MEDICAL SCHEMES FOR WORKERS

ISSUES FOR DISCUSSION AND DEBATE

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Health Insurance

MEDICAL SCHEMES FOR WORKERS

T.U.R.P.
TRADE UNION RESEARCH PROJECT

NOVEMBER 1989


The poor guy will probably have another heart attack when he sees the medical bill.
HOSPITAL RECEPTION

CONTENTS

INTRODUCTION

Medical insurance schemes have become one of the many fringe benefits being negotiated by unions. Medical insurance schemes are tied to the struggle for an adequate health service. Workers' decision on whether or not to join medical insurance schemes has an important bearing on the operation of health services in a future democratic society.

What this booklet covers

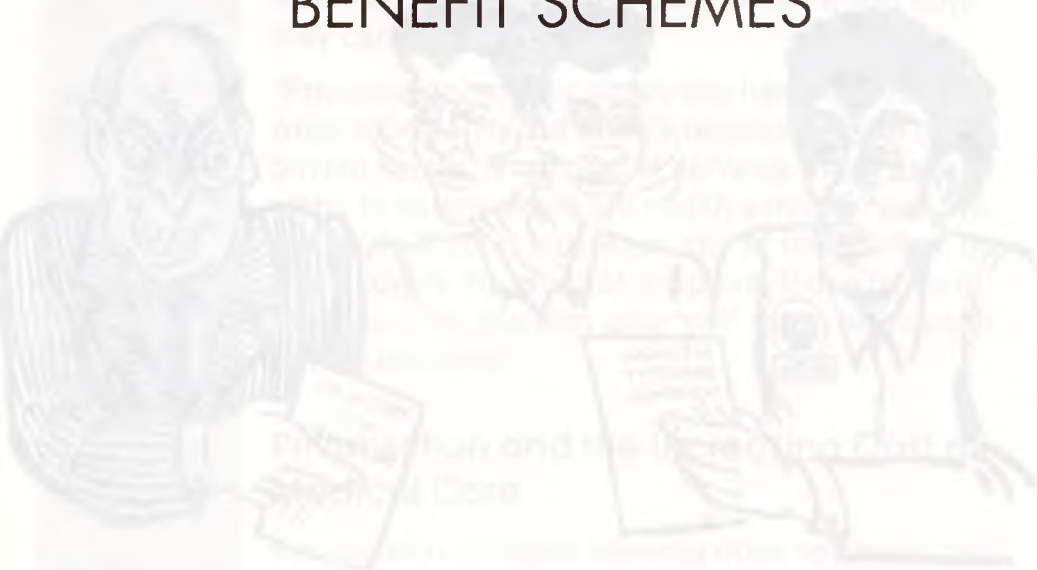
This booklet examines medical aid schemes, their advantages and disadvantages, how they operate and what possible alternatives to medical aid schemes exist. The booklet also looks at the state's health strategy and how medical aid schemes fit into this.

Chapter One of this booklet discusses the broad issues relating to medical insurance. Medical Aid Schemes and Medical Benefit Schemes are discussed in chapters two and three. Chapters four and five are for extra information. Some specific medical aid schemes are evaluated in chapter four. Chapter five looks at the tariff structure (cost) of medical services provided at Natal Provincial Hospitals.

What is Medical Insurance?

Medical Insurance means all the different types of schemes that operate to insure people against medical costs. A medical insurance could take the form of a medical aid scheme, a medical benefit scheme or other types of schemes. This booklet concentrates on medical aid and medical benefit schemes.

PART ONE
MEDICAL AID & MEDICAL BENEFIT SCHEMES



CHOOSING BETWEEN A MEDICAL AID SCHEME AND A MEDICAL BENEFIT SCHEME

CHAPTER ONE PRIVATISATION AND THE NEED FOR MEDICAL INSURANCE

Why is Medical Insurance Important?

The government's policy of privatisation has forced workers to look closely at medical insurance schemes, what they are, how they work and how they can be used.

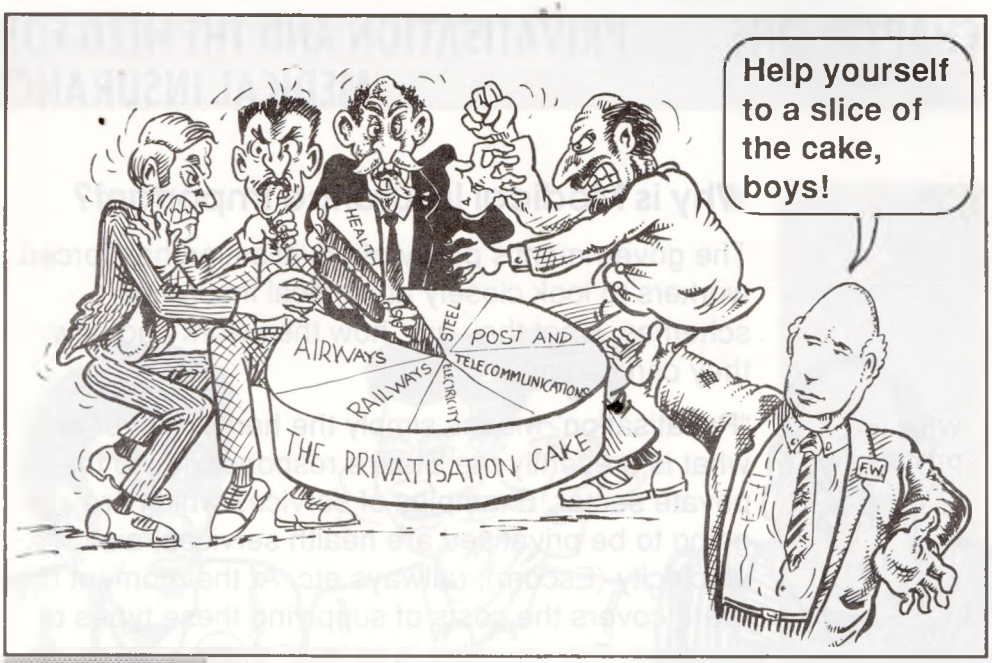
What is privatisation?

"Privatisation" means simply the handing over of what is presently the State's responsibility to the private sector. Examples of services which are going to be privatised are health services, airways, electricity (Escom), railways etc. At the moment the State covers the costs of supplying these types of services. The intention is to "sell" these services to private business.

Privatisation and the Increasing Cost of Medical Care

Privatisation increases Medical costs

Privatisation of health services does not mean that all the hospitals will be sold to the private sector. King Edward VIII, for example, will continue to be run by the State or rather the Natal Provincial Administration. The idea behind privatisation is to "force" employed persons to get private medical care in the future. As privatisation is implemented, the costs of medical care at state run hospitals (hospital tariffs) will rise (in fact they are rising) to rates which will not be affordable to workers who do not belong to medical aid schemes. Already, the



Costs of a consulation at King Edward Hospital

increases in hospital tariffs have been so high that it is sometimes cheaper to consult a private doctor.

For example, a single person earning over **R800** pays **R22** for a consultation at King Edward hospital in Durban if the person does not belong to a medical insurance scheme. Most private doctors charge **R17.50** for a consultation.

If the person belonged to a medical aid scheme the charge for a consultation at King Edward will be **R25**. The **R25** will be paid by a medical aid scheme that pays 100% of costs. A medical aid scheme will pay up to **R17.50** for a consultation at a private doctor.

A person earning **R600** will pay **R55** per day as an in-patient at King Edward. A full list of charges at Natal Provincial hospitals is shown on Page 36. The tariffs show clearly that public health care is extremely expensive. As privatisation continues, costs will increase even further.

Goverment encourages privatisation of health

The government is encouraging privatisation. The government is also encouraging employers to set up medical aid schemes for workers. The government is saying that employers should take responsibility for "their" workers health and not rely on the State to supply health care.

As more and more of the health services are privatised more and more people will be forced to join medical insurance schemes. Ideally health care should be available and accessible to all people and all people should have access to the same type of health care. This means that even though someone cannot pay they should get the same type and standard of care as someone who can pay.

A National Health Service

A National Health Service is a long term goal.

A National Health Service would be a solution to the problem of unequal access to health care. This is a long term goal and one that should be continuously supported. As the move to privatisation becomes more real, workers will be obliged to join medical aid or other types of medical insurance schemes to ensure that they and their families have access to medical care.

Medical Insurance and Privatisation

Medical insurance encourages privatisation.

Whilst the state's intention to privatise health care has forced workers to address the issue of medical insurance, the success of the privatisation campaign is dependent on workers' participation in medical insurance. The state's plan to privatise health care cannot succeed unless there is a massive increase in the demand for private (as opposed to state) health care. The only way that the demand for private health care will increase is if Black workers start demanding private health care. Black workers will only demand private health care if they belong to medical insurance schemes. Thus, the state's attempt to privatise is dependent on the co-operation of workers. If workers do not join medical insurance schemes, the state will have difficulty with privatising health services.

Medical insurance schemes thus release the state from a duty to provide adequate health care for the entire population.

CHAPTER TWO MEDICAL AID SCHEMES

A Medical Aid scheme is an insurance

What is a Medical Aid Scheme?

Medical Aid schemes are established to assist members to pay for their health needs. It is a type of insurance scheme. For this service members and their employers pay regular contributions to the scheme. Although various schemes have different expenditure limits and exemptions they generally provide medical, nursing, surgical and dental services including medicines, medical appliances and hospital accommodation.

How are Medical Aids Schemes Administered?

Each scheme is a non-profit organisation which is controlled by a management board. The board, which is responsible for policy decisions (like setting rates and conditions), is elected by the contributors to the fund. The fund may be administered by persons employed by the board or by a commercial firm. In practice, most schemes are administered by commercial firms who make massive profits by administering these schemes.

Medical Aid insures against high medical costs

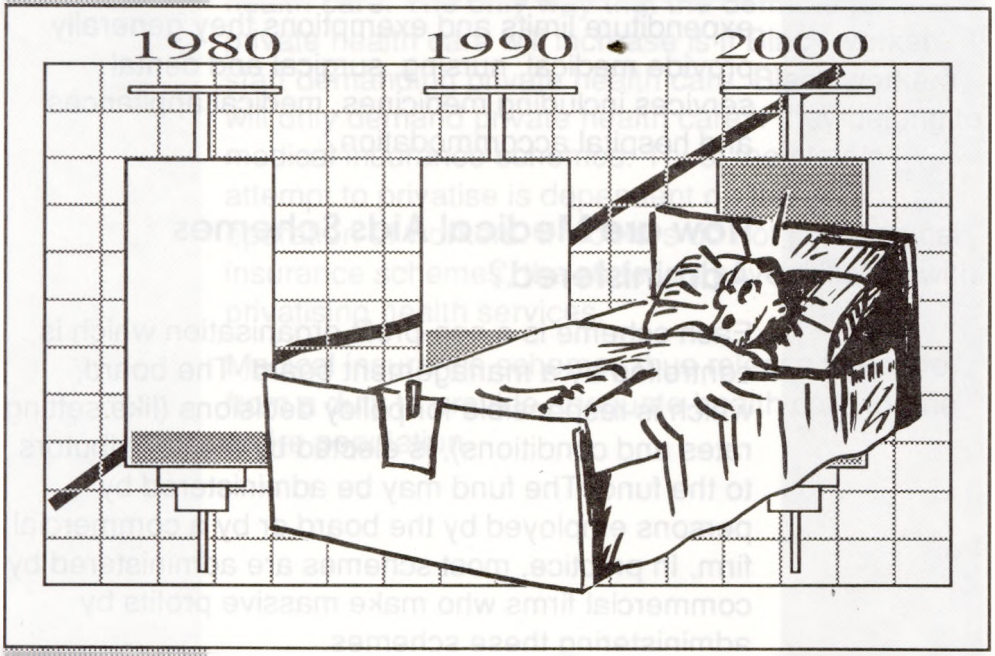
Advantages of Medical Aid Schemes

The most obvious advantage of medical aid schemes is that workers and their families are insured against paying large, unexpected medical costs. Workers would also have access to better

medical care since they may attend private doctors, clinics and specialists instead of overcrowded public hospitals. Furthermore, patients on medical aid would not have financial reasons for delaying medical care.

Disadvantages of Medical Aid Schemes

The Cost of Medical Aid Schemes



Medical Aid schemes are expensive

Most workers do not belong to medical aid schemes simply because it is extremely expensive. For most families living in poverty, private health is hardly a priority. Furthermore, the increases in medical aid subscriptions have been extremely high. Since 1981, subscriptions to medical aid have been in-

creasing at an average annual rate of 20%. This is way above the average inflation rate for the same period. If this trend continues, the average monthly medical aid subscription by the year 2000 will be R890 per month (Financial Mail 24.03.89). Thus, medical aid will become too expensive even for those who can afford it today.

Migrant Workers and Medical Aid Schemes

Medical aid for a worker with dependants in the rural areas is virtually useless for these dependants as private health care facilities are virtually non-existent in rural areas.

Medical Aid Schemes have Hidden Costs

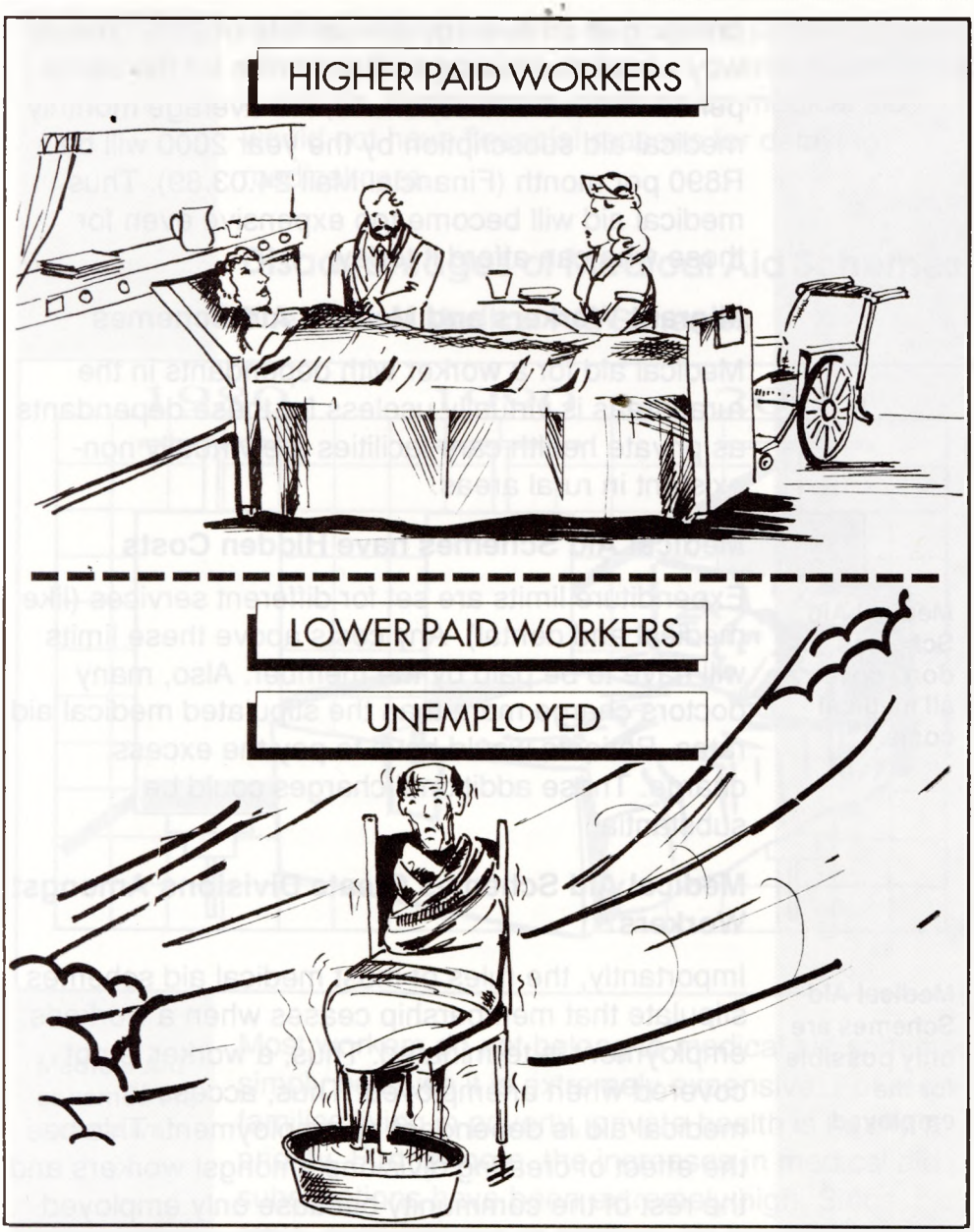
Medical Aid Schemes don't cover all medical costs

Expenditure limits are set for different services (like medical and dental). Any costs above these limits will have to be paid by the member. Also, many doctors charge more than the stipulated medical aid rates. Patients would have to pay the excess charge. These additional charges could be substantial.

Medical Aid Schemes Create Divisions Amongst Workers

Medical Aid Schemes are only possible for the employed

Importantly, the rules of most medical aid schemes stipulate that membership ceases when a worker's employment is terminated. Thus, a worker is not covered when unemployed. Thus, access to medical aid is dependent on employment. This has the effect of creating divisions amongst workers and the rest of the community because only employed workers have access to medical aid and decent



HOW MEDICAL AID SCHEMES DIVIDE WORKERS

health services. Also, because of the costs involved, medical aid is only feasible for higher paid workers. Thus, medical aid schemes also create divisions amongst higher and lower paid workers.

Medical Aid depoliticises health care

By shifting the provision of health on to the private sector through medical aid schemes, the government effectively depoliticises health care. The lack of adequate health care now becomes the fault of the individual not the government.

Types of Medical Aid Schemes

There are basically four types of medical aid schemes. These are

1. Industrial council negotiated schemes : Certain industries have medical aid schemes that have been negotiated between employer representatives and registered trade unions at Industrial Council level. Management of these schemes is usually equally representative of employers and union members. Thus, workers through their unions will have a direct impact on the functioning of these schemes.

2. Company "in-house" schemes : Many larger companies (eg. Tongaat Hulett, O.K.Bazaars) have "in-house" schemes for their employees. Since unions now negotiate nationally with larger companies, it is feasible for unions to influence "in-house" schemes much as unions can on an industrial council level.

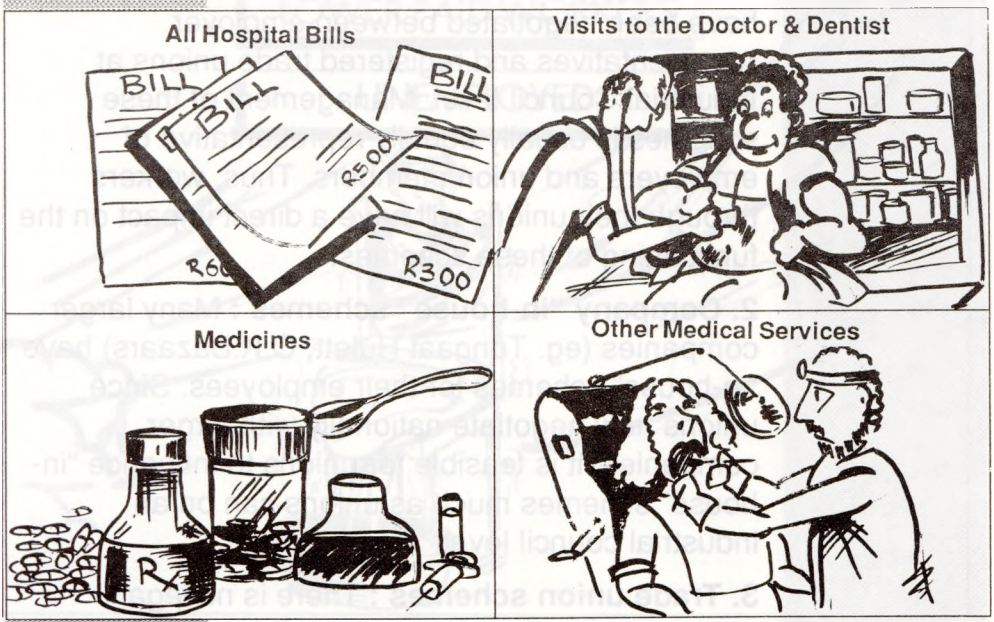
3. Trade union schemes : There is no legal obstruction to stop a union establishing and

Unions can start their own schemes

registering its own medical aid scheme except for the fact that a minimum of R200 000 must be put up as collateral (a guarantee that the fund can meet expected expenditure). There might however, be a problem getting employers to make contributions to a purely union controlled fund.

4. Commercial schemes : These are schemes which workers can join as a group. These are normally more expensive and workers have far less say over the running of the scheme. The discussions which follow are based mainly on commercial schemes. e.g. The Sizwe scheme.

What Benefits do Members of a Medical Aid Scheme Enjoy?



SERVICES INCLUDED IN MEDICAL AID BENEFITS

By law medical aid schemes must pay for the following medical expenses :

- all hospital bills
- visits to the doctor and dentist
- medicines
- other medical services like special dentistry and physiotherapy,etc

These are the expenses covered by most medical aid schemes. There are schemes which offer more benefits than those listed in this booklet. However the above benefits offer a general picture of the benefits offered by most schemes.

Problems with Medical Aid Benefits

1. The Percentage of Expenses paid by the Scheme

This can basically be divided into two types :

a) Schemes that pay 100% of costs - no problem with these schemes in this regard though they are generally expensive.

Medical Aid Schemes that pay 80% of costs

b) Schemes that pay only 80% of costs - These schemes are particularly problematic. The extra 20% of medical costs is borne by the member. With the high costs of medical services, this 20% could be expensive.

2. The Scale of Benefits

The maximum amount that Medical Aid Schemes can pay is laid down by the law...

The scale of benefits is the maximum amount that medical practitioners "ought" to charge for particular medical services. These scales which are determined by the Representative Association of

Medical Aids (RAMS) are published in the government gazette. Thus, they are scales which apply in law.

...but doctors can charge as much as they like.

The amount that medical aid schemes pay towards medical services may not exceed these scales. But doctors are not bound to charge according to these limits. Therefore, if a doctor charges in excess of these scales, the excess is not paid by the medical aid scheme. Instead, this cost must be paid by the member. These costs could be extremely high.

3. Limits to Benefits

There is a limit to the benefits paid by Medical Aid Schemes

Some Medical Aid schemes set limits for benefits. Limits are set for particular services. For example, the SIZWE scheme sets an annual limit of **R480** for dental expenses and **R720** for prescribed medicines for a single member. Any costs above these limits will be have to be paid by the member.

Annual overall limits are also set by some schemes. These limit the total medical expenditure that will be paid by the scheme in any particular year. The annual overall limit for a single member in the SANITAS scheme is **R2400**. Any costs above this will have to be paid by the member.

These limits generally increase as the number of dependants increase and the cost of medical care rises.

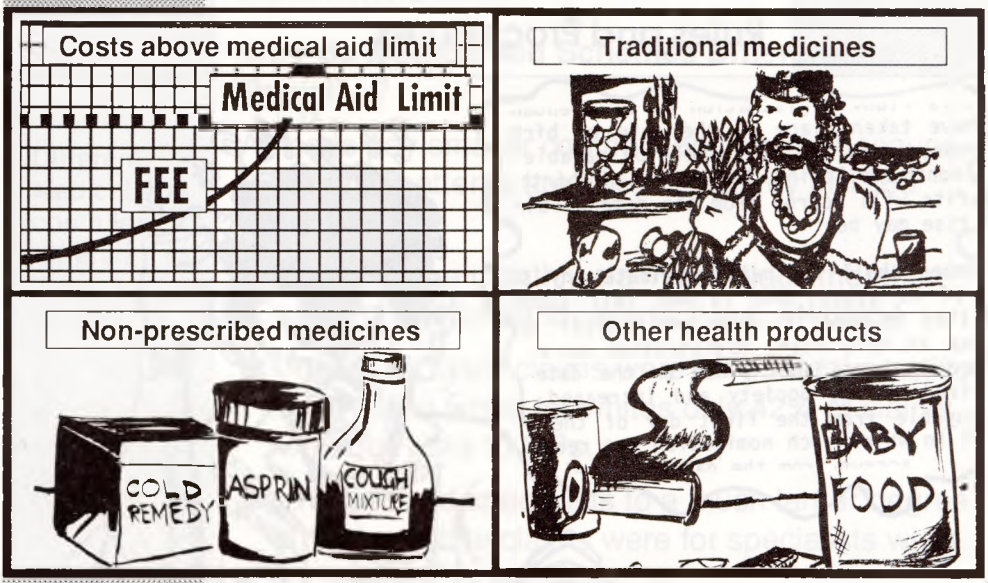
4. Levies

Most schemes contain the provision that a levy is paid on all prescriptions for medicines. These levies

range from R5 per prescription to 20% of the total cost of the prescription. With the high prices of medicines from chemists, a 20% levy could be a sizeable amount.

5. Higher Costs for Medical Aid Members

At provincial hospitals, members of a Medical Aid are charged higher tariffs. This could also be applied to doctors who sometimes charge Medical Aid patients higher rates. This factor is particularly problematic for Medical Aid schemes which pay 80% of medical costs. The 20% that is paid by members could end up being extremely high.



SERVICES EXCLUDED FROM MEDICAL AID BENEFITS

6. Exclusions

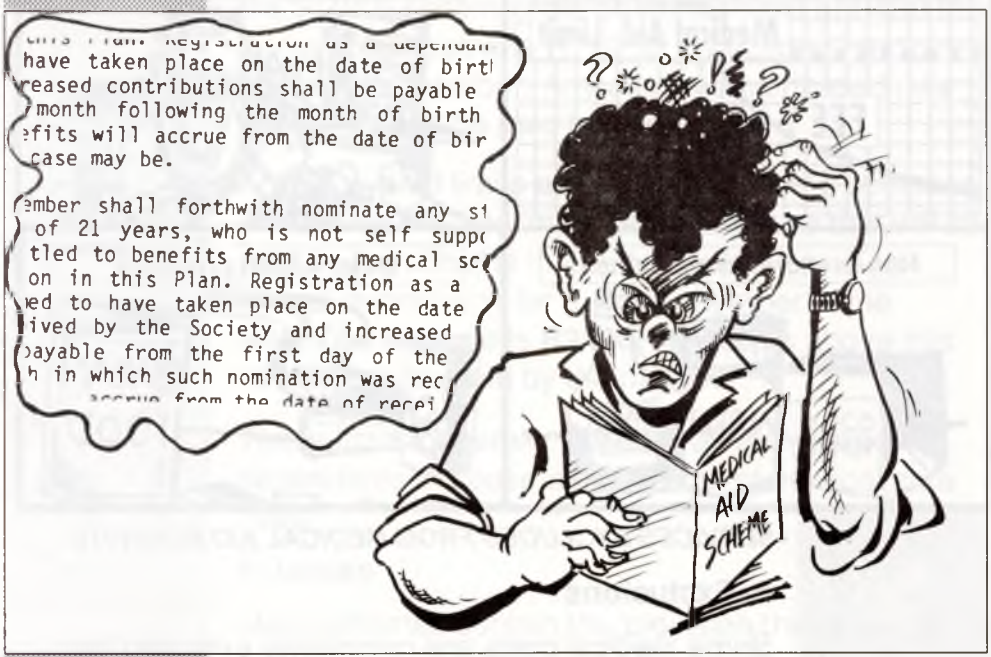
Some medical costs are completely excluded from Medical aid benefits. The full costs of these services

Costs that are not covered by Medical Aid Schemes

must be paid by workers. Examples of costs which are not covered by medical aid schemes are:

1. Any costs above the annual limits set by the medical aid scheme .
2. The buying of medicines that are not prescribed by a doctor.
3. The costs when a patient is treated by a person not recognised as a doctor. For example, a sangoma or other traditional healer.
4. The buying of traditional medicines.
5. The buying of bandages, baby foods, contraceptives, etc.

Rules and Procedures



MEDICAL AID RULES CAN BE BAFFLING

Rules are complicated and difficult to understand

The numerous rules and procedures which apply to medical aid schemes make it a complicated system. In particular, some schemes have many procedures that need to be followed before the scheme pays accounts. If these procedures are not followed, the member could be liable to pay the account.

Racial Discrimination and Medical Aid Schemes

A particular problem facing trade unions is that contributions to some Medical Aid schemes are different for different "population groups". "Africans" pay lower contributions.

Why do Medical Aid Schemes Differentiate Racially ?

Different Medical Aid costs for different "race groups"

Africans pay smaller contributions simply because their claim patterns are lower. A survey in 1985 found that :

- The average monthly claim per black member was R23,49 while for whites it was R108,54
- 70% of all black claims were for general practitioners (GPs) whilst for whites only 42% of claims were for visits to GPs.
- Whites used specialists to a much larger degree. 21.8% of white claims were for specialists whilst for blacks this was only 7%

Thus, running racially defined schemes is justified by the administrators of these schemes. Otherwise, "Blacks" would be penalised for the more expensive use patterns of other groups.

Whilst the claims patterns above cannot be disputed, it is important for us to recognise why "African" claim patterns are lower. The following factors are appropriate :

"African" claim patterns are lower not because they are ill less, but rather because they do not have similar access to health care facilities. This is due to:

- Lack of health facilities in townships
- Limited access to specialists and private hospitals.
- No private health care in rural areas (where family is)
- Traditional medicine is not covered by medical aid schemes.

Choosing a Medical Aid Scheme

Points to consider in choosing a Medical Aid Scheme.

Some of the factors to consider in deciding on a medical aid scheme are :

- The costs to workers
- The proportion of the costs that will be paid by the employer
- Who will control the management board ?
- What percentage of medical costs does the scheme pay ?
- What expenditure limits does the scheme set ?
- Does the scheme discriminate according to race?

- Is the scheme compatible with workers needs ? For example, does the scheme recognise traditional marriages and the birth of children in these marriages?

A Comparison Between Some Schemes

Most medical aid schemes are similar in terms of the types of medical expenses that are paid by the scheme. However, some schemes are better than others. Examples of a few medical aid schemes are shown on Page 28 (Chapter 4). The benefits, the problems, costs and advantages of these medical aid schemes are discussed.

CHAPTER THREE ALTERNATIVES TO MEDICAL AID SCHEMES

The discussion above shows that there are many problems with medical aid schemes. However, because the costs of health services are rising substantially, workers need some form of health insurance. It is thus necessary to look at alternative forms of health insurance.

As pointed out earlier, there are no legal obstructions to unions or federations of unions starting their own medical insurance schemes. These could be structured to address particular problems which workers face (for example unemployment, use of traditional doctors, etc).

Medical Benefit Schemes

The idea of a **MEDICAL BENEFIT SCHEME** has been suggested as a viable alternative to Medical Aid schemes.

Medical Benefit Schemes are also a form of health insurance

A medical benefit scheme is very similar to a medical aid scheme. A medical benefit scheme is also a form of health insurance. Like a medical aid scheme, workers and their employers contribute weekly (or monthly) to a fund. However, in the case of medical benefit scheme, medical care is provided by the scheme itself. This is done through either employing its own doctors and specialists or negotiating a fee with a panel (small group) of doctors

who will then provide health services to members of the fund. A medical benefit scheme could operate its own clinics and hospitals.

Medical Benefit Schemes and Workers Control

Workers can control Medical Benefit Schemes

The most important difference between medical aid and medical benefit schemes is the fact that workers could exercise greater control over medical benefit schemes. The control that workers can exert on medical benefit schemes affects the costs and quality of health care that the scheme provides. This control also allows medical benefit schemes' rules to be structured in a manner that suits the needs of its members.

Costs can be controlled

The cost and expected cost of medical aid schemes was raised as one of the main problems with these schemes. Medical benefit schemes can be much cheaper than medical aid schemes. A medical benefit scheme negotiates with a panel of doctors to provide care at a certain rate which is lower than the rate charged to other patients. For this reason, costs are controlled. For schemes that employ their own doctors, costs can be controlled to a greater extent.

Medical benefit schemes have some control over the health care that members receive because schemes choose (or employ) the doctors and other medical personnel that provide health care to members of the scheme. This gives members some say over the quality of health services that they receive.

Medical Benefits Schemes limit the choice of health services

On the other hand, because a medical benefit scheme works only with a panel of doctors, members have a limited choice of health services. Thus, a member cannot go to a doctor of his\her choice if that doctor is not part of the panel.

An Example of a Medical Benefit Scheme - The SAMWU Scheme

The SAMWU medical benefit scheme in Cape Town was established in 1952. It has approximately 13 000 members with 26 000 dependants. The fund is run by the union. The AGM of the fund elects a worker committee to manage the fund. The committee reports to the union's structures at least once every 3 months.

Benefits

SAMWU Scheme allows visits to non-panel doctors

The scheme operates with a large panel of doctors which members can use. The panel doctor is paid directly by the fund. Members can visit a non-panel doctor. In this case the fund refunds the member the amount that would have been paid to a panel doctor. Other benefits offered by the scheme are similar to those offered by medical aid schemes, although there are limits on all benefits.

Costs

Contributions to the fund are 1.3% of income per adult plus 0.6% per dependant child. Members contribute 40% and employers 60% of total contributions. A family with one breadwinner earning **R800** and having two children would "pay"

R10.40 for each of the husband and wife plus **R4.80** for each of the children. This amounts to **R30.40** per month. The member would only pay **R12.16** (40% of **R30.40**). In comparison, the cost of the MCG medical aid scheme for the same family would be **R154.76** per month. If the member contributed 40%, this would amount to **R61.90** per month.

The scheme's administration is fully computerised. This allows a strict monitoring of costs.

Other Benefits

SAMWU Scheme runs medical education programmes

The scheme has employed a medical field worker to run an education programme amongst members. The scheme is also investigating the possibility of setting up a clinic.

Medical Benefit Schemes - Summarised

Costs of Medical Benefit Schemes lower than Medical Aid Schemes

The advantage of medical benefit schemes is the fact that workers have a larger say regarding the policies of the scheme. Furthermore, the cost of medical benefit schemes is much lower than the cost of a medical aid scheme. Medical benefit schemes however only pay for basic health care costs. No provisions are made for major unexpected medical costs like operations. These costs which are much higher than costs for visits to a general practitioner are borne by the individual.

Medical Benefit Schemes are also tied to employment

Like medical aid schemes, medical benefit schemes are tied to employment. Only employed workers and their families have access to medical benefit schemes and the services that these schemes

provide. Only employed workers will have access to cheap and adequate health care. This creates divisions between employed workers and the rest of the community.

Managed Care

The idea of a "managed care" system has been suggested as an alternative to medical aid schemes. This is another example of a medical benefit scheme. This would involve setting up a scheme which collects subscriptions from members in the same way as medical aid schemes. This money is then used to employ doctors to work for the scheme, to buy medicines and rent space in hospitals where members can be treated. The scheme would develop health care centres where members can get full medical care.

Workers developing their own health care centres

CONCLUSION

Health care system is in crisis

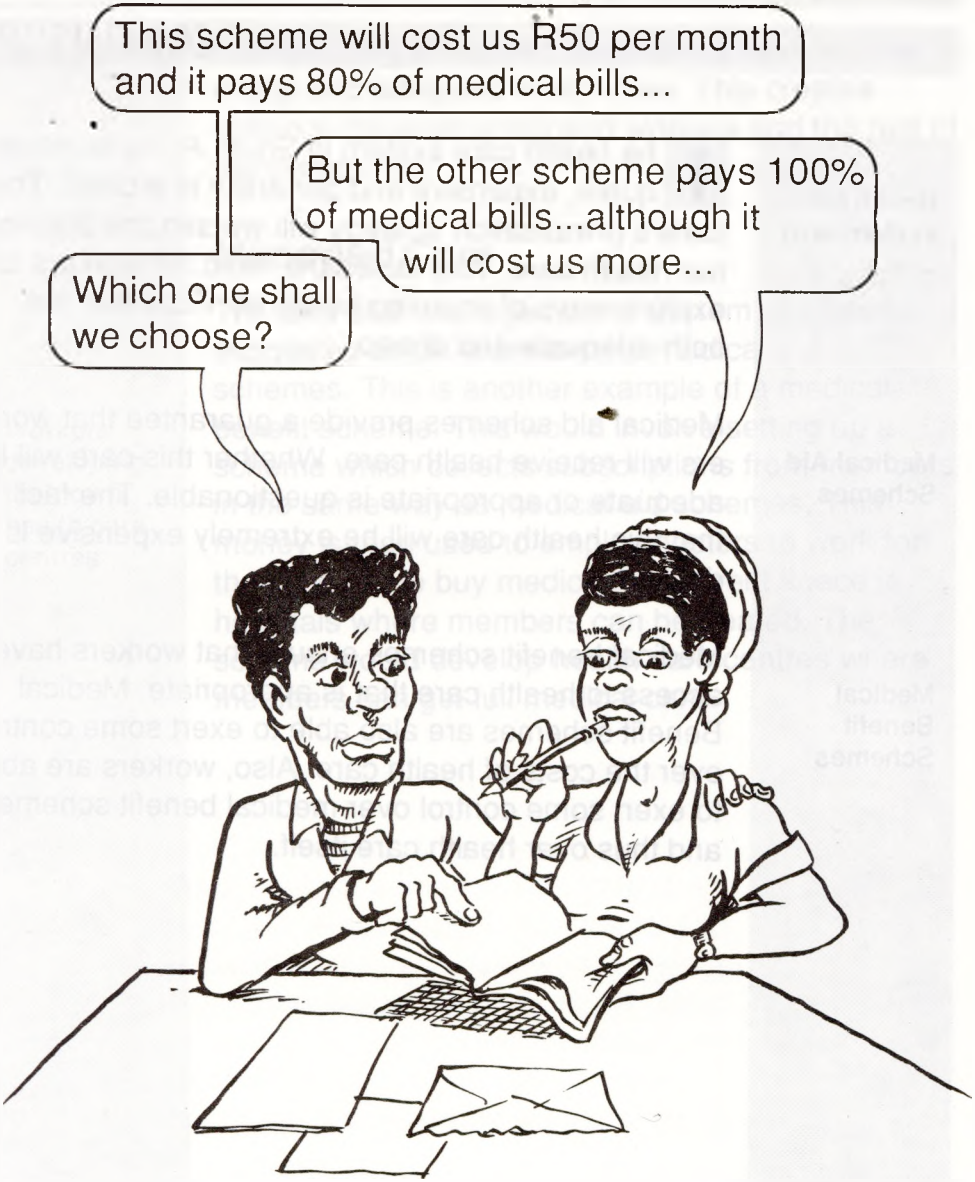
The health care system in South Africa is inadequate, expensive and generally in a crisis. The state's privatisation strategy will worsen the state of our health care. This raises the need for workers to explore ways of ensuring health services that are both adequate and cheap.

Medical Aid Schemes

Medical aid schemes provide a guarantee that workers will receive health care. Whether this care will be adequate or appropriate is questionable. The fact that this health care will be extremely expensive is definite.

Medical Benefit Schemes

Medical benefit schemes ensure that workers have access to health care that is appropriate. Medical Benefit schemes are also able to exert some control over the costs of health care. Also, workers are able to exert some control over medical benefit schemes and thus over health care itself.


This scheme will cost us R50 per month and it pays 80% of medical bills...
But the other scheme pays 100% of medical bills...although it will cost us more...
Which one shall we choose?

PART TWO
ADDITIONAL INFORMATION

CHAPTER FOUR COMPARISON BETWEEN SOME SCHEMES

The following are the contribution tables and comments on a few medical aid schemes. Note that the contributions shown are the total contributions (i.e. the contributions of workers and employers in total).

The NMP Scheme

The NMP offers a choice of schemes. Members can either join a scheme that pays 80% of costs or a more comprehensive scheme that pays full costs. As the tables below show, subscriptions to the comprehensive scheme are higher than for the scheme that pays 80% of costs.

The table below shows contributions to the NMP scheme that pays 80% of costs.

Monthly Income	Contribution by number of dependants				
	00	01	02	03	04+
R 0 - 800	94	188	200	206	212
R 801 - 1600	100	200	212	218	224
R1601 +	106	212	224	230	236

The table below shows contributions to the NMP scheme that pays 100% of costs.

Monthly Income	Contribution by number of dependants				
	00	01	02	03	04+
R 0 - 800	150	260	274	286	298
R 801 - 1600	170	280	298	310	320
R1601 +	190	300	312	324	334

The NMP scheme has the following advantages :

1. Parents, brothers or sisters who are not earning may be registered as dependants.
2. Pensioners can continue being members of the fund at reduced contributions.
3. There are no annual overall limits.

The MCI Scheme

The contribution table for the MCI scheme is as follows :

Monthly Income	Contribution by number of dependants			
	00	01	02	03+
R 0 - 520	106.80	165.90	176.90	187.20
R 521 - 650	117.90	195.30	210.10	215.60
R 651 - 800	129.00	202.70	224.80	230.40
R 801 - 1000	136.30	213.70	232.10	239.40
R1001 - 1200	145.70	219.40	239.40	245.10
R1201 - 1500	151.00	226.70	245.10	254.20
R1501 - 2000	156.70	235.80	257.90	267.10
R2001 - 2500	160.30	240.90	263.20	272.60
R2501 +	162.40	255.20	276.10	290.00

The MCI scheme has the following advantages :

1. The scheme pays 100% of most medical expenses with the exception of private hospital costs (it pays 90%) and costs for spectacles (it pays 90%).
2. The limits set for any particular expenditure are high.

3. There are no annual overall limits.
4. Use of claim forms is optional. Thus, claims procedure is simple.
5. There are no racial classifications.
6. Widows of members that contributed to the fund for at least five years can continue being members of the fund. The first year's membership is free. Thereafter contributions are dependant on income according to the contribution table above.
7. The scheme pays for medicines that are not prescribed by a doctor for minor self diagnosed ailments like influenza, skin irritations, etc. The value of these medicines may not exceed **R10.00**

MCI Scheme is expensive!

The most obvious disadvantage of the scheme is the high costs involved. The contributions are much higher than those for any other scheme in this booklet. However, the benefits are much better.

Members need to pay a levy for prescribed medicines. This levy is limited to **R10** per prescription.

The MCG Scheme

The contributions to the MCG scheme are as follows

Monthly Income	Contributions by number of dependants			
	00	01	02	03+
R 0 - 303	20.14	38.92	54.46	62.30
R 304 - 390	25.72	49.66	71.02	82.06
R 391 - 520	42.26	81.14	105.12	118.44
R 521 - 650	60.98	104.64	124.86	136.30
R 651 - 800	81.88	127.02	144.54	154.76
R 801 - 975	96.56	141.46	157.16	167.24
R 976 - 1200	105.42	154.44	179.42	190.94
R1201 - 1500	115.72	169.54	196.94	209.60
R1501 - 2000	126.50	185.54	215.02	229.22
R2001 +	133.80	194.02	223.00	239.74

The MCG fund has the following advantages :

1. It pays 100% of most medical costs with the exception of private hospital costs (pays 80%), dentures (pays 85%) and spectacles (pays 80%).
2. There are no annual overall limits.
3. The scheme does not classify members according to race.
4. Widows of members who contributed to the fund for a period of at least five years remain members. The first year's membership is free. Thereafter widows pay greatly reduced rates.
5. The MCG scheme is much cheaper than the MCI scheme.
6. Claiming procedure is simple.

Disadvantages

The disadvantage of the MCG scheme in comparison to the MCI scheme is that the limits set for particular services are much lower in the case of the MCG scheme. For example, for a single member the limit for prescribed medicines in the case of MCI is **R2000**. For the MCG scheme the limit for prescribed medicines is **R1200.**

A levy limited to R10 is payable for prescribed medicines.

The SIZWE Scheme

Contributions to the Sizwe fund differ according to race. The contributions are as follows :

TABLE APPLICABLE TO BLACKS ("AFRICANS")

Mnth Inc.	Contribution by number of dependants					
	00	01	02	03	04	05+
R 0 - 150	20.00	40.00	44.90	49.40	55.00	59.50
R 151 - 200	25.10	50.20	54.80	59.80	64.70	70.00
R 201 - 250	30.70	61.40	67.00	71.30	76.80	82.10
R 251 - 300	36.00	72.00	77.50	82.20	87.50	93.00
R 301 - 400	44.20	88.20	93.40	99.20	104.90	110.60
R 401 - 500	51.00	101.90	107.90	113.00	119.20	124.70
R 501 - 800	62.50	125.00	130.30	135.80	142.00	147.80
R 801 - 1000	64.10	128.20	133.40	139.00	145.10	151.00
R1001 - 1200	66.10	132.10	137.60	143.50	149.40	155.20
R1201 - 1500	77.00	154.10	166.70	173.90	181.30	186.00
R1501 - 2000	91.20	182.30	199.70	208.70	217.70	227.00
R2001+	92.80	185.50	204.20	213.10	222.50	232.20

TABLE APPLICABLE TO "WHITES" AND "INDIANS"					
Monthly Income	Contribution by number of dependants				
	00	01	02	03	04+
R 0 - 300	64.30	128.50	141.10	147.60	153.80
R 301 - 400	84.80	169.60	185.20	194.60	203.00
R 401 - 600	97.60	195.10	214.30	224.30	233.90
R 601 - 800	102.50	205.10	224.20	235.80	246.00
R 801 - 1000	107.90	215.60	236.50	247.60	258.60
R1001 - 1200	110.50	220.90	242.50	254.50	264.70
R1201 - 1500	113.00	226.00	248.30	259.60	270.80
R1501 - 2000	115.70	231.20	253.70	265.30	276.70
R2001 +	118.10	236.20	259.70	271.30	283.10

TABLE APPLICABLE TO "COLOURED" MEMBERS					
Monthly Income	Contribution by number of dependants				
	00	01	02	03	04+
R 0 - 200	41.20	82.20	90.20	94.60	98.50
R 201 - 300	51.40	103.10	112.80	122.50	127.70
R 301 - 400	64.10	128.40	141.10	147.60	154.10
R 401 - 500	66.60	133.30	146.60	153.40	160.20
R 501 - 600	69.20	138.60	152.40	159.20	166.40
R 601 - 800	71.80	143.50	158.00	165.10	172.30
R 801 - 1200	76.90	153.70	169.30	177.10	184.60
R1201 - 1500	85.40	170.90	184.80	192.60	201.10
R1501 - 2000	115.70	231.20	253.70	265.30	276.70
R2001 +	118.10	236.20	259.70	271.30	283.10

The Sizwe fund has the following advantages :

1. It pays 100% of most medical costs subject to limits.
2. Pensioners and widows of members can continue being members with reduced contributions.
3. Aged parents can be registered as dependants.
4. Second wives and their children can be registered as dependants.
5. Claims procedure is simple.
6. There are no annual overall limits.
7. No levies are payable for prescribed medicines.

The disadvantage of the Sizwe fund is its racial classifications.

Note

The rates shown above are the total that needs to be paid to the medical aid fund (the employee and employers' portions). The portion that is paid by the employer is not stipulated by any law. Most companies pay 50% of the costs. Workers are free to negotiate a higher employer proportion of medical aid costs.

Better benefits offered by schemes that are expensive

Generally, the more expensive schemes offer better benefits. The limits that are set for any particular medical cost are normally higher for schemes that have higher contributions. The table below which shows the limits for prescribed medicines for a single member earning **R1000** per month illustrates this point.

Scheme	Annual Limit	Monthly Contribution
NMP(100%)	R2 500	R170.00
MCI	R2 000	R136.30
MCG	R1 200	R105.42
SIZWE	R 720	R 64.10*

*Sizwe contribution for Black member

Thus, it is clear that the more expensive schemes have higher limits.

CHAPTER FIVE HOSPITAL TARIFF STRUCTURE AT NATAL PROVINCIAL HOSPITALS

The Natal Provincial hospitals differentiate between part-paying and full-paying patients. Part paying patients are defined as people who earn up to **R1000** per month for single persons or **R2000** for family units. Anyone earning above these limits is classified as a full-paying patient. A member of a medical aid scheme is automatically classified as a full-paying patient.

Part-Paying Patients

Part-paying patients are further divided into groups depending on wages. The table below shows the different groups and the wages that apply to that group.

GROUP	SINGLE	FAMILY UNIT
A	R801 -1000	R 1601-2000
B	501 - 800	1001-1600
C	251 - 500	501-1000
D	UNDER 251	UNDER 501

The fees charged to part-paying patients for particular health services depending on groups, is shown on the next page:

	GROUP A	GROUP B	GROUP C	GROUP D
OUT-PATIENTS per visit				
Para-medical service	11.00	7.50	3.50	2.00
Consultation	22.00	15.00	7.00	2.00
Maternity charge*	84.00	75.00	55.00	27.00
IN-PATIENT				
Day patient	75.00	55.00	27.00	8.00
Long term patient (per month)	150.00	110.00	27.00	8.00

*inclusive of ante-natal classes, visits and delivery

Full-Paying Patients

A full-paying patient is any single person earning over R1000 or any family unit earning over R2000. Anyone who is a member of a medical aid scheme (irrespective of earnings) is also a full-paying patient.

The tariffs for full-paying patients are shown below.

OUT PATIENT	
Para-medical service	R12.50
Consultation	25.00
IN PATIENT	
Day patient	84.00
Service charge	22.00
Theatre	143.50
Minor surgery	67.00

Note :A full-paying maternity patient who had a caesarian birth and stayed in hospital for 3 days, would pay:

Day patient R84 X 3 days	R252
Service fee R22 X 3 days	R 66
Theatre fee	R143
Limited surgery	R167
	R628

The cost for the patient would be R628 without medicines and any other services that might have been provided. In addition, the fee for surgery could be much higher depending on time spent performing the operation.

We have used a number of publications in producing this booklet. These are :

1. Medical Aids, Medical Benefits and Health Services for Workers by the Workplace Information Group (WIG). This booklet will be published shortly.
2. Medical Aids - Questions for Unions, by Max Price and Phakamile Tshazibane in the South African Labour Bulletin Volume 13, number 8.
3. A stepping stone to national health, by Broomberg, Price and De Beer, in Work in Progress, number 59.

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- sector and industry analysis
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