Health - who can afford it?

With the rocketing cost of health care and the deterioration of the service provided by the public health sector, many workers are looking to their unions to provide some form of medical benefits. This has consequences for the privatisation of health care. Frank Meintjies and Dirk Hartford examine these consequences, what it means for workers and how unions are responding to the challenge.

At the same time as President de Klerk unbanned organisations and released some political prisoners, he confirmed that his government was interested in ruling in the interests of the rich. The economic policies he outlined at parliament's opening - more free enterprise, more privatisation and more deregulation - are nothing less than an attack on the livelihood of millions of poor people in this country.

De Klerk's policies mean that decent health care is going to be even more the privilege of the rich few. Working class people already suffer because they cannot afford treatment. With the growth in medical aids and private health care, and the concomitant decline in public health care, the position is going to become even worse.

So what are the organisations of the working class - the trade unions in particular - doing about the situation? The ANC, COSATU and all other formations of the mass democratic movement (MDM) support the demand for a national, unitary health service; one controlled by the people and for the people.

The MDM's hospital defiance campaign last year targeted racism in health and sought to end the divide between segregated inferior hospitals for the masses and superior hospitals for the white minority group. This campaign, however, did not concentrate on the issues of privatisation, poor conditions at most "black" hospitals, inadequate health facilities, poor wages and working conditions of health workers and the escalating costs of health care.

Health and social service organisations, who have recently staged marches for open hospitals and opposing privatisation, do not have an easy time bringing health issues onto the agenda of leading mass organisations.

Privatisation of health services demands that a significant layer of workers be drawn into medical aid schemes. This has meant that unions are finding themselves at the cutting edge of the government's major privatisation drive.

How unions respond will have a decisive effect on where South Africa's health system develops. Unions can help lay the basis for a national health service (NHS), or

can see their members become the support-base for health privatisation. The latter will further rob the working class of its right to equal and affordable health care.

The unions occupy this important position because privatisation will work best if the medical insurance system can deliver the patients, presently reliant on public health care, to private doctors, clinics and hospitals.

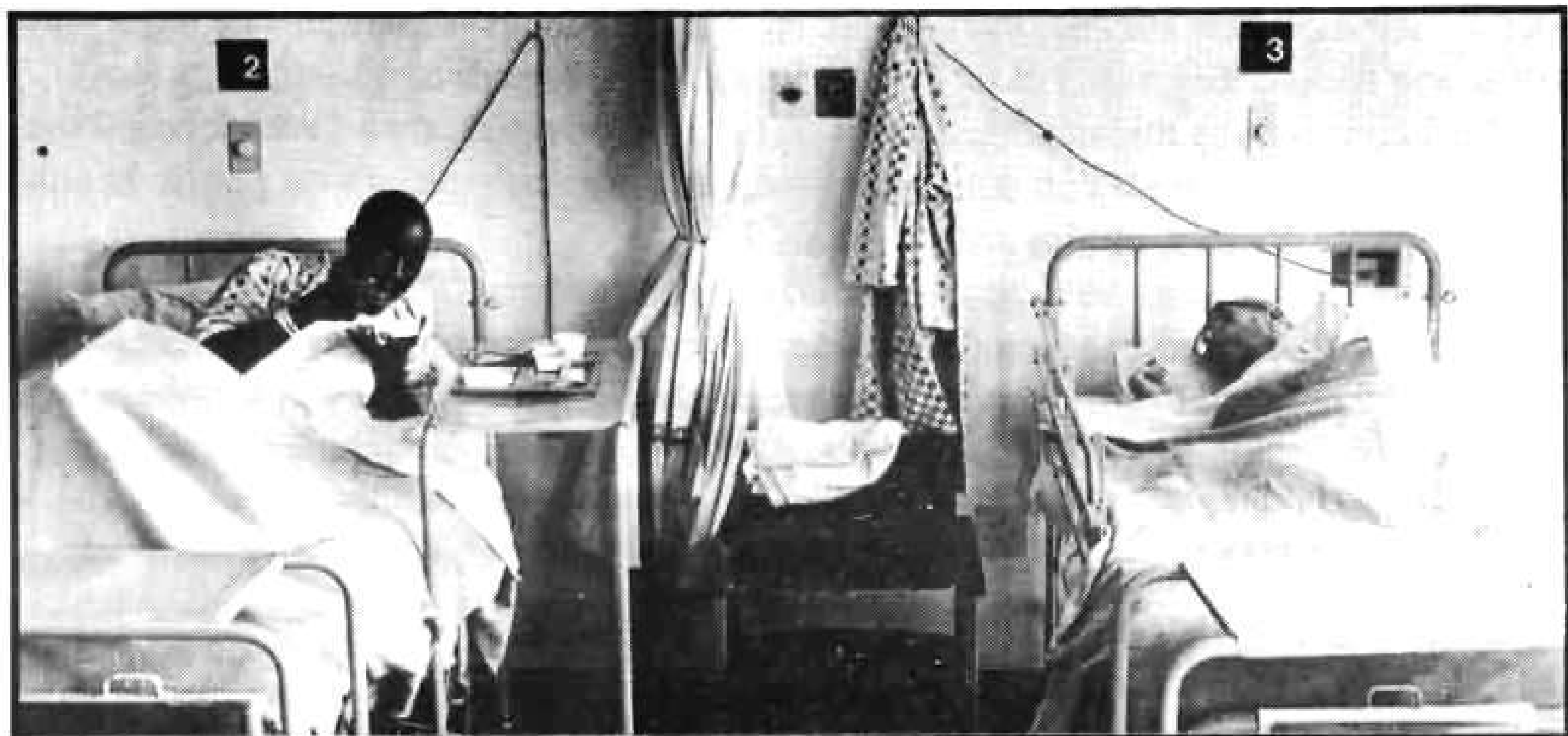
Medical aid schemes hold potential disaster for workers. They deny any form of worker control and are continuously rising prices. Furthermore, they cut across the demand for a national health scheme, threatening division between union members and the broader community as well as between the employed and unemployed workers.

How are unions responding to the issue?

Most unions run the danger of being caught off-guard on the issue. On the one hand many unions are operating under pressure, with resources spread around the tasks of consolidating structures and taking up a range of issues not directly related to health care.

As a rule, health and safety structures in unions range from frail to non-existent. Health and safety as whole is a low priority in most unions.

In their response to the demand for medical aids, unions can help lay the basis for a NHS, or can see their members becoming the support-base for health privatisation.



Rocketing fees are preventing many poor people from obtaining health care.

Low paid workers are likely to bear the brunt of the push to privatise. Hospital fees have gone up by approximately 700% in the last 5 years. Minimum fees are R5 a day at a clinic and if one sees a doctor one pays R18. These fees start rising rapidly as wages increase. The moment a worker earns more than R9 000 a year (R750 a month) she/he is classified as a private patient; fees due in this case are R30 a visit and R180 a day.

The rocketing fees are part of the plan to shunt more people into the private sector; for the low-paid and the unemployed, these fees further close off access to medical care. Recent press reports point to an escalating crisis - many thousands who have needed medical attention just cannot pay, or are refusing to pay, despite threatening letters from hospitals. The Transvaal Provincial Administration (TPA) hospitals are reportedly engaging private debt collecting firms to chase up an estimated 120 000 patients who have not paid their hospital bills. In addition, more unemployed are reportedly being turned away from hospitals.

But the strong pressure towards the private sector is taking its toll among layers of unionised workers who are earning higher wages. Many more workers are prepared to dip into hard-earned and limited wages to pay for private treatment. This has relative advantages: one does not have to take the whole day off from work and one can see the same doctor every visit. One can also be spared the deteriorating conditions of public hospitals. But there are also many problems. There is a shortage of township-based doctors and the result is often a fast, conveyer belt service. Patients often have to take whatever service they get and sometimes have to pay extra for medicine.

In line with the moves to privatisation, more and more managements are embracing the need to extend medical aid schemes to cover black employers as well. The multinationals - pushed by employer codes and other pressures for an end to racial employment discrimination - have spearheaded these moves.

Studies have shown that in 1977, only 0,9% of African people were members of medical aid schemes while in 1986, the number had jumped to 3,6%. At the same time, the growth of health insurance among the white group had reached saturation level with about 70% of people being covered.

According to Johnny Broomberg, from the Centre for The Study of Health Policy (CSHP), the medical aid schemes, together with high costs and worsening conditions in the area of public health, are seeing to the "demand side" of privatisation. In other words there cannot be a major shift to privatised health without speeding up the demand among black people and, more pertinently, the black workers.

NUMSA - a response to medical aid schemes

NUMSA is the only union that has formulated a strategy in response to the creeping influence of medical aids. Their response is based on a critique of medical aids and a commitment to a national health service. It has commissioned research which shows that large chunks of NUMSA's 180 000 members are drifting into medical aid schemes.

In a survey conducted by the CSHP, 23% of metal workers were in a medical aid. Between 45% and 50% outside of these schemes indicated they wanted medical aid. However, further research showed that the minority of workers who wanted medical aids *understood the way they worked or their limitations. No figures are available for other* sectors, but several unions report that members in small companies and plants have already gone onto medical aid.

Union struggles have pushed up real wages of metal workers over the last few years. Taken together with falling standards at public hospitals, and rapidly increasing fees aimed at pushing people into the private sector, one can see why many workers are being drawn to the illusory promised land of health insurance. The schemes are seen as providing at least partial protection against rocketing health expenses.

BARAGWANATH Hospital and its sister health centres in Soweto have enlisted the services of a debt collecting firm in an effort to recover monies owed by patients, a *Sowetan* investigation has revealed.

The investigation has found that more than 120 000 people - some of whom owe as little as R8 - have been handed over to the Hillbrow-based debt collecting agency.

The agency in turn charges up to R70 a case, to "cover its collecting and tracing costs".

The hiring of the agency was confirmed yesterday by Dr George Louw, chief superintendent of Soweto health care centres.

Louw said this followed a directive

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Press clipping from the Sowetan newspaper - 22 March 1990.

NEHAWU and the NUWCC are actively fighting health privatisation in their campaigns.

NUMSA has responded with the idea of an industry-wide union benefit scheme for its members, pensioners and their dependents that would bypass medical aid schemes. The proposal schemes have already been tabled at the metal industrial council and with a small number of large individual employers. The immediate goal is cheaper health care and greater worker control.

According to NUMSA organiser, Schreiner: "We had to come up with something. You either intervene in that process or find that the bulk of one's members are on medical aid."

The NUMSA plan is for workers to have at least 50% control of the scheme. They also envisage that in the long term the schemes would "through a relatively easy process" be swallowed into a NHS.

Just how easy it would be depends on the union's ability to mobilise and organise around health, but the difficulties (of a translation from privatised health to an NHS) are massive and extremely daunting: how would the union stop members from getting accustomed to private medical care and from forming a fixed attitude against public care? How would a strata of better-off, urbanised and educated people be persuaded to support a health system which de-emphasises curative and doctor-centred care?

The union claims the answers are built into the way the scheme is organised. Some

details of the scheme are:

■ The scheme would involve community-based clinics which would also provide services to the broader community. Members of the community would have to pay for the services. The clinics would also be the launching pad for preventive initiatives e.g. screenings, awareness campaigns, etc.

■ The union hopes to negotiate with providers of the service, especially progressive doctors who will be contracted into the scheme, to bring down costs. In this regard, the link with progressive health workers and their organisations could be important. In addition, the union wants to wants to encourage greater emphasis on low cost and preventative type treatment through a system of payment per person. The aim is to avoid unnecessary treatment and frequent dispensing of services - a practice encouraged by the fee for service system of medical aid schemes - which has escalated costs.

■ The scheme ought to be a base to mobilise pressure on the state to meet its responsibilities with regard to health. Firstly, the unions would demand subsidies for the clinic in order to increase services to the community.

Secondly, it views the clinics not just as health centres, but as focal points for the campaign for an NHS, probably starting with immediate issues such as the campaigns demanding a state subsidy of clinics. By starting to politicise and distribute control locally, the union believes it is also laying foundations for a decentralised NHS, with greater control "at the point where services are dispensed".

■ A key aim of the scheme is to divert funds from the private sector to the public sector. The scheme would marshal resources - earmarked by the bosses to stay in the private sector - to contribute to public facilities and to, it is hoped, the building of an NHS. The alternative is to sit back, says the union, and see the ever-increasing contributions from workers and employers going to swell the coffers of private owners with more commitment to profits than to the basic human right to decent health care.

Some implications of a benefit scheme

Schreiner says there is a (minority) voice in the union which is opposed to the union's movement towards a benefit scheme. "They point out that health, retirement and other such benefits should be state responsibility. The short term initiatives of a benefit scheme could undermine the long term goal (of an NHS)."

This group believes that energy should rather be used to pressurise the state into providing better benefits. But, says Schreiner, "the pressure from workers for some form of medical scheme is so strong that the union has to find a way of dealing with it". He says the lack of medical aid and other benefit schemes in NUMSA has also retarded the union's ability to attract and "hold "coloured" and Indian members". So much so that the union is taking steps toward, and has negotiated terms of entry into the A scheme,

(the B scheme, formerly geared to black unskilled workers, provides benefits which the union and workers regard as "useless"). Membership of the scheme will be automatic but workers will have the option of withdrawing from it. This action is seemingly to appease higher paid workers (formerly members of more conservative unions) who lost their medical aid benefits when they came into NUMSA through the merger process.

The union admits that the schemes are "potentially dangerous if they go wrong". The medical benefit scheme carries the risks that go with all union interventions into the area of social benefits. The employed urban worker is relatively privileged compared to the unemployed, the rural and the marginalised. In several recent statements NUMSA has expressed concern that metal workers were looking more and more like an insulated privileged sector concerned only with the unions's annual wage struggle. The union has urgently called for stronger worker involvement in joint campaigns and solidarity with other COSATU unions as an antidote to this trend.

The worst scenario is if the benefit scheme becomes an institution similar to the two-tier health systems of Brazil, where the union members enjoy a superior health service, while non-members among the working class endure shockingly inadequate health facilities.

NUMSA will have to make sure the benefit scheme does not lose its progressive direction by keeping it within a political understanding of health.

"The short-term initiative must go in tandem with a campaign against the state, otherwise it would be just privatisation by another name," says the union.

Medical aid schemes and other unions

Most unions surveyed had not taken up the issue. Some had no idea whether medical aid was making inroads among their members. This makes it difficult to conceive of a meaningful campaign involving all COSATU unions. Those few which have given thought to the issue often lack the capacity to organise such a campaign.

SAMWU has, since 1968, developed a ten million rand medical benefit scheme that it hopes, some day, to extend to all municipalities. Members have access to free medical, dental, optical care as well as physiotherapy and homeopathy. The scheme is run by a board of SAMWU worker leaders.

FAWU has a clinic, with a small fulltime staff including a doctor, in Paarl. It is financed with equal contributions from management and workers, based on a percentage of the lowest wage found in each particular factory.

SACTWU also has a medical benefit scheme covering garment workers in the Western cape region, but it hopes to move towards community clinics with access to the broader community.

SARWHU and POTWA members are on medical aid schemes which existed before

the arrival of the unions in these sectors. The unions have not yet had time to work out what to do about these schemes.

CWIU reports that workers in some of its organised plants have taken voluntary medical aid. On the one hand, there has been a push by workers wanting medical aid. On the other hand, workers who were part of schemes have been complaining about schemes not paying the full amount, about certain doctors not accepting their cards and about the high costs of these schemes in general.

The National Unemployed Workers Co-ordinating Committee (NUWCC) and NEHAWU are the only COSATU unions actively fighting health privatisation. Last year, according to assistant secretary Siphiwe Ximba, the NUWCC stepped up its campaign for free medical benefits from the state with a Witwatersrand march, media exposure and talks with the Transvaal Provincial Administration. They are concerned that the unemployed are "chased away from hospitals because they don't have money".

Future directions

NUMSA believes that the way forward is to bring a group of researchers together to focus on social benefits and the policy issues involved. Although NUMSA itself would look into this, the union says a COSATU initiative - similar to the Economic Trends research - would obviously be much more effective. (Economic Trends has been given a mandate to look at the economy in general, to get a sense of trends, in order to facilitate COSATU's formulation of direction in specific areas.)

In the health arena, such research would look at what is presently being provided, but more importantly, what a future state could deliver. "There are unrealistic expectations of what a future state would be able to provide in the short term," says Schreiner. "But we would need to look at ways of strengthening the capacity of the public sector."

There would be many areas to examine if the aim is to expand the state's capacity to provide benefits and the possibility exists for unions, as NUMSA suggests, to steer the contributions they win from managements back into the public sector as well as into expanding the manufacturing sector in the longer term.

But whether such a research programme alone will succeed in getting unions mobilised for united action around health policy issues depends more on whether unions can build organisation and struggle around healthy and safety issues. There is potentially *a vital link between health and safety struggles and mass union mobilisation for a NHS.* The challenge ultimately is for unions to activate that link. Only in this way can the full weight of organised workers be brought into the campaign against health privatisation and the struggle for a NHS.

By Frank Meintjies and Dirk Hartford.

What is a medical scheme?

Medical schemes are insurance policies that cover members' costs when they have medical treatment. Each member pays a fixed amount into the scheme monthly. Part of the amount is paid by the worker and part by the employer.

The scheme uses the money paid in to pay the medical bills of the members. If a member does not have medical bills for that month, they do not get a refund, The money is put into a fund and is used to cover bills of all of the members. Many people think that the money they don't get refunded is profit for the medical aid. This is not true. Members don't get a refund because the members who do not have *a lot of claims help to subsidise those members who do.*

There are two kinds of medical schemes: medical aids and medical benefit schemes. They are similar in many ways but there are also important differences.

Medical aids

This is the most expensive kind of medical scheme.

Advantages

- ❑ The scheme pays for most medical bills.
- ❑ A member can see a doctor without having to pay straight away and a member is covered for large bills like expensive operations.
- ❑ The member can see a doctor of their own choice.

Disadvantages

- ❑ Most schemes do not pay 100% of the bill. The member usually has to pay part of it.
- ❑ A member may have to pay part of a doctor's bill or a certain amount every time they get medicines from a chemist.
- ❑ If a person is sick before they become a medical aid member (e.g. with diabetes or high blood pressure) the scheme will not usually pay for the treatment of this illness.

❑ There are annual limits to the amount a member can spend on certain kinds of care, such as visits to psychologists. For example, a scheme may pay R200 a year for a psychologist but the member spends R600. The member will have to pay R400 of the psychologist's bill.

Medical benefit schemes

These are much cheaper than medical aids. They are cheaper to run and so cost the member much less in monthly contributions.

The medical benefit scheme negotiates a contract with doctors and other health workers. The doctors agree to charge the scheme less in exchange for the scheme sending people to them.

Advantages

❑ Members do not have to pay such high amounts every month.
❑ Benefit schemes can provide a structure for negotiations between members and health workers, to negotiate for quality of care and to keep costs down.
❑ Members and unions can negotiate for representation on the decision making bodies of the scheme. This will give unions and members more control over the running of the scheme.
❑ Benefit schemes use public services for many of the needs of members.

This does not have the same effect as medical aids, which force people into private care and encourage the growth of the private sector at the expense of the public sector. In this way, benefit schemes can make a positive contribution to building appropriate health services for the future.

Disadvantages

❑ The member can only see a doctor who is contracted into the scheme. Sometimes these doctors don't give members very good service. Some people believe that doctors do a bad job because they get paid less for looking after benefit patients.
❑ If the money put into the scheme is not spent properly, it is possible that members will not get the best care for their money.