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International Applications of American Managed Health Care Case Study: South Africa

Elizabeth Ann Uphoff

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INTERNATIONAL APPLICATIONS OF AMERICAN MANAGED HEALTH CARE

CASE STUDY: SOUTH AFRICA

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A.B., Dartmouth College, 1990

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INTERNATIONAL APPLICATIONS OF AMERICAN MANAGED HEALTH CARE
CASE STUDY: SOUTH AFRICA

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I would like to first thank my family and friends for their untiring support. My achievements have been constructed on the foundation of their love and encouragement. In addition, I would like to thank the following people who assisted me in my efforts towards producing, and at times surviving, this thesis: Howard Bailit, Hudson Birden, Barbara Blechner, Joan Segal, Laurene Powers, Carol Delark, Ronnie Van Der Merwe, Marlene Heymans, Jonathan Lewis, Maarten Van de Vijver and Elizabeth Driscoll.

“Grasp the subject, the words will follow”

Marcus Porcius Cato (Cato the Elder)

234-149 B.C.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>TITLE</th>
<th>PAGE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>♦ CHAPTER I South Africa: the country at a glance</td>
<td>7</td>
</tr>
<tr>
<td>♦ CHAPTER II Background of the healthcare system to date in South Africa</td>
<td>17</td>
</tr>
<tr>
<td>♦ CHAPTER III Development of managed health care in South Africa</td>
<td>26</td>
</tr>
<tr>
<td>♦ CHAPTER IV Managed care in practice</td>
<td>36</td>
</tr>
<tr>
<td>♦ CHAPTER V Government response</td>
<td>58</td>
</tr>
<tr>
<td>♦ CHAPTER VI Lessons learned and prospects for the future</td>
<td>68</td>
</tr>
<tr>
<td>♦ CHAPTER VII Other trends</td>
<td>76</td>
</tr>
</tbody>
</table>
Introduction

Managed care has revolutionized the healthcare business in America. Fifteen years ago, few could have imagined the impact of the new terms that flood our healthcare vocabulary today: HMO, PPO, utilization review, “gag rules”, “drive-by delivery”. The managed care experiment in America has at times followed a tortured path, and has not been without its fair share of controversy. In fact, it has become a popularly despised issue, with patients, providers and politicians raising the cry against the corporatization of medicine. Today, numerous “patient protection” bills and other forms of managed care regulation crowd the legislative landscape across the states and at the federal level. This is not to say that managed care is going to go away. Despite recent financial troubles of several high-profile managed care companies, the days of fee-for-service, free-for-all medicine most likely will not be resurrected.

The United States arguably has the most sophisticated medical and medical insurance system in the world. As one of the world’s wealthiest countries without a socialized national health system, we have seen our private medical sector develop with few constraints. Innovative medical technology and research have been well funded. Legislation through the years has generally favored the promotion and development of hospitals and medical personnel. Compensation packages for medical personnel are among the highest in the world. Despite this, our system is not perfect. Enormous disparities in the level and quality of accessible health care still persist between the
wealthy and the poor, the rural and the urban, and between those who possess health insurance and those who do not (at latest count, over 42 million people). Managed care has not been the panacea to these ills, but it has wrought other important changes. First, it has controlled spiraling health care costs that were threatening to overwhelm the system in the late 1980s and early 90s. This has been achieved through a variety of measures, most particularly utilization review and management. The lower prices of HMOs have increased access to health care for some populations. In addition, we have seen the formation of disease management programs, quality measurements and reviews, and an increase in health services research, including outcome measures. Managed care programs also incorporate a philosophy that prevention today is a key to lowering future health care costs, hence an increase in aggressive screening and prevention programs.

The success of American managed health care companies in lowering health care costs and managing utilization has not gone unnoticed around the world. The exportation of American managed health care services is on the rise for several reasons. Other countries can benefit from the expertise of the Americans in lowering their own health care costs. In addition, the exportation of American style managed care is another market for American companies to penetrate. As we shall see, it is not always an easy fit. The model of American managed care must be flexible enough to adjust to the needs of the local population. Attempts to "cookie cutter" managed care onto a foreign population and culture may be not entirely successful. Further, the negative perception and subsequent backlashes that plague managed care in America could very well occur in a
foreign setting. Despite these drawbacks, the potential for the international managed care market appears to be growing.

This paper will provide a general overview of trends in the international application of American managed health care systems. However, its focus will be on the country of South Africa. South Africa has rapidly adopted many managed care principles in its private health care system over the last several years. South African companies have looked to America for their managed care technology and, in some cases, have formed alliances or partnerships with American companies, such as United HealthCare. For these and other reasons, South Africa provides an illuminating example of how American style managed care is being adapted in a foreign setting. The success or failure of managed care in South Africa may indicate what we should expect in other areas around the globe. Or, it may not. Each country and culture which adopts managed care may do so in entirely different ways according to the local economy, social, medical and political culture. There is as much to learn about the common themes we shall see in the South African experience as there are in the differences.

South Africa retains features in its private healthcare system which make it a particularly fascinating example to study. On one hand, it is comparable to the American healthcare system. The private sector boasts first-rate care and expertise, and is utilized mainly by consumers covered by traditional fee-for-service plans, similar to the U.S. before the advent of managed care. South Africa’s private healthcare system is being
increasingly burdened with the costs of lifestyle induced chronic illness (heart disease, cancer) in its aging white population, similar to the United States. For these and other reasons (technology, overutilization), the South African private healthcare system has seen huge increases in costs over the past several years, and is turning to managed care to help bring things under control. The rapid pace at which this is occurring is astounding. Managed care has only existed in South Africa for a few years, and its penetration of the private healthcare system is literally galloping along when compared to the length of time that managed care has taken to develop in the United States.

However, the private healthcare system in South Africa serves only a fraction of the country’s population. Approximately 6.5 million people in South Africa have private health insurance, out of a population of about 42 million. The majority of citizens receive public state-funded care on a scale that is in no way comparable to the American Medicare and Medicaid system. This is part of the legacy of apartheid. Apartheid, the policy of deliberate political and social discrimination by the whites against the blacks and coloreds developed under the Afrikaner led National Party regime (1948-1994), created, among other things, huge disparities in the amount of healthcare resources available to its population. Four years after the first majority representative government was elected with Nelson Mandela as its President, the wealthy, predominantly white, formally employed population still enjoys access to far better healthcare resources than the majority of South African citizens. One of the goals of the new government is to reform health policy in order to achieve a more equitable distribution of healthcare
resources. Led by headstrong Health Minister Dr. Nkosazana Zuma, the African National Congress has demonstrated a willingness to legislate its agenda regardless of the interests of the private sector that caters mostly to the whites. This is in contrast to the U.S. For all of the politicians jumping on the anti-managed care bandwagon in the United States, the American private health care sector still enjoys much greater political support and influence than in South Africa. As can be imagined, there are many interested parties in the healthcare policy debate, and the outcome could have a profound impact on the future and success of managed care in South Africa.

Other major differences between the United States and South Africa include that, comparatively speaking, the United States is a far wealthier country than South Africa and can afford to put more money aside for health care (and even this capacity is being strained under the dwindling Medicare trust fund). South Africa, while it has pockets of great wealth, essentially functions as two countries—a first world country with all the amenities living side by side with a third world country. The United States has far better health data on its citizens; one of the essential components to making managed care work. The struggle to make managed care work with limited data is one of the biggest challenges right now in South Africa. Finally, South Africa is currently faced with an explosive HIV/AIDS epidemic that promises to severely challenge the already limited resources of the public and private healthcare systems. To date, the government has not had much success in combating the AIDS epidemic. In light of these and other challenges, it remains to be seen how managed care will succeed in South Africa. It is
still new in the country, and the effect of newly passed regulation will not be seen for some time. However, it is a compelling experiment that should be of interest to anybody studying the expansion of managed care into foreign markets.
CHAPTER I

South Africa: the country at a glance

First, here is some information to acquaint the reader with some basic facts about present day South Africa. (See Map, Appendix item A) The Republic of South Africa is located at the southernmost tip of the African continent, south of the equator at roughly the same latitude as Florida is north. It is 1,219,912 sq km in area, slightly less than twice the size of Texas, yet is remarkably diverse in its climate and landscape. Deserts, mountains, semi-tropics and Mediterranean coastal plains are all found within South Africa’s borders. It is rich in natural resources and is one of the world’s top producers of many precious metals and gems, including gold, diamonds, chromium and platinum. It also is a major agricultural producer despite having limited arable land (10%). In comparison to other African countries, South Africa has a remarkably well developed infrastructure in terms of electricity, water, transport and communications. Despite the political turbulence of the past and the uncertainty of the future. South Africa has the most highly developed and best-managed economy in sub-Saharan Africa and is generally regarded as the economic backbone of the African continent. It has a population estimated at \textbf{42,327,458} as of July 1997. Features of the South African population include:

\textbf{Age structure:}

\textit{0-14 years: 35\% (male 7,470,444; female 7,340,734)}
15-64 years: 61% (male 12,729,753; female 1,132,517)

65 years and over: 4% (male 762,041; female 1,132,517) (July 1997 est.)

**Population growth rate:** 1.51% (1997 est.)

**Birth rate:** 26.89 births/1,000 population (1997 est.)

**Death rate:** 11.89 deaths/1,000 population (1997 est.)

**Net migration rate:** 0.09 migrant(s)/1,000 population (1997 est.)

**Sex ratio:**

*at birth:* 1.03 male(s)/female

*under 15 years;* 1.02 male(s)/female

*15-64 years:* 0.99 male(s)/female

*65 years and over:* 0.67 male(s)/female

*total population:* 0.98 male(s)/female (1997 est.)

**Infant mortality rate:** 53.2 deaths/1,000 live births (1997 est.)

*(note-a black child is nearly ten times more likely to die during the first year of life than a white child)*
Life expectancy at birth:

*total population:* 56.29 years

*male:* 54.4 years

*female:* 58.23 years (1997 est.)

Total fertility rate: 3.22 children born/woman (1997 est.)

Ethnic groups: black 75.2%, white 13.6%, Colored 8.6%, Indian 2.5%

Religions: Christian 68% (includes most whites and Coloreds, about 60% of blacks and about 40% of Indians), Muslim 2%, Hindu 1.5% (60% of Indians), traditional and animistic 28.5%

Languages: 11 official languages, including Afrikaans, English, Ndebele, Pedi, Sotho, Swazi, Tsonga, Tswana, Venda, Xhosa, Zulu

Literacy:

definition: age 15 and over can read and write

total population: 81.8%

male: 81.9%

female: 81.7% (1995 est.)
**GDP:** purchasing power parity - $227 billion (1996 est.)

**GDP – real growth rate:** 3% (1996 est.)

**GDP – per capita:** purchasing power parity - $5,400 (1996 est.)

**GDP – composition by sector:**

- **agriculture:** 5%
- **industry:** 37%
- **services:** 58% (1995 est.)

**Inflation rate – consumer price index:** 9% (1996 est.)

**Labor force:**

- **total:** 14.2 million economically active
- **by occupation:** services 35%, agriculture 30%, industry 20%, mining 9%, other 6%

**Unemployment rate:** 34% (1996 est.); note- an additional 11% of the workforce is underemployed
Additional information about the South African population, including data stratified by race, may be found in the Appendix, items B and C. The items in the Appendix illustrate disparities in health status according to race.

The statistics listed above reflect only part of the story. As previously mentioned, South Africa retains a dualism, operating as two worlds within one country. The rich, mostly white population enjoys a standard of living comparable to any first world country, with all the creature comforts of the modern age. On the other hand, much of South Africa remains a third world country with all of its attendant problems. A recent report by the Development Bank of South Africa found that after Brazil, South Africa has the most skewed income distribution in the world.iii The poorest 50% of its people receive about 15% of total annual household income, and the poorest 10% only 1.4%. Compare this with the top 10% of households, who control 42% of income. While the poorest 20% earn under (in South African rands) R5,700 (approximately US $1,140) a year, the richest 20% earn more than R76,000 (approximately US $15,200) a year. As in many parts of the world, women and rural dwellers are worst off: male-headed households earn double the income of female-headed households, and urban households earn double that of rural households. To the degree that health status and economic position are linked, this is cause for concern. The condition of public schools further reflects the disparity in income. Many children who are white or who come from wealthy families attend private schools. Of the public schools, 83% lack libraries, 61% are without phones, 24% do not have water, 52% lack electricity, and 12% lack toilets.
These are utilized mainly by the majority black population. Only 1 of 100 black South Africans entering first grade will finish high school.\textsuperscript{iv} Housing is another problem. Approximately 48\% of all South Africans lack adequate housing. An estimated 34\% lack safe drinking water and 45\% lack inside sanitation. Only 12\% of black households have electricity.

There are many more examples of the disparity that exists in South African life today between the rich and the poor. Most of it runs along racial lines, a legacy of apartheid. Any discussion of South Africa today is incomplete without acknowledging its complex, multiracial history. The white man’s history in South Africa began almost four hundred years ago when Jan van Riebeeck, commander of the Dutch East India Company’s expedition to the Cape, made landfall at Table Bay (modern day Cape Town) in 1652. He established an agricultural refilling station there for the trading ships as they made their way back and forth between Europe and the Far East. From this station grew a colony, the descendants of which eventually spread out across the country as farmers. They called themselves the Boers and developed their own distinctive Afrikaner language and culture. Although mostly Dutch, the Boers also included people of Scotch, German and French descent. The Boers founded the republics of the Transvaal and the Orange Free State and have been called Africa’s one true white tribe. Other Europeans came to settle in South Africa, notably the British, who took over the Cape colony from the Dutch and also established the colony of Natal (present day Kwa-Zulu Natal). The relationship between the Boer republics and the British colonies was often acrimonious, culminating
in the Anglo-Boer War in 1899 which the British eventually won in 1901. During the early years of white settlement there were also frequent skirmishes between the whites and the blacks. The Battle of Blood River between the Boers and the Zulus in 1838 is one of the better known battles. In the aftermath of the Anglo-Boer War, the Boer republics rejoined with the British colonies and in 1910 created a unified government that basically remained unchanged in form until South Africa formally separated its ties with Britain and became a Republic in 1961.

From South Africa’s earliest days as a unified government in the early 1900s the black people were never allowed to participate in the democratic process. They were represented in government by whites. The colored people, people of mixed-race descent, fared slightly better, but lost most of their political rights later during the apartheid years. The ‘apartheid years’ refer to the period from 1948 to 1994. During this time, the conservative, Afrikaner-led National Party (the ‘Nats’) ruled South Africa. The cornerstone of their political and social philosophy was that of apartheid, literally, “apartness”. It was seen as the best way of ensuring white rule and the preservation of Afrikaner culture. This policy was engineered through a series of legislative acts that ensured segregation of the races. Chief among these acts was the Group Areas Act of 1950, which segregated the country’s residential areas. Further statutes involved freedom of movement, identity documents, the formal classification of people according to color, regulation of workplaces and many stringent security laws. In 1959 the government established black homelands with the Promotion of the Black Self-Government Act. The
homelands can be compared on some levels to the Native American reservations in the United States, although Native Americans still enjoy the rights of American citizenship. The creation of the homelands effectively denied black South Africans the right to vote or to claim South African citizenship, as they were legally citizens of their black homeland, not of South Africa.

As was to be expected, the political and social discrimination in South Africa would not be tolerated forever. Internal and external pressure eventually led to the dismantling of the apartheid laws in the early 1990s. In 1994 the country’s first free democratic elections took place. The black, mostly Xhosa, African National Congress (ANC) became the ruling party and immediately set out to write a new constitution and bill of rights for the “Rainbow Nation”. Since 1994, many drastic changes have occurred in South Africa. Symbolic changes include a new flag, new national anthem and new names for provinces and cities. Aggressive affirmative action policies have been put in place, hoping to empower the previously disenfranchised. The Truth and Reconciliation Commission has completed the extraordinary task of unearthing the truth of the country’s troubled past in order that healing may begin. But it has not been an entirely smooth transition. The currency has plummeted against the US dollar, while interest rates and inflation have risen. Crime rates have skyrocketed with seemingly little intervention from the government, fueling the migration of wealthy and educated citizens from the country. Evidence of corruption and mismanagement is undermining confidence in the new government. Political violence between rival parties threatens to further destabilize
parts of the country. With elections looming in 1999, the black populace is demanding results from the ANC, promises like new housing and jobs that may take years for the government to deliver. There is a sense of fatalism among many whites in South Africa today. Many white people feel, probably fairly, that they are now the ones being discriminated against, and many are not optimistic about their own prospects for the future. Even coloreds and Indians are subject to discrimination in favor of blacks. Many blacks in South Africa still feel enormous resentment towards the whites, and the disparity in living standards still persists. Clearly, it will take a while for the society to adjust and for the nation to fully move on from its past.

The new South Africa is, in short, a complex society struggling to implement its vision of a truly integrated community. Although the balance of political power has now been struck in favor of the blacks, the struggle for control of economic power and resources and cultural influence is still ongoing. This is important to remember when debating any issue in South Africa, whether it is health care, crime, the economy or even sports. In light of the past, it is not surprising today that an atmosphere of intense political correctness exists and colors most debates. However, many innocuous sounding terms are also thinly veiled code for discriminatory behavior on all sides. The issues are not as simple as black vs. white, or Afrikaner vs. English, or Xhosa vs. Zulu, or rich vs. poor, but these are some of the underlying conflicts that float beneath the surface. As we look at the healthcare debate in South Africa and the role of managed care, it is important
to frame any arguments within the context of South African society and the myriad challenges facing the new South Africa.

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CHAPTER II

Background of the healthcare system to date in South Africa

In order to appreciate the development and current position of managed care in South Africa, it is helpful to understand the structure and history of the healthcare system, as well as the role of government. Also, please note the terms ‘medical aid’, or ‘medical scheme’, terms which are used to describe health insurance in South Africa. Provision of health care in South Africa has developed along two lines—a public sector and a private sector. The public health sector was first established in 1919, in response to the worldwide influenza epidemic. It provides subsidized care to all South Africans, with the majority of money going toward tertiary hospital care. The public sector is also responsible for the education and training of medical personnel and the maintenance of academic health centers. This arrangement has provided South Africa with well-trained doctors, but left little money for primary care facilities. It has tended to concentrate resources in well-populated urban areas, leaving little for the rural areas. The majority of South African citizens depend on the public health sector for care, since it is heavily subsidized by the state. Over the years, they have suffered from limited access to primary care services, part of the reason for the disparity in health status we see in South Africa today.

In addition to the public sector, private general practitioner services also developed, largely through the evolution of medical aid schemes, or private health
insurance. Medical aid schemes have been around for a long time in South Africa. The first one was established in 1889 by the De Beers Consolidated Mines Ltd. Benefit Society. By 1910 seven medical aid schemes were in place to serve the needs of the urbanized middle class, which was almost exclusively white. Post-WWII growth fueled the private and public sectors, but in different ways. By 1960, virtually all whites had shifted away from the public services provided by the government into private schemes. In contrast, 95% of 'non-whites' received care from the public services. In the 1970s the public health sector was in fairly good shape. Although it was segregated, 60% of the country’s doctors cared for 80% of the population. There was some access to state-of-the-art treatment in most specialties. The public sector accounted for 70% of the nation’s health expenditure, and the ratio of earnings of private to public doctors was about 2-3:1. However, this all changed in the 1980s as more doctors went into the private sector, and the development of private tertiary medical and surgical services competed directly with the publicly funded academic medical centers. The proportion of South Africa’s GNP spent on health care rose to 8%, of which 60% was now consumed by the private sector. The private sector in the 1980s served only about one-fifth of the country’s population. The proportion of privately insured people included 80% of whites, and 15% of blacks. The salary ratio between private and public doctors widened to about 3-5:1. The public sector suffered as the wealthy private sector lured away medical staff, and it was very difficult to get doctors to serve in rural areas. The emigration of doctors due to political instability further strained the system, along with the challenge of limited budgets. And still the emphasis in the public sector was on
tertiary treatment and funding academic medical centers. Effective primary care services continued to dwindle for the majority of the population.

It was against this backdrop that the election of the ANC to power occurred in 1994. This promises to be the most significant event to impact the healthcare systems in South Africa, both public and private. South Africa today spends about 8.5% of its gross domestic product on healthcare. It is frequently quoted that 60% of healthcare funds go to the private sector, which provides care for only 23% of the population. One of the priorities of the new government is to revamp the healthcare system in the hope of erasing previous inequities and increasing primary care access for all citizens. To this end, several steps have been taken. One of Nelson Mandela’s first acts as President was to declare that all health care for pregnant women and children under the age of six would be free. On a more substantive level, on April 16, 1997 the Department of Health issued a White Paper for the Transformation of the Health System in South Africa. This document serves as a blueprint, detailing the goals and philosophy of the new government regarding healthcare. Many of the goals of the White paper are already beginning to be implemented with the passage of the National Health Bill. Briefly, the White Paper addresses the following topics:

- CHAPTER 1: Mission, goals and objectives of the health sector
- CHAPTER 2: Reorganising the health service
- CHAPTER 3: Financial and physical resources
• CHAPTER 4: Developing human resources for health
• CHAPTER 5: Essential national health research
• CHAPTER 6: Health information
• CHAPTER 7: Nutrition
• CHAPTER 8: Maternal, child and women's health
• CHAPTER 9: HIV/AIDS and sexually transmitted diseases
• CHAPTER 10: Communicable diseases
• CHAPTER 11: Environmental health
• CHAPTER 12: Mental health and substance abuse
• CHAPTER 13: Oral health
• CHAPTER 14: Occupational health
• CHAPTER 15: Academic health service complexes
• CHAPTER 16: National health laboratory services
• CHAPTER 17: The role of hospitals
• CHAPTER 18: Health promotion and communication
• CHAPTER 19: The role of donor agencies and non-governmental organisations
• CHAPTER 20: International Health
• CHAPTER 21: Year 2000 health goals, objectives and indicators for South Africa
Although the White Paper does not specifically address private healthcare financing (that is addressed later in a separate policy document), it covers all other areas of healthcare in South Africa. The groundwork for policy and practice changes is laid out in each chapter. The scope of this paper does not require detailing every goal. However, a few should be noted.

From Chapter One of the White Paper: “The task of improving the health of South Africa’s population is not that of the health sector alone. It forms part of the RDP (Reconstruction and Development Programme) framework whereby the health of all South Africa must reflect the wealth of the country and lays the foundation for a process of democratising the State and society that will foster the empowerment of all citizens and promote gender equality. The health sector strategies is based on a common vision which reflects the principles of the RDP, and are as follow:

- The health sector must play its part in promoting equity by developing a single, unified health system.
- The health system will focus on districts as the major locus of implementation, and emphasise the primary health care (PHC) approach.
- The three spheres of government, NGOs and the private sector will unite in the promotion of common goals.
- The national, provincial and district levels will play distinct and complementary roles.
• An integrated package of essential PHC services will be available to the entire population at the first point of contact.

From the mission, goals and objectives it is clear that, in order to realise their mission it is essential to obtain the active participation of all sectors of South African society in health-related activities. It is envisaged that the management of services should be decentralised and strongly focused on the district health system. Restructuring the health sector has the following aims:

• To unify the fragmented health services at all levels into a comprehensive and integrated NHS (National Health System);
• to reduce disparities and inequities in health service delivery and increase access to improved and integrated services, based on primary health care principles—,
• to give priority to maternal, child and women's health (MCWH); and
• to mobilise all partners, including the private sector, NGOs and communities in support of an integrated NHS.”

The emphasis on primary health care is a clear break from the past. As a consequence of reallocating budgets and resources to build primary care clinics in rural areas, many academic facilities in urban areas are now facing enormous budget cuts. For example, in the Western Cape province, the budgets of its two academic facilities have
already been cut by 15% over recent years\textsuperscript{vii}. They will face cuts of a further 50% over the next five years in order to expand primary care services and bring per capita public health expenditure into line with that of other provinces. In order to meet financial goals, only emergency operations were allowed at Groote Schuur hospital in Cape Town during the first three months of 1998.\textsuperscript{viii} While investment in primary care is long overdue, the provinces will have to take care in order to avoid incapacitating the facilities that already exist. As much as primary health care is needed, so are tertiary surgical services for the poor. On a plane ride from New York to Johannesburg, I sat with an American doctor who was traveling to South Africa to teach doctors how to surgically treat cervical cancer. He told me that late stage cervical cancer is often found in the black population, and he personally lamented the fact that these types of services may be cut. However, he also acknowledged that with limited resources, the government must do the best that it can to achieve equity.

While the White paper deals mainly with the public sector, it does address the private health sector. It specifically emphasizes that the public and private health sectors “\textit{should be integrated in a manner that makes optimal use of all available health care resources. The public-private mix of health care should promote equity in service provision}”.\textsuperscript{ix} Historically, the public sector and the private sector have not had much to do with each other. The two sectors have historically been segregated by race and income. The private sector was for the wealthy whites, and the public sector was for the poor blacks and coloreds. That is not to say that whites never used the public sector, or
vice versa. However, they have essentially functioned as two separate segregated systems, with little interaction. The government would like to increase the interface between the two systems. How this will be accomplished is not always clear. Most commonly, there are references to the government contracting with private doctors and private facilities for public patients. The government is well aware that the private health sector gobbles up most of the healthcare resources in the country, and they would like to make the private sector more accessible to the whole population. To be sure, the private sector benefits at the public sector's expense. All medical personnel are trained in the public sector, benefiting from government money and resources. If a doctor leaves the public sector to go into private practice (as often happens), then the public sector loses its human capital investment almost entirely.

What does all this have to do with managed care? Frankly, quite a bit. The private health sector, like the public health sector, is subject to the authority of the Department of Health. Many believe that Dr. Zuma and others would like to scrap the entire private health sector in favor of a wholly nationalized healthcare system. The government is keeping a close eye on managed care to ensure that the principles of equity among other things are followed. In August of 1997 the Department of Health published another draft policy document titled “Reforming Financing of Private Health Care in South Africa: The Quest for Greater Access and Efficiency”. This document formed the basis of the Medical Schemes Act of 1998, which has created a storm of controversy in South Africa. The contents of the policy document and the bill and their relevance to managed care will
be discussed later. Suffice to say, the Department of Health exercises a great deal of power over both public and private health sectors.

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2 Ibid
4 Ibid
CHAPTER III

Development of managed health care in South Africa

As we have seen, the public health sector has generally fared poorly in
collection to the rich private system. But the private sector has faced its own challenges
too. From 1982 on health care costs steadily increased with annual real per capita costs
rising at 7.2\%\textsuperscript{1}. South Africa was facing the consequences of rapidly rising drug costs,
advanced technology, increased chronic illness and an aging white population. The
structure of the unmanaged fee-for-service system, similar to the United States, amplified
the effects of these burdens. A report on managed care in South Africa estimated that at
least 50\% of healthcare costs were due to over servicing, which was encouraged by the
following factors:\textsuperscript{ii}

- The traditional fee-for service system provided no incentives for cost-cutting.
- General practitioners earned more if people were sick than if they were well.
- Medical aids assumed full responsibility for medical costs; members and service
  providers assumed no responsibility.
- While medical aids assumed the full risk of healthcare funding, they in no way
  attempted to manage this risk.
- An oversupply of general practitioners in the private sector encouraged over-servicing
  as general practitioners strove to make ends meet.
Fraud is rampant, and a fee-for-service based payment system had no means of curbing this.

In South Africa, provider fees were centrally set by an organization called the Representative Association of Medical Schemes (RAMS). Efforts by RAMS to control costs had limited effect, as they could only influence the amount of money paid for services, not limit the number of services used. Doctors and hospitals, naturally, took measures to ensure their profit margins, even if it meant using more services than needed. As the private sector became more expensive, people started leaving their schemes because they were too expensive to maintain and turned toward the overburdened public system for care.

It was clear steps would have to be taken to control costs. First, in 1989 legislation was passed which allowed private medical schemes to risk-rate their populations on the basis of age, sex, experience and geographical region. Until then they had only been allowed to engage in community rating on the basis of income and number of dependents. Then in 1994 new amendments to legislation permitted medical schemes to own health facilities and contract directly with medical providers. It also allowed schemes to exclude or limit cover for certain procedures and assess and reject claims. The Medical Schemes Amendment Act was intended to deregulate the private medical scheme industry which, it was hoped, would lead to more price competition and control healthcare costs.
The effect of these two pieces of legislation produced a couple of trends. First, it encouraged the rise of competitive schemes which “cherry-picked” young, healthy workers who were unwilling to pay the high costs of traditional medical schemes. By allowing risk-rating discrimination on a number of fronts, private open medical schemes (versus in-house schemes, offered directly by employers) lost the traditional cross-subsidization between older, sicker members and younger, healthier ones. The legislation also led to the development of risk-management principles by providers and administrators of the schemes, better known as managed care. Several factors have influenced the development of managed care in South Africa, but it was the passage of this legislation that purposefully opened the door to it.

Now that deregulation had occurred, the stage was set for the entrance of managed care principles. Indeed, many were saying it was the industry’s only hope for survival as medical inflation continued to increase, averaging 25% a year between 1993 and 1998. During that same time salaries (on which medical aid premiums are based) only increased by about 10% a year.iii The number of registered medical aid schemes dropped from 220 in 1993 to 174 in 1998, and many of those remaining were technically insolvent. Desperate, companies started turning to the American model of managed care to see if it would work in South Africa.
First, some things to keep in mind about managed care. The term ‘managed care’ is an umbrella phrase for a number of practices. Broadly, it can be defined as “any mechanism which puts structures in place to reduce or contain costs while maintaining adequate standards of health care”. These mechanisms include, but are not limited to, the following practices:

- Utilization review, utilization management and case management
- Hospital pre-certification/pre-authorization
- Direct contracting and preferred provider arrangements/networks
- Disease management programs
- Drug formularies and bulk purchasing arrangements
- Clinical protocols
- Capitation
- Adoption of coding systems for data analysis and management
- Various combinations of risk-sharing between provider, patient and scheme administrator
- Quality benchmarks

Many groups have interests at stake in managed care. These groups include, but are not limited to:

- Health care providers, including doctors. Health care providers may have interests as individuals, or as members of a group, or both.
- Health care consumers, including patients
- Hospitals, including medical clinics
- Third party claim administrators, including private fee-for-service schemes and managed care companies
- Government officials, economists and policymakers
- Pharmaceutical and other medical supply companies
- Professional and trade associations
- Investors

In America, managed care has frequently been a controversial issue. Common concerns we have seen about managed care include, but are not limited to:

- Loss of patient freedom of choice when picking a provider or a hospital
- Potential of third party involvement to undermine relationship between patient and provider
- Confidentiality of patient records
- “Gag rules”, which restrict provider to discussing only medical options covered by plan
- Perverse incentives for provider to under-treat patient (capitation, withholds, etc.)
- “Drive-by deliveries”, “Drive-by mastectomies”, and other hospital services perceived to be restricted by managed care
- Power of managed care companies to deny care, and overrule doctors’ judgment
- Loss of physician autonomy
Concerns about quality of care

When managed care first appeared on the scene in South Africa, there were many questions regarding what it was, how did it work, and how was it going to affect people. For doctors, patients, and all the other players involved, there was an enormous learning curve to hurdle. The education of South Africans about managed care has been handled in several different ways. For private health care consumers, i.e. patients, education has come about in two general ways: by A) personal participation in a managed care scheme or by B) learning about managed care through the lens of the media (television, newspapers, etc.) Since managed care in South Africa has been based on the American model, many articles refer to experiences in the United States. Given the negative backlash against managed care in the US, one might expect to see similar reactions in the South African media. However, that does not appear to be the case at first glance. In one news article, a scheme administrator admitted that “the transition was traumatic for some members”, yet also stated that “an attitude of consumerism has developed among members, who are trying to manage their benefits with the assistance of the scheme. This is an extremely positive development”. And as for the relationship between the scheme and the IPAs it has contracted with, “The response has been surprisingly positive, the preferred providers assist us a great deal in case management by providing feedback about members’ utilisation of benefits – as well as reporting possible abuse or over-utilisation of the facilities”. A couple of articles have devoted themselves to defining the different terms of managed care for the public, such as
capitation, utilization review, pre-authorization, networks and health maintenance organization. Some articles have clearly warned consumers about the pitfalls of managed care. One relates the following story from America:

“A woman in Washington DC needing an operation to her knee, failed to convince her health plan – a managed care plan – of the need for a particular specialist in a specialist hospital. Neither the doctor nor the hospital were contracted to the plan, and it would have cost the plan more money than it wanted to pay. Not only did the plan refuse her pleas for the specialised care, but failed to recognise that she had an addiction problem in the past and needed specialised care in the use of pain-killers to avoid a recurrence. Several operations later – and now having to use the specialist and his hospital the plan first rejected – the woman may lose her leg altogether, and is addicted to a wide range of painkillers, all prescribed by doctors. Now she requires her plan to take care of that problem too. This is a worst-case scenario for managed care disasters – but completely true.”

The same article outlines the fight over “drive-by deliveries” in the United States. Overall, I found that the reaction of the media to managed care so far has presented a fairly balanced view, acknowledging problems and concerns, yet not entirely condemning it. There may be several reasons for this. It is common knowledge that medical inflation is threatening the survival of the private health sector, and managed care is seen as a viable solution, so people are willing to give it the benefit of the doubt.
Also, since managed care has been in South Africa for a relatively short while, I don’t believe that there has been enough time for the South African public to develop a fully articulated response to it. Based on what they know about it from America, some apprehension is natural. As another news article noted, “The managed care debate is already generating some heat. Patients don’t want to lose all freedom of choice. Doctors don’t want outside interference in their relationships with patients. Suppliers don’t like pressure on their margins but members don’t want medical inflation to balloon out of control, either. In the interests of an informed debate, it is best that the terms be defined so that everyone knows what everyone else is talking about.” So far, there has not been the widespread outcry against managed care by the public that we now see in the American media. However, that may change as time goes on.

The education of South African doctors about managed care has, naturally, been broader in scope and more specific in details. Doubtless most doctors have learned a lot about managed care by means of professional connections within the industry. One of the most effective vehicles for communicating information about managed care to doctors that I discovered was a publication titled ‘Managed Care & Quality Review’ (MC&QR-later changed to Managed Care Review). This publication appears as an insert in the South African Medical Journal (SAMJ), produced by the Medical Association of South Africa (MASA) and sponsored by Sanlam, the country’s second largest insurance company. The information contained in the MC&QR serves as a valuable primer on all aspects of managed care. It was started in October of 1995 as part
of an educational effort by MASA to enable its members to succeed in a managed care environment. It covers a multitude of topics, from negotiating contracts to managed care and medical ethics to giving advice on what kind of PC to purchase in order to accommodate the new data collection systems. Issues of MC&QR also give up-to-date news on what types of mergers and IPA arrangements are occurring in the country, tips on putting together a business plan, explanations of disease management programs, utilization review, drug formularies and actual case studies. Protocols for treating specific conditions are reviewed. For example, one issue covered “malaria prophylaxis for adults algorithm”, while another covered “assessment of acute low back problems algorithm”. One series of articles that stood out to me was a five-part series on managed care based on a series of workshops given by an American doctor. This series, titled “Believe me, it will not go away” gave first-hand knowledge about managed care from a Dr. Richard Corlin, a gastroenterologist from California. His is the voice of experience, as evidenced in his opinion on who should sign up with the managed care plans and who should not. “It is relatively simple: If you are 60 or over, your mortgage is paid off and your kids are out of college, you can afford to ignore what is taking place in the market. If you don’t meet those criteria, you cannot afford to ignore it.”

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CHAPTER IV

Managed care in practice

With the advent of managed care in South Africa, several things occurred which are worth making note of.

- **American involvement, American technology:** From the beginning, Americans have been involved in the implementation of managed care in South Africa. Some have been involved directly, the best-known example being United HealthCare’s stake in Southern HealthCare JV. However, many other companies have purchased American managed care technology, or have sought consulting alliances with American companies. In March of 1998 a group of American managed care executives visited South Africa on a trade/study mission sponsored by the Academy for International Health Studies, an American organization which sponsors an annual Summit on International Managed Care Trends. The American delegation included representatives from the American Association of Health Plans; AvMed Health Plan; CAPP Care; Cigna HealthCare Employers Reinsurance Corp; Epstein, Becker & Green; HBO & Co; HIP Health Plan; Kaiser Foundation Health Plan; Medical Care Management Co.; Milliman & Robertson; PacifiCare Health Systems; Physicians Health Services, Searle; UHP Health Plan; and United American Healthcare Corp. While in South Africa, the delegation met with leading providers, insurers, economists, investors and government officials in Johannesburg and Cape Town. Americans have been also been giving advice to the South Africans through
workshops and via publications such as the Managed Care & Quality Review. Why are Americans so heavily involved? Primarily because America is the country that South Africa adopted managed care principles and technology from. In order for South Africans to understand managed care and make it work, collaboration with Americans is necessary. An essential component of successful managed care is possessing good data of clinical information, such as diagnoses, gender, age, and procedural information. These are necessary for analyzing and managing utilization patterns, identifying clinical patterns of disease in a population and tracking quality control procedures. In the United States, a tremendous amount of this information exists, due in part to the Current Procedural Terminology (CPT) coding, as well as the Resource Based Relative Value (RBRV) scales and the International Classification of Diseases (ICD-10) coding. In South Africa, the Representative Association of Medical Schemes (RAMS) has a similar procedural coding system of “tariff codes”. However, the RAMS tariff codes only number about 2,500 in contrast to the approximately 7,000 CPT descriptor codes. In the RAMS tariffs, some procedures are lumped together and not as many diseases are specifically identified. Overall, the quality of data in South Africa needed to make managed care work is very poor and the existing data had not been collated in anticipation of analysis. In order to remedy this, the South Africans have agreed to introduce American CPT-4 and ICD-10 coding systems. However, this has presented its own set of problems. For the doctors, it presents another learning curve, as some of the American terminology is different from what is commonly used in South Africa, and South African conditions
are not exactly comparable to American ones. One of the biggest problems, however, is that the CPT codes do not come with fee schedules attached, and the medical aids have found it very difficult to adapt their fee structures to the CPT codes. To assist doctors with this problem, the Private Practice Committee (PPC) of MASA decided to adopt the American RBRV’s and adopt them to South African standards, including values for services not covered by the RBRV’s, such as pediatrics and obstetrics. These were issued in the SA Compendium, a document that contains the short descriptor of the CPT code, the relative unit values attached to that procedure, and the rand (monetary) value. It also contains all the definitions that are relevant for South Africa, together with accounting guidelines and exceptions that are not addressed in the CPT codes. Given the involvement of American technology and business in South Africa so far, it is probably safe to assume that it will continue into the future. However, that might not be the case. The value of the South African rand has been dropping against the American dollar for four years. If this trend continues Americans will find it difficult to A) find South African companies who can afford their expertise and B) may find it hard to make profits if they set up shop in South Africa.

- **Resistance from providers, organization into groups, and a scramble to secure contracts:** Doctors and hospitals were naturally suspicious of managed care.

Concerns of doctors are similar to concerns found in the United States. Contentious areas include having to sign contracts, the access to a patient’s confidential records, pre-authorization and utilization review, and the implication that the doctor may not
be the best judge of the appropriate treatment for the patient. Doctors fear that managed care will undermine the relationship between doctor and patient with its "gag rules", and they also fear their own loss of income. Resistance to managed care manifested itself in several ways. Some doctors refused to sign contracts, and many vocalized their aversion to managed care. However, the threat of managed care has also galvanized doctors to organize themselves into groups. This has given them greater bargaining power against the managed care companies and a voice in the political process. To be sure, the doctors in South Africa have enjoyed a relative advantage over their American counterparts in that there are no anti-trust regulations to prevent them from forming companies to represent their specialized interests. Many groups, including the Representative Association of Surgical Disciplines (RASD), advised their members initially not to sign managed care contracts until favorable terms could be negotiated. However, this behavior in turn attracted the attention of the Competition Board. In July of 1997 it launched an inquiry into whether or not doctors and other providers were engaging in anti-competitive practices. In the struggle for power, many groups set prices and essentially told the managed care companies "These are the prices—take it or leave it". In September of 1995 representatives from all the major IPAs in the country established an umbrella organization to act as an advisory, negotiating and administrative body on their behalf. Originally called the Managed Care Coalition, it is now known as the South African Managed Care Co-Operative, or SAMCC. It currently has 17 affiliated IPAs all over South Africa and represents some 7,000 practitioners. Chair Dr.
Dennis Dyer states that, initially, the managed healthcare concept was perceived as a US invasion into South Africa in order “to squeeze every cent out of the health-care rand and to try to make the exorbitant profits that have been made in the US by managed-care companies.” He goes on to say, “Managed health care should be welcomed as a mechanism to make health care more affordable and accessible. It should be developed by South Africans for South Africans and the inputs should come from a broad base of expertise.” To that end, the SAMCC has established its own formulary for which it has negotiated discounted prices for its members. It has established the formulary in the hopes that “we as providers do not surrender control of the clinical aspects of medicine to profit orientated managed care companies, and that tendered prices be passed on to patients.” The SAMCC is also negotiating with funders, managed care organizations, private hospitals, trade unions and the public health sector. Dr. Dyer’s attitude suggests that there will probably be less physician backlash to managed care if physicians take more responsibility for managing and containing costs, and maintain ownership of clinical decision-making. There will be enormous resentment if managed care companies usurp this role. However, not every group of doctors is adopting such a conciliatory tone towards managed care. In May of 1996 a group called the Association of Private Practising Doctors and Dentists of South Africa (PPDD) was founded. This group is decidedly against managed care, its main purpose being to warn members of its profession against the “American style managed health care invasion, which is aimed at destroying the patient’s free choice
of doctor.”"viii The PPDD is also opposed to the introduction of the CPT-4 coding system into South Africa as it “gives the Manacled (sic) Healthcare guys the tool to rule absolute over the medical fraternity.” The PPDD has aligned themselves with the Association of American Physicians and Surgeons (AAPS), an anti-managed care group in the United States. However, the AAPS itself has been described as being made up of “politically extremely conservative right-wing physicians who believe that they should contract only with their patients, and patients have the responsibility to pay whatever doctors want.”"ix Given the trend toward managed care in South Africa, it is unlikely that a group like the PPDD will be able to effect a change back to the old days. Doctors have not been the only ones organizing themselves into groups. In March of 1996 a national network of 106 hospitals and day clinics was established, spanning the whole country and including 90 points of service in all of the main city centers.\textsuperscript{x} Participants in the National Hospital Network (NHN) include large companies like PresMed, Hospiplan, Lifecare, Maddocs Healthcare, the Muelmed group and PE Medical group as well as different individual hospitals and day clinics. NHN not only delivers private hospital services but also contracts with employers and managed care organizations. This was not the only large hospital group that has emerged. Afrox Healthcare and Medi-Clinic got together to form Apex, a national network of hospital and doctor services which comprises 36 hospitals with about 6,000 beds.\textsuperscript{xi} A third large hospital grouping is Netcare/Clinics with 34 hospitals.\textsuperscript{xii} The private hospitals have even more reason to be fearful of
managed care, as there is an excess supply of hospital beds in the private sector. The number of fee-for-service beds skyrocketed to 20,991 in 1996 from 9,825 in 1988, resulting in an average 70% occupancy rate. Many have criticized the hospitals for contributing to exploding healthcare costs by trying to maintain their profit margins with an oversupply of hospital beds. Reduced utilization in the age of managed care will hurt these hospitals, and there has been fierce competition among the hospitals to align themselves into groups and secure contracts with the managed care organizations. They have promised discounts in exchange for large volumes of patients, but if the volumes don’t materialize, private hospitals will be facing hardships.

- **Rapid proliferation of managed care companies:** In a little over two years, the number of managed care companies in South Africa has jumped from one or two to over ten, with mixed results. Whether sensing opportunity or struggling for survival (or both), many companies rapidly set about establishing managed care protocols and building networks. In South Africa two dominant types of managed care company have developed. The first type to emerge was founded along the lines of a medical savings account. With a medical savings account, routine medical expenses such as doctor’s bills are paid out of an amount of money allocated each year by the medical aid to an account in the member’s name. Any surplus money at the end of the year can either be paid back to the member in the form of a dividend or in the form of a reduced contribution or higher benefits. This type of scheme was pioneered in 1992 with the establishment of Momentum Health (now Discovery Health) and has quickly
grown to be one of the most successful types of medical scheme in South Africa, with the market growing at more than 25% per year. These ‘new generation’ schemes, as they are known, are popular with young, healthy people, who are more able and willing to assume a degree of risk in maintaining their health. Medical savings accounts have also borne the brunt of criticism for being schemes which “cherry-pick” healthy workers at the expense of traditional medical schemes. The other sort of company to develop has been more along the lines of a traditional managed health care plan, contracting with providers and specializing in utilization management, but not involving the patient in managing risk to the degree that the medical savings account schemes do. The first company of this type to set up shop in South Africa was Southern HealthCareJV, which became fully operational in January 1997. Most of the companies have not yet evolved to fully capitated HMO models. At this point, most are set up along contracts with IPAs and PHOs and employ various forms of utilization review and management. Managed fee-for-service might be a more accurate term to describe it. Please view Appendix item D for an overview of selected managed care companies in the South African market.

At the moment approximately ten companies exist in South Africa practicing managed care. The market is changing all the time, with big insurance players like Old Mutual rumored to be soon entering the field, and a few companies have already experienced defeat. Concurrently, the field of insurance in general is in a state of flux, experiencing reshuffling and consolidation. Norwich Life, Protea Life and Commercial
Union have all recently been involved in mergers. How this will affect managed care remains to be seen, but the general trend in South Africa is moving toward the emergence of a few big players. A report on managed care predicts that the long-term scenario for that industry, too, has room for no more than three or four national competitors. The authors say that fewer players would encourage collusion, while more players would reduce economies of scale and create unnecessary fragmentation of community risk pools. They think there may also be room for a few regional and niche market players.

Following are a few in-depth profiles of some selected companies to illustrate how managed care is being adapted in South Africa, and some of the issues these companies have faced. As we will see, there is no one formula for success that managed care companies in South Africa have been adopting. The market has been characterized by companies integrating elements of managed care piece by piece and rapid changes in strategy and partners as everyone struggles to increase market share.

**Southern HealthCare JV**

On September 12, 1995, United HealthCare Corporation (UHC) in Minneapolis announced a joint venture with two of South Africa’s largest insurance companies to create a managed health care company in South Africa. The new company, Southern HealthCare JV (commonly known as SHC), is a joint venture between South African companies Anglo American (40%), Southern Life (40%) and the American company United HealthCare from Minneapolis, MN (20%). Based in Johannesburg, SHC was
initially managed by a team of United HealthCare executives who moved to South Africa for about two years to establish operations. The initial patient base for SHC came from Anglo American and Southern Life. Anglo American transferred approximately 90 percent of its covered South African employees and their dependents (235,000 lives) to the new venture, and Southern Life transferred approximately 192,000 lives. xvii

United HealthCare president William McGuire, MD, stated that “South Africa is faced with the enormous challenge of bringing affordable, quality health care to all its citizens. We look forward to working with our South African partners to introduce proven, successful managed care principles to help the South African people realize the level of health care they desire. We are proud to be part of this historic partnership and look forward to assisting other health care systems in the world through the application of our managed care tools and expertise.” xviii Kathy Walstead-Plumb, senior vice president of group services administration at United HealthCare, became the chief executive officer of the new venture. This was a first for an American company in South Africa. As Ms. Walstead-Plumb put it, “What we are bringing to South Africa is American technology, American process and American information. United’s specific technology takes several different software systems and integrates them into a fully integrated managed-care approach. We have perhaps a dozen tools in our toolbox. Which ones we end up using here depends on the information we are able to collect and on what the market wants – that is both the provider community and the employer group.” xix While American technology and expertise is clearly an asset for SHC, it has also proved to be a liability in
the eyes of some. While all the new companies have faced problems in implementing managed care, SHC’s American affiliation led to its detractors dubbing it the “Minnesota Mafia”, xx emphasizing the fact that these were outsiders coming in to change the way they did business.

SHC faced several challenges in the early days of operations. One of the biggest problems was poor data. Ms. Wal stead-Plumb explained in a news article that the collation of extensive databases is critical to the success of managed health care in South Africa. Right now, “Such data is virtually non-existent. The RAMS tariff codes are a good start but they are not specific enough. This is a huge disadvantage.”xxi SHC required providers to use CTP-4 coding for procedures and ICD-10 coding for diagnoses, which required doctors not only to learn a new way of approaching their billing but also required an investment in technology on their part. SHC also had trouble adapting United’s expensive technology to South African conditions. For example, in the US there is no best practice for tuberculosis or for malaria, common ailments in South Africa.xxii

SHC also faced a lot of problems with providers over setting up contracts. One early conflict manifested itself between SHC and a group of pharmacists. A group calling themselves United SA Pharmacies broke a written contract with SHC because they were unhappy with the size of the negotiated discounts, which were about 28% off retail medicine prices.xxiii Of the 1,190 chemists who had signed the agreement, about 82
were recorded as not being in compliance with it and demanding cash up front for medicines. Another high-profile conflict occurred over SHC (and Sanlam) choosing Clinic Holdings and Apex as their preferred provider hospital networks. The chair of rival National Hospital Network (NHN) publicly criticized the choice, stating that “Statistics clearly show that NHN facilities render their services much more cost-effectively than do competing networks. We believe that these contracts were concluded because of Southern’s and Sanlam’s substantial shareholdings in Clinic Holdings and Mediclinic.” NHN made a complaint to the Competitions Board against SHC for refusing to allow their members to utilize hospitals of their choice. Then doctors entered the battle, refusing to sign provider contracts unless SHC also included NHN in its network. Fourteen doctors from East Rand resigned from the provider network, followed by another hundred or so. In Southern’s defense, Ms. Walstead-Plumb stated that SHC wanted to contract only with some of the individual NHN hospitals in some geographic areas, and that the NHN’s “all-or-nothing-attitude” did not help. The outcome of this battle was eventually in NHN’s favor, with SHC relenting to pressure from doctors, and agreeing to put all of the NHN hospitals onto its network.

Finally, SHC also endured a flood of complaints from its new medical aid members when they were switched to SHC before SHC had had time to adequately establish its networks. Many of the problems SHC encountered were highly visible because it was one of the first companies on the scene. Resistance from an industry that had never been managed before was expected, but Ms. Walstead-Plumb remained
convinced that “This (managed care) is the right thing for South Africa. For that we are willing to take the heat and fight the bullets.” Now, two years after the inception of SHC, many of its problems appear to have worked themselves out. Provider relations have improved, and the American startup management team has returned home. The quality of the data is improving, and plans to test a state-of-the-art fraud and abuse detection system are in the works. It is still not a fully integrated or evolved managed care company. SHC has the capabilities to implement a capitation agreement, but has chosen not to do so at this stage. Perhaps they are choosing to avoid any more heated controversies until the country has grown more acclimatized to managed care. SHC will probably prove to be a dominant player in the long run, as they continue to take advantage of their American partnership and technology and have proved themselves a flexible player in the South African market.

Sanlam Health

Sanlam Health is a wholly owned subsidiary of Sanlam, one of the largest financial services groups in South Africa. Along with Southern HealthCare JV, it was one of the first companies to enter the managed care market along the lines of a traditional plan. Because of its affiliation with Sanlam, it had early access to a large patient member base, about 600,000 people. In contrast to SHC, Sanlam did not enter into a joint management venture with an American company, therefore escaping some of the anti-American criticism that was directed at SHC. In fact, this was underscored by Sanlam’s medical director, Dr. Herc Hoffman, when he stated in a news article, “We are
not bringing an Americanised way of practising medicine to South Africa. The enemies of change often quote only the negative aspects of managed care in the US. We have the advantage of being able to avoid the mistakes made there. It took the US 20 years to evolve managed care. We in South Africa have only two or three years to make it work. However, Sanlam has invested heavily in American technology in its efforts to implement managed care. Sanlam purchased the CappCare hospitalization management system, which was then reviewed by the Unit for Cost Effective Medicine at Stellenbosch University. More than 7,000 changes were made to the program to adapt it to the South African environment, including adjustments to length of stay in hospital, protocols and level of care.

Sanlam Health also entered into a three-year contract with the American company USQA, the quality algorithms division of Aetna U.S. Healthcare in Hartford, CT to help develop protocols and a quality assurance program. First, they bought the Diamond system for claims processing which would help them capture data elements with which to build a data warehouse. Then, working with USQA, they set about developing performance measurement methodologies for hospitals, specialists and primary care physicians. As with Southern, Sanlam has encountered difficulties because of the lack of good data. However, to date they have already identified 38 chronic diseases within their population. According to Carol Delark, the project manager from USQA, this is a “huge accomplishment”. The hope is that eventually Sanlam will be able to determine what,
example, is the standard of health care for diabetes. They will also be able to develop process measures, outcome measures, satisfaction surveys and patient access measures.

The investment in American technology appeared to pay off at first. Sanlam Health established a quality reference center at their headquarters near Cape Town to help manage hospital utilization. According to medical Director Dr. Hoffman, “Before we started managing hospital utilisation, Sanmed paid for about 860 bed-days per 1,000 lives per year. We have lowered that to 640 bed days per thousand lives per year in the first eight months of the quality confirmation centre’s operation. More specifically, when we compared 18 different conditions in the first six months, we found that we saved 1,800 bed-days on 4,000 admissions, at a cost saving of R1.7 million, without compromising the quality of health care.”

Sanlam also established a 24-hour, toll free phone-in medical advice line called MedXpert for its members. The service includes the assessment of symptoms, counseling, home care and mother-baby programs, as well as referral to local professionals, community services and support groups. MedXpert can handle calls in several different languages, including Afrikaans, English, Xhosa, Zulu and Sotho. The purpose of MedXpert, according to senior international manager Peiter Swanepoel, is to ensure that “Members get the appropriate level of care for their circumstances and do not waste money or time in obtaining ineffective or inappropriate medical care. We not only provide an advice service, we try to prevent patients making unnecessary visits to doctors’ rooms wherever possible.”

MedXpert has also proved to be effective in reducing utilization. In its first two months of operation, the staff dealt
with calls from some 1,500 callers – 67% of whom would have normally visited a general practitioner. But since MedXpert was able to deal with most of the problems upfront, only 24% of callers went on to visit a doctor, resulting in an estimated cost savings of R100,000.xxxii

This is not to say that it has been all smooth sailing. Like Southern, Sanlam Health encountered initial resistance from providers and haggling about contracts. In addition, Sanlam Health had major problems with the administration and billing side, and was severely criticized by providers for late payments. Although savings have been documented, overall Sanlam Health posted an underwriting loss of over 50 million rands for two consecutive years. In the words of Sanlam managing director Desmond Smith, this is “a clear indication there is something fundamentally wrong in health-care delivery in South Africa.”xxxiii In response, Sanlam agreed to outsource some of their administrative functions, including payment. Sanlam Health has also recently revamped their entire management structure, according to Dr. Ronnie Van der Merwe, assistant Medical Director to Dr. Hoffman. The transition to managed care required a whole new approach, one that was not well-served by the old fee-for-service mentality.

Dr. Van der Merwe commented to me that South Africa at this point doesn’t have true managed care, it is more like managed indemnity. So far, he feels there have not been spectacular results because the market is not mature and people are not really buying the concept. Managed care is a data-driven business and South Africa possesses
poor data. Finally, it will take a while for managed care to adjust to the South African environment. Time, however, is one thing that they don’t have much of. As Dr. Van der Merwe puts it, there is a fight for survival going on in the private health insurance industry. The trend towards managed care is part of the battle for survival, and South African companies will never see the huge profits that have been made in the US.

Although Sanlam Health has so far not been profitable, it is buffeted by the fact that it is part of the powerful larger entity, Sanlam. In November of 1998, Sanlam demutualized its shares and became the largest new listing ever on the Johannesburg and Namibian stock exchanges. By going public, Sanlam has increased its access to capital, which may help Sanlam Health to weather the current storms. Then again, the economy and currency in South Africa are volatile at the moment, and it is difficult to speculate on just what effect this will have on Sanlam’s success on the open market. Still, Sanlam Health is a major player in the managed care market, and most predictions are that it will survive to be a force in the industry.

Momentum/Discovery Health

Momentum Health originally introduced the concept of Medical Savings Accounts (MSA) to South Africa. Momentum Health was founded in 1992 by Dr. Adrian Gore and is part of the Rand Merchant Bank (RMB) holdings. As was previously mentioned, medical savings accounts work on the premise of shifting risk to the patient. The way it works is that part of a member’s monthly contribution is deposited into an
MSA. Interest is earned on unspent money and charged on a negative balance. The full amount is available to the member from day one, and the member can usually increase his or her contributions to the MSA at any time. Money from the MSA is used at the member’s discretion. It can be used to pay for visits to a doctor, dentist or specialist, prescribed drugs and over-the-counter medicines, ambulance, laboratory preparation of dental implants, and outpatient treatments at hospitals and clinics. Any money that is not used accrues interest and belongs to the member, not the medical scheme. Simply put, the less one utilizes the system, the more money one makes.

Medical Savings Accounts hold a great appeal to young and healthy workers. They are inexpensive, and most young people do not have ailments that would force them to utilize medical services often. Young and healthy people can afford to ration their own health care, but there, too, lies the danger. The fear is that in the interest of saving money people will prevent themselves from seeking care when it is necessary. Minor problems could potentially pose major threats to health if not treated in a timely manner, and it is not always safe to assume that patients are the best judge of evaluating their own medical conditions. The attraction of young people has also led to accusations of “cherry-picking” members away from the traditional medical schemes, exacerbating their problems of containing costs and spreading risk across a large pool. Finally, although people find Medical Savings Accounts very attractive while they are young and healthy, it remains to be seen how they will react when they grow older and sicker and must
expend more of their money on health care. It may not turn out to be such a great savings after all.

Nevertheless, Momentum Health has thrived, becoming one of the biggest players in the market. Between 1997 and 1998 Momentum almost doubled its premium income to 1.2 billion rands, and is targeting income of 2 billion rands for the current financial year. In 1998 CEO Dr. Adrian Gore was named as South Africa’s Best Entrepreneur of 1998, an award sponsored by Ernst & Young, Absa and Business Times. Members have become acculturated to conserving their utilization of health care, and are reaping benefits. In 1998 it was estimated that 65% of all members would have positive balances in their accounts, with an average balance of 1,500 rands. Momentum also offers additional incentives for its members to save money by encouraging activities like joining fitness clubs or smoking cessation and weight-loss programs. Momentum has allied itself with partners in these fields, and members receive points for every healthy activity they engage in. Rewards for members include prizes, reduced contribution rates and access to greater benefits. Additional point-scoring activities include completing childhood vaccinations, registering for a managed maternity program, becoming a blood donor, and (in the case of adult women) getting annual pap smears.

In addition to its Medical Savings Account product, Momentum is also involved with traditional managed care activities like hospital pre-certification and utilization review. Momentum has also called on the services of an American company, HealthCare
Compare, to assist in developing their systems.\textsuperscript{xxxviii} Currently Momentum is building a data warehouse, and future plans include the introduction of clinical guidelines, disease management programs and dental benefit management.\textsuperscript{xxix} One well-publicized feature of Momentum's managed care activities is its managed maternity care program. South Africa has a very high rate of births by Caesarean section in its private sector—up to 68\% by some accounts.\textsuperscript{xl} Momentum's managed maternity program offers women pre-natal care and education about their birthing options. In addition, Momentum will pay for a nurse to stay at a woman's house for two days if she is discharged from hospital within two days of a vaginal birth or three days after a Caesarean section. All these efforts are in the hope that the number of costly Caesarean section births will be reduced, without compromising the health of the mother and the quality of the care that she receives.

While Momentum Health has been extremely successful, its "cherry-picking" tactics have been viewed with suspicion by the government on the grounds that it encourages discriminatory behavior and is responsible for the loss of cross-subsidization as young members leave traditional type plans. In the last year there has been a movement to outlaw Medical Savings Accounts. As a result of intense lobbying, MSAs have remained intact for now, but they may well be adversely affected by newly passed legislation that will be discussed later in this paper. Recently Momentum Health changed its name to Discovery Health, to reflect the name of several of its products. Despite pressure from the government and a number of competitors offering similar MSA products, newly named Discovery Health promises to remain one of the industry's
dominant players. It is blessed with innovative products, excellent marketing skills and a charismatic leader in Adrian Gore, and has proven its ability to be flexible and adapt to changes in the marketplace.

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CHAPTER V

Government response

After the passage of the Medical Schemes Amendment Act in 1994, the government essentially sat on the sidelines and watched the market develop. While managed care practices did help to reduce costs, the lack of regulation drew the government’s concern. On May 12, 1997, a workshop was held to provide senior officials at the Department of Health with information on managed care, and initiate the development of public policy on the subject. At the introduction of the workshop, the following concerns were raised:

*On behalf of providers;*

- Concerns that the interests of providers and patients are not considered
- Concerns that the doctor-patient relationship will be compromised
- Access by providers to managed care networks
- Nature and process of contracting, with perceptions that contracts are being “slapped down” on providers
- Lack of grievance and complaint procedures
- Profit motive associated with managed care companies
- Concerns with regard to patient protections

*On behalf of patients;*

- Geographic access to care and nature of benefit packages
• Pre-authorization requirements for care
• Access to specialty care
• Concern that pressure to contain costs may be hurting quality of care
• Continuity of care following enrollment

*On behalf of the government;*

• A keen focus on both cost containment and quality outcomes
• Ensure adequate access, both to provider networks and to a properly specified minimum package of benefits
• Competition for members should be on the basis of provision of a similar package of benefits and costs of such a package
• Standards for contracting with providers may have to be defined and agreed upon
• Impartial mechanisms to resolve disputes may have to be established
• Issues of open disclosure to patients need to be reviewed

In order to address these concerns, the workshop divided into four theme committees which addressed the following topics: 1) Patient protection under managed care; 2) Provider protection under managed care; 3) Financial regulation of managed healthcare plans: What is appropriate?; and 4) Industry concentration and vertical integration: How should government respond?

The recommendations of the workshop participants in May of 1997 have not been transformed into a policy document or a bill regulating managed care....yet. However,
soon after this workshop the government unveiled a policy document that would have far-reaching implications for the entire private medical schemes industry. In August of 1997 the Department of Health released a draft policy document on Reforming Financing of Private Health Care in South Africa: The Quest for Greater Access and Efficiency. This documents covers many topics, but for the government, clearly one of the most pressing issues was the proliferation of non-indemnity medical insurance which, fueled by risk-rating rather than community rating, had led to “cream skimming”, or “cherry-picking”, and the loss of the traditional cross-subsidization between the old and young. This, the government argued, had led to old and sickly people being forced to pay even more for their premiums at a time when they could least afford it. Many of these people were falling back on the public system for care, a “dumping phenomenon” at a time when the public hospitals did not have adequate capacity to provide these additional services.ii Health Minister Dr. Zuma also had harsh words for the individual medical savings accounts schemes, like Momentum’s. In addition to accusing them of encouraging people to drop out of traditional type medical schemes, she said they “create perverse incentives that discourage use of preventive health care. They can also create opportunities for tax avoidance. Lastly, low income persons and those who left employment frequently may be grossly underfunded under a savings accounts regime, as they would be able to save less and to meet fewer of their health care needs.”iii The proposed solution to re-establishing cross-subsidization was to re-enforce a community rated medical schemes’ environment. The main characteristics of this system would entail.iv
• Avoidance of the individual’s age, gender, claims patterns, experience and health risk when determining contributions

• Residual ability to use members’ incomes and/or number of dependants for determination of contribution rates

• Membership of the scheme will define the “community” for the purposes of determining contributions

• Anybody must be able to enter a medical scheme if they can afford to pay the average contribution, regardless of their health condition. In this regard open schemes will be required to accept all applicants while employer based schemes may accept any applicant. This provision will be subject to protections against adverse selection.

• Anybody must be able to stay in a medical scheme, regardless of their health condition

The policy document proposes to register all medical scheme products, including managed care products, under a single act and be subject to that authority. In addition, it recommends that a prescribed set of minimum benefits be mandatory, and that medical schemes increase member representation in their governance structures. On the subject of medical savings accounts, the government supported phasing them out, but stated that it was willing to consider the continued interim existence of these schemes under the following conditions:
• Only a maximum of 15% of annual contribution income can accumulate into an individualized savings account; the remaining 85% should be paid into a pooled fund

• All services in the proposed prescribed minimum benefits package should form part of the pooled, community rated portion of the fund

• Where withdrawal of benefits occurs, these should be subject to a final withholding tax

Following on the heels of the policy document, in 1998 the government unveiled its Medical Schemes Amendment Bill. In an address to the national council of provinces, Health Minister Dr. Zuma hailed the bill as “a fundamental piece of legislation in our ongoing efforts to transform South Africa, and to build the kind of democracy that will result in tangible benefits to all our people.” This Bill formalized many of the proposals put forth in the policy document. Key features of this bill included the following points:

• Community rating to replace risk-rating, along the lines outlined in the policy document

• Guaranteed acceptance into a medical aid, regardless of experience

• Everybody would pay the same premium, regardless of age or health

• The term “dependents” was widened to include anyone who is financially dependent on the fund member and living under the same roof

• Medical schemes must provide a set of core services
• Medical schemes must reimburse public hospitals in full for any services their members access, as long as those services are part of the minimum package of benefits

• Individualized savings accounts would not be permitted

• Membership in a medical scheme would not be mandatory, but once a member joins, the medical scheme cannot cancel benefits

Not surprisingly, the proposal of this bill generated heated controversy. The abolishment of risk-rating had many insisting that community rating, without mandatory membership, would further hasten the departure of young healthy people from traditional medical schemes as premiums would rise to accommodate the community ratings. This would bring about the opposite desired effect, making schemes go bankrupt. As one critical editorial put it, “Imagine if the Minister of Finance proposed legislation which abolished those actuarial tables which insurance companies use to decide the level of premiums to charge. This would, of course, destroy the insurance business. It appears, however, that our hyperactive Health Minister, Nkosazana Zuma, in her headlong rush to transform the health industry, is not interested in reality. There can be little doubt that her latest piece of madness, known as the Medical Schemes Bill, has as its precise objective, the destruction of the SA medical aid movement.” vi In addition, the policy of open enrollment and the extension of the definition of ‘dependents’ are controversial. The modification of the term “dependents” clearly has racial overtones. As Dr. Zuma states in her introduction of the bill, this provision will “reflect the spirit and character of
the vast majority of our population. A traditional family not formally acknowledged or
respected by the former government and the interests that propped it up will now get long
overdue recognition.”

Most at risk of extinction from the new bill were the medical savings accounts
schemes, which were slated to be outlawed, and in any case, relied heavily on risk-rating.
Intense lobbying by Dr. Adrian Gore of Discovery Health and others eventually
succeeded in allowing medical savings accounts to exist and be formally acknowledged
in law. The argument used was one guaranteed to generate political pressure against the
government. Dr. Gore argued that more South Africans will have access to insurance if
medical savings accounts and other low-cost benefit plans are marketed to young, black
workers. “They are the future. You have to remember that a community rating system
also would subsidize the aging white population. There would be resentment.”
Apparently the argument worked, and medical savings accounts survived the chopping
block.

Adding to the controversy surrounding the bill, Dr. Zuma took the highly unusual,
and some said sneaky, step of presenting the bill to the cabinet for a rubber-stamping
before putting it through the standard parliamentary procedure. The bill was not
released to the public for comment, and a group called Business South Africa (BSA) took
legal action against the health department in order to force it to submit the bill to the
National Economic Development and Labour Council for review. BSA claimed that it
had repeatedly called for an independent actuarial analysis of the bill to assess the effects of the development of future demand and the costs of services, but this had not been done. Health Ministry spokesperson Khangelane Hlongwane responded by saying that the court application would be opposed, and that “It is unfortunate that this government is prevented from performing its duty of looking after the interests of the poor.”

Despite all the controversy, the Medical Schemes Amendment Bill was passed in parliament in November 1998. However, it will take at least 18 months to implement. What effect it will have on the medical aid industry is not clear. Whether it spells doomsday, as some say, or creates positive effects, as the government contends, remains to be seen. It will most certainly increase the number of people entering the private sector for their health care, and managed care schemes may well benefit from the additional members. I personally would not be surprised to see further legislation arrive which specifically addresses managed care, and the concerns that were discussed at the workshop in May of 1997. So far, that has not yet occurred.

As previously noted, the private sector and the public sector in South Africa have historically had little contact with one another. Like many institutions, the health care systems have been largely segregated along racial lines. Although the private medical sector is technically available to anyone who can afford it, it remains almost exclusively white in its personnel and the population it serves. Now that a black government has been elected, it remains to be seen how long two racially segregated systems can survive.
I believe that is the crux of many of the current controversies over the Medical Schemes Bill. Detractors of the bill claim the government is trying to destroy the financing of the private healthcare system, which will then lead the way to nationalized health care, and force the private system to accommodate everyone. Nobody dares talk about race in this debate, but it is clearly present. Personally, I think as much as the government might like to have an entirely nationalized health system, they cannot force it on the white population. There would be an enormous outcry from the whites, who are still a powerful force in the society. The government can push the issue only so far at this point. In the future, that may change. Presently, the government’s tack is to increase access to the private health sector through legislation. In addition to the legislation already passed, there is discussion of a national social health insurance bill, whereby all employers and employees would be required to contribute to a fund that would guarantee private health insurance for every formally employed person in South Africa. In the long run, it is difficult to say if two segregated systems can survive. I believe there will always be a strong private sector in South Africa available to anyone who can pay for it. However, through legislation and the growth of the economy, more people will have access to the private sector, and it certainly will not be an exclusively white institution in the future.


CHAPTER VI

Lessons learned and prospects for the future

When reviewing the entry of managed care into the South African market, a few things become apparent:

- It is not possible to fully implement managed care from a fee-for-service environment in six months. It is a gradual process.
- Provider and patient resistance should be expected. It takes time for these groups to acculturate to a managed care environment.
- Companies cannot run good managed care plans without sound actuarial predictions and, most importantly, good data.
- Companies cannot just buy American technology and expect it to work. Technology must be adapted to the local market.

One of the most important questions regarding managed care, however, is what impact will it have on the public health of South African citizens? To the extent the lower prices will make the private medical sector more accessible, this promises to have a positive effect, as the private sector generally offers superior care to the public sector. In addition, the newly passed Medical Schemes Bill could promise to almost double the ranks of citizens who enjoy private health care. The incentives for preventive health care (screenings, joining health clubs, smoking cessation programs) will probably have a
positive effect on people’s health. The trend toward people assuming risk by way of medical savings accounts may be positive, but it has been acknowledged that this can also work the other way, with people refusing to seek care when they really need it. This should be closely monitored, either by an independent review board or by the government.

Will managed care compromise quality of care? I think this is a debatable point, although it is one of consumer’s top fears. Personally, I don’t believe quality of care will suffer too much under managed care. Quality benchmarks and processes are currently being put in place by many companies, where none existed before. Due to poor data collection from the past, there is not much information to compare today’s quality to past quality. Furthermore, the emphasis on maintaining quality care by the companies assures at least that the subject is being addressed. Should patients worry about doctors under-treating them? Certainly that risk exists, and should be monitored. However, hardly any doctors are fully capitated in South Africa at this point and most still enjoy wide latitude in treating their patients. However, as managed care evolves in South Africa toward full capitation, any perverse incentives to patient care should be monitored. Another question to consider is whether managed care will work in opposition to the public health sector or with it. Indications to date are that it probably will work in a complementary manner. Certainly it is the mandate of the government to forge closer working relationships between the public and private sectors. In fact, if applied correctly, managed care
principles could be adapted to aspects of the public care system as well, similar to what we have seen in America with Medicare and Medicaid managed care.

The one wild card in the whole healthcare equation in South Africa, aside from the government’s actions, is what impact a burgeoning HIV/AIDS epidemic is going to have. Although the AIDS epidemic hit South Africa relatively later than it did in the rest of Africa, it has rapidly caught up to speed. South Africa currently has one of the highest infection rates in the world. Exact figures are not certain, but it is estimated that upwards of 3 million people are already infected and that each month 50,000 new infections are occurring.\(^1\) Countrywide, anywhere from 16 to 27 percent of pregnant women tested for HIV are found to be positive, and researchers say an average of 200 HIV-positive babies are born every day. By 2005, if the rate of infection does not slow down, 80 percent of South Africa’s hospital beds will hold AIDS patients; now, the average is 30 percent to 50 percent.\(^{ii}\) AIDS will devastate South Africa in many ways, including the strength of its work force. It is estimated that within the next five to ten years, 25% of the South African working population is expected to be infected with HIV, which could knock off a full 1% a year off of South Africa’s GDP growth rate.\(^{iii}\) Hardest hit in South Africa is the black population. HIV incidence is highest among members of the mining and trucking professions, due to a brisk trade in prostitution around these industries. In turn, wives and girlfriends of these workers are also at a high risk. To date, the government has not produced an effective response against the AIDS epidemic. In fact, government efforts have been plagued with scandal, notably the Sarafina II fiasco. In this case a contract
worth millions of rands went, without public bid, to a friend of Health minister Dr. Zuma in order to produce a traveling anti-AIDS show. It was soon canceled after AIDS experts complained about its inaccurate content, and a special investigative team was established to try to recover the money. Recently Dr. Zuma canceled a pilot program that would have enabled HIV-positive women to receive AZT, provided at a discount by the British pharmaceutical company Glaxo. Critics say her decision was due to her socialist ideology and her disdain for western drug companies that would have profited from supplying the drug. In Dr. Zuma’s defense, spokesperson Mr. Hlongwane said “Naturally Glaxo wants to sell a product. Glaxo is in the business of manufacturing drugs and it would like to maximize its profit, but unfortunately government has got a responsibility not just to spend all the money it has on drugs developed by Glaxo, but to look at measures it can take to arrest the spread of the disease.” So far, other measures have not met with much success, and the AIDS epidemic continues to roar across the landscape.

AIDS is clearly a serious problem in South Africa, and only promises to get worse with time. How will managed care respond to the resource demands of the AIDS epidemic? It is very difficult to say. Disease management programs could be established with the aim of monitoring and alleviating the course of the infection, and managed care companies are exploring such options. Recently Sanlam announced that it will offer HIV insurance as part of a primary health care package, with an emphasis on prevention and early management. In a managed care environment it is possible that rands will stretch
further along the treatment span than a fee-for-service plan which encourages reactionary type treatment rather than proactive disease management. The more treatment that can be afforded to AIDS patients, the better. Managed care companies will find that managing HIV will certainly not be a money-making business, but it is hard to predict whether the costs will bankrupt the companies at this point. The companies probably will not cover unlimited access to expensive drugs, but if effective HIV-managing protocols and aggressive prevention programs are put in place, the suffering of AIDS patients may, at least, not be any worse than it would be under a traditional plan.

Finally, is managed care a good thing for South Africa? Personally, I believe it is in that it will lead to more standardization of care through professionally accepted protocols, possibly better quality of care through vigorous quality checks and almost certainly better access to the private health care sector for many who previously had no access. Managed care has already started to lower private health care costs, one of the primary reasons for its introduction. Whether savings will be sustainable in the long run remains to be seen and will be major test of its longevity in South Africa. The future of managed care in South Africa looks fairly good at the moment, though the effect of the Medical Schemes Bill has yet to be seen. The problem of integrating US systems to South African situations seems to be working its way out as time goes on. A backlash against managed care exists, but not anywhere near the degree that we see in America. People realize that managed care may be only salvation for the private system. Provider relations with managed care organizations have been improving, and doctors have
managed to create a strong, involved presence in the managed care market. Studies have shown that managed care is unlikely to compromise equity, one of the main concerns of the government. This should score points with the government, as much of the future of managed care has been said to rely on the department of health and the “Zuma factor”. Critics of Dr. Zuma say that although managed care could have a profoundly positive effect on the private health care sector, “The department of health may not give the private health sector sufficient time to get its house in order before re-regulating it out of existence as part of the department’s centralist/socialist policies on the way toward a national health system for South Africa.” Regardless of what actions the government takes, I believe the future success of managed care in South Africa will depend on players who do the following things:

- Spread out risk over a large population to avoid fragmentation and collapse of schemes
- Develop positive working relationships with providers and the government
- Develop good information management systems and collect meaningful data
- Manage utilization costs successfully without compromising quality of care
- Take a pro-active stance on managing diseases and promoting preventive care
- Become consumer friendly

Based on South African experience, what should one expect from the entry of managed care into a new market? It is probably safe to assume that one will encounter initial resistance from providers and patients, haggling over contracts and problems with
implementing technology and managing costs if there are not good data to work with. How to counter these problems? Communication and cultural sensitivity to the local culture are key, and perhaps government can play a moderating role. In new markets one should also not expect to see all aspects of fully integrated managed care programs emerge immediately. Managed care takes a while to implement and will most commonly be seen starting out in pieces, such as utilization management programs. In South Africa, nobody is going to make the kind of profits we have seen in the US, and this is likely to be true for other markets.

It will be interesting to follow the managed care market in South Africa over the next several years and see what trends emerge. Personally, I think utilization of managed care techniques in South Africa will increase, and eventually both private and public sector will reflect a mix of managed care practices integrated with more traditional practices. Ultimately, South Africa is not serving a huge population, and for managed care to succeed there will have to be cooperation and partnerships between all the involved parties. It could lead to innovative public-private partnerships that we have not seen in other places. Specifically, there are indications that the government will resort to more contracting with private doctors and facilities to serve the needs of those in the public sector. In order for South Africa to handle the pressing needs of A) providing basic health care services to the masses and B) handling the AIDS epidemic, some sort of public-private partnerships will be necessary, and perhaps managed care will play a role. In any case, it will be worth keeping an eye on this country, half a world away.
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CHAPTER VII

Other trends

As we have seen in the case of South Africa, the application of American managed health care is on the rise. In December of 1998 the Academy of International Health Studies (AIHS) and the American Association of Health Plans held a summit conference on *International Trends in Managed Care*, which drew participants from all over the world. Topics covered ranged from managed care entry strategies for emerging economies, to rationing, stealth privatization and health equity, to public health and wellness strategies for global managed care. In addition, AIHS sponsors foreign trade and study missions for healthcare executives to foreign countries, like the one to South Africa that was previously mentioned in this paper. Examples of American companies penetrating foreign markets with managed care products can be seen all over the world. These include:

- **Community Health Plan from Latham, New York, which launched Russia’s first HMO with a loan from the Agency for International Development.**

- **Aetna International, which has organized a joint venture in New Zealand to contract with primary care services under that country’s national health system.**

- **United Healthcare, in addition to its work in South Africa, has developed a utilization review and a disease management program in Germany, and has executed product designs for Hong Kong and Mexico.**
These are just a few examples. Many other American healthcare companies are on the international scene. Some are actively pursuing partnerships with local partners, while others are testing the waters by entering into consulting agreements. Will managed care face the same challenges abroad that it has in America? That remains to be seen. According to Dr. Jonathan Lewis, president of AIHS, prospects for continued growth remain strong. “I’m optimistic that within our lifetime American managed care will be American multinational managed care.”

However, even though the international managed care market is experiencing growth, there are several causes for concern. One of the biggest challenges to managed care in the US has been the enormous consumer backlash against it. This backlash is being manifested in several ways, most notably through anti-managed care legislation. It remains to be seen if an anti-managed care backlash will ultimately hinder expansion of American managed care into foreign markets. In addition, many managed care companies in the US are financially struggling, as efforts to control costs and provide quality care are proving to be more difficult than expected. According to Weiss Ratings, Inc., the majority of American HMOs lost money in 1997, accumulating nearly $800 million in losses. United Healthcare, for example, misjudged how expensive it would be to provide care under Medicare and reported a $565 million net loss this year. The long-term success of managed care in America is by no means assured. At the moment,
however, it promises to be another American export for the next several years, even all the way to Africa.

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APPENDIX ITEM B

Basic demographic composition of the

South African population and projections

<table>
<thead>
<tr>
<th>Year</th>
<th>Whites</th>
<th>Indians</th>
<th>Coloureds</th>
<th>Africans</th>
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<tr>
<td>2000</td>
<td>5,427,100</td>
<td>1,122,100</td>
<td>3,782,400</td>
<td>37,259,900</td>
<td>47,591,500</td>
</tr>
</tbody>
</table>

Annual growth rates (%)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>0.7</td>
<td>1.6</td>
<td>1.8</td>
</tr>
<tr>
<td>1995</td>
<td>3.1</td>
<td>75.1/68.1</td>
<td>74.9/67.9</td>
</tr>
</tbody>
</table>

Percentage urbanised
<table>
<thead>
<tr>
<th>Year</th>
<th>1980</th>
<th>1993</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>88.3</td>
<td>90.6</td>
<td>93.0</td>
</tr>
<tr>
<td>1993</td>
<td>91.1</td>
<td>96.2</td>
<td>91.0</td>
</tr>
<tr>
<td>2000</td>
<td>95.0</td>
<td>93.0</td>
<td>91.0</td>
</tr>
</tbody>
</table>

Percentage <15 years (>/-65 years)
<table>
<thead>
<tr>
<th>Year</th>
<th>1985</th>
<th>1993</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>25.2 (8.5)</td>
<td>22.1 (9.4)</td>
<td>22.4 (10.3)</td>
</tr>
<tr>
<td>1993</td>
<td>34.1 (2.8)</td>
<td>30.5 (3.4)</td>
<td>25.5 (5.5)</td>
</tr>
<tr>
<td>2005</td>
<td>76.3 (3.3)</td>
<td>83.2 (3.4)</td>
<td>91.0 (3.5)</td>
</tr>
</tbody>
</table>

Percentage deaths < 5 years (>/-65 years)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>2.9 (62.8)</td>
<td>7.4 (37.3)</td>
<td>20.4 (29.2)</td>
</tr>
<tr>
<td>1985-1990</td>
<td>20.4 (29.2)</td>
<td>NA</td>
<td>64.0/56.9</td>
</tr>
<tr>
<td>1995-2000</td>
<td>28.6 (4.3)</td>
<td>67.6/60.2</td>
<td>NA</td>
</tr>
</tbody>
</table>

Life expectancy at birth (in years: women/men)
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1985-1990</td>
<td>74.9/67.2</td>
<td>64.8/56.9</td>
</tr>
<tr>
<td>1995-2000</td>
<td>75.1/68.1</td>
<td>67.7/60.9</td>
</tr>
</tbody>
</table>

Level of literacy (%>13 years with more than 6 years schooling)
<table>
<thead>
<tr>
<th>Year</th>
<th>1980</th>
<th>1988</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>96.8</td>
<td>100.0</td>
</tr>
<tr>
<td>1988</td>
<td>79.3</td>
<td>88.7</td>
</tr>
</tbody>
</table>

Source: Yach D and Harrison D in Public Health in North-South Perspective, 1994

---

APPENDIX ITEM C

Race and regional variability in the infant mortality rate, 1990

<table>
<thead>
<tr>
<th>Race</th>
<th>IMR</th>
<th>Range across 9 regions</th>
<th>RATIO: Highest/Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7.3</td>
<td>3.9 – 10.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Indian</td>
<td>9.9</td>
<td>4.3 – 31.6</td>
<td>7.3</td>
</tr>
<tr>
<td>Coloured</td>
<td>36.3</td>
<td>15.2 – 83.4</td>
<td>5.5</td>
</tr>
<tr>
<td>African</td>
<td>54.7</td>
<td>37.2 – 74.5</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Source: Yach D and Harrison D in Public Health in North-South Perspective, 1994

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http://www.healthlink.org.za/hst/sahr/tab34.htm
### Appendix Item D

#### Analysis of Selected Managed Healthcare Players in South Africa

<table>
<thead>
<tr>
<th>Name of Managed Healthcare Provider</th>
<th>Assume Risk</th>
<th>Managed Care Services Offered</th>
<th>Size of Patient Base</th>
<th>Supplier Network</th>
<th>Protocols and Formulary</th>
<th>Managed Care Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Management Services</td>
<td>No</td>
<td>PBM MBM QC</td>
<td>200,000</td>
<td>1,300 general practitioners</td>
<td>local protocols</td>
<td>fully operational locally developed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>250 dentists path</td>
<td>local drug formulary</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>optometrists pharmacies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>radiologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanlam Health</td>
<td>No</td>
<td>PA RUR QC</td>
<td>600,000</td>
<td>pharmacies GP’s</td>
<td>protocols</td>
<td>American not fully operational</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90+ units 8000 beds</td>
<td>drug formulary</td>
<td></td>
</tr>
<tr>
<td>Southern Healthcare JV</td>
<td>No</td>
<td>PA CM</td>
<td>160,000</td>
<td>1,200 GP’s 1,800 pharmacy</td>
<td>American protocols</td>
<td>American major problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>130 units</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14500 beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medscheme</td>
<td>No</td>
<td>PBM HBM</td>
<td>2 mill</td>
<td>X</td>
<td>42 units 6500 beds</td>
<td>drug formulary ?</td>
</tr>
<tr>
<td>Davidson &amp; Ewing</td>
<td>No</td>
<td>PBM HBM</td>
<td>480,000</td>
<td>5,000 physicians</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medimo</td>
<td>Yes</td>
<td>MBM PBM RUR</td>
<td>120,000</td>
<td>4,730 general practitioners</td>
<td>local medical protocols</td>
<td>local fully operational</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42 units 6500 beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fedsure Health</td>
<td>Yes</td>
<td>PA HBM</td>
<td>300,000</td>
<td>X</td>
<td>specialists hospital</td>
<td>limited</td>
</tr>
<tr>
<td>Momentum/Discovery Health</td>
<td>Yes</td>
<td>HBM PBM PA CM, RUR</td>
<td>170,000</td>
<td>X</td>
<td>Negotiating with all willing participants</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Local/international operational</td>
</tr>
<tr>
<td>Pharma Clinic</td>
<td>No</td>
<td>MBM HBM</td>
<td>3,500</td>
<td>Primary healthcare centres, nurses GP’s</td>
<td>Local protocols, drug formulary</td>
<td>Local not fully operational</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24 units 4500 beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UHC*</td>
<td>Yes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Notes:**
- PBM - Pharmacy Benefit Management
- MBM - Medical Benefit Management, includes PA, CM
- HBM - Hospital Benefit Management
- RUR - Retrospective Utilisation Review
- CM - Case Management
- PA - Pre-authorisation
- QC - Quality Control
- X - potential new market entrant
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