800,000 employees and close on 50,000 employers”, as shown in the table above. There are wide ranges in the numbers of employers and employeesⁱ, for example the number of employers ranges from “22 for the Laundry Cleaning and Dyeing Industry (Cape) to 18,000 for the Motor Industry Bargaining Council (National).”

The bargaining council funds fulfil a number of different needs. The authors found pension funds, provident funds, medical and sick benefit funds, sick pay funds, disability cover, survivor benefits, leave and holiday pay, unemployment benefits and a range of funds for other purposes, including housing benefits, maternity benefits and education.

In addition “[t]here are five public sector bargaining councils, of which the Public Service Co-ordinating Bargaining Council acts as the overarching body. The other public sector councils are the Education Labour Relations Council, the General Public Service Sectoral Bargaining Council, the Public Health and Welfare Bargaining Council and the Safety and Security Sectoral Bargaining Council.” However the public sector bargaining councils do not have any funds under their direct control. A significant number of these employees participate in the Government Employees Pension Fund (GEPF) and the Government Employees Medical Scheme (GEMS). These are described briefly below.

“Bargaining councils are established in terms of the Labour Relations Act. **Sectoral determinations**, in contrast, are promulgated under the Basic Conditions of Employment Act (BCEA) to govern sectors which are not well organised enough to have self-government under a bargaining council. [Quoting Godfrey et al (2006), it is estimated] that while all bargaining councils between them cover approximately 25% of the 9,5 million employees falling under the LRA and BCEA, the nine sectoral determinations that have come into effect since the BCEA was introduced cover approximately 36%, or about 3,4 million employees. This estimate excludes the old wage determinations which automatically became sectoral determinations. The recent promulgation of the hospitality sector determination will have increased the number of employees covered by determinations.

“The Labour Relations Act makes provision for **statutory councils** alongside bargaining councils. Section 43 of the Act states that the powers of such councils include the establishment and administration of pension, provident, medical aid, sick pay, holiday, unemployment schemes” or other funds for the benefit of the parties. “At this point, there are only two statutory councils”, the Amanzi Water Board and Printing and Packaging.

5. Bargaining Council Schemes and Healthcare Delivery

Adams *et al* said⁶: “In the current environment, [these Bargaining Council] schemes provide the only real opportunity to extend health insurance cover to low income earners These schemes provide significantly limited medical benefits, usually restricted to primary health care benefits with very few schemes offering hospital cover in the private sector.”

Budlender & Sadeck¹⁰ described the health delivery model in one Bargaining Council: “The Clothing Health Care Fund in the Western Cape provided figures to support its claims of value for money. The fund pays an average of R98 for a visit to a doctor, whereas the doctors concerned would usually charge about R120. This lower cost allows workers to visit the doctor more often than they might otherwise do. In addition, members have unlimited use of clinics that include social workers, physiotherapy students, psychology students, an oral hygienist, among others. This grouping of skills and services would be found in few, if any, private group practices.”

“In terms of overall cost, the fund currently brings in contributions of R29m and has expenditure of R35m. Internal calculations suggest that if the service was costed out, it would be valued at around R100m. An external reviewer found similarly that the cost stood at around 33-35% of the market

ⁱ The Jewellery and Precious Metal Industry (Cape) did not submit an estimate of the number of employees.

cost. The estimates above raise another, partly non-monetary, aspect of value for money, namely the ability of these funds to adapt to particular circumstances.”

“One striking example of such an adaptation was given in the Clothing Industry, where the medical scheme found that employees were using services less and felt that this might reflect workers’ fear of losing their jobs and losing wages in an industry under great stress. In order to assist workers, the fund started providing family planning services and counselling in the factories, so that workers did not need to take time off. The clinic has also been seeing increased numbers of workers on Saturdays, as this is not a usual working day.” ...

“One of the main differences between the council schemes and most others is the council schemes’ focus on primary health care rather than hospital care. Related to this, is a common practice of having a panel of doctors who provide services or even, in a few cases, employing doctors. When members visit these doctors, they are generally not required to pay out-of-pocket beyond what they have already contributed, except perhaps in respect of medicine. The panel doctors are paid in different ways, including fee for service, a fixed fee, and a per item fee.”

“The advantage for the doctors is a more or less captive market. The advantage for the funds is that the doctors are prepared to charge lower rates. Some restriction is usually placed on the number of visits that any one member can make. As a result, where funds have both panel doctors and a clinic, the former tend to deal mainly with acute care, while the clinics – where visits are unlimited – provide service for chronic conditions.”

The healthcare services delivered by these funds might seem to fall under the definition of “the business of a medical scheme” in the Medical Schemes Act of 1998. There was considerable discussion about Bargaining Council schemes at the Council for Medical Schemes in the first five-year review.¹¹ “A grey area in the policy and regulatory framework around registration of medical schemes has been in relation to bargaining council funds that have historically been regulated by the Department of Labour in terms of the Labour Relations Act. ... a situational analysis was initiated jointly in 2004 between the Council and the Department of Labour, to gain a better understanding of these schemes [This document is not publicly available].”

“The legal and administrative uncertainty over the regulation of bargaining council schemes must be resolved A significant concern is the lack of adequate legal protections that members of these schemes are currently exposed to. Even though several such schemes reported good solvency levels, there are concerns that these levels are not sustainable and that, despite good solvency, members have access to inadequate or sub-standard benefits. Another concern ... is the apparent overlap between the use of medical contributions in some sick benefit funds to fund ... other social benefits too, sometimes via the administration fees payable to bargaining councils.”

“Nevertheless, ... , it needs to be acknowledged that by and large they are carrying out an important function that is complementary to the objectives of the Council for Medical Schemes. These schemes provide an alternative to many of their members who otherwise would not afford medical scheme coverage.”

“Bargaining council schemes themselves acknowledge their strategic importance. While several schemes reported during interviews that they are not averse to being more fully regulated, they fear that integration under the Medical Schemes Act would threaten their existence as an integral part of the collective bargaining process.”

“Preliminary recommendations ... suggest that it is necessary to separate out the business of the medical scheme from other social benefits derived from the collective bargaining process.” There would be benefits to members of being under the Medical Schemes Act “particularly in the context of moves towards risk equalisation and social health insurance. ... [W]hereas some of these funds collect contributions which are adequate to cover the costs of PMBs, a special dispensation may need to be developed in relation to coverage of PMBs by other funds, especially if integration of these schemes takes place at a time when income-related cross subsidies are not yet in place.”

“[S]ome of these funds have developed some interesting preferred provider organisation arrangements, or have in place operations that resemble health maintenance organisation arrangements. In the absence of effective regulation of risk transfer arrangements in the context of managed care, there is a risk that similarly inappropriate arrangements will develop as occurred in the context of reinsurance. These funds have many years of experience in providing health care directly to their members. These models should be seriously investigated to determine whether they can be rolled out to cover more members from their relevant economic sectors.”

The Council for Medical Schemes acknowledged that to put in place mechanisms for the appropriate regulation of Bargaining Council Schemes “is ultimately dependent on total buy-in from critical stakeholders.” These include the Department of Labour and trade unions. “The National Association of Bargaining Councils (NABC)^j is also another vital stakeholder in the process. Even though not all bargaining councils are subscribers to this organisation, it nevertheless possesses strategic influence over its members and other non-member bargaining councils.”

6. Employer Clinics and Extending Occupational Health Facilities

There is extensive legislation governing occupational health issues in the workplace. A useful summary table of all the applicable acts in the workplace is found in the chapter on workplace health by Adams *et al* in the SAHR 2007 and is reproduced below.

Table 3: South African legislation pertaining to occupational health and safety, health service provision and compensation (Source: SAHR 2007, Chapter 7⁶)

	Act	Function	Enforcement agency
Occupational health and safety	Occupational Health and Safety Act (Act 85 of 1993). ²⁵	Ensures that employers provide workers with a healthy and safe work environment	Department of Labour
	Mine Health and Safety Act (Act 29 of 1996). ²⁶	Ensures a healthy and safe working environment for workers in the mining sector	Department of Minerals and Energy
	National Occupational Health and Safety Bill, 2005. ²³	Allows for the establishment of a National Health and Safety Authority which will act as a forum for policy-making and standard setting in occupational health and safety with overall regulatory responsibility for occupational health and safety in South Africa	Department of Labour
Health care provision and funding	Medicines and Related Substances Act (Act 101 of 1965). ²⁷	Provides for an authorisation permit to be issued to a nurse to dispense schedule 1-4 substances at workplace health services	Department of Health
	Labour Relations Act (Act 66 of 1995). ²⁸	Allows for the establishment of bargaining councils that have the right to establish and administer pension, provident funds, sick pay and medical aids for the benefit of the members Outlines procedures for dealing with ill-health causing incapacity in the workplace	Department of Labour
	Medical Schemes Act (Act 131 of 1998). ²⁹	Allowed the establishment of a Council for Medical schemes to regulate the activities of medical schemes and protect the interests of members of medical aid schemes	Department of Health
	National Health Act (Act 61 of 2003). ³⁰	Sets out rights and duties of health care providers, health workers, health establishments and users Provides for the provision of occupational health services by provincial departments of health	Department of Health
	Nursing Bill (Bill 26 of 2005). ³¹	Outlines the scope of practice, duties and responsibility and level of accountability of nurses within government and other health service organisations	Department of Health
Compensation of occupational injury and disease	Occupational Diseases in Mines and Works Act (Act 78 of 1973). ³²	Provides mainly for the compensation of occupational lung diseases in mines and quarries	Department of Health
	Compensation for Occupational Injuries and Diseases Act (Act of 1993). ³³	Provides for medical cover and compensation of occupational injuries or diseases arising from workplace exposures	Department of Labour

Adams *et al* said⁶: “Workplace-based health services are modelled on either a staff-based model or a directly-contracted model. Employers may choose to provide clinical services by hosting in-house clinics employing permanent staff, with the vast majority being occupational health nursing staff. Employers may also choose to contract with independent private practitioners who do sessional work at the workplace (directly contracted model).”

“Occupational medical practitioners in contracted models are usually employed on a part-time consultancy basis although some large companies employ the services of full-time medical advisors. Alternatively, employers may also choose to outsource the provision of occupational health services to specialised companies who provide the systems and human resources to manage the occupational health programme. This is increasingly favoured as a more efficient and effective method of occupational health service delivery but may not be accessible to small and medium enterprises due to budget constraints.”

“Workplace-based occupational health services may be engaged in the promotion and maintenance of employee health, maintenance of workforce efficiency, the fulfilment of legal compliance with regulations and obligations to the workforce and enhancement of company performance through professional health management.”

“In addition, many provide primary health care services as well as consultative, rehabilitation and administrative services. It is difficult to ascertain the extent of coverage of the workforce due to a lack of data on occupational health service provision in the private sector. However, one of the largest service providers currently only services 120,000 workers in 186 clinics and 17 mines countrywide, suggesting that whilst coverage of workers is higher in the private sector, it still covers only a fraction of the workforce in the formal sector. This is particularly true of workers in the non-mining sector ...”.

7. The Mining Model

The Mine Health and Safety Act of 1996 compels mines to employ occupational medical practitioners to carry out medical surveillance of miners. The rural isolation of many mines meant the development of staff-model healthcare arrangements where the mine owns a hospital or clinics and nurses, doctors and other health professionals are employed. Mining companies are the only private companies permitted to employ their own medical staff and they have thus developed “extensive experience of providing primary and other care for those without medical insurance”.⁶

Söderlund and colleagues reported¹² that in 1997 there were 66 mine hospitals with a total of 6,088 beds, and extensive associated primary health care facilities. “Mine health services differ from other occupational health services in that they provide a comprehensive range of services, from primary health care to hospitalisation. The reason for this is primarily because of a statutory obligation on mines to provide comprehensive occupational health services which was not imposed on other employers in South Africa. The labour intensive nature of gold mining in particular, and consequent large workforces, meant that it was economical for mines to build and run their own hospitals, rather than providing health insurance cover.”

“The decline in the gold price, the development of more efficient mining techniques, and the fact that many gold reserves are becoming depleted has led to drastic reductions in employed miners, however, and in-house delivery of hospital services would almost certainly have ended in many instances were it not for the fact that significant costs had already been sunk into these institutions. There has been a decrease of 29% in the number of mine hospital beds between 1985 and 1997”.

In a report on private hospitals in 2006, Matsebula & Willie¹³ reported only 5 mine hospitals with 1,470 beds (5.3% of the total private beds). This reduction over ten years seems unrealistic and it is possible that some hospitals classed as “independent” or belonging to one of the groups had previously been mine hospitals.

In recent years some mine medical schemes have been closed and amalgamated with open schemes. A good example of a low-cost medical scheme based in a mining environment is Impala Medical Plan. The scheme is self-administered and had the lowest non-healthcare costs in the country: R3.28 pbpm compared to R65.20 pbpm for restricted schemes and R128.78 pbpm for open schemes in 2008.

Another mining scheme, Platinum Health Medical Scheme (PHMS) is described and compared to Polmed in a review commissioned by FinMark Trust¹⁴: "PHMS benefits were mainly accessible at the PHMS-owned medical centre or from contracted healthcare service providers, hospitals and other facilities. Primary care, including GPs' services, optometry and dentistry, was mainly provided through the PHMS-owned medical centre, and secondary care mainly through contractual relationships between the PHMS and specific hospitals and specialists."

"In cases where required services were not covered by the contractual relationships, they were procured on a fee-for-service basis. Such procurement was, however, on a case-by-case basis subject to prior authorisation and negotiation by the PHMS. In all instances, access to specialist and hospital care was subject to referral by the Platinum Health Medical Centre. Beneficiaries that could not access the medical centre – for example, because of where they lived – accessed their benefits through fee-for-service arrangements. However, access to specialist and hospital care was subject to prior authorisation by the PHMS, which included prior negotiation with the relevant service providers."

"The PHMS employs its own GPs, dental practitioners and optometrists on a full-time or part-time basis, which eliminates the cost-driving incentives associated with fee-for-service. The specialists that provide services to PHMS beneficiaries are, in most instances, reimbursed on fee-for-service basis. It is interesting to note that this is the only cost category that has a similar level to that of Polmed. The PHMS has long-term contracts in place with hospitals, and these came under review in 2007 and 2008."

"Cost savings are achieved by controlling procurement of medical supplies and diagnostic services. PHMS beneficiaries are required to obtain their medicines from facilities owned by Anglo-Platinum. This enables the PHMS to manage the selection of medicines, the number of items prescribed per script and the number of scripts. Radiology and pathology services are procured through the PHMS medical centre or from the hospitals with which the PHMS has contracts. Combined with strict clinical management protocols applied through the PHMS's general practitioners, this relationship gives less scope for unnecessary services."

"Co-ordination between workplace health and medical services offers scope for reducing costs. The PHMS employs nurses for certain primary and preventative healthcare services (auxiliary service costs), resulting in a higher auxiliary benefit cost than Polmed. This reduces the reliance on GPs to provide such services, reducing cost of GPs' services. This approach, which is typical of health maintenance organisation delivery systems, has the added advantage over Polmed that it allows for issues of preventative care, absenteeism and referrals to higher levels of care (for example, hospitalisation) to be addressed more effectively."

"Out-of-pocket expenditure can be avoided with contracted provider arrangements. An important feature of a delivery system such as the PHMS health maintenance organisation and contracted network is that beneficiaries are less likely to incur out-of-pocket costs when caregivers and service providers raise fees substantially, as happened between 2007 and 2008. In 2008, on average, the PHMS paid 98% of the amounts claimed, which compares very favourably with the 61% of claims paid during the same period in the Polmed environment."

Fazel Randera, former health advisor to the Chamber of Mines, speaking at the CDE Roundtable, November 2010, said¹⁵: "The legislation for PPPs^k is in place, but in practice very little has happened, and this is due both to the private sector not coming to the party and the public sector having an ideological position that stops it from giving major contracts to the private sector. Taking the mining sector, where I have worked, as an example, it is involved in providing NPO health care services in many parts of the country. Historically these were only for workers, but despite some movement to

^k Public Private Partnerships

include dependents and surrounding communities this is not happening, and neither the Department of Health nor the industry itself have made a move to make more of it.”

“The one area where PPP has been successful is HIV and AIDS. The United States President’s Emergency Fund for AIDS Relief (PEPFAR) has donated about \$850 million to South Africa. Most of that has gone to non-public sector entities, but the work that has been done has included the public sector. Whether it has been building new clinics, staffing them, or providing laboratory services, it has worked very well. We need to look at why it has been so successful when people say there is no basis for a relationship between the public and private sectors; at how PEPFAR and the Global Fund have worked with the groups that they have distributed billions of Rands to; and why every cent that has come into the country has been accounted for. We need to write that up as a case study.”

“If I were the Minister of Health, I would support PPPs, but only as a means to an end. The end is to honour the commitment to provide a national health system that the government made to those who elected it in 1994. On this issue the private sector should not wait for the minister to ask what we can do; we should be knocking on the door all the time. What I have learnt from our two colleagues today is that we don’t have to adopt a particular model. Whether it is a tax-based system or an insurance-based system, we need a national health system, and the private sector has a massive role to play in providing it.”

8. Employer Provision of HIV/AIDS Treatment

An area where the mining houses lead and other employers have followed has been in the widespread provision of testing and treatment for HIV/AIDS. Dr Brian Brink was one of the pioneers and major advocates of treatment and continues to be involved in the employer response to the disease¹: “Dr. Brink passionately expressed his sentiments that “TB death is unacceptable; a death by TB is a failure.” Even with the high incidence of TB in South Africa, especially in the mining industry, he sees no reason why the industry cannot have a positive impact to change cultural, social and business norms so that no death due to TB is seen as an acceptable loss. Dr. Brink currently leads the Private sector Delegation on the Board of the Global Fund to fight AIDS, TB and Malaria.”

This policy brief is too short to do justice to the important topic of HIV/AIDS and the employer response. The reader is referred to the material produced by the South African Business Coalition on HIV & AIDS (SABCOHA)^m.

“SABCOHA aims to co-ordinate a private sector response to the HIV/AIDS epidemic. It is a member-driven organisation and, since the beginning of 2007, its membership base has undergone significant growth, with several big corporates, medium-sized enterprises and smaller companies, including service providers, joining forces in the private sector initiative to combat HIV/AIDS.” ... “Under the leadership of SABCOHA, the private sector has developed a unified response to combating HIV/AIDS through the Four Zeros Policy, namely:

- Zero tolerance for new HIV infections;
- Zero tolerance for AIDS-related illnesses and deaths;
- Zero tolerance for new babies born with HIV; and,
- Zero tolerance for discrimination.

“SABCOHA strives to help companies, both large and small, in their efforts to combat the epidemic through workplace initiatives. The organised business environment offers a unique opportunity to target the millions of employees affected by the pandemic.” “Over 90 percent of people with HIV/AIDS are in the most productive period of their lives – be they workers, managers or employers.

¹ <http://blog4globalhealth.wordpress.com/2010/10/12/south-african-mining-industry-recognizes-its-key-role-in-tb-fight/>

^m South African Business Coalition on HIV & AIDS (SABCOHA): <http://www.sabcoha.org/>

According to the International Labour Organisation as many as 36 million of the 39 million people living with HIV are in some form of productive activity. There is no doubt then that HIV/AIDS affects business – causing costs to escalate and markets to contract. While many would argue that business has a moral responsibility to help tackle the worst health crisis the world has seen in 700 years, there is also the matter of the bottom line.”

“Research shows that if companies invest in prevention and treatment programmes, the savings outweigh the costs. Providing care and treatment for HIV-positive employees can reduce the financial burden of HIV/AIDS by as much as 40%. For anyone doing business in South Africa, 10 to 40% of the workforce is likely to be infected with HIV. But the impact and potential impact of HIV/AIDS varies from one company to the next. Labour and capital-intensive industries, as well as those with a high mobility of labour, are most affected. Research in South Africa shows that the mining, metals processing, agribusiness and transport sectors are most affected by the pandemic, with more than 23% of employees infected with HIV/AIDS and with prevalence rates two to three times higher among skilled and unskilled workers than among supervisors and managers.”

9. ANC NHI Proposals and Effect on Workers

Adams *et al* in the SAHR 2007 said⁶: “Improving the performance and access to occupational health services is seen as integral to improving workers’ health. There has been good progress in this area in the mining sector but very little in the non-mining sector ... with some sectors such as the agricultural sector having little or no provision or access to occupational health services. The WHO argues for the provision of basic occupational health services in countries with low coverage. Such services should be guaranteed by the public sector and mechanisms for delivery and financing should be put in place through integrating the development of occupational health services into national strategies for reforming the health system and improving its performance” [emphasis added].

“ In South Africa this strategy was embraced in the White Paper on the Transformation of the health system, with the Department of Health (DoH) focusing specifically on the provision of occupational health services to historically neglected sectors such as small and medium enterprises, the public sector, workers in the informal sector and the unemployed. Whilst the National Health Act refers to the delivery of occupational health services as a function of provincial departments of health, there is currently no delivery of basic occupational health services within the primary or secondary tiers of the health system.”

In some companies, the provision of occupational clinics has been extended to provide services to family members. It is clear from the LIMS process that many workers have access to additional healthcare for themselves and their families due to their employment. The model of the bargaining councils is useful in showing how workplace health can be extended to meet the needs of local workers and in many cases, their families.

It is thus surprising that the ANC proposals on NHI³ 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 current proposals envisage that medical schemes may continue on a voluntary basis but that workers must, in the first instance, contribute to NHI through the payroll tax. Other forms of employer-based healthcare are not mentioned at all.

In section 2 the rapid growth of GEMS was discussed and it was shown that public sector and related Government entities account for 59% of restricted scheme beneficiaries. Government has attempted to amalgamate more public sector workers in GEMS but has met with resistance in some casesⁿ. Any attempts to make public sector workers pay twice for medical schemes (NHI contributions and voluntary medical scheme membership) are likely to be met with fierce resistance from the public sector unions. Calls for compensation to maintain take-home pay could only be satisfied by increasing

ⁿ The parliamentary fund refused to amalgamate with GEMS. Attempts to bring provincial and municipal workers into a single public sector workforce with common wage scales and benefits seems to have lost momentum.

the public sector wage bill. In all likelihood, therefore, it seems that some form of compromise on the issue of workplace health and restricted medical schemes will become a necessity. One possibility is that membership of approved or accredited schemes becomes a legitimate substitute for NHI.

The issue was raised by National Treasury in considering retirement reform. Budlender & Sadeck¹⁰ were tasked with finding out from Bargaining Council the likely implications of the National Treasury proposals. "Where informants did not know about the proposals, they were asked what it would mean if they were all required to be part of a single fund. Neither organised labour nor organised business were said to have come up with a formal position on the proposals. Business had, however, discussed the pros and cons, and Business Unity South Africa has plans to establish a committee to come up with a consolidated employer view. One of the most common concerns was whether and how a single fund would cater for the specific needs of low-paid workers, as well as for the specific needs of particular sectors that are currently provided for by the different council funds. This concern is not minor given the great diversity of provisions There was a related concern about the loss of decision-making power and oversight currently held by employees and employers."

"A contrasting concern, from someone who knew more about the Treasury proposal, was that if employees with earnings below a certain threshold were covered, this would leave very few workers contributing to and benefiting from the council funds. This would make the funds unviable."

"These benefits, which employers and employees have considered important enough to bargain over, would be lost. Beyond the immediate losses to the employees (and probably employers in terms of efficiency of use of funds), there is a larger question as to what dissolution of the funds (and perhaps councils) as a result of insensitive design of the National Treasury approach would mean for the country's belief in the importance of collective bargaining and participation in decision-making more generally."

"The overall finding at this stage is that the council funds are providing a wide range of benefits to workers who would not otherwise receive them, and certainly not for the given size of contributions. These benefits are often tailored to meet particular needs. There are several characteristics of the councils and funds that mean that these funds are likely, if anything, to be more efficiently run than many private sector funds, and better governed. Design of a new system needs to avoid losing these good elements in a one-size-fits-all approach."

While Budlender & Sadeck's conclusions above dealt with retirement reform, precisely the same issues would arise should existing healthcare schemes and workplace arrangements be replaced with a monolithic single purchaser NHI. National Treasury had at least commissioned the report and listened to the concerns of workers and employers. As yet there is no evidence of the same openness on the NHI proposals.

At the very least, the NHI proposals need to be taken to The National Economic Development and Labour Council (Nedlac)^o where labour unions, employer-groups and civil society can openly debate the issue. "Nedlac's origins lie in the struggle against apartheid, against unilateral decision-making, and in the calls from all sectors of society for decisions to be taken in a more inclusive and transparent manner."

The graph below 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. The estimate is derived from the work on insurable families and phased membership of NHI, reported in IMSA Policy Brief No. 2¹⁶. The patterns from the General Household Survey 2005 have been applied to the StatsSA mid-year population 2009 and the numbers in medical schemes at year-end 2009⁸ have been deducted.

^oThe National Economic Development and Labour Council (Nedlac) "is the vehicle by which government, labour, business and community organisations will seek to cooperate, through problem-solving and negotiation, on economic, labour and development issues, and related challenges facing the country." <http://www.nedlac.org.za/home.aspx>

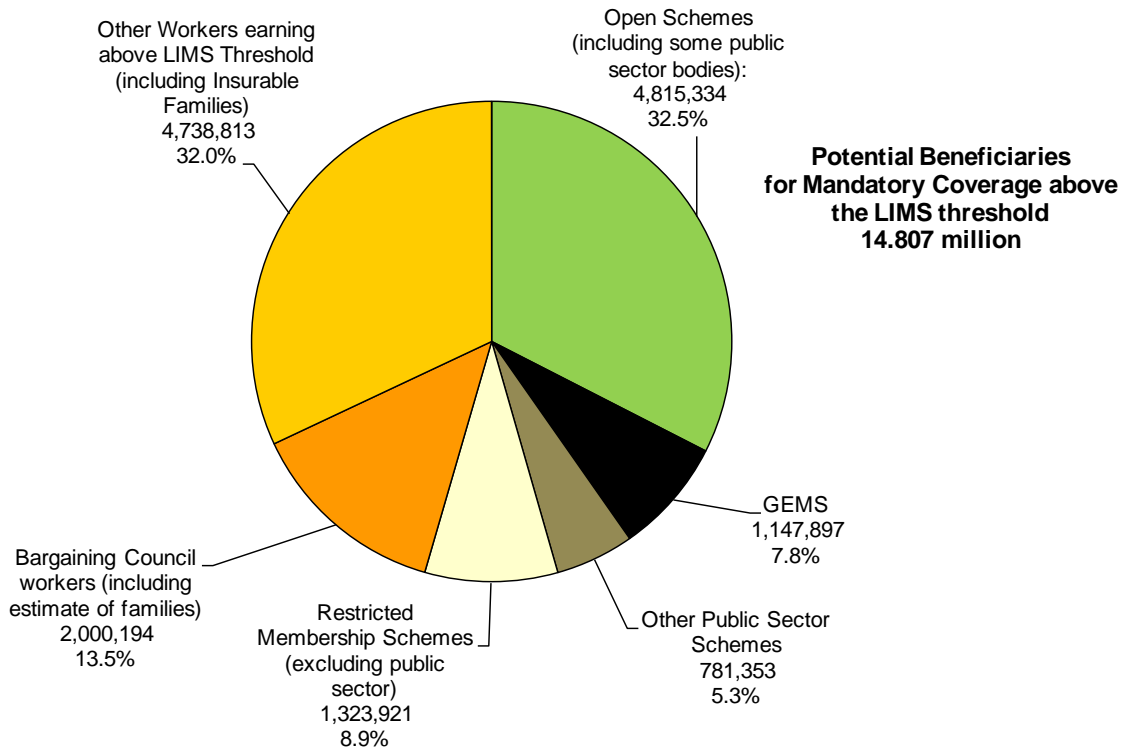


Figure 4: Possible Mandatory Health Insurance linked to Employment, 2009

The estimate of the families covered by Bargaining Council funds is derived from the total number of workers in Bargaining Councils¹⁰ circa 2007, multiplied by a dependant ratio of 2.8^p and deducting the beneficiaries in the Moto Health Care medical scheme^q as at end December 2009⁸. This suggests there may be a further 2.0 million beneficiaries in Bargaining Councils with funds who could be incorporated in a future mandatory health system if a viable means is found to incorporate these arrangements.

Workplace health arrangements fulfil an important role in healthcare provision in South Africa. They are part of the assets we have in healthcare provision and rather than discourage these arrangements, we need to find a way to encourage, develop and incorporate them into the health system on an equitable basis.

National Treasury has already made a beginning in altering the tax treatment of employer-provided healthcare¹⁷: “Government’s central policy objective with regard to amending the tax treatment of medical expenses is to encourage improved medical scheme coverage and providing more affordable medical treatment for most South Africans. The cost of medical treatment can be borne by the individual either directly as medical expenses incurred by that individual or indirectly through medical scheme coverage purchased by that individual. The cost can also be borne directly or indirectly by the employer.”

^p The ratio of beneficiaries to members in registered medical schemes fluctuated in a narrow band between 2.7 and 2.9 between 1977 and 1996. It is only in more recent years that there has been a reduction in the ratio to 2.3. This may be partly due to smaller families but is probably largely due to affordability pressures under which the family does not cover all the children in the household. As lower income families tend to have more children, the estimate of beneficiaries from Bargaining Council funds could be conservative.

^q MOTO Health Care is a Bargaining Council Fund registered with the Council of Medical Schemes in October 2007. The Fund is restricted to employers and their employees operating in the Motor Industry in South Africa. <http://www.motohealthcare.org.za/>

“All four funding methods should be addressed through the tax system on an equitable basis to give the individual the opportunity to elect the most effective form of finance for his specific circumstances. The harmonisation of the tax treatment of medical expenditure by employed persons, self-employed persons and firms into a single consistent framework is desirable.” The new tax treatment was implemented in 2006 although it still does not go far enough to assist lower income workers^{18,19}.

The thinking in the paragraphs above on equity in the tax system 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 monolithic single purchaser NHI.

The views expressed are those of the author.

Professor Heather McLeod

15 December 2010

Resources on the IMSA Web-site

The following is available on the NHI section of the IMSA web-site: www.imsa.org.za

- The graphs and tables used in this policy brief [PowerPoint slides].

As the purpose of this series is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system, we would be delighted if you make use of it in other research and publications. All material produced for the IMSA NHI Policy Brief series and made available on the web-site may be freely used, provided the source is acknowledged. The material is produced under a Creative Commons Attribution-Noncommercial-Share Alike licence.



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