AN EXAMINATION OF THE MEDICAL SCHEMES ACT, 1967

This Paper will be divided into three main sections.

The first section will deal with the question of medical care Industry, the rôle of the State and then the applicability of Act. It will also detail the scope, structure and administra of the Act. Section B will deal with the control which the A exercises over Medical Schemes and the final section will exa the Act as arbitrator between the Schemes and Medical Practitioners.

SECTION A

This Paper has taken for granted the relevance of medical mat rs to industrial life in general and to trade unions in particul . There is - or can be - a community of interest between unions nd employers on the question of the provision of medical care for workers. This interest does not necessarily stem from the same type of concern, nor from the same motives, but one should be aware that it exists and therefore be able to make use of suc *interest. Despite having a so-called free enterprise system,* State, in the form of Central, Provincial and Local Governmer has taken some interest in the provision of medical services the population in general, and industry in particular. The under consideration has served to introduce the State into the relationship between various private organizations such as, Medical Schemes, private hospitals, and doctors, etc. The Act has had the effect of making the State an arbitrator of sorts in these relationships. This has been done without granting any financial contribution to any of the private organizations ar , apparently with no idea of moving towards a State-run Medical Scheme.

The word "medical" has been used deliberately, rather than that of "health" because the latter has a much wider application a was obviously not envisaged by the framers of the Act. The W Health Organization definition of "health" reads "a state of complete physical, mental and social well-being and not merel the absence of decease or infirmity". In the South African context, this definition would be extremely difficult, if not impossible to implement, without an extensive re-organizatior f the medical, social and political system.

SCOPE OF THE ACT

Medical schemes run by trade unions are covered by this Act

those run by Industrial Councils are, broadly speaking, only affected should the Minister of Labour ask for such cover to be extended. In December 1968, however, a significant change to the Act was made by the Government. This change concerned the question of membership of two Medical Schemes by one individual. When the Act was published in 1967, Clause 38 effectively prohibited an individual from belonging to, or submitting claims against, more than one Medical Scheme. This provision was then extended to Schemes which had hitherto been excluded from the operations of the Act, namely Medical Schemes established by agreement under the Industrial Conciliation Act, the South African Railways and Harbours Sick Fund and those Funds established under the Police Act, the Defence Act and the Prisons Act. This change took place despite vigorous protests from such bodies as the Transvaal Clothing Industry Medical Aid Society. The latter, in a memorandum published in February 1969, pointed out that this extension of the scope of the Act would severly curtail the benefits enjoyed by many women in the Industry. Many of these women were married to men who worked in industries such as Furniture and Leather, where medical benefits were not as extensive as those provided in the Clothing industry. The relevant clause did not allow a dependant of a member to choose to which scheme she should belong and consequently many people were deprived of medical cover - a situation hardly in keeping with the declared aims of the Medical Schemes Act. The result of this change was to force Industrial Council Schemes to divide into two - one exclusively for sick pay, the other for medical benefits. Women whose husbands belonged to a Medical Scheme could therefore still receive benefits from the Sick Pay Fund.

Those Schemes which include medical cover as part of their benefits but which contain other provisions that make them liable for registration either under the Pension Funds Act or the Friendly Societies Act are not exempted from registration in terms of the Medical Schemes Act. Such schemes shall be registered under the latter Act, only after registration has been effected under one of the two Acts. When a Pension Fund or Friendly Society ceases to be registered under the applicable Act, registration under the Medical Schemes Act automatically lapses. Section B of this Paper will indicate the control which the Medical Schemes Act exercises over the rules adopted in the constitutions of schemes which are registered as Pension Funds or Friendly Societies.

In indicating the scope of the Act, recognition has been given to the existence of two distinct types of schemes, namely Medical Aid and Medical Benefit. The Act's scope, however, is equal for both types.

STRUCTURE FOR THE ADMINISTRATION OF THE ACT

The Central Council for Medical Schemes was formally established in terms of the Act and was given certain functions which will be discussed later. Not less than seven and not more than nine ordinary members are appointed by the Minister of Health, who also appoints the Chairman and the Vice-Chairman. The Council contains members who represent various interests namely a medical practitioner, a dentist, a chemist and druggist, someone with a special knowledge of Medical Benefit Schemes, another who has special knowledge of Medical Aid Schemes, one who has special knowledge of hospital service and another person who on the recommendation of the Minister of Labour would have special knowledge of Schemes established under Industrial Conciliation Agreements.

The Act prescribes two specific functions to the Council, namely the control and promotion of Medical Schemes, and the investigation of complaints and settlement of disputes concerning medical schemes. Other functions can be allocated to the Council from time to time. The Minister of Health is also obliged to consult the Council before appointing the Registrar of Medical Schemes.

The Council also has extensive duties to perform in connection with complaints and disputes. The latter can include disputes in connection with the rules under which schemes operate. The Council is also empowered to enquire into complaints by medical practitioners or dentists or any supplier of service against a scheme or schemes and complaints by the latter against medical practitioners, dentists, etc. where such complaints could not be dealt with under the Medical, Dental and Pharmacy Act. Disputes which concern financial arrangements and fees payable to medical practitioners can also be placed before the Council for consideration and there are fairly lengthy portions of the Act devoted to the settlement of such disputes.

The Act also gave recognition to the two national associations representing the different types of schemes. Both the National Association of Medical Aid Schemes and the National Association of Medical Benefit Schemes were given recognition in the original Act, although this specific provision was removed in 1969.

A Secretariat with a Registrar of Medical Schemes at its head was also established. This officer is directly responsible to the Secretary for Health and the Minister. He has wide powers to call for information and statistics as well as extensive powers with regard to the registration, cancellation and all suspension of registration of the various schemes. Such registration forms an important part of the control measures introduced by the Act and will be dealt with in the following section.

SECTION B

CONTROL OF SCHEMES

All medical schemes, whether aid or benefit, in existence at the time the Act was published, or which came into operation after 1967 were required to register as Medical Schemes. Each scheme has to satisfy the Registrar that rules and other provisions comply with the Act before a certificate would be issued. The Registrar has powers to grant provisional registration should he feel that the scheme did not comply in full with the Act, thus allowing time for alteration in order to satisfy the necessary requirements. Medical Schemes would not be permitted to carry on any business other than that of the provision of medical care. Certain minimum provisions are required in the rules of each scheme namely:-

(a) The appointment of manager or public officer,
(b) Stipulation of minimum benefits,
(c) A provision that dependants of members would also be entitled to the same benefits,
(d) The provision of continuation membership for people who retire or terminate employment on account of age, ill health or other disability,
(e) That the scheme grants cover to widow-members,
(f) A stipulation that a scheme would be obliged to admit as a member any person who had previously been registered with another medical scheme for a continuous period of at least two years,
(g) The settlement of disputes between members and schemes,
(h) Provision for amendments to rules of the scheme.

Any changes to the rules of a particular scheme would have to be approved of by the Registrar and registered accordingly. Those schemes which are also registered under the Pension Fund Act or the Friendly Societies Act are also obliged to apply to the Registrar for permission to alter or cancel rules connected with the medical section.

Should any scheme be dissatisfied with the ruling which the Registrar may have given, provision has been made for appeals to the Medical Schemes Appeal Board which consists of three members appointed by the Minister. This seldom occurs as most disputes are handled by the Central Council.

The Council also has the power, with the approval of the Minister, to make regulations with regard to certain matters which include the provision of benefits to members of schemes, the payment of subscriptions, the supply of statistics, etc. The latest and most important of these regulations were issued on the 29th December 1972, and came into force on the 1st July of this year. These

made certain radical changes with regard to the payment of benefits to members of both medical aid and medical benefit schemes. The Council introduced minimum and maximum benefits which will have the effect of making members of such schemes pay a certain amount each time they visit general practitioners or are supplied with medicines by such practitioners. These regulations were adopted in order to apply disincentives to all members of medical schemes. The minimum levy for each visit to a general practitioner is 50c per consultation; for home visits, 75c per consultation and during weekends and public holidays, a minimum of R1 per visit. The regulations also make it necessary for schemes to make a charge for each prescription which members receive.

While these provisions do not, as yet, apply to members in Industrial Council schemes, they are an indication of what the Government and the Central Council regard as the method by which to counter the growing use and possible abuse, of medical cover. These measures might have an effect on the over-use of medical services (mainly by higher-income groups) in the short- term. It is unlikely, however, that they could be anything but stop-gaps in the struggle to provide effective and expanding cover without allowing costs to increase a great deal.

SECTION C

The Act as arbitrator between schemes and medical practitioners.

1. Tariff of fees : Several sections of the 1967 Act dealt with this matter (e.g. Clauses 29, 30 and 31) and emphasised once again the importance with which the matter of payment is viewed by the Government. It might also indicate the priorities which the latter have set in regard to medical care.

The Tariff applies mainly to Medical Aid Societies as they pay on a fee-per-visit basis. Originally it was thought that changes to the Tariff would come about on application to the Central Council from either the Medical or Dental Association acting together with the National Association of Medical Aid Schemes. Should the latter and either (or both) of the medical associations not reach agreement on such changes, a dispute would be referred to the Central Council. This body would nominate an arbitrator who would make a final and binding (not less than 12 months) award.

These provisions were changed in 1969 in order to allow for the appointment of a Remuneration Commission, which now meets every two years to consider the question of tariffs. The Commission receives representations from the professional medical bodies and the various Associations representing Medical Schemes including

the National Association of Medical Benefit Schemes. Although the last Commission did not give extensive increases to the practitioners, it seems probable that it would find it difficult not to do so next year. While the Tariff does not affect Medical Benefit Schemes as much as it does the Medical Aid Schemes, it is obviously also an important indicator of cost and payment patterns for the benefit type of Society. The large section of the original Act dealing with payment to medical practitioners by the Benefit Societies was too unwieldy to prove effective and was subsequently removed in the amendments to the Act published on the 30th June, 1969. One important provision contained in these sections was the one which allowed doctors and dentists to "contract out" of the Act. This meant that the Tariff of fees would not apply to such people who could therefore charge in excess of the "normal" rate. Not unnaturally, the Medical Schemes have felt that the opportunities for "contracting out" give an undue advantage to the practitioners. Members who consult such doctors receive the accounts direct and have then to recover payment from the Schemes. Dentists were also covered by the Act but recently their Association has let it be known that all dentists have decided to "contract out" and consequently new moves are being made to deal with this situation.

The title of this Paper obviously sets a fairly narrow limit to its content and therefore the three sections have aimed merely at giving some idea of the major features of the Act.

One possibly interesting point for discussion which would extend the range of the Paper is a consideration of one of the most neglected features of the Act. This is the one which encourages the Central Council for Medical Schemes "to.....promote, encourage .....development and functioning of medical schemes". One would have imagined that this directive would involve a close look at the kind of medical care which schemes are, or should be providing, i.e. whether promotive, preventative and educational programmes should receive as much encouragement as purely curative services?