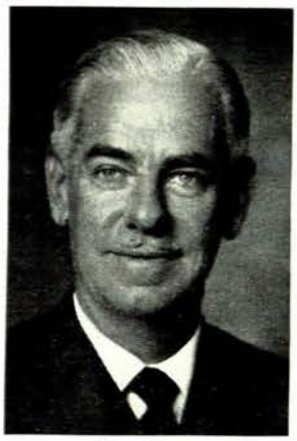
PREPAID MEDICAL AID SCHEMES*

I. C. VERSTER, *President, Cape Western Branch (M.A.S.A.), 1962*

Each year, when the President makes his valedictory address at the conclusion of his term of office, he has usually selected his subject from a vast variety of material available and has made his particular choice either because of its unusual interest, or because he is especially well versed in it, or because he is able to present some new aspect of the subject. This year none of these apply because my talk has been dictated more by circumstance than by choice, by the importance of the subject rather than its interest, and by a sense of duty towards members of this Branch.



Dr. Verster

Tonight I wish to talk to you about the important moves that are taking place at government level which will no doubt lead to a profound change in the practice of medicine as we know it today. I think it is most important to inform Branch members of what is taking place in medico-political circles in order that they may take an active interest in this development and evolution. Many of you are already well informed about the matters of which I will speak, and I therefore crave your indulgence and forbearance. I have no wish to preach to the converted, but hope to interest those Branch members who know little of what is taking place. And sometimes even the most devout derive benefit from repetition.

One of the main attractions that medicine holds for us is that it is not a static science, but one that is constantly changing as new concepts and discoveries oust the old and often long-established teachings. The doctor, like his science, has to keep abreast of the times and, with a supple flexibility of mind, be prepared to accept that what is regarded as true today may be proved false tomorrow, and what is new today may be antiquated tomorrow — this being the way in which our science progresses from day to day. But the scientific doctor does not accept that what is new is of necessity better. He wants proof, or at least a convincing argument, that the newer tenets justify the rejection of the old.

But the average medical man is not nearly as scientific in his outlook and actions when it pertains to his mode of life or the manner in which he practises medicine. The majority are quite prepared to leave matters of medico-political importance to others to debate and decide, but reserve the right to criticize those who have acted on their behalf and condemn their decisions if they consider them unwise. Would it not be far wiser for them to take an intelligent interest in these matters from their inception, and to offer comment and constructive criticism as they develop rather than futile condemnation at the end. Our well-known, often catatonic, apathy toward such matters must now give place to intelligent cerebration and concerted action, or we will find that the impending 'winds of change' have blown over us without disturbing one forelock of our complacency. But since it is the duty of Branch executives to draw the attention of members to matters of importance, I have tonight decided to devote this talk to the changes pending in our medical lives, by firstly painting in a little of the background and then trying to point out some of the salient features, with the hope that it will stimulate some thought and careful consideration.

Group medical insurance has received a good deal of attention and thought since World War II as a means of safeguarding the health of the community, for there seems little doubt that some form of prepaid medical care is the modern way of insuring the health of the public — in this way the cost of illness is pooled and distributed into average amounts, which inflicts little financial hardship on the individual and allows the cost of sickness to come within his budgetable means. Various schemes for implementing this ideal have been brought into existence all over the world with varying success. For any scheme of prepaid health insurance to be workable, it must be acceptable to the State, the doctor and the patient. Thus far, no scheme has been evolved which has been enthusiastically acclaimed by all three groups as being the ideal solution, but over the years various plans have come into being which are at least acceptable and practical.

In various countries, health insurance has become compulsory, whereas in others it is on a voluntary basis, as in the United States and South Africa. The British National Health Service has been in operation for many years now and has shown up some of the shortcomings of a compulsory scheme. There are few of us who would welcome working under such a service. Recently the President of the British Medical Association announced that less men were being attracted to the medical profession and that if it were not for temporary overseas graduates, a serious shortage would exist. In the United States, on the other hand, the Blue Cross is just one of the medical insurance organizations which gives nation-wide cover on a voluntary basis. Let me point out here that medical aid has a *preferential* tariff of fees, designed for groups of *lower* and *middle income* bracket patients.

In South Africa prepaid group medical schemes are divided into (1) medical benefit groups, (2) medical aid societies, and (3) medical assurance, that is medical aid sponsored by assurance companies.

The first medical aid scheme, the De Beers Consolidated Mines Ltd. Benefit Society, was started in 1889. During the next 20 years, 6 more such schemes came into existence. By 1939 the number had risen to 48. After 1945 the numbers increased rapidly and by 1960 there were over 200. Furthermore, the two assurance companies that sponsored large-scale group medical aid are today believed to cover 8,000 groups.

There has also been a steady increase in the number of persons belonging to medical aid schemes, e.g. from 1940 - 1960 the membership of the United Banks Medical Aid Society increased from 5,000 to 20,000, that of the Civil Service Medical Aid Association from 900 to 9,000, and that of the Durban Municipal Employees Medical Aid Society from 200 to 1,800. Today approximately 1·5 million Europeans enjoy privileges in regard to medical expenses.

But what of the rest of our European population? Two main groups remain: (1) The high income group who can afford private medical care and who do not require group medical cover. This group is small and presents no real problem; and, even though they are theoretically debarred from acquiring medical aid cover under our present system, nevertheless many do achieve it. (2) The other class is of course the indigent poor, who cannot afford any medical care and who have to rely on the State for medical protection. This is indeed a good thing provided that they can be hospitalized or are able to attend hospital outpatient departments. Their domiciliary cover is however inadequate and leaves room for much improvement. Our large non-European population falls almost entirely into this group.

Our Government, conscious of the rising cost of medical care, the shortcomings in adequate cover, and the large numbers who could not afford to be ill, set up two commissions to investigate the problem — the Reinach Commission and the Snyman Commission.

The Reinach Commission was appointed in January 1960 and consisted of Dr. N. Reinach of the Department of Agriculture, who is not a medical doctor, and Mr. Lindeque of the Department of Labour. They were instructed to investigate, consider and report on the defrayal of the high cost of medical services and medicine by the instrumentality

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of (1) medical aid and benefit schemes and/or (2) insurance schemes, and the desirability that the State should encourage and safeguard such schemes. I have been fortunate in seeing a copy of this report, although it is not generally available as yet.

The important recommendations of this Commission may be briefly summarized as follows:

1. Medical aid membership should be compulsory, whereby the healthy subsidize the sick.
2. The income of members should not be a determining factor.
3. Complete uniformity among all schemes.
4. Provincial hospitals should not discriminate between members and non-members of schemes.
5. No compulsion with regard to the payment for medicines by the schemes.
6. The State should subsidize administrative costs.
7. Provision for dependents, pensioners and widows should be made.
8. No member be excluded on grounds of ill-health.
9. A Central Board be established to control and mediate in disputes between schemes and the Medical Association.
10. A central fund be established.

The Snyman Commission was a larger body under the chairmanship of Prof. H. W. Snyman, and was appointed to enquire into the high costs of medical services and medicines and anything pertaining thereto in all its aspects. Although this commission completed its investigation about a year ago, its report is not yet available to the general (medical) public and, therefore, its contents are unknown. I am led to believe that the report of the Reinach Commission was embodied in the Snyman report in its entirety, so that for practical purposes there is only one report — which the medical profession has yet to see.

But the Government has already acted on this report by establishing the Central Board envisaged, under the chairmanship of Dr. Reinach, and it would appear that he has already actively set about implementing the recommendations referred to previously. Furthermore, it is expected that Parliament will legislate to give this body statutory powers with possible far-reaching effects. Dr. Reinach is no doubt a very capable man and a man of action who lets no grass grow under his feet. But are not things moving a little too quickly? The medical profession as a whole has had no chance to comment on these impending changes and, without full information, how can they comment? Surely the availability of the Snyman report is a prerequisite: We can see that many of the recommendations put forward by Dr. Reinach are contrary to established medical aid practice and at variance with the present agreements between the Medical Association and medical aid societies. If these recommendations are implemented it means that there will no longer be private patients, since all Europeans will belong to a medical aid scheme. Will the medical aid societies be able to operate economically with the additional burden of pensioners and widows, and will the smaller benefit societies survive or will they be engulfed by more powerful schemes? Will our teaching hospitals be affected and will they still have adequate clinical material available for the instruction of students? And what of the Medical Association? Will the Association become completely subservient to the Central Board in its dealings with Medical Aid Societies? And will the doctor, by being restricted to a fixed fee, perchance be obliged economically to sacrifice quality for quantity, or may we envisage that seniority, skill and experience will gain the recognition that it deserves in an amended tariff?

These and many other questions need to be answered. As yet we do not know what further recommendations are embodied in the Snyman report. The Council of the Cape Western Branch has, as you may have already heard, formed a Vigilance Committee to watch these developments and keep members informed. Other Branches share our deep interest and perplexity.

The Chairman of Federal Council has asked branches to forward their comments and recommendations to Federal Council by 31 March 1963. We can but hope that by then we will have had more information and ample opportunity of making suitable comments and recommendations, which will help our Federal Councillors to formulate conclusions, representing medical opinion throughout the Republic, for transmission to the Central Board.

Let me make it quite clear that I can express no opinion as to whether these developments will be beneficial or detrimental. Who can say with our present stage of knowledge? I am sure most doctors welcome our Government's investigation into the ways and means of improving medical services throughout our country, for are we not dedicated to succour the sick and help all who need medical care? But we would also welcome and should insist upon, the opportunity to express our opinion adequately on matters which are pertinent to us and which may affect our future, and to be kept informed of developments as they occur.

It is essential that we keep a watchful eye on the future, analysing all eventualities with a clear, unbiased and open mind — expressing our opinions freely, but giving due deference to the opinions of others. In this way our Medical Association will help to ensure that whatever scheme eventuates, it will have had the benefit of adequate thought and expression, and that no stone will be left unturned in the quest for a service that will be beneficial and equitable to the patient, the doctor and the State alike.