

INDUSTRIAL COUNCIL MEDICAL AID AND
MEDICAL BENEFITS SCHEMES IN SOUTH AFRICA

D. Cooper

INTRODUCTION

In this paper I will examine the medical aid and benefit schemes established under the Industrial Councils in various industries.

The differences between medical aid and medical benefit schemes will be looked at in some detail. Some case studies of benefit schemes in particular industries will be discussed in order to illuminate these.

An attempt will be made, through reviewing the Industrial Council medical schemes in existence, to gauge the viability and benefit to workers of these schemes.

Social security measures covering workers' health in South Africa can be divided into the following areas:

Health Conditions at Work:

These are governed by the Factories, Machinery and Building Work Act and the Shops and Offices Act. These regulations lay down minimum requirements with regard to floor space and ventilation, lighting, toilet facilities, protective clothing and appliances and so forth. They also form the basic legislation laying down sick leave and sick pay provisions. This is in addition to the Unemployment Insurance Act. Exemptions may be obtained from these sick leave provisions if other provisions are made in a sick fund, an Industrial Council agreement or a Wage Determination. These provisions are supposed to be an improvement on those in the Factories Act. Some health provisions which apply specifically to African workers are laid down in the Bantu Labour Regulations Act.

Industrial Diseases and Accidents:

This area is governed by the Workmen's Compensation Act. It involves accidents or diseases contracted in the workplace. The Government-appointed Commission of Inquiry into occupation health (The Erasmus Commission) whose report was published in 1976, called for sweeping changes in legislation affecting Industrial health. They found that a very serious situation existed in South African industry with regard to officially recognised industrial diseases.

Medical Schemes:

This is the third area of workers' health, which will form the main subject matter of this paper. These three areas are not mutually exclusive, but overlap, each affecting the other. Chronic illness as a result of exposure to occupational disease, for example, can have important bearing on the need for future medical attention covered by medical insurance schemes.

The present system of medical schemes (together with other forms of social security such as provident, funeral and pension funds) can be seen to originate partly from the early mutual aid societies and partly from the private commercial insurance schemes. The mutual aid societies developed in Europe with the appearance of an unorganised mass of unskilled labourers in the towns. The formation of mutual aid clubs were often the basis for later emergence of industrial trade unions.

MEDICAL AID AND BENEFIT SCHEMES

There are two types of medical schemes in operation in South Africa which assist workers in paying for medical services, after the payment of a regular contribution. These are medical benefit and medical aid schemes. Although the most common distinction made between the two is based on the fact that medical aid schemes allow the

member a free choice of doctors whereas medical benefit schemes appoint doctors on a panel basis, there are more significant differences.

The medical aid scheme is generally aimed at the more skilled, higher income workers. The contributions deducted are higher and the benefits extended generally more comprehensive, from a curative perspective. Medical benefit schemes are aimed at lower paid workers, who are usually semi-skilled or unskilled. The contributions deducted are much lower than medical aid contributions. Not all medical benefit societies render full services, many of them operating on the principle of gradualism. Initially only doctor's services and medicine are provided free, but as finances are built-up benefits are extended and further benefits are included.

The medical benefit societies tend to have a more preventative bias than medical aid societies, which tend to provide straight insurance aid. This manifests itself in the establishment of clinics, free immunisation and mass x-ray programmes. This lack of preventative measures by medical aid schemes exists despite the fact that many of these schemes include amongst their aims that of promoting good health amongst their members.

The first medical aid scheme was started in 1899 by De Beers for its employees. By 1910 there were 7 schemes and 48 schemes by 1939. After World War II there was a marked increase in the number of medical aid schemes established. In 1960 there were 171 schemes and 2292 in 1975 (1).

In 1967 the Medical Schemes Act was passed. The Act came 5 years after the report of the Commission of Enquiry into the high cost of medical services and medicine, (The Snyman Commission of 1962). Many of the recommendations of this commission were incorporated into the Medical Schemes Act. The Act provides for the establishment of a Central Council for medical schemes, and a medical schemes fund which will be administered by the Secretary for Health. It lays down minimum benefit requirements with which medical

schemes must comply. One of these is that the dependants of a member must be entitled to the same benefits as the member. Exemptions from complying with certain of the minimum benefits can be applied for on a yearly basis. These are granted at the discretion of the Central Council.

Different types of medical schemes exist: a) Commercial schemes run by Insurance Companies, b) employer-initiated private schemes, c) Trade Union initiated and administered schemes and d) Medical schemes established in terms of Industrial Council Agreement. These schemes have been established by trade unions together with employer organisations in the different industries where Industrial Councils exist. It is this last type of medical scheme on which we will be concentrating on.

INDUSTRIAL COUNCIL MEDICAL SCHEMES

Industrial Councils have been formed in certain industries under the Industrial Conciliation Act (Act No. 28 of 1956). The Industrial Councils, which are formed by representatives of the registered trade unions and employers' associations in an industry, publish agreements relating to the wages and working conditions in that particular industry.

Parties to Industrial Council agreements can only include trade unions that have been registered. As Africans do not belong to registered trades unions, they cannot be represented on the Industrial Council. These agreements can be extended to African workers in the industry if this is recommended by the Bantu Labour Board.

In all Industrial Council Medical Schemes, management committees are formed. There is equal representation and participation of registered trade unions and employers' associations on these. African worker representatives cannot participate in the decision-making process of the committees. It would be possible to bring in these representatives at a sub-committee level. However, it is doubtful whether this is frequently done. The medical

doubtful whether this is frequently done. The medical schemes established under Industrial Council jurisdiction are exempt from complying with the Medical Schemes Act. They fall under the Industrial Conciliation Act. The only obligation they have to the Medical Schemes fund is to furnish information annually in respect of their finances and expenditure.

The medical schemes are required to be an improvement on the basic health provisions laid down in the Factories Act and Shops and Offices Act. There is often ambiguity as regards this, however. For example, in a recent memorandum recommending the establishment of a sick benefit scheme in the Iron and Steel Industry, the workers complained that the new agreement gave a longer period of sick leave than the main agreement for the industry, but did not include a comparison with the Unemployment Insurance Fund which also extends sick pay. It is thus not always clear that the health provisions have, in fact, improved. Sixty nine percent of white, coloured and Indian workers who fall under Industrial Council jurisdiction are covered by medical schemes. Only 8% of Africans to whom these agreements are extended are covered (2) (See Table 1).

TABLE 1

MEMBERSHIP BY RACE OF MEDICAL AID AND MEDICAL BENEFIT SCHEMES
ADMINISTERED BY INDUSTRIAL COUNCILS

	Whites	Col.	Asians	Africans	Total
No. of workers covered by all I.C.'s (1971)	218 686	192 915	61 486	537 475	1 010 562
No. of workers with medical aid coverage in terms of I.C. agreements (16 (I.C.'s))	145 865	40 593	7 017	549	194 924
No. of workers with Medical Benefit coverage in terms of Industrial Council agreements (29 (I.C.'s))	10 629	76 316	31 127	40 468	158 540
No. of workers with either Medical benefit or medical aid coverage as % of all workers covered by I.C.'s	72%	61%	62%	8%	35%
No. of workers who could have been covered if those Industrial Councils who have medical aid had extended scheme to all workers in those industries	178 450	94 158	15 059	420 659	708 326

No. of workers who could have been covered if those I.C.'s who have medical benefit had extended scheme to all workers in those industries.	10 792	77 701	31 305	47 885	167 683
No. of workers covered by I.C.'s who have no medical scheme	62 192	76 006	23 342	496 458	651 998
% of workers covered by I.C.'s which operate medical aid	81%	43%	46%	Negligible	
% of workers covered by I.C.'s which operate a medical benefit.	99%	98%	99%	84%	

SOURCE: W.H. Thomas (ed.), Labour Prospectives in South Africa, p. 191

Medical Aid Schemes

Table 1 shows that a racial bias exists, in terms of which medical aid schemes tend predominantly to cover whites. This stems from the skilled-worker bias of the medical aid schemes and the fact that whites monopolise skilled positions. The contributions for medical aid schemes are also too high for lower-paid workers. It is, however, the parties to the Industrial Council agreements who decide on contributions rates and so forth. The parties are the registered trade unions and the employer organizations. For the most part, medical aid schemes exist in industries in which the trade union is still organised on a craft union basis. These include: Building, Printing, Electrical undertakings, Engineering, Iron, Steel, Metallurgical Industries, Hairdressing and Furniture. Eighty one per cent of white workers are covered, whereas Africans have virtually no medical aid coverage (See Table 1). The high exclusion rate of Africans and relatively high exclusion rate of coloureds and Indian workers could be due to the fact that these workers are not employed in skilled positions.

Medical Benefit Schemes

Medical benefit schemes cover the majority of workers in industries where Industrial Council medical assistance schemes have been established (See Table 1).

Of the 40 468 Africans who have medical benefit coverage, 30 274 are in the clothing and knitting trade (3).

Generally, medical benefit schemes are to be found in industries where industrial unions (rather than craft unions) operate.

All medical benefit schemes operate on the basis of a panel of contracting doctors whom members consult. Medical benefit societies on the whole cater for lower paid workers (hence the low contribution rates) and have less extensive benefits than medical aid societies. There are

circumstances in which the member can consult a non-panel doctor. These circumstances include occasions when a worker takes ill away from the centre in which he usually receives treatment from the panel doctors.

Industrial Council medical benefit schemes operate in the following industries: Baking and Confectionery (P.E. and Uitenhage); Bespoke tailoring (Witwatersrand); Bedding Manufacturing (Tvl); Canvas Goods (Witwatersrand and Pretoria); Chemicals (Witwatersrand and Pretoria); Clothing (Cape, George, N. Cape and O.F.S., Tvl, E. Province, Natal); Cotton Textile, Retail Meat (Witwatersrand); Millinery (Cape); Tobacco (Tvl); Worsted Textile (Cape); Laundry, Diamond Cutting and Leather industries. The average contribution rate of these medical benefit schemes is 28½c per week. (The average is calculated on the basis of Industries listed above in which medical benefit schemes were studied). This average amount is considerably lower than for medical aid funds. The Diamond Cutting Medical Benefit Fund (average contribution of R1,65) and that of the retail trade (R2,32 on average) have been excluded from these calculations as these are schemes which cater for skilled categories of workers and constitute exceptions to the general rule that skilled workers are covered by medical aid schemes.

In all except one of the industries listed above (Bespoke tailoring) in which medical benefit schemes exist, the contributions vary in proportion to earnings, thus a true average could not be worked out as the number of workers in each category is not known.

In all except two (Bespoke tailoring and Bedding manufacturing) the employers paid in an equal amount on behalf of the workers. The difference in contributions in the two exceptions amounted to a few cents.

In four of the twelve industries examined, the average contribution rate was less than 20c.

These contributions appear to be low, but it must be remembered that workers usually contribute to other funds as well (pension, provident and so forth). This is apart from trade union subscriptions and Unemployment Insurance deductions.

Of the twelve industries in which medical benefit schemes were examined, only one extends benefits to dependants. The contributions are low and the funds claim they do not have the finances to include dependants. All the funds have free medical treatment by a panel of doctors. All have pharmaceutical benefits. In three of the funds, a minor part of the cost of medicine is borne by the member. In one there is an annual limit on pharmaceutical benefits. Four of the funds allow a limited number of visits to specialists or make provisions for this, at the discretion of the management committee. Three of the funds make provision for partial payment of hospital fees. Eight funds have optical benefits and nine have dental benefits. Both of these are partly in the form of subsidies.

The main benefits from medical benefits schemes are free medical attention from general practitioners and pharmaceutical benefits prescribed by the panel of doctors. African workers are excluded from the medical benefit schemes in the Bespoke tailoring and Bedding Industry. This is because the Minister of Labour did not extend the provisions of these agreements to African workers. Although there is a tendency towards more preventatively based medicine in medical benefit funds, to provide general health education for workers, only the Clothing and Millinery Industries and the Baking and Confectionery Industry provide practical benefits in this direction. The Baking and Confectionery industry provides for vaccinations and preventative injections. The Clothing and Millinery industries have established gynaecological, optical and dental clinics. They conduct mass immunization campaigns and have in the past carried out worker health surveys.

This bias towards curative medicine is very apparent in medicine in South Africa, in general. For example, Government and local authorities expenditure on hospitals as a percentage of total expenditure on health has risen from about 80% (1949-50) to about 83% (1950-60) to about 84% (1970-71) and to about 85% (1974-75). On the other hand Provincial expenditure on Public Health as a percentage of total expenditure on health has decreased from 3,6% (1949-50) to 0,7% (1959-60) to 0,07% (1970-71) to an almost negligible percentage in 1974-1975 (2).

All the medical benefit schemes require between thirteen and sixteen weeks of weekly contributions to the fund, before members are eligible for benefits.

Sick Pay Benefits

Of the twelve industries reviewed here, in which medical benefit schemes exist, all have sick pay benefits as part of their schemes.

Sick pay funds have been established where other medical and pharmaceutical benefits are not provided. In June 1972 there were forty-nine sick pay schemes administered by Industrial Councils, covering 348 756 workers (4).

If sick pay provisions are included in medical benefit schemes or in other Industrial Council sick pay funds, exemption must be obtained from the Factories Act and Unemployment Insurance Act sick leave provisions. Exemption from the Factories Act sick leave provisions can be obtained if a sick pay fund exists to which both employers and workers contribute an equal amount and which is said to be more favourable than the two weeks sick leave on full pay accorded by the Factories Act. No contributions are required by the worker under the Factories Act. Sick pay benefits vary considerably. Most payments range between 30% and 100% of the minimum wage and average about 45% (5). The internationally accepted standard based on the I.L.O.'s medical care and sickness benefits Convention is 60% of the total earnings.

TABLE 2
NUMBER OF WORKERS COVERED BY I.C. SICK PAY FUNDS

	Whites	Coloureds	Indians	Africans
Covered by sick pay funds.	140 243	115 905	40 051	52 557
% of workers covered by I.C. who have a sick pay Fund.	74%	70%	81%	11%
% of workers covered by all I.C.'s (i.e. those that do and those that do not operate sick funds).	64%	60%	65%	10%

SOURCE: Thomas, W.H. (ed.) Labour Perspectives in South Africa, p. 195.

It is difficult to gauge exactly to what extent workers benefit from sick pay fund provisions. It seems to emerge from the sick pay benefits examined that a longer period (than that allowed under the Factories Act) is granted for the period of illness but the remuneration is much lower. To see to what extent workers benefit from lower pay but longer sick leave, one would need to know the number of days sick leave needed on average, for the average worker for sickness. One might find that most illnesses do not take more than 12 days to recover from (except the more serious ones). In the twelve industries reviewed the maximum average time of absence allowed was 41,7 days, whereas under the Factories Act 14 days is the maximum sick leave allowed. Most sick pay funds do not pay for between one and two day's absence. Only after three day's absence does the member usually become eligible. (The full amount for the previous two days is then granted if the absence is three days or more.) A certificate is required from the panel doctor before sick pay is administered. Under the Factories Act the first two days of absence are included in the sick pay and a doctor's certificate is required only after the second day of absence. Some of the trade unionists interviewed felt that a sick pay fund benefited the employer, who would otherwise have to pay the full amount of sick pay under the Factories Act. It was felt that the amount received, if under 100% of the full pay, served to force workers back to work, as they found in many cases that they could not possibly live on only 50% of their normal pay. It was feared that this led to a return to work, before the worker was fully well, which might cause damage to the worker's health, a possible relapse and more absence in the future.

CASE STUDIES

Four case studies of Medical benefits schemes in the Cape are examined. These are the Clothing; Laundry, Dyeing and Cleaning; Cotton Textile; and Food Industries. The Clothing, Textile and Food Industries are amongst the major ones in the Cape, particularly the Cape Peninsula. Three of the schemes are administered by the Industrial Council and one (in the Food Industry) is trade union administered.

TABLE 3

MEDICAL BENEFIT SCHEMES IN FOUR WESTERN CAPE INDUSTRIES

	Clothing	Laundry Dyeing and Cleaning	Cotton Textile	Food
Membership	All workers in the clothing industry earning below R86,55 per week and R375 month. African workers included.	All workers in the industry earning under R500 per year. This includes African workers.	All workers in the industry regardless of race. All grades of workers up to (and excluding) foreman.	All workers in the industry including African workers.
	Wages	Wages	Wages	Wages
Contribution	Up to R20 per week = 20c per week. Over R20 week = 25c a week. Equal amount contributed by employer.	Under R19,50 per week = 10c per week. Over R19,50 per week = 15c per week. Equal amount contributed by employer.	Weekly wages and contributions R14,01-16,00 = 14c R16,01-18,00 = 16c R18,01-20,00 = 18c R20,01-22,00 = 20c	Under R20 per week = 13c per week Between R20 and R24 per week = 15c per week Between R24-R30=16c per week Between R30-R36=18c per week. Over R36 = 20c per week. The employer contributed 9c for each worker per week.
Benefits	<u>Consultations</u> with the fund's panel; about 65 surgeries in the Cape Peninsula and W. Cape. Doctors have been contracted in Langa and Guguletu in Cape	<u>Consultations</u> . From the panel doctors. <u>Medicine</u> up to R20 per year. (5 years ago this was R5,00 per year.) No clinics have been established and no surveys carried out.	R22,01-24,00 = 22c R24,01-26,00 = 24c R26,01-28,00 = 26c R30,01-32,00 = 30c R32,01-34,00 = 32c R34,01-36,00 = 34c R36,01-38,00 = 36c R38,01 and over = 38c	<u>Consultations</u> with fund's panel doctors. Doctors in Paarl, Tulbagh, Wellington, Ashton, W. Coast and so forth. Doctors are paid R1,50 per worker.

TABLE 3 (CONTINUED)

	Clothing	Laundry Dyeing and Cleaning	Cotton Textile	Food
Benefits	<p>Town for African workers. There is a maximum of 6 visits per illness. This can be raised at the discretion of the management committee.</p> <p><u>Clinics.</u> <u>Gynaecological</u> <u>Ante-Natal</u> <u>Optical.</u> Free eye-test, lense and spectacles.</p> <p>Members pays for frames. <u>Dental.</u> Free fillings, 30c for extractions. For dentures members pay the dental mechanic's fee. Member of 5 years standing get a subsidy of 20% for this fee. Member of 10 years standing - 40% subsidy. <u>Medicines</u> obtained from panel doctors - free.</p>	<p><u>Spectacles</u> up to R10 per year</p> <p><u>Dentures or extractions</u> up to R10 per year.</p>	<p>Equal amount contributed by employer.</p> <p><u>Consultations:</u> A panel of doctors from whom workers can choose.</p> <p><u>Medicine.</u> No maximum on amount but some limits on the types of drug which may be prescribed. <u>Dental and Optical:</u> Some benefits, depending on duration of membership of scheme.</p>	<p><u>Medicine.</u> up to R10 per year. <u>Dental.</u> R3,00 per year (about 3 extractions.) <u>No optical</u> benefits. From January, 1978 the fund is starting to pay out-patient fees. <u>Influenza</u> immunization programmes are carried out <u>Vitamin tablets</u> - distributed. <u>Clinics</u> - At Paarl and other centres at lunch time. <u>T.B. X-rays:</u> In 1978 there was a mass programme to cover about 9 000 workers.</p>
Sick pay	<p>About 50% of normal wage. Maximum of 40 working days sick leave per year.</p>	<p>If the worker earns under R19,50 per week-receives R7,50 sick pay per week. Maximum of 6 weeks sick leave per year.</p>	<p>Ranging from R1,95 per day for worker earning between R14,01-R16,00 week to R5,07 per day for workers earning R38,01 or over.</p>	<p>15 days maximum sick leave per year at 70% of normal pay (In mid-1977 was 60%). Additional pay given at discretion of committee. It is felt by some members of the committee that the first 2 days illness should be paid for. (It is not at present.</p>

All the funds examined cover all workers in the industry.

None of the funds pay for hospitalization of members and no specialist treatment is offered, except in the clinics established in the clothing industry.

None of the funds cover the dependants of the members. A certificate is required to confirm illness from the first day of absence, even though the worker is not paid from the first day if he is ill less than three days because the sick leave provisions of the funds require an absence of three days before sick payments are made.

In the Clothing Industry thirteen weeks of contributions are required before the member is eligible for benefits as is the case in the Laundry, Cleaning and Dyeing Industry. In the Food Industry four contributions are needed before a member is eligible for medical benefits and eight contributions for sick pay benefits.

The Clothing Industry medical scheme has extensive preventative medical measures as does the Food Industry schemes although they are not as extensive as those in the Clothing Industry.

1. The Clothing Industry (Cape)

Many clinics and preventative measures have been initiated in the clothing industry.

A Gynaecological Clinic was established in 1958. It was initially open $\frac{1}{2}$ day a week then later four days a week. The services offered are: examinations, family planning advice, administering of oral contraceptives (10c a month); a uterine cancer detection service, utilization of equipment for cauterization in the case of uterine cancer, and injuries from childbirth are treated. In 1961 1 497 women was treated for uterine cancer. An ante-natal clinic was established in 1962. In early 1963 an optical clinic was established. Specialist services are offered at clinics on appointment basis. A survey was carried out in

1963 on visual deficiency which showed that this was not being corrected because of the expense of glasses. In March 1973 a dental clinic was established.

Attempts have been made through the years to establish psychiatric clinics. These have not succeeded.

In 1964 a medical clinic and physiotherapy service was established. The medical clinic was supplied with a portable cardiograph machine. This was taken to the various areas to test the workers. The physiotherapy service was offered during lunch hours and after working hours.

In 1963 an influenza immunization survey was carried out. This formed the basis for later immunization programmes. The last influenza immunization campaign was carried out in 1976. Employers pay for this service at reduced rates obtained by the Industrial Council.

There were complaints of 'malingering' by employers when sick pay provisions were introduced. These were apparently unfounded.

Absenteeism Per Member of Fund.

1959	-	average	of	2.2	days	per	member	per	month.
1960	-	average	of	2.3.	"	"	"	"	"
1961	-	average	of	2.2	"	"	"	"	"
1962	-	average	of	2.4.	"	"	"	"	"
1963	-	average	of	2.8	"	"	"	"	"

In July/August 1963, there was a very severe outbreak of influenza, which explains the increase in 1963. In August 1962-63 it was found that 81% of those workers absent because of illness, showed a positive diagnosis (temperature or other such symptoms). Seventy two per cent of the work-force was responsible for 80% of the sickness in the industry. Eighty two per cent of persons consulting doctors in 1966 were female. More than 72% of the work force at that time was female.

It seems, therefore that sickness was fairly well spread amongst the labour force. The fund thought that this showed that the claims of 'malingering' were unfounded.

Medical benefits are not transferable, if the worker leaves the Clothing Industry. This creates a problem because there is a high turnover of workers in the Clothing Industry. Thus one would find that many workers sometimes pay in money without getting adequate benefits from the fund.

In case of the dissolution of the fund, after debts have been paid, of the money goes to the employer; to the trade union and to the consolidated revenue fund.

2. Laundry, Cleaning and Dyeing Industry

This fund was established about 37 years ago. Workers in this industry are mostly female (about 80% or more). The wages are low. Depot workers earn between R18-R20 a week. The workers are being hard hit during the recession, as a result of a decrease in laundry work as this constitutes a luxury item, which many people eliminate during a recession. Contributions are therefore low and thus benefits cannot be very extensive. Workers however, favour the payment of higher contributions despite the low wages and high unemployment, but employers have been against this as they pay an equal contribution. The Laundry, Cleaning and Dyeing Workers Union is struggling for an increase in contribution rates which will lead to an increase in benefits.

3. Cotton Textile Sick Benefit Fund.

The cotton textile industry has a predominantly female labour force. About 70% of the workers are female and this percentage is increasing over time.

The Cotton Textile Sick Benefit Fund was established about fifteen years ago as a sick pay and medical benefit fund.

The fund started off providing surgeries at some of the factories. This involved very basic medical benefits and although there were provisions for dental and optical benefits even at this stage, they were not really operative. When the fund was started, the sick pay was only 50% of the worker's salary. (See table 3, for present rate).

The fund applies mainly to the country areas such as Wellington, Worcester, Paarl, Tiervlei and Bellville. It excludes Cape Town because when the Industrial Council in this industry was started about 20 years ago, the most organised areas were the country areas. Hence this became the registered area of jurisdiction of the Industrial Council. When the Cape Town area is better organised, permission to extend the area of jurisdiction will be applied for.

A panel of doctors is the "system" used by the fund as it is felt that if there is too wide a range of doctors there can be little control over possible abuse of benefits. At the large factories, covered by the agreement there are doctors' surgeries on the factory premises. Initially there was an agreement with the doctors serving the fund, that they would be paid on a per capita basis. However, it was found that this often led to neglect on the part of the doctors, who were thereby assured of a certain income. The scheme has therefore now changed to payment on a consultation basis.

Problems have been encountered by the fund. One problem has been some abuse of the fund by doctors and dentists. This has generally occurred in the countryside, where there is often only one doctor or dentist available. This has led to the doctor or dentist concerned often charging exorbitant prices. These fees have had to be met either by the fund or the workers themselves, as there is no other option open to them.

Other problems have occurred with the sick pay fund. In recent years workers received sick pay from the first day of absence on presenting a doctor's certificate. This brought about a tremendous drain on the fund. This has therefore been changed, with workers only receiving sick pay from the second day of absence onwards.

It seems fairly certain that a sick pay fund benefits the employers. They would have had to pay out the full amount in sick pay to workers when they were ill, under the Factories Act, whereas the fund works on the basis of equal contribution by employers and workers. It seems that employers also have more control over workers taking sick leave through the fund, as there is closer contact between the employers and doctors who treat the workers. The relative benefits to the workers of this scheme as opposed to the provisions under the Factories Act and Unemployment Insurance Act, are more difficult to assess.

There is a large turn-over of the work-force in the textile industry which creates problems in terms of the benefits the workers get from the fund. In these circumstances it might happen that many workers pay in their contributions, but leave the industry before they have received adequate benefits for the amount they have paid in.

There are no preventative measures taken by the fund, however X-rays are done occasionally at particular factories, on request. The fund has no clinics. Besides the fact that the money collected through contributions does not allow for this, it is felt that the area in which the factories are situated were far too widely dispersed for the clinics to be easily accessible to all workers involved in the scheme.

No attempts have been made to bring African representatives in at sub-committee level in the decision-making of the fund. Contact with all workers does occur at the factory level, however.

Improvement in benefits over the years have been centred mainly on improving the benefits of those workers who have the longest membership.

4. Food Industry Medical Benefit Fund Administered by the Food and Canning Workers Union.

There is no Industrial Council in the Food industry. Instead, a Conciliation Board of employer and trade union representatives is in operation.

This scheme falls under the Medical Schemes Act. It has to apply for yearly exemption from certain provisions. So far this has been granted.

The sick fund consists of about 13 workers representatives. This is called the central committee. Quarterly meetings are held with employer and worker representatives. Other meetings are held only with workers representatives present. Every factory is meant to have a medical committee whose representatives are elected at meetings at the various factories. Representatives on the medical committee usually work part-time for the fund. At Ashton and Paarl there is one full-time worker.

This fund was established in 1950. At that stage only four canning firms participated. In the first year the income was just on R2 000 with an average membership of 1 540.

When the fund started the contributions were 2½c a week. By 1955 this had risen to 5c a week. The average membership had more than doubled by 1956/7 and stood at just over 4 000. In 1957 panels of doctors were set up and free medical attention was provided. (Up until then the only sick benefit had been pay).

1958 clinics were set up. The staff consisted mainly of first-aid attendants and nurses. Panel doctors attended lunch-hour clinics at factories as well as seeing members at their surgeries.

Mass X-ray programmes for the detection of tuberculosis were started in 1958. In 1959 free dental treatment up to a limit of R2,00 a year was introduced. In 1960 the limit on free medicines was raised from R4,00 to R6,00 and that on dental treatment was doubled. Clinics were then operating in all member factories except Wolseley and Worcester.

Between 1960 and 1973 medical and dental benefits have increased more than fourfold and now run at more than R20 000 a year.

In 1969 the Fund was registered in terms of the Friendly Societies Act. It held dual registration with the Departments of Health and Finance. (The latter has not been waived).

In 1972 the first mass immunization against influenza took place. Over 3 500 workers were immunized at a cost to the fund of R2 659. This was repeated in 1974. This has not been done since, as there are doubts as to its effectiveness.

Present Situation: (Table 3 shows Membership, Contributions & Benefits). At present one firm, South African Preserving at Tulbagh, has given permanent workers the option of belonging to the Cape Medical Plan. In this case the employer pays 2/3 (about R15 per month) of the contribution to the Cape Medical Plan. This factory still belongs to the Food and Canning Workers' Union fund, however, so that seasonal workers will be covered.

Members retain benefits for two months after they stop working. This is because of the seasonal nature of the food industry in which most workers are laid-off for part of the year.

The areas which this fund covers are very dispersed. This creates difficulties with regard to health education which is thought to be important by the members of the fund. The doctor's contacted within the various towns, is usually used for this purpose; however this is not always as satisfactory as the fund would like it to be.

Four contributions are needed before a member is eligible for medical benefits and eight contributions for sick pay benefits.

TABLE 4
MEDICAL BENEFIT FUND FOR THE FOOD INDUSTRY.
YEAR ENDING DECEMBER 1976

<u>Benefits to members</u>	<u>1976</u>	<u>1975</u>	<u>Difference</u>
Total	R53 349,81	R40 767	+ 12 582 81
Administrative expenses	R17 053,69	R20 107	- 3 054
Total expenditure	R70 403,50		
Contributions received:	R60 020,52	R56 083	
Income from investments:	R16 327,49	R13 575	

CONCLUSION

The following points emerge from the previous discussion. Firstly the skilled worker and racial bias of medical insurance schemes should be noted. (69% of whites who are predominantly skilled or semi-skilled as opposed to 8% of Africans, predominantly unskilled, are covered by Industrial Council medical schemes.) More concern is shown for the health of skilled workers who are less easily replaceable, than for that of unskilled workers.

The curative bias of medical schemes in general (to a lesser extent, medical benefit schemes) is another fact which emerges. This is a general feature of medicine in South Africa. The Clothing and Food Industry medical benefit schemes show attempts at initiating preventative health programmes. These remain some of the few isolated examples. The benefits extended by medical benefit schemes are much less comprehensive than those offered by medical aid schemes which cater for skilled, higher paid workers. (On the one hand, the low contribution rates of medical benefit schemes must be borne in mind here, but on the other, the greater concern shown for skilled workers' health must be noted.) Complaints have been levelled at the high cost of administration of medical schemes in general, compared with amounts paid out. As figures on expenditure were unavailable in most cases, the truth of this could not be assessed with regard to Industrial Council medical schemes.

As already mentioned, the benefit to workers of a sick pay fund which often accompanies medical benefit funds is dubious. It was felt by most of the trade unionists that this was attained on the initiative of the employer rather than the worker and tended to benefit the former. It gave the employer greater control over sick leave taken by the worker, as the worker needed to obtain a certificate from the panel doctor from the first day of illness. The doctor, working on the factory premises, often had close contact with the employer, and, it was felt, was sometimes more sympathetic to the requirements of the employer than the illness of the worker. This was particularly prone to occur in small towns, where the population is small and the employer and the doctor are often good acquaintances. It must also be noted that under the Factories Act the employer would have to pay out the sick pay in full, while the employer and worker each pay in an equal contribution into a sick pay fund. The point made earlier about the different sick pay benefits provided in terms of the Factories Act and the various sick pay funds needs to be

re-emphasized. Under the Factories Act two weeks sick leave on full pay is allowed whereas the sick pay funds provide less than full pay (an average only 45%) but for longer periods. It was felt that this tended to force workers back to work before they were completely well, as they found it impossible to cope on the reduced pay. They would therefore be unlikely to benefit from the increased period of sick leave in terms of sick pay funds, but would be disadvantaged, as compared with the terms of sick pay under the Factories Act.

The mobility of unskilled labour where they move from industry to industry as a result of the contract labour system and for other reasons, militates against it being in the interests of these workers to belong to medical schemes. Between thirteen and sixteen weeks contribution are required by most of the schemes before a member becomes eligible for benefits. In many schemes, long membership allows the members extra benefits. These workers would lose out in this case and might find themselves paying in quite a large amount without getting adequate benefit from it. The present high rate of unemployment and retrenchment increase the likelihood of this happening.

The number of medical schemes established by the Industrial councils are few, considering the number of industries under their jurisdiction (101 I.C.'s exist). The demands for a greater number of medical schemes in isolation, without concern for the general situation of workers, need not necessarily be a progressive move, however: "The great danger lies in purchasing a benefit scheme in lieu of substantial wage increases in a situation where the absolute level of real wages is very low. The 'trade-off' has to be considered with particular circumspection in South Africa where the vast majority of workers are in an especially disadvantageous position vis-a-vis employers' parties in negotiations of any sort (6).

Footnotes:

1. All figures from Matheson J: The Economics of Health in South Africa - A Survey. Unpublished Economics Honours Thesis, University of Cape Town, 1977, p.47.

2. Ibid., p. 22.
3. Statistics calculated from a weighted average of the number of workers covered by each Industrial Council.
4. Information from the Dept. of Labour.
5. Calculated from statistics available to the author.
6. Horner D.: 'Comment' in Thomas, W.H. (ed) Labour Perspectives in South Africa, David Philip, Cape Town, p.208.