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COMMISSION OF INQUIRY INTO THE HIGH COST OF MEDICAL SERVICES AND MEDICINES

(S N Y M A N C O M M I S S I O N)

Summary of the Commission's Recommendations regarding Medical Aid Schemes

It was decided at the last meeting of the General Purposes Committee, held on 25th February 1964, that information should be compiled on the recommendations of the Snyman Commission, with particular reference to Medical Aid Schemes and the reason for the Commission recommending that these should, at least for the present, not include Non-Whites.

In January 1960 the government appointed an eleven-man Commission, headed by Professor H.W. Snyman, to investigate the high cost of medical services and medicines. The Snyman Commission was given the following terms of reference. (1):

"To investigate, consider and report upon -

(i) all factors which are responsible for the high cost of medical services and the manner in which it can be reduced;

(ii) all factors which are responsible for the high cost medicine and the manner by which it can be reduced; and

(iii) any related matter which may be deemed necessary by the commission;".

The Commission examined the picture abroad and then, limiting its investigations to South Africa, it examined the general cost structure and the general factors affecting costs. It went on to examine specific cost factors under the following heads:

a) Hospitals
b) Public as cost factor
c) Medical practitioners (including specialists)
d) Dentists
e) Nursing staff
f) Para-medical staff
g) Medicines
h) Dealers in instruments

The Report contains much interesting statistical data regarding both Whites and Non-Whites. Although generally speaking the recommendations did not apply to a specific race group there were a number which affected the Non-White people. Among these were recommendations concerning the setting up of clinics, especially in the urban areas, the training of Africans in all spheres of medical services and the greater use of auxiliary staff. The recommendations however to be dealt with in this memorandum are those concerning medical aid schemes.

Departmental / .....

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(1) Report of the Commission of Inquiry into High Cost of Medical Services and Medicines.

Departmental Committee

In addition to the Snyman Commission, the Government appointed a Departmental Committee of two in January, 1960, for the purpose of preparing a report on Medical Aid, Benefit and Insurance Schemes with the following terms of references:

"To investigate consider and report on the combating of the high cost of medical services and medicines by means of:-

(i) Medical aid and benefit societies, and /or

(ii) Insurance schemes,

and the desirability of the State encouraging and safe-guarding such schemes.

"For further elucidation, the Hon. the Minister of Health informed Dr. N. Reinach (a member of the Committee) orally that the inquiry should cover all aspects of Medical Aid, Benefit and Insurance Schemes in regard to Whites and any relevant matters that might be deemed necessary". (2)

The Committee sent questionnaires to all known medical aid, benefit and insurance schemes and in 26 cases the questionnaire was supplemented by letters in which the bodies were requested to submit memoranda. In addition, interviews were arranged.

The Committee's investigation revealed that almost all countries recognised the need for comprehensive sickness insurance and the Committee traced the origin and growth of medical aid schemes both overseas and in South Africa. It pointed out that in South Africa there are 1,333,653 Whites who enjoy medical cover in one form or another, and that if the members of schemes which failed to submit information were added to the above figure, it might reasonably be assumed that approximately 1½ million Whites or 48 per cent of the White population of South Africa, based on the census estimate as of 30th June, 1960, enjoyed benefits in respect of medical costs.

The Committee pointed out further that in addition to the above mentioned medical cover where the individual himself attempted to provide for medical costs, considerable contributions towards the health of the population were made by the Central Government, provincial administrations and local authorities. A short summary of the various services had been submitted to the Committee by the Department of Health and was included in the report.

The Committee stressed the need for medical insurance for the entire White population. The need for united action in this connection had already been recognised by the medical schemes themselves in 1950 when they established an Advisory Council of Medical Aid Societies. Up till the time of the report the Council had not been very active.

Prior to the promulgation of the Friendly Societies Act, 1956 (Act No. 25 of 1956), there had been no control whatsoever over medical aid schemes. This Act came into force on 31st December, 1959, and from this date all medical aid schemes, with a few exceptions, had to be registered before they could start functioning. The control enforced by this act is mainly of a financial nature. Although this act had helped to ensure stability, the Committee felt that there should be more comprehensive legislation to bring all other aspects of sickness insurance under suitable control.

In considering / .....

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(2) See page 137 of the Report.

In considering whether persons from all income groups should be included in medical aid schemes the committee concluded: "From the report of the International Labour Office, 1944 (Social Security Principles and Problems arising out of the War, Report IV (i) p.66), it is clear that most countries find no justification for the introduction of a limit on income. It is said: "The inclusion of the whole population without limit is recommended by the majority of experts, organizations and commissions who have worked out plans for future medical care services". (3)

In most countries as well as in 55 per cent of the schemes in South Africa the lower income groups are subsidized by the higher and the Committee accepted this principle as practical and fair. Regarding contributions by employers to medical aid schemes the Committee said that an analysis of the position in South Africa clearly showed that the principle involving contribution by employers enjoyed almost general acceptance.

The Committee considered that the only effective way in which medical security could be extended to include as far as possible the whole of the White population was to establish a central statutory body with powers, inter alia, to organize groups and to create medical schemes and manage them until such time as they may be able to function as independent schemes.

In addition to recommending the establishment of a central statutory body, the committee recommended the establishment of a Central Fund. In discussing the purpose of this fund the Committee said: "When sufficiently strong, the fund may be utilized for further expansion of medical security and subsidising of administration of medical security and subsidising of administration costs of medical aid schemes and any supplementary services that may become necessary".

Introducing its recommendations the Committee pointed out that in medical schemes the costs of medical care were considerably reduced because members were entitled to a preferential tariff which was approximately 33⅓ per cent lower than the usual private tariff. The administrative costs of such schemes generally did not exceed an average of 10 per cent so that the actual medical costs to members were reduced by approximately 20 per cent. However, the greatest advantage of such schemes was indirect because risks in respect of medical costs were spread and people in a group helped to bear each others burdens on a basis of mutual aid.

A full report of the Department Committee was officially submitted to the Snyman Commission at the beginning of 1962 for consideration and inclusion as part of its report.

THE SNYMAN COMMISSION

The Snyman Commission considered the Committee's report in the light of its own investigations and conclusions. It made a number of recommendations based on the findings of the Committee and, in addition, accepted the recommendations included in the Committee's report subject to the quoted amendments.

From the Departmental Committee's Report the Snyman Commission drew the following conclusions:

"In connection " .....

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(3) See page 148 of the Report.

"In connection with the consumers in the triangular relationship (4) mentioned earlier, it is clear that together with the expected further rise in the cost of medical care, the cost per unit can be lowered if the total costs can be spread over the largest possible number of participants and over the longest possible period of time.

"In regard to the two major possible methods by which costs can be reduced, the Commission wishes to declare itself most emphatically opposed to a State Medical Service and most definitely in favour of a scheme based on selfhelp for the community.

"This idea can be applied to non-Whites as effectively as to Whites. The Commission is of opinion, however, that ambitious expansion of this principle to non-Whites should be postponed until such time as the new deal and administrative control are firmly established.

"The Commission directs attention to the great variety of existing schemes providing medical cover for a large portion, amounting to almost half, of the White population. In this connection, roughly one third of the White population receive medical care provided by the authorities and approximately one fifth has not yet obtained any medical cover.

"The Commission is pertinently aware of the great need for judicious use of medical services by the consumers and that they should constantly bear a share of the costs".

The Commission went on to make the following recommendations:

Recommendation No. 46

In this conviction, and in view of these considerations, and in order to obtain, as soon as possible, the maximum advantage of spreading costs over the greatest possible numbers and the longest possible period, the Commission recommends that all White taxable citizens, regardless of income, should join existing or future schemes providing medical cover.

The two possible ways of attaining this objective are -

(a) compulsion; and

(b) voluntary participation and organising.

(a) With regard to compulsion, the Commission wishes to point out the following advantages and disadvantages: The main advantage is that the contemplated cover would be obtained as soon as possible and would have the maximum distribution. In other words, all people would be immediately included. The main disadvantage would be that the State, in imposing such obligations, could become involved in the

provision / .....

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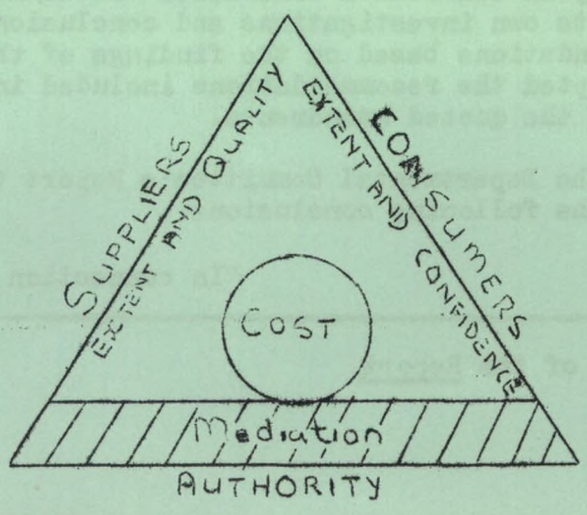
(4) FIGURE 1.



provision of the facilities for the cover. It could result in the public not taking the initiative in seeking and organising cover and the State might possibly have to enter the field as supplier. A further disadvantage is that the State might find itself in the position of having to enforce the obligation upon the unwilling citizen. A further objection could be that this group of reluctant citizens could create various additional problems for the State.

(b) The advantages of the voluntary approach are that the private and personal initiative would be retained and that by voluntary co-operation even saving of costs in the administration of the cover, could be achieved. Amongst the important possible disadvantages may be mentioned that people may be inclined to delay taking out the contemplated cover because their existing good health may make future needs of medical care seem improbable; because there may be immediate financial embarrassments to join; because prosperity reduces the need for cover and because the indifferent would not join timeously.

Recommendation No. 47

The Commission recommends that as an experiment and example, compulsory membership of funds should be made a condition of service for all employees of the various public authorities.

Recommendation No. 48

Following on Recommendations No. 46 and 47 the Commission recommends that -

(a) a representative central body be established to control and advise funds;

(b) existing schemes be expanded and stabilised;

(c) new schemes be established for that portion of the population not covered at present by assistance of (a);

(d) contributions for each scheme be calculated on the basis of services rendered and on taxable income;

(e) the indigent and those legally covered be defined by the Government for purposes of exemption;

(f) provision be made for dependants, widows and pensioners;

(g) as a general measure to ensure that sufficient clinical facilities are available for the teaching of medical students, nurses and paramedical staff, all patients admitted to provincial, state and state-aided hospitals be made available for medical teaching; this availability to be made a condition of admission to such institutions; provision may still be made for exemption on own request from this specific requirement to which the attention of the patient should be drawn beforehand.

Recommendation No. 49

The Commission recommends that, as a general principle, each scheme should make compulsory partial provision for the following services: General practitioner, specialist, hospital, medicines, operations, anti-natal care and confinements, radiodiagnostic and laboratory examinations. Further, that special exemption from certain services be granted to funds on the recommendation of the central body.

In the / .....

In the foregoing, it was the Commission's intention to indicate only principles and broad outlines.

Recommendation No. 50

In recommendation 50, the Commission commented point by point on the Committee's main recommendations. The following is a summary of the recommendations made by the Departmental Committee and the amendments and comments made by the Snyman Commission.

Paragraph 18

If agreement between Medical Association of South Africa and the Medical Aid Societies cannot be reached, the matter at issue should be submitted to the Central Council mentioned in paragraphs 187 and 189, for arbitration.

In the light of recommendation 48 part (a) endorsed.

Paragraphs 24 and 40

It is suggested that a central statutory body should be established with powers, inter alia, to organize groups and to create medical schemes and manage them until such time as they may be able to function as independent schemes.

See recommendation 48 (a).

Paragraph 31

(a) A medical scheme with compulsory membership for all White employees of the Central Government.

(b) A compulsory medical scheme for all White employees of Provincial Administrations. These employees could be grouped into one scheme or into four separate provincial schemes.

(c) A compulsory medical scheme providing for the inclusion of all White employees of local authorities. These employees may be grouped into one scheme or into four separate provincial schemes.

See recommendation 47.

Paragraph 39

That the bodies in control of medical aid societies be so constituted that at least half their members are chosen by and from the ranks of members.

In the light of recommendations 46,47 and 48, endorsed.

Paragraph 45

Income of members or groups of members should not be taken into consideration as a factor determining whether or not schemes should be approved by the Medical Association of South Africa.

In the light of recommendation 46, endorsed.

Paragraph 50

Acceptable classification of income groups according to which premiums could be determined, is proposed.

See recommendation 48 (d).

Paragraph 51 / ....

Paragraph 51

It is suggested that premium adjustments necessitated by salary increases be made only once a year.

Is supported with the recommendation that it should happen in accordance with the Central Council's decision.

Paragraph 61

There should only be three divisions on a family basis on which premiums should be based i.e. single, married without children and married with children irrespective of their number and in the proportion 1:2:2½.

See recommendation 48. The ratio suggested can be determined after further consultation.

Paragraph 69

The present system under which magistrates decide whether persons are indigent should be changed, and, with due regard to assets and number of dependants, an income ceiling should be laid down, and that the families of all persons earning less should automatically be treated by district surgeons and be supplied with all medical aids free of charge.

See recommendation 48 (e).

Paragraph 80

Although the rand-for-rand basis is regarded as ideal, the formula mentioned above, namely, that employers should pay at least 33⅓ per cent but not more than 50 per cent of the total contributions, should be accepted for all employees of public authorities.

The principle is supported and the particulars left to the Authority.

Paragraph 102

Medical aid societies should be obliged to make provision for the services of general practitioners and should contribute at least 75 per cent of the cost of visits and/or consultations.

In the light of recommendation 49, endorsed.

Paragraph 106

All medical schemes should be obliged to make provision for specialist services and should contribute 75 per cent of the costs (operations excluded).

In the light of recommendation 49, endorsed.

Paragraph 110

Medical schemes should be compelled to make provision for operations and should contribute at least 75 per cent of the cost whether the operation is performed by a specialist or by a general practitioner.

In the light of recommendation 49, endorsed.

Paragraph 114 / .....

Paragraph 114

No difference whatsoever, should be made by provincial hospitals as far as admission, treatment and hospital fees are concerned, between members of the public and patients who are members of a medical aid society.

In the light of recommendation 49, endorsed.

Paragraph 116

Medical schemes should be obliged to make provision for hospitalisation of their beneficiaries and should contribute 75 per cent of the cost limited to a maximum amount per day equal to the tariff applicable in provincial hospitals for general wards.

In the light of recommendation 49, endorsed.

Paragraph 117

All medical schemes should be obliged to provide maternity benefits and should contribute 75 per cent of the costs of medical attention, nursing and treatment in an institution in respect of normal confinements, with a maximum amount to be fixed by each scheme.

Amended in the light of recommendation 49.

Paragraph 122

It is suggested that the extraction and filling of teeth, but no luxury treatment, should be included in schemes as benefits and that benefits should not exceed 50 per cent of the total costs.

Is supported in order that conservative dentistry be given preference in the cover.

Paragraph 128

That no obligation in respect of medicines should be placed on medical schemes except when associated with hospitalisation or when the material is in the form of an injection administered by a doctor, and that medical schemes should contribute 75 per cent of such costs.

Lapses in the light of recommendation 49.

Paragraph 130

All medical schemes should be compelled to make provision for radiological services and should contribute 75 per cent of the costs.

In the light of recommendation 49, endorsed.

Paragraph 133

All medical schemes should be compelled to make provision for the investigation of pathological samples and should contribute 75 per cent of the costs.

In the light of recommendation 49 endorsed.

Paragraph 138 / .....

Paragraph 138

The Committee considers it advisable that all schemes as far as possible, should fix their maximum yearly limitation at R200 for single members, R400 for married members and R500 for married members with children.

The Commission supports the desirability of fixing details but recommends that this should apply for periods of 3 years.

Paragraph 147

No medical scheme should be allowed to include additional benefits of a non-medical nature.

Is endorsed.

Paragraph 153

Where the costs of administration of a medical scheme amounts to -

(a) five per cent or less;

(b) over 5 per cent but not exceeding 7½ per cent;

(c) over 7½ per cent but not exceeding 10 per cent;

of the membership fees, including the contribution made by the employer, the State should contribute towards the administrative costs respectively (a) 50 per cent; (b) 30 per cent; and (c) 20 per cent, on the understanding that such schemes comply with all conditions described elsewhere.

Is endorsed.

Paragraph 161

No medical scheme should be registered if provision is not made for dependents.

See recommendation 48 (f).

Paragraph 162

All medical schemes established in terms of the Industrial Conciliation Act, must make provision for dependants.

Is endorsed.

Paragraph 168

(a) Pensioners and widows of deceased members with their dependants, should be allowed to continue membership at premiums laid down by the schemes concerned on condition that these would not be higher than those laid down for members in the same income group.

(b) Provision should be made by the Services in respect of pensioners and widows of deceased members with their dependants for the continuation of the various medical services to which they were entitled during their period of service.

Is endorsed.

Paragraph 170 / .....

Paragraph 170

If a person has been a member of a medical scheme or enjoyed medical cover as a condition of service and changes his employment, he must be accepted as member by the scheme applicable in his new sphere of employment without any reservation such as waiting period, age limit or the provision of a medical certificate.

Is endorsed but it lapses if compulsory cover is instituted.

Paragraph 171

No scheme may terminate membership of a person on grounds of high claims resulting from his own or his dependants' state of health.

Is endorsed.

Paragraph 183

It is suggested that insurance companies undertaking sickness insurance, should also be made subject to all laws and provisions applicable to other independent schemes.

In the light of recommendation 49, endorsed.

Paragraph 187

New legislation should be introduced incorporating all the relative financial and other provisions of the Friendly Societies Act, (Act No. 25 of 1956) and making provision for the establishment of a Central Council for Medical Aid Societies and the machinery neccessary for the execution of the Act under control of the Department of Health.

See recommendation 48 (a). The Commission recommends, however, that the Central Body should resort under supervision of the Department of State Health.

Paragraph 188

The composition of the proposed Central Council is suggested.

The principle of representation in the constitution of the Council is endorsed.

Paragraph 189

The duties and functions of the proposed Central Council are suggested.

Paragraph 190

(a) It is, therefore, desirable that the Act provisions be included empowering the South African Medical Council to inquire into and act on complaints by third parties.

(b) All accounts for services rendered by doctors, dentists, medical auxiliaries, hospitals, nursing homes and pharmacists should be fully specified and that the nature and date of service, type and quantity of medicine should be indicated.

(c) No member / .....

(c) No member or beneficiary may belong to more than one medical aid scheme.

(d) That medical aid societies should not pay any benefits in cases where provision is made by another Act for the costs of medical treatment, or where compensation in respect thereof has been awarded by a court.

Is endorsed.

Paragraph 194

That a Central Fund be established and that all medical schemes, except those sponsored by insurance companies, should pay to the fund a levy in respect of each member and that the State also make a contribution.

Is endorsed.

SUMMARY OF POSITION REGARDING INCLUSION OF NON-WHITES

1. It is clear from the report that the Minister of Health instructed the Departmental Committee to confine itself to Whites. (See page 2).

2. The Commission stated that the principle of the medical aid scheme recommended could be applied equally to Non-Whites. However, it recommended that this should be postponed until such time as the "new deal and administrative control" were firmly established. Nowhere in the report does it make it clear what is meant by these phrases.

3. The Commission stated that at least 95 per cent of the medical care of the Non-White population was rendered by State authorities and that almost the entire Non-White population, almost 80 per cent in three provinces and in Natal almost 90 per cent, enjoyed free medical care.

4. It pointed out further that in most countries the law provided that any person receiving less than a stipulated minimum income was entitled to free medical attention, and that this principle had already been adopted by the provincial hospitals in which a means test, taking account of dependants, was applied.

ACTION FOLLOWING SNYMAN COMMISSION REPORT

1. During 1963 a Central Committee for Medical Aid Funds was created in an advisory capacity to give effect to this recommendation.

2. A draft Bill was placed before Parliament in 1963, copies of which were sent to interested groups and organizations in order that they could comment and critize. The Bill was postponed and is expected to come before Parliament during its present session (1964).

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