

ORIGINS AND EVOLUTION OF PRIVATE HEALTH FUNDING IN SOUTH AFRICA

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DECLARATION

I hereby declare that this is my own unaided work, the substance of or any part of which has not been submitted in the past or will be submitted in the future for a degree in to any university and that the information contained herein has not been obtained during my employment or working under the aegis of, any other person or organisation other than this University.

Yolande Hagedorn-Hansen

Signed.....

on this..... day of at

Student Number 0010676p

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ABSTRACT

This dissertation is a histo-graphic account of the origins and evolution of private health funding in South Africa. It commences with a history of medicine within the context of the provision of health care and health funding. The arrival of the Dutch and the influence of the different rulers are highlighted throughout the different eras, up to the formation of the first private medical scheme in 1889. From this point onward, the historical development of private health funding is recorded with due consideration of the appointed commissions of enquiry and legislative developments. The dissertation concludes with a review of the study.

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Glossary of terms

Derived from Nkosi, E (2000: 118) unless otherwise stated

Access: a patient's ability to obtain medical care. The ease of access is determined by components such as the availability of service providers and their acceptability to the patient, hours of operation and the cost of care.

Adverse selection: the tendency of those with impaired health status, or who are prone to higher than average use of benefits, to be enrolled in a medical scheme.

Benevolent society is a 'well-wishing, friendly, charitable' society (Longman 1968: 102).

Capitation: a fixed amount paid by a health plan, per member for a predetermined period to a health care provider to provide an enrollee (member) with a defined package of medical services. Providers are not reimbursed for the services that exceed the allotted sum. The rate might be fixed for all members or it may be adjusted for the age and gender of the member, based on actuarial projections of medical utilisation. Capitation payments are prepaid and fixed for the duration of the contract, regardless of use of services.

Case Management: a process whereby the medical scheme monitors a member's progress through costly hospital procedures, and liaises with the doctors and hospitals to ensure that the patient receives the most appropriate and cost effective levels of care.

Co-payment: That portion of a claim or medical expense that a member must pay him/herself.

Claims review: the method by which an enrollee's health care services claims is reviewed prior to reimbursement. The purpose is to validate the medical necessity for the provided services and to be sure that the cost of the service was not excessive.

Community rating: a system in which all members in a geographic area pay the same level of premium contribution, irrespective of their current or historical health, their age or the likelihood of their using medical services. This implies that the healthier or less severely ill patients will be subsidising the more severely ill patients.

Cost sharing: the general set of financing arrangements whereby the consumer must pay personally to receive care, either at the same time of initiating care, or during the provision of health care services, or both.

Federal Government: 'Characterised by or constituting a form of government in which power is divided between one central and several regional authorities;' 'union of states recognises the sovereignty of a central authority while retaining certain residual powers of government;' 'National' especially in reference to the government of the United States.¹

Friendly Society: is defined in terms of legislation and confined to the legislation itself. The Acts pertaining to friendly societies passed in South Africa are detailed in the study. In general terms, a friendly society is a voluntary association of members paying regular contributions in order to secure certain benefits (Longman 1968: 420). In America, it is referred to as a benefit society. In South Africa Friendly societies are essentially mutual organizations, in the sense the organisation is not owned by anyone and it

¹ <http://define.com/Federal> and <http://www.thefreedictionary.com/federal> accessed 14 December 2010

exists for the benefit of its members. They were once known as mutual aid societies. No employer-employee relationship is required. The Friendly Societies Act of 1882 (Cape) was the first legislation of its kind which was followed in 1897 when the Natal equivalent was passed. The Friendly Societies Act of 1956 presently governs friendly societies and supervision thereof is vested in the Financial Services Board (Katz 1998: 4).

Gatekeeper: a primary care physician responsible for overseeing and co-ordinating all aspects of a patient's medical care.

Health Maintenance Organisation (HMO): an organisation that offers prepaid, comprehensive health coverage for both hospital and physician services. It contracts with health care providers (Physicians, hospitals and other health professionals), and members are required to use participating providers for all health services.

Homelands: 'Independent black states' (i.e. Transkei, Bophuthatswana, Venda and Ciskei) and the self-governing black states as promulgated in 1970's.

Independent Practitioners Association (IPA): a physician HMO delivery model in which the HMO contracts with organisations on behalf of individual physicians. The IPA physicians practice in their own offices and continue to see fee-for-service patients. The organisations reimburse the IPA on a capitated basis. However, the IPA usually reimburses the physician on a fee-for-service basis.

Industrial welfare: is a term mainly used to describe the condition and well-being of the labourer in the context of health, welfare and safety in the workplace. Although it is in evidence back to the middle ages, it started officially with the Industrial Revolution in 1760 and the development of the factory system in England around 1813. Industrial welfare work only started in the United States around 1863 and, according to Warner

et al (1894: 379), the benefits were: (a) the recognition of the individual in industry, (b) the improvement of the relationship between the employer and employee, and (c) improved production. Industrial welfare expanded to housing, nursing, provision of first aid as well as benefit societies. Eventually whole towns (Pullman, Illinois in 1880) were built and owned by large industrial companies. ‘This centralised control was, however, was resented by the people who opposed the invasions by the company of what they considered their private rights’ (Warner *et al* 1894: 379).

Managed Health Care (MHC): a general term for organising doctors, hospitals, and other providers into groups, to enhance delivery of cost-effective health care. MHC includes any form of intervention elements in health care to provide cost effective health care delivery. These elements include selective provider contracting, utilisation management, pre-authorisation, negotiated payments, quality management and other principles used to provide cost effective health care delivery.

Medicaid: is a federal programme in the USA administered and operated individually by participating state and territorial governments which provides medical benefits to eligible low income persons needing health care.

Medicare: a federal programme in the USA that covers the medical care of patients over 65 years old and people under 65 years old who are disabled or have chronic kidney disease.

Missionary Society: would be associated with a religious group and funds would be provided from collections within this group and collections from third parties.

Network Model Health Maintenance Organisation: An HMO that contracts with two or more independent group practices to provide health services. This type may include a few solo practices, but is primarily organised around groups of service providers.

Open Access: a system in which members' age and existing health profiles may not disqualify them from eligibility for medical cover in any scheme.

Promotive: tending or serving to promote; measure promotive of good health²

Participating provider: a health provider who participates through a contractual agreement with a health care service contractor, HMO, PPO, IPA or other managed care organisations.

Peer Review: a review by the profession members regarding the quality of care provided a patient, including documentation of care (medical audit), diagnostic steps used, conclusions reached, therapy given, appropriateness of utilisation, and reasonableness of charges claimed.

Per Case reimbursement: A fixed-fee hospital reimbursement, per hospital case, regardless of the duration of stay

Per Diem reimbursement: a health care arrangement between purchasers of care (employers, insurance companies, etc)

Philanthropic Society: defined as 'doing good works, actively benevolent' (Longman 1976: 840).

Preferred Provider: a health care arrangement between purchasers of care (employers, insurance companies) and providers, that offers benefits at a reasonable cost by providing members with incentives (such as lower

² <http://www.merriam-webster.com/dictionary/promotive> accessed 25 February 2011

deductibles and co-payments) to use providers within the network. Members who decide to use non-preferred physicians may do so, but at a higher cost to themselves. Preferred providers must agree to specified fee schedules in exchange for preferred status, and are required to comply with certain utilisation guidelines.

Pre-authorisation: a method of monitoring and controlling utilisation by evaluating the need for medical service prior to it being performed. Schemes penalise members who fail to obtain prior authorisation for any expected hospital procedure.

Registrar of Medical Schemes: an official appointed in terms of the Medical Schemes Act 131 of 1998, responsible for registration of medical schemes and their rules and the application of the Act and these rules.

Scale of Benefit: benefits, based on the relevant schedule of benefits, which a medical scheme may allow its members, by virtue of its internal rules, as full or partial compensation for expenses incurred in respect of medical, dental and related services. (Browne Commission 1986: 31)

Schedule of Benefit: a schedule of maximum fees for medical, dental and related services on which a medical scheme may base its benefits to its members, and which a medical scheme may pay directly to the supplier as remuneration for such services (Browne Commission 1986: 31)

Sectarianism: ‘Sectarian groups are religious, political or ideological organisations whose services are limited to a particular set or who require recipients to adhere to a specific dogma, political point of view or religious practice in order to receive services’³

³ Sectarianism definition www.reasoned.org/glossary.htm accessed on 12/01/2011

Sectional: ‘Concerned only with your own small group in society or in an organisation, as opposed to being concerned about society or the institution as a whole’⁴

Social insurance: is defined as a system of compulsory contributions by a defined group of employees toward a special fund(s) from which benefits were paid and a person’s right to such benefits were secured by his participation and contribution record without any test of need or means (Fourie, 2008) Collie on the other hand (1936: 5) defines social insurance as ‘the term used to indicate that portion of the total field of insurance in which the risks or hazards covered result from the inability of the workman either to make a wage contract of a kind which will enable him to maintain a satisfactory standard of living for himself and his family or to carry through his part of the contract owing to physical incapacity.’

Utilisation Review: (also known as utilisation management or utilisation control): a systematic means of reviewing and controlling patients’ use of medical care services as well as the appropriateness and quality of that care. Usually involves data collection, review and/or authorisation, especially for services such as specialist referrals and hospitalisation.

⁴ Sectional definition www.Idoceanline.com/dictionary/sectional accessed on 12/1/2011 and Longman

Introduction

The purpose of this study is to set out the historical development of private health funding. The origin of private health funding in South Africa is found upon the arrival of the Dutch in the seventeenth century. A form of occupational health practice was established by the employer, the Dutch East Indian Company (VOC). Within the context of the history of medicine, the study continues with the involvement of government and its influences on private health funding. The study is concluded with an overview of the evolution of private health funding.

This research does not contain the traditional concept of a research question as its purpose is to provide a basis for future research.

The South African health care industry comprises large private and public health care sectors:

The Private health care sector is made up as private and traditional health providers, the institutions that represent these providers, private health facilities such as hospitals and the funding mechanisms of private health services such as medical schemes, life and short-term insurance and out of pocket expenses (Hassim *et al* 2007: 165).

The private healthcare sector forms part of the overall healthcare industry. Medical aid schemes form a link between the member and the suppliers of health services and its objective is the provision of third party funding for healthcare costs. It is necessary to distinguish, from the beginning, between private health financing and public health financing. The features which are used to distinguish between the two are the source or mode of funding:

Van Rensburg *et al* (2004: 380) cite the four main sources of finance for health care being government, households, employers, donors and non-governmental organisations. According to De Beer, public sources would be tax revenue and a centrally regulated system of public health insurance. Public health service would be paid for by the State, provincial administrations and local authorities. Private

sources of funding are out of pocket expenses at time of service, contributions to private health insurance or private medical schemes such as health maintenance organisations and would include benefit societies, services paid for by employers and philanthropy (De Beer 1990:4).

This dissertation will focus on private health funding in South Africa.

The first chapter provides a background with regard to the poor and the provision of healthcare. Within this context, an overview is provided of European customs and its effects on Britain and its poor laws. This includes the effects of the migration of the poor to large towns after the collapse of the feudal system in the 1400's, the registration of the poor in France during the 1500's and the introduction of programmes of employment of the poor in Germany during the late 1700's. The provision for the poor in Britain led to the rise of social security in Britain and the idea spread to the United States. The history of healthcare provision in Africa was shaped by its diverse cultures. Colonialism introduced certain European practices to Africa, as witnessed in South Africa during the later years. These topics prior to and after the settlement of the Dutch in the Cape in 1652, will be detailed in the first Chapter.

Chapter 2 provides a history of medicine in which a chronological account of events and influences which shaped the health care industry in South Africa, within the funding context, is given. These historical events are depicted in the context of the different era's in South African history, commencing with the arrival of the Dutch in 1652, the first British Occupation in 1795 and Batavian period starting in 1803 through to the British establishment of the colonies and emerging Republics in the late 1800's. Medical services to colonial employees and colonial officials were provided by their governments. According to Verhoef, this concept originated in Britain and was extended to British colonies (Verhoef 2007: 34). This is confirmed by Van Rensburg *et al*: '...especially pertinent in shaping health care in colonial Africa was the relationship of dominance-exploitation between imperial powers and their subordinate colonies, through which characteristics of the mother

countries were transferred to their respective colonies and protectorates' (2004: 34). These influences leading to the formation of the first private medical scheme, including the formation of friendly societies, are detailed.

Chapter 3 deals with Private Healthcare funding, commencing with a précis of the medical societies and associations up to the first medical society in 1889. The basis of private medical legislation is found in the enactment of Friendly Societies Act in 1882. This led to the formation of the first private medical society, the De Beers Medical Society in 1889. Two events had a major influence on South African history namely the discovery of diamonds in 1867 and the 1873 gold rush, especially since: 'Gold made it the richest and militarily the most powerful nation in Southern Africa' (Pakenham 1998: historical note xxi). The lure of medical practitioners to the country combined with pressure on mining houses to address mining-related illnesses and provide facilities for their ill, resulted in a unique division of health care provision between the State and privately owned companies.

Diamond mining company, De Beers established the first private medical scheme for its employees. A detailed history of this Scheme spanning over a century is provided to create an understanding of the issues facing private health funders during this period. A review of social influences in terms of social insurance, as introduced by Bismarck, is provided. This chapter continues with the post-1889 era's, highlighting influences on healthcare funding. This commences with the Anglo Boer War in 1902, the Reconstruction and Integration period up to the formation of the Union of South Africa in 1910 and the period to 1960, just prior to the formation of the Republic of South Africa.

During this time several Commissions of Enquiry were appointed by Government. Details of their findings and recommendations are provided in the different chapters. These findings formed the basis of parliamentary debates and discussions which led to the passing of legislation. Valuable insight into the status of private

health funding matters at the time of the different enquiries, were provided by these Commissions.

Chapter 4 records the development of the private health funding industry since 1960 and continues to 2010. It is demonstrated that South Africa did not follow the United Kingdom health funding model of national health care strictly nor the United States of America's Consumer Sovereign health care. Instead, South Africa adopted a dual approach to health funding. A summary of each of the interest groups within the private health funding structure is provided.

Chapter 5: The study concludes with an overview of the origins and evolution of private health care funding, commencing from the seventeenth century, to date.

With regard to terminology used in this Dissertation, the author supports the statement made by McIntyre and Dorrington (1990: 125):

In considering the mal-distribution of health care expenditure it was necessary to use the terms 'Whites', 'Coloureds' 'Asians' and 'Blacks'. However, we would endorse the World Health Organisation's disclaimer in this regard: 'In South Africa, social, economic and political institutions are so structured by an all-pervasive racist ideology and practice that they have material effects on the incidence of disease and the provision of health care. It is therefore impossible to describe the daily reality of millions of South Africans in any other way, and such terms as 'black', 'white' and 'coloured' cannot be avoided in this Report. Their use, however, does not imply the legitimacy of racist terminology.

This statement includes reference to 'Natives' and 'Bantu' in this dissertation.

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Chapter 1:

Background: Poor Relief and Health Care

By the beginning of the eighteenth century, the Cape was a mixture of many different nationalities. The influences of the different cultures, particularly the Dutch and English, lay the foundation for the social environment in which the provision of health care in the Cape began. 'It was the home of a small but vital mass of people of European origin who had become an increasingly independent force in shaping the colonial society' (Thompson 2006: 44). The treatment of the sick and poor and the responsibility of the formal authorities in providing and funding treatment, emerged.

In addition to demographic influences, social and economic factors impacted on health care and ultimately, the funding of health care. The similar manners in which Europeans and Africans approached the care of the poor and the sick from the earliest times are demonstrated in this chapter. :

1.1 European influences

The plight of the sick and the poor has been a concern of modern man for many centuries. Mediaeval hospitals in England originated as charitable institutions designated as 'Houses of Hospitality' – a basic shelter for all visitors and known as a hospital, derived from the Latin word *hospes*, a host or guest. These were intended as ecclesiastical rather than medical institutions. Travellers were accepted and given shelter and lodging and at least two 'hospitals' or hospices were founded in Yorkshire during the tenth century, 925-940. These institutions expanded and in the eleventh century, St Wulstan of Worcester founded a hospital bearing his name near his cathedral city and asked: 'In pre-Norman days, the solemn question that is still asked today: "Wilt thou shew mercy and kindness, for the name of the Lord, to the poor, the stranger, and all in want"' (Clay 1966: 2).

In support of the above, Van Rensburg *et al* (2004: 7) state that the origin of hospitals and nursing in the Middle Ages is directly related to the Christian faith and its teachings of compassion; Judaic doctrine of loving one's neighbour and the Protestant ethic of saving for the future/ prudence. In turn, this formed the spiritual base for cooperative feudal societies, which ultimately led to the modern worldwide health insurance movement.

These feudal estates of medieval Europe lived as condensed social groups, providing mutual aid in time of need. Serfs and villains were shielded from disaster by the protection offered by their lords, the land owners. According to Warner, social work developed as these communities expanded and grew more complex (Warner *et al* 1894: 9).

The fifteenth and sixteenth centuries marked the period of the European Renaissance. The economic and industrial changes in England saw a rise in poverty. In addition, war was declared by Henry VIII against Charles V in 1528, which directly affected the weavers of England due to loss of sales to Flemish markets. Consequently, poverty became a concern of government (De Schweinitz 1943: 11).

The rest of Europe contributed to the developments in Britain, such as the work by Juan Luis Vives, a native of Spain, who published: 'Concerning the Relief of the Poor' [translated] in 1526. In response to his recommendations in 1531, Henry VIII registered the poor in the different parishes in order to receive relief via the overseers [See further details in 1.2]. Relief was mostly received via private contributions and in 1536 public improvements were utilized as a source of jobs.

In Germany, Martin Luther had issued an appeal to the German nation in 1520 to abolish begging and provide assistance to the poor. In 1525, Zwingli of Switzerland proposed a plan for relief. During 1536 Francis I of France ordered each parish to register its poor and provide for these from internal funds. The

feudal system had broken down across Europe. The poor became destitute as they were no longer taken care of by the nobles and lords (De Schweinitz 1943: 30-38).

During the latter part of the 17th century, England resisted Dutch dominance in commerce. This dominance extended to the sea route via the Cape to the East for trade purposes. The Dutch settlement at the Cape was established in 1652 to optimise the economic benefits of this route. ‘The English writers of the period are full of admiration for their rivals: Dutch thrift, Dutch industry and Dutch skill in turning raw materials into finished articles of trade are constantly cited’ (De Schweinitz 1943: 48). The absence of beggars and the admirable organisation of almshouses were held up as examples of how the problem of poverty could be solved.

1.2 Britain and British Poor Laws

By the middle of the fourteenth century feudalism was close to its end and wages were paid for labour which symbolized the freedom of the labourer from the bond of serfdom. Social security therefore commenced with the shift from feudalism to capitalism.

The famine in 1315 and the Black Death in 1347 almost eliminated more than one third of the population in England which caused a further decline in labour output as there was a shortage of healthy, skilled workers. Workers became scarce and landowners had to pay increased wages or not work on their land. In order to curb inflationary increases and to ensure that able workers continued working, the enactment of the Statute of Labourers was brought about.

According to De Schweinitz (1943: 1), the administration of social security in the United States and Britain found its origin in this proclamation issued in 1349 by King Edward III in the ‘Statute of Laborers’:

Because that many valiant beggars, as long as they may live off begging, do refuse to labor, giving themselves to idleness and vice, and sometime to theft and

other abominations; none upon the said pain of imprisonment, shall under the color of pity or alms, give anything to such, which may labor, or presume to favour them toward their desires, so that thereby they may be compelled to labor for their necessary living (De Schweinitz 1943: 1).

It was only during the reign of Henry VIII that the Government of England took some responsibility for poor relief by making provision for those, genuinely in need. The approach at this time was to punish the idle. The first Statute, enacted in 1531, made officials responsible for seeking and registering the poor to beg, up to certain limits set by the officials. This was seen as a considerable step to administering relief by legalizing begging. The 1536 Statute saw government taking responsibility by ensuring the administration of funds through contributions (De Schweinitz 1943: 23). This is seen as the onset of the ‘old poor laws’ and set the trend for the next four centuries in Britain. The principle of public responsibility was established, at that stage the burden still fell on the parish, mainly the householder, to take up the responsibility of caring for the needy.

Between 1536 and 1539, Henry VIII expropriated the monasteries which weakened an already weak social resource. Until then, the monasteries were an excellent means for the relief of economic distress:

The church, along with the hospitals and religiously inspired philanthropies, represented the positive approach to human distress. With this resource available to the person in need, government could be negative in attitude and action. It was only when, in the presence of the overwhelming effects of great social change, the church and private charity could manifestly not relieve the vastly increased distress that public provision supported by funds secured through taxation was introduced. Even then, this was done only after government had tried through the church to use and develop the voluntary method – and had failed (De Schweinitz 1943: 19).

In 1563, ‘natural’ persons in Britain were almost forced to provide charity to the poor, which can be seen as a form of taxation. In 1601, the 43rd Elizabeth, Chapter 2 was passed and is seen as the last Consolidation of the poor law in the history of the relief of economic distress. It required each parish to impose a definite tax for employing the able bodied, apprenticing children and maintain the poor in almshouses. It also established the liability of relatives to support their needy and

those who refused to work or pay poor taxes were threatened with jail or house of correction (Warner *et al* 1894: 17). ‘The 43rd Elizabeth is the parent of governmental relief in England and in the United States, the parent in relation to which our present system of social security expresses both development and revolt’. (De Schweinitz 1943: 28) Finally, the leaders of England realised that the use of public resources would be the only way to alleviate individual need.

During 1662, the Law of Settlement was promulgated. Although it was modified almost a century and a quarter later, ‘...it represented the most extreme and cruel form of localism that England had known previously or has known since’ (De Schweinitz 1943: 39). It forced the poor to remain in their parishes of birth, combining the principle of forbidding the movement of labour and the principle of transporting the poor. There was a general outcry against the Laws of Settlement, shared by many of the authors of the time.

Sir Matthew Hale, the Lord Chief Justice, published the *Discourse Touching Provision for the Poor* in 1683 where he proposed an economy be built utilising the poor and localizing production to Britain. This program was advocated by Sir Josiah Child, the chairman of the [English] East India Company and urged the employment of girls and boys in workhouses. ‘The [se] projects did not succeed for the same reason that no similar projects have ever succeeded’ (De Schweinitz 1943: 56).

It is important to remember that in the early 1700’s prior to the Industrial Revolution in Britain, life expectancy was a mere 36 years. At the time the population was 5,500,000 people and most of the people still worked in agriculture (Stokes 2010:1). This compared to medieval Britain, the average lifespan at birth was 30. If you were an aristocrat, your life expectancy increased to 59. Adam Smith cited the child mortality figures in Scotland, where it was not uncommon for a woman who had borne twenty children to have only two survive: ‘This great mortality, however, will everywhere be found chiefly among the children of the common people, who cannot afford to tend to them with the same care as those of

a better station' (Smith 1776 reprinted 1991: 84). In this context, care included health care. Aristocracy and the rich would enjoy better sanitation, nutrition and medical care which would impact on life expectancy and explain the differences cited above.

During 1788 and 1790 the Germans addressed the poor problem by using the Municipality as the supervisor and administrator of funds for the poor. This concept spread to Britain. An American, Benjamin Thompson, was the originator of this system of administration in Munich:

This system of districted visitation under an overall supervision was typical of European methods just as the workhouse and the independently operated parish were typical of English Administration. At Ypres, Belgium the system was in its earliest stages; at Hamburg it appears in a much more developed form; and half a century later it attracted attention anew at Elberfeld, in Germany, whence its influence spread to the United States as well as to England (De Schweinitz 1943: 97).

This system worked better than the British poor laws, because employment was the focus of the plan: Baron von Voght testifies: 'For the last seven years...hardly a beggar has been seen in Hamburg...We not only did much toward the relief of the poor, but...we gained some steps toward the more desirable, yet but slowly attainable end, the *preventing some of the causes of poverty*' (De Schweinitz 1943: 93). This programme was based on poor relief where subscriptions were collected from the neighbourhood and distributed on an 'as needed' basis. In addition, premises and care were supplied to young children. Older children were educated and paid an allowance for their schooling, plus a salary for working the remainder of the time. Doctors visited the sick diligently and care was administered efficiently.

Thomas Paine in his book, *Rights of Man* strongly criticized the rulers of the British government and the provision for its poor, which he attributed to the unfair distribution of taxes. Essentially, he wanted to reduce poor taxes in order for the poor to be able to provide for the aged, children and widows. Paine did not advocate the use of state expenditure on the poor but rather a reduction of taxes on

the poor so the poor are able to support themselves from the money they paid in taxes. Paine calculated the cost for providing for 630 000 children to be £2,520,000. This would be paid from the proposed remission in taxes. This would enable the poor to become better educated and ultimately support themselves:

I proceed to the mode of relief of distribution, which is, to pay as a remission of taxes to every poor family, out of the surplus taxes, and in room of poor-rates, four pounds sterling a year for every child, under fourteen years of age (Paine 1791: 193).

Paine (1791: 33) talks about the rights of man as it was codified in France at the time of the French Revolution and the resultant reduction in taxes by several millions a year versus the increase in Britain of nearly a million a year. He goes further to discuss the civil rights of man: ‘Man did not enter into society to become worse than he was before, not to have fewer rights than he had before, but to have those rights better secured.’

Paine believed that civil rights are those that accrue to man as a result of him being a member of society, particularly relating to his own security and protection. Paine questioned government’s role by asking ‘*What is Government more than the management of the affairs of a nation?*’ (Paine 1791: 103) and concluded that ‘*Government is nothing more than a national association, acting on the principles of society*’ (1791: 125).

Paine had high regard for the Americans and their system of government, for which he was in no small part responsible. He was particularly impressed with Government and their efforts at inclusion of the nation in matters affecting them:

...by the simple operation of constructing Government on the principles of Society and the rights of man, every difficulty retires, and all the parts are brought into cordial unison. There the poor are not oppressed; the rich are not privileged... Their taxes are few, because their Government is just; and there is nothing to render them wretched, there is nothing to engender riots and tumults (Paine 1791: 124).

In this section, we see how the poor started off as the responsibility of the private household and the Church. Rules were set up for the registration of the poor and different measures introduced such as to contain them to their parishes of birth or forcing them to register for work. Only when these approaches failed, did the State intervene and take responsibility for the plight of the poor.

1.3 Health provision in Africa

According to Van Rensburg *et al* (2004: 33), when the Arabs introduced Islam to Africa in 7th Century AD it ‘exposed African magico-religious medical beliefs and practices to scientific principles fundamental to Western medicine.’ This is confirmed by Gonzalez-Cressi (2007: 8): ‘The world owes an incalculable debt to the scholars of what has been variously called Islamic, Arab or Arab medicine for having perpetuated the classic legacy of Greece and Rome’.

Human occupation in Africa dates back some 2.5 million years and modern man inhabited Southern Africa for more than one hundred thousand years. African tribes had migrated southward and lived possibly a thousand years prior to the landing of the Portuguese at the East South coast of Africa. These were mainly the pastoral Khoisan⁵ people/communities who migrated southward from South Central Africa and were regarded as on a higher cultural scale to the Bushman. Living in reed huts with oxen for transport, their main activity was working with skin and pottery. The Stone Age Bushmen entered South Africa, displacing or absorbing *Boskop Man*, his predecessor (Laidler and Gelfand 1971: 9).

It is clear that during the 1500’s that the pattern of diseases found in Southern Africa was experienced throughout Africa. Ityavyar reports that: ‘The recurrent epidemics of alien diseases recorded at this time are said to have been stimulated by trade, travel, warfare and drought’ (Falola and Ityavyar 1992: 189).

⁵ According to Thompson (2001: 10) the Europeans referred to the hunter-gatherers as Bushmen, the pastorals Hottentots and mixed farmers, Kaffirs. In ethnic terms they are now respectively called San, Khoikhoi and Africans.

Smallpox was an imported disease that became prevalent after 1500, in particularly near trade routes such as the Cape and its devastating effects were mostly felt in the concentrated urban commercial centres. Distant regions did not face such epidemics (Falola and Ityavyar 1992: 189). Smallpox eradicated thousands of Africans – especially certain Khoisan tribes in the Cape Colony.

The Tomlinson Commission⁶ quotes Theal (1955: 1) stating that during the Sixteenth century the Southern Group Bantu were still living north of a line extending from a point 25 to 30 miles to the north of Walvis Bay, though the headwaters of the Vaal River to the Drakensburg, then east of the Drakensburg to the Umtamvuna River. The South African Bantu peoples can be separated into four main groups namely Nguni (59.6% of the population), Sotho, Venda and Shangaan-Tsonga. The Nguni Group is the biggest and includes the Zulu (24.5% of the population) and Xhosa (25.5% of the population) tribes.

The economic system of the Bantu was mainly keeping of livestock, cultivation of crops, collection of wild fruit and spinach, hunting of game and practising home industries. The Bantu-speaking mixed farmers were generally healthy people attributed to a healthy lifestyle and a rich and varied diet. 'Ludwig Alberti found that the Xhosa enjoy exceptional health...very rarely suffer from infectious diseases or fatal illnesses' (Thompson 2006: 20). They also had a good knowledge of the medicinal benefits of plants grown in their area.

Tomlinson (1955: 4) continues: 'In the Bantu community, there are no special institutions for caring for those in need.' As in any primitive society, relations cared for their needy. Although it is stated that the Bantu had a strong sense of mutual responsibility where those in need were cared for by relatives and those who could afford to do so.

⁶ The Tomlinson Commission was appointed to report on the Socio-Economic development of the Bantu areas in 1955

In 1636,⁷ the Portuguese founded a hospital in neighbouring Mozambique. The members of the Order of St John cared for the sick and were reimbursed 3 500 cruzadoes a year for their expenses. The Portuguese claimed the founding of the first hospital in Southern Africa 'but thereafter little is recoverable concerning their medical activities' (Laidler 1937:2). On the other hand, Franciscan missionaries in Angola discovered ruins of a hospital in 1774, believed erected by Capuchins during 1640, 'this appears to be the first recorded instance of medical work by Europeans South of the Sahara' (Hailey 1938:1115).

A nineteenth-century observer summarises the herding sector of the Africans which settled in the Cape Peninsula and its vicinity, before the seventeenth century:

'Nearly every tribe is found to consist of three distinct classes of persons. Firstly, the wealthy class. Second, a portion of the poorer class disposed to reside with and serve the former, and third, the remainder of the latter class who either from disinclination to servitude or an inability to obtain it, trust for support to other means, and in pursuit of them remove from the haunts of their more settled countrymen and establish themselves in positions best adapted for the objects they have in view. It is this class which forms...the detached pauper population of a tribe' (Thompson 2006: 15).

The development of African society in the 18th century was influenced by four main activities, namely: the political; socio-economic; the cultural and the medical. The structure within which these activities developed was the family unit, which was a basic and simple unit of production. As a result agriculture and commerce was well developed which led members of society to expand into commerce and industry. In turn, this led to a flourishing trade in Southern Africa (Falola and Ityavvyar 1992: 35).

⁷ Burrows (1958: 32) reports this as 1507

The concepts of health and a healthy individual were well defined and a variety of specialists ranging from public health to surgery emerged. 'Health services in pre-capitalist Africa were decentralized'. In terms of payment for health services, it is stated 'Payment was not a barrier to service' (Falola and Ityavyar 1992: 40). Although these services were not free, payment was affordable and would be a chicken or goat in the farming communities and such exchange or barter payment as was the customary practice.

Many people had access, although it was unequal access:

This, in turn, laid the foundation for the parallel existence of at least two divergent medical or health care systems, viz. Western medicine and the traditional tribal medicines of the indigenous peoples, characterised respectively by a professional-scientific orientation in respect of health care on the one hand, and a magico-religious orientation on the other. This split structure even today characterises South African health care, though Western scientific medicine in time (especially after 1807) gained official status, while the rest continued to exist alongside it as non-official (even 'illegal') forms of healthcare (Van Rensburg *et al* 2004:68).

Health policies were also influenced on how the ruling party implemented its vision for development: 'Health policies strongly reflect the priorities and the self-interest of the ruling classes and are significantly influenced by a self-interested medical establishment' (Falola and Ityavyar 1992: 218). Falola state that were three basic health services models in eighteenth century Africa namely: *Colonial Health* models focussed on European health and maintenance of social control and extraction of enough funds to cover costs, *Basic Health* services models generally were implemented after independence and focussed on rural health and emphasised preventative medicine and the role of the paraprofessional health care worker and integration of the Health Service Industry. *Primary health models* emphasised the restructuring of priorities in national health care systems to promote equity, redefining health and health policy.

'Pre-capitalist Africa was not a classless society and access to medical care, pretty well reflected the distribution of wealth that existed at the time' (Falola and

Ityavyar 1992: 41). They stated that profit and personal gain were not the prime motives for medical practice.

Five types of health care systems in Africa were reported by Falola and Ityavyar (1992: 224). These were: free enterprise welfare state; underdeveloped country; transitional and socialist. Primary determinants were levels of economic development (what to distribute) allocation mechanism (how it is distributed) and socio-political organisation (why it is distributed in a certain way) – with due consideration of historical and cultural influences. In this context, South Africa health care can be seen as a combination of free enterprise and socialist medical care.

This section has demonstrated that there were synergies between Europe and Africa insofar its poor and sick were treated. Initially they were the responsibility of relatives which developed to the responsibility of those that could afford to.

1.4 The Cape and the route to the East

The East had always held a certain attraction for Europeans, particularly for trade purposes. When the Ottoman Turks invaded Asia and the harbour cities in Constantinople during 1453, the inland and Adriatic routes were lost. The Portuguese believed they could find an alternative route to East India via Africa. On 10th October 1486 Bartholomew Diaz, a knight of the royal court, was appointed by King Juan II to head an expedition to find such a route. The Cape of Good Hope was only sighted during his return voyage. On 3rd February 1488, Diaz landed at what is now known as Mossel Bay. This expedition continued to anchor at Kwaaihoek, near the Bushmens River on 12th March 1488 where he erected the Padrao de Sau Gregorio (the Diaz Cross). He reported to the King that he had rounded Africa, sailed north and then returned. Burrows quote Joao de Barros:

they discovered that so many ages unknown promontory, which they called Tormentosa or Stormy, because of a great tempest they met with there; but our

King gave it the name of Cabo de Boa Esperanca [translated Cape of Good Hope]...from the great hope it gave of discovering the Indies (Burrows 1958: 14).

Portuguese nobleman, Vasco Da Gama, successfully reached India via the Cape of Good Hope thereby opening the route to India in 1497: 'It was one of the greatest achievements in the history of mankind' (Burrows 1958: 14). The Cape of Good Hope emerged as a strategic sea-route to the East for the Portuguese, Dutch and the English.

1.5 The VOC, the origin of private health funding in South Africa

Among these great maritime powers, the Dutch became the greatest sea power during the 16th century. After 1598 the States General of Holland suggested the amalgamation of various companies. In 1602, this was accomplished when the Dutch Government amalgamated investors and the States-General, the highest authority in the Republic of the United Netherlands, and granted a charter to form the 'Vereenigde Landsche Ge-Oktroyeerde Oost-Indische Compagnie' (Hereinafter referred to as the VOC translated: Dutch East India Company,). 'Holland had found what was for two centuries to be the main field for successful joint-stock enterprise' (Warner *et al* 1894: 362). The Charter granted a trading monopoly and the right to acquire and govern Dutch possessions in the Orient for a period of 21 years. This was extended in 1623 and 1647. It was 'a state outside the state' (Thompson 2006: 32).

The VOC was in charge of the settlement in the Cape. It was divided into six Chambers. The Heeren XVII (Seventeen Lords), the government body of the company, was a court of seventeen directors. It was the first multinational corporation in the world and the first to issue stock. Its only share issue took place in 1602 which raised start-up capital of 6 424 588 Guilders. During its 200 year history, the VOC became the largest company of its kind, trading spices (mainly nutmeg, cloves, cinnamon and pepper) and other products (tea, silk and Chinese porcelain) (Ramerini 2010:1).

The VOC business was on a much larger scale in the eighteenth century than it had been in the seventeenth. In 1608, the Dutch had 40 ships manned by 5 000 men in Asia, 20 ships with 400 men off the coast of Guinea and 100 ships with 1 800 men in the West Indies. In 1644, the VOC alone had 150 ships and 15 000 men and in the last quarter of the 17th century it had in the East Indies over 200 ships and 30 000 men (Ramerini 2010:1). From 1621 to 1700, revenue rose from 327 000 000 Rixdollars and 450 000 000 Rixdollars between 1700 and 1780 (Reynders 2010:1).

According to Tomlinson (1955: 5) it was never the intention of the Dutch to bring the Khoisan within the political sphere of influence of the Netherlands when it settled in the Cape. The Company's jurisdiction was up to the boundaries of its cultivated lands only. However, as the European settlement grew, the Khoisan started working as herdsmen for the Europeans especially after 1959 and 1973. This employment was encouraged by the Company's Commissions 'provided it took place on a friendly and just basis' (Tomlinson 1955: 5). In a later chapter it will be seen that health care provision and funding was transferred to the master of these slaves.

By the 1700's, the Cape population had split into the well-paid officials at the Castle and the poorer town burghers. The Burgher Raad or Senate developed in 1725 with permission from the Council of Policy whilst the Company still controlled town matters. The Senate, comprising six members and appointed by the Governor, was the first evidence of a municipality in South Africa (Laidler and Gelfand 1971: 34). The poor paid as much tax as the rich and the Council of Policy decided that everyone should be taxed according to his fortune. The Burgher Raad objected as they already levied a capitation tax which included three rixdollars per person toward the night watch (Laidler and Gelfand 1971: 34).

No mention of provisions for health care is made, however the link between sanitary conditions and health was understood and one of the Council of Policy's objectives was to ensure a healthier environment at the Cape.

This Chapter served as an introduction to the earlier influences on treatment of the unhealthy and the poor. The plurality of the Cape population was highlighted in this Chapter, which laid the foundation for the differential treatment in terms of the provision and funding of health. This will be explained in later chapters.

Chapter 2: Development of Private Health Funding Against a History of Medicine in South Africa (1652-1889)

To gain a balanced perspective of health funding the historical development of health and medicine is examined. Whilst the focus of this dissertation is the private health sector, this section will demonstrate that the private and public health sectors were inextricably linked from the earliest days and affected one another at all levels.

The previous Chapter showed how social work had progressed through the centuries. The poor and the sick had finally become the responsibility of the State. According to Warner *et al* (1894: 343): ‘The connection between medicine and social work for centuries consisted largely in the fact that certain institutions received only persons who were both physically incapacitated and financially destitute’. This was evidenced in charitable hospitals and dispensaries in the 17th century where drugs and medical advice was given to the ‘sick poor’ and ‘indigent sick’ at ‘medical soup kitchens’.

The jump from medical charities to modern public health was attributed to improved medical service in terms of physical and biological discoveries; preventative medicine in terms of quarantine, sanitation, vaccination, education; thirdly source of financial support and control and fourthly the integration of social case work with medical services. Warner states that ‘much health service is still on the basis of public poor relief or middle class humanitarianism’ (1894: 343) but one finds more health centres, organisations operated by insurance companies for their policyholders, by trade unions for their members, corporations for employees and schools for their pupils.

It is important to remember that from the time of the ancient Greeks through to the twentieth century, disease led to inevitable death and was the fate of countless victims. This is evidenced in the high death rate at an early age during these times.

Survival was difficult and health care as we know it did not exist. Rampant infectious diseases such as tuberculosis, diphtheria, rheumatic fever, influenza, smallpox swept through communities. This was experienced in the Cape from the earliest day and will be elaborated upon in this Chapter.

Medical science developed throughout the different eras to the high level that it is today. During the Middle Ages, cadavers were occasionally opened to explain some aspects of the person's life or following an unexplained death or suspicion of foul play and were: 'Performed by ardent co-religionists, any finding was likely to be interpreted with a strong theological base' (Gonzalez-Crussi 2007:171).

During this time there were three classes of medical men practising in France namely physicians who prescribed and gave advice, were schooled at university and knew Latin. Surgeons could dress wounds, set fractures but not perform incisions. Barbers, viewed by the above as menials, were originally occupied to shave monks, could bleed patients, lance boils and perform invasive surgery but could not speak Latin nor were they trained at university (Gonzalez-Crussi 2007:29). In the thirteenth century the Barber Surgeons Guild was formed (Burrows 1958: 19).

In London, a Barbers Company was formed in 1376. It was only in 1540 that a charter was signed to incorporate barbers and surgeons into a common guild called the United Company of Barber Surgeons 'Physicians could merely grapple with lethal ailments, console the afflicted, exhort survivors to resignation, and apply whatever fragmentary observations they could muster toward a meagre alleviation' (Gonzalez-Crussi 2007: 207). In short, medical science as is known today did not exist.

Jan van Riebeeck, the surgeon-founder at the Cape, belonged to the select Guild of the Barber Surgeons. At this time in Holland, physicians were university graduates and surgeons were products of the guilds. Physicians and *doctoren* received no training in the first three years at Leyden University and had to qualify doing

postgraduate work. They could also not operate. The surgeons or *chirurgijns* received training through hard practical experience as apprentices which lasted for three or four years. They could operate on certain days and times only – and under the direction of physicians. In the countryside, there were members of the half surgeon guilds – who could treat wounds, draw teeth and let blood. The barber surgeons held the monopoly but *opérateurs* and quacks (*wonder-doeners*) that peddled their remedies to all and sundry were also present. Members of guilds were not regarded as lesser compared to university graduates. Apprentices were required to have: ‘...a strong and healthy and comely body, relationship to a known family of unblemished reputation in civil life, a knowledge of Latin and abject obedience to its members’ (Burrows 1958: 19).

By 1679, by which time the Dutch had landed at the Cape, a Swiss anatomical pathologist Bonet, published three volumes totalling 1706 pages on 2 934 clinical cases and their related autopsies (Gonzalez-Crussi 2007:172). The Science of Medicine was developing, however, the practice thereof at the Cape and on the voyages to the Cape was not advanced, even by the standards of the day.

The past 120 years saw profound advances in medicine which has affected the humankind. In 1895 a German physicist, Wilhelm Conrad Rontgen, accidentally discovered a species of rays which could pass through, amongst others, the human body. The X-ray developed, termed ‘the greatest revolution in visual diagnostics’ (Gonzalez-Crussi 2007:158). The discovery of the germ theory and antibiotics (penicillin in 1929) had dramatic results worldwide in improving health and extending life expectancy (Falola and Ityavvyar 1992:45). This is confirmed by Helms (2008: 5): Life expectancy in the sixteen developed countries increased from 39 years in 1940 to 60 years in 1970.

The arrival of the Dutch to settle at the Cape marked the beginning of a diverse South African nation, bringing many cultural and European influences to the African continent:

2.1 Dutch Era (1652 – 1795)

The surgeon-founder of the Cape was Jan van Riebeeck who was sent by the Company and landed at the Cape on the 4th April 1652. The objective of the settlement at the Cape was to build a fort, a revictualling station and provide medical care for sailors of the Company's passing ships. Van Riebeeck was in charge of the 126 men stationed at the Cape Settlement. One of his first assignments was to erect a hospital, which he did as temporary structures, including tents. In 1653 a '*matrozen huis*' was completed and two surgeons appointed by the Company. The chief Surgeon was Adriaen de Jager. The permanent hospital structure, constructed of plank walls and thatched roof, was only accomplished four years later after the completion of the fort in January 1656 (Burrow 1958: 31).

Van Riebeeck drew up the regulations for the administration of the hospital himself, influenced by the regulations of the *Binnen Hospitaal* at Batavia drawn up in 1642. Similar to Batavia the management of the hospital was vested in *regenten* or directors, in this case the senior surgeon, the *siekentrooster* and the sergeant of the fort, the highest ranking military man in the Cape. The surgeon's role was to save lives, the *siekentrooster* souls, and the latter had to 'spot malingers' (Burrows 1958: 32). Admission was by consent of these directors.

The southern parts of Africa were occupied by Bushmen and Khoisan when Van Riebeeck arrived. The Khoisan were mentioned by the Dutch in terms of their medical abilities in healing via herbs, cupping, and bloodletting. They 'had extensive medicinal lore' (Laidler and Gelfand 1971: 9). It is believed that their medicinal knowledge was derived from the Bushmen. The settlers showed much interest in the herbs used for medicinal purposes. Plants were collected and sent abroad for analysis in universities and pharmacies which resulted in an export trade of aloes and buchu (*Barosma betulina*) (Steenkamp 1978: 4).

The Company effectively provided medical and health care in the Cape to its employees only to enable it to achieve its economic goals. Whilst sick, the person only received enough money to pay for minor expenses, if that: 'Indirectly the person paid for everything and if he recovered the Company retained the sole right to his services' (Laidler and Gelfand 1971: 24). Funding was provided by the Company and it is suggested that this era of health funding in the Cape was based on occupational health principles. Essentially occupational health deals with the prevention and treatment of illness and injuries sustained at the workplace and the obligations of employers to compensate employees for such illness and injuries.

This theory is strongly advocated by Searle (1965: 22):

The motivating force behind the decision of the Company to establish a settlement at the Cape was a commercial one, but in it lay the threads of preventative medicine, particularly that branch of preventative medicine known as occupational health practice. **In fact one can say that occupational health was the accoucheur at the birth of the South African nation and became the father of medical practice on these shores** [my emphasis added].

Tomlinson (1955: 4) states that Van Riebeeck had clear instruction from the VOC as to his conduct toward the Khoisan insofar as it should be a peaceful relationship which would be to the economic advantage of the Company and lead to trade for cattle. Emergency care was given to the Khoisan by the surgeon, presumably free of charge. On 11 May 1652, a badly wounded Khoisan was treated by the surgeon (Laidler and Gelfand 1971: 6).⁸ This is the first record of treatment being provided by the Dutch to a member of the indigenous population. Based on evidence from later years, one can assume that this limited health care was provided as a social duty and, if there was any payment involved, it would have been on a barter basis.

The prime motive for the settlement at the Cape as being a medical one appears contentious. According to Searle:

⁸ Searle (1965:29) quotes the Journal 'Today a Hottentot, a very badly wounded, was brought to our Surgeon. As far as we could gather from the natives they had an encounter with the people from Saldanha, and two were killed.'

From the very beginning until the end of the Rule of the Dutch East India Company, the chief purpose of the settlement at the Cape was a medical one. Every official activity, every commercial transaction, in which the Commanders engaged, had but one end in view, ensuring that the Cape would meet its medical commitments (Searle 1965: 36).

Muller (1984: 20) has a different view: 'From the information available it appears that the most important aim of the undertaking was to ensure the safety of the fleets and to provide them with fresh produce'.

Meanwhile in Europe, it was customary for the lower-middle classes and upper middle classes to tend for their sick at their homes. The women of the house, friends and neighbours tended to the ill. Hospitals were institutions of charity and aimed at the poor and destitute. '... solid burghers, even those of slender means, avoided them like the plague' (Searle 1965: 27). Evidence of this European mindset continued in the medical practices of the Dutch immigrants on arrival at the Cape. 'They would have followed the custom of their class and nursed their sick in their own homes, even if the homes at that stage were only tents and a wooden shack' (Searle 1965: 28).

'On 10 April, 1655 the first public health legislation in this country was enacted in the form of a Placaat which prohibited washing and bathing above the place where drink water was drawn' (Searle 1965: 27). This was as a result of a complaint from the Council of India to the Commander concerning the substandard water supplied to voyages from the Cape to the East which had caused illness among the sailors.

According to Searle, the Cape Settlement was of 'profound social and economic importance to the Company' and a note written by Van Riebeeck to the Company on 9 November 1654 is quoted: 'Our plan had very much diminished the number of sick in the latter case, [Batavia – my insertion] whilst the mortality on Board, has likewise sensibly decreased...' (1965: 33). Searle contends that despite the large number of sick admitted, the death rate was low 'once the organisation of patient care had got properly under way' (Searle 1965: 33). Notwithstanding

Searle's statement, the table below does not show a substantial improvement in the mortality figures between 1655 and 1661:

Table 1

Cape: Number of ships and deaths between 1655 and 1661

Year	Number of ships which called at the Cape	Average Number of patients landed, per year	Number of Deaths at the Cape, of persons landed
1655	45	1350	11
1656	48	1440	8
1657	27	810	6
1658	32	960	15
1659	25	750	19
1660	31	930	13
1661	33	990	13
TOTAL	241	7 230	85

Source: Searle (1965: 33)

In 1657 the Company released some of its servants to become semi-independent farmers. Burrows contend that the Heeren Zeventien had broken their ban on colonizing and in doing so had 'laid the foundations of a permanent European community at the southern end of Africa' (Burrows 1958: 36). The freemen, also known as burghers, settled in the Liesbeeck valley. Official medical service was continuously replenished and charged from overseas, when permission had to be obtained from the *Heeren Zeventien* for larger expenditures.

In terms of civil health provision, the first surgeon to be released from Company employ by the Council of Policy to serve these freemen, Jan Vetteleman, was appointed during 1657. He was the first South African private medical practitioner.

The demand for hospital services in the Cape increased as trading expanded. An average of 64 ships per annum arrived for the nineteen years, commencing 1672. Ships originated from Holland, England, Denmark, France and Portugal. An average Dutch ship carried 170 sailors, equating to approximately 10 880 visitors

per annum. Only the Dutch were permitted into the hospital. Foreign sick had to be cared for in tents set up on the beaches where fresh food and medical supplies were made available, the latter at the cost of the Company. Slaves and local servants were treated at the expense of the Company (Searle 1965: 38).

From 1685, the Slave Lodge originally provided by the Dutch East India Company was utilized for sick slaves, cared for mostly by fellow slaves. Conditions at the Slave Lodge were dismal: ‘immorality and infectious diseases were rife’ (Searle 1965: 39). This included inadequate bedding and no separation of the sexes.

French Huguenots, fleeing from France following Louis XIV’s decision to revoke the Edict of Nantes, arrived in the Cape during the period 1688 to 1690. They were of a better social class – skilled artisans such as vine and olive-dressers. From a health perspective, they brought with them medical experience in the form of surgeons and experienced midwives (Laidler and Gelfand 1971: 20). These surgeons consulted privately within their areas of settlement and charged a fee payable by the patient for example in 1698 a visit by a doctor would be billed at 6 Rix-Dollars (Burrows 1958: 41).

In 1694, on the route between Holland and the Cape, 527 deaths occurred at sea and 143 deaths at the hospital, Burrows (1958: 24) cites an example of three ships’ figures for 1694 and ten ships for 1782:

Table 2

Comparison of illness and death statistics on vessels: 1694, 1782

Year	Men aboard	Dead en route to Cape	Sick arrival on at Cape	Percentage sick or dead on arrival at Cape
1694	256	85	103	73.4%
	345	74	163	68.6%
	159	60	83	89.9%
1782	2 653	1 095	915	75.7%

Source: Burrows (1958: 24) adapted

Note that the figures in 1782, almost a century later, showed no major improvement in mortality rates of the sailors, notwithstanding statements to the contrary in other literature.

The surgeons found the reason for these high deaths was due to the length of the voyage, the poor clothing, lack of fresh food and water, unsanitary conditions on board the ships as well as inadequacy of medicine. Sickness and high mortality rates meant delays, reduction in profits and possible loss of entire vessels.

A new hospital commissioned by Simon van der Stel in 1697 was designed to accommodate 500 patients. Completed in 1699, it was known as the Cape Hospital but always referred to as '*t siekenhuijs*' (Burrows 1958: 41). Van der Stel replaced Van Riebeeck's *regenten* in terms of a resolution of the Council of Policy in 1697 with the *Regulament voor 't siekenhuijs*. The board controlled the hospital and comprised members of the Council of Policy and their wives. The Council of Policy was the body of authority during the Company's rule at the Cape (Burrows 1958: 33). Systems were set up for the financing of health costs: seamen and Company staff were treated as a Company expense whilst surgeons consulted privately to townsfolk and their slaves.

The burghers or freemen were mostly used the Company surgeons at the hospital and there is a reference in official records of slaves being admitted to hospital for treatment by these surgeons, the owners of the slaves being billed accordingly (Burrows 1958: 45). 'As they made substantial sums in this way, they must have devoted a considerable part of the day to this private work'. (Searle 1965: 44) Daily cost per patient increased more than 160 percent in 55 years from 3 stuivers 5 penning in 1700 to 9 stuivers, 3 penning in 1755. Large amounts were spent by the Company to ensure that patients received good care. However, this was not achieved due to management problems in achieving the standards set by Holland (Searle 1965: 53).

The VOC was hailed for caring for sick crews arriving at the Cape by Mentzel, a German traveller to the Cape in the 1750's:

It reflects greatly to the credit of the noble Company. In it the sick and injured servants of the Company are attended and the weak and fatigued recuperate...Be it remembered to the everlasting credit of the Company that all the sick from any crews or passing vessels are taken to the hospital and tended, not merely as long as the ship remains in the Bay, but for six weeks thereafter without any charge whatever...⁹ (Burrows 1958: 47).

In the case of sailors in the Company's employ, they were remunerated at full pay during this time. All servants of the Company employed at the Cape were entitled to treatment with full payment for six months and another six months, thereafter at half-pay, after deduction of fifty percent toward hospital expenses. Should they not recuperate after a year and a day, their services were terminated and they were repatriated to Europe (Burrows 1958: 47). In 1748, this hospital was praised by Commissioner Nolthenius, however, by 1768 it was again blamed by the administration in Batavia for the high death rate.

The plight of the poor in the Cape

The earliest trace of relief toward the poor is four years after the settlement of the Dutch in 1656 when 'Van Riebeeck sent a sum of money collected locally by him for the poor of Holland' (Laidler and Gelfand 1971: 11) His efforts were snubbed by the Council of the Company who wrote back saying that he should cease collections for the poor in Holland and rather keep it for the poor in the Cape, who would appear in time. Van Riebeeck heeded the advice and established such a fund. By 1664, with only sixteen free families in Table Bay, church collections contributed toward relief of the poor, needy and sick, widows and orphans (Laidler and Gelfand 1971: 11). The Poor Fund soon amounted to 1,268 guilder, 16 stuivers.

⁹ It is not certain that this statement is aimed at sailors not employed by the VOC. See Searle statement contradicts this (1965: 38)

As the Company could not spend its funds on charitable institutions nor people not in its employ, the Church was used to provide poor relief. This is in line with the early religious nature of Poor Relief in Britain as demonstrated in Chapter 1. 'Before the establishment of a Congregation of the Dutch Reformed Church in 1665, no system for Poor Relief existed.' (Searle 1965: 58) The Company paid toward minister's salaries. The Church therefore took over this social responsibility and established the '*Diakonie*' (College of Deacons). These people set up boarding systems with widows and less well-to-do white families to care for the poor and destitute. Funds to pay for these services were collected on a voluntary basis and duties were mainly medical and social in nature (Searle 1965: 59). By 1667, Van Riebeeck's hundred '*volkeplanters*' had doubled, due to immigration and natural increase (Burrows 1958: 39).

In 1672, orphans became wards of the Church Diaconate. The *Weeskamer* [translated: Orphan Chamber] was established in 1673 in the Cape by the VOC. It was run by officials of the VOC and the Free Burghers. The *Weeskamer* registered and regulated wills, made inventories of deceased estates and dealt with insolvencies. As its name indicated, it primarily acted as guardians for orphans. It was established for most of Cape Town's citizens, rich and poor. In 1691 there were thirty six pupils which expanded by the year 1700 to one hundred and seven. Orphan funds were invested by the *Weeskamer* and, in the absence of banks until 1793, also acted as a loan institution (Baikoff 1988: 8). This institution was abolished by William IV, King of England by proclamation in March 1834. The duties of the *Weeskamer* were taken over by the Master of the Supreme Court in the Cape.

There is reference in Laidler to the Cape Town Poor Fund during the period 1710 to 1750. The poor had become a continued source of concern to the Dutch Government who 'wondered whether any more people could be settled at the Cape without becoming a charge upon the Company or the Poor Fund for subsistence' (Laidler and Gelfand 1971: 45). At this stage, it was debated by the Company to bring in European farm servants who would be cheaper than slaves. The Poor Fund

was utilized primarily for land, housing and furniture and ‘assistance of the suffering and indigent sick’ (Laidler and Gelfand 1971: 46). Donations came mostly from the wealthier burghers.

The surgeons were in the employ of the Company but continued to consult privately with the burghers. During this period there is evidence of surgeons entering into annual contracts in advance with the burghers for the provision of health services. It was common practice to pay with produce from the farm such as barley, sheep and butter. Surgeons performed these services mostly at the homes of the burghers as rarely would they consider going to the hospital which was for ‘rough sailors and common soldiers’ (Laidler and Gelfand 1971: 46). The disparity between the rich and the poor in health funding is obvious.

During the smallpox epidemics, the Company relinquished its policy of admittance of employees only to their hospitals and provided temporary isolation facilities. Smallpox broke out in the Cape in 1713 which hit the Khoisan hardest. In addition, a fifth of the slaves died. In 1755 almost 2 000 whites and slaves died, wiping out many of the Hottentot tribes (Burrows 1958: 64).

The first suggestion of separate hospital facilities for slaves is witnessed when doctors suggested to the Council of Policy separate houses for the sick slaves with their own surgeon in attendance (Laidler and Gelfand 1971: 55). Two hospitals were established by the Company during these outbreaks, one for the slaves and another for poor Europeans. The richer burghers received treatment at their homes and were charged a fee and an additional fee of ¼d a day for their slaves, if admitted to hospital. Burgers still continued to pay fees to the town church in the event of death. This covered the costs borne by the administrators or ‘*Diakonie*’ during illness, including the setting up of empty houses as temporary hospitals for the poor sick. This section clearly illustrates the differences in health funding between the rich and the poor as well as evidence of the employer’s responsibility to fund the employee’s health expenditure.

Searle (1965: 55) stated: ‘persons who were independent and self-supporting was against the idea of hospitalisation of the sick. This idea had been transplanted from Europe’. This dissertation supports this statement and shows that attitude played a major role in setting the foundation for private health care in South Africa. Burghers at the Cape were consolidated in the attitude that ‘Poor Relief’ originated largely from a medico-social nature whereas in Europe the homeless, destitute and incapacitated were cared for by charitable institutions.

The standards of patient care at the Cape were still comparatively better than those in Europe: ‘Poor standards of patient care prevailed throughout Europe in the eighteenth century. ‘According to the Dutch historians, these standards were much lower than those which existed at the Cape’ (Searle 1965: 53). According to Searle this can be attributed mainly to the commercial purpose in which hospitals were run to nurse the labour force back to better health, whereas in Europe the purpose was ‘Christian care of socially and physically destitute people’ (1965: 53). There was therefore a commercial interest in curing people and having a healthy workforce for the Companies’ financial benefit. Sickness and high mortality rates meant delays, reduction in profits and possible loss of entire vessels. Searle however points out that poor local management undermined the Company’s good intentions at the hospital:

Enormous sums of money, by the standards of that day, were spent by the Company in order that the patients should have good care, but money could not put right the inability of the officers at the Cape to manage a hospital on the lines desired by the authorities in Holland. Patient day costs increased from 3 stuiwers 5 penning per man day in 1700, to 9 stuiwers 3 penning in 1755, but the benefits did not show a proportional increase (Searle 1965: 53).

During 1754, Governor Swellengrebel persuaded Nicolaus Fuchs of Rensburg to stay on as surgeon to provide civil medical services. The latter applied for and received a grant of land as his services became essential to the public. In 1759, the Company, in an attempt to provide civil health assistance to a growing number of burghers, provided private ground to Chief Surgeon Jan van Schoor in order to erect private consulting rooms (Laidler and Gelfand 1971: 51).

In 1768, a report from Batavia to the Heeren Zeventien blamed the conditions of the Cape hospitals on the high death rate at the *Binnen Hospitaal* in Batavia citing 2 039 deaths in 1766 (Burrows 1958: 49).

Foundations for a third hospital, called the 'New Hospital', later known as the Caserne, were laid during between the church and the castle in 1772. Designed to accommodate 1 450 patients: 'It was the first time in the history of the Cape that patients, other than employees of the Administration, were allowed into the hospital' (Laidler and Gelfand 190 71: 64). In 1780, there were 307 housed in the old, dilapidated hospital. It was finally sold, including the site, for 54,583 rds or £4,093 (Laidler 1937: 12).

During the 1780's health and sanitary conditions on board Dutch ships did not receive much attention from the Company. 'The fact remains that the malnourished human flotsam which comprised the crews could not withstand the rigours of the outward-bound voyages' (Searle 1965: 39). Company servants at the Cape were similarly treated in terms of health and sanitation. In 1795, the entire new hospital became barracks for the different regiments sent to the Cape.

Around 1775, the Burgher Council governed Cape Town and was in control of social, and therefore public, services. This included health matters such as prevention of water pollution. The Cape Patriots 'rebelled against the monopolistic and bureaucratic control that the still-Honourable but fast declining Company exercised over them' (Burrow 1958:63). The Burgher petition marked the first signs of nationhood in South Africa.

The VOC diminished through corruption, competition and the war. That it would failure had become quite evident by 1780 and it was finally liquidated in 1798.

In summary, during this era health care and the funding thereof were mostly provided by the only employer in the Cape i.e. the Dutch East India Company. The balance was provided as a social obligation by the Company toward non-

employees and locals who did not have the means to pay for such services. The individuals who had the financial means to do so, contracted privately with providers of health care services. There were no regulations in regard to the provision of health care services.

2.2 First British Era (1795 – 1803)

This era witnessed an important shift in health funding from the Company to the British military however it was generally felt that the frequent changes in administrators at the Cape after 1795 did not have a significant effect. Burrows (1958: 71) states ‘its administrators possessed basically the same outlook: they were all products of the New Europe’.

On the 16th September 1795 The British annexed the Cape. The Dutch and British had found themselves on opposite sides during the Napoleon war and the British needed to safeguard their route to the East. Ownership of the hospitals passed to the British Government and became military hospitals. The number of Dutch patients decreased dramatically as personnel from ships from the Company no longer could be tended for at these hospitals. The British had excellent organisation and administration skills/systems, which forged the all important step in the development of medical reform at the Cape.

The plight of the poor remained undefined: ‘Generally the care of the poor in the land was subject to individual and sectarian conscience’ (Laidler and Gelfand 1971: 88). Rice rationing to the poor was probably the ‘first such instance of official care in South Africa’ (Laidler and Gelfand 1971: 88). There was evidence of institutional housing in 1799 when a widow Moller presented a scheme to the authorities for the provision of a home for old women. This grant was approved nine years later.

The disparity between the rich and the poor continued to be in evidence at the Cape. On the one hand there was rice rationing to feed the poor, while on the other

hand there were high salaries paid to the upper classes of society. Back in 1652 Van Riebeeck started his refreshment post on a monthly salary of £75 (Muller 1984: 585). By 1797 the first British Governor at the Cape, Lord Macartney earned £10,000 per annum plus a £2,000 entertainment allowance which made him 'comparatively speaking one of the highest-paid civil servants in the history of South Africa' (Muller 1984: 585). In comparison, a District surgeon in the Cape country earned £100 to £150 per annum and could derive additional income from private practice.

This era witnessed the onset of social services:

With the nineteenth century an era of practical religion commenced for South Africa that was to give birth to social services. It was to become a period for the improvement of the sense of personal responsibility to the poor as well as the betterment of their environment for both white and black (Laidler and Gelfand 1971: 83).

This sentiment is shared by Searle: 'Prevention of physical and mental breakdown and the care and rehabilitation of the sick is a basic social service. National healthcare is a fundamental requirement for national wealth and greatness' (Searle 1965: 182).

2.3 Batavian Era (1803-1806)

In 1803, the Cape reverted back to the Dutch in terms of the Peace of Amiens. As the VOC had dissolved, it reverted to the Batavian Republican Government and became a province of the Netherlands. The hospital became state-controlled and its staff, public servants. The hospital was referred to as *Groot Hospitaal te Cabo de Goede Hoop*. It was still a military hospital and the Principal Medical Committee in Holland tried to introduce beneficial regulations to regulate practitioners. By then the total civil population of the Cape and Stellenbosch totalled 24 485 in respect of Europeans and slaves only.

Negotiations between the Batavian Republic and the British government had already commenced in 1802 and military and naval staff figures reduced. The great army hospital was taken over by the Batavians and regulations for the provision of medical services were printed as detailed below (Laidler and Gelfand 1971: 84). The hospital was run as a military institution and only soldiers and sailors, including foreign sailors, were treated. Searle writes: 'Although mainly intended for soldiers, sailors from passing Dutch ships and civilian paupers were also admitted to it, though they appear to have been confined to male patients' (1965: 60).

In June 1802, regulations were printed for the medical services of the Batavian troops at the Cape. 'Regelen van den Geneeskundigen Dienst by de Troupes der Betaafsche Republiek aan de Caab de Goede Hoop 1802.' The Batavians also established the first Health Bureau or 'State Health Department' in this country (Searle 1965: 61). It was initiated by authority of the Batavian Council of War to administrate medical services to the troops and the hospital and to advise the Commander-in-Chief on medical matters: 'It corresponded fairly closely, therefore, to the Medical Department of the British Forces during the Occupation' (Burrows 1958: 96). Burrows added that most medical staff had a diploma of the medical department of the National Republican Army of Batavia. The health department was housed in the hospital and provided services such as vaccinations to the public. During this time social, rather than medical, services were rendered to the poor at the gaols.

Benjamin Thompson, the person referred to in Chapter 1.2 as the originator of the system of administration of the poor in Munich became Commander-In-Chief of the general staff of the Batavian Army in 1790, where he became more involved in the problem of providing relief, in particular supporting the poor and instituting cleanliness regimens for the poor, where disease was rife.

Forty years later, Batavia maintained their poor based on these principles. In addition, it was operating a public employment bureau almost 100 years in advance of the English Labour Exchange and the United States Employment Services.

It would be reasonable to assume that the principles of this treatment of the poor had filtered down to the Cape when it became part of the Batavian Republic in 1803.

The Batavian authorities had a significant influence on the development of the medical history in South Africa, notwithstanding its short span. During this time several laws addressing health issues were passed, such as public responsibility for sanitation, care of sick and the poor.

2.4 Second British Occupation (1806 – 1815)

On the 10th January 1806, the British re-captured the Cape from the Batavians and took control of the Colony. The military government managed the civilian medical profession. Public medical services improved as services were monitored and regulated.

The Slave Lodge continued to operate until the second British occupation in 1806. Trafficking of slaves was abolished in 1807. Sick slaves were transferred to rented quarters in 1811. The morals and education of the slaves were also overseen by the surgeon in charge, usually a military officer.

The Supreme Medical Committee was established in 1807. The ‘First Medical Proclamation’ issued in the Cape was on 24 April, 1807¹⁰ arising from ‘the disgraceful state of the medical art in the Cape’ (Laidler 1971: 104). Laidler (1937: 4) declared ‘probably is the most important in the history of South African medicine’. This was to regulate the sale of bad drugs ‘and the practice of medicine by unqualified and untrained persons’ (Laidler 1971: 104). Tariffs and fees were

¹⁰ Laidler (1937: 4) shows this as August 18th 1807

published in terms of the ‘Second Medical Proclamation’ dated 18th August 1807 (Laidler and Gelfand 1971: 107). The medical committee was mainly presided over by the Principal Medical Officer of the Army in the Cape. By 1810 the military and naval establishments formed the basis for progress in the medical and healthcare professions. The six regiments in the Cape each had its own regimental hospital serviced by professionals.

Severe poverty prevailed and in 1812 the ladies of Cape Town collected 2 666 rixdollars for the relief of the poor. Calvinist and Lutheran churches provided for their own poor. At the time, slaves had to be provided for during old-age by their owners (Laidler 1971: 120).

Searle (1965: 66) states that, although the Cape was a British Colony, South African medical practitioners were far ahead of their British counterparts. This included legislative issues – Britain registered their doctors only in 1815 in terms of their Apothecaries’ Act whilst South Africa did so in 1807 by means of the establishment of the Supreme Medical Committee.

2.5 British Colonies and the emergence of Republics (1816 – 1898)

The Cape Colony

In the 160 years since Jan van Riebeeck released the Free Burghers on the Liesbeeck ‘no provision had ever been made for the institutional treatment of the civilian sick’ (Burrows 1958: 107). The hospitals in the Cape were either provided by the employer (Dutch era) or the military (British and Bavarian era’s) whilst the *status quo* may have changed during epidemics.

During 1814 the only hospital in Cape Town was the exclusive military hospital the 'Groot Bataafsche Hospital'. Merchant seamen were not allowed since the British occupation and were treated with paupers in gaols. 'The contrast between military and civil provision was evident'. (Laidler and Gelfand 1971: 141) 'The Government drew the attention of the Burgher Senate to the increasing free population of the town, the number of strangers and an augmenting commerce, which induced His Excellency the Governor (evidently not for the first time) to recommend in the strongest manner the establishment of a hospital' (Laidler and Gelfand 1971: 141). The establishment would depend on public, voluntary subscriptions. Governor Somerset provided the land for the hospital to be built on.

The First Private hospital - 1818

The first private hospital was the Somerset hospital. It was erected at the private expense of a doctor Samuel Silverthorne Bailey and was officially opened on 1 August 1818. He posted a notice in the *Cape Town Gazette*:

...he intends opening his Hospital and Lunatic Asylum on the first of August, for the reception of Merchant Seamen and the Slave population of the Colony, on the under-mentioned Terms...the Hospital will be **established on similar Principles with those in Europe** [emphasis added] and he begs leave to remark, that nothing shall be wanting in his Power, to render the same useful and comfortable (Burrows 1958: 109).

Annual Subscriptions were to be paid in advance for groups of slaves in respect of medical treatment and medicine. Additional fees were levied in the event of hospitalization. By 1820, Bailey offered the buildings to the Burgher Senate as the mortgage payments were a burden. In 1821, it was taken over by the local authority at a price of £4 500 and became known as the 'Town Somerset Hospital'.

The table below gives a comprehensive overview of the population of the Cape within the different Groups. It is interesting to note that there was one private hospital catering for a population of over 105 000 people.

Table 3**The population of the Cape in 1820**

Town	Christians/ Europeans	Free Blacks	Hottentots [Khoisan]	Bantu Apprentices	Slaves
Cape Town	7 646	1 797	443	851	7 090
Cape District	2 584		837	356	3 526
Simonstown	544	135	181	99	221
Stellenbosch	5 500		1 769	154	9 007
Swellendam	5 740		2 793	30	2 875
Graaff-Reinet	10 244		10 146	12	2 487
Uitenhage	3 066		3 560	35	782
Tulbagh	4 394		4 557	35	4 047
George	3 389		2 689	1	1 754
TOTAL	43 107	1 932	26 975	1 573	31 789

Source: Laidler and Gelfand (1971: 146)

Note: Total population 105 376. Government slaves totalled 150

In 1828, the Slave Lodge became known as the Hospital for infirm government slaves and government apprentices only in this year were slaves allowed to visit the Somerset Hospital, when it became a government hospital (Laidler and Gelfand 1971: 237). Slaves were emancipated in 1834. Searle (1965: 67) states that although conditions at these slave quarters were deplorable, this was no worse than conditions in British workhouses up to the middle of the 19th century. The Infirm Hospital at the Slave Lodge ceased to exist as such in 1839, yet in 1841 it still cost the Government £155 and had 11 white and 77 coloured inmates (Laidler and Gelfand 1971: 238,239).

According to Tomlinson (1955: 5), Ordinance 50 issued in the Cape in July 1828 made the Xhosa equal to the European in law. This was achieved only because the London Missionary Society had put pressure on Britain against disguised slavery in protest against the Pass Proclamation and apprenticeship systems of the Cape Governors.

The old order in the Cape was changing: English became the official language, the currency changed from the rixdollars to the pound and the *Weeskamer* was abolished. The abolishment of the latter led to the establishment of the world's first trust Company, founded in Cape Town on 22 April 1834. It was called the South African Association for the Administration and Settlement of Estates. On 22 August 1838 the Board of Executors (BOE) was established and continued until recently.

The Home Government in Britain devised a scheme to attract 'unemployed Britons' to man the frontier at the Zuurveld in Grahamstown against the Xhosa. This scheme became known as the '1820 Settlers'. Less than half the settlers were farmers, the rest being skilled artisans and professional men (Burrows 1958: 165). The arrival of the 1820 British settlers had a large influence on the local society where Dutch rule had officially ended. Almost 4 000 Britons arrived who were offered free passage and provisions as well as land (Burrows 1958: 160). The Colony became unilingual, in particular: English when magistrates resided in the Courts, missionaries moved north to convert the heathen. 'It was the age of philanthropy and awakening social conscience and each of the mushroom benevolent societies provided work for one or more of the town's practitioners' (Burrows 1958: 137).

The three decades following the arrival of the 1820 settlers is seen as important in the evolution of South African history. The Cape Colony and Natal became established British Colonies and Transvaal and Orange Free State became Republics with the settlement of the '*trek-boeren*'.

Barry period 1816-1826

The period 1816-1826 is known as the 'Barry period' and refers to a Dr James Barry. It is said that he was one of the most outstanding practitioners to have performed in South Africa and also a leading social reformist. During this period progress was made in regulating the dispensing of medicine as well as the quality

of medical practitioners employed. A Colonial Medical Inspector and a Director of the Vaccine Institute was appointed. Barry suggested that regulations be promulgated to govern the district surgeons' work. Police officers, prisoners, convicts, apprentices and paupers were treated free of charge and surgeons were reimbursed by the District (Laidler and Gelfand 1971: 153).

The condition of health institutions continued to deteriorate and complaints against Governor Somerset reached England whereupon a commission was appointed during 1825. The Colonial Medical Committee was abolished upon orders from England. The Supreme Medical Committee of 1825 was re-established. In the same year, the Supreme Medical Committee became the Colonial Medical Committee and 'this committee was to superintend all civil medical concern of the country and was given power to examine and license medical practitioners' (Laidler and Gelfand 1971: 209). It was duly controlled by civil practitioners. The 1823 Medical Proclamation in respect of tariffs was revised and the new ordinance no 82 of 1830 was proclaimed. In addition, hygiene standards were introduced as well as hospitals built to care for the poor.

On 1st October 1821 the same doctor Bailey opened another private hospital, the Merchant Seamen's Hospital. As in the case of his previous hospital, services were advertised in the *Cape Town Gazette* aimed at 'Merchant Seamen, Free people of all Descriptions and Slaves' (Burrows 1958:112). This increased demand forced Bailey to approach the directors to create a 'poor fund'.

By 1826, conditions at the Somerset hospital were dismal. Searle (1965:70) states that, in line with British custom, pauper convalescent patients assisted more serious patients in order to keep costs down. Management of the Somerset hospital changed in 1827. At this time, a surgeon was earning 2 500 rixdollars or £187. The Town Trustees were appointed as trustees to the hospital. Government was unhappy with municipal conduct, which led to an investigation by the Secretary of State in London. From 1828, all fees had to be paid into a Colonial Treasury from which expenses were paid. Officials had discretion to change fees depending on

circumstances. The Superintendent of Police or the police surgeon could send patients they deemed as ‘nuisances to the Community’ to the hospital. The hospital was used by ‘townspeople for admission as paupers’ with consent being obtained, even at a later stage, from the Governor (Laidler and Gelfand 1971: 216).

In 1831, smallpox broke out again, this time within the Griquas community that claimed as much as 90 percent of their population. In 1839, measles broke and spread from the Cape to Pietermaritzburg. The poor were treated at the Slave Lodge at no cost and by June of the same year it was proposed to the Government that doctors took care of the poor whilst the Government provided medicine at no cost. During this time public health prevention and practice was still in ‘trial and error’ stage (Laidler and Gelfand 1971: 273). Despite this huge loss of life, these epidemics were important as the authorities recognised that ‘epidemics are preventable to a great extent by public health measures’ (Burrows 1958: 304). This led to the first purely medical legislation proclaimed by the Colonial Parliament namely the: Contagious Diseases Act (No 1 of 1856).

The white population was dominated by the Dutch Afrikaners¹¹ who were prepared to submit to British Rule; however, a republican minded minority on the northern frontier resented Imperial interference. On 1st December 1834, slavery was abolished in the Colony by Britain. The slaves were to become apprentice labourers within a minimum period of four years. This gave rise to the exodus of 5 000 *Voortrekkers* from the Cape to the North-Eastern frontiers between 1835 and 1838, known as the Great Trek. This is referred to as a ‘centre point’ in South African history where in less than 20 years the area of white domination had more than doubled itself (Burrows 1958: 188).

The Eastern Province became a British colony in 1834. Governmental hospital expenditure for the Western (Cape) and Eastern Regions (i.e. Uitenhage, Graaff-Reinet) were estimated at £4 604.6.8 during 1837 (Laidler and Gelfand 1971: 289). The apothecaries sent medicines at their own expense to the region. Although

¹¹ Also termed ‘Boers’ which means ‘farmers’ – see Lehmann J (1972) *The First Boer War*

official civil establishments are not mentioned, district surgeons were present in the Cape Country areas. Makeshift hospitals were erected during this time, but only in 1843 was permission granted to build a military hospital at Fort Beaufort. More military 'hospitals' were erected. Examples are Trumpeters Drift, Fort Brown and Waterloo Bay. According to Laidler: 'The medical organisation of the military forces employed in these border wars was excellent...' (Laidler and Gelfand 1971: 294).

After the 5th Frontier War in 1835, Sir George Gray settled German legionaries in Kingwilliamstown to create a nucleus for a white frontier against the further invasions of the Bantu. The province of British Kaffraria was proclaimed a Cape Colony Province after the 6th Frontier war. It was 'solely a military and buffer state, under direct Imperial control' (Laidler 1971: 295).

By the 1840's, the lepers and mentally unstable were moved to Robben Island. These patients were only charged a fee if they had the means to pay. There was no distinction between Black, White or Coloured. In 1846, Robben Island was destined to become home for 'the destitute old and sick poor' (Laidler 1971: 240). The only two medical institutions left in the Cape in 1846 were the Somerset Hospital and the 'Hemel en Aarde' Leper Asylum. In 1863 the old Somerset Hospital was re-opened to accommodate the overflow from Robben Island (Laidler 1971: 365).

During the period 1827-1840, prospective medical doctors still preferred studying in Leyden, Holland (13 South Africans registered at this university during this time). This was notwithstanding British Rule that continued for almost 25 years. By 1880, most South African undergraduates were studying medicine in Scotland (Burrows 1958: 149). Influences from these countries would have been carried back upon their return.

Conditions deteriorated at the Somerset Hospital until the appointment of an Inspector of Colonial Hospitals from 1840 to 1856. Quarterly visits were

conducted by Army medical officers. During 1842, most admissions were from the Government and totalled 103 made up as follows: Colonial Office patients 77; Police 22; Emergencies 4 (Burrows 1958: 120). Hospitalized patients were charged 1s.3d a day with a special tariff of 3 shillings a day for 'those of a higher class including masters and chief officers of ships and all other persons who are able to make the payment' (Burrows 1958: 120).

The different religious institutions and benevolent sectors of the population attended to the poor during the late seventeenth and early eighteenth centuries. This voluntary method of funding was only subsidised by the State when funding was found to be inadequate. These payments by the State can be seen as an indiscriminate method of funding.

The provision of medical services improved to such an extent in the mid-1850's that a firm foundation by local medical practitioners was laid for future medical care (Searle 1965: 65). In the 1850's, the Cape had a military hospital, a naval hospital, Robben Island, the Somerset hospital, the Vaccine institute and the old lunatic asylum, with the Colonial Office in complete control of these establishments.

The provision of care for the poor and sick by religious institutions in the development of the South African health cannot be underestimated. The first women belonging to a religious order arrived in South Africa on 3 December 1849. These Roman Catholic and Anglican women were highly trained nurses and arrived from many parts of the world to attend and educate the poor and sick in all parts of South Africa, including the most remote parts (Searle 1965: 153).

According to Burrows, the medical profession underwent a peaceful revolution in the decades following the 1850's due to the discovery of diamonds and gold and the vast influx of people it created. The number of licensed practitioners in the Cape trebled from 105 to almost 450 in the two decades following 1865, the

majority settling in small villages where previously only quacks and ‘*wonder-doeners*’ had practised (Burrows 1958: 325).

In 1852, the Somerset Hospital admitted patients based on the employer’s guarantee based on outstanding wages owed to the ill person. ‘Paying patients were now admitted on a charge of two shillings a day...’. (Laidler and Gelfand 1971: 353). This had to be deposited prior to treatment or guaranteed by a responsible person. Government issued orders to admit non-payers for free as well as accidents and emergencies as they occurred. According to a report to Parliament in 1856 regarding the Somerset Hospital, free treatment was given to 1 500 people annually between allocated times each day. In 1855 fees received totalled £284.2.3 versus net cost to the public of £1,646.6.3½ (Laidler and Gelfand 1971: 353).

In 1853, a representative government was introduced at the Cape. Khoisan, Coloured persons and Bantu who fulfilled the qualifications for the franchise received an equal vote to the Europeans and were placed on the common electoral roll (Tomlinson 1955: 5). Khoisan were settled on the banks of the Fish and Kat rivers.

Local initiative prompted the opening of two of the country’s biggest hospitals in the Eastern Cape, namely the Albany Hospital in Grahamstown and the Provincial Hospital in Port Elizabeth. The hospital in Grahamstown remained private until 1858, when the Albany Hospital opened its doors to the public. In 1859 expenses totalled £1 000 and of the 63 Europeans treated, 14 people paid a total of £38.10.0 (Laidler 1971: 354). The founding statement of the Albany Hospital confirmed the fundamental rule that: ‘... all sick, wounded or diseased persons are to be admitted irrespective of their colour and that religious beliefs or professing or belonging to any particular Creed or Religion is to form no bar against admission’ (Burrows 1958: 315).

During the 1860’s, the doctors accepted produce and stock as compensation. Farmers and officials would pay cash, but this was not common. With the

development of the rail system, came the new post of the railway medical officer. Patients requiring care erected flags along the railway and spotted by the railway medical officer. The train would be stopped and aid provided. The schedule of medical fees for medical practitioners employed by the Cape Government was £15 to £20 a year. Their duties included visits to the gaols, autopsies, etc (Laidler 1971: 336).

The New Somerset Hospital opened its doors in 1862 and accommodated 130 patients. It remained a hospital for merchant seamen but fell under the auspices of the Governor of the Colony. In 1863, the number of paying patients reduced which Laidler attributes to the fall in merchant seamen, the largest percentage of contributors and the development of sick clubs and benefit societies during the railway works. During 1866 proposals were made for voluntary subscription to support the hospital, on the same lines as existed in Grahamstown and Port Elizabeth. During this time, it was generally felt that the Colonial Office was not the best authority to decide which type of patients should be admitted (Laidler 1971: 356).

Generally, it was thought that more could be done for the sick and poor and processes were put in place to enhance the confidence of the public. By 1897 the hospital had 124 daily in-patients and received annual support from the Government amounting to £10 000. 'The Colonial Secretary again proposed (1897) to place the Somerset Hospital on a similar footing to that of other state hospitals, without enforcing the usual voluntary contribution toward its upkeep equal to the grant from the Treasury' (Laidler 1971: 441). The proposal was subsequently accepted and a constitution was approved by the Government and the Board elected.

Another private hospital was erected in Faure Street, Cape Town in 1897. It is not clear how ownership was vested, although Laidler noted that 'The management was by a medical committee which met half-yearly or more often if required' (Laidler and Gelfand 1971: 441).

The problem of providing for sick paupers in a sparsely populated environment led to authorities setting aside a few rooms in each gaol for accommodation of the sick. These gaols catered primarily for indigent Khoisan, foreign adventurers and sick prisoners. The Dutch and English had set up their own system of health care and did not require this social service (Searle 1965: 72).

Table 4

Number and Percentage of patients treated and deaths in gaol and other hospitals for the year ended 31 December 1890

Class of hospital	Total number of cases treated	Percentage of total	Number of deaths	Percentage of total
Gaol and convict hospitals	5 000	37.9	134	14.7%
Other hospitals	8 170	62.1	775	85.3%
Totals	13 170	100.0	909	100.0%

Source: Searle (1965: 72)

Wives of the chief jailers became the matrons and were paid a fee. ‘On 25 May 1854, the authorities gave instructions to all district surgeons to render free professional service to all sick prisoners, and to such paupers as had been admitted to hospital by order of a magistrate’ (Searle 1965: 72). According to Searle, the combination of the gaol system with the service provided by district practitioners to the poor started the concept of large public hospitals in South Africa.

The first African Hospital

The Governor, Sir George Gray, approved the first African hospital in a pensioners’ village in Kingwilliamstown in 1856. The reason for this hospital was not only humanitarian, but also political. Grey wrote to the British Government:

The plan I propose to pursue is to attempt to gain influence over all the tribes between this Colony and Natal....by employing them upon public works which

will open up their country; by establishing institutions for the education of their children, and the relief of their sick... (Searle 1965: 125)

As a result, the Imperial Government approved an annual grant of £40 000 for 'a sufficient European population for British Kaffraria to vanquish in arms and conquer by civilization the native tribes...Sir George Grey envisaged a medical scheme for Kaffraria which was to consist of a large central hospital with small feeder hospitals and dispensaries serving the outlying areas' (Searle 1965: 125). The duties of the Superintendent of the African hospitals included health care for missionaries. Europeans were admitted from time to time, strictly only if they could not afford medical care. The first concerted attack was launched by the same Sir Grey: 'The witch-doctor, the traditional medical consultant of the indigenous inhabitants of Africa whose vigorous opposition to European medical methods has yet to be overcome in Africa' (Burrows 1958: 192).

Dr. Fitzgerald was appointed to personally supervise the erection of the African Hospital in Kingwilliamstown. Although he was allowed to conduct a private practice, he soon found himself devoted to providing services to the inhabitants of the town, including free medical assistance to missionaries and their families and the Xhosas. The national suicide caused by starvation of the AmaXhosa in 1857 led to 37 000 people surviving out of a total of 105 000 (Tomlinson 1955: 8). On 11th June 1859, the Grey Hospital and Frontier Medical School in King Williamstown opened its doors to both black and white patients (Burrows 1958: 180).

Farmers 'and others of a similar class were charged three shillings a day' (Laidler 1971: 298). A standard treatment cost one shilling and threepence a day. This was reduced depending upon circumstances. Paupers were free if agreed by authorities, the cost being borne by the State. Patients included Africans, Dutch, German and English. After the outbreak of yet another smallpox epidemic in 1859, the hospital had to apply for a grant to alleviate their overdraft in the bank. Several reports were made to the Governor on the difference the treatment had made to the patients. These reports seem to be an attempt to alleviate the deteriorating hospital

and Laidler remarks: ‘Soon it was realized that the civilization by Western standards of masses of Africans in an illiterate state, was hardly possible through a few missionaries and doctors’ (Laidler 1971: 302).

By 1891 the Government ceased financial support to Grey hospital and it became dependent on voluntary subscriptions. Parts of the cottages on the premises (previously referred to as pensioner’s cottages) were let out or sold to defray expenses (Laidler 1971: 440).

This table shows the total medical expenditure of the British Government.

Table 5

The medical expenditure voted in by Parliament in 1878

Institution	Expenditure	Daily average in-patients
New Somerset	£7 114	112
Old Somerset	£4 796	208
Robben Island Infirmary	£16 056	About 300
Grey Hospital KingWilliamstown	£?	89
Lunatic Asylum Grahamstown	£4 924	61
Provincial Hospital Port Elizabeth	£5 222	63
Albany Hospital Grahamstown	£1 689	20
Midlands Hospital Graaff-Reinet	£2 505	?
Frontier Hospital Queenstown	£1 132	17
Total	£47 872	

Source: Burrows (1958: 324)

Note: Totals exclude questioned areas.

In 1875, the Cape Colony census was taken where the total population equalled 720 984 (Laidler 1971: 467). The population was stated to be homogeneous. The mass of the people were agricultural with small groups of artisans in small towns. ‘The healthiest race appeared to be the African’ (Laidler 1971: 373).

During this time a marked change could be seen in the demographic make-up of the country. Towns expanded as a result of urbanization. Clubs, Societies and Associations had been established in larger towns. By 1880, Cape Town had 19 Masonic Lodges, 9 general hospitals, 298 doctors and 179 chemists. This figure excluded military or naval institutions (Laidler 1971: 373).

Social insurance

Olivier (1999: 13) distinguishes between social insurance and social assistance and explains the difference as follows: Social insurance originated during the Bismarck era and was financed via contributions of a group of people. Social assistance is financed from the general revenue of the country and administered by the State as seen in the Beveridge model in the 1940's, detailed in Chapter 3. Oliver also states that normally social assistance is superseded by contributory social insurance.

The origin of social insurance is found in Germany during the period 1881-1889. As its name indicates, social insurance was financed by compulsory contributions, normally the employer and employee, but the State could contribute as well. Workers contributed to a fund, spreading the risk and supporting others. Solidarity of the workers plays an important role in the concept of social insurance. The social partners were organised business, organised labour and the State (Olivier 1999: 13).

Chancellor Bismarck established the principles of the welfare state whereby the passage of social insurance gave rise to legislation. According to De Schweinitz, his underlying motive was to win over votes. His social reforms included the introduction of workmen's compensation when the Emperor suggested insurance against accident and sickness in his address at the opening of the Reichstag: '...those who are disabled from work by age or invalidity have a well grounded claim to greater care from the state than has hitherto been their share' (De Schweinitz 1943: 204). The Reichstag enacted legislation in 1883 affording

insurance against sickness. Two thirds of the medical system for sickness insurance was funded by the workers, one third by the employer. Invalidity and old-age insurance was separated from sickness insurance and came into effect in 1889.

Similarly in the 1870's Britain started an active campaign toward social insurance. *The Times* 8 December 1871 is cited by Rose: 'Even if we give it up as a bad job and confess that Prussia beats England in Social organisation, as in a few other matters, let us be honest and wise and admit the fair inference that the fault lies within ourselves' (Mommsen 1981: 67).

Reverend Blackley was instrumental in proposing a national compulsory insurance model where young people between 18 and 21 contributed to a State fund which would ensure the contributor receive sick pay of 8 shillings per week should they become unable to work due to illness. Many other suggestions for voluntary, aided and unaided schemes emerged, however Charles Booth called for a universal pension of 5 shillings per person after the age of 65 to be paid out of current taxes.

When the Labour Party came into power in 1905 and people saw government as a means for social change, particularly with people such as Winston Churchill who launched a broad attack upon poverty. The great period of social legislation started in 1906 and in 1908 the Old-age Pensions Act was passed, based on Charles Booth's proposals. This 'represented a dramatic step away from the Poor Law' (De Schweinitz 1943: 206).

According to De Schweinitz, apart from the German influence, there was precedent for health insurance derived from benefits extended by friendly societies and trade unions. During 1909, Lloyd George announced that the Board of Trade was working on a scheme: '...which, while encouraging voluntary efforts of trade unions, would extend the advantages of insurance to a larger circle of workmen, including unskilled workers' (De Schweinitz 1943: 206).

Taking inspiration from a fundamental characteristic of English life – the thrift of the people as expressed in the friendly societies, the cooperative societies, and the mutual-benefit features of trade unionism, and utilizing with appropriate modifications the program developed by Bismarck in Germany, social insurance provided a system through which the government aided the people to pool their resources as a means of obtaining security (De Schweinitz 1943: 208).

On 19 May 1909, the British Prime Minister Winston Churchill announced government's intention to implement a compulsory insurance scheme. After two years of campaigning, on December 16, 1911, the National Insurance Act passed. Part I provided for Health Insurance: 'Health Insurance was administered through approved non-profit societies, organised by friendly societies or labour unions, or as adjuncts of commercial insurance companies' (De Schweinitz 1943: 207). Industrial insurance companies established societies and persons could purchase industrial insurance via the corporates. 'This Act was a significant departure from previous policies and was introduced by its sponsors with specific reference to the parallel German experience' (Hennock quoted by Mommsen 1981: 84).

Social insurance was now legislated in Britain and David Lloyd George, Chancellor of the Exchequer, took the lead. He was personally influenced by Bismarck's program when visiting Germany in 1908. Mommsen (1981: 97) refers to the *Memorandum on Sickness and Invalidity Insurance* which accompanied the Bill in May 1911. It is pointed out in the opening statement that the fundamental difference between the German and British systems is that of organisation. The British Scheme combines sickness and invalidity insurance, whereas in the German scheme these are administered separately. It explained the British system as being superior to the German on the following grounds:

- a. Administration would be entrusted to established, or still to be founded, friendly societies
- b. As the State will not make good deficits due to non-attendance, the above societies would be encouraged to look after administration of the scheme

- c. The British system assumed the principle of self-government whereas the German system was more bureaucratic in its management.

The National Health Insurance Act provided for two types of benefits namely a cash maternity or disability benefit and medical services in the event of illness. Both the health insurance and unemployment schemes were reliant on contributions of the state, employer and employees. 'All manual workers between the ages of sixteen and sixty-five, as well as non-manual workers earning below a stipulated maximum, were required to contribute to and participate in the program' (Feldman 2000: 16). This minimum was initially set at £160. [It increased to £420 in 1941]. Persons could make use of the services of medical practitioners anywhere. Only medical practitioners remunerated on a per capita basis could refuse treatment.

By 1913, more than ten million people were insured in terms of this Act, however according to Verhoef (2007: 21) this model, although closely followed in Canada, was not followed in South Africa at the time.

De Schweinitz concludes by explaining the difference between relief and health insurance. Relief is based on need where the individual looks upon the state for any shortfall, whereas in health insurance there is payment upon agreed terms and the individual is responsible for his own economic situation. It will be demonstrated in later chapters that in South Africa social inequities had resulted in different health profiles for different race groups.

Similarly in the Cape, 1881 was a year of progress where law, health care, institutions and care of the poor improved. However, this progress was marred by another outbreak of smallpox in 1882 when almost 4 000 people died in the Peninsula alone. Emergency measures were put in place to deal with the epidemic. In 1883 the Public Health Act 4 (Cape) was passed as a consequence of the epidemic, and power was given to local authorities to set up departments and

hospitals and Government agreed to advance 50 percent towards the cost of maintenance. This Act also regulated conditions upon the outbreak of smallpox (Laidler 1971: 428). The first Quarantine Law was passed in Natal in 1858, with a further eight amendments up to 1899. This regulated health matters on vessels entering ports and the ports themselves (Raats JI 1950: 147).

The foundation of private medical aid

An important development was the passing of the Friendly Societies Act (no 7 of 1882) [repealed in 1892] which was promulgated in the Cape for the encouragement and protection of Friendly Societies. This formed the basis of the private medical aid as it was known. A total of twenty-seven societies were registered in the Cape and surrounding provinces, the last being the Eastern System of Railway Permanent Mutual Sick and Funeral Benefit Society which became the Union's Railway and Harbours Sick Fund¹² (Laidler and Gelfand 1971: 374).

The twenty seven societies were situated in Cape Town (13), Woodstock (4), Mobray (1), Simonstown (1), O'okiep (1) Port Nolloth – copper mine (1), Beaconsfield – diamond mine (1), Port Elizabeth (1), Uitenhage (1), Grahamstown (1) and East London (1) (Laidler and Gelfand 1971: 374).

Laidler contends that the reason for the promulgation of the Friendly Societies Act was that: 'The Government's interest was aroused seemingly by the appearance of sums of money and the temptation to the less conscientious thereby established. The control of property was directed by Government; the production of finance by the worker' (Laidler 1971: 374).

On the 11th April 1882, the Frere Hospital in East London was formally opened by the mayor and the hospital was ranked as being the best charitable institution of the land. It only housed about nine patients: 'They are pretty equally divided between white and black, and we have found but little difficulty in overcoming the

¹² Date of formation not provided

prejudice which the natives have with respect to hospitals. There is no right of any recommendation of patients attached to subscriptions or donations. Any applicant for admission presents himself or herself to the House Committee, and is admitted or rejected, upon the merits of the case, the medical officer for the week processing the right to veto always' (Hartley1884: 13).The premises belonged to the Town Council and management of the hospital was under a House Committee.

Again, evidence of the British influence exists: 'Our present Lady Superintendant is a thoroughly trained lady nurse, brought out from England under a three years engagement' (Hartley 1884:14).

The unemployed were registered and in 1886 there were 1,141 registered unemployed in Cape Town. Soup kitchens and refuge for the poor were set up (Laidler and Gelfand (1971: 374).

In 1891, the Valkenburg Asylum was opened by the Colonial Government in the Cape was hailed as a 'first of its kind in the country' as it separated delinquents from adult criminals or regular hospital patients (Laidler and Gelfand 1971: 437). It admitted both African and European patients. Their income was derived from a Government grant of £1 000 per annum, a rent income of about £400 per annum, payment from paying patients and voluntary subscriptions. In addition, there was a Samaritan Fund for destitute patients, plus income from donations received from boxes placed in various public buildings. General expenditure was £100-£120 per month (Hartley1884: 14).

In 1891, a committee drew up regulations changing the conditions at the Grey Hospital in KingWilliamstown such as attracting a better class of paying patient, improving the quality of care, encouraging Africans to pay for treatment and charging for medicines to outpatients (Laidler and Gelfand 1971: 440). As a result the Government ceased to support the hospital, as was the case in East London and Grahamstown.

The Friendly Societies Act 5 of 1892 repealed the 1882 Cape Colony Friendly Societies Act and set new standards pertaining to regulation and re-grading of existing societies. Constitutions were set up and trustees had to be appointed. 'Their main object was the relief of unnecessary hardship, the provision during sickness of medical attendance and the insurance for a payment in cash at birth or death'. (Laidler and Gelfand 1971: 374) The Public Health Amendment Act of 1897 created a Colonial Public Health Department which structured powers and duties of local authorities, which included sanitation and water supply issues, buildings, spread of contagious diseases and burial grounds (Burrows 1958: 333).

The Colony of Natal

In 1836 the first large group of Voortrekkers arrived in Natal, already inhabited by large groups of African tribes. In 1842 a small British force occupied the harbour. The following year Natal was brought into the British Empire (Thompson 2001: 91). Subsequently, Natal became increasingly British in culture). There were only two doctors in the Republic of Natal during the 1840's, one of which was a qualified civil practitioner. Settlers from Britain arrived "Five thousand men, women and children arrived in the years 1849-5" (Thompson 2001: 95). They were mainly responsible for the increase in the white population from 3 000 in 1845 to over 12 000 in 1860. Most were artisans, some were mechanics and farmers. Twenty-three were medical men. Voortrekkers in Natal elected to return to the Transvaal and Free State in 1846. In 1851 Government issued a notice: 'no person not possessing the necessary diplomas will be admitted to practise surgery within the district of Natal' (Burrows 1958: 207).

First 'nursing home' in Natal was started by a Dr Blaine who treated patients in his house in New Germany. Another doctor, Dr. Bryan extracted teeth and performed medical services such as midwifery for half a crown a consultation and three shillings a visit, including medicine. During this time a district surgeon employed in Pietermaritzburg in Natal earned £200 per annum in 1860.

During the 1860's, a Dr Matthews travelled through Natal and made observations regarding African health customs: He identified four kinds of doctors: 'Inyanga gokubula' or witch doctor, rain doctor, the lightning and hail doctor and fourthly the medicine doctor 'Inyanga yokwelapa'. There is evidence of African payment habits: 'It used to be a case of *'no cure no pay'*, if the patient did not recover. But he observed that on first attendance the doctor required a preliminary fee of ten shillings, mostly to purchase medicine, and at the same time he stipulated a bullock, should the patient be cured (Matthews 1976: 43).

In accordance with a public meeting held in 1852, a civil hospital was to be built in Pietermaritzburg. It was expected that the Natal government would contribute toward its expenses, however this building was only completed years later. The government had previously promised its support to the Benefit Society, which was formed in February 1853 which caused the delay in the building of the hospital.

In 1855, Sir George Grey arrived at Pietermaritzburg from the Cape and made a £1 000 Imperial grant for the building, on condition the municipality provided the land and that municipal trustees ran the establishment, and provided African and European patients be admitted on an equal basis. In terms of Law No 4 of 1877, responsibility for the Grey hospital passed to the Colonial Government and a new Board of Trustees formulated hospital regulations, appointed consultants, etc. This board was equally represented by Government and local authority (Burrows 1958: 216).

In 1856, Natal became a Crown Colony and the Governor granted £1 000 for the Bayside hospital building, which was completed in Durban in 1861. 'The institution was designed primarily for Africans: Europeans preferred to be ill in their own homes' (Laidler 1971: 386). It was never well attended, even by the poor. 'Zulu's regard admission as tantamount to a death sentence...'. (Burrows 1958: 220) As there was no hospital for Europeans, any European cases would be treated, provided there was accommodation.

In 1862, Law 20 of Natal ¹³ was promulgated for the encouragement and relief of friendly societies. The Master of the Court had to certify the rules of the society. Generally the rules had to be set-up, a positive vote of 83.3 percent was required to dissolve the society and security had to be provided. The society had some legal standing as it could litigate in the name of the Secretary. One of its prime objectives was to ‘diminish public burdens’ (Laidler 1971: 372).

The Addington hospital replaced the Bayside hospital in 1879. During the Zulu War, the hospital was annexed by the military for injured and sick soldiers but handed back to civilian authority once the war had ended (Laidler 1971: 386).

Medical practice in Natal remained depressed but in the 1860’s this changed with the change to wholesaling of sugar cane and the wealth it brought. In addition, due to labour shortages, Indians were imported in November 1860 to work on the Natal cane fields. ‘The Indian, introduced into Natal for purely commercial reasons, played an important part in the race relationships, the politics and even upon the type of medical practice of the country’ (Laidler 1972: 438). In terms of an agreement reached with the Indian government, regular medical care was provided by local Medical Officers who were appointed accordingly (Burrows 1958: 213). A fee of one shilling a month was charged. By the 1890’s, cottage hospitals such as Stanger and Pomeroy were built especially for Indians and controlled by the Indian Immigration Trust Board. By 1913, the Immigration Act was passed to stem the flow of Indians, although it did not refer specifically to Indians. It applied to Asians as well (Muller 1984: 398).

Government now provided hospitals from funds collected via voluntary sources. Plans were made for cottage hospitals to be erected in each district to cater for Africans and the objective was to reduce dependence on witchcraft and reduce the African mortality rate. A medical missionary was sent in 1892 by the Home Board of the American Zulu mission to create a medical department at Adams College in

¹³ Melamet Commission (1994:87) cites the first law governing friendly societies in Natal as Law 7 of 1897 which was repealed in 1956.

Amanzimtoti: 'Missionary endeavour now also entered the field of medical institutional care' (Burrows 1958: 223). A Dr Nembula was the first Zulu to qualify in medicine and return to practice in Natal where he was eventually appointed district surgeon and administered medical care to all races.

In the late 1850's, the death rate of Europeans in Natal was 16 per 1 000 living which was double the death rate of Africans.¹⁴ The total population of the Colony was 6 625 Europeans and 102 105 Non-Europeans. During 1857, revenue for the Colony of Natal totalled £34 700. Taxation of Europeans raised £13 751.2.0 and Africans £12 376.8.0. Government expenses were only in respect of education and amounted to £1 883 on Europeans and £70 on Africans (Laidler and Gelfand 1971: 325). Here one can see an unequal spending pattern as the European population totalled 6.5 percent of the African population at the time yet tax yields from Europeans almost equalled the income from African sources.

In 1871, Grey's hospital (Pietermaritzburg) moved from Governmental control to the Town Council. The latter gave the hospital 1 000 acres of town land. The Natal Government still contributed £1 000 per annum toward expenses, the balance was paid by the town council (Laidler and Gelfand 1971: 326). Burrows states that the £1 000 grant was subject to certain conditions, *i.e.* it had to be used to erect the hospital and European and African had to be admitted on an equal basis (Burrows 1958: 214). The Government continued to support the formation of friendly societies although individuals were still responsible for their own medical costs (Laidler and Gelfand., 1971: 326). In terms of Law No 4 of 1877 responsibility for the Grey hospital passed to the Colonial Government and a new Board of Trustees, equally represented by Government and the Town Council, was appointed (Burrows 1958:216).

In accordance with growth seen in other provinces, as towns and villages grew, so did the demand for medical care and hospitals. In 1879, the Government completed

¹⁴ This could be ascribed to the African deaths not being recorded. This was only rectified by law in 1867.

Addington Hospital holding 70 to 80 patients. In 1897 there were at least nine Government-controlled rural cottage institutions. More hospitals were erected in 1897 (Butterworth) 1899 (Cradock) and 1887 (Wynberg). By 1900 the Addington hospital had grown to a 700-bed institution at a cost in excess of £500 000. During the year 1897, the Maritzburg Medical Society requested the Board of Trustees to allow paying patients to Grey Hospital, to be attended by non-resident doctors but the trustees refused this request (Laidler 1971: 440).

In 1890, the Durban hospital was under direct government control. Of the 1 267 patients admitted, only 664 paid fees, the rest were free. Of the paying patients over one half were employed by Government departments such as Harbour works or Railways. Of the 292 European patients treated 60 percent were treated for free.

Table 6

Admissions to Durban hospital in 1890 by gender and race

	Male	Female	Total	Percent
European	446	38	484	38.2
Indian	274	50	324	25.5
African	439	20	459	36.2
Total	1 159	108	1 267	100

Source: Laidler and Gelfand (1971: 439)

Within a decade of the establishment of the British Natal Colony , the question of the independent trekker Republics was settled in terms of the Sand River Convention (1852) and the Bloemfontein Convention (1854). accordingly The Queen's representatives now, , recognised the Transvaal and Orange Free State Republics respectively. The population was sparse and rural with a slow advance of medical practitioners to the more inhabited parts (Burrows 1958: 227).

Orange Free State

The period 1830 to the discovery of diamonds in 1867 was a period of consolidation of the territories. The number of districts increased from nine to forty

four. The British took over the Xhosa territory of King Williamstown while the Voortrekkers continued their northbound navigation from the Eastern Province and into the northwest. At all these frontiers, doctors were present and the number of doctors increased from eleven to more than sixty.

In 1848, British sovereignty was proclaimed over the Orange Free State and many English peacefully joined the Boers. Both Republics 'were little more than political concepts....pathetically devoid of money...' (Burrows 1958: 227) This meant that the authorities in the two Boer Republics spent little on health and medical funding; they had little to spend.

As people settled in Bloemfontein in the Free State, there was evidence of the Cape history of 50 years prior, being repeated. The South African Mutual Life Assurance Company [which became Old Mutual in 1845] in Cape Town declined applications for life policies in Bloemfontein on the basis that 'they were beyond the bounds of civilization' (Laidler and Gelfand 1971: 308). The Natal Fire Insurance and Trust Company was noted as the first insurance Company to appear, however neither Companies had any form of health insurance or funding. As the population increased so more doctors and missionaries arrived from Germany and France and as far afield as Australia. The population of the Free State in 1858 was 12 859 Europeans and 4 000 non-Europeans. In the same year households voted for a municipality, who levied tax on water and immovable property in order to provide public improvements. Another outbreak of smallpox in 1859 saw the gaol used as a hospital for the ill (Laidler and Gelfand 1971: 311,312).

Discovery of diamonds

Health funding issues were shaped by major historical events occurring during the onset of this period such as the discovery of diamonds in 1867 near Hopetown in the Northern Cape. Laidler hails this discovery as 'the birth of a new medical era' (Laidler and Gelfand 1971: 397), mainly as a result of the introduction of modern nursing, which originated from the Protestant and Roman Catholic orders. In 1871 the Union flag was hoisted by the Cape police on the diamond fields.

The Du Toit's Pan Hospital was the first hospital to be erected on the Dry Diggings. A basic tent, it was serviced by a Roman Catholic priest and replaced by a larger tent of 12 feet by 8 feet. The Dry Diggings hospital with 120 beds followed. By 1872 a wood and iron hospital structure was erected, followed by a raw brick structure named the Diggers' Central Hospital, housing twenty beds. The hospital was voluntary and admitted diggers and non-European labourers. 'There was no provision for private paying patients although such a need was becoming acute' (Laidler and Gelfand 1971: 398).

In 1874, the Southey administration built a Provincial Hospital, later called the Carnarvon Hospital, with 20 beds. To finance this, the Medical Tax Act (No 2 of 1874) was passed by the Government. This amounted to one shilling a month levied upon each African at the diggings. The tax was strongly disapproved of by the diggers. In 1876 and 1882 wards, including an African ward, were added. The medical tax 'remained in abeyance until the hospital matters were controlled by the local board in 1882 when the diggers' companies deducted this amount from the wages of each miner' (Laidler and Gelfand 1971: 399). The total amount varied from £10 000 in 1882 to £6 000 in 1885 (Matthews 1887: 105).

It was in Kimberley where the nursing school of Henrietta Stockdale was founded in 1877. This school had a major influence on the Colony and formed the foundation of modern nursing practices in South Africa. Henrietta Stockdale motivated the passing of Act 34 of 1891 by the Cape Parliament which put nurses on an equal footing to other medical professionals. South Africa became the first country in the world to register midwives and mental nurses, both in 1891 (Searle 1965: 103, 117). The following table shows the death rate in Kimberley per Population Group:

Table 7**Death rate in Kimberley in 1879**

	Population	Deaths	Rate/1 000
Europeans	6 574	263	40.005
Other than Europeans	7 595	604	79.052
Total	14 169	867	61.014

Source: Laidler and Gelfand (1971: 400)

In Bloemfontein, the first hospital was opened on 22 June 1877. This ‘cottage hospital’ was established in Bloemfontein by the Anglican Church and funds were raised by the community and nurses and surgeons provide services gratuitously. The funding was raised via a loan of £1 000 and £2 000 via subscriptions by the public. Nurses received board and lodge for free but no wages or salaries. All fees went to the Anglican Church (Laidler 1975: 359).

Government granted £150 per annum in 1877 for a second hospital in the Free State, namely the St George’s Hospital. On 10 September 1880, it was decided not to admit Africans to the hospital. It was seen as ‘the first limitation of the original intent being to admit without distinction of nationality, creed or class’ (Laidler and Gelfand 1971: 361). During 1876, the hospital was supported via fees collected via workingman’s collections; proceeds from concerts and dramatic entertainment and collections from outside towns such as Fauresmith and Ficksburg. The number of paying patients increased and the hospital still supplied free medicines to the gaol, borough police and district surgeon cases. Medicines were supplied at cost to the Cape Police and the Lock Hospital (Laidler and Gelfand 1971: 363).

The Kimberley Hospital was formed in 1882 by the amalgamation of the two hospitals mentioned above. Africans occupied 66 surgical and 42 medical beds; 29 poor whites, 20 for paying whites and 4 beds in an isolation ward. Statistics in 1885 showed admission of 709 Europeans and 1 019 Africans (Matthews 1976: 105). By 1883, this hospital had debt amounting to £9 000 and the sheriff seized its assets in 1884. The Government intervened and dismissed the Board and the

Magistrate was instructed to form another. The situation improved by means of a yearly subsidy and the personal involvement of the magistrate.

By 1888, only six years after the amalgamation – the Board of Management reported a daily in-patient average of 255 which was more than twice that of the New Somerset Hospital and four times that of the next largest Colonial Hospital, the Provincial at Port Elizabeth (Burrows 1958: 262).

According to Laidler and Gelfand (1971: 471), by 1892, the Free State was the more advanced than the Republics in terms of education and prosperity. In Bloemfontein, during 1894, the Government opened the first state hospital, called *Volks Hospitaal* at a cost of £10,500 (Burrows 1958: 292). This was in opposition to the St George's Cottage Hospital, originally erected and managed by the Anglican Church in 1877. Regulations were promulgated in terms of Law 21 of 1894. There was a fixed tariff and patients had to provide surety upon admission. The poor could be admitted free, for a limited stay, upon application to various authorities such as the State Secretary or the *landdrost* (Burrows 1958: 292). Only in 1932 was this State '*Volks Hospitaal*' replaced by a new National hospital.

During another smallpox outbreak in Kimberley from November 1883 to December 1884 the inhabitants and mines of Griqualand West paid just over £37 503. This included the medical tax of 1s a month levied on Africans as instituted by the Legislative Council of Griqualand West (No 2 of 1874) (Laidler and Gelfand 1971: 399).

In the same year, Sister Henrietta moved from the Kimberley Hospital to the St Michaels Home in Kimberley and started a Nurses' Co-operative Agency. The Agency was financed by nurses contributing a percentage of their earnings into a central fund. Many more such agencies were set up in different areas, sometimes organized by a group of volunteer women. In such cases, a full-time nurse would be dedicated to provide care to the poor. This was the start of free care to the poor by the nursing fraternity which advanced to 'voluntary agencies, and later provided by provincial and state services' (Searle 1965: 179). Nurses charged fees to all

private patients whom could afford it, ranging on a scale of affordability: ‘As both doctors and nurses did a considerable amount of *pro deo* work, they recovered their losses by charging high fees for their services for those who could well afford to pay’ (Searle 1965: 179) It became a service for the wealthy and a social status symbol:

Table 8

Scale of Fees charged by trained private duty nurses in 1896

Nature of service	1896-FEES				1960-FEES
	Natal	Cape	OFS	SA Republic	Transvaal
Single visit in town of residence	2/6	2/6	2/6	3/- to 10/-	75 cents to R1.25
1 visit per day for a week	10/6	10/6	10/6	21/- to £3 10/-	n/a
1 whole day	7/6	7/6	7/6	10/- to 30/-	R4.90
Assisting at an operation	10/6	10/6	10/6	21/- to 63/-	n/a
The poor	Free	Free	Free	Free	

Source: Searle (1965: 179, 375)

Public health was a team effort ‘directed to the improvement of the social, physical and mental welfare of the community as a whole’ (Searle 1965: 348). It appears as the concept of public health was linked to employment of health officials by local authorities. In 1885, a scheme was approved for employment of district nurses in rural areas. The Government funded this service. During this time the role of voluntary organizations, ‘*vroueverenigings*’ and ‘order of nurses’ in addressing public health issues in rural areas should not be underestimated. By the end of 1938 there were 217 white and 76 non-white district nurses and midwives working in rural areas (Searle 1965: 353).

South African Republic

‘It was the Voortrekkers who created Natal, the Orange Free State and Transvaal and they were the first to call themselves ‘South African’’ (Burrows 1958: 188). .

These people relied on the '*huis apotheek*' administered by the elder ladies in each group, which consisted of home and herbal remedies. Doctors and hospitals were never consulted since none existed and seldom did these people get very ill. They were not the first whites to venture into these areas. Many missionaries were already in evidence (Burrows 1958: 188).

An Ordinance was passed in 1836 authorising the establishment of municipalities (South Africa Yearbook 1920: 155). These bodies regulated public health and were largely undertaken by district surgeons or local medical practitioners.

In April 1844, the first medical legislation enacted in the Voortrekker Republics was Article 14 of the Thirty-Three Articles promulgated by the Voortrekkers at Potchefstroom which regulated doctors in terms of qualifications as well as licensing of doctors (Burrows 1958: 238). During 1851, Dutch physicians enquired about practising in the area and received the reply from the Lydenburg Volksraad that they had no medical men in the area and therefore they could be doctors on their own but they would like somebody with knowledge of medicinal herbs to join them.

The Sand River Convention in 1852 conferred the right of Boers to govern themselves in the Transvaal, however they could not form any alliances with neighbouring black states and had to abolish slavery (Laidler and Gelfand 1971: 307). The latter was one of the reasons the trekkers originally left the Cape. The Rustenburg General Assembly declared in 1853 that none but the Dutch Reformed Church should be tolerated in the Republic. Coloured people could not sit on this Assembly before the tenth generation. In 1858, the Volksraad (Legislative Council of the Republic) resolved that 'Europeans would not tolerate equality with the Coloured, neither in church nor in state (Laidler and Gelfand 1971: 315). This is evidence of the onset of separate locations for Coloured, Asians and Africans in the Transvaal and the movement toward separate development of healthcare and funding on the basis of race.

Discovery of gold

Gold was found in the Transvaal near Lydenburg in 1873 and Barberton 1885. By 1874, the Transvaal was still referred to as: ‘the happy hunting ground for the ill-qualified and the quack’ (Laidler and Gelfand 1971: 317). The British annexed the ‘almost bankrupt’ (Laidler 1971: 410) Transvaal in 1877, however the Boers were determined to win back their independence and in December 1880 and the First Boer War¹⁵ broke out.

Experienced military (British) and medical services arrived accordingly – mainly field hospitals, base hospitals and convalescent depots were set up. There was a scarcity of doctors throughout the territories in the south of Africa.

In terms of the Transvaal Medical Act 1880, the first statutory body namely the Transvaal Medical Committee was formed in terms of Law 8 of 1881 during the British occupation. This statute declared that any person wanting to practice as a physician, surgeon, surgeon-accoucheur, apothecary or chemist had to provide certificates and diplomas ‘for the examination and approval of the said Committee’ before he could be admitted’ (Burrows 1958: 284).

On 21 March 1881, peace was declared after the defeat of the British at Majuba under the leadership of Paul Kruger and, once again, the South African Republic rejoined its independence (Pakenham 1998: historical note xxi). By 1881 there were still no hospitals or asylums but a medical committee was established to address the ‘civil medical concerns of the territory’ (Burrows 1958: 243). In August of the same year the Republican Government in the Transvaal was restored in terms of the Pretoria Convention. This triggered a decade of advances in many fields in the Transvaal Republic, including medical.

¹⁵ Also referred to as War of Independence. For greater detail consult Lehman J (1972) *The First Boer War*

The Republican government changed the Transvaal Medical Committee to the *Geneeskundige Commissie*. Several Acts were passed during this period ensuring that the poor, prisoners and public sectors received care. The most noteworthy of these Acts was the Public Health Act 4 of 1883, repealing the 1856 regulations, and the Medical and Pharmacy Act 34 of 1891, repealing Ordinance 82 of 1830. An important improvement was that the power was given to local authorities to set up departments and hospitals and Government agreed to advance fifty percent of the cost of expenses of its maintenance. The 1891 Act was promulgated primarily to make provision for registration and licensing of medical practitioners, dentists, chemists, midwives and nurses and set the constitution and general powers of the Colonial Medical Board. The 1883 Health Act was not very effective and Act 10 of 1884 was promulgated to provide better application, particularly within the Kimberley area, in order to harmonise the different parties, including the mining boards (Laidler and Gelfand 1971: 430,431).

A special act was passed in November 1884 which gave the 'Board of Health power to levy rates on boroughs and mines, and to defray expenses' (Matthews 1887: 110). Ordinance 41 of 1885 was passed empowering the government to pay 50 percent of all expenditure for smallpox. 'Though previous to this the government had acted with great liberty, having defrayed one-third of every expense' (Matthews 1887: 110). In 1884, regulations for district surgeons were passed which ensured that the poor, prisoners and public servants including their families received free medical care. These medical costs were defrayed, wholly or partly, from public revenue.

With the discovery of gold, the Witwatersrand became the centre of activity when Johannesburg was founded in 1886. The Republic was almost bankrupt. 'The land was fenceless, roadless and almost doctorless' (Laidler and Gelfand 1971: 476). A few benefit societies made their appearance. Government did little to assist in this regard: 'The sole Government activity appears to have been the appointment of a teacher to the deaf and dumb at an annual salary of £300' (Laidler and Gelfand 1971: 375).

In January 1887, the South African Republic approved £500 to build a temporary hospital in Johannesburg. A permanent hospital was opened in 1890. The number of licensed medical practitioners within Johannesburg totalled 16 in 1890. By 1898 they had increased to 107 (Burrows 1958: 284). Within a few years Johannesburg grew larger than Kimberley, Barberton and any of the towns in the Transvaal. The gaol was initially used as a hospital and in April 1887 a galvanised iron building was erected. To finance the increasing cost of caring for the diggers, a hospital tax on the native labour force was introduced on a similar vein to what applied in Kimberley.

There was a shift from the diamond fields to the gold diggings which included a large migration of civilians. In 1886, the Barberton Hospital was the ‘oldest institution of its kind in the Transvaal’ (Burrows 1958: 273). However, it was merely a tent which catered for the influx of 5 000 persons to the town. The problem became too large to remain a private matter. The Generals of the Volksraad agreed to contribute £2 000 to its cost, subject to certain stipulations: The mining commissioner must be chairman of the Board of Management; Government must approve regulations; private subscriptions must continue (Burrows 1958: 273). The hospital remained under voluntary subscription and donation whilst the *Volksraad* made an annual donation of £500.

Several makeshift or temporary structures were built for the sick. President Kruger and the government donated land and a loan of £6 000 to build a permanent hospital. There were 120 beds which included Africans. This was completed only in 1890 at a cost of over £43 000. The Johannesburg hospital was to be maintained via public subscriptions. Funds were also gathered from ‘Hospital Saturdays’ which produced £3 000. In addition a pass fee of one shilling per month was levied on all Africans. The latter raised £40 000 with the prospect of more (Laidler and Gelfand 1971: 477). The Government appropriated the fees, increased the pass fee to two shillings per month and instead paid a much lower subsidy of £30 000 to the hospital. The profit gained in this manner was in excess £250 000 per annum.

By 1894, expenses exceeded receipts by £7 000 and the Volksraad wrote this off in terms of a resolution passed on the 23rd June 1894 and evidence shows another write-off totalling £7 528. The Government still controlled the hospital and set its objective as to ‘afford medical and surgical aid and treatment to indoor and outdoor patients, to provide proper nursing to the sick, and to educate nurse-probationers’ (Laidler and Gelfand 1971: 478).

Summary: Colonies and Republics

By 1898 the provision of medical services had been established in the entire region. Below, is table 9 depicting the total number of institutions:

Table 9
Number of Hospitals and asylums in 1898

Cape Colony	42
Orange Free State Republic	6
South African Republic	11
Natal Colony	16
Total number of hospitals excluding mental asylums	75

Source: Searle (1965: 90) adapted

Note:- Total number of beds 3005+

With the turn of the century came increasing prosperity, advances in medical sciences, industrialisation and general improvement of living standards. The end of the nineteenth century saw a consolidation of health matters. The European ‘public health’ concept filtered through to South Africa. A hospitals branch was established to take care of the organisation of the medical institutions of the Colonial Government. Nineteen medicine and health bills were passed by the Colonial Parliament between 1879 and 1899. An example is Act 5 of 1882, which set new standards pertaining to regulation and re-grading of existing societies (Burrows 1958: 332).

The transition between the old and the new order in South African medical affairs is seen at the end of this era. Post-1889 saw an increase in public health services, medical education, the South African War resulting in the installation of a British administration, deep level mining and the ensuing entrance of mines as providers of health services, large revenues from gold and the impact of European healing methods on native customs and traditions.

This chapter has seen the *ad hoc* advance of health funding. It advanced from the benevolent treatment of the poor, to the active involvement of the churches. The allocation of cost for health treatment between the Republics, the Colonies and the population was based on affordability. Tariffs and costs for hospitals and were negotiated, rather than regulated.

Chapter 3:

Private Health Funding – Historical overview 1889 to 2010

Please refer to the Glossary for an overview of terms used in the voluntary, as opposed to the formal, funding methods utilized in South Africa. The Friendly Societies Act of 1882 (Cape) can be seen as the foundation of private medical funding legislation. A discussion on the different societies and medical associations leading up to the formation of the first private medical aid in 1889, follows. A historical overview of the influences, post-1889 to before the declaration of the South African Republic in 1961, is detailed in this chapter.

3.1 Medical Societies and Associations in the nineteenth century

Throughout the period of British rule, there was a number of independent groups showing concern and attempting to improve health services as well as Government sanction of societies formed in this regard. The following are some of the groups which operated in South Africa:

One of the first societies created for mutual help in the Cape appears to be the European Sick and Burial Society which was sanctioned by the Government in 1796. Financial problems were encountered by 1801 with high claims and non-payment of membership fees (Laidler and Gelfand 1971: 88). Members were the respectable but poor teachers, shoemakers, carpenters. It will become evident that over the next two hundred years this would remain as one of the main problems facing the health funding industry: high claims and expenses with spiralling effects on funds and member contributions

From the outset, provision for financial support during illness was included as part of the benefits. Membership for the first year totalled 204 members. In 1802, regulations for the management of the fund were passed. This is the first evidence of underwriting criteria used in accepting members: ‘Any Europeans of character and good health were eligible to become a member on payment of a stipulated sum

according to his age for his introduction' (Laidler and Gelfand 1971: 88). Monthly contributions varied between four pence and halfpenny to one shilling and sixpence. In 1830, the European Sick and Burial Society membership had reduced to 150 members (Laidler and Gelfand 1971: 259). The Society had accumulated substantial assets in the form of three houses in Oranje Street. By 1840, financial problems were again experienced resulting in a request for remission in municipal taxes; however these problems could not have been severe since it is stated 'The European Sick and Burial Society still flourished and in 1856 its capital reached £1,500' (Laidler and Gelfand 1971: 369). By then the age limit for members to join was fifty. Monthly contributions were three shillings and the entrance fee was between 10 and 30 shillings. By 1859, membership had reduced to two.

The South African Missionary Society was formed in 1799. This Society was based on Christian charity and its aim was to provide a chapel to the parish with the proceeds of collections.

In 1819, the Cape Ladies' Society for the Relief of the Poor was started by a widow, Matilda Smith. Based on the British health visitor concept, widows were appointed to care for the sick and medicines were supplied. Six rixdollars a year was paid to the widows in this respect. When Smith died in 1820, the Society became the Ladies' Benevolent Society for the Relief of the Poor. By 1843, it had conducted fourteen district visitors and conducted nursing and social duties for the poor. 'The medical profession made a considerable contribution through attendance' and in 1835 the Committee thanked the Doctors accordingly (Laidler and Gelfand 1971: 257).

In 1820, the Saint Andrew's Friendly Society was established. It provided medical aid during sickness plus paying an allowance for a year, if the member did not recover. Membership criteria were introduced: persons had to be of good character and between the ages of 16 and 55 years (Laidler and Gelfand 1971: 256). Funds totalling £400 were loaned out with interest being charged, benefits being half a guinea a week during the first six months if ill and an allowance of nine pence a

day after a year. This is the first reference found by the author to the concept of 'medical aid'.

In 1821, a poor relief fund was started, its title changed in 1823 to 'The Society for the Relief of Distressed Settlers in South Africa'. Funds were collected from England and even India. Another society appears to have been formed by the Governor for the sick in 1822 (Laidler and Gelfand 1971: 147).

During 1823 the Philanthropic Society of Cape Town was established to elicit the freedom of female slaves and their children (Laidler and Gelfand 1971: 255). With the emergence of this 'social conscience', sectarian and sectional societies for the relief of old age or sickness were formed. The Supreme Court promulgated rules for actions by and against paupers on 31 March 1828. A poor fund was established by the Court, the Master of the Court appointed as Treasurer.

The South African Infirmary Society (1823): 'afforded Medical Aid to individuals who [are] wholly without the means of defraying the expenses which their destitute situation requires' (Burrows 1958: 137). The South African Infirmary Fund was created with the Governor's consent. The fund was financed via subscriptions as well as donations from the churches, the aim being to extend medical care to 'a class of people not exactly paupers' (Laidler and Gelfand 1971: 181). In order to achieve this, a levy was added to medicines dispensed from the Merchant Seamen's Hospital. The Infirmary Society report for the period 1st July 1823 to 30 September 1824 shows that 20 patients had been admitted, 11 discharged, 6 died and 3 remained in hospital. Donations and subscriptions totalled 2 915 rixdollars of which 2 362 Rixdollars had been spent (Laidler and Gelfand 1971: 181).

Based on the model of benefit societies in Britain, the St Patrick's Society was established in 1829. Religious institutions such as the Dutch Reformed Church, Church of England as well as the Jewish communities became more involved in providing for the poor.

According to Burrows (1958: 138), insurance in the Cape developed from these benevolent sick and burial societies. Dr. Bailey (founder of the private hospital) was appointed physician to the Cape of Good Hope's South African Fire and Life Assurance Company in the 1830's. The following further three Companies were established during the 1840's: Protecteur Fire and Life Assurance Company; Cape of Good Hope Trust Assurance Company and the South African Mutual Life Assurance Company.

The Cape Town Friendly Society (1836) covered the largest territory, namely Cape Town, Wynberg and Simonstown. Amongst its objectives was to provide support to the poor during illness.

In terms of Ordinance 50 of 1838¹⁶ a certain legal minimum lodge plus food rations could be claimed by the poor. During this time the St Stephen's church in Cape Town was an old military theatre and it housed the coloured, including Khoisan and ex-slaves. In 1843 there were 880 members and fees ranged from sixpence to a shilling monthly. For this, they received free medicine during illness and burial in case of death (Laidler and Gelfand 1971: 257).

The *Zuid Afrikaansch Privaat Voorsorg Genootschap* was formed in 1841. Included in its objectives was to provide sick relief at an annual subscription of 10 shillings for people aged below 30 years and escalating up to the age of 60. It was not wholly 'mutual' or private, but charitable. According to Laidler and Gelfand: (1971: 260) 'The European was now fairly supplied with the means of relief but the state of the Coloured and the aged slave was deplorable'.

A mutual benefit society was started in Grahamstown in 1849 and had 226 members, and allowances were made for medical attendance and medicines. The Bengalese Civil Service created a friendly society for Anglo-Indians in Wynberg. The Union Relief and Benefit Society appeared about 1856, again to assist with the sick.

¹⁶ Tomlinson (1955: 5) states that this Ordinance 50 was issued in July 1828.

A short list of some Societies formed during the period 1795 to 1898, not mentioned in the text: (Burrows 1958: 138); (Laidler and Gelfand 1971: 375-376).

Bloemfontein, OFS Attempt to found a relief fund	1850
Bloemfontein, OFS the Brethren Benefit Society	circa 1852
Pietermaritzburg, Benefit Society	1853
Pietermaritzburg, Building Society	1853
Cape Friendly Society (Baron von Ludwig)	1835
Cape Town, Mechanics Institute	1853
Cape Town, Interdenominational Sailor's Home	1854
Cape Town: Wesleyan Mental Improvement Society	1857
Cape Town: Almshouses, Papendorp	circa 1859
Orange Free State Relief Fund	1859
Cape Town, Bishop Grimleys Society for the Promotion of Temperance	1862
Cape Town, St George's Orphanage for white and coloured	1862
Cape Town, President Co-operative Society	1862
Durban Benevolent Society	1862
Cape Town Friendly and Benefit Society	1866
European Sick and Burial Society (Wehr)	1795
Potchefstroom, Total Abstinence Society	1867
King William's Town, Town Ladies Benevolent Society	1868
Cape Town, St Mary's Mutual Benevolent Society	circa 1868
Cape Town Wesleyan Dorcas Society	1868
Cape Town, Jewish Philanthropic Society	1868
Cape Town, Aged Ladies Home	1876
Cape Town, D.R. Church Kinder Zending Huis	1883
Cape Town, Dorcas Almshouses	1883
Cape Town, United Services Institute	1887
Cape Town, Soldiers and Sailors Help Society	1889
Johannesburg, Rand President Building Society	1890
Cape Town, Anglican St Micheale's Home	1894

Cape Town, D.R. Church Eben Haezer for Superannuated Parsons	1894
Cape Town, Rogelin home for old and aged men	1896
Cape Town, Jewish Ladies Association	1895
Cape Town, Anglican Missions to Seamen Club	1897
Pretoria, Ladies Benevolent Society circa	1898
Seamen's Friends Society	1845
St Helena, Working Man's Christian Association	1875
St Helena, Church Provident Society for Women	1878
St Helena, Church Benefit Society for Children	1878

Regulation of the Medical Industry

The Supreme Medical Committee was founded in 1807 and governed the medical profession at the Cape for almost a century. On 14 August 1807, the Government Gazette published a list of medical practitioners, apothecaries and chemists. Tariffs and fees were published in terms of the 'Second Medical Proclamation' dated 18th August 1807 (Laidler and Gelfand 1971: 107). It was strictly forbidden for anyone to practice unless their name was published in the Government Gazette, with a possibility of a fine up of 1 000 rixdollars.

In 1830 the Supreme Medical Committee was changed to Colonial Medical Committee and the management thereof moved from the military to civil practitioners (Burrows 1958: 300). Its functions was 'inspecting hospitals and other colonial institutions, supervising district surgeons and fixing tariffs of medical fees, advising on legislation, public health and the individual merits of persons applying for permission to practise medicine in the Colony' (Burrows 1958: 300). Up to May 1844, district surgeons serving the Colony received a fixed remuneration. This was changed by the issue of a Proclamation whereby detailed claims of expenses had to be submitted to the Medical Committee for approval and settlement.

The South African Medical Society was founded in Cape Town in 1827 'or even earlier' (Burrows 1958: 130) and thrived to 1847. The minute book entry describes the leaders as 'men imbued strongly with human and philanthropic instincts' (Burrows 1958: 130). From 1831 to 1834 the South African Medical Society performed the duties of the Colonial Medical Committee such as ensuring enforcement of legislation and ultimately became the official advisory body on medical matters to the Government (Burrows 1958: 133). The Committee was replaced by the Colonial Medical Council and Pharmacy Board in terms of the Cape Medical and Pharmacy Act (No 34 of 1891) (Burrows 1958: 79). This Colonial Medical Council was taken in as part of the South African Medical and Dental Council in 1928.

The Cape Colony was granted Representative Government in 1854 and the medical institutions received more attention. The medical fraternity was well established and in 1860 a free outpatient facility was opened 'to grant, without distinction of colour, class or creed: medical attention and advice in sickness, and medicine gratuitously in cases such as appear to require aid' (Burrows 1958: 302). The Colonial institutions grew during the 1850's with hospitals being established in the Eastern Cape.

The Cape Legislative Council appointed a committee in 1862 to investigate the state of the medical practice in the British Colony. 'It found medical aid deficient in all country areas' (Laidler and Gelfand 1971: 339). The law was not adhered to and people 'enriched themselves at the expense of their patients' (Laidler and Gelfand 1971: 339). He cites as examples licensed chemists practicing as district surgeons. This led to further legislation being passed regulating the number of years a pharmacist had to study.

The first copy of the South African Medical Journal was published in East London on January 19th 1884 at an annual sub of £1,1s. In it, reference is made to the South African Medical Association as follows: 'The South African Medical Association was instituted in July 1883 in Cape Town, it is established on the broadest basis,

and has for its objects, the Union of the Medical Profession in South Africa, and the advance of medicine and its allied Sciences.’ (Hartley 1884:1)

By 1886, doctors had branched off into the Eastern, Frontier and Kimberley Medical Associations, however, the entrance of the British Medical Association caused these, and other branches (for example Natal), to follow suit. In Johannesburg however the Transvaal Medical Society started in March 1889. Other than pure medical matters, the fees of practitioners were regulated by this Society. Examples are visits to the wealthy at 21 shillings but to others 10 shillings and sixpence (Burrows 1958: 354).

The first South African Medical Congress was held in Kimberley in 1892. A motion was rejected to amalgamate all these societies under the South African Medical Association. At that time the British Medical Association had branches in Cape, Eastern Province and Natal, whereas the Transvaal and Pretoria Medical Societies remained independent. By 1894, the Grahamstown and Eastern Province branches had their own representatives at the annual meeting of the British Medical Association in Bristol. According to Burrows (1958: 354), ‘In many respects affiliation with the British Medical Association acted as a red herring in the development of medical trade-unionism in South Africa.’ This dual medical fraternity seemingly caused division within the industry.

On 29 December 1896 the formation of the South African Medical Association was approved. It however took many years to fulfil its intended purpose of uniting all the different regions and doctors in SA, qualified outside Britain. By 1897, membership numbered 250 (Laidler and Gelfand 1971: 500). During the same year subscribers of the South African Medical Journal totalled 270 (Burrows 1958: 366) but when the South African Anglo-Boer War broke out in 1899, publication was suspended.

Civil servants in the Transvaal were mostly British, brought in by the High Commissioner, Lord Milner. The Civil Service Medical Benefit Association of

Johannesburg (CSMBA, Johannesburg) was founded in 1903. 'Aspects of British social organisation were soon replicated in the former Boer society' (Verhoef 2006: 602). The CSMBA was a voluntary organisation modelled on the Friendly Society concept (Verhoef 2007: 26). Free cover was provided for medical and dentistry visits. Men paid 4 shillings, women 2 and children 1 shilling per month. In return they were provided with medicine and cosmetics (Verhoef 2007: 28). The provision of medical aid to civil servants will not be investigated in terms of this dissertation.

As part of the post-war effort to unify legislation, The Orange River Colony Medical Society was founded in 1902 and the name of its periodical named: *South African Medical Record*. The District Surgeon Association was formed during 1903 in Cape Town. Its title was changed to the Cape District Surgeons' and Medical Officers Association. Its prime concern was the plight of the district surgeon in coping with the demand made on it by the Colony in terms of supply of free medicine and the fees charged to the various groups. At the end of 1903 'the association wanted to deal with the ethical code, the supply of practitioners and the formation of a benevolent society' (Laidler and Gelfand 1971: 503).

In the Transvaal and Orange River Colony the Medical, Dental and Pharmacy Ordinance 1 of 1904 was passed aimed at regulating registration of health providers and the sale of drugs, medicine and poisons (Burrows 1958: 295). Ordinance Amendment 18 of 1905 was purely to incorporate the Transvaal into many of existing regulations. The Transvaal Medical Council and Medical Council of the Orange River Colony were the controlling bodies in these regions.

The attempts at medical organisation failed in many respect before the war – and two decades later the British Medical Association and South African Council were still struggling over domination, which was only resolved when it separated completely from the British Medical Association and became the Medical Association of South Africa in 1927 (Burrows 1958: 367).

3.2 De Beers Medical Society (1889-2010)

De Beers' Consolidated Mines Limited Company was started in 1889 by Cecil John Rhodes (Burrows 1958: 257). The De Beers Consolidated Mines Limited Benefit Society was established in terms of a meeting held on 14 February 1889. This was at the request of Cecil John Rhodes after the event of a devastating fire at the De Beers mine in 1888. It is the oldest registered Medical Scheme in South Africa and 'is known as the first medical scheme in South Africa' [translated] (Verhoef 2007: 25) It was also the oldest registered benefit society established in terms of the Friendly Societies Act of 1882 of the Cape of Good Hope.

The material for this section was almost exclusively drawn from the De Beers Commemorative Brochure published on the centenary of the Society in 1989 and compiled by the Manager of the Society at the time, Gordon Dally. The purpose is to give a comprehensive chronological account of developments within a benefit society, spanning over a century in time.

The objectives of the Society were: 'To raise a fund by subscriptions, fines, donations and also by interest arising from the accumulated fund of the above which shall be applied for the following purposes, as mentioned and set forth in these rules and for no other purpose whatsoever: (i) for insuring a sum of money to be paid on the death of a member, to the widow or relative for defraying the expenses of interring a deceased member; (ii) for assisting members during sickness as specified in these rules; (iii) for assisting members under such peculiarly distressing circumstances as on the discretion of the Committee shall be deemed advisable'(Dally 1989: salient_features1).

Members' first contributions amounted to an entrance fee of 2/6d plus a fortnightly subscription of 2/6d which entitled members to medical attendance by a medical officer, medicine and hospitalisation. Benefits included permanent disability and death payments and patients received 50/- per week sick pay. It is not clear if this payment was limited to a certain term. Family members received medical

attendance and medicines at reduced rates. The De Beers Company matched the subscriptions on a pound for pound basis.

On 28 March 1890, the Kimberley Central Company Benefit Society, owned by the Kimberley mine, amalgamated with the De Beers Benefit Society when the mine was purchased from Barney Barnato at a price of £5 338 650. At the time of amalgamation, membership totalled 942 and with funds amounting to £420/-. In 1891 the Society purchased reinsurance from the English and Scottish Law Life Assurance Association for ensuring payment of £100 for accidental death at a premium of £1/7/6 per head.

In 1896, only one work-related death was reported out of a membership of 1 314. Membership increased to 1 792 when Premier mine was acquired. In 1899, the siege of Kimberley caused the society to reduce its activities and focus on the war. 'War risks' were not taken into consideration when the Society rules were drafted therefore the fund was exposed to events of this nature. In 1902 the first actuarial valuation found a deficiency of £1 456.7s.9d.

The registrar of Friendly Societies for the Cape of Good Hope, James McGowan wrote to the Government (Dally 1989: salient_features3):

'A fundamental principle in the calculation of the contribution must be the graduation of the contribution according to the age of the contributor when he joins the Society. To fix a uniform contribution for all ages at entry is an attractive method from the simplicity of its working, but it is very unjust to the younger members and once it is recognised (and the fact is indisputable) that sickness and death rates increase with age, the only proper course is to adopt a scale of contribution graduated according to age at admission.'

The De Beers Medical Society noted a drop in members originating from the United Kingdom from 69 percent in 1892, to 49 percent in 1910. In 1911, the cost of medicines remained high and 1912 was hailed as a record year as not a single case of typhoid fever was reported. In February 1914 the Society won their dispute against the Government to register the rules of the Society in terms of the Friendly Societies Act of 1882 or 1892. De Beers suspended all mining activities with the

onset of World War I in 1914. Similarly the Benefit Society suspended all subscriptions, yet continued to pay for medical treatment and medicines, as well as death of members on active services. By the end of the war the Society showed a shortfall of £42 884 and subscriptions were levied according to age, as proposed by the actuary. Subscriptions, suspended as a result of the War, were reinstated on 1 August 1918.

The Spanish Flu epidemic in October 1918 led to 192 deaths at a cost of £29 658 to the Society. De Beers suspended mining operations and donated £7 000 toward costs. In 1919, the Society agreed on a scale of fees for anaesthetics and in 1920 a 25 percent surcharge was levied on medicine supplied by chemists. By 1921, the worldwide depression had started and its effects noted in terms of retrenchments. The deficit was £11 001 and the actuary warned 'that it was unsatisfactory for a Society to be chronically insolvent' (De Beers 1989: 6). In 1924, membership was extended to retired employees and in 1925 dentists accounts were settled in full and recouped from members over several months. In return, dentists discounted their rates.

In 1926, a report on medicines show 16 261 items had been dispensed at an average cost per member of 17.1d. Several improvements to the benefits were made in 1927 such as sick pay for the first 3 days, free hospitalization for younger members, dental treatment for members' families and dropping the age limit of 45 for new entrants. Comparisons with other societies on the Rand showed that the benefits of the De Beers society were the best. By 1919 membership rose to 2 063 and amount invested to £88 047.17.6d.

During the 1930's and the Great Depression membership declined from 1255 to 1205. The death rate was 20 per 1 000. The actuary presented its second valuation of the depression which declared that the society was financially sound. By 1934, free medical attendance of families was withdrawn. In exchange, the society paid medical accounts in full and recovered the amounts, less 25 percent, from members in pre-arranged instalments (De Beers 1989: 8). By 1938, expenditure relating to

members' dependants increased by 39 percent, with the cost of medicine being 150 percent higher than 30 years ago. In response, the officers at the De Beers medical scheme limited the supply of patent and proprietary medicines and instead compiled a list of preferred medicines.

The Society had its 50th anniversary in 1939. It had paid out nearly £670 000 for the assistance of the sick and had accumulated funds totalling £100 000. When war broke out in 1939, assistance was given to enlisted members. The Society refused to consider 'excessive increases in the tariff rates' whereupon all the dentists resigned on 31 October 1943. 'The Society's move was supported by the combined unions'.

When WWII ended in 1945, De Beers resumed mining operations. In 1946 the Society were advised that pharmacists could not dispense medicines to any Benefit Society which had not been recognised by the executive of the Pharmaceutical Society. The new minimum dispensing tariff issued by the Pharmaceutical Society was much higher than the old and would result in an increase in the cost of medicines to the Society of R1 000 per annum.

In 1952, members were encouraged to have regular medical check-ups and in 1953 the Society agreed to pay 50 percent of maternity costs to the doctor. By 1957, the Society agreed to increase reimbursement of doctors' fees by 20 percent. The cost of medicines had increased from £2 992 in 1942 to £11 291 in 1957. The Society formed a propriety company in compliance with the South African Pharmacy Board and opened its own dispensary in 1958. In the same year, the Society agreed to pay a capitation fee [see definition] to medical officers, in exchange for free medical attendance to members' dependants. Subscriptions increased by 7/6d per month. The 70th annual report published in 1959 was the last report submitted in terms of the Friendly Society Act 1882 of the Colony of the Cape.

In 1963, legislation was proposed by Government for Medical Aid Schemes to replace Sick funds and or Benefit Societies. The De Beers Society joined the

protest against this imminent legislation and joined the Advisory Council for Medical Benefit Schemes.

This following is derived from the commemorative brochure, however the distinction between benefit society and medical aid scheme seems unclear: ‘1964: The State, on investigating Medical Aid Schemes, reported that the [De Beers Benefit – my insertion] Society was the oldest Medical Aid Scheme in the country’ (Dally 1989: salient_features12.asp).

In May 1967, the rules of the De Beers Society were registered in terms of the then new Medical Schemes Act of 1967. The main changes were the suspension of death, funeral and sick benefits. The scope of cover permitted in terms of the new legislation was much more restrictive than the cover which has been provided by De Beers. The De Beers Friendly Society was formed to cater for funeral and death benefits and De Beers took over the sick pay benefits.

On 1/1/ 1968, the following levies were introduced on medicines:

Approved maximum quantities	In Excess of approved quantities
1 st item 20 cents	1 item 40 cents
2 nd item 10 cents	2 item 20 cents
3 rd item 10 cents etc	3 item 20 cents etc

In 1972, the Chairman of the Society, noted in response to the new regulations to the Medical Schemes Act that: ‘They [the new regulations – my insertion] cut right across the pattern of providing benefits which has been in vogue with this Society since it was founded in 1889’ (Dally 1989: salient_features13).

He also referred to the fact that the new Act introduced certain levies. He cited the prime reason for this introduction was to provide disincentives which should discourage members from the overuse of medical services. The Chairman quoted Fr. Reischach, chairman of the Central Council as follows:

The Medical Schemes Act was amended in 1969 to make provision for the Council to promulgate regulations in respect of maximum benefits provided by

medical schemes. We have experienced that during the last years, premiums of all and every medical scheme were raised not only annually but periodically, and in some cases even twice a year. The necessity of this can be attributed to increased claims (Dally 1989: salient_features13).

He concluded that new regulations introduced by the Central Council was not new and referred to the Snyman Commission of 1961 which suggested members pay a portion of each account as services. He stated that members of schemes over-utilize available medical manpower and that the country cannot afford it. Members have to pay a portion of each account, which may curb the problem of constant increases in premium.

In January 1976 the Society reported that Cape Provincial hospitals increased their rates from January 1976 by over 100 percent such as daily general ward rates from R6 to R12. The estimated annual additional cost to the Society was projected at R100 000. New regulations to the Medical Schemes Act came into effect 1 January 1977. This meant that Benefit Societies need no longer be registered as Friendly Societies and hospital benefits had to be paid in respect of maternity cases.

As is evidenced from later years, the efficient provision of a medical administration service is reliant on expensive computer equipment and packages. In 1986 the Society purchased an IBM computer system and a computerized medical accounts package for R250 000. In the same year contributions increased by 60 percent - the highest increase in the Society's 100 year history. The De Beers Friendly Society was finally liquidated in 1987.

In 1989, generous benefits were introduced including one hundred percent benefits in respect of general practitioners, dentists and medicines used in hospitals. On 14 February 1989 the Society celebrated its 100th anniversary. Membership reached a record 8 781 with 18 502 registered dependants. In December 2009 the De Beers Benefit Society showed Net contribution income of R223 639 867 and total assets of R358 349 622. Net healthcare results (such as managed care, administration

expenses and post-retirement medical expenses) totalled a loss of R20 212 296 (De Beers Benefit Society 2009: 1).

3.3 *Influences on private health care funding: Post-1886*

In South Africa, the latter part of the nineteenth century was characterized by the expansion of health care services. State grants were given to some hospitals but the public became more involved with the financing issues of their local hospitals. Private medical practitioners were allowed to practice in state controlled hospitals.

As a rule it was the private medical practitioners in the various towns who persuaded the local community and the government that a hospital was necessary in that area. The medical practitioners had come to appreciate that it was not only to their economic advantage, but a safeguard of their patients' welfare, to admit their patients to hospital (Searle 1965: 180).

As more patients were admitted, medical practitioners supported these institutions more. This reform brought about improvements and innovations in all spheres of health provision, including health funding.

The first local authority in Johannesburg was a Diggers' Committee elected in 1886 which was replaced a year later by a *Gezondheids-Comite*'. This remained the controlling body of the gold fields until the Municipality of Johannesburg was established in 1897. Initially, the only accommodation for the sick was a gaol constructed from mud and poles. The first black and white mining casualties were admitted free of charge and paid for by the State. A hospital tax was levied on all native labourers. By April 1887, more mines opened which increased demand for a hospital and exerted financial pressure on the State. The Temporary hospital was erected in 1888 costing £3 500 with 33 beds. Costs were met from a subscription list and £500 granted by the Volksraad. Additions to the structure were made almost immediately and paid for via voluntary subscriptions by the ladies of Johannesburg (Burrows 1958: 276).

Doctors flocked to the Rand and within a short space of time there were too many 'until 1914 most doctors had no option but to rely on part-time jobs on the mines' (Katz 1994: 100). White miners elected their own doctors from the mine benefit society panel, however, black mineworkers had a doctor appointed by the mine manager who charged the mine per capita.

In Pretoria, the 'New Public Hospital' was funded via a £1 500 voluntary subscription from the ladies of Pretoria holding a bazaar and a grant of £1 500 from the *Volksraad*. The latter also donated the site. It opened its doors in June 1888 and had 12 beds for non-paying patients and 3 for paying patients (Burrows 1958: 287). Another hospital, the *Volks hospitaal*, was opened in 1891 also to serve the Transvaal capital, Pretoria. The majority of the patients were white but blacks were also admitted.

The Johannesburg Hospital opened on 5 March 1890 at a cost of £43 000 with a bed capacity of 130. Voluntary subscriptions amounted to £8 000, Government provided £6 000 and the balance was covered mainly by loans. By 1930, the hospital had 500 beds. The establishment of the Witwatersrand lured highly qualified medical professionals and prompted the establishment of large contemporary foundations which escalated medical progress, hailed as a 'remarkable phenomena of modern history' (Burrows 1958: 297). By 1902, it was the largest institution of its kind in South Africa.

The growth of the Witwatersrand, due to influx of gold diggers was considerable. This led to an important development in South Africa, namely the private provision of healthcare facilities and treatment for patients employed in this industry. In 1898, the Zimmer and Jack Proprietary Mines Company in Johannesburg started its own 32 bed hospital for its own employees. The concepts of industrial or occupational medicine was peculiar to deep-level mining. 'In this respect – and particularly in the field of pulmonary afflictions such as pneumoconiosis, the Witwatersrand medical fraternity led the rest of the world'

(Burrows 1958: 278). A full discussion on silicosis and its effects is highlighted in this chapter.

By 1899, the Registrar¹⁷ of Practitioners showed the growth in medical practitioners in this region:

Table 10

Transvaalse Staats Almanak of 1899: Number of medical practitioners

Town	Doctors	Dentists	Chemists	Total
Johannesburg	95	7	30	132
Pretoria	18		1	19
Potchefstroom (ex-capital of Republic)	3			3
TOTAL	116	7	31	154

Source: Laidler and Gelfand (1971:480)

3.3.1 Anglo-Boer War (1899-1902)

The South African Republic declared war on the British on 11 October 1899. President Kruger proclaimed martial law in the Transvaal and in terms of a treaty between the two Republics, President MT Steyn mobilized his burghers. Together the soldiers totalled approximately 52 000 between the ages of 18 and 60. ‘...It proved to be the longest (two and three quarter years), the costliest (over £200 million) and the bloodiest (at least twenty-two thousand British, twenty-five thousand Boer and twelve thousand African lives were lost) war for Britain between 1815 and 1914’ (Pakenham 1998: introduction).

Thousands of civilians in concentration camps and soldiers died during this period, mostly from war-related injuries, typhoid, measles and pneumonia. This was due to the British underestimating the duration of the war and the shortcomings of the medical services of the British Army. The Army Medical Corps were put in charge of the hospitals which were run as barracks rather than institutions to care for the

¹⁷ Registrar:- believe this to be Register

ill, at the cost of the British Government. Conditions at all these medical institutions were dismal due to lack of supplies and qualified staff: 'The Army Medical Corps had been totally unprepared to cope with the need for medical services' (Searle 1965: 185). This was attributed as a result of the influx, including local component, of 388 749 men between August 1899 and December 1901.

When the Anglo-Boer war broke out there were eleven hospitals in the South African Republic or in the process of being built, excluding mental and leprosy institutions (Searle 1965: 84). In Pretoria, expenses for the hospital were recouped via public subscriptions and a pass fee was levied on Africans 'As the proceeds from the tax grew large, the Government appropriated it and instead gave a much smaller subsidy out of the general revenue as they had done in Johannesburg' (Laidler and Gelfand 1971: 482). The Government therefore profited from these measures. Again, accident patients and the poor were treated without charge, the latter subject to approval by various bodies. Paying patients paid five shillings a bed in a general ward, adjusted upward for private wards.

The Red Cross was established in 1896 in the South African Republic, prior to the war, but was put on war footing when the War seemed inevitable (Laidler and Gelfand 1971: 204). The opposing Burghers relied on the '*Het Transvaalsche Roode Kruis*' to provide nursing and medical services (Searle 1965: 204). This organisation provided most of the resources during the first few months of the War. Resources were mainly financed by the public and a small grant from the Republican Government (Searle 1965: 204). Despite complaints the resources, such as food to the sick, remained limited until the appointment of a Military Medical Commission to the Government in 1900. The latter took control of all State hospitals and met the medical needs of family members of soldiers.

The Railway Company and Dynamite Factory respectively owned hospitals in Johannesburg and Waterval-Onder. These industrial hospitals developed in response to occupational health needs as the Republic became industrialized. The State Artillery built its own hospital in 1898.

In June 1901, the high mortality rate amongst the woman and children in the concentration camps caused concern. The mortality rate for children was 120 per thousand. Emily Hobhouse was the founder of the South African Women and Children's Distress fund. She issued a damning report in Britain following five months of visits to these camps where 80 000 lived under canvas. It caused a political sensation and in the House of Commons, Campbell-Bannerman famously described the British manner of waging war on civilians as 'methods of barbarism' (Muller 1984: 353). By 1902, measures were taken to curb the hardships, however a total of 26 000 people died in these concentration camps (Muller1984: 353). War came to an end upon the signing of the Peace Treaty of Vereeniging in 1902. By this time, the total number of British troops that participated in this war amounted to 448 725.

3.3.2 Reconstruction and Integration (1902-1910)

Responsibility for the structuring and executing of British rule in South Africa following the war until April 1905 was Lord Milner, the High Commissioner for South Africa, Governor of the Transvaal and the Orange River Colony. A total of £16 500 000 was paid out for repatriation and resettlement which included free grants to those unable to fend for themselves as well as compensation for British, black and natural foreign subjects. In May 1903, Milner explained:

One of the strongest arguments why the white man must rule is because that is the only possible means of raising the black man, not to our level of civilization – which is doubtful whether he would ever attain – but to a much higher level than that which he at present occupies (Milner papers quoted by Muller 1984: 366).

This report will consider how this mindset influenced the disparities on health expenditure between white and black during the ensuing years.

In addition to the colonies of Cape and Natal, the British Empire annexed the Transvaal and Orange River and legislation had to be unified accordingly. A

guaranteed loan of £35 000 000 was raised by the Transvaal and Orange River Colonies to nationalise the railways, construct new railways and public works and purchase land for new settlers (Muller 1984: 364). It is unclear if this included health expenditure. Ordinances were passed mainly to regulate registration of doctors and nurses. After peace was declared, many of the 900 overseas nurses recruited during the war period remained in South Africa. British nurses were given priority in appointments to public hospitals which led to the South African nurses delivering a private duty in nursing. The attitude of these British nurses would have influenced the care of the local patients.

In 1904, the Colonial Office sanctioned the Labour Importation Ordinance passed by the Transvaal Legislative Council. This sanctioned the importation of 62 200 Chinese labourers to work on the gold mines, addressing the problem of labour shortages. The importation of Chinese labour was met with stiff opposition nevertheless the value of gold production increased from £12 628 057 in 1903 to £27 400 992 in 1907. Due to protests in Britain and opposition by the Boers, most Chinese labourers had returned to their mainland by 1910 (Muller 1984: 365).

The South African Nurses Association of 1905 had as one of its aims to raise funds for a sick fund, old age pension fund and to build a convalescent home for nurses in the Colony. Another aim was ‘...to try and make a provision whereby to meet a poor class of patient in the Colonies’ (Searle 1965: 239). Problems persisted in the cohesion of these nurses’ associations until the formation of the South African Trained Nurses Association in 1914. Again, one of its aims was: ‘To take such steps towards the formation of Benevolent Funds or Pension Schemes as may be thought necessary’ (Searle 1965: 242).

‘Between 1892 and 1910, almost an entire generation of professional miners from abroad died from an accelerated form of silicosis...such a death-rate from a single occupational disease must be unparalleled in the whole industrial world’ (Katz 1994: 213). This dissertation will now examine the importance of the mining industry and the financing of mining-specific diseases.

3.3.3 Mining-specific diseases and healthcare funding

The position of the mineworker, since the discovery of gold, was unique. The treatment of the miners' health, both from a medical funding as well as an occupational disease perspective can be seen as ahead of its time. Employers acknowledged the risks associated with mining and instituted measures aimed at the workers. An understanding of mining-specific diseases and the manner in which the mine owners dealt with the treatment thereof, will provide insight into the development of private health funding.

During the 1880's, the extraction of gold became more complex as gold ore was no longer to be found on the surface. The first Chamber of Mines had its inaugural meeting on 7 December 1887 in Johannesburg (Lang 1986: 25). In 1892, a successful extraction method, the MacArthur-Forrest cyanide process, was developed. With a recovery rate of ninety percent of gold from pyritic ore, it paved the way for deep-level mining. Levels ranged between 1 000 and 3 500 feet. Large capital expenditure was necessary in order to industrialise the gold mines. During this time nearly three tonnes of ore had to be excavated to produce one ounce of gold. Development and production had to increase in order to fund the capital. The introduction of mechanised rock drills advanced the drilling methods used but led to larger dust deposits in confined areas.

The First Volksraad in the Transvaal Republic 1893-1897. At the time the majority at the Rand, were British. The mining industry contributed nine-tenths of the revenue of the state (Lang 1986: 88). In 1897 the Industrial Commission of Enquiry into the mining industry was appointed to investigate the depression in the industry and the losses it made since the stock market collapse. By 1899 at a Chamber of mines meeting, the Transvaal was proclaimed the first gold producer of the world (Lang 1986: 113). Mining engineers were talking about mining at depths of 6 000 and 12 000 feet. A shortage in black workers on the mines was due to high wages earned during the war effort, high post-construction demand for

blacks after the war, good harvests and the Chamber of Mines' decision to reduce the schedule of mine wages (Lang 1986: 139). In 1899, there were 90 000 blacks employed on the mines.

By 1901 'the mortality on the mines in that year was horrendous, particularly Blacks from tropical areas who did not acclimatize readily to the freezing Highveld winter, and who had little resistance to the pneumonia which raged in the compounds' (Lang 1986: 146)

In 1902, the Governor of the Transvaal, Lord Milner, under pressure from Britain, appointed the Weldon Commission (also called the Miners' Phthisis Commission of the Transvaal) to investigate the cause and extent of silicosis in the gold mines on the Witwatersrand. This followed the Government Mining Engineer's report ending 31 December 1901 which stated that 255 of 1377 miners died of miners' phthisis in the six months to January 1902 (Department of Mineral and Energy affairs 1981: 1). The commission reported that 25 percent of Europeans working underground had silicosis, also known, at the time, as miner's phthisis. The cause of the disease was correctly identified as fine silica dust that lodged in and affected the functioning of the lungs. Recommendations were made to reduce dust in the workplace by improving ventilation and using water at the point of production. These recommendations were often not enforced and the miners' resisted using water to contain dust as the water was contaminated.

In 1902, 299 new mining companies were registered (Lang 1986: 145). After long debate and investigation between different parties regarding the availability of African labour, the Chamber endorsed the importation of Chinese in 1903, discussed above. The quantity of gold production increased from 2 859 482 ounces in 1903 to 6 220 227 ounces in 1907 (Lang 1986: 161)

The effects of silicosis was known by all the parties and measures were taken to address this: 'From 1902 to 1925 silicosis was the subject of no fewer than nine legislative acts, six commissions, ten parliamentary select committees and four major state-industry reports' (Katz 1994: 5). In 1902, the average working life of

rock drillers was a mere seven years. Despite the effects of the disease being known and widely publicized, government did little to intervene, in fact the death rate increased between 1907 and 1910 (Katz 1994: 207). The same can be said of the medical practitioners: 'To safeguard their positions, doctors often compromised their medical standards to accommodate the economic needs and wishes of the industry' (Katz 1994: 100).

Interestingly the Chamber of Mines reported the following, which may tie in with the findings of Katz: In February 1903 a commission of doctors was appointed to investigate the causes of deaths among black mineworkers. It found pneumonia 41.7 percent, diarrhoeal disease 20.5 percent and scurvy 12 percent. Recommendations focussed upon improved diet and accommodation and improvements were duly instituted. In 1904, Portuguese government officials were 'favourably impressed by the living quarters, food and hospitals' (Lang 1986: 147). It was generally agreed that Africans at the mines were far healthier than upon their arrival. In 1905, Lord Milner's term of office came to an end.

By the end of 1910, there were 84 mines on the Witwatersrand employing 10 000 White and 120 000 non-White miners. They were using 5 500 dry rock drills at a maximum depth of 4 500 feet (Erasmus 1972: 5).

The treatment of silicosis required intensive planning and resources from the mining fraternity. This was provided to all employees of the industry suffering from the disease. The Cape of Good Hope, Natal and the Transvaal already afforded workmen statutory protection following work accidents, before the formation of the Union of South Africa (Dept of Mineral and Energy Affairs 1981: 3). In terms of the historical development of compensation development, the mining industry focussed on the interests of mineworkers and this led to the passing of the Occupational Diseases Act.

The protection of the workman corresponds in broad outline to that of compulsory insurance against the consequences of accidents and occupational diseases where

the employer pays the premium. In effect, therefore, the statutory provisions amount to a fringe benefit for the worker in that he obtains a measure of insurance cover in respect of his normal work risk, that is the risk of sustaining an injury or contracting an occupational disease in the course of his work (Department of Mineral and Energy affairs 1981: 3).

From 1907 small *ex gratia* payments were seen. ‘The Miners’ Phthisis Act 34 1911 was the first milestone in the field of statutorily enforceable compensation for mining-specific occupational diseases’ (Department of Mineral and Energy affairs 1981: 4). The Mines and Works Act was passed the same year and dealt with measures instituted in the mines to reduce the occurrence of disease. Passing of the two acts effectively separated health and compensation for occupational diseases. Several further acts were passed in respect of phthisis i.e. 1912, 1919, 1925 and 1934. In 1946, the Silicosis Act 47 was passed. Each Act saw an increase in benefits and a redefinition of the disease and the environment in which it occurred (Department of Mineral and Energy affairs 1981: 4). Silicosis benefits were paid to the African miners ‘In 1951/53, expenditure under this head amounted to £302 716 paid on behalf of 3 376 sufferers from silicosis’ (Tomlinson 1955: 64).

3.3.4. Union of South Africa (1910-1960)

On 31 May 1910, the four South African Colonies were united to form The Union of South Africa. Modelled on the British Westminster system, it made provision for essentially a sovereign all white Parliament with a Senate (upper chamber) and House of Assembly (lower chamber). Ultimate executive power rested with the King who was represented by the Governor-General-in Council. The Governor-General acted on advice of the cabinet. Herbert Gladstone, the British Home Secretary was chosen for this position. General Louis Botha was appointed as the first Prime Minister (Muller 1984: 380).

Four provinces were formed and these provincial governments were given the power to legislate ‘hospitals and charitable institutions’ (Searle 1965: 256). The

four provinces were the Cape of Good Hope, Natal, Transvaal and Orange Free State. The constitutional basis of the Union of South Africa, namely the South African Act of 1909, did not address the need for a public health service and the functions of the various health authorities were not well defined. The constitution was a unitary one with distinct federal traits, contrasting the tightly-knit federal constitution of Canada and the looser federal constitution of Australia (Muller 1984: 382).

Government did not combine public health and healing services into one national body. The colonial governments became provincial administrations and retained certain functions such as local government including municipal and divisional councils, hospitalization and 'education other than higher education' (Cluver 1949: 317). Until 1918, disease prevention and health promotion issues fell under these three headings.

From the formation of the Union, little progress in public or private health matters were made for the first eight or nine years, in fact, there is reference to a period of retrogression: 'Public Health is not even mentioned in the Act of Union, and whether it was to be a Union or a Provincial matter could only be settled by inference and tacit arrangement between the Government and the Provinces' (Department of Health Annual Report 1927: 3). Some provinces had almost no public health laws and in other they were allowed to lapse. The functions of the Union Government and Provincial Administrators were unclear 'which inevitably led to over-lapping, neglect and inefficiency' (Annual Report 1927: 3).

The dual Colonial Medical Council and Pharmacy Board, Natal Medical Committee, Transvaal Medical Committee, Medical and Pharmacy Council of the Orange River Colony continued to function as separate professional bodies. Only in 1928 were they unified under the South African Medical and Dental Council (SAMDC), in terms of the Medical, Dental and Pharmacy Act 13 of 1928 (Van Rensburg *et al* 2004: 324).

In 1911, several race-related laws were passed, such as the Mines and Works Act of 1911 which refined the 1903 Act passed in the Transvaal. This Act excluded blacks from skilled positions in the mines and became the cornerstone for job reservation in the mines. Ordinance 5 of 1912 ensured that indigent persons received free medical treatment via honorary medical personnel, who in turn received payment from the hospital boards. Persons with private means could be admitted to private wards in public hospitals (Digby *et al* 2008: 28). This Ordinance also regulated hospital districts which were controlled by a board. ‘The boards are financed by provincial subsidies, calculated on the amount of their revenue derived from patients’ fees and voluntary contributions and bequests’ (Malherbe 1940: 175).

On 16 June, the Natives Land Act 27 of 1913 was passed restricting ownership rights of Africans to 7.5 percent [10.4 million morgen] of the land. This followed complaints about Black encroachment on White areas (Muller 1984: 394). These developments would impact on the treatment of blacks in general but also on healthcare positions. There is an association in the passing of this Act and the provision of health service between the different provinces in terms of race:

Although the bill was applicable to the whole of South Africa, in practice it applied only to the Transvaal and Natal. In the Free State legislation prohibiting Blacks from purchasing land in White areas (Ordinance 5 of 1876) was already in force. In the Cape property-ownership was one of the qualifications for the Black franchise. Since the Black franchise in the Cape was entrenched in the constitution of the Union of South Africa, a law forbidding Blacks to own property would be in conflict with the constitution (Muller 1984: 394).

3.3.5 First World War (1914)

The First World War had worldwide repercussions and a brief overview of South Africa’s role is summarised below:

Austria-Hungary declared war on Serbia on 28 July 1914, followed by Russia, France and Germany. On the 4th August 1914 Britain delivered an ultimatum to Germany. On the same day the Union of South Africa indicated its support for

Britain when it notified the British that it would conduct its own defence, if British troops in the Union were needed elsewhere. The British accepted the Union's limited assistance. Understandably, against the history of the Anglo-Boer War, South Africa siding with the British was not universally accepted by the South African population. In October 1914, ten thousand Boers rebelled and took up arms in defiance of the SA Prime minister's declaration of war against Germany, this rebellion was quelled. In February 1915, 43 000 South African men invaded German South-West Africa. The war ended in 1918 when peace was declared and both Smuts and Botha signed the Treaty of Versailles on behalf of the Union on 28 July 1919. Botha died in 1919 and was succeeded by Jan Smuts.

During this time, the regulation of medical matters continued in terms of Act 11 of 1914 (Natal) which abolished the Board of Health and assigned a Minister of Interior or any other minister assigned by the Governor-General relating to public health (Statutes 1914: 44). In 1916 the Jeppe Commission was appointed and issued their Report on the Relief and Grants-in-Aid in Transvaal. In this Report the plight of the poor was visited. Medical treatment in towns was provided by way of district surgeons and out-patients at provincial hospitals. The British poor laws and 'health visiting' is investigated in this Report and recommendations made that the Transvaal follow similar lines as Britain (Jeppe 1916: 121). In terms of medical development, legislation relating to universities was passed in 1916 particularly health education of Africans with the opening of the South African Native College.

From an economic perspective, the Union of South Africa produced 76.4 percent of the world's output of diamonds in 1919. This percentage declined in 1926 due to increased production in British Guiana, Brazil and Belgian Congo. The Pienaar report (1927: 27) shows employment in the alluvial diggings to be 12 000 whites and 40 000 non-Europeans and remarks on the positive affect diamond mining had on unemployment figures during this time. The role of the mining industry continued to grow in importance and the increased employment of the population meant an increase in private medical provision to most people employed by mines.

The Influenza epidemic in 1918 claimed approximately 150 000 South African lives. It is estimated that fifty to one hundred million people died worldwide, surpassing even the current AIDS mortality figures (Gonzalez-Crussi 2008: 126). The Public Health Act 36 of 1919 was promulgated following investigations by the Influenza commission in the same year. This Act was hailed as ‘the first comprehensive legislative measure on health services in the Union of South Africa’ (Essop 1998: 35). It did not amend the South Africa Act, leaving local government and hospitalisation the responsibility of provincial administration. The positive development was that in terms of Section 4 of the Act it structured the Council of Public Health headed by its own Minister. The Council advised the Minister and the Department of Public Health on matters described in Section 4 of the Act (Malherbe 1940: 158).

Central government controlled a minority of hospital services including a number of tuberculosis institutes and mental hospitals. Most of the curative services, including most of the hospitals, fell under the control of the different provincial administrators. Public health matters fell under central government. Environmental controls, social health services and control of communicable diseases fell under local authorities in the provinces (Malherbe 1940: 157). Up to 1970, all health services fell under the control of the Department of Health.

The National and Labour Party alliance unseated the South African party during the election held in June 1924 and Hertzog took over as Prime Minister until 1939. According to Muller (1984: 412), his two main ideals for South Africa were to obtain sovereign independence and ensure the white minority was not dominated by the black majority. He took on the portfolio of Native Affairs to attain this ideal.

In 1925, the Vos Commission issued its Report of the Committee of Inquiry re Public Hospitals and Kindred Institutions. It was tasked to report on the accommodation and facilities available in public and related hospitals, the financing, administration and management of such hospitals, availability of training within these hospitals and lastly public services generally both in urban

and rural areas (Vos 1925: 6). Again an *ad hoc* approach to financing of hospitals is witnessed – as well as disparities between the provinces such as their approach to charging fees. Private hospitals or institutions were subsidised by the State in the form of the respective Provincial Administrations.

Reference to the native tax referred to in the late 1800's at the Kimberley alluvial diggings is repeated here. 'The law provides for a ten percent tax on all diamonds found and in addition a pass fee of 6d per month for each native employed and a claim license has to be paid. The whole of this revenue goes to the Union Government and amounts to a very considerable sum' (Vos 1925: 25). The Commission found conditions at these new fields and new areas dismal with no hospital services aside from three Dutch Reformed nurses. 'In the Cape Province therefore this means that the local community through the Divisional Council must be taxed for this service while the Union Government takes the whole of the revenue from the diggings' (Vos 1925: 25).

Evidence of Hertzog's policy referred to previously is the passing of the Mines and Works Amendment Act of 1926 which introduced job reservation in the mines on the basis of colour by limiting the issuance of competency certificates for blasters, machinists and surveyors to whites and coloureds only (Muller 1984: 416). Act 41 of 1925 the Poll Tax Act was passed where each Black man had to pay 20s in direct tax to central Government – this equalled one or two months' wages for some. It had no age limit - persons from 18 to 80 were taxed. By 1927 the Industrial and Commercial Workers Union was the most important non-White trade union. This Union had 100 000 members. The white man paid tax related to his income. In 1927 two further laws were passed namely the Immorality Act, criminalising sexual acts between the races, and the Native Administration Act which effectively laid the cornerstone for a native state within the state of South Africa.

This 'protectionist policy' was aimed at stimulating industrialisation during the period 1927-1929 which led to an increase in number of factories from 6 009 to 6

238, Gross Product rose from £24 million to £33 million and the number of workers from 115 000 to 141 000 (Muller 1984: 418).

Pienaar Commission (1927-1929)

It was in 1927 that the Union of South Africa appointed the Pienaar Commission to *Report on Old Age Pensions and National Insurance*. Three successive reports were issued during the period 1927-1929. The First Report was devoted largely to old age pensions, the aged and infirm and the Third Report on Unemployment insurance. The Second Report was aimed at sickness insurance and is elaborated upon and referenced below.

Two members of the Pienaar Commission were selected as government delegates to attend the Geneva conference convened by the International Labour Organisation (ILO) of the League of Nations during its tenth session on 25th May 1927. The following principles were adopted:

- a. A Convention concerning Sickness insurance for workers in the industry and commerce and domestic servants
- b. A Convention concerning Sickness insurance for agricultural workers
- c. A recommendation concerning the general principles of sickness insurance
- d. A resolution concerning compulsory sickness insurance in sparsely populated countries where geographical conditions render communications difficult.

The commission had to obtain information from other countries particularly Great Britain, Germany, Denmark and Holland with regard to their system of insurance against the risk of sickness, accident, unemployment, etc. With regard to voluntary sickness insurance the Report states that Denmark had the largest success rate of 60 percent and Switzerland 30 percent of the population receiving medical

benefits. The reason attributed to the high rate in Switzerland was a higher government subsidy; a large percentage of married women enrolled to receive maternity benefits, societies had great autonomy and co-operation in rural areas in order to secure medical services (Pienaar 1927: 27).

The Commission was appointed to examine and report on:

- a. The payment of pensions by the State to necessitous aged and permanently incapacitated persons who are unable to maintain themselves and for whom no provision at present exists.
- b. A system of National Insurance as a means of making provision for the risks of sickness, accident, premature death, invalidity, old age, unemployment and maternity.

According to Pienaar, sickness and social insurance was a result of the industrial development of modern times (1927: 9). During feudal times, the employee resided with the employer who took care of him during sickness, similar to the South African Master and Servants Act. The poor law and church provided those who failed to look after themselves. These provisions were soon to be found inadequate with the move of workers from rural areas and the start of factories in these large cities, making it impossible to plant their own crops which meant that mostly inadequate wages had to be paid to sustain themselves. The commission commented on the different mining industries and the positive effect on unemployment, concluding: 'It appears as if the Union is fairly well placed as regards employment, not only of the natives but also the coloured and European communities, as long as normal conditions obtain' (Pienaar 1927: 26). Unfortunately unemployment statistics were not given. The number of poor whites was stated by the minority report of the Economic and Wage commission as being 100 000 to 150 000 which equalled to 8-10 percent of the white population (Pienaar 1927: 27).

In terms of the members belonging to Friendly Societies reflected in the table below, the Pienaar Commission remarked: 'We think that it may be assumed that

the majority of the members are Europeans and that the proportion of European members to the total European population is about 2 per cent' (Pienaar 1927: 28):

The table below shows that, although not a significant increase in the number of societies, there was a marked increase of 68.8% in the number of members, contributions and expenditure of Friendly societies.

Table 11

Union of South Africa Friendly Societies: 1919-1927

Year	Number of Societies	Number of Members	Members Contributions	Total Revenue of Societies	Total Expenditure of Societies
1919-1920	91	353	£133 822	£160 335	£123 588
1922-1923	84	377	£127 512	£174 331	£138 770
1926-1927	108	596	£213 553	£283 342	£237 347

Source: Pienaar (1927-1929: 29, 30)

Note: Members contributions exclude levies, entrance fees etc

Table 12

General Hospitals – Cape of Good Hope 1914-1921

Year	Daily average number patients	Ordinary revenue £	Ordinary expenditure £	Daily cost per patient	Grants in aid £
1914	34.41	166 627	127 804	9s 1.31d	69 557
1918	36.81	174 459	187 629	9s 1.98d	61 893
1921	37.57	306 735	329 324	11s 8.25	184 978

Source: Holloway (1925:195)

The recommendations of the Second Report pertaining to sickness insurance are summarised as follows:

- a. It recommended a scheme of compulsory insurance against sickness applicable to workers in industrial areas
- b. To extend the scope of services of the district surgeons in rural areas
- c. A scheme of Health insurance in native areas is impractical and suggested a partially trained native medical service instead
- d. Co-operation of existing public health services with prevailing insurance sickness schemes and their doctors to eradicate the source and causes of national ill-health
- e. Contracts to be entered for supply of drugs between insurance schemes (in this case medical aids and societies) and pharmaceutical companies.
- f. The commission was of the opinion that South Africans have a larger habit compared to other countries of taking medicine and that any scheme which includes medicines should introduce regulations for the control of excessive prescribing and unnecessary consumption of drugs.
- g. The Commission thought it undesirable to make any distinction on the basis of colour in an insurance scheme
- h. Employers of persons earning less than £36 per annum should be compelled to contribute to the Insurance Fund unless they have made provision for hospital and medical treatment.

The following table was extracted from the Pienaar Report and shows certain details of the health funding methods in selected countries used to assist the Commission in their investigations:-

Table 13
Health funding methods in different countries 1927

Country	Date of original Act and Method of Organisation	Scope of System	Sources of Income	Benefits
Denmark Voluntary – Societies subsidized by State (In addition Compulsory insurance for all alien seasonal workers – special sick funds, contributions by employers, state 1 Kroner per person)	1892 Sick funds which, in order to be recognized, must comply with certain conditions and be under the supervision of the Sick Funds Inspector	Recognized societies must have a minimum membership and trade or local limitations and admit all persons between ages of 14 and 40 years, subject to certain property and income qualifications	Contributions of members. State contributes 2 Kroner per member per annum, and one-quarter of the amount expended on sickness benefit and a further amount for chronic or incurable cases Communes must also contribute towards chronic and incurable cases	a) Medical and Hospital treatment must be provided for members and their children under 15 years of age b) Sick pay, minimum 40 ore, max 6 Kroner per day c) Maternity benefit, minimum 1 Kroner per day for 10 days 1 Kroner = 1s 1.33d
Germany Compulsory Insurance	1883 Local sick funds Rural sick funds Establishment funds Guild funds Miners' sick funds Substitute funds All under supervision of the Imperial Insurance Bureau	All workmen, journeymen, apprentices and servants without regard to amount of income Officials, clerks, teachers, tutors, home workers, crews of ships, etc with incomes not exceeding 3,600 marks per annum	Contributions, not exceeding 7.5% of the basic wage of each class of workers, payable two-thirds by insured persons and one-third by employers In guild funds the contribution may be equally shared In miners funds three-fifths of the contribution is paid by the insured and two-fifths by the employer	a. Medical attendance, medicine, spectacles, trusses etc b. Sick pay, one-half basic wage for 26 weeks c. Hospital treatment with half sick pay d. Maternity benefit, medical attendance and sick pay for 10 weeks and a lump sum 10 marks e. Nursing benefit, half sick pay for 12 weeks f. Funeral benefit, an amount equivalent to 20 times the daily basic wage g. Dependants receive maternity benefits and, at option of fund, medical attendance

Country	Date of original Act and Method of Organisation	Scope of System	Sources of Income	Benefits
United Kingdom Compulsory insurance	1911 Ministry of Health (England and Wales) Insurance Commissioners (Scotland) Ministry of Labour (Northern Ireland) Insurance committees Approved Societies Deposit contributors	All employed persons, of both sexes, over 16 years of age, excepting those employed otherwise than by way of manual labour with incomes over £250 per annum	England, Wales and Scotland Employee, man 4.5d, woman 4d per week; employer 4.5d N Ireland: Employee male 3.5d; female 3d; employer 3.5d Where wages do not exceed 4s per day employer pays a larger proportion, and where they do not exceed 3s employer pays the whole State pays one seventh of the cost of insurance in the case of men and one-fifth in the case of women	a) Medical attendance, medicine and appliances (except in N Ireland) b) Sick pay 15s per week for males, 12s for females for 26 weeks a. Disablement benefit 7s 6d per week, after expiration of sick pay b. Maternity benefit, £2 c. Sanatorium benefit in Northern Ireland only
Holland Voluntary insurance not subsidized by State	Mutual and other benefit societies, many of which are organised by trade unions or employers' associations Medical institutes founded by physicians	According to the Rules of the Society	Contributions of members. In some instances, employers also contribute	About one-third of the societies provide medical attendance only, more than one half provide sickness benefits only, the remainder provide both benefits

Source: Pienaar, Second Report (1927: 87)

In terms of the implementation of 'Social Insurance' this Report refers to the studies done in other countries as detailed above and states that it had positive effects on an employee's efficiency in the work environment. It suggested the Union enter into reciprocal arrangements with countries which have similar schemes. Whether the Union could adopt such a scheme was dependant on industry's ability to bear the cost of such a scheme. It recommended that the cost of administration of such an insurance scheme be borne by the State.

The Medical Dental and Pharmacy Act 13 of 1928 (1928: 180) was passed to consolidate and amend the laws in the Union relating to medical practitioners, dentists and chemists.

In 1929, General Smuts delivered a speech at the Rhodes Memorial Lecture in London. In this speech he remarked that Africa was developing under different European influences where often conflicting doctrines were applied in, amongst others the administrative, social, legal, educational fields and that no survey of Africa as a whole in these respective fields had been conducted. A committee under the directorship of Lord Hailey was formed to carry out such a project called: ‘An African Survey’. Its findings were comprehensively recorded and relevant parts will be elaborated upon here:

Table 14

African Survey Union of South Africa: Population statistics 1925-36

Area Square miles	Total Population 1925	Total Population 1930-1	Total Population 1935-6	Density Per SQ mile 1935-6
472 000	7 525 000	8 075 000	9 588 665	20.3

Source: Hailey (1938: 108)

In the Union, a separate Government Department, the Ministry of Public Health, was established in 1919, and medical and health work is under the general control of the Secretary for Public Health of the central government. Private practice is fully developed and the hospitals depend to a large extent on part-time work by practitioners and specialists. The provision of hospital facilities is mainly the responsibility of the provisional governments, which afforded it very considerable financial assistance (Hailey 1938: 1154).

Table 15

Hospital facilities in 1936, in South Africa

	Hospitals	Beds	Patients
European	260	9 413	172 555
Non-European	122	15 372	127 951
Other, including private nursing homes, maternity homes, mine and factory hospitals	162		* 198 177
Total	544	24 785	498 683

Source: Hailey (1938: 1155)

* This figure represents the number of non-Europeans treated in mines and factory hospitals

3.3.6 Great Depression (1930)

In South Africa, the combination of several savage droughts and the Great Depression affected the population. Maize production reduced by eighty percent and plunging wages was in evidence. Poverty was a main concern of Government.

The second Carnegie inquiry (1932) into poverty and development in SA dealt with poverty and the individual's health and his ability to purchase insurance or benefit from governments' attempts at addressing this problem. Unfortunately, it was only directed at 'poor whites' and found that 300 000 out of a white population of 1.8 million could be classed as 'very poor'.

Traditionally, patients paid the health service provider directly. During the early 1930's due to the depression, doctors accepted a lower fee, in exchange for direct settlement by the employer – this was called a preferential tariff. The discount ranged between 10 and 33 percent and was the result of negotiation between employer, later medical schemes, and the Medical Association of South Africa.

The link between the poor and the payment of the medical practitioner is important and explains future trends in healthcare witnessed in South Africa. In this respect

Leipoldt (1930: 89) refers to the Carnegie report and discusses the continued role of the medical practitioner to provide free services to the poor, yet be taxed the same as other professions such as lawyers:

Some Divisions [my insertion: referring to MASA branches] have declared themselves against the formulated policy of our Association that we should continue to treat the sick poor in exactly the same way as we have done since Bishop Basileus established his free hospitals...There can be little doubt that among those of us who have been trained in the old traditions, who look upon medicine more as a vocation than a profession or trade, and who are imbued with the spirit that has made a success of voluntary hospitalisation, there is a strong tendency to overlook the enormous changes that have taken place in the social system during the past half-century

Leipoldt linked the Carnegie report to the changing role of the State (1930: 89)

We are chary of facing the important truth that the State has now accepted, not vicariously but directly, the charge of the poor man, whether ailing or well, and that such acceptance logically carries with it the obligation even to pay for medical attendance that has hitherto always been ungrudgingly given free by the profession.

A statement is made that the time had therefore come to readjust relationships between the State and the profession.

...although in England, the home and stronghold of voluntary-ism in hospitalisation, reservations are implied or stated under the impression that a paid hospital staff is likely to close the door to voluntary service altogether...Our system is entirely different from the pure voluntarism of the large London and provincial hospitals, and it is perfectly clear that none of our hospitals can exist, even with the devotion of self-sacrifice of its medical staff, unless it received ample support from the State (Leipoldt 1930: 89).

In 1931, the Federal Council of the Medical Association of South Africa wrote to the Minister of Public Health saying that: 'There is an unquestionable and urgent need to make immediate provision for more extensive medical and nursing services in rural areas for both Europeans and Natives' (Gluckman 1970: 415).

At the time, about three million Africans were affected. In the same year Dr Napier in his presidential address to the Medical Association of South Africa discussed the demand for a State medical service. In 1935, a motion was passed in the Union

House of Assembly where the Minister of Health emphasised the need to understand the concept of a State medical service as converting the medical and allied professions of the entire country into servants of the State. Gluckman cited the failure of this system in countries such as New Zealand and the Soviet Union as being a) their inability to provide medical services in rural areas b) the elimination of private practice and c) the supply of enough practitioners for the scheme.

Before 1935, providers submitted accounts and medical schemes deducted the agreed percentage. After 1935, medical schemes paid a tariff as negotiated between themselves and the providers. Determination of tariffs and the involvement of the different parties in negotiation of such tariffs had been complex as well as ensuing legislation passed – ranging from Medical Association of South Africa and Advisory Council of Medical Aid Societies in 1947 to a Remuneration Commission in 1967. By 1974, four such commissions had been appointed (Browne Commission 1986: 13-17).

Roos Commission (1934)

In 1933, the Department of the Interior of the Union of South Africa appointed the Roos Provincial Commission who issued the Report of the Provincial Finance Commission to:-

Examine and report upon- *inter alia*:-

- a. The financial relations at present existing between the Union and the provinces
- b. Upon the present financial position of the several Provincial Administrations

Hospital Costs in the Transvaal were quoted below (Roos 1934: 31) – note numbering follows original document:

65. 'In regard to the £408 319 spent on hospitals and charitable institutions, it should first be mentioned that the Transvaal hospitals are subsidised institutions, like those in the Cape and Free State, but unlike those in Natal which are Government institutions. The total subsidy for 1932 of £295 846 formed 64.9 percent of the total expenditure on hospitals. Fees and donations which accrued direct to the hospitals amounted to 27.2 percent and 6.5 percent respectively, while the cost per patient-day had decreased from 12s. 8d. to 11s. 10d' (Roos 1934: 31).

66. The annual poor relief expenditure in the Transvaal of £40 9311 was distributed as follows: District Surgeons' fees for attending to the poor £14 138, General Relief £10 653, Poor relief in the districts £6 316, Feeding Necessitous School Children £7 083, Relief Works for Old People £2 581 and Repatriation of Paupers £160 (Roos 1934: 31).'

Table 16

Provincial Heads of Expenditure and Revenue 1932-33

Expenditure	Cape	Natal	Transvaal	OFS	Total
Amount (000)	£279	£216	£408	£64	£967
Percentage of total spend	5.31	15.59	10.65	4.61	8.16
vs. Total Revenue (000) Revised	£5 369	£1 335	£3 954	£1 158	£11 816
Population	3,228,300	1,772,000	2,698,800	783,500	8,482,600

Source: Roos (1934: 130)

Note: Expenditure below relates to Hospitals and Charitable Institutions only

Roos noted (1934: 145) that hospitals were state-aided in the Province of Orange Free State and receive patient's fees direct. 'Hospital fees have ceased to be a source of revenue to the Provinces, except on Natal with its State Hospitals, but

under the system of subsidised hospitals, which obtains in the other three Provinces, the respective Hospital Boards get the fees.’ Roos (1934: 13)

Roos commented on the Economic Conditions of the Union as at 1934. He stated that depressions ran in 6.5 year cycles and that the Union should be preparing for the next depression whilst things are prospering. ‘Our main sources of wealth are gold and diamonds and these are diminishing and wasting assets’ (Roos 1934: 37). He further stated that the country is relatively poor and its 466 000 square miles are sparsely populated. He added that its small European population of 1,889,500 has to do justice to 6,478,700 non-European souls. It is assumed, in this context, Roos was reporting on the ability of the European to support/uplift the poor non-European in economic terms.¹⁸ He compared South Africa’s gross debt of £143 per European person against Canada’s of £58 per head for all races. He referred to the Malherbe Commission who found that half of the Europeans in South Africa are poor versus one fifth of families in Europe.

Section 197 of the Report ‘State Hospitals cannot expect Donations’ is quoted below (Roos 1934: 69):

The hospitals of the Union are divided into State hospitals in Natal alone and community hospitals or State subsidised hospitals in all the other Provinces. It was said by the Secretary for Public Health of the Durban Hospital that it was run primarily for the poor sick. It has no private wards and admittedly run for people who cannot afford to pay the fees charged by the nursing homes, which primarily cater for those who can pay. The Natal system has undoubtedly brought the cost per patient-day down very considerably, if we compare it with the Transvaal cost. The difference between the two systems is that the Transvaal system encourages the benevolent instinct in man towards the houses of sickness and suffering, to the extent that the Johannesburg hospital receives £14 000 or £15 000 in donations annually from the public and the other Transvaal hospitals proportionately. Natal does not encourage voluntary gifts and the Durban Hospital gets practically nothing from the Municipality or from the Durban community chest which collects annually about £20 000 for charitable purposes. On the other hand for special purposes like the Addington Children’s Block or the Radium Fund the Natal public has been very generous.

¹⁸ Note disparities between the Roos and Hayley figures quoted

Section 199 of its Report 'Hospitalisation of Natives' is quoted below (Roos 1934: 69):

Much evidence was also adduced as to who is to pay for the hospitalisation of Natives, the Union having deprived the Provinces of the right of taxing the Natives, on all except their dogs and vehicles, the Provinces have had to take up the burden. The two facts are, however, lost sight of, viz. that the Native cannot pay more taxes, his tax-bearing limit having been reached, and that the available balance of the proceeds of his present poll tax is paid over to the Province for his education. Since the Native cannot pay for his own hospitalisation, the only alternative is that his employer must do so. The mines generally shoulder the burden without question already, and under Natal Acts, No 40 of 1894 and 12 of 1908, the Commission was told in Durban, the master must, if the Native lives with him, pay 2s a day for his hospitalisation for a maximum period of two months. The other Provinces do not have any direct provision, but there is no reason why something similar should not be legalised or required by law by the Union Parliament. The alternative is a pass fee collected from the master, but we are fast approaching the end of the anachronistic pass fees. For Natives who are not employed, the Native Urban Areas Act, no 21 of 1923, with suitable amendments under Section 23, ought to be able to bring relief to the hospitals.

The Commission, therefore, recommended:-

- a. That the Union Government must assume the definite responsibility of a national health policy; that such policy be clearly laid down in a comprehensive national Health Act; that this should be undertaken with the definite purpose of clearing up the confusion which presently exists, and should allocate definite financial and functional responsibilities to the authorities concerned. Your Commission further recommends that the revision of the old and the compilation of a new comprehensive Health Act be undertaken in closest consultation with the Provincial and Local Government bodies to which responsibilities are to be assigned.

The Commission is convinced that there need be no infringement of Provincial or Local Government autonomy as it holds that it is essential to provide for the greatest measure of decentralisation of administration to Provinces and Local Health Authorities.

- b. That the salaries and pensions and other conditions of service of hospital nurses be fixed for the Union by statute.
- c. That the Masters and Servants Acts of the Union be amended to make masters responsible for the hospitalisation of their Native servants and Local Authorities under the Native Urban Areas Act for Natives in urban areas who have no master, and that the Transvaal Native pass fees be abolished.'

In the period 1932-33, the Union, between the four provinces, spent £69 337 on charities and £113 436 on poor relief. With regard to poor relief, essentially the

Commission found a lack of cohesion between Union, provincial, local governments and private organisations and recommended legislation was enacted to remedy the problem. In this regard the Public Health Amendment Act 57 of 1935 empowered the Minister to grant subsidies on an approved basis to hospital boards, local health committees and charitable institutions.

The Government's official policy during the period 1934 to 1948 was one of segregation of the African nation – evidenced by the passing of the Native Trust and Land Act 1936 and Natives' Laws Amendment Act of 1937.

Collie Commission of Enquiry (1936)

National Health Insurance – Report of the Departmental Committee of Enquiry Appointed by the Minister of Public Health, Chairman: James Collie in November 1935.

The terms of reference of this Enquiry was:

To consider and report upon the practicability of the introduction in South Africa of a scheme of National Health Insurance for the purpose of providing adequate medical advice and assistance to any section of the population for which at present inadequate provision is made, and if such introduction be deemed to be practicable, to make recommendations as to the details of such a scheme, including the benefits to be provided and the nature of the arrangements to be made with members of the medical and pharmaceutical professions – The Committee to give consideration in this connection, *inter alia*, to the report and evidence bearing on this subject of the Commission on Old Age Pensions and National Health Insurance (1927-28); and, further to make such recommendations as it may think fit with a view to improving the system of medical assistance to any section of the people, where it considers that the needs of such section are not adequately provided for by any system at present in force or are not likely to be adequately provided for along the lines of policy already initiated and cannot satisfactorily met by the scheme of National Health Insurance (if any) recommended by it.

This Committee was also tasked to investigate and make additional recommendations following the Report of the Commission on Old Age Pensions and National Insurance 1927-8, the Royal Commission on National Health

Insurance (Great Britain, 1926) and the 1928-Loram Committee report on the 'Training of natives in medicine and public health' (Collie 1936: 4).

This reinforces statements made in this report stating that South Africa consulted and relied heavily on the British model throughout its medical funding history. The Commission also tasked the International Labour Office in Geneva to compile a prospectus of the Acts in force in thirty four countries such as Australia, Canada and Denmark, United Kingdom and the United States of America relating to sickness, maternity and funeral benefits. This dissertation assumed that the date of the Geneva report was 1936. Voluntary insurance where societies are not subsidized by the State are shown as well as compulsory models as follows:

Table 17
Prospectus of Voluntary Societies Acts operational in 1936: Selected
Countries only

Country	Date of original Act and Method of Organisation	Scope of System	Sources of Income	Benefits
Australia Voluntary – societies subsidized by State	Registered friendly societies under State supervision	Generally persons in good health between ages of 16 and 45. Some societies have religious, local or other restrictions	Contributions of members. In New South Wales only, a subvention is made by the State in cases of aged persons in receipt of continuous sick pay	Medical Attendance Sick pay generally £1 per week for 26 weeks, 10s for further 26 weeks, and 5s per week thereafter c)Funeral benefit varying from £10 - £200
Canada Voluntary – Societies subsidized by State	1919 Friendly societies under State supervision	According to the Rules of the society...	Contributions of members...	According to the Rules of the society
Denmark Voluntary – Societies subsidized by State (In addition Compulsory invalidity insurance fund for all citizens between 21 and 60 who are registered members of sick fund)	1892 Sick funds which, in order to be recognized, must comply with certain conditions and be under the supervision of the Sick Funds inspector	Recognized societies must have a minimum membership and trade or local limitations and admit all persons between ages of 14 and 60 subject to certain health, property and income qualifications	Contributions of members. State contributes 2 Kroner per member per annum, and one-quarter of the amount expended on sickness benefit and a further amount for chronic and incurable cases Communes must also contribute towards chronic and incurable cases	a) Medical and Hospital treatment must be provided for members and their children under 15 years of age b) Sick pay, minimum 40 ore, max 6 Kroner per day c) Maternity benefit at same rate as sick pay for 14 days
Japan Compulsory Insurance	1922 Health insurance societies – persons not insured in these are insured directly by the State	All persons working in industrial, mining or transport undertakings employing 5 Or more persons Administrative employees with annual incomes over 1,200 yen are exempt from insurance	Employees, up to 3 per cent, of daily remuneration Employers, same amount as employees State, 10 percent, of the expenditure, maximum 2 yen yearly per insured person	a. Medical or hospital treatment for 180 days b. Sick pay, 60 per cent of daily wage for 180 days c. Maternity benefit, 20 yen and sick pay d. Funeral benefit, 30 times daily wage, minimum 30 Yen

Country	Date of original Act and Method of Organisation	Scope of System	Sources of Income	Benefits
United Kingdom Compulsory insurance	1911 Ministry of Health (England and Wales) Department of Health (Scotland) Ministry of Labour (N Ireland) County insurance committees Approved Societies Deposit contributors	All employed persons, of both sexes, over 16 years of age, excepting those employed otherwise than by way of manual labour with incomes over £250 per annum	Employee, man 4.5d, woman 4d per week; employer 4.5d Where wages do not exceed 4s per day employer pays a larger proportion, and where they do not exceed 3s employer pays the whole State pays one seventh of the cost of benefits in the case of men and one-fifth in the case of women	a) Medical attendance and medicine b) Sick pay 15s per week for men, 12s for unmarried woman, 10s for married women, for 26 weeks e. Disablement benefit at half sick pay, after expiration of sick pay. f. Maternity benefit, £4 for insured women, £2 for wife of insured man
USA Compulsory insurance	1935 Social Security Board	All employed persons except agricultural workers and domestic servants	Equal contributions of insured and employer. Initial rate, 1 per cent of wages each 1937-1939 Maximum basic wage 3000 dollars a year	Old-age pension at age 65, after receipt of at least 2,000 dollars and employment on some day in 5 calendar years, from 10 to 85 dollars a month according to total amount of wages earned after 31/12/1936

Source: Collie (1936: 90-115)

The Departmental Committee of Enquiry submitted its report in August 1936, where its main recommendation was a national health insurance scheme aimed at employees of all sections of the population earning less than £400 per annum located in the urban areas of the Union of South Africa. Doctors would be remunerated via a capitation fee in respect of each consultation.

The Departmental Committee Report also looked extensively at ten countries in Africa such as Sudan, Northern Rhodesia and Nigeria but the focus was on training

of African medical staff and schemes of medical services and will not form part of this dissertation.

The Collie Committee Recommendations and Conclusions are summarised as follows (1936: 71):-

- a. Co-ordination of Schemes of Social insurance: There should be the closest possible co-ordination between any new scheme of social insurance and those in existence and when a new scheme is under consideration the possibility of further schemes should be kept in view (Para 11).
- b. State Medical Service: **The time is not yet ripe for a State medical service in this country** [emphasis added] (Para 35).
- c. Compulsory Health Insurance in urban areas: A scheme of insurance embracing medical, maternity, funeral and sick-pay benefits applicable to employees in the urban areas of the Union could be successfully instituted under the conditions outlined their Chapter XI, and should be introduced as early as possible.
- d. Medical Benefit: Medical benefit should include in addition to a general practitioner service the free supply of drugs, medicines and curative appliances, a specialist service and hospital benefit (Para 198).
- e. General Practitioner service: The general practitioner service to insured persons should follow the lines of the British scheme (Para 46).
- f. Hospital Benefit: Hospital benefit should consist of a payment in cash of not exceeding nine shillings per diem to insured persons falling into wage-groups (f) (g) (h) and their dependants for each day spent in hospital not exceeding thirteen weeks in respect of any illness (Para 198).
- g. Dental Benefit: Dental benefit should be included in the scheme as soon as experience of running the scheme has been gained (Para 61).
- h. Medical and Pharmaceutical Contracts: A contract should be entered into between the management of the insurance scheme and the South African Medical Association for the supply of a general practitioner service to insured persons and their dependants as detailed in the scheme (on the basis of an annual 5 fee of 9s for insured persons with incomes below £180 per annum and each dependant and of 13s for insured persons with incomes of from £180 to £400 per annum and each dependant) (Para 152-3); A contract should similarly be entered into between the above-mentioned parties for the services of specialists including surgeons, pathologists and radiologists payment to be based on a capitation fee (of 2s. 3d. per annum for insured persons and their dependants with incomes of less than £180 and 3s. 3d. per annum for those with incomes of £180 - £400) (Para 154); A contract should be entered into between the management of the Fund and the associated pharmaceutical societies which will be binding on all dispensing chemists who elect to serve the Fund for the supply to insured persons of drugs, medicines and curative appliances payment to be made on the basis of a fee for dispensing prescriptions plus the cost of medicines and materials used (Para 161).
- i. Friendly and Benefit societies: Although members of these societies are not excluded from the scheme of compulsory health insurance the societies

- should be encouraged to continue in existence for the purpose of providing benefits additional to those provided by the insurance scheme (Para 182).
- j. Foreign Workers: So far as the compulsory health insurance scheme is concerned no distinction should be made between South African nationals and nationals of other countries (Para 184).
 - k. Rural Areas:
Taking the rural areas as a whole the medical needs of the vast majority of the inhabitants are at present inadequately provided for (Para 223); The time is not ripe for the initiation of a scheme of health insurance for our rural areas (Para 239); The present area of a number of district surgeries is too large and should be divided; More district surgeoncies should be created and the services of doctors residing in rural areas should be utilised as district surgeons (Para 249); Periodical tours under Act No 36 of 1927 should be increased in number and frequency (Para 250); The completion of the district nursing service should be speeded up; the district nursing service should be a State service; district nurses should be provided with quarters and adequate means of communication (Para 253-4); The necessity for further progress in plans for meeting the needs of the inhabitants of the rural areas should be kept always in view (Para 256);
 - l. Native Areas
The medical service for the native areas of the Union is inadequate to the needs of the inhabitants (Para 270); There exists in the Union all the factors required to form the nucleus of a scheme for providing an adequate medical, nursing and hospital service for the native population of the native areas; The scheme which is being inaugurated by the Department of Public Health should be extended as soon as possible and the inauguration of a native nursing service should be speeded up (Para 284 and 285); There should be close co-operation with the governing bodies of the missionary societies in the erection and management of mission hospitals (Para 285); The possibility of employing in the medical service for the native areas young native men as health visitors should be explored. (Para 285); Fees for medical and nursing services well within the natives' capacity to pay should be imposed (Para 288).

Two of the members of the Committee did not agree with the report and issued their minority reports accordingly, mostly pertaining to the lack of medical care to urban dwellers. It did not have an effect on health financing issues.

Actuarial analysis submitted in the Report of estimated cost of national health insurance – including sickness insurance:-

Table 18**Cost of National Health Care in 1930**

	Cost of Benefits	Contributory Parties	Contributions Per annum	Number of Insured
Ordinary Medical	£1,599,412	Government	£776,735	
Specialist	£247,922	Employers	£2,663,315	
Hospital	£675,995	Insured	£1,891,641	
Maternity	£569,276	Total	£5,331,691	882,683
Funeral	£161,407			
Sickness	£1,358,309			
Total	£4,612,321			

Source: Collie (1936: 142, 143)

It is clear from the above table that the application of this proposal was very limited. The number of insured as at 1936 was stated as 882 683 persons. It was known to the Commission that the population numbered 8 135 000 in 1931. A meagre 10 percent of the South African population was affected by these proposals.

In addition South Africa was negatively affected by a shortage of medical professionals. The population was serviced by 2 496 doctors. This equated to 3 258 persons per doctor or alternatively 6 319 as provided by different sources (Collie 1936: 12). Should one compare these statistics to Australia the number of patients per doctor equal 800, USA 1 500 and UK 1 800. During this time, Hailey reports that there were 544 hospitals, which included private nursing homes, maternity homes, mine and factory hospitals. European hospitals totalled 260 with 9 413 beds and non-European hospitals 122 with 15 372 beds. It is pointed out by Hailey (1938: 1155) that more than half the native hospitals and beds were provided by the mines and factories.

The Commission quoted the then late Dr EP Baumann MP whose submissions to the Commission estimated present annual outlay for medical advice and treatment by entire population of the Union equated to £6,000,000. The Union was at the time providing free services via the Provincial Administrations and larger municipalities free medical services to prisoners, Government officials, Police and members of the permanent defence force including wives and families, persons employed under Government relief work schemes, pupils at vocational schools, persons in areas lacking medical aid, etc. 'In each Province there are fully staffed and completely equipped State or State-aided hospitals maintained by the Provincial Administrations, primarily for the benefit of persons who are unable to pay anything at all toward the cost of treatment' (Collie 1939: 13) It is concluded that 75 percent of persons treated at these facilities were treated free of charge.

The Commission concurred with Baumann's view that it is not the right time was not ripe for a State medical service in South Africa.

Previous reference to the role played by the medical profession in the acceptance of nationalisation of health services is supported by the following: The Commission stated their agreement with the International Labour Office in its summing up of the present position as affecting the states adhering to the League of Nations amongst other being:-'....The medical associations are putting up a vigorous and sometimes vehement defence of the free exercise of their profession, and are resisting, often successfully, a process which they regard as the subordination of medicine to the State, with a resulting 'officialisation' of their profession...' (Collie 1939: 13).

Another shortcoming of this report was the rural dwellers and unemployed whose plight was in urgent need of address were left out. The questionnaires were directed at agricultural societies, organised bodies of employers and employees, friendly and benefit societies, farmers associations and church- and woman's organisations. Many respondents such as the Cape Chamber of Industries, South African Federated Chamber of Industries SAFCI and Transvaal Engineering and

Allied Industries Federation felt that it would severely burden their industries. The Transvaal Chamber of Mines added: ‘Even if the Government were to undertake such liabilities out of public revenue, the industries of the Union, and especially the gold mining industry, would ultimately, directly or indirectly have to bear the main portion of the charge’ (Collie 1939: 7).

During the House of Assembly debate the Minister of Health, referred to it as ‘a beautiful dream of the future’. The objections were that it could not be applied to rural areas or African reserves, it made no provision for the independent worker or the small employer, it was inapplicable to the individual receiving an old age pension or invalidity pension and it would do nothing towards the shift from curative to preventative medicine.

The *status quo* with regard to Friendly Societies is illustrated in the following table. The figures relate to all societies, lodges, clubs and other associations created to grant financial assistance to their members in case of incapacitation, sickness, death, unemployment and other causes. Insurance Companies were not included, however, mine benefit societies, railway friendly societies and friendly insurance societies were included:

Table 19
Friendly societies 1934 to 1938

Year	Number Of Societies	Funds £	Benefit Members	Revenue £	* Expenditure £
1934-35	145	935 994	106 521	621 209	465 982
1935-36	153	1 097 489	147 434	742 977	528 448
1936-37	166	1 455 815	233 527	954 602	632 278
1937-38	165	1 562 100	253 425	1 051 148	730 695
1938	165	1 627 785	265 274	1 113 134	751 960

Source: Malherbe (1940: 202,204)

*Note: Death payments to members and wives deducted

There is continued evidence during this period of the Government’ attempts at extending public healthcare to the public at large with support from voluntary

sources of funding. On 31 January 1938 the 710-bed Groote Schuur Hospital in the Cape Province opened its doors. Its core role was to be a general hospital for the population at large, especially the poor, but also a clinical teaching hospital. The Cape Provincial Administration raised a 40-year loan from Central Government on behalf of the Cape Hospital Board for the building amounting to £870 000. It was partly funded by donations of £75 000.

3.3.7 Second World War (1939)

This decade is seen as a turbulent period in South African history. The contested decision by Government to enter the Second World War marked the beginning of this era ‘The Second World War transformed the face of South Africa like no other era since the reconstruction period following the Anglo-Boer War’ (Dubow *et al* quoting Bonner 2005: 170). Dubow adds that South Africa had the advantage of gold to finance this war as it produced one third of the world’s gold output. Production increased during this time, despite acute labour shortages. This era ended with the Nationalist Party taking over power in 1948, introducing apartheid as it formally became known, for the next forty-six years.

With the outbreak of World War II, South Africa was faced by an internal political turmoil caused by the dual loyalties existing in Parliament. Although South Africa was allied to Britain, the South African Prime Minister Hertzog was anti-British and pro-Afrikaner and lost the vote. After intense Parliamentary debate the former Prime Minister, Smuts was appointed Prime Minister and war officially declared on September 4th 1939, a day after British ultimatum expired and Britain went to war against Germany. South African involvement consisted of supply of troops, airmen and material to the North African and Italian campaigns. A total of 334 224 volunteers participated of which 9 000 were killed in action (Dear, 2005: 800).

The idea of mutual medical aid grew slowly. By 1910 there were only 7 schemes and by the outbreak of World War II there were 48 schemes. After World War II, death rates declined mainly because of improved sanitation and better personal

hygiene. This was also due to the systematic removal of sewerage and garbage from public places which resulted in an improvement in the quality of drinking water – a major cause of disease. Although not apparent in 1942-4, a medical revolution was in the making. Modern medical science was born as antibiotics came into widespread use first in the armed forces and then after the war in general medical practice (Dubow *et al* 2005: 91). South Africa's main infectious diseases – syphilis and especially tuberculosis – were transformed with antibiotic treatment.

This dissertation focuses on several Committees appointed by Government and other interest groups, particularly from 1940, onward: 'Governments often appoint commissions as a way of testing the political climate or, more cynically, to defer action on tricky problems.' (Dubow *et al* 2005: 10) Smuts appointed a number of considerable commissions in the 1940's such as Van Eck (1940) industrial and agricultural requirements; Smit (1942) social conditions of urban Africans; Lansdown (1944) working conditions of African miners; Fagan (1948) black urbanization, black migrant workers and influx control; Gluckman (1944) national health system; Social Security Committee (1944) advantage of a comprehensive system of welfare and benefits. Several recommendations such as proposed by Smit and Gluckman were ignored or rejected by the Smuts government in their conservative phase (Dubow *et al* 2005: 10).

It is summed up in the following statement: 'Official, lay, and professional views and reports emphasised not only the basic inadequacy of medical services, but also the accentuation of the inadequacy through the lack of organisation of services privately rendered, and through the complexity and in-co-ordination of the administration of those which were provided by public authorities' (Raats 1950: 150).

For the purposes of this study, the view is that different Commissions gave invaluable information pertaining to developments prevailing at the time. The Smit Committee below highlighted the plight of the poor, particularly the Blacks. This

state of affairs appears similar to the British, centuries ago. The disparity of expenditure on health between the rich and the poor was highlighted.

Smit Committee (1942)

This committee was appointed in 1941 to investigate the improvement of the non-Europeans in terms of economic, social and health matters. Its aim was stated: 'to explore possible ways, other than merely increasing wages, of improving the economic, social and health conditions of the Natives in urban areas, to collate facts, and to make suggestions to the Government as to what is practicable in the above direction'.

The Smit Commission Report of the Inter-Departmental Committee on the social, health and economic conditions of urban natives was issued by the Union of SA Government Printer. In terms of the social and economic considerations, the Committee reported (1942: 1), note number corresponds to Report:

7. The Committee has been impressed above all by the poverty of the Native community. This poverty is a factor, the ill-effects of which permeate the Native's entire social life. In most of the smaller towns the poverty of the Natives was seen against a background of general poverty, where not only a large population of white citizens, but even the municipalities themselves seemed unable to shoulder any burdens additional to those they were already carrying.

11. Local authorities are required to maintain Native Revenue Accounts, out of which the expenditure on public services such as administration and the maintenance of locations, sanitation and water supply is met. The Committee draws attention to the fact that such Accounts, which are maintained out of direct and indirect taxation of the Native, whose income is below an economic living standard, cannot meet the entire cost of services which should be provided. Since the Native by his presence in the urban areas, contributes toward the welfare of the local community at large, contributions from the General Revenue Account into the Native Revenue Account are fully justified. Indeed many municipalities are rightly adopting this principle. At those centres, however, where Native Revenue Accounts are expected to be self-balancing, the essential public services required by the Native community must fall below an adequate standard. That such deficiencies should exist in any centre where the General Revenue Account is well able to contribute toward the essential needs of the Native community cannot be too strongly condemned.

It remarked on the high incidence of ill-health, the inadequacy of the provision for dealing with declared disease and of the comparative neglect of measures to preserve health. Conditions in locations were such that it would produce ill-health among the inhabitants, in turn encouraging the spread of diseases. The lowest standard of public hygiene was tolerated. 'The saying that disease knows no colour bar has been worn threadbare by South African publicists in health matters, but the practical results which should flow from the acceptance of this axiom are not yet in evidence in the great majority of South African towns' (Smit 1942: 7).

It found around 40 percent of Native schoolchildren in Durban had signs of malnutrition. A report of the superintendant of Edward VIII hospital during 1938-1939 is quoted with regard to native admissions '...One can safely say that about half of them were grossly undernourished...' (Smit 1942: 5). The Commission quoted Section 122a of the 1919 Public Health Act pertaining to Native population's housing: 'of such construction or in such as state or so situated or so dirty or so verminous as to be injurious or dangerous to health'. The committee commented on the one-sided application of the Slums Act 53 of 1934: 'The Committee regarded this provision of the Slums Act as itself an example of the tendency toward the adoption of dual standards of public hygiene, which is incompatible with a scientific approach toward this subject' (Smit 1942: 8).

Smit continues:

The individual Native householder is too poor to provide a hygienic house and latrine, too poor to provide himself with proper storage receptacles for refuse and slops, too poor to meet economic charges for sanitary removal services. Collectively the Natives are too poor to provide these services even on a communal basis, which is another way of saying that their cost cannot be met from the Native Revenue Account alone (Smit 1942: 9).

Smit attributed this state of affairs to failure by local authorities to comply in terms of Section 10 of the Public Health Act.

Smit stated that poverty and insanitation were accentuated by ignorance. ‘Not only is the Native ignorant, but he is also superstitious and in consequence – encouraged thereto by the whole tribe of herbalists and quacks, including Europeans as well as Natives – he often spends his money on expensive but useless remedies’ (Smit 1942: 9). As a result Smits’ main recommendation was greater expenditure on training by Government and expansion of hospital, dispensary and nursing services in urban areas. He also states: ‘In the Department of Native Affairs there is no justification for excluding Natives from the Old Age Pension Scheme while Coloured people are included’ He roughly estimated the cost of the inclusion to be (1942: 30):

Towns at £1 per month	£300 000
Outside areas at 15s per month	£603 000
Total	£903 000

Smit estimated child mortality rates for Africans to be 200 per thousand births and closer to 300 per thousand births in locations (Smit 1942: 10). The Committee was ahead of its time insofar as disparities on racial lines were highlighted and commented upon in a straightforward and open manner, such as the disparities in feeding schemes, hospital beds as opposed to other population groups. It also recommended the abolition of the detested ‘pass laws’. Its recommendations centred on the improvement of public health matters which would result in an overall improvement in health.

Pentz Commission (1942)

The Pentz Commission issued its report on free hospitalisation in the Transvaal. Its main terms of reference were:-

‘To consider and report upon:-

- a. The advisability and feasibility of extending the existing field and scope of free hospitalisation so as to cover –

- a. all classes of the community
- b. certain classes of the community only, these classes to be defined by the Commission ('Free hospitalisation' must be taken to connote the free hospital services given in the Transvaal today to all persons not in a position to contribute towards the cost of hospital treatment, including maintenance charges, free use of theatre, drugs, dressings, X-ray, electrotherapeutic department, all forms of specialised treatment and free medical services).
- c. In the case of (b) above, the possibility of limiting the cost of all services included under the term 'free hospitalisation' in respect of all patients not admitted as free patients
- d. What organisation, if any, should there be of decentralised clinics, related to hospitals, particularly as regards natives...' (Pentz 1942: 2).

It is interesting to note the preparatory remarks of Pentz on the role of the medical profession in accepting any suggestions by the State of nationalising health, which coincides with earlier observations made in the Reinach report twenty years later:-

I had high hopes at one stage that at the conclusion of an arduous but interesting task I might be able to acknowledge the closest co-operation and assistance from the medical profession as represented by the Transvaal Branches of the South African Medical Association.

I regret to say that, whilst individual members were very helpful, the Medical Association as a body refused to co-operate.

There was nothing at the outset of my investigations to lead me to suppose that the medical profession as a body, and as represented by its organisations, would take up the attitude reflected eventually in the following resolution of its Federal Council:-

'The Federal Council of the Medical Association of South Africa (B.M.A) is of the opinion that any scheme for the institution of free hospitalisation by the Provincial Authorities of the Transvaal, at the present moment and in view of the appointment by the Government of a Commissioner to investigate and plan medical services to the whole country, will be not only inopportune but likely to prejudice and vitiate the object of such a Commission. Furthermore until this Commission publishes its report the Federal Council of the Medical Association of South Africa (B.M.A) is not prepared to co-operate.'

I do not wish to accuse the Medical Association of downright disingenuousness, but I am bound to refer to the representations of its Parliamentary Committee to the Government, to whom the view was conveyed that whilst the Association was anxious to cooperate with this Association, it felt that it had 'not so far been given an opportunity of discussing the details of the proposed scheme and of offering any comment on it.'

This makes strange reading in the light of the concluding words on the resolution quoted above, that it 'is not prepared to cooperate', and also the fact that the questionnaires submitted to the Northern and Transvaal branches of the Association were actually discussed when I interviewed a deputation consisting of representatives of both these branches.

The reason for non-cooperation can, in my opinion, only be described at best as specious.

The system of hospitalisation of the Transvaal, whether in its present form or any other form, has obviously nothing to do with State medical services for South Africa, so long as hospitalisation remains the function of the Province, and so long as its scope remains what it is today.

How can it be 'inopportune' to bring the cost of hospitalisation within the bounds of reason for the public of the Transvaal?

How can it be 'prejudice and vitiate' the object of the Commission to be appointed by the Government, to provide hospitalisation at a reasonable cost, or to pay medical men directly for their services instead of having a spurious system of honorary medical officers?

To the public of the Transvaal I leave judgement of the medical profession on this issue.

Perusal of the report which follows will show that throughout I have borne in mind the private interests of the doctors, consonant, of course, with the interests of the sick and the suffering and the public in general.

If the public is forced to the conclusion that in the view of the Federal Council of the Medical Association the first consideration in hospitalisation is not the good and well-being of the sick, but the private gain of the doctor, the Association has only itself to thank... (Pentz 1942: 2, 3).

In 1943, Smuts and his United Party won the elections based on their promise to provide a 'better life for all'¹⁹ where there would be no forgotten men in Society (House of Assembly debate 12.1.1942 5-6). Smuts also promised a society which

¹⁹ Interestingly the same election manifesto as the ANC in 1994: 'A better life for all' (Seekings quoted by Dubow *et al* 2005:62)

was more racially inclusive where civilised standards would apply to prosperous and respectable Africans.

Poverty and resultant hunger in rural areas and the effects of Government's restrictions on movement to urban areas was recognized. Changes were not fuelled from 'below' but rather by officials and academics looking at industrialized countries for solutions.

For mining and manufacturing capital, a public welfare system offered considerable benefits: the welfare of a low-paid black workforce could be improved not through higher wages but out of income taxes paid by white workers, undoing some of the 'distortions' introduced into the labour market by the political power of organized white labour (Dubow *et al* 2005: 60).

The same disparity in taxes as in the 1920's emerged again in the 1940's and reported in the Roos Commission addressed: The fact that real taxation per head of the white population rose by 75 per cent between 1939 and 1945 illustrates the very real political pressure Hofmeyr [then Minister of Finance – my addition] was under to be efficient in his use of government revenue' (Dubow *et al* 2005: 22).

Unfortunately, social reforms were reversed by the National Party coming into power in 1948 where 'they would monopolise the benefits of social reform for the next two decades' (Dubow *et al* 2005: 61).

3.3.8 United Kingdom and the Beveridge Report (1942)

At this point this dissertation will deviate from the South African discussion and focus on the British Beveridge Report of 1942. This Report had wide-ranging consequences in many parts of the world such as Rhodesia, Ceylon, West Indies, Canada and New Zealand and impacted on the International Labour Organisation (ILO). The Gluckman Commission appointed in South Africa in 1942, studied and referred to this Report in their recommendations as reported below.

A brief background of Britain during the 19th Century is provided below. This will create an understanding of the events which led to the appointment of the Beveridge Commission in 1942.

Britain increasingly became a constitutional democracy in terms of giving all citizens to the right to vote. The middle class were enfranchised into a representative government by the Reform Act in 1832 (Heaton 1948: 389). Although this was not, at the time a fully democratic system i.e. 'one man one vote', since the franchise remained qualified, De Schweinitz contends that this democracy triggered the equal provision of healthcare in Britain. As a result, the poor acquired more rights to services, previously reserved for the rich (De Schweinitz 1943: 90).

By 1832, the cost of the provision for the poor became prohibitive and the British government appointed a Royal Commission tasked with 'Inquiring into the Administration and Practical Operation of the Poor Laws'. Although the population had doubled from 1760, the cost of Poor Relief had escalated five and a half times during the same time. The increase in Britain's wealth was derived from manufacture and related industries whereas the taxes for poor relief came from home owners and occupiers of property (De Schweinitz 1943: 90).

The Royal Commission published a book in 1833 *Extracts from the Information Received by His Majesty's Commissioners as to the Administration and Operation of the Poor Laws* which their results were summarised:

It is now our painful duty to report, that in the greater part of the districts which we have been able to examine, the fund, which the 43rd of Elizabeth directed to be employed in setting to work children and persons capable of labor, but using no daily trade, and in the necessary relief of the impotent, is applied to purposes opposed to the letter, and still more to the spirit of that law, and destructive to the morals of the most numerous class, and to the welfare of all (De Schweinitz 1943: 118).

The findings of the Commission centred on the able-bodied labourer and his acceptance of relief. The emphasis was on the discrepancy between poverty relief

and the labouring man. There was no incentive for the poor to work because their income and conditions were better than the labouring man's. Once the Commission had established this information, it continued to apply a principle which dominated the administration for the next 75 years. The doctrine of 'less eligibility' controlled the English government's approach to the relief of destitution for the nineteenth and part of the twentieth century. Their recommendations are summarised:

- First recommendation: relief other than to able bodied persons in regulated workhouses was declared unlawful.
- Second recommendation: a central board appointed to regulate and unify the administration of workhouses, as well as the nature of relief and labour needed.
- Other recommendations: Combine or remove parishes and parish officers; provision and qualifications of personnel; recommend candidates.

This set England on the road to national supervision and larger administrative units (De Schweinitz 1943: 124,125). On 14 August 1834 the recommendations of the Royal Commission were enacted in terms of the Poor Law Amendment Act, commonly referred to as 'the new poor law' as opposed to the 16th century poor laws.

Rose (Mommsen 1981: 51) believes the emergence of a welfare state was seen as a reaction to the cruelties of the New Poor Law system by the gradual institution of alternative organisations of welfare which had no connection to the Poor Law. 'The broad theory is that the British welfare state grew out of popular revulsion for and a gradual official rejection of the [New] Poor Law...' (Mommsen quoting Fraser 1981: 9). Mommsen (1981: 51) quotes O.R. Macdonagh in explaining the origin of national health: 'In one area the New Poor Law had almost from the start turned upon its tracks and developed in a fashion alien to its origin and object alike. This was ill health. Here the rudiments of a free, non-pauperising national service gradually developed'.

By 1837, government expenditure in England on poor relief reduced by more than one third compared to 1834. Demand for relief increased as the number of poor increased, following events such as the harsh 1860-1 winter, cotton famine and the British Depression of 1866. During this period through to the early 1860's, philanthropic activity increased in public response to the severity of the Poor Law. The most important Society formed as a consequence of the New Poor Law was the London Society for the Relief of Distress. A large and influential part of the ruling class was involved in the operation of public relief but also the way in which private charity was managed.

The following table demonstrates the increase in expenditure on poor relief over the 50-year period showing an increase in excess of 130 percent from £5 015 610 to £11 565 876 'Increased administrative functions were mirrored in the proportion of expenditure devoted to non-pauper purposes' (Mommsen 1981:20).

Table 20

**Poor Relief Expenditure as Percentage of Total Expenditure in Britain
1844-1900**

Year	Total Expenditure (£ m)	Percentage Expended as Poor Relief
1844	6,99	72,69
1854	7,32	72,82
1864	9,68	66,80
1874	12,85	59,64
1891	18,35	50,88
1900	26,31	43,96

Source: Mommsen (1981: 20)

Charles Booth, the English philanthropist and social researcher, showed the disturbing extent of poverty and deprivation toward the end of the century in England and commented:

It began to be evident that deterrence in the administration of relief had not solved but had rather contributed to the problem of destitution. A community can secure in human welfare very nearly what it is willing to pay for. The nineteenth century was not willing to pay because it thought the individual could and should foot the bill himself. On this basis it succeeded in its campaign to reduce expenditures for relief (De Schweinitz 1943: 165).

In June 1941, it was announced in the House of Commons that an interdepartmental Committee had been appointed, headed by Sir William Beveridge. Composed of representatives from eleven departments, the committee reviewed existing schemes of social insurance and related services; studies of governmental departments and various commissions; testimony and memoranda of 127 organisations plus consultative services from the International Labour Office. Essentially Beveridge addressed ‘an attack upon five evils’ in the form of poverty, disease, ignorance, inadequate shelter and unemployment (Dubow *et al* 2005: 51). In essence this meant, the capacity of the state to promote the welfare of its citizens.

This led to a route of welfare elected by South Africa in the mid-twentieth century where the State provided relief by means of cash transfers to the poor whereas most other British colonies opted for agrarian reform. ‘In Southern Africa...it is not so much the interruption of earning power as the inefficiency of earning power which causes poverty. The great majority of the population is in poverty, in work and out of it’ (Dubow *et al* 2005: 55).

The outcome of the investigation was the concept of a ‘national minimum’ and that control of health matters would be vested in one organisation, namely a ministry of Social Security. The national minimum was a contractual right to a basic income in the event of sickness, which the individual had contributed toward. Hence: ‘Health is held to be so important, both to the family and to the nation that it is not left to individual arrangement’ (De Schweinitz 1943: 231).

This Report recommended that a National Health system be developed:

The main feature of the Plan for Social Security is a scheme of social insurance against interruption and destruction of earning power and for special expenditure arising at birth, marriage or death. The scheme embodies six fundamental principles: flat rate of subsistence benefit; flat rate of contribution; unification of administrative responsibility; adequacy of benefit; comprehensiveness; and classification. These principles are explained in paragraphs 303-309. Based on them and in combination with national assistance and voluntary insurance as subsidiary methods, the aim of the Plan for Social Security is to make want under any circumstances unnecessary (Beveridge 1942: 9).

The basic benefit would continue as long as the sickness continued. Benefits were actuarially related to contributions which would prevent the fund going bankrupt. Contributions would be a flat rate within certain categories: Every male over 21 would pay 4 shillings 3 pence a week and every employed female, 3 shillings 6 pence. It was proposed that voluntary insurance subscriptions be scrapped and government appoint a statutory corporation to supply industrial insurance. Thus, the National Health Service (NHS) of the United Kingdom was introduced in 1948.

The sickness and disability benefit was separated from the administration of the health service. The former is to supply income, the latter to provide treatment and cure. There was one national programme of aid. The basic principle of universal payments and benefits was instituted and that all citizens were treated equally.

The total annual expenditure for the social security programme for 1965 was projected at £858 million. This was two and half times the expenditure in 1938-39 of £342 million. This was recouped as follows (De Schweinitz 1943: 242):

Government	£519 million
Insured Persons	£192 million
Employers	£132 million
Other, chiefly interest	£ 15 million

According to Veliotis (1991: 43) the main strength of the NHS was that it provided good primary care to the British population. This has been achieved as follows:

1. cost containment measures such as: 'Gatekeeper' role of the general practitioner resulting in low hospitalisation costs;
2. Limiting medicines in terms of cost escalation mainly via negotiations with pharmacists. Medicines represented eight percent of total health expenditure;
3. review and monitor of prescribing practices of prescribing doctors: Doctors and nurses were paid relatively low salaries;
4. low expenditure on capital investment.

Similar to the South African experience, the medical profession initially opposed National Health insurance:

While at the outset there appears to have been some resistance by the medical profession to the introduction of health insurance legislation, opposition to the Act quickly disappeared as physicians' incomes increased under National Health...Indeed many hoped for a closer and more extended relationship with the government (Feldman 2000: 16).

Reforms were introduced to the NHS in 1991 to introduce competition thereby promoting efficiency by separating financing and provision of health care.

The National Health Services Commission (Gluckman) (1942)

On the 17th February 1942 Henry Gluckman, as a Member of Parliament, delivered a speech to Government appealing for the appointment of a National Health Services Commission. The effort was to be jointly performed by the medical profession, the people and the State, the role of the latter being stressed as providing moral and financial support. He ascribes the shortcomings of the current system to the 'cumulative effect of policies and trends pursued by practitioners, patients, hospital trustees and superintendents, health officers, educators,

philanthropists, industrial employers and employees and government departments generally' (Gluckman 1970: 416).

He also cited the divided control of hospital services as a source of the problem. In 1942 the general hospitals were under provincial control; while the control of infectious disease hospitals vested under local authorities; and tuberculosis and venereal disease hospitals fell under Public Health and mental hospitals under the jurisdiction of Department of Interior.

During this time, the treatment of disease was changing to a more holistic approach to health. The Planning Committee of the Medical Association of South Africa emphasised four factors namely the promotion of health, the prevention of disease, the treatment of disease and the rehabilitation of the convalescent to the community.

The Commission was formally appointed in the House of Assembly on the 25th August 1942 to enquire into, report and advise as to (a) the provision of an organised National Health Service which will ensure adequate medical, dental, nursing and hospital services for all [emphasis in original] sections of the people of South Africa, and (b) the administrative, legislative and financial measures needed to provide this service. The commission had to focus its attention on the following: i) the provisions of the Public Health Act of 1919 and its amendments, ii) the functions of the Department of Public Health in relation to the Department of Social Welfare, iii) the relationship between the Union Department of Public Health and provincial administrations and local authorities, iv) the organisation of the South African military medical services, v) the report of the Departmental Committee of Inquiry on the subject of national health insurance, vi) free hospital services, vii) training of medical students, nurses, public health officers, etc., viii) existing facilities for research services ix) the National Nutrition Council, x) the Housing Act.

The findings of the commission were that the statistics pertaining to preventable diseases are high compared to Europeans and they found support for this conclusion: 'existing administrative, legislative and financial measures are not adequate to provide, by any mere process of expansion, a national health service of the range and quality necessary to remedy the state of affairs' (Gluckman 1970: 454).

The Commission attributed the basic causes of ill-health to poverty, ignorance and the inability for certain sections of the population to provide adequate nutrition. In 1938, the Commission refers to a survey done by the Department of Public Health showed malnutrition amongst European boys varied from 47.6 percent in the Transvaal and 43.6 percent in the Free State to 44.5 in African boys to 90.4 percent in Letaba. Local authorities were ill-equipped to address this, and other socio-economic problems encountered in this respect (Gluckman 1970: 454). 'The commission, having come to the conclusion that personal health services should henceforward be regarded as a citizen right to be provided according to needs, recommend that this should be done through a service nationally controlled and directed' (Gluckman 1970: 456).

In terms of the recommendations, ultimate legislative and financial responsibility would fall under executive control of the Minister of Health, responsible to Parliament. The minister would be assisted and advised on policy and health matters by a National Health Council. An Executive National Health Board would perform day-to-day administrative services and carry out policy. This latter body was to be decentralized into approximately 20 regional organisations which were to be further divided into 400 health centres throughout the country. Democratically constituted advisory bodies would be appointed to advise these national, regional and peripheral levels (Gluckman 1970: 483). A National Health Service Personnel Commission would deal with appointments and service conditions. A national health congress was suggested to consult with technical staff as to views on technical, scientific and employment issues.

Personal health services included hospitalisation, maternity and child welfare, health education and were to be unified under the national health authority. Non-personal services directed at promoting the health of the nation such as water, sanitation and housing would fall under local authorities escalating to provincial and national authorities. Gluckman explains: 'The most fundamental of the commission's recommendations was that the provision of personal health services to all sections of the people be accepted as a national responsibility' (Gluckman 1970: 458).

The commission suggested a blanket tax of 4 percent which would shift the position from inequitable, where each person is taxed according to his degree of ill-health, to equitable where each is taxed according to his means. An all-encompassing service including home doctoring, chemist, maternity, X-ray would be provided to safeguard health at every step of the way. Contributions of the very lowest of society would amount to a mere 5s per annum whereas the £300 per annum income group would increase their contribution from £9 (1936-census) to £12 for much more care. The group adversely affected would be the earners in the £400-£1 000 income bracket however the Commission showed that this group spent most on individualistic medical benefits as it was. Although their expenditure would increase marginally, they could rest assured that all citizens were be cared for such as his employees, domestics and labourers.

The Social and Economic Planning Council found that in 1941-1942 the country spent £14 000 000 on ill-health and health services of which £10 000 000 was spent by the general public. The latter was direct spending such as hospital fees by individuals plus indirect payments to sick funds, etc. Instead the commission proposed that there be a radical change in financing the services from private to public expenditure in the form of a health tax to a common fund. From this fund the National Health Authority planned to finance national health needs. Revenue from the taxes envisaged above would amount to £10 250 000 plus yields from Workmen's compensation and Native regulation acts which would leave central government contributing £3 250 000, which was only £1 250 000 more than it was

spending at the time of the report. An example of the average number of public versus private patients treated at Groote Schuur Hospital in 1941 is 610 public patients and 34 private patients, roughly 5 percent (Digby *et al* 2008: 23).

In 1944, the report issued by the Gluckman Commission on health of the working class in South Africa was seen as decades ahead of its time in the western world. 'Through the National Health Services Commission Henry Gluckman made a contribution to world medicine both in theory and in practice which, after more than 20 years, remains unique.' Professor Gale stated in his 'aftermath of the Gluckman report' (Gluckman 1970: 495). The commission found that health care in South Africa had become a commodity to be bought and sold and the main consequence of this was that 'private practitioners provided health care to the wealthy who could afford it' (De Beer 1984: 67).

The National Health Services Commission understood the possible negative effect it would have on professionals and that it may curb their financial freedom. To counteract this, the commission recommended that doctors retain their professional independence and certain safety measures to attain this, be taken. He quotes resolutions as positive and passed by the Federal Council of the Medical Association of South Africa held on the 3rd February 1945 and the Government's statement of policy.

In concluding the findings of the Commission to Government, Gluckman refers to the Beveridge Social Security Report and their Governments' acceptance to spend £148 000 000 per annum on an organised health service. Equating it to the recent war effort, he urged Government to act with all its resources to develop a national health service for the people. The motion was seconded and Government accepted the recommendations in February 1945 with two reservations namely that the service would be established within the framework of the constitution and secondly to introduce the health service in a series of measures, rather than one big step.

Insofar as the implementation of the National Health Act was concerned, the National Health Council was established with the Minister of Health chairing as chairperson. Various State officials supported the NHC such as the Secretaries of Social Welfare, Native Affairs, Labour, Education, and the Director of Veterinary Services. The NHC was accepted as a foundation of providing a health service. Such centres would be opened first in needy areas to focus on and promote health. Urgent health matters relating to serious illnesses such as tuberculosis and typhoid were addressed by the expansion of health centres, education and nutrition. Legislation was enacted for the financing of these measures via local authorities. Hospital accommodation was extended by the purchase of five military hospitals for £2 000 000. Health care graduates were trained by the state in health centre techniques, which created employment. Within one year of the acceptance of the recommendations of the Health commission, Gluckman was appointed Cabinet minister of the department responsible for the implementation of the findings and Minister of Public Health in 1945.

An important recommendation of the Commission was moving control of general hospitals, municipal clinics, infectious disease hospitals, medical societies, some aspects of private practice of the hospitals to national government. This required parties to relinquish their control. The provinces were however unwilling to surrender their control to a national authority' (Gluckman 1970: 484).

An important part of the findings was the introduction of the basic division of personal and non-personal health services into categories of promotive, preventative, curative and rehabilitative. The report distanced itself from the belief that medical practice must evolve around hospitals. The report itself states that:

...the health centre is the practical expression of two of the most important, and universally accepted, conclusions of modern medical thinkers. The first is that the day of individual isolationism in medical practice is past and that medical practitioners and their auxiliaries can make their most effective contribution to the needs of the people through group or team practice. The second is that the primary aim of medical practice should be the promotion and preservation of health (Gluckman 1970: 501).

The Public Health Amendment Act of 1946 separated the functions of the Central Government and the Provinces. The provinces were responsible for general hospital services and outpatient services. The Government was to provide extra institutional services through the development of health centres. An amount of £100 000 was provided in the 1945-6 budget to provide for these centres (Raats1950: 154). Difficulties in implementing services and funding arose.

In a speech to the South African Medical Congress on 9 November 1946, Henry Gluckman discussed the lower income groups and how they financed their expenditure on health. Firstly they joined medical benefit schemes. A large number could not afford this and the second group would merely do without care with the resultant detriment to their health. This would outweigh the economic burden on the community to provide free health services. A third group received free services from private practitioners.

In 1948, the Nationalist Party came into power and changed the health policy. Gluckman had to surrender his tenure as minister. Forty peripheral health centres were established throughout the country in the two years prior to this and continued to develop after 1948. The work done by the Gluckman commission in terms of the concept of 'comprehensive medicine' and the health centre concept found interest in many parts of the world.

The constitution of the World Health Organisation was adopted in 1948. It was based on the principle that health is essential to the happiness and security of this world. It is the right of every person and government has a duty to provide the benefits of medical, psychological and related knowledge and adequate health and social services.

Life expectancy discrepancies between the European and Africans can be seen. In 1950-1955 it was 43.2 years in Southern Africa, whereas in England it was 66.4 for males and 71.5 for females (Ityavyar quotes Pearce 1992: 190). This was mainly attributed to communicable diseases and nutritional inequities. During the

1920's industrial diseases increased. Post-Colonial Africa witnessed a downward spiral in health and poverty, particularly in rural areas whereas the flow to the cities due to industrialisation would have seen relative prosperity as illustrated below.

In 1927, the Pienaar report remarked on industrialisation and its effect on the movement of labour from farming and rural areas to the cities and the social and economic effects it had. Manufacturing in South Africa rose from 12 percent of GDP in 1939 to 19 percent of GDP in 1949. This led to a rapid expansion of employment in this sector, particularly blacks rising 7.7 percent per annum between 1939 and 1945 and 6.8 percent per annum to 1950 (Dubow *et al* 2005: 24). Pienaar's remarks regarding urbanisation is witnessed in the forties when blacks became more urbanised, notwithstanding the 1923 legislation restricting black access to urban areas.

The 1950's

On 1 January 1950 the Cape Province accepted financial and administrative responsibility under Hospital Ordinance 18 of 1946 for paying for in-patients at its hospitals and recouping the cost from provincial taxation. The new Nationalist Party Government reminded the Administration that the Union did not provide free health services, save for indigent persons and 'expressed the greatest concern about the Cape decision not to levy any fees after 1 January 1950' (Digby *et al* 2008: 29).

The ordinance was suspended in 1950 for 3 years in respect of free medical treatment. All patients could receive free hospital services however medical treatment had to be paid for, unless the patient was classed as private, Workmen's Compensation or Motor Vehicle Insurance beneficiaries. These latter parties paid in all instances. Only persons who could provide a certificate as to their financial inability to do so from a magistrate, medical doctor, etc would be exempt (Raats 1950: 186).

Provision and funding of health services continued to be fragmented and Government policy differed between provinces. The Transvaal public hospitals were administered in terms of the Public Hospitals' Ordinance 18 of 1928 and controlled by autonomous hospital boards. Patients were expected to pay fees according to their means except if they could provide a certificate stating their inability to do so. Paying patients had to pay fees for their private medical attendants who were honorary medical practitioners appointed by the hospital staff to render services. The Board was subsidized by the Province but also relied on donations.

The whole conception of hospital services was largely based upon the voluntary hospital principle common to English-speaking countries, and the hospital boards were charged with the whole responsibility of providing the service the patient needed, subject only to a measure of provincial approval in such matters as expansion of the hospital or provision of additional staff (Raats1950: 187).

Table 21

The 1951 population census of the Union of South Africa

Race Group	Number 1951	Representing Percentage of total	1952 Mortality	1945-1947 Life Expectancy
Asiatic	367 000	2.9%	10.9/1000	50.3
Bantu	8 535 000	67.5%	27-32 /1000	36.4
Coloured	1 103 000	8.7%	19.9/1000	42.8
European	2 643 000	20.9%	9/1000	66
Total	12 648 000	100%		

Source: Tomlinson (1955: 25, 26)

Note: - Mortality figures for Bantu not available - Estimated

Tomlinson Commission (1955)

Tomlinson (1955: 61) summarised the Health Services for the Bantu areas and services provided by the different bodies as it existed at the time of the Report. It provided meaningful insight into services provided by non-statutory bodies during that time:

- a. Services provided by Statutory Bodies – this will not be expanded upon in this dissertation
- b. Services provided by Non-Statutory Health Bodies – this will be expanded upon in this dissertation

Missionary Societies maintain mission hospitals and sometimes operate district nursing services with liberal financial assistance of the Union Health Department.

Charitable organisations, in the form of voluntary committees provide district nursing services with the financial assistance of the Union Health Department. Financial assistance is also available from the Deferred Pay Interest Fund in those areas where the Bantu are recruited for employment on the mines.

Other voluntary bodies, such as the S.A. Red Cross Society, the S.A. Council for the Blind, the Cripple Care Association, and the National Council for the Deaf provide services which in most cases are available to all races

c. Services provided by Private Practitioners

18. Most of the doctors in the Union, including specialists, provide their services by private practice at a fee payable by the patient. There is no racial bar between doctors and patients and most of the doctors in the Bantu Areas are Europeans.

19. A fair number of nurses practice their calling privately either through a nursing agency or as independent practitioners, either as general nurses or midwives or in both these capacities. If considered necessary and in the public interest, the Union Health Department supplements the earnings of a private nurse, European or non-European.

20. The great majority of dentists in the Union provide their services by private practice at a fee payable by the patient. There is no racial bar between dentists and patients. A measure of free dental services available to all races is provided by the provincial administrations, the Union Health Department, certain local authorities and voluntary organisations subsidised by the statutory bodies, and by the two universities with dental facilities.

The Tomlinson Commission (1955: 161) reported that in 1951 there were 5 755 medical practitioners listed on the Medical Register. In the Union there was one

doctor for 2 381 persons whereas in the five Bantu areas there was one doctor to 4 640 Bantu. Generally there should be one doctor to 1 000 persons. Hospital beds were one per 644.3 in African rural areas. Mission hospitals provided 43.8 percent of the available general beds. This Commission urged the Government to extend health services in Bantu areas and recommended that health services be under the control of the Union Department of Health working through African commissioners. A health tax would be levied on all African taxpayers plus small charges on medicines and dressings made. A white paper issued by Government stated that the recommendation of taking over all mission hospitals over a period of time was not attainable.

In 1954, Strijdom was elected Prime Minister. He was a Republican, 'an advocate of apartheid and famous for his intolerance towards un-Afrikaans and liberal ideas' (Muller 1984: 468). After the 1958 elections Verwoerd, seen as the 'architect of apartheid' became Prime Minister until his assassination in 1966. During his term (and as Minister of Native Affairs since 1950) the Group Areas Act 41 of 1950 was adopted, Coloureds were removed from the voters' roll in terms of the South Africa Act 9 of 1956 amendment act, the Natives Resettlement Act 19 of 1954 was instituted to remove 'black spots' in white areas. See also the Bantu Education Act 47 of 1953 which segregated white and black education. Promotion of Bantu Self-government Act 46 of 1959 abolished Black representation in the House of Assembly and set standards for development of the homelands, an important development in health funding (Muller 1984: 483, 484, 485, 486).

At the end of 1959, the Cabinet approved the appointment of two Committees of enquiry into Medical Aid Schemes namely the Reinach and Snyman Commissions. Their frames of reference and findings are discussed in Chapter 4. In the same year, the first edition of the Hospital and Nursing year book was issued, Edited by MacCarthy. It provides a concise summary of the health funding model at the time.

By 1959, the Department of Health still operated in terms of the Section 2 of the Public Health Act of 1919 with the underlying basis of the Act being

decentralisation. Health matters of local concern devolved upon local authorities, subject to financial assistance on defined bases from the Department which may be extended to provincial authorities. The provinces were responsible for the establishment, control and administration of hospitals (MacCarthy 1959: 7).

MacCarthy (1959: 9) quoted the Gluckman report of 1944 insofar the policy of Government regarding the respective spheres of the Provinces and Central Government in relation to personnel health services was concerned. ‘Recently the Provinces, with a view to relieving the pressure on general hospitals, decided to accept a greater measure of responsibility in respect of the provision of extra-institutional curative services, i.e. outpatient and district nursing services’. Provinces were to do this at their own cost but relieved of certain other costs previously enacted in terms of the Public Health Amendment Act 60 of 1956. Reference is also made to the Central Health Services and Hospitals co-ordinating Council which became a statutory body in terms of the Public health amendment act 51 of 1946 for ‘the effective correlation and co-operation of hospital and other personal health services of the Union...for the general benefit of the community’ (MacCarthy 1959: 9). Poor relief was transferred from the four provinces to Central Government.

Thus, the provinces provided extensive hospital services to White and non-Whites.

These services are no longer free since a means test is applied to each patient. In addition, the provinces subsidize a large number of private hospitals and nursing homes. In the non-White territories hospital services are mainly provided by the mission hospitals which are generously subsidised by the provincial authorities in each case (MacCarthy 1959: 13).

The Friendly Societies Act 25 of 1956 was an amendment of former Friendly Society Acts in existence from the previous century and spread over several of the colonies. ‘The Act required that funds be registered as friendly societies before they could operate their particular scheme. ‘At that stage the control exercised was mainly of a financial nature’ (Melamet 1994: 7). ‘A friendly society can be defined as a formal mutual organisation existing with the purpose of providing its members

and its relatives with benefits, relief or maintenance when in financial difficulty due to, among other things, sickness, death, unemployment and retirement” (FSB Circular 2000: 33).

There were 1,100 such societies with a membership of 500 000 in 1956 and amongst its aims were assistance with medical expenses. ‘Members were generally the poorer classes of people, often Non-Whites’ (Horrell 1956:216). In 1957 the average net income per capita was R248 per month. According to Reinach there was no control whatsoever over medical aid schemes prior to this enactment of section 25 of 1956. The Reinach Commission felt that although it made registration of schemes compulsory, the benefit was mainly financial and that more legislation would bring better control (Reinach 1961: 23).

Tomlinson (1955: 61) reported:

Certain large *employers* of labour, such as the gold mining companies, provided extensive medical services. They carry out medical examination of recruits for their respective industries and promote the health of their labourers by good feeding, housing and the provision of adequate medical and hospital facilities. A certain amount of health education work is also undertaken.

Considering the importance of this statement, further information is provided in terms of these gold mining companies and members of the Chamber of Mines: The industry employed 380 000 African employees and 47 000 White employees with more than 100 white full-time medical officers. ‘A number of mines have their own fully-equipped Native hospitals and others close to one another have centralized hospital services’ Complicated cases were referred to the Native Labour Association Hospital and had 1 100 beds and was also used for persons suffering from lung disease in terms of the Pneumoconiosis Act. Most Europeans were treated at provincial hospitals but serious cases are referred to the Chamber of Mines hospital in Johannesburg which is private and described as ‘one of the finest traumatic hospitals in the world’ (MacCarthy 1959: 46, 47).

The following tables summarize the private health funding scenario at the end of the 1950’s. The number of hospital beds (including public) had increased from

3920 in 1898 by 2 290 percent to 93 690 in 1958. Medical aid memberships had increased by almost 500 percent in the 20 years from 1940-1960. A large increase in the number of independent medical aid schemes is witnessed in terms of Table 25. This trend is much higher than the population growth during this time, which had increased in the region of 188 percent from 5,176,000 in 1904 to 14,928,000 in 1960 (see previous reference in this regard).

The reason for the growth in the private healthcare industry, as seen from the 1960's to date, could be ascribed to encouragement of the State and private interests to expand this industry. Note Essop's statement below:

Concerns about the ability of governments to finance health services adequately, and about the poor performance of public health service delivery systems, as well as the desire to expand the choices available to patients, have resulted in the adoption of a strategy of encouraging the expansion of the private sector in a number of developing countries (Essop, 1998: 31).

Table 22

Summary of Hospital Beds in the Union of South Africa 1958

Province	Type	European	Non-European	Total
Cape	Provincial	4 068	4 343	8 411
	Private	2 594	5 836	8 430
Natal	Provincial	1 712	5 079	6 791
	Private	1 281	4 447	5 728
OFS	Provincial	859	475	1 334
	Private	600	1 003	1 603
Transvaal	Provincial	5 957	6 374	12 331
	Private	3 503	5 503	9 006
Union Health Dept	TB	333	3 019	3 352
Union Health Dept	Leper	48	1 943	1 991
Union Health Dept	Mental	7 773	12 271	20 044
	Private Mental	432	54	486
Santa	TB		5 503	5 503
Transvaal and OFS		190	8 490	8 680

Chamber of mines				
Total Union of SA		29,350	64,340	93,690

Source: MacCarthy (1959: 13)

Table 23

Five largest medical Schemes: Growth in members 1940-1960

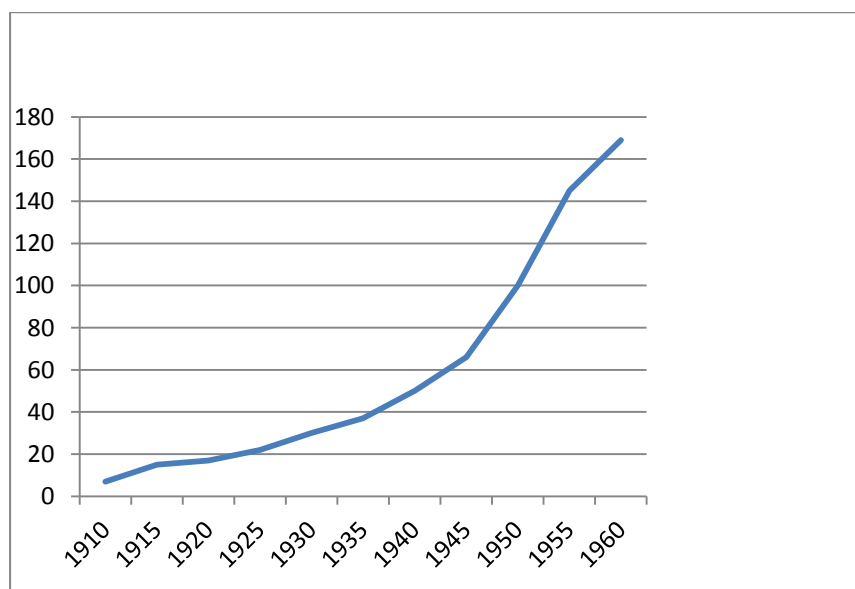
	NUMBER OF MEMBERS				
Scheme	1940	1945	1950	1955	1960
State Employees Medical Aid	927	1 164	2 053	3 750	9 467
Durban Municipal Employees	201	401	1 030	1 435	1 874
Post Office Medical Aid	1 147	1 886	4 526	6 417	10 714
Shell Medical Aid	801	724	1 339	1 905	2 300
Consolidated Banks	5 802	7 971	13 094	17 126	20 865
Total	8 878	12 146	22 042	30 633	45 220
Percentage increase from previous period stated		36.8%	81.5%	38.9%	47.6%

Source: Reinach (1961: 14)

Table 24**South Africa Nursing Statistics: 1898-1960**

Year	Number of Hospital Beds	Registered Nurses and midwives	Estimated Mid-Year Population	Nurse to patient ratio
1898	3 930			
1924	18 500			
1933		6 515	9 074 000	1:1 393
1944	65 922			
1953		24 676	13 182 000	1:534
1960	102 857	35 113	14 928 000	1:425

Source: Searle (1965: 259,265) adapted

Table 25**Number of Independent Medical Schemes: 1910-1960**

Source: Reinach (1961: 13)

Note: Independent schemes shown are not underwritten by insurance companies

In this chapter we have witnessed the continued fragmentation of the private healthcare industry in terms of supply structure. It was demonstrated that the State, mines, industries and charitable organisations all played a role in the funding of private healthcare.

CHAPTER 4: DEVELOPMENT OF PRIVATE HEALTH FUNDING: HALF- CENTURY 1960 to 2010

Many private health funding developments were witnessed at the onset of the 1960's. This era is considered important as Government involvement in private health care increased. This chapter provides a chronological account of the events which shaped the private funding industry to what it is today.

During the 1960's- three Commissions of Enquiry reported their findings namely the Reinach Commission in 1961 on Medical Aid, Insurance and Assistance Schemes; the Snyman Commission in 1962 on the High cost of medical services and medicines and finally the Coertze Commission in 1965 on the proposed Medical Schemes Bill which led to the passing of the Medical Schemes Act 72 of 1967. The sixties was seen as a turbulent period fuelled by the refusal of medical practitioners to accept preferential tariffs for medical aid schemes, which led to further enactment in 1969.

The tariff debacle continued and led to the appointment of the Erasmus Commission in 1971. Political unrest in the 1970's culminated in the Soweto riots in 1976 seen as a turbulent political era and a recession in the South African economy. Private health funding consisted mainly of the provision of medical aid by employers. Hospital services were provided to private patients by the State, in exchange for a fee. Medical practitioners charged private patients and provided free services to those who could not afford it.

The Browne Commission was appointed in the 1980's. By the end of the 1980's investigations on a national health scheme started. On the private funding side, the *status quo* remained fairly stable however toward the end of this decade a concerted effort was made by Government to expand private funding toward the public sector.

4.1 The period 1960 to 1989

The Department of Health (2002: 19) noted three types of private medical schemes in the 1960's namely:

Sick funds – the oldest type of scheme where members had limited choice from a panel of practitioners who were remunerated on a per capitation basis ‘Sick funds were crude fore-runners of pre-paid plans equivalent to health maintenance organisations and independent practitioner associations’.

Benefit Funds – members paid a fee and had free choice of practitioner who was remunerated on a preferential tariff per service. Funds were provided by groups of professionals or medical practitioners. No clear distinction between the above two. Benefit funds did not fall under the friendly societies act.

Assurance Schemes – originated to supplement the benefits of benefit funds. The scheme operated on the basis that a third party took initiative to provide medical cover, for a profit.

During 1960, approximately 1 500 000 whites in South Africa provided for their own medical benefits in terms of medical expenditure in one or other form. This equalled 48 percent of the white population based on the 30 June 1960 census predictions. It is assumed that no Black members of the population had this cover. This assumption is based on comments found in the relevant Commission Reports and highlighted herein. Of the 169 independent schemes, 137 had compulsory membership as a condition of employment. Most of the members interviewed were in favour of compulsory membership and only 2.3 percent were in favour of voluntary membership (Reinach 1961: 25).

Reinach added a third group of individuals who could be underwritten by insurance companies, such as farmers and attorneys who did not belong to

employer groups. The Commission remarked that insurance companies targeted this group however had to be restricted. A large number of groups then broke off their relationships with insurance companies and MASA retracted their preferential tariff from a large company '*Assuransie skyn dus nie die oplossing te wees nie*'[translated Insurance therefore does not seem to be the solution] (Reinach 1961: 32).

The legal framework of medical services was based on the 1909 Act which was still in force in 1960 and summarised by Snyman (1962: 28) as follows:

- a. The administrations of the four provinces could promulgate ordinances to erect, maintain and manage hospitals in terms of Sections 85(c) and Section 95.
- b. The Public Health Act 36 of 1919 made infectious diseases and environmental hygiene the responsibility of Central Government. Importantly this ties in with the British system 'This Act chiefly followed the pattern of an existing British Act...' (Snyman 1962: 28). Mental patients fell under Central Government.
- c. Local authority comprised the third level of service
- d. The fourth level of service was the independent profession engaged in private practice.

By 1960, most of the peripheral health centres established in terms of the Gluckman recommendations had been closed down or handed over to provincial administrators, who converted these to out-patient clinics practising curative medicine only (Gluckman 1970: 515). Funds for health services were reduced. The staff employed by these centres migrated to other countries and continued the concept of these health centres.

In 1961, South Africa became a Republic. 'Although the Public Health Act of 1919 was frequently amended, it nevertheless still served as a valid basis in regard to the Constitution of the Republic of South Africa which was adopted in 1961' (Van Rensburg et al 1982: 200) The rest of the existing health legislation was retained without change (Van Rensburg *et al* 1982: 200).

From media reports in the early 1960's the role of the medical associations and their relationship to the medical profession particularly with regard to tariffs, came to a head:

Doctors throughout the Southern Transvaal are greatly alarmed at reports that the Federal Council of the Medical Association of South Africa has approved co-operation by the profession with insurance companies running Medical Aid Schemes...the uproar has been accentuated by the fact that the Southern Transvaal Branch voted solidly against preferential tariffs for insurance company schemes at its January meeting...several insurance companies stated that no profits accrue from the Medical Aid Schemes, but this is hotly disputed by many doctors...the doctors are convinced that recognition of insurance company schemes will be the death of those sponsored by private employers which will affect many people²⁰.

In 1962, the Snyman Commission found that 2.4 percent of national income was spent on health services translating to R7.02 per capita. The Commission also found that at the time, it was impossible to quantify total private health expenditure in South Africa. Reinach found 169 independent medical schemes with 368 890 members and 588 997 dependants. These figures excluded approximately 45 independent schemes which did not respond to this Commission (Reinach 1961: 25).

South Africa was not lagging behind the rest of the world in terms of medical care. Medical history was made when the first successful heart transplant was performed in the world on 3 December 1967, performed by Professor Christiaan Barnard at the Groote Schuur Hospital in Cape Town. This was a state subsidised hospital with a small proportion of private patients. The following table illustrates the growth in the number of hospitals, particularly in respect of non-whites, from 1958 to 1962. Notwithstanding this development, the ratio to total population remained low:

²⁰ The Star 12 March 1960

Table 26
Number of hospitals and medical practitioners 1945-1967

	1945	1956	1958	1962	1967
Medical practitioners	4,441		7,549		9,639
Hospitals: Total	623	581		717	
Whites	279	229		196	
Non-Whites	159	145		296	
Mixed	185	207		225	

Source: South African Bureau of Statistics October 1968

The following table provides a further detailed analysis of the Hospitals and Beds in the Republic in terms of method of funding. It shows that more than 33 percent of hospitals were provided by the State, 16 percent by private concerns whereas an additional 15 percent were provided by Industry or Mining concerns:

Table 27
Number of hospitals and beds in terms of funding, 1962.

Public Authorities			Private Hospitals		Industrial	Religious	Welfare Org	Total
Central	Provincial Government	Local Auth	Inc	Un inc	Mining & other			
Number of Hospitals:								
17	169	54	39	82	105	119	127	717
Number of Beds:								
4,456	35,290	4,709	5,137	1,252	12,366	15,386		

Source: South African Bureau of Statistics October 1968

Questions surrounding employment and benefits for nurses continued into the 1960's and the development of medical benefit schemes appeared to be a threat to white nurses, insofar as more beds would be devoted to white private patients: 'This could have serious repercussions for white nurses, for an increasing proportion would then be employed in a type of service which at present does not provide provident fund or pension facilities' (Searle 1965: 371). Nurses entered the debate regarding the funding of private patients:

Nurses generally are not happy about the provision of hospital facilities on a private profit-making basis, and are of the opinion that hospital beds both for the

poor or for the citizen who purchases hospital accommodation via a benefit society or insurance scheme, should be supplied by the State, leaving only the really wealthy who choose private facilities for themselves to private profit-making concerns (Searle 1965: 371).

The Reinach Commission was appointed in 1960 to investigate, consider and report on the containment of the high cost of medical services and medicines through interaction with medical aid and assistance companies and/or insurance schemes and the desirability of the State in supporting and safeguarding such schemes (Reinach 1961:2).

Reinach Commission (1961)

Dr Reinach headed the Committee appointed by the Department of Health to investigate the manner in which medical schemes functioned and furnished its report in 1961: '*Verslag en Aanbevelings van die Departementele Komitee van Ondersoek insake Mediese Hulp-, Bystand- en Assuransieskemas*' [translated Report and Recommendations of the Departmental Committee of Enquiry regarding Medical Aid, Assistance and Insurance Schemes].

In brief, its recommendations were that all medical aid schemes must:

- a. be placed on a healthy footing
- b. be controlled insofar aspects of health services is concerned
- c. be controlled by the Department of Health
- d. a Board must be established and operate in a co-ordinating and advisory capacity

The Commission stated that sickness insurance '*siekteversekering*' in South Africa was on a voluntary basis and related it to the USA. The Commission quoted Yahreaes (Reinach 1961: 12): 'Prepaid group medical practice is a modern way to insure the health of the public and make it available to people who need it at a price they can afford. It should be encouraged by every progressive individual and community.' Since 1957, two assurance companies, Sansom and Old Mutual,

started underwriting group medical schemes with the result that they provided medical cover to almost 8 000 groups (Reinach 1961: 13).

Waar assuransiemaatskappye siekteversekering aan groepe verskaf, is dit 'n diensvoorwaarde dat all toekomstige werknemers van sulke groepe by die skema moet aansluit. Volgens die jongste gegewens geniet 105 477 lede en 191 494 afhanklikes mediese versekering wat deur assuransie onderskryf is'. (Reinach 1963: 24, 25) [Translated where assurance companies provide sickness insurance to groups, it is a condition of employment that all future employers of such groups join the scheme. According to the latest figures 105 477 members and 191 494 dependants enjoy medical insurance which is underwritten by assurance].

The Commission recommended that members be partly responsible for the cost of medical bills and suggested medical aid schemes contribute a minimum of 75 percent toward the cost of consultations. It stated the same for specialist consultations, operations and several other medical procedures. At the time, administration costs of independent schemes averaged around 10 percent.

The Report comments on the *status quo* of private health funding. Public hospitals were extensively utilised by private patients, however medical aid societies complained that accommodation was inadequate, forcing them to utilize private hospitals and nursing homes at a much larger cost (Reinach 1961: 75). An example quoted was the Mines Benefit Society's utilization of public hospitals in Johannesburg which ranged between 1.14 and 18.4 percent only. This increased their cost by 136 percent. The Commission strongly advised that medical aid members should not receive preferential treatment in terms of public hospital admission compared to the general public (Reinach 1961: 76).

One of its recommendations was to start a central fund to fund operations in instances where schemes limit their liability such as open heart surgery which would cost an unaffordable R2 000. This could be achieved via a special levy on each medical scheme based on its membership numbers plus State contributions. It compared this fund to the unemployment fund where the State contributed R1 million. It envisaged that the Central Fund would earn the State investment capital and that the fund could be expanded to safeguard medical expansion, subsidise

administration costs of medical aids and ‘any additional services which may be necessary in the future’ (Reinach 1961: 119).

The following services were provided by the Department of Health. This provides insight as to which free services were provided to the general public at that time:

- a. Lepers were treated and hospitalised free
- b. Certified persons were treated and hospitalised free
- c. District doctors treated the poor for free, outside hospitals
- d. Poor persons were provided free prophylactics, spectacles and glass eyes but paid proportionately if they could afford to
- e. Smallpox vaccine free to local authorities and private doctors
- f. *Witseerkeel* and stomach fever free to local authorities
- g. Polio vaccine at 5c per dose which is lower than the cost to manufacture. Polio Department funded the difference
- h. Poor tuberculosis patients treated free, the local authority paying 1/8th and the Department 7/8th.
- i. Poor suffering from contagious disease were treated for free and cost for hospitalisation shared by local authority and department
- j. TB home treatment was also subsidised by local authority and department
- k. According to the ‘*Zuid Afrika Wet*’ the different provincial administrations are responsible for treatment of the poor with contagious diseases within hospitals for free – non-poor pay according to a set scale
- l. The Department carried 7/8th and the relevant administration 1/8th of the above costs.
- m. The Department subsidised local authorities and other organisations via the salaries of district nurses doing house visits via a 7/8th subsidy
- n. There are 391 part-time and 63 full-time district doctors in the Union paid by Central Government (Reinach 1961: 19).

The Commission referred to the Commercial and Industrial Medical Aid Society which was formed to provide medical aid on a nationwide basis to groups of employees. This was an important development in terms of private health funding. The Commission stated that medical schemes have developed since World War 2 without a co-ordinating and advisory body. In response, the medical aid companies went ahead and formed the Advisory Council of Medical Aids in 1950.

It is clear that this Commission only focussed its findings on the white population:

‘...bestaan daar nogtans ‘n groot behoefte om sover moontlik die hele Blanke bevolking by mediese versekering te betrek. Hierdie behoefte is so groot dat by verskillende politieke kongresse en selfs in the Volksraad daarop aangedring is dat the Regering the inisiatief moet neem vir die daarstelling van ‘n landswye mediese skema’ (Reinach 1961: 19). Translated [...there still exists a great need to include the entire White population as far as possible into medical insurance. This need is so great that at different political congresses and even in the Volksraad, it is insisted upon that the Government take the initiative for the institution of a nationwide medical scheme]

The Commission did not support a national scheme on this basis, citing the reasons being other parties’ interests could not be incorporated at this stage – it is not clear if these parties referred to the black majority.

The annual contributions of members [including employer contributions] were detailed in this Report – average contribution R43, lowest R8.20 and the highest at R87.55. This was information supplied by 169 independent schemes (Reinach 1961: 48). The members were all White and of them 1 333 652 persons enjoyed medical aid in one form or another – which roughly equated to 48 percent of the white population based on the 30 June 1960-census (Reinach 1961: 15).

The medical profession and its position of power is referred to in the Report (Reinach 1961:21):

18. Dit is vir die Komitee duidelik dat the mediese professie in ‘n magsposisie verkeer en dat hy (sic) sy (sic) wil kan afdwing. So ‘n toedrag van sake word as uiters onwenslik en ongesond beskou’ [translated It is clear to the Committee that the medical profession is in a position of power and that he (sic) can force his (sic) will. Such a status quo is seen as very unwanted and unhealthy].

The Snyman Commission into the high cost of medical services and medicines was appointed in January 1960 by A. Hertzog, the Officer administering the Government-in-Council:

Snyman Commission (1962)

This Commission was appointed to inquire into, consider and report on the following:

- a. all factors, which are responsible for the high cost of medical services and the manner by which it can be reduced;
- b. all factors which are responsible for the high cost of medicine and the manner by which it can be reduced;
- c. any related matter which may be deemed necessary by the Commission (Snyman 1962: 3).

The Commission drew on extensive information from the United Kingdom and United States respectively. In its findings, the Commission related the position in South Africa to other Western countries and noted that large increases in medical spending were almost universally experienced. It looked at the role of the State as well as to how the uninsured population, without cover, attempted to meet medical expenditure. The percentage of costs borne by the State was cited in countries such as Denmark (27 percent) and United Kingdom (95 percent) which equalled per capita expenditure of R35. The scenario in the USA was regularly referred to i.e. the percentage spent for medical service was 6 percent of national income – equating to about R75 per capita expenditure per annum.

In 1960, South Africa spent 2.4 percent of its national income on health services translating to R7.02 per capita. Large sick funds spent an additional R42.6 on white members whilst medical aid societies spent R68.58. This equalled to total per capita expenditure of R49.62 and R75.60 respectively. The Commission stated: ‘It was impossible to arrive at the total amount spent privately in the country as a whole’ (Snyman 1962: 177). By sampling and prediction of Bureau of Census Statistics, the Commission estimated this expenditure to be R75.00 per annum per white family.

The following table was extracted to illustrate the size and membership structure of the largest and more well-known schemes in the early-sixties. It will be noted that

most schemes were compulsory schemes provided as part of employment conditions.

Table 28

Summary of Medical Aid, Benefit and Insurance Schemes at 1959/1960

Name Extract Only	Established	Total Members	Dependants	Total Beneficiaries	Membership
Chamber of Mines	1914	4 649	6 105	10 754	Compulsory
De Beers Cons Mines Ltd	1889	1 400	2 222	3 622	Compulsory
Iscor	1934	8 446	16 356	24 802	Compulsory
Jhb Municipal Employee	1908	3 012	6 163	9 175	Voluntary*
Mines Benefit	1940	41 743	82 982	124 725	Compulsory
Printing Industry	1953	14 100	19 000	33 100	Compulsory
SA Railways	1913	123 706	252 720	376 426	Compulsory
Santam/Sanlam	1939	1 836	986	2 822	Compulsory
University of Wits staff	1950	493	741	1 234	Compulsory
Total		368 890	588 997	957 887	137 Compul 32 Voluntary
Sansom	1957	60 359	106 673	167 032	
SA Mutual	1954	45 118	84 821	129 939	
Total - Insurance		105 477	191 494	296 971	
SA Police		12 001	21 721	33 722	Condition of Service
Prisons		2 633	4 404	7 037	Condition of Service
SA Defence Force		8 100	15 900	24 000	Condition of Service
Total Services		22 734	42 025	64 759	
Total Hospital Services		14 035		14 035	Condition of Service
Grand Total		511 136	822 516	1 333 652	

Source: Snyman (1962: 172)

Notes:

*Prefers compulsory

In total 114 schemes did not offer additional benefits such as death and funeral whilst 55 schemes did.

An extract of the financial particulars supplied by Independent Schemes is shown below for the period 1959-1960. Most schemes produced a surplus and had reserve funds:

Table 29

Extract of Independent Schemes: 1959-1960

Name	Total Income	Medical Expenses	Cost of Admin	Average Medical Costs per member per annum	Average Member-Ship fees per member per annum	Employer Contribution	Reserve Fund
Chamber of Mines	360 652	329 702	7.7%	71.37	76.35	50%	90 716
De Beers Cons Mines Ltd	107 000	67 300	10.2%	48.00	68.55	50%	280 000
ISCOR	573 980	491 580	5.4%	58.2	67.5	50%	135 544
Jhb Municipal Employee	187 282	148 476	9%	49.3%	61.85	33.33%	13 900
Mines Benefit	2 249 028	1 605 360	6.5%	38.45	53.85	Nil	597 308
Printing Industry	366 038	377 980	10.4%	34.00	25.5	33.33%	119 584
SA Railways	4 813 006	5 052 248	6.4%	40.84	36.60	37%	Nil
Santam/Sanlam	21 716	22 460	Co *	24.00	8.5	Nil	Nil
University of Wits staff	29 582	28 000	4%	47.75	58.00	50%	25 754
Total	15 836 228	14 292 380	30.8%				3 256 286
Sansom	2 697 354	2 928 892	25.9%				59 436
SA Mutual	2 046 706	2 146 272					150 038
Total Insurance	4 744 060	5 075 164					209 474
Grand Total	20 580 288	19 367 544					3 465 760

Source: Snyman (1962:174)

Notes

*Company

- Average membership fees include both member and employers contributions
- Some schemes did not include any medical costs of dependants
- A total of 169 autonomous schemes participated – 61% had been established prior to World War

The Commission made fifty (50) recommendations mostly relating to administrative issues of public hospitals, training, maximizing utilisation of nurses, pharmaceutical controls, including the use of generics, etc. The four main recommendations made to contain medical and medicinal costs are extracted below:

- a. The Commission recommends that active steps be taken as soon as possible to lay down a new formula for a real interlinked health service that will be effective as well as economical
- b. As far as the Department of State Health is concerned, the Commission recommends that the immense savings which preventative measures could possibly achieve, should be exploited more profitably by intensive health education of all sections of the population. In this connection the role of White and non-White education is borne in mind.
- c. The Commission recommends that a uniform system of cost analysis be instituted by all hospital administrations. In such a system, drugs should be shown as a separate item. The Commission further recommends that an effective record system be instituted to counteract the striking lack of facts in connection with medical services
- d. The Commission recommends that these service bodies also be included in the more effective interlinking of health services aimed at (see recommendation No 1.) (Snyman 1962:176-178).

With regard to the Private sector, recommendation 18 related to a minimum charge to be levied on all patients to curb unnecessary services. The *status quo* regarding medical practitioners' remuneration was summarised. The rich and poor had traditionally been charged different fees – referred to as the 'Robin Hood' motive. This had changed to the State taking control of the indigent and the poor, therefore relieving the medical practitioners of this responsibility. The Commission supported the introduction of a tariff structure in terms of Recommendation 19:

The Commission recommends that after consultation with the medical profession, fixed tariffs of fees be laid down for the private sector, as has already been done in the fund sector. Further, that a countrywide tariff be laid down with latitude between the minimum for the private sector and that for the benefit fund sector (Snyman 1962: 186).

The Report was completed in 1962 and upon its recommendation the Central Council for Medical Schemes was brought into operation with effect from 1 October 1962. It was charged by the Department of Health to promote the more effective functioning of existing medical schemes and assisting in the establishment of new ones.

three years later The Coertze Commission noted that although the Council did good work 'its lack of statutory authority inhibited co-ordinated planning and development of medical schemes' (Coertze 1966: 22).

In March 1963, the Editorial of the *South African Medical Journal* (1963: 251) centred on the outcome of the Reinach and Snyman Commissions and Government's bid to bring consistency to prepaid medical care and to lay down minimum standards for medical aid schemes. The Central Council for Medical Schemes had already been set up and appointments made by the Minister of Health. Reinach was appointed chairman of the Council and ten persons were elected in their personal capacities from medical professions and bodies. 'The Central Council will have the duty of bringing about a measure of uniformity among all medical aid schemes, and the professed aim is to enable all White persons to join these schemes irrespective of income' (Blignaut 1963: 251).

'Many doctors feel or believe that the end of all private practice as we know it is in sight. Others consider that the profession will be dictated to by the Council, which, as a statutory body, will have far greater powers than the present medical aid societies or even the insurance companies which have ventured into the medical insurance field' (Blignaut 1963: 251) Whilst the author conceded that escalating costs would cause the average patient to seek assistance and that the Council may have the answer, it highlighted that the success of the venture would depend on the medical profession: 'The answer must be found, however, in conjunction with the medical profession, on whom the success of the venture will in large measure depend' (Blignaut 1963: 251).

Reinach then wrote to the Medical Association saying: 'There must be consultation and cooperation' [between the parties]

He added:

To this end I take this opportunity of stating unequivocally that there is no intention whatsoever of dictating fees or anything else to the medical profession...We state further that there is no desire to introduce a National Health Service, but of expanding the medical aid society along traditional lines with its inherent freedom of choice of practitioner enshrined therein. There will also be no usurping of the functions and powers of the South African Medical and Dental Council (1961: 182).

A special meeting of the Federal Council of the Medical Association was scheduled for 29 March 1963 to elicit the views of the Association via the Federal Councillors on the proposed Bill. Two months later the State president JR Swart appointed the Coertze Commission to enquire into the proposed Medical Schemes Bill:

Coertze Commission (1965)

Coertze was commissioned to report upon the subject of the Medical Schemes Bill and to submit an amended Bill by July 1965. The Medical Schemes Bill had been published for general information and comment in Government Gazette Extraordinary No 1048 of 26 February 1965 (Coertze 1966: 4).

The need to safeguard the public from the financial hardship caused by the cost of health services was stated, particularly mutual insurance 'Whereby funds are accumulated and from which the costs of medical services are defrayed' (Coertze 1966: 7).

According to Coertze (1966: 7), funds were mainly managed by:-

- a. societies established for that purpose,
- b. alliances between employers and employees of certain industries,
- c. Companies with insurance as their core business, and

- d. Companies which were exclusively insurance companies against medical costs – all known as medical schemes, which can be further defined as medical aid schemes or medical benefit schemes.

In terms of Medical Aid Schemes, doctors could be freely approached by patients. In addition to contributions, patients had to pay a portion of the costs in accordance with a preferential tariff of fees. This applied if the scheme was recognised by MASA as detailed below. Tariffs were generally one-third lower than those charged to private patients and was the result of negotiation between MASA and representatives of medical aid schemes.

The Commission received many complaints as to practitioners abusing their position in regard to this negotiated process (Coertze 1966: 11); of MASA discriminating among schemes (Coertze 1966: 12) and disparities between MASA's treatment of medical aid schemes and other medical service plans. Further complaints about medical aid schemes are summarised as follows: disparity in the application of preferential tariffs; only members, not dependants, were entitled to benefits in terms of the rules of certain schemes; no provision was made for continuance when the member retired on pension or no provision was made for surviving spouses to retain their membership upon the death of their member-spouse; constitutions of some schemes barred married couples from remaining with their individual schemes after marriage or depriving wholly dependent dependants from enjoying benefits; and patients with pre-existing conditions were excluded from membership.

On the other hand, Medical Benefit Schemes members enjoyed full cover and therefore did not have to pay the medical tariff when visiting practitioners. Complaints received by the Commission about Medical Benefit Schemes was the limited choice of practitioners (doctor-panel system), over-consultation in terms of excessive number of consultations made by members, inferior service and of physicians receiving an inadequate fee. These complaints were investigated and

largely found to be unfounded, although the commission found that some medical benefit schemes remunerated practitioners inadequately.

An interesting example was a Medical aid scheme which changed to a Medical benefit scheme. It ascribed its financial troubles to over-visiting of doctors, unnecessary procedures and high accounts, changed to a Medical benefit Scheme. This move elicited a 40 percent saving in the cost of health benefits to its members/dependants (Coertze 1966: 20).

The commission was satisfied that Medical Benefit Schemes had merit, however cautioned:

...there are abuses, malpractices and anomalies which give rise to objections and complaints between the suppliers and the recipients of services and (your) Commission is of the opinion that some means should be provided for preventing, removing and solving such problems (Coertze 1966:21).

Table 30
The five largest Medical Benefit Schemes in 1964

Scheme	Date Established	Membership 1964	Beneficiaries 1964	Total
SA Railways & Harbours Sick Fund	1913	131 140	249 674	380 814
Mines Benefit Society	1940	43 975	89 391	133 366
Iscor Medical Fund	1935	11 119	22 953	34 072
Vanderbijlpark Medical Fund	1945	8 908	18 474	27 382
SASOL Medical Fund	1953	3 287	5 587	8 874

Source: Coertze Commission (1966: 15)

The table above shows the large involvement of Government and the mines, in providing medical benefit schemes to its employees. In 1965, there were 186 medical aid schemes in the Republic of SA. Membership equalled 775 000 white persons. Of these schemes, 158 were recognised by the Medical Association of South Africa, 18 were not recognised and charged their own rates, 3 were

insurance companies. MASA is a voluntary association of doctors who would charge a preferential tariff to recognised schemes. 'A preferential tariff was a certain tariff charged by doctors to members of medical aid schemes in recognition of them being recognised by MASA' (Coertze 1966: 8). In addition, there were 46 Medical Benefit Schemes with a membership of 660 000 white persons. Here, a doctor provided his services to members on a panel, at a per capita remuneration. In addition there were 34 medical schemes established in terms of the Industrial Conciliation Act 28 of 1956 which has mixed membership but only the white membership number is shown namely 175 000 (Coertze 1966: 8-10)

Free medical services were provided to employees of certain institutions as conditions of employment:

'3.11 Over and above the beneficiaries under the types of medical schemes mentioned above, approximately 101 000 white persons enjoy free medical services as a condition of employment' Examples cited were the police, prison and defence services' (Coertze 1966: 10).

In addition, free medical services were provided to pensioners and indigent persons who were 'dependant on free medical services provided by the State by means of district surgeons and provincial hospitals' (Coertze 1966: 10).

Benefits varied from scheme to scheme i.e. the inclusion of hospitalisation services. Not all whites were members of established medical schemes. These included persons who did not enjoy cover prior to retirement and indigent persons. These had to seek free medical care from the State (Coertze 1966: 12).

All the persons and bodies who gave evidence to the Commission, except one, supported the view that control of medical schemes should be regulated by law. They envisaged amendments of existing legislation namely: the Friendly Societies Act 25 of 1956, the Medical, Dental and Pharmacy Act 13 of 1928 and the Industrial Conciliation Act 28 of 1956. The Commission did not support the latter and it recommended new legislation be affected which would be instituted via a

semi-state institution in order to promote the present hitherto spontaneous and voluntary development of medical schemes (Coertze 1966: 25).

The Commission recommended a Central Council for medical schemes be established. It also recommended a National Association of Medical Aid Schemes and a National Association of Medical Benefit Schemes to be established to represent the two bodies. Medical Aids were to utilize the tariff for approved medical aid societies which was in operation on 1st January 1966. It would be attached as a Schedule to the Medical Schemes Bill. Increases would be amended via proclamation. Disputes would be settled by arbitration. Similarly, disputes relating to remuneration of providers in terms of Medical Benefit Schemes would be settled via a similar mechanism (Coertze 1966: 34). Suppliers of medical services could continue contracting out of services to medical aid schemes.

The Medical Schemes Act was duly passed and Medical Schemes became regulated in terms of the Medical Schemes Act 72 of 1967 following the recommendations of the Coertze Commission with a commencement date of 1 July 1967.

Basic compliance requirements were set up for registered medical schemes.

Act 72 of 1967 defines **Medical Scheme** as:

‘medical aid scheme’ means a medical scheme of which the rules provide for the rendering of medical and dental services to the members thereof and to the dependants of such members by medical practitioners and dentists of their own choice and at fees not exceeding the fees calculated in accordance with the tariff of fees;

Medical Benefit Scheme is defined in terms of Act 72 of 1967:

means a medical scheme of which the rules provide for the conclusion of an agreement between such scheme and any medical practitioner or group of medical practitioners or any dentist or group of dentists, as the case may be, by way of a salary or by way of an amount calculated on the basis of the number of members of such scheme and dependants of such members for whose treatment such medical practitioner or such member of such group of medical practitioners or

such dentists or such members of such group of dentists, as the case may be, is under such agreement responsible.

Medical Benefit schemes were controlled by the Central Council for Medical Schemes. Contributions were collected from both employer and employee. Fees were reviewed by a Remuneration committee. Medical practitioners could elect if they accepted patients in terms of Act, or to levy private fees. 'Most have decided to render services under the Act'. (Van der Spuy 1974: 724)

The definition of the **Medical aid scheme** was altered in terms of the Medical Schemes Amendment Act 95 of 1969:

medical aid scheme' means a medical scheme of which the rules provide for the rendering of medical and dental services to the members thereof and to the dependants of such medical practitioners and dentists of their own choice **[and at fees not exceeding the fees calculated in accordance with the tariff of fees]** (Harrison 2008: 4)

This Act was passed to resolve the conflict between medical schemes and the medical profession. The Remuneration Committee set up in terms of this Act would investigate the tariff of fees at least every two years. The medical profession eventually saw this Committee in a negative light (Department of Health 2002: 22).

1970's - Reform

During the 1970's labour disturbances increased and fuelled political unrest, such as the 1976-Soweto riots. The country's economic downturn deepened into a recession with evidence of a weakening currency by mid-1970. The National Treasury took measures to curb government spending. This included health expenditure.

According to Van Rensburg *et al*, it was difficult to define the proportional share of each of the private and public sectors. By the mid-1970's the public sector was

defined as government, the four provinces and local authorities and collectively, these supplied two-thirds of hospital facilities. Community health services, namely: personal and environmental services were provided on an organised basis by different levels mainly by the public sector: 'The private and public sectors thus appear to be equally represented in health care' (1982: 196). Hospitals, clinics and nurses tended to be run by the public sector whereas general practitioners, medical specialists and dentists tended to be in the private sector and represented free-enterprise.

Up to 1970 all health services were controlled by the South African Department of Health. Bantustan health services in homeland areas were placed under 'local governments'. Bantustans fell under the jurisdiction of the Department of Bantu Administration and Development. The SA Department of Health acted on their behalf. These changes did not impact on the overall structure of health services (Seedat 1984: 63).

Erasmus Commission (1972)

This Commission was appointed on 12 November 1971 by the Minister of Health to enquire whether the tariff of fees for medical practitioners and dentists needed amendment. Their recommendations centred briefly among vesting discretionary powers upon Minister of Health to review the tariff of fees.

The 1974 Report on South Africa defines the role of private hospital as non-profit organisations, which admit paying patients only. No financial assistance was rendered by the State, although registration was required and inspections ensured the maintenance of unified standards. With regard to private hospitals in Natal: 'A large number of private institutions receive financial subsidies from the administration' (Van der Spuy 1974: 721).

Van Rensburg quoted the Director General of Health describing the position in 1975:

Looking at health services in South Africa today we find a structure which is almost bewildering in its complexity and diversity, and certainly much maligned for its fragmentation. In fact, little more than the general co-ordination and the overall social and fiscal responsibility has ever been formally centralised, and actual co-operation was more often than not on a purely voluntary basis (Van Rensburg *et al*, 1982: 201).

Table 31

Private versus State Hospitals in 1974

Province	Private Hospitals 1974	Provincial Hospitals 1971	Public Expenditure 1971
Cape	38	82	70 441 000
Orange Free State	5	22	15 359 700
Transvaal	40	61	83 309 000
Natal	26	22	36 490 171
Total	109	187	205 599 871

Source Van der Spuy (1974: 721)

Table 32

Personal Expenditure on Health Care by Race in selected areas 1975

Item	White		Coloured		Asian		African Urban	
	R	%	R	%	R	%	R	%
Medical Aid & Insurance	100.83	33	13.49	29	19.44	16	2.26	1.2
Doctors & Dentist	97.11	31	7.15	15	37.23	31	2.55	9
Witch Doctor & Herbalist	-	-	.01	-	.24	-	1.33	5
Nurses & hospitals	28.49	9	4.95	11	11.53	10	1.89	7
Medicines on prescription	44.08	14	.49	1	1.19	1	0.11	-
Other Medicines	19.83	6	14.53	31	21.0	18	13.17	49
Debentures Spectacles	21.1	7	6.22	13	28.33	24	5.66	21
Total Expenditure	311.44	100	44.82	100	119.46	100	26.97	100
Expenditure As % of income	3.0		1.5		3.1		1.2	

Source: Westcott quoted McGrath (1979: 129)

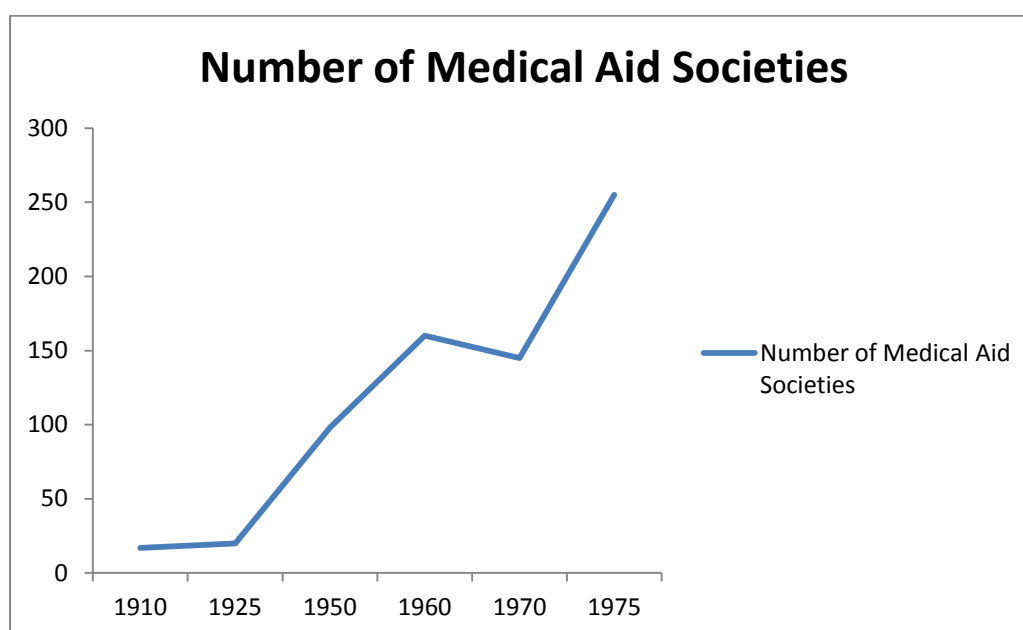
Constituent associations of Medical Schemes were established before 1975. Pre-1975, it had to have a minimum aggregate of 100 000 members and represent a minimum of fifteen medical schemes. Post-1975, newly established schemes had to have a minimum of 250 000 members in the aggregate and represent a minimum of twenty-five medical schemes (Veliotos 1991: C2).

The Central Council for Medical Schemes which was established on 1st October 1962 continued to control medical schemes in the late 1970's. No employee was compelled to join a medical scheme unless it was a condition of employment. Employers would subsidize contributions, ranging between 50 and 100 percent of contributions. Recommendations were that schemes have a minimum of 1 000 members, although exceptions would be allowed (Van Rensburg *et al* 1982: 266).

The table below shows the continued growth in the number of Medical Aid Societies over the decades:

Table 33

Number of Medical Aid Societies 1910-1975



Source: Snyman Commission (1962: 141) and Registrar of Medical Schemes 1978

The Public Health Act of 1919 was regularly amended as shown in preceding Chapters and was only changed when the Health Act 63 of 1977 was implemented to effect comprehensive and fundamental change to health legislation in the Republic.

Act 63 of 1977 was intended to co-ordinate and rationalise the health service by the establishment of the Health Matters Advisory Committee and the National Health Policy Council. It included Provincial Administrations in the same way that Local Authorities were previously involved. The Department of Health now had the functions of co-ordinating health services rendered by Provincial Administrations and Local Authorities as well the provision of additional services necessary to establish a comprehensive health service for the entire population of the Republic of South Africa. The provinces remained responsible for hospital services. Local authorities were responsible for preventive and promotive care, and the central department was responsible for overall co-ordination.

As shown in Table 33 above, the period from 1940 to 1970's showed a large growth in medical schemes and Table 32 shows the entry of Black members into medical aid and insurance companies. In 1940, there were 48 medical schemes which increased to nearly 100 by 1950 and 214 by 1960. By 1968, there were 24 schemes registered in terms of the 1967-Medical Schemes Act, which increased to 260 in 1973 (Van Rensburg *et al* 1982: 266-268). In 1974/5, average personal income for whites was R2 534 and Africans R237 per capita. 'The Gross National Product of South Africa is one of the highest in Africa and among the top 30 in the world, but the wealth is very unevenly distributed' (Seedat, 1984: 20). By 1977, 76 percent of the white population but only 3.4 percent of the black population were covered in terms of medical schemes, totalling 16.4 percent of the total population. By 1978, there were 254 schemes categorized as either medical benefit, or assistance schemes and medical aid schemes (Seedat 1984: 76).

The Medical Schemes Amendment Act 51 of 1978 became law on 26 May 1978. It abolished the Compensation Commission and the Commission responsible for advising the Council on fees [see Amendment act 95 of 1969]. It introduced a new system of determining tariffs for members of Medical Schemes (Department of Health 2002: 22).

The Steenkamp Commission was appointed in 1978 to inquire into the Pharmaceutical Industry. The only relevance to this dissertation is the large disparity between the private and public sectors, insofar Pharmaceutical Companies were charging for pharmaceuticals. It also showed that ‘economically objectionable practices exist’ (Steenkamp 1978: 34).

228. The prices charged to the public sector are, as a rule, much lower than those charged to the private sector (Steenkamp 1978: 26).

It is however noted that the South African net profit margins were not exceptional and, with regard to the disparities:

229. There are several reasons for the large differences between the tender and the other prices. In the first place, tender business means large production volumes and, therefore, lower unit costs of production. In the second place, there is a saving in marketing costs. Finally the buyers, in this case, have strong bargaining power (Steenkamp 1978: 26)

Table 34

1977 Comparison of pharmaceutical prices: Public vs. Private Sector

Item	Tender Price	Price to the wholesaler
Caps Orbenin 250mg	R2.40	R7.27
Tabs Deltacillin 250mg	R0.96	R4.88
Tabs Stelazine 5mg	R1.72	R19.41
Tabs Zylprim 100mg	R5.00	R7.77
Tabs Brufen 200mg	R3.00	R6.22

Source: Steenkamp (1978: 26)

The Report showed the resultant profit made by pharmaceutical companies at 19.4 percent to be considerably higher than other industries such as food averaged 12.9

percent; Clothing 11.8 percent and Basic metal industry ferrous and non-ferrous 11.4 percent. Research and Development costs accounted for average of 0.9 percent only. Essentially it could be seen that this was at the expense of the private health industry. It could be argued that the private sector was indirectly contributing toward the costs of the public sector.

239. The 19.4 percent average return for 1973 of the 15 pharmaceutical firms is appreciably higher than that of nearly all the industries represented in the table based on the figures published by the Department of Statistics...(Steenkamp 1978: 26, 27, 28).

It does not appear as if this Report had lasting impact on the price of medicines since prices continued to exceed the consumer price index in the ensuing decades (by 30 percent in 1990) with an estimated 49 percent increase in the real cost of medicines for the period 1981-1987 (Folb 1990: 121).

1980's: – Privatisation and Primary Health Care

From an economic perspective this decade continued to be characterised by internal political instability as well international pressure, such as sanctions and boycotts as a means of compelling South Africa to change its apartheid policies. A depreciating currency continued to place pressure on the cost of medicine and capital equipment. Magennis suggested a real economic growth rate of 4 percent was needed in order to significantly improve real per capita incomes. 'GDP in real terms has risen by only 0.6 per cent per annum between 1980 and 1988. Employment creation has lagged behind the growth in labour supply and real incomes of Whites have fallen' (Magennis 1991: 15).

'High utilisation rates in the private sector are attracting attention to the 'fee-for-service' and 'third party' payment systems' (Magennis 1991: 255). Magennis concluded that mal-distribution of expenditure such as between White and Non-White and public and private sectors, placed pressure on Government to restructure limited resources.

‘The health service today is a mixture of statutory, private and charitable facilities (Seedat 1984: 63).’ For the wealthier or members of medical aids, the doctor was the first contact on a fee-for-service basis. If further treatment was required, the patient was referred to a specialist or hospital. The poor would enter public hospital via out-patients or casualty departments.

During the 1980’s, the government changed emphasis from health being largely a government social responsibility to a private sector concern making individuals responsible for purchasing medical aid insurance as well as encouraging medical schemes to significantly expand their base to include more blacks. In 1978, a group of black businessmen and doctors established Sizwe Medical Fund. By the end of 1982, it had over 6 000 members and cash reserves over R400 000 (Seedat 1984: 76). In the same year the first black private hospital, the Lesedi Clinic was built in Soweto at a cost of R3 500 000. According to Veliotis (1991: 3) the increase in Black participation in private medical schemes can be ascribed to dismal conditions in public hospitals, growth in independent trade unions, improved wages and employment in larger organisations offering medical scheme benefits.

The period from 1980 onward continued to be characterised by a high degree of fragmentation in the public health services. The four provincial administrations effectively covered the vast majority of the population. Discrepancies continued in resource allocations within and between provinces and between the provinces and homeland administrations (implemented in the 1970’s). Public facilities continued to be segregated with separate services for the non-white population. This separation extended to entire facilities with separate white and non-white hospitals.

In 1982, the state changed its objective to ‘self-help’ and ‘community development’ where people pay for their own health care by using private doctors. In the same year, an alternative association for registration of doctors and nurses from all population groups was formed: NAMDA, the National Medical and

Dental Association. 'It reportedly arose out of dissatisfaction among many doctors that their views were not adequately represented by MASA'. (Seedat 1984: 96)

Between 1980 and 1984, tariffs were set by the Minister of Health and Welfare whereupon medical schemes movement determined schedule of benefits, after consultation with professional movements (Browne Commission 1986: 13-17). The Medical Schemes Amendment Act 59 of 1984 eliminated the principles of contracting-in and contracting-out. In addition it added a new definition of service which was then incorporated into the definition of 'medical scheme':

'service' means any medical, psychological, paramedical, nursing, surgical or dental treatment, and includes the supply of medicines or of medical, surgical, dental or optical requirements or appliances, or of accommodation in a hospital or maternity or nursing home.

Consequently, there was an amendment to the definition of 'medical scheme' to incorporate the above wording. 'This amendment was simply a technical amendment to accommodate the new definition of service...' (Harrison 2008:5).

'Health officials in South Africa stress the need for the private sector to play a greater role in the provision of health services, reflecting a new direction of state policy. The state's aim is to create a situation in which people pay for their own health care by using private doctors. This is disguised as self-help and community development'. (Seedat, 1984 72)

Browne Commission (1986)

The Browne Commission was appointed in 1980 by the State President M Viljoen and presented their findings in 1986. The Commission was appointed to report on Medical Scheme Matters, as detailed in a) – (i) below. In terms of this dissertation, only sections pertaining directly to private financing matters will be dealt with here. Public and other Sectors will not be fully detailed.

- a. 'the rationalising of medical schemes, the administrative costs of schemes, the assets and reserves of schemes, the profits and/or remuneration of

entrepreneurs, the utilisation of manpower, the extent of the costs of and the coverage offered by schemes, the running of pharmacies by schemes, delay in meeting obligations to members of schemes and suppliers of services, the population covered, the effect of schemes that have been exempted in terms of the Medical Schemes Act 1967, from the provisions of the Act

- b. having regard to the Report of the Commission of Enquiry into the Pharmaceutical Industry, the extent to which the recommendations of the Commission concerned have been implemented and the effect they have had, problems encountered in the implementation of the recommendations, the influence that the activities of the manufacturers have on the cost structure of medicines to the consumers, and the supply prices to retailers, wholesalers and medical practitioners;
- c. having regard to the Report of the Commission of Inquiry into Private Hospitals and Unattached Operating Theatres, the extent to which the recommendations of the Commission concerned have been implemented and the effect they have had, and problems encountered in the implementation of the recommendations;
- d. services and facilities supplied and provided by the State, provincial administrations and local authorities, (also the means test according to which patients are required to pay for services), including services and facilities in private hospitals and unattached operating theatres, and with reference to State hospitals, provincial hospitals and private hospitals and unattached operating theatres – (i) number of beds; (ii) percentage bed occupancy; (iii) ratio of staff to beds; (iv) average stay per patient; (v) special clinical/pathological examinations; (vi) highly specialised services; (vii) cost of services per annum and in relation to population; (viii) training of staff; (ix) distribution of beds; (x) ratio of beds to population; (xi) medicine prescribing pattern; and as far as State and provincial hospitals are concerned, out-patients;
- e. the range and cost of services provided by local authorities, the staff input per service, the cost of services in relation to the population, the subsidies received from the State for services and the percentage application of available money in respect of preventative, promotive, curative, rehabilitative and environmental health services;
- f. the cost to a pharmacist of conducting his practice, the profit margin on dispensing, the profit margin on other commodities, the number and distribution of prescriptions, and the prescribing patterns;
- g. with regard to private and full-time medical practitioners, dentists and supplementary health service staff, the average taxable income of each category, the patient load of each category, the patient distribution of each category, the fringe benefits of each category, the prescribing pattern of each category, the distribution of manpower of each category; and with regard to such private practitioners, the practice and running expenses of each category, the method of determination of fees in respect of services rendered to members and dependants of members of medical schemes and the right of the individual to decide whether or not to render services at such tariffs;
- h. The over-utilisation of services by patients, the introduction of disincentives for the over-utilisation of services, extra payments and contributions by members of medical schemes in settlement of accounts, and the contributions by employers; and

- i. Any related matters – note the *Second interim report on Blood Transfusion services*.

The Interim Reports follow the same headings as above and conclusions and recommendations will be elaborated upon here.

This section does not impact on this dissertation but gives a comprehensive breakdown of statistics in the health care industry, as detailed above. The conclusion was that there was a concentration of health care providers in urban areas, disparities in different providers to population groups based on ethnic group.

The Commission concluded:

Apart from the ever-rising costs of health services – a problem which pervades this whole inquiry – the evidence presented on the subject did not reveal any major problems in the medical schemes movement. In fact, from the available evidence it appears that the medical schemes movement in the RSA is among the best in the World. This does not imply that certain significant changes are not desirable.

The Browne Commission recommended:

- a. Rationalisation of Medical Schemes
- b. The number of medical schemes should be controlled by free market principles
- c. Medical benefit schemes should not be forced to become medical aid schemes (reversed by MSA)
- d. Exempted schemes should be recognised (reversed by MSA)
- e. Administration costs
- f. Free market principles and competitions should be promoted
- g. Both in-house and entrepreneurial schemes should be encouraged provided they conform to the Registrar's guidelines.
- h. Utilisation of Manpower
- i. In order to control tendencies toward demand creation by doctors and the over compensation of services by patients, medical schemes should increase their skills as far as computerised systems are concerned.
- j. Medical schemes should consider expanding their range of services by running their own private hospitals and dispensaries (reversed by MSA).
- k. Extent and Cost of Cover
- l. The employer and the administrator should determine the most appropriate level of benefits for a particular group (reversed by MSA).

- m. The establishment of an additional type of medical cover or insurance for members who exceeded their annual maximum benefit should be considered (reversed by MSA).
- n. Running of Pharmacies by Medical Schemes
- o. Medical schemes should consider the possibility and effectiveness of a system of allowing a higher percentage of benefit where a generic substitute is dispensed at a lower cost than the prescribed medicine (reversed by MSA).
- p. Medical schemes should investigate methods of establishing pharmacies or medicine distribution depots on collective bases in major centres (reversed by MSA).
- q. Medical schemes should be allowed to establish their own pharmacies and to employ pharmacists to run them (reversed by MSA).
- r. Medical schemes should be permitted to negotiate prices of medicines with retail pharmacies (reversed by MSA).
- s. Disincentive Allowances
- t. No provision for compulsory disincentives must be made and individual schemes should allow for disincentive allowances, if they so choose.
- u. In order to make both users and providers cost-conscious, education is vital (reversed by MSA).
- v. Employer Contributions
- w. Employers should consider subsidising fifty percent of all employee contribution fees (reversed by MSA).
- x. Cost Containment Recommendations
- y. Discounts for cash payment of prescription medicine, medical services and accommodation in hospitals should be considered (reversed by MSA).
- z. Generic substitution and limits on the quantity of medicines that may be prescribed, should be considered.
- aa. The HMO concept should be promoted (reversed by MSA).
- bb. Diagnostic Related Groupings (DRG's) should be introduced. This will ensure that the cost of diagnosis, treatment and aftercare are all included at a predetermined fixed rate.
- cc. General
- dd. Additional cover should be insured by a voluntary insurance system (reversed by MSA).
- ee. The medical scheme movement should consider HMO's and PPO's as developed in the United States (reversed by MSA).
- ff. Alternative methods of providing health care should be seriously looked at and new approaches should not be rejected merely because of existing vested interests.
- gg. Greater flexibility in contribution rate determination should be allowed, thus enabling schemes to underwrite and charge different contribution rates for different classes of risk (reversed by MSA).

According to Van Rensburg *et al*, (2004: 90): 'From the outset it was clearly not the intention of the Browne Commission to change the existing health care system radically'.

The Commission therefore proposed the privatisation of health care via privatisation of public hospitals, contracting out services in public hospitals, instituting more private hospitals, making patients responsible for payment of care whereas the State subsidized the indigent only. Pillay is quoted in Van Rensburg *et al*: 'It is significant that the Commission made numerous recommendations that sought to protect the private health sector and to promote greater operation of the free market even though it found that this system was contributing to the spiralling costs of health care in the country (2004: 91).

From the Commission's recommendations the National Health Plan came into being in 1986. Its objective was to align the health care system within the 1983 constitutional reforms and to bring about structural alignment (Van Rensburg *et al* 2004: 91).

The study will focus on the economic climate which prevailed during this decade and how it influenced the private health sector. The different views are set out below:

The private healthcare sector in South Africa is now and was during the development of its history largely controlled by free market forces. Competing parties offered their commodities to consumers who make their choices based on quality and price. The consumer determined what was produced and the system ensured the efficient use of resources (Ward 1993: 19). Facilities such as hospitals were owned by private stakeholders. Members had a choice of providers and tender fee-for-service. Large selections of product were available, targeting the different needs of the population via medical aid schemes or brokers. 'Cost containment programmes, such as managed health care models and disincentive allowances are a notable feature of this system' (Ward 1993:19).

De Beer supports the view that health care is a commodity in economic terms. Although it is not a material thing, services such as medical treatment have taken on the nature of commodities as they are 'things of use which are sold to buyers'

(1984: 67). He cites two consequences of the commodity form effecting the nature of health services namely for those involved in selling commodities, the target group is the those who can afford to pay and if you want something you have to be able to pay for it: 'The market for a commodity is made up of those who need it and can afford to pay for it. Their requirements will determine what sort of commodity is produced' (1984:68). He argues that most of the people live in large towns and cities could afford to pay for private medical care, which explains the concentration of doctors in large towns. This explains why such a high proportion of expenditure goes on researching and developing complex medical technology, while large numbers of people do not have access to a basic minimum of health care. 'The wealthy, who are the major buyers of health care, have their basic health needs met by adequate nutrition, housing and hygiene, which are enjoyed by the relatively privileged sectors of our society'. De Beer argues that 'the specific nature of capitalist economic transaction has helped to shape the development of medical practice' (1984: 67).

Ward (1993: 20) quoted Enthoven who believed health should be left to the free market as it would operate effectively, notwithstanding its complexity. Fourie disagreed and argued: 'The delivery of healthcare services and products however cannot be left up to general market forces, owing to a number of identifiable types of market failure' (Fourier 2008: 36). He cites the sources of market failure as the monopoly power of providers, consumer ignorance and lack of information and an element of externality. Fourie (2008: 36) stated that State intervention is required to ensure that the greater public interest is protected through the introduction of specific social policies that seek to enhance social welfare. This intervention would be via regulation to counter these market failures. Reekie quotes Enthoven who argued that health care precedes rights: 'It is a good or service which should be allocated Crusoe fashion, i.e. there is a known social utility function' (Reekie 1997: 285).

Chopra and Sanders contend that South Africa is a stark example of 'combined and uneven development' where the process describes peripheral states being

compelled by global capitalism ‘to accelerate development of industrialization and urbanisation whilst retaining earlier modes of production’ (2004: 159). The combination of both backward and advanced socio-economic conditions led to ‘the structural foundation for the combination of the different stages of development’ (Chopra 2004: 159). Almost half of the population is in rural areas engaging in declining subsistence production and increasingly depending on welfare payments versus an increasing urbanised population depending on unregulated casual, subcontracted or informal employment (or unemployed). At the top end of the scale are the elite comprising of the skilled, professional and managerial employees. The latter has seen a rise of the black elite into this group through the removal of racial barriers in state and parastatal bureaucracies as well as Governments economic empowerment policies. Chopra and Sanders conclude that this socio-economic scenario explains the changes in health and mortality as witnessed during the 1990’s.

Van Rensburg *et al* maintain that health care in South Africa contains components of both free enterprise and socialised medical care. The former renders service, facilities and requirements in terms of a free market service in exchange for payment. This service is provided by private entrepreneurs aimed at the more affluent of society which means a superior service is offered. Socialised medical care in the form of services, equipment and facilities is provided by central government free-of charge or on a heavily subsidised basis to the less privileged, and therefore the majority of society. ‘The plurality of the population clearly gives rise to a similarly differentiated system of health care’. (1982: 197) Van Rensburg refers to this divergent development as ‘apartheid health care’ and attributes this to priority given to the white population in mostly urban areas. They also predominate in numbers and proportion of manpower in the health service. His views tie in with preceding statements.

The Browne Commission findings detailed above, agreed to and named the imperfections as (a) inadequate information on the price and nature of the commodity; (b) demand for health services in insensitive to price; (c) providers of

health care can influence the nature and quality of service provided; (d) innovative products serve to increase demand for health services rather than to reduce price; (e) medical schemes may support suppliers to charge high prices as they assist members to meet cost of treatment (Browne 1986: 24).

On 1 April 1986, free hospitalisation for all categories of patients in the Cape Province was abolished. A tariff based on income and number of dependants was introduced. Provincial hospitals such as Groote Schuur Hospital offered treatment to persons with individual medical aid, who were charged a tariff to recoup the full cost of treatment. One in five patients fell into this latter category (Digby *et al* 2008: 77). The following table will show total healthcare expenditure in 1987. It is noteworthy that the public sector provided 80 percent of hospital beds and services to approximately 80 percent of the population although only 56 percent of total expenditure was on public health (McIntyre and Dorrington 1990: 128):

Noteworthy was the continuing disparity upon racial lines. In order to contextualise these statistics, the population in 1980 was: (Davenport and Saunders 2000: 428)

African	18,965,327
White	4,453,273
Coloured	2,554,039
Asian	794,639
Total	23,771,970

Table 35**Total South African Health Care Expenditure 1987**

	R million	Percent
Public Sector:		
Central Departments	822.6	15.8
Provincial Administrators	2 870,7	55.2
Local Authorities	306,1	5.9
Homelands	883,6	17.0
Other Departments	313,6	6.0
Total Public Sector	5 196,6	56.4
Private Sector		
Medical Schemes	2 690,9	67,0
Services (approx)	378,3	9,4
Non-Scheme	949,8	23,6
Total Private Sector	4 019,0	43,6
Total Health Expenditure	9 215,6	
Percentage of GNP	5.8%	

Source: McIntyre and Dorrington (1990: 126)

Table 36**Per Capita Health Expenditure by Population Group 1987**

Blacks	R137.84 per annum
Coloureds	R340.16 per annum
Asians	R356.24 per annum
Whites	R597.11 per annum

Source: McIntyre and Dorrington (1990: 128)

In 1989 a paper ‘Can privatisation solve the problems in the Health Sector’ was presented by Price and De Beer at the University of Cape Town. It shed important light on the role of private funding of health care during this period:

Privatisation has been advanced as a popular solution to the widely recognised failings of the current system, and is supported by a wide coalition of interests. Privatisation of health care is official state policy and is promoted by private sector think-tanks, by many of this already involved in providing health care, and by some sections of the organised medical profession. This is a relatively recent development. (Price and De Beer 1989: 20)

Price and De Beer refer to the De Villiers Commission appointed in 1974 which had an opposing view, namely that the State should as far as possible provide all hospital services.

In 1977, Government opinion changed: 'It is essential to note that the role of private practitioners forms an integral part of comprehensive health service...Every encouragement must be given to the private sector to contribute and expand its share in achieving a comprehensive health service' (Price and De Beer 1989: 29).

The Department of Health and Welfare in its 1980 National Plan for Health Service Facilities proposed the inclusion of private practitioners to attain its primary care strategy: 'In order to encourage the rendering of services by private practitioners, the health authorities will have to consider consulting rooms for private practice on a selective basis at certain community health centres' (Price and De Beer 1989: 29). 'The shift in government policy is a major factor promoting health service privatisation' Articles relating to the Medi-Clinic Corporation is cited to confirm this statement 'Medi-Clinic's entry into the hospital field comes at a time when rising costs of treatment at provincial hospitals have encouraged entrepreneurs to develop independent hospitals – to the extent that more than 20 are on the drawing boards or under construction throughout the country' (Price and De Beer 1989: 29).

The Managing Director of Medi-clinic is quoted: 'Hospitals have a great future as the government hands over the medical care of everyone but the indigent to the private sector' (Price and De Beer 1989: 30).

In 1985, 81 percent of whites were members of medical insurance schemes, curative care hospitals or fee for service. In 1987 there were 73 such hospitals from 40-300 beds – owned mostly by three companies, two of which were subsidiaries of two of South Africa's largest corporates: ANMED owned by Afrox and Medi-Clinic owned by the Rembrandt Corporation (Price and De Beer 1989: 31).

Price and De Beer cited common arguments for privatisation: 'Privatisation will bring additional funds into the health sector resulting in better health care for the poor' (1989: 35) and 'The private sector will do the job more cheaply' (1989: 37).

According to De Beer *et al* (1990: 5) certain regulations governing medical aid schemes changed in terms of the Medical Schemes Amendment Act 19 of 1989. The Act allowed for risk-rating to be applied to the calculation of contribution rates and benefit levels, as detailed below. Section 8(2) compelled medical schemes to retain widows, pensioners, members who terminate employment due to age, ill health or disability. Lower fees could be charged.

Regulation 8 allowed the subscriptions of members to be calculated, or rated, as follows (Veliotes 1991: 15):

- a. Income of member
- b. The number of dependants of member
- c. The area in which the member resides
- d. The age of the member
- e. The claims experience in respect of a specific member
- f. The extent of cover afforded to the member
- g. The member's period of membership of the scheme
- h. Where schemes consist of various groups, the number of members in a specific group.

American Model

The dissertation will now focus on the American model which influenced the South African private health funding model. In support of this statement Keith Hollis, founder of South African administrator Medscheme, was interviewed and stated on 7 July 2009: ‘... the big thing was the American model. That was the key. What happened was that we went to conferences every two years and just hanging on to the words of the Americans. They were measuring and controlling panels and contracts with doctors and so forth. We never realized the complexity of this. It was huge...The answer is that the model was not UK but America private sector, which started about 1990 in South Africa’.

The concepts of managed care, tax deductions of treatment and company contributions as well as the emergence of medical savings accounts are all evidence of the American influence. A history of the American model is detailed below to conclude this Section dealing with the 1980-decade. As this influence was largely witnessed in the 1990’s in South Africa, it would serve as a valuable background and introduction to the next Section in this Chapter.

The administration of social security in the United States originated from the British. This section demonstrates how welfare in the United States developed in the twentieth century to being the responsibility of the employer, whereas the State took on this responsibility in Britain.

In 1919, the US Bureau of Labour Statistics published the report: *Welfare work for employees in Industrial Establishments in the United States* which showed that out of 400 establishments, 375 had some form of medical service (Warner *et al* 1894: 382). Mutual benefit associations were set up by employers to meet the risk of sickness of their employees. Employers would contribute to the benefit fund directly i.e. 10 cents per week provided a benefit of \$1 per day for 13 weeks. An example of this industrial co-operation is found in the 1928 Philadelphia Rapid Transit Employers Cooperative Association. The wage fund totalled \$14 000 000

administered by trustees elected by employees. Membership totalled 11 200 and contributions totalled \$1.50 per member with the company equalling the amount. In return the employee received sick benefits, pension and life insurance (Warner *et al* 1894: 384).

It is clear from the above that American health funding was primarily employer-based. In 1940, 9 percent (12.3 million) of the population had some form of health insurance. By 2006 this number had increased to 82 percent of the population. According to Helms, 62.2 percent of the non-elderly population was provided for by the employer. Individually purchased policies totalled 6.8 percent and public health funding totalled 17.5 percent of the population, leaving 18 percent with no health coverage whatsoever (Helms 2008: 2).

Modern health insurance in America was shaped during the depression years when hospitals experienced lower revenue and occupancy rates. In response, they developed ‘hospital service plans’ collecting small payments from employees in large companies in exchange for hospital care when needed. It was initiated institutionally in 1929 in Texas. By 1933 twenty six such plans were in operation which encouraged the American Hospital Association (AHA) to regulate certain conditions namely the plans had to be non-profit, tax exempt and free of state insurance regulation. In 1946, AHA became the ‘Blue Cross’ and the AHA plans directed at physician services, the ‘Blue Shield’. *Most physicians were opposed to any form of health insurance as they believed it would influence their income [emphasis added]*. They noted the expansion of hospital insurance and the increasing trend to advocate the expansion of social security for the inclusion of the provision of compulsory health insurance (Helms 2008: 3, 4).

The AMA also lobbied for enabling legislation in the states but insisted that these plans provide indemnity coverage, a type of payment that paid the physician a fixed amount. This allowed the physician to ‘balance bill’ the patient and retained the physician’s ability to charge different prices to different patients (Helms 2008: 4).

In the USA, health insurance, as provided by commercial insurance companies, expanded only after World War II. This was after the successes of the Blue Cross and Blue Shield was witnessed by Health insurance companies. During the 1920's, hospitals were seen as 'dangerous places where people went to die' (Helms 2008: 4). Thus, Health insurance was seen as a high risk venture. Insurance Companies began to experiment with more innovative products. The war prompted policy change and increased the pace of medical research which led to the discovery of penicillin in 1929. This, and other medical discoveries, resulted in the Life expectancy in sixteen developed countries increasing from 39 years in 1940 to 60 years in 1970 (Helms 2008: 5). This was similarly witnessed in South Africa Life expectancy statistics for Africans was recorded in 1945-7 at 36 years for males and 37 for females. By 1965-70 it increased to 51.2 for males and 58.9 for females (Seedat 1984:9). As much as two thirds of the increase was ascribed to better medical procedures and structural changes. As people witnessed this advancement and changed their views: '...perceptions that medical care might have positive benefits and be worth paying for' (Helms 2008: 5).

In another empirical study conducted from data collected 1931-1955, Thomasson concluded (Helms 2008: 20):

The growth of the health insurance market between 1930 and 1950 resulted from no single force, but rather the simultaneous occurrence of a number of factors. Starting from the prepayment schemes fostered by the hospitals in the early 1930's, health insurance grew into its own as improvements in medical technology stimulated the demand for health insurance, and insurance companies began offering insurance to employee groups. Government policy in the 1940's and 1950's reinforced this trend, and cemented the employer-based system of private health insurance that the United States has today.

World War II directly affected American tax and wage policies: The National War Labor Board instituted wage controls in an effort to counteract labour disputes which would limit wartime production. In addition, labour shortages were experienced due to demands in agricultural and the all-important war sectors. This forced the Labour Board to take control and establish rules for many aspects of employment such as wage increases, inflation adjustments to salaries, overtime

payments. This had a direct influence on health funding as employers in the face of wage constraints, attracted labour by offering improved fringe benefits, primarily pension- and health insurance. These benefits also fell under the auspices of the Labor Board which ruled, in line with the IRS, that the employer's provision of pension and health insurance benefits are not to be treated as taxable income.

This meant that the employer's portion of health insurance was not treated as taxable income in the hands of the employee. It was capped at 5 percent of the employee's annual salary. Annual salary was therefore calculated without the inclusion of group life, health and accident insurance. This cap was removed in respect of health insurance in 1954. The ratio of health insurance premium to disposable personal income grew from 0.40 percent in 1940 [US\$0.3 billion total premium to US\$75.7 billion disposable personal income] to 2.91 percent in 1970 [US\$20 billion total premium to US\$687.8 billion disposable personal income] (Helms 2008: 8).

According to Paul Jacobs of the Kaiser Family Foundation, from 1960 to 2006: '...employer payments for health benefits have increased as a share of total compensation in every decade, reaching 7.2 percent of compensation in 2006' (Helms 2008: 13). This illustrates that tax policy successfully provided a government funded discount for health expenditure and employer-provided health insurance. This tax policy is resembled in the South African private healthcare scenario many years later.

Demand for health insurance increased mainly due to the 31 percent improvement in wages during the period 1945 to 1955. Higher income earners were willing to pay more. The total number of persons covered for hospital care increased from 12.3 million in 1940 to 175.4 million in 1970 (Helms 2008: 11).

The collection of data to assess potential entrants and the analysis thereof improved, which assisted insurance companies in accepting risk and price setting. It was easier to sell health insurance to employer groups as adverse selection was

less of a problem due to employed people being healthier and younger. The relative growth of health care purchased by the employer versus individuals' purchasing health care was significant (Helms 2008: 11).

The War Labor Board (1945), the National Labor Relations Board (1949) and the Supreme Court (1949) made rulings which enabled the labour movement to 'bargain for health benefits as part of wage negotiations under collective bargaining arrangements' (Helms 2008: 12). The number of workers with health insurance negotiated by unions grew from 600 thousand in 1946 to 12 million in 1954. This represented approximately a quarter of the health insurance purchased in America (Helms 2008: 12).

Medicare for the aged and disabled was introduced during 1965 in an attempt to expand the public health programme. All American citizens older than sixty-five years were automatically entitled to this cover. Medicare was administered by a Federal Agency.²¹

Medicaid was instituted as extensions to the Social Security Act and was a combined Federal and State programme which pays for the health care needs of the poor. A wide variety of benefits were offered between the different States as coverage and standards differ from State to State.

Federal Government imposed administrative cost controls on hospitals and doctors servicing Medicare programmes. State Medicaid programs tried to get the Federal Government to pay a larger share of their costs and reduced their reimbursement rates and restricted their benefits.

According to Helms (2008: 14), the following three changes affected the private health industry in America:

²¹ Federal agency is an administrative unit of the USA Government

Firstly, the development toward self-insurance, prompted by federal legislation and court decisions. In terms of Federal legislation, companies that could self-insure did not pay State premium taxes. An insurance company would then contract with an employer to administer their health insurance plan whilst the employer paid the benefits and bore the risk. The employer's cost was still excluded by the IRS from the income of the employee. An influence which may have reduced the demand for health insurance in the beginning of the 1980's was the reduction in the marginal tax rate from 87 percent in 1963 to approximately 39 percent in 2008 (Helms 2008: 16).

The second development was 'managed care'. During the period 1988 to 1996 it is said that the reduction in the rate of growth in medical costs was due to the managed care movement (Helms 2008: 15). In an effort by federal legislators and employers to control the cost of health insurance, they approached hospitals and suppliers of medical care and products, offered them access to their insured group of members, in exchange for discounted rates for medical services.

Legislation was passed in 1996 allowing Medical Savings Accounts (MSA's) and Health Savings Accounts (HSA's) in 2003. This is the third major change in health insurance namely the institution of catastrophic cover, high deductibles and a tax-favoured savings account to fund the said deductible (Helms 2008: 16).

In the USA, many economists attribute the growth in health insurance to government's liberal tax policy. The tax benefits could accrue in two ways: Firstly the employer's contribution to the premium is deducted as a business expense. Company tax is calculated thereafter. The medical contributions thus results in a business deduction which in 2007 amounted to \$4.8 billion. Secondly the employer-provided insurance is excluded from the employee's taxable income. This exclusion from employee income estimated at \$133.8 billion in 2007 (Helms 2008: 18).

Helms (2008: 18) states that government tax policy increased the demand for health insurance as they were funding the above discounts. The higher the marginal tax rate the larger the saving for the individual. Feldstein and Allison are quoted by Helms in conclusion of their study, stating that the subsidy: ‘causes a substantial revenue loss, distributes these tax reductions very regressively, encourages an excessive purchase of insurance, distorts the demand for health services, and thus inflates the prices of these services’ (Helms 2008: 19).

A study done by Melissa Thomasson on the early post-war effect on health insurance found that tax policy had a major effect on health insurance and the growth of employer-based coverage (Helms 2008: 20):

- a. The demand for group health insurance increased
- b. The tax subsidy increased the amount of coverage purchased by 9.5 percent
- c. There was a shift from individual insurance to group insurance
- d. Households with group policies bought larger amounts of coverage after the tax subsidy was enacted; and,
- e. Households with higher marginal tax rates were more likely to have group coverage, and purchased larger amounts of coverage, than they did before 1954.

Although the American health care system has its strengths, such as cost control measures, wide selection of doctors and hospitals and high quality care, Veliotis concurs (1990: 60) that one of the major weaknesses of the American health care system was that in 1989, thirty-seven million people under 65 years of age had no health cover.

Medicare and Medicaid had been providing declining protection to its beneficiaries. In 1984 the latter only provided 40 percent of America’s poor with benefits. In 1998 16.3 percent equating to 44.3 million people had no health insurance in the USA (Van Rensburg *et al* 2004: 16). This shows an increase in the number of members with no health cover of 19.7% over a period of 9 years.

Leaders and politicians in the USA have been grappling with finding an equitable solution to balancing private and public healthcare provision to the general public for many years ‘President Clinton’s health care reform proposals for 1993 represented the most far-reaching program of social engineering to be attempted in the United States since the passage of Medicare and Medicaid in 1965’ (Feldman 2000: 1).

Reekie (1995: 103) relates the medical scheme industry problems experienced in the USA to South Africa but defines the difference: ‘To them [SA] is added the dimension of a rapidly growing private health-care sector placed in the heart of an emerging economy’.

The table below summarises the situation as it stands today, health an escalating cost representing a growing section of the GDP from year to year.

Table 37

Summary of Health Expenditure in USA 1960-2008

Type of Expenditure (US\$ billions)	1960	1970	1980	1990	2008	Percent Change
National Health Expenditure	28	75	253	714	2 339	8 253.7
% of GDP	5.2	7.2	9.1	12.3	16.2	211.5
Source of Funds:						
Private Expenditures	21	47	147	427	1 232	5 767
Public Expenditures	7	28	106	287	1 107	15 714
Per Capita Amounts: National Health Expenditure (US\$)						
Private	111	223	638	1684	4046	3 545
Public	36	134	462	1130	3635	9 997
Federal	15	84	311	764	2683	17 786
State and local	21	49	151	366	952	4 433

Source: US Department of Health & Human Services www.hhs.gov accessed on 15 December 2010

4.2 Period 1990 to 2010

These two decades illustrate a period of reform of the public and private health industries in order to address large funding inequalities. The Apartheid era witnessed disparities between racial groups in terms of socio-economic status, occupation, standard of living and health (Nkosi 2000: 1). The representative ANC government was voted into power in April 1994, which impacted on future health policies, particularly toward elimination of these inequalities.

One of the key issues facing the health industry worldwide was the provision of quality health services within the cost restraints posed by the different economies. In 1990, industrialised countries accounted for almost 90 percent of the total expenditure on formal health services which equated to US\$1500 per capita average versus US\$41 in developing countries (Van Rensburg *et al* 2004: 23).

Similarly, private health care spending had escalated in Western Europe and North America. The reasons cited by Ward (1993: 26) was summarised as follows:

1. The key role of the doctor in the fee-for service system
2. The combination of the fee-for-service system with third party payers
3. The increase in sophistication of medical technology
4. Ageing of the population
5. Increasing number of providers of health services
6. The emergence of new diseases such as AIDS
7. Limited competition amongst health care providers
8. The increase of medical aid fraud
9. Excessive hospital capacity
10. Unhealthy life styles, environmental pollution, and little or inappropriate health planning
11. The impact of tax laws
12. The earlier diagnosis of diseases
13. Inefficient Government involvement

14. General inflation in all products and services

The private healthcare industry in South Africa was in crisis and a bleak future was predicted by many. This was essentially due to the healthcare industry's inability to contain costs which in turn influenced profits. The decade 1982 to 1991 showed an increase in claims from R815 million to nearly R7 billion. In 1992/3 South Africa spent R30 billion on health services which represented 8.5 percent of GDP. Sources of financing were public sector 38.7 percent, donors 0.5 percent and private sector 60.8 percent. The population growth rate peaked at around 2.9 percent per year in the early 1980s.

In 1989, the total SA population was approximately 30 million people with 69.9 percent blacks and 16.5 percent whites (Veliotes 1990: 20). Only 17 percent of the population were members of medical schemes and 23 percent had regular access to private health care with health care providers heavily skewed toward the private sector (General practitioners 62% and dentists 93%). Medical schemes spent 15 percent more on their patients compared to the public health sector (*South Africa Survey* 1996: 208).

Noted in the tables below, the White beneficiaries remained relatively stable compared to increases in other population groups, particularly the Blacks. The ratio was however still not by any means representative of the population. From 1982 to 1993, medical aid member's annual contributions had increased 1000 percent from R442 to R5 229. This represented an increase of 25 percent per annum versus 14 percent of the CPI. In 1991, this equated to 8 percent of annual wages (*South Africa Survey* 1996: 212):

Table 38
SA Population, Medical Scheme Membership and Beneficiaries 1982-1991

	1982	1991	Percentage change
1. Population	27.1m	31.2m	15.1
2. Medical Scheme Beneficiaries	4.9m	6.3m	28.6
3. (2) as percentage of (1)	18.6	20.1	-
4. Medical Scheme membership	1.9m	2.4m	26.3
5. (4) as percentage of (1)	7.1	7.7	-

Source: Reekie 1995: 103

Table 39
Beneficiaries of Medical Schemes 1982-1991

Population Group	1982	1991	Percentage change
Asians	229 394	329 488	43.6
Whites	3 473 742	3 490 001	4.7
Coloureds	672 873	948 164	40.9
Blacks	484 898	1 523 702	214.2

Source: Reekie (1995: 104) derived from Melamet report

In June 1990, the Competition Board Investigation (1990: 48-57) issued a working document and found the following practices to limit competition:

- i. Maximum and minimum benefits
- ii. The limitation of non-medical schemes (such as insurance companies) from entering the health care market
- iii. The limitation on medical schemes from participating in other businesses such as offering short-term insurance
- iv. The guarantee of direct payments as being 'under suspicion' of being a restrictive practice
- v. The scale of benefits and the fact that it had to be drawn up according to the relativities.

vi. The pricing and marketing of medicines.

Many parties predicted the downfall of the private health care sector which by 2010 did not happen. Ward concluded (1993: 70) ‘The research confirms the suspicions of the researcher of the imminent collapse of the private health care sector.’ He stated that the major problem faced by the private healthcare industry was cost containment against spiralling medical inflation. According to Essop (1998: 2), the only way to contain these costs was either through Government intervention or market control. Given the ideals of a new ANC government wishing to equalise healthcare to the nation at large, he concluded that the future of private healthcare was bleak, unless drastic changes were made. Veliotis (1991:118) shared this dim view:

Never before has there been a greater imperative for the South African health system to undergo explicit change. Although no perfect health care system exists, as a result of fundamental socio-political and economic changes, the prevailing system is becoming incompatible with the environment.

Three inequalities in the pre-1994 stood out in particular – the public-private health sector mix which showed approximately 60 percent of health care expenditure on approximately 20 percent of the population, mal-distribution of health care services between geographical areas and lastly the discrepancy in allocation of public sector resources between socio-economic groups. The rich magisterial districts had nearly five times more doctors and 31 times more specialists than the poorest magisterial districts (Van Rensburg *et al* 2004: 379).

Van Rensburg points out that the health reforms in the 1990’s were not entirely a consequence of the new government. The previous government launched several health proposals, however, could not bring about essential changes due to its ‘underlying structural problems in health care i.e. the problematic societal and political dispensation in which health care was embedded and from which the numerous structural problems in this sector emanated, especially the apartheid dispensation in health care’ (Van Rensburg *et al* 2004: 98). The need to rationalise policy was understood, as well as the need to amalgamate

health departments and abolish the racial restrictions on the occupancy of beds. “By a stroke of the pen, in May 1990, the Government responded. It opened all provincial hospitals and the “white” ambulance services to members of all races” (Davenport and Saunders 2000: 663).

Another reason cited for this crisis was the low growth rate of the South African economy in the decade preceding 1990. Increased unemployment estimated at 30 percent in 1994 resulted in a decline in per capital income. ‘This has placed considerable pressure on resources available for financing health care’ (Veliotes 1990: 18).

Since the 1990’s, the AIDS/HIV epidemic in South Africa has dominated the main demographic and population trends. The HIV prevalence in adults has risen from 12.9 percent in 1997 to 19.9 percent in 1999. Life expectancy in 2001 had reduced to 50 years. By 2011-2016 it is expected to further reduce to 48 years (Van Rensburg *et al* 2004: 179, 183, 279). This would impact on future Government health expenditure.

De Beer and Broomberg (1990:119) found in their study that the public sector was unable to provide adequate care to the population on the budget available, mainly due to the fact that the public sector was seriously underfunded and equalled 3.3 percent of GNP. They cited the following reasons: inefficient use of resources and administrative waste due to fragmentation and duplication of services, excessive bureaucratic management structures and undue emphasis on expensive curative care, high technology tests and interventions.

Interesting De Beer and Broomberg refer to the medical profession and the private medical schemes and the combined contribution to the present crises, which ties in with observations highlighted in this dissertation:

The responses to these crises have been typical of the partisan and parochial defence of vested interests that has characterised the health sector to date. **The medical aid schemes, private practitioners, hospitals and pharmaceutical**

industry have all acted primarily in their own economic interest [my emphasis]. One example is the recent legislative changes, long lobbied for by the medical schemes movement, that give schemes greater flexibility in the packages they provide, and in the setting contribution rates. Rather than act to contain costs, the schemes have acted primarily to maintain their market. The net effect of the resulting changes will be that decent coverage for care in this sector will become increasingly unaffordable for the average earner (De Beer and Broomberg 1990: 119).

This view is supported by Folb (1990: 121) ‘The traditional insistence of the profession that policies which limit doctors’ autonomy and clinical independence are tantamount to compromising patient care will have to be carefully reconsidered in present times. The alternatives to self-control by the profession may be worse’.

During this 1990-debate two interesting thoughts evolved, particularly Government’s stance on privatisation: ‘In the case of the public sector crises, the Government’s response has, until recently, been to further promote privatisation as a means of unburdening itself of its vital responsibilities’ (De Beer and Broomberg 1990: 119) as well as the perceived future role of the private health industry:

A basic aim of centralised State funding is the progressive eradication of the two-tier health care system. If this is to be achieved, it must not be possible for relatively privileged strata of society to pay for their ordinary health care needs in a system from which others are excluded because they are unable to pay (De Beer and Broomberg 1990: 146).

McIntyre and Dorrington (1990: 125) stated that the ‘lack of critical distinction between the public and private health sectors and what they represent has allowed the claim to be made that South African health care expenditure levels compare favourably with international standards’. They added that per capita expenditure in the private sector outstripped the public sector during the 1980’s. In support, a paper was written to highlight trends in this regard and, insofar private sector expenditure is concerned: ‘The only published source of national private sector health care expenditure is the Reserve Bank’s estimate of private consumption expenditure on medical goods and services’ (McIntyre and Dorrington 1990: 126).

In May 1990, the Minister of Health identified the following principles and guidelines for the reconstruction of health services (Veliotes 1991: 24):

- a. Accessibility to health services
- b. Efficacy of health care programmes
- c. Affordability of health services
- d. Equity in the provision of health services
- e. Acceptability of health services

At that time, considerable debate occurred among the medical profession and medical schemes and centred on health maintenance organisations, independent practice organisations and preferred provider organisations. It was generally believed that the American ‘managed care’ concept would assist in the containment of cost and resource utilisation. Dr Mandell’s, Chairman of the Federal Council of MASA commented on the De Beer and Broomberg article cited above:

In the USA, one of the major developments has been the independent practice association phenomenon and its offshoots. If this successful development of the managed care system is to prosper in South Africa, then it is important that the Medical Association be involved in its development, and it should develop alongside the ‘fee-per-service’ system. If it is found that through good physician management costs can be contained and the spiral of escalation can be reduced, then ‘managed care’ may be what the future holds for us (Mandell 1990: 143).

In 1991, there were five Associations aimed at medical schemes, namely: the Advisory Association of Medical Schemes; Federation of Medical Schemes; National Association of Medical Aid Schemes; National Association of Medical Benefit Funds and the Southern African Association of Medical Schemes (Veliotes 1991: C2).

LD Hollis, brother of founder Keith Hollis and shareholder in administrator Medscheme responded to questions posed in 1991 by Veliotes (1991: Appendix H 21). The entire quotation gives a comprehensive summary of the private health

industry in the 1990's and includes comments on the proposed Medical Schemes Bill:

The present system is not acceptable because in order to qualify for the guaranteed payment, providers must abide by the scale of benefits which is unrealistically low. This forces health care providers to over-service in order to make ends meet;'

Therefore, there is no disincentive for patients to utilise services more appropriately. One of the major areas which have resulted in excessive cost escalation is medicines.

During the last decade, medical aid contributions have escalated at a rate well in excess of inflation. The differential was more prominent in the case of the less affluent contingent of the medical aid membership;

The majority of medical practitioners charge according to the scale of benefits rate, especially when providing services to the poorer segment of the population. The scale of benefits rate is not sufficient compensation for services provided. It has been found that practitioners who charge according to the Guide to Fees provide a better service.

Many aspects of the current Act relating to Medical Schemes are unacceptable to medical practitioners and therefore the profession has identified the need for change. However, changes must be carefully thought through and should never be considered only from a cost minimisation point of view.

To review the Medical Schemes Act in isolation and without consideration of its impact on the equity of the overall health care delivery system is unacceptable. The over-riding concern is that the Bill does not address the strong and urgent need for efficiency and equity in the entire health care system. It is an attempt toward cost minimisation in the private sector, but offers patients no assurances of continued and expended access to health services. In contrast, it affords medical schemes unlimited monopolistic powers to control the use and provision of services.

The doing away of the guaranteed payment is unacceptable because:

- a. Payment of funds to members rather than to suppliers may increase the use of these funds for purposes other than that for which membership of the medical scheme was acquired;
- b. It can restrict patient access to health care particularly in poorer areas;
- c. Neither the existing system nor the proposed draft Bill meets the criteria of efficiency and equity.

As far as the draft Bill's abolition of exclusions, limitations, minimum and maximum benefits, is concerned, there are both advantages and disadvantages.

- the advantages are that it will provide flexibility to tailor medical scheme packages to meet individual needs and will increase competition which can lead to innovation and improved efficiencies. Also, it can improve the financial position

of medical schemes and increase the use of incentives and/or disincentives to discourage over-use of services. The draft Bill will allow medical schemes to extend their role in the provision of health care services such as to establish or own their own pharmacies, hospitals and other disciplines. The flexibility to underwrite, insure or re-insure in order to provide additional cover for members is a favourable development because:

- There is improved risk sharing and cross-subsidisation within the medical scheme movement.
- It can improve the financial position of medical schemes
- Additional funds could be raised for dealing with expensive treatment, thereby making the treatment more accessible.

However the disadvantages totally outweigh the advantages. They are:

- The increased use of risk rating and
- The shift of responsibility for the indigent and sickly onto the State.

Managed Health care systems are good, provided they are not operated for:

- a. Financial exploitation
- b. Do not directly or indirectly influence practitioners' behaviour toward patients
- c. Are in accordance with professional codes of ethics
- d. State responsibility has been clearly defined
- e. They are not granted special monopolistic powers by statute;

There is a danger that the draft Bill will create an omnipotent RAMS with statutory monopolistic powers. RAMS should be a voluntary organisation and not statutory;

Equity and efficiency in a future health system can be achieved by:

- a) Immediate submission of accounts by suppliers of services directly to medical schemes in order to get prompt payment;
- b) The introduction of a user charge payable by the patient;
- c) Use differentiated subscriptions to discourage abuse of medical services;
- d) Responsible limits of the number of visits over a period of time;
- e) The State, in conjunction with all the relevant parties must clearly define its responsibility for the provision of health services.

The private sector will increase in size in the future and will be responsible for the provision of health care. The State will play a major role in the funding of the health care and must be responsible for equal access. There must be a strong co-operation between the private and public sector.

Primary care, funding of health services, preventative medicine as well as the co-ordination of services must be the responsibility of the State. This basic package provided by the State must be clearly defined and the private sector would be supplementary and parallel to the State system.

Managed care is an important concept derived from the American model and is further investigated below. The definition by the American Medical Association is quoted below:

...the control of access to and limitation on physician and patient utilisation of services by public or private payers or their agents through the use of prior and concurrent review for approval of or referral to service or site of service, and financial incentives or penalties (Orelowitz 1996: 13).

According to Orelowitz (1996: 16), the fundamental principles in a managed care environment were cost containment and the most cost effective use of resources.

This is the opposite of fee-for-service as members would pay a set premium per month and in turn receive medical care from providers who have entered into agreement with the fund or plan to provide a service at a predetermined lower price. The choice of providers is restricted by the managed care plan and different models are used i.e. gatekeeper model where members must choose a general practitioner from an approved list. This practitioner must authorise all referrals for hospitalisation, specialists or expensive procedures. In turn, risk reward plans are forged between the funder and provider i.e. capitation method where the provider services health needs within an umbrella of revenue. The larger the amount by which revenue exceeds cost, the larger the provider's share of income, within a framework of quality control measures. (Orelowitz 1996: 13-14)

Managed care organisations employ certain methods to control costs and offer alternative treatment options. Orelowitz (1996: 16) cite these as follows:

- Reimbursement methods:- the general practitioner is reimbursed by the plan via fixed salary (no incentive to oversupply) fee-for-service (the more services he renders, the higher his payment – seen as major contributor to rise in health care costs in America) and capitation (per capita payment – incentive to either grow patient base or provide less services).

- Reimbursement mechanisms measures were introduced to limit the fee-for-service method and shifting risk by pressurising physicians and hospitals to reduce the number and cost of service within a balance of ‘overtreatment’ or ‘under-treatment’. Another limitation introduced was levels of payment where payers negotiated with providers on price or agree on fee schedules as set by payers (Orelowitz 1996: 18). Positive financial incentives and bonus schemes were introduced, rewarding physicians for high standards of care given, rather than punishing over-servicing of patients. Another measure was utilisation review programs, which were methods introduced to limit excessive utilisation.

Also in the early nineties, Magennis (1991: 259) found some of the following mega-trends to be emerging in a health care delivery system design:-

- i) deregulation of the professions to pave the way for transformation of managed care systems and a team approach to health care
- ii) the de-scheduling of medicines, and acceptance of generic substitution growing support for a national health insurance system
- iii) deregulation of medical schemes to provide increased flexibility in forming managed care systems, and innovative methods of funding health care in the private sector
- iv) continued vertical integration, particularly by manufacturers, pharmacists and medical practitioners
- v) an increased need for the full-liner wholesaler as the professions are deregulated, the price of medicines is reduced, and the government looks for non-politicized ways of increasing private sector involvement in health care delivery
- vi) an increased involvement by multi-nationals in health care policy formulation.

The Financial position of Medical schemes as at 1992 was summarised and Income of 9,882 billion reported, of which 94,8% was membership fees. This represented an increase of 22,5% on the previous year. Total benefits paid equalled R8,741 billion which was a 26.8% increase (Annual Report of the Registrar of Medical Schemes (1993) :10) Average administration costs per person per month was R6.89.

Table 40

Total membership of medical schemes as at 31/12/1992

Medical Aid Schemes	Benefit Schemes	Exempted Schemes
4,764,732	757,655	531,580

Source: Annual Report of the Registrar of Medical Schemes: 1993: Annexure 1

In 1993, Steinmetz issued its Report of the National Committee following investigations into the Rationalisation of Health Services in the Republic of South Africa and the Self-Governing Territories.

Steinmetz Commission (1993)

Its recommendations are listed as follows:

- a. The present structure for the delivery of health care be replaced by a decentralised one-channel structure for the delivery of health care and the financing thereof;
- b. The new structure be on a regional base;
- c. Urgent attention be given on the level of service to be provided by the public sector and that very sophisticated disciplines be scaled down;
- d. The available health care facilities in the public and private sector be better utilised by making the surplus facilities available in each sector to the other;
- e. The training facilities for health care professionals be scaled down so as to provide in the needs of South Africa alone;
- f. The mal-distribution of medical practitioners in South Africa be addressed by introducing incentive schemes to improve the situation;
- g. Steps be taken to address the number of pharmaceuticals and medical disposable items available and to revise the controlling and financing systems of these items;
- h. The present method of funding of health care which is based on subsidisation of the institution, be changed to subsidisation that is directed at the patient; and
- i. Note be taken on the impact of the treatment on non-RSA patients on the funding of health care in South Africa (Steinmetz 1993: 1).

On 6th August 1993, the State President FW de Klerk appointed the Melamet Commission of Inquiry into the Manner of providing for Medical Expenses

Melamet Commission (1994)

The Commission comprised of the Honourable Mr Justice D.A. Melamet, Professor WD Reekie and Mr CC van der Meulen. Hearings commenced in October 1993 to February 1994. Its mandate was: ‘to inquire into and report on:-

- 1.1 whether or not the manner in which medical schemes are funded at present is sufficient and whether it is desirable to subject the financing of medical schemes to actuarial discipline and supervision, with specific reference to aspects such as –
 - investigation into the existence of the rights of members and the accrued interest of members including the necessity to protect such interests, if any;
 - the protection of members’ accrued interests in medical schemes against creditors;
 - the transferability of accrued interests of members in medical schemes;
 - the management of accrued interests of members in medical schemes in the case of death or divorce;
 - the investment and management of assets (including the prescription thereof and supervision thereof);
 - the provision of lifelong medical cover after retirement;
 - the implementation of levels of funding;
 - where administrative supervision should be placed;
- 1.2 the feasibility of and the manner in which the insurance industry can play a role to enable individuals to provide for future medical expenses, with particular reference to matters such as: –
 - the extent to which existing legislation adversely affects the provision of schemes or products, providing for medical expenses;

- the extent to which existing legislation places unnecessary limitations on the demarcation of the operational scope of insurers and of the suppliers of medical cover and whether such legislation leads to unwarranted competition;
- 1.3 the feasibility of and the manner in which related institutions can play a role in enabling individuals to make provision for future medical expenses, with particular consideration of institutions such as -
- (a) Mutual aid societies
 - (b) Benefit funds
- 1.4 the marketing of membership of the said institutions and the remuneration paid by the said institutions to intermediaries such as recruiting agents with particular consideration to aspects such as –
- a. the desirability of the regulation thereof;
 - b. the control over the receipt, maintenance and management of contributions; and
 - c. the determination of benefit levels;
- 1.5 Any other related manner which may come to the attention of the Commission and which may in view of the main purpose of the investigation, require the attention of the Commission.
2. To make recommendations in view of the investigation and conclusions drawn therefrom with regard to the amendment of any existing law in order to place the provision for medical expense on a sound financial basis, to bring about a more equitable system and, in general, to enable the individual to make sufficient provision for his own medical expenses.’
(Melamet 1994: 9)

Recommendations pertaining to health financing per se:

That the Council for Medical Schemes be made responsible to the Policy Board for Financial Service and Regulations as the committee arranging the supervision of any and all non-statutory entities which accept money from the public as an intermediate body with the purpose either of paying directly or indirectly any provider of a health-related service upon treatment or rendering of a health-related service by such a provider or compensating, reimbursing, benefiting or indemnifying or attempting to compensate, reimburse, benefit or indemnify the member directly or indirectly, in full or in part, upon the member's contracting of any illness or any health-related condition or upon the need arising for any health-related treatment (Melamet 1994:12).

It is recommended that the Council for Medical Schemes, either on its own or through the Policy Board for Financial Services and Regulations, give serious consideration to the introduction of a single 'Private Health Finance' Act having regard to the different entities, some controlled by another supervisory body and some uncontrolled, involved in the financing of health care (Melamet 1994:12).

We recommend that the Registrar of Medical Schemes determine a set of guidelines for the computation of the provisions for unanticipated claims. The rules should be sufficiently flexible to account for the above complexities but sufficiently transparent and comprehensible that the auditor of schemes can verify that the model accounting practices have been adhered to. We recommend further that the Registrar use the term 'underwriting surplus or loss' to refer to the surplus or loss after providing for unanticipated claims. Similarly the term 'trading surplus or loss' should be applied after the underwriting surplus or loss has been adjusted for investment income. As with our other recommendations we also believe that the Registrar of Medical Schemes should scrutinise the returns of open schemes vis-a-vis in-house schemes more strictly (Melamet 1994: 33).

We recommend that the tax treatment of medical scheme contributions in the hands of the employer be retained. We further recommend that if and to the extent that subsection 11 (1) of the Income Tax Act is retained as is then its scope should be extended to embrace the insurance industry (Melamet 1994: 45).

...given the overall desirability of continuing to provide an incentive for people who can provide for their own health care needs, while simultaneously extending the scope for expanding the private provision of care (Melamet 1994: 47).

The Medical Schemes Bill previously referred to by LD Hollis, became operative in terms of the Medical Schemes (MAS) Amendment Act 23 of 1993 on 1 January 1994, its aim to introduce flexibility to an Act seen as inflexible (Melamet 1994: 8). It was seen as a 'significant move toward deregulating the industry' and gave medical aid schemes more authority to manage their affairs than previously (Dry

1994:14). According to Essop (1998: 36), this act assisted the ‘emergence of new generation benefit plans.’ The amendments ‘further deregulated the industry by eliminating statutory minimum benefits, establishing guaranteed payment for claims and permitting schemes discretionary exclusion or limitation of cover for some procedures’ (Jekwa 2006: 19). It also eliminated compulsory direct payments to service providers and allowed medical schemes to ‘risk rate’ patients.

Just before the first democratic elections in 1994, the Health Expenditure Review was undertaken. Its objective was to provide information to assist the new government in considering health sector restructuring options, particularly from an equity and efficiency point of view. It found that hospitals in the public sector were largely based on curative care and located in urban areas. Public Sector hospital inefficiency was significantly higher than the private sector. Medical schemes particularly saw increases in contributions from 7 percent of average formal sector salaries in 1982 to 15 percent in 1992. The Review identified a few major contributors to this problem namely: ‘fee-for-service’ reimbursement of providers by a third party, overuse of health services by scheme members and oversupply by health care providers who are rewarded for each additional service provided (Van Rensburg *et al* 2004: 378).

Public Health and a New South African Government

It is important to focus on the new Government and public health financing as a background to developments in private health funding.

The extract from Dr Coen Slabber, Director-General of the Department of Health at a MASA board of trustees meeting in November 1994, highlights the direct link between public and private financing issues following the appointment of the new Government:

All public health services will in future be a function of the different provinces, while only those formal tasks rendered at a national level will remain with the national Department of Health. This includes functions like the norms and

standards of certain regulations and registration, the registration of medicines and medical aid schemes and the marketing of health services (Sanders 1995: 14).

...private practice has reached a turning point in history in the way it has been financed. Problems experienced in the medical aid scheme industry and general resistance from employers to increase their contribution toward medical funding has given rise to the concept of national health insurance that will be funded by Government and the private sector. The Minister of Health, Dr N. Zuma, thinks it might be possible to implement this in phases from April this year. Initially it will consist of a capitation basis, but there is not yet any clarity on how it will operate or who should run it. Any services beside the basic package will have to be paid for privately. The general practitioner will be part and parcel of this scheme (Sanders 1995: 15).

On 10th April 1994, the ANC government was voted into power and Nelson R. Mandela became the first Black president of South Africa. The new government inherited a health system fraught with inequities as noted by the Health Policy Coordinating unit (1995). It attempted to deal with this problem via establishment of a Reconstruction and Development Programme, RDP. The first budget aimed at “finding R2 billion for health, welfare, education, housing, land, water urban renewal and other development projects...” (Davenport and Saunders (2000): 569)

The previous Government believed: ‘that there is an individual responsibility on the part of each person to protect and maintain well-being through self-care and self-medication’ (Ward 1993: 48). This had to be achieved within the community. Ward added that Government’s responsibility was limited to health promotion and the provision of preventative services to those who could not afford private treatment. The individual had to contribute to his own health care via participation in employer-linked health insurance schemes (Ward 1993: 49). Government has since departed from this strategy and this dissertation has shown its efforts in this regard.

A National Health Plan for South Africa was launched by the ANC in 1994. It laid down the boundaries for fundamental reform of the health care system. The Plan proposed a ‘complete transformation of the national health care delivery system and all relevant institutions. All legislation, organisations and institutions related to health have to be reviewed’ (Van Rensburg *et al* 2004: 114). As part of its health

transformation programme, Government embarked on an affirmative action programme to ensure a representative workforce in the public sector

The ANC based their basic health policy on the principles of the International Conference on Primary Health Care held at ALMA-ATA on the 12th September 1978 in the former Union of Soviet Socialist Republics (USSR). The World Health Organisation and United Nations Children's Fund adopted the declaration as follows:

- a. The conference strongly reaffirms that health which is a state of complete physical, mental and social well being, and not merely the absence of disease infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.
- b. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
- c. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health statuses of the developing countries. The promotion and protection of the health of people is essential to sustained economic and social development and contribute to a better quality of life and to world peace.
- d. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.
- e. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.
- f. Primary health care is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing the first element of a continuing health care process.

The Report continues with a full explanation pertaining to Primary Health Care, the section endorsing a national health system

- viii) All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally. Declaration of Alma-Ata (1978: 1-3).

The final declaration was: '*Health for all people of the world by the year 2000*' which essentially redirected the course of global health care toward primary health care and made it action-oriented (Van Rensburg *et al* 2004: 28).

The inequities between the public and private health systems needed redress, particularly seen in the context of the 1995-budget expenditure between the public and private sectors.

The Constitution of the Republic of South Africa was passed in terms of Act 108 of 1996. In terms of Sections 27 (1) (a) (2) (3):-

1. Everyone has the right to have access to
 - a) health care services, including reproductive health care;
 - b) sufficient food and water; and
 - c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance;
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights;
3. No one may be refused medical treatment.

In addition, Sections 11 and 24 apply specifically to medical care i.e. the right to life and right to an environment that is not harmful to health.

This effectively removed the legacy of apartheid and constitutionally ensured that all South Africans had equal access to health care. ‘In doing so, the Constitution clearly lays the foundation for both a liberal and egalitarian health care system and thereby signals a break with the legacy of gross inequality, and it guarantees everyone the right of access to basic health care systems’ (Van Rensburg 2004: 116).

In terms of Section 9 (2) of the Constitution under the theme ‘equality’ Affirmative action is defined as: the additional corrective steps which must be taken in order that those who have been historically disadvantaged by unfair discrimination (particularly black people, women and people with disabilities) are able to derive full benefit from an equitable employment environment (Van Rensburg 2004: 348).

‘The October Household Surveys (OHS) from 1995 to 1998 recorded information about individuals who required medical attention during the twelve months prior to the survey. When asked about the type of consultation, two answers featured prominently, namely public hospitals and clinics, and private hospitals, clinics, doctors or specialists. A very small proportion of people mentioned traditional healers’ (Hirschowitz 2001: 86).

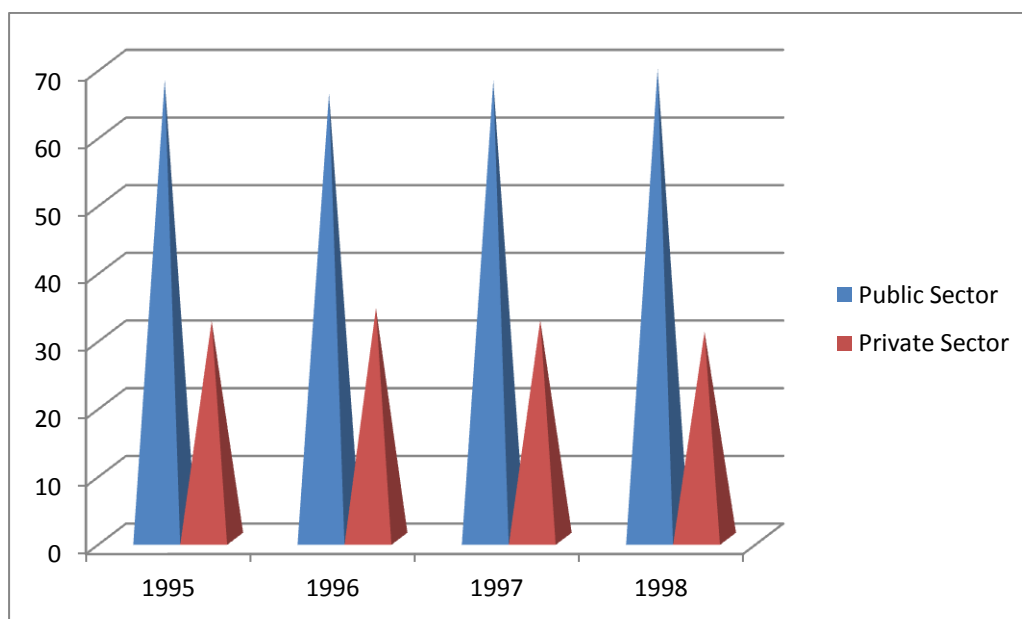
In each of the four years under comparison, public facilities were the most commonly used health-care facility in South Africa. In Diagram 41 below, it is shown that there was a gradual increase over time in the use of public health-care facilities, and a gradual decrease in the use of private facilities.

The OHSs of 1996, 1998 and 1999 recorded information as to whether each household member had access to a medical aid, or a medical benefit scheme or any other form of private health insurance. Across all three years, fewer than 20 percent of South Africans reported that they had some form of private medical

cover (Hirschowitz 2001: 87). By 1998/99 expenditure of the South African health care sector equalled R70.2 billion (Van Rensburg *et al* 2004: 380).

Diagram 41

Changes in sector used by households for health care between October 1995 and October 1998

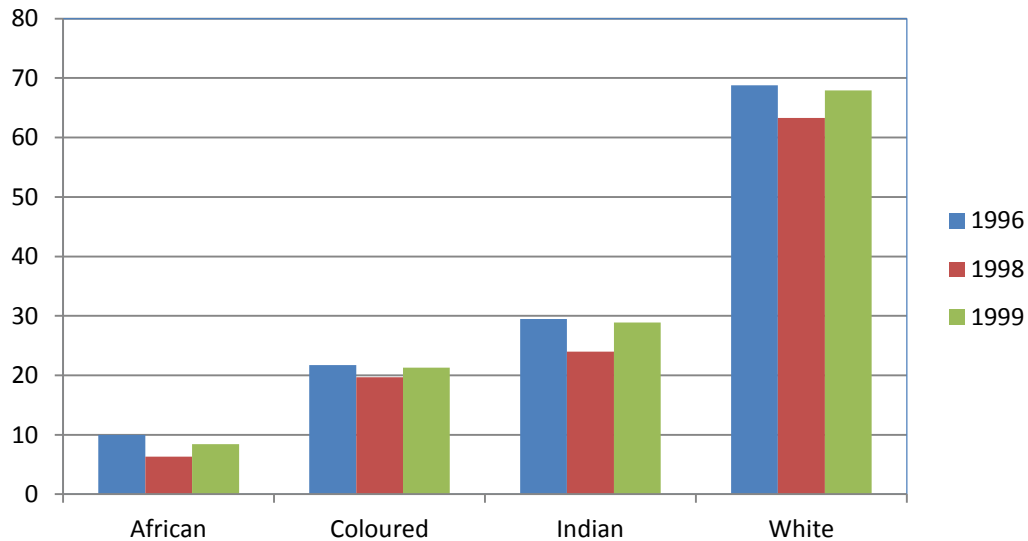


Source: Hirschowitz (2001: 86)

The table below shows that, while there was very little change in access to medical cover over time, there were considerable differences between the population groups in terms of access to medical cover. ‘The proportion of African people with medical cover, at less than 10 percent, was the lowest of all population groups in all three years. The proportion of coloured people with medical aid cover remained more or less constant over the period at just over 20 percent. The trend line for the Indian population showed that approximately 25 percent had this type of cover over the time period. On the other hand, close to seven in every ten white people across the three years had medical aid cover’ (Hirschowitz 2001: 87).

Diagram 42

Percentage of people with medical aid cover October 1996, 1998 and 1999



Source: Hirschowitz (2001: 87)

In mid-1996, the Government introduced its Growth, Employment and Redistribution Framework Strategy (GEAR) which was a macro-economic strategy for rebuilding and restructuring the economy. It was criticized for not being in the interest of the poor as it signalled an ideological shift in development thinking from growth inspired to market orientated (Van Rensburg 2004 *et al*: 113). It was said to compromise the RDP programme which highlighted social reform.

On the national front, SA government initiated several policy reforms which set the basis for the National Health Act. In 1997, the white paper for the Transformation of the Health System in South Africa set out the principles of a national health plan. It spelled out Government's objectives as being more community orientated and aimed at Comprehensive Primary Health Care. In the same year, the White Paper on Transforming Public Service delivery was documented. It commented that greater supply of private beds leads to greater utilisation and rising costs in the private sector due to supplier-induced demand. Skilled medical personnel were

also attracted to the private sector, at the loss of the public sector (Van Rensburg *et al* 2004: 120).

The period 1998/9 witnessed a continued decline in the standards of patients care, mainly attributed to staffing deficits. This trend was seen nationwide but is referenced particularly to Groote Schuur Hospital: 'services were reduced, numbers of beds declined and staff shortages hit vital areas such as ICU's and theatres' (Digby *et al* 2008: 78). During the period 1980 to 1994, 47 specialists resigned from the Department of Medicine, the average number of days spent in a hospital such as Groote Schuur reduced from 15.5 days in 1949 to 4 in 2005/6 (Digby *et al* 2008: 23,77).

In 1998, affirmative action was formalised in terms of the Employment Equity Act. The National Department of Health instituted the Affirmative Action Policy in 1999 and the programme was adopted by the provincial departments. Racial disparities has changed in line with population trends i.e. prior to 1994 the number of whites employed in managerial positions in the National Department of Health totalled 90.2 percent which had reduced to 48 percent by 1995 (Van Rensburg 2004 *et al*: 348, 349). Similar disparities in race representation extended to the private healthcare sector: 'the small proportion, not simply of black specialists in the country, but of the lack of black graduates and professors...[and] the small number of black South Africans in executive positions in the private health sector' Van Rensburg *et al* (2004: 351). Another significant change was the rise of the black elite as a consequence of these economic empowerment initiatives and the de-racialisation of employment practices in the private and public sectors.

The Patients' Rights charter was issued in 1999. In accordance with the Government RDP and GEAR strategies, a draft White Paper for a Population Policy (1996) followed by the White Paper on Population Policy in 1998 (Van Rensburg 2004: 120). The 1998 White Paper on Local Government provided for the complete transformation of the old local government structures with a new

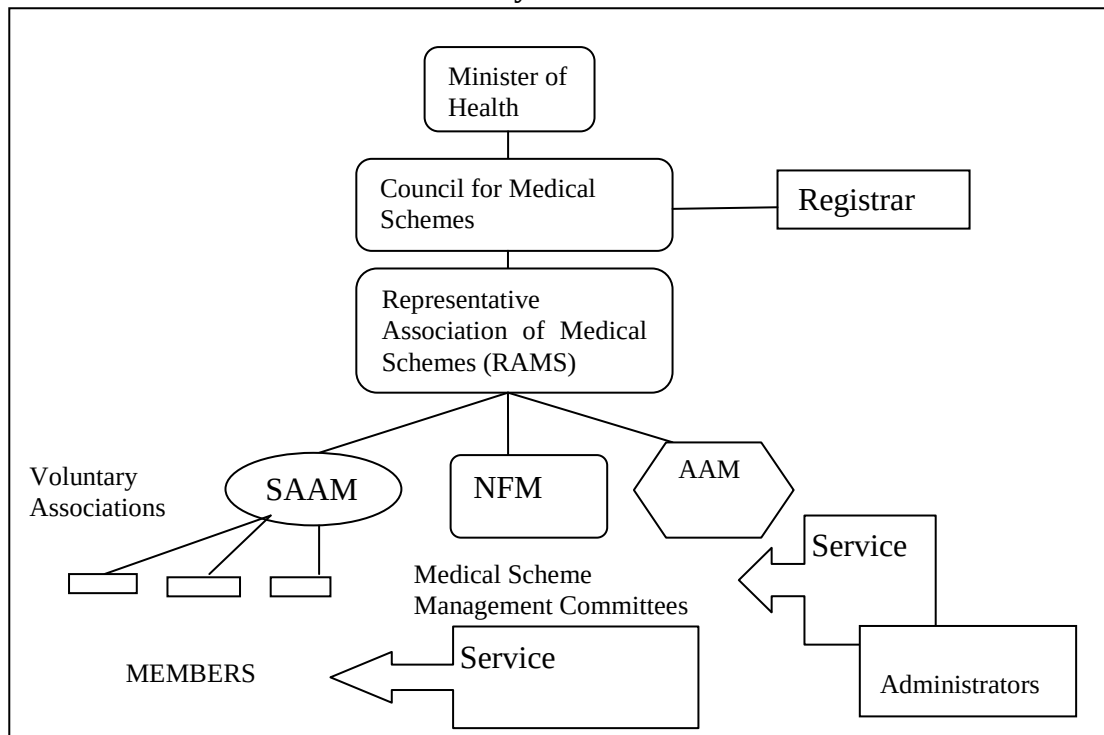
structure/ policy framework which would meet social and economic needs of the community in a holistic way (Van Rensburg 2004: 124).

During 1999, approximately 7 out of 100 South Africans received social assistance from the government. In 1989 expenditure in respect of social assistance was R11.8 billion which had increased to R19.8 billion in 1999/2000 (Olivier 1999:16).

Private Health and a new Government

Diagram 43

Structure of the Medical Aid Industry in 1994



Source: Dry 1994: 15 quoting Melamet Commission (1994).

RAMS was a voluntary association which represented the interests of registered medical schemes. They presented a unified pressure group when entering negotiations with various parties, supportive services, forum for discussion of industry trends and formulation of policies (Dry 1994: 16). This body has since been dissolved.

There were seven basic types of health funding schemes identified during the 1990's: State schemes for civil servants, parastatal schemes, university schemes, corporate in-house schemes, open schemes for organisations not large enough to warrant their own scheme, union-based schemes and individual schemes which were open to individuals (Dry 1994: 22).

During this time, private health care was critically dependent on Medical Aid Schemes (Ward 1993:7). Medical Aid and Medical Benefit schemes were sectors within a wider healthcare and health financing industry. Medical aid schemes formed an essential link between patients and suppliers of medical services (Dry 1994: 12). Medical Aid schemes are legal bodies registered in terms of the conditions of the Medical Schemes Act. Members and their dependants were the primary beneficiaries of the scheme's funds

According to Ward (1993: 8) Medical Aid Schemes funds were derived from three sources:

- a. Third party payments made up of a 50 percent contribution of the employer which is tax deductible in the hands of the employer plus 50 percent deductible from the employee's wages, which is tax deductible in the hands of the employee.
- b. Out of pocket expenditure being co-payments for medical aids where they do not cover 100 percent and cash payments to cash practices
- c. Payments from Workmen's Compensation Commissioner for private medical care of people injured in circumstances of relevant Act.

'Open and close schemes' refer to membership boundaries of the schemes. Members of a closed scheme belong to a particular organisation whereas an open scheme has no such restriction (Veliotes 1991: Appendix 1).

The Rules for Medical Aid Schemes was an all-inclusive document governing the Scheme's affairs, and the terms of which are subject to agreement by the Registrar

in order for the scheme to be registered. In terms of the rules of a medical scheme the management is performed by a committee elected by the members and/or employers. The executive officer of a scheme is the Principal Officer in accordance with Section 17.2 of the Registrar's rules. In terms of Section 17.12 the committee can delegate its powers to the Principal Officer or any of its sub-committees. (Dry 1994: 30)

Many intricate issues face medical committee's in the performance of their duties such as rapid cost escalation, cost containment programmes, introduction of managed care, growth in fraud, changes in legislation and regulation, democratisation of schemes and changing profiles of committee members, political pressure to expand the scope to more people, sophisticated medical technology and treatments (Dry 1994:48). The Melamet Commission reported that the people elected to the committees did not possess the required expertise to manage a scheme '...often the case that the more experienced and qualified members of a scheme do not have the time or the inclination to serve on the committee of a scheme' (Melamet 1994: 18).

From 1995, medical schemes introduced managed health care to address escalating private health care costs. 'New Generation Benefit plans' were introduced. Notwithstanding these measures, private medical costs outstripped the consumer price index. In response, Government re-regulated the private sector, aiming to make this sector more affordable for the general population or working class (Nkosi 2000: 2). These regulatory reforms in the medical schemes industry applied to both the public and private health sectors. 'The private sector reforms are aimed at ensuring that those that can afford private care are adequately covered privately, thereby freeing up public resources for those who can least afford care' (Jekwa 2006: 6).

Medical schemes that were 'risk rated' in 1995 were financially strong compared to being vulnerable the year before. Structural problems identified were escalating medical costs, efficiency defects leading to abuse by interested parties, substitute

insurance products enticing healthy members away; poor financial controls (*South Africa Survey* 1996: 211).

The Annual Report of Medical Schemes was published in 1996 and total membership is shown as 13,560,290. This figure includes dependants and beneficiaries (Annual Report of the Registrar 1995: 1).

A draft discussion document included reference to the Melamet Commission report as well as various public funding policy matters. ‘The basic principles are aimed to regulate private health funding systems more closely with public health policy’ (Annual Report of the Registrar 1995: 2). Several measures were suggested such as phasing out of individualised medical savings accounts, mandatory solvency requirements. The unlawful practice of funding funeral benefits from medical schemes was addressed.

Medical Schemes continued to fund approximately two-thirds of private health care spending in a complimentary role to the national health system. The funding of benefits was characterised by a pay-as-you-go, non-profit structure, based on fee-for-service and predetermined negotiated agreements as remuneration structures (Annual report of the Registrar of Medical Schemes (1995): 5)

The Medical Schemes Act 131 of 1998 was published in the Government Gazette on 2nd December 1998. It was implemented early 2000. Its stated objectives were:

To consolidate the laws relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the coordination of medical schemes; and to provide for incidental matters (Government 1998: 2)

It aimed to achieve the following main objectives:

- a. To re-introduce community rating versus risk rating in medical schemes – differentiation was on the basis of income and number of dependants only, not age or ill-health

- b. To improve access to medical schemes for people who were previously excluded, thus compulsory acceptance of eligible applicants
- c. To mandate a Prescribed Minimum Benefit Package (PMBP) to ensure that all members have essential hospital cover – this was to prevent medical schemes from discarding their members when benefits have been depleted, at the expense of public hospitals
- d. To improve financial management and governance of schemes.

According to Van Rensburg, one of the objectives of this Act was to encourage the extension of private medical cover to the middle and lower income earners, thereby increasing coverage to a larger percentage of the population. However, due to spiralling expenditure and the high cost of cover ‘...the Act is likely to have a relatively limited impact on redressing the inequities in the current public-private mix’ (Van Rensburg 2004: 403).

The Registrar of Medical Schemes wrote: ‘The Act introduces a new approach to governance, regulation and supervision of medical schemes and related activities. The Act seeks to provide greater protection to the public, and to enhance access to private health cover within a community rated environment’ (Annual report of the Registrar of medical schemes (1998): 4).

The net assets and contributions of Medical Schemes continued its increased growth seen in the late 1980’s, totalling Net contribution income of 20,332 million. Total Benefits Paid iro registered and exempt schemes totalled 21,668 million.

Table 44:

Membership analysis of Medical Schemes as at 31/12/1998

Members	Dependants	Beneficiaries
2,695,045	4,296,466	6,991,511

Source: Annual Report of the Registrar of Medical schemes (1998: 18)

According to Essop (1998: 38), the private health care market in 1998 could be grouped into four main categories: traditional medical aid schemes; new generation medical schemes; managed care schemes through HMO and PPO's and health savings plans.

- a. **Traditional Medical Aid Schemes** are the oldest of the four and dominated the industry in the early 1990's, the number of which has steadily reduced due to their inability to control costs. Essop quotes Van der Walt (1998: 36): '...their number diminished from 220 in 1993 to 174 in 1998.' Basically, the traditional medical aid scheme became the building block for introducing managed care options such as HMO's. The reduction in numbers of traditional schemes is due to this reason.
- b. **New Generation Schemes** were modelled on the above but incorporated incentives such as allowing schemes to control costs using advanced computer and data technology; sanction patients regarding treatment choices and well-being programmes; Monitoring patient and service provider profiles to prevent overuse/abuse. It normally includes a savings account structure. **Health savings plans** are generally a component of NGO's and operates as savings accounts with incentives built-in to limit medical care.
- c. **Managed care schemes** originated in the USA and refer to private health care services where providers get a fixed payment for a specific range of services. The most common models used in the USA are Preferred Provider Organisations (PPO) and Health Maintenance Organisations (HMO's). Benefits include cost effectiveness, accountability and importance is placed on preventative care rather than curative.

The main restrictions of HMO's are that members do not have freedom of choice in respect of the health care provider, service is limited geographically, medical practitioner's independence is restricted and there is a possibility of inferior care Veliotis (1991: 58). According to Veliotis, the main advantages are cost effectiveness, control, accountability and emphasis on preventative care. He concludes that most of the restrictions have been overcome by the introduction of PPO's (Veliotis 1991:59).

The Katz Commission of Inquiry published the sixth interim report on certain aspects of the tax structure of South Africa, particularly relating to Friendly Societies, Registered Medical Schemes. It is important to know the tax implications on private health expenditure as its impact was clearly illustrated in terms of the American model and continued throughout in South Africa:

Katz Commission (1998)

According to Katz, Friendly society benefits provide a wide range of services such as relief during minority, old age, sickness, granting of annuities, etc but in practice, strict restrictions are placed on the operation thereof such as prevention of registration as an insurer and benefits may not exceed R5 000. The total assets for 109 societies in 1994 was R200 million with contributions totalling R34 million, split between employer R8 million and employees R26 million (Katz 1998: 4).

Its main recommendations were that Friendly Societies and Registered Medical Schemes retain their tax-free status. Employer contributions were no longer tax deductible for Friendly Societies. However, registered Medical Schemes could continue to claim a deduction for the employer in respect of contributions on a 'rand for rand' basis only i.e. for every R1 contributed by employees, the employer could contribute another R1 and claim it as a deduction from taxable income (Section 4.12). Self-employed persons could deduct 50 percent of their contributions. The commission recommended a withholding tax on interest

credited to, cash withdrawals and no-claims bonuses from medical savings accounts.

The Millennium year (2000)

Private health financing had come under the spotlight. Approximately R70 billion was spent by private health scheme members on health care each year. National Treasury provided R15 billion of this in the form of a tax subsidy in recognition that those who fund their own health care are not a burden on the public sector.²² At the time, the government was looking critically at these issues and may change the way forward which would have wide-ranging economic effects for all the stakeholders involved.

The *Medical Schemes Amendment Act* was passed in 2001.

This Act sought to amend the Medical Schemes Act (131 of 1998). This Act prohibited medical schemes from discrimination against members, or potential members, on the basis of age. In addition, the right of beneficiaries is extended to dependants of the principal member. This Act also empowered the Registrar to request financial statements from the Board of Trustees of medical schemes on a quarterly basis.

The Council of Medical Schemes in 2001 showed a total of 154 registered medical schemes. It also reported 'stable' membership at 7 020 806, which represented a nominal increase of 0.23 percent on 2000 figures. Medical schemes cover only 16 percent of the population and total benefits paid by medical schemes equalled R30.8 billion. Gross contribution income for all medical schemes was R37 billion in 2001 and profit from operations amounted to R278 million compared to a loss from operations of R1 billion in 2000 (Registrar of Medical Schemes Annual Report 2001: 8).

²² Star, 13 June 2009

In terms of policy, a 2001- survey by the University of Cape Town's Centre for Actuarial Research recommended that consideration should be given to move away from 'fee for service' to 'risk sharing' payment methods. This would attract more low income people into private schemes. Public hospitals should be considered to provide differential amenities as well as specialist services (Annual Report 2001: 29).

National Health Act 61 of 2003

Finally this Act was published in the Government Gazette on 23rd July 2004: 2.
The aim of the Act:

To provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith.

Its aim was to regulate national health and to provide uniformity in respect of health services across the nation by:

- a. Uniting the elements of the national health system to promote and improve national health
- b. Offer a system of co-operative governance and management of health services including provinces, municipalities and health districts
- c. Institute a health system based on decentralised management, sound governance, equity and international standards which encourages participation
- d. And – **importantly for private health** – promote a spirit of co-operation and shared responsibility among public and private health officials and providers and other sectors within the context of national, provincial and local plans (National Health Act 2004: 1).

In 2004/5, South Africa healthcare expenditure equalled R114 billion. This equals to 8.2 percent of GDP. This is high compared to other African countries but not, if

compared to Europe and the USA²³. Government funding still makes up the largest source of funding for healthcare via general taxation, licenses, sale of utilities, user charges at public facilities. (Fourie 2008: 34-35).

By 2006, the Council for Medical Schemes showed a reduction in the number of registered medical schemes to 124. Number of beneficiaries stood at 7 127 343, which was 1.5 percent up from 2001. Expenditure on health care benefits increased 40 percent from 2001 to R51.3 billion. Gross contribution income for all medical schemes was R57.6 billion in 2006 (per beneficiary per month equalled R687.13) and again turned to a loss from operations of R2.1 billion (Annual Report 2006: 54-65). By 2007, contributions for medical schemes had increased to R64.7 billion (per beneficiary per month equals R736.6) and beneficiaries rose by 5 percent to R7 478 040. Number of schemes reduced marginally by 2 (Annual Report of the Registrar of Medical Schemes 2007: 62). Therefore in 2008, only 7 million in a population of 48 million had access to private healthcare, representing 14,8 percent of the South African population (Annual Report of the Registrar of Medical Schemes 2007:62)

Medical Schemes Amendment Bill (2007)

The main objective was the establishment of a Risk Equalisation Fund and the application of risk equalisation to medical schemes, subject to certain exemptions (RSA 2007). It was intended to extend the functions of the Council for Medical Schemes and has not been enacted to date.

According to Fourie (2008, 24) there were five primary mechanisms for the funding of private healthcare seen during this period namely: taxation; donor funding; social health insurance; voluntary health insurance and out-of pocket payments or user payments:-

²³ USA 15,4%; Germany 10,6%; Namibia 6.8% derived 30 September 2011
http://www.nationmaster.com/graph/hea_exp_tot_of_gdp-health-expenditure-total-of-gdp on

Tax-based systems. General tax revenue is generally the most effective method and is used in the USA, UK and South Africa. Tax is imposed at national level on the population at large via various sources such as income, savings, investments, profits, household taxes and also indirectly such as Value added tax. Tax can also be levied via regional or local structures. However, disparities between richer and poorer regions would have to be addressed via equalisation. According to Fourie, other countries also using this healthcare funding model in Europe is Denmark, Italy, Portugal and Spain (Fourie 2008: 25).

Donor funding equates to less than 1 percent of total South African healthcare spending and will not be elaborated in this dissertation.

Social health insurance was initiated during the Bismarck era and details thereof can be found in Chapter 1. Social health insurance is collected via funds contributed by individuals, employers and government subsidies. Although many European countries such as Germany, France and Netherlands followed the principles of social health insurance, each one has its own variation. ‘A single optimal health insurance system that can be universally applied does not appear to exist’ (Fourie 2008: 26). According to Fourie, there is growing consensus that a form of mandatory health assurance be followed in South Africa, in order to create greater equity within the insured population.

Voluntary health insurance can take two forms in that it can replace the statutory social health insurance scheme such as the UK where private health insurance is purchased or complement an existing social health insurance plan. Fourie quotes McDaid (2003: 167): ‘Health insurance that is taken up and paid for at the discretion of individuals or by employers on behalf of individuals. Voluntary health insurance can be offered by public or quasi-public bodies and by for-profit and not-for-profit private organisations.’ (Fourie 2008: 28) According to Fourie this insurance is unlikely to cover the whole population as it is dependent on willingness to pay or a perception by individuals of health insurance as an important commodity. It is also risk-rated which would draw low risk individuals.

Out-of-pocket payments or **user charges** are generally levied as either a fixed amount or a percentage of cost against healthcare services such as pharmaceuticals, dentistry or primary care consultations (Fourie 2008:28). The purpose is to collect extra funds but also to discourage unnecessary/excessive/fraudulent use of healthcare services.

SUMMARY

The parties to the private health financing industry in South Africa by 2010

- 4.1.1 The Government
- 4.1.2 The Minister of Health
- 4.1.3 The Council of Medical Schemes
- 4.1.4 Medical Aid Administration Companies
- 4.1.5 Medical Practitioners
- 4.1.6 Pharmaceutical Industry
- 4.1.7 Nurses
- 4.1.8 Board of Healthcare Funders
- 4.1.9 Financing Intermediaries:
 - Medical Schemes
 - Health Insurance

4.1.1 The Government

South Africa is a quasi-federal country with significant executive powers vested in the provincial governments (Van Rensburg 2004: 380). Central Government is the largest contributor of total health care funding. As a major funder it has considerable powers on patterns of public expenditure (Van Rensburg 2004: 380).

Government increased its healthcare contributions to R31 billion in 1997/98 but this started declining in 1998/99 to R814 per capita (1999/2000 prices). Van Rensburg (2004: 382) attributes this to Government's macro-economic policy,

GEAR policy which limited public expenditure growth to below economic growth and the health increase budget (2000) being limited to below overall government budget. During the 2002/03 to 2005/06 period it was projected that Health would receive annual increases of 9.3 percent compared to overall budget increases of 10.2 percent (versus Defence increases of 20 % per annum during this period) (Van Rensburg 2004: 382).

The role of the Government in the supply of private health care is mainly from a regulatory point of view in determining the extent and conditions under which private healthcare funders can operate. The role of the Government expands to safeguard the rights of patients in the private sector. Government's perspective on private hospitals is summarised by Jekwa (2006: 30) in that competition in medical care, in the absence of limits on expenditure, increases cost as services are duplicated. The increase in private beds results in greater utilisation and increased costs due to supplier-induced demand (Jekwa 2006: 30).

As in any democracy, the role of the government is to provide health care in terms of its constitutional responsibility of each person having access to health care services. The ANC's 2009-election manifesto proposed a 'National Health Insurance' system as a key component of its continued efforts to address the provision of health care to the entire population. It is questioned whether by optimizing private health funding these stakeholders can play an active role in building public health funding.

The Department of Health has adopted the 10-point plan for 2009 to 2012 which includes the provision of strategic leadership and creating a social compact for better health outcomes as well as the implementation of a National Health Insurance (NHI) system. Point 4 relates to the overhauling of the healthcare system and improving its management, and Point 5 which refers to improving the quality of health services which may impact on the private sector (Bhaktawar N 2010: 288).

In South Africa, issues surrounding unemployment and the size of the tax base, still prevail. This influences government's ability to raise sufficient funds to provide a comprehensive medical service to the nation at large.

National Health Insurance will be summarised here as it will impact on the future of private health funding. The entire summary is derived from the *South Africa Yearbook* 2009/2010:

The Department of Health seeks to establish an NHI system, which will introduce the necessary funding and service-delivery mechanisms to enable the creation of an efficient, equitable and sustainable health system in South Africa.

The key proposal is that the NHI be funded from two sources of revenue, namely, general tax revenue and an earmarked mandatory contribution. All employed individuals would make an appropriately determined mandatory contribution to an intermediary health fund.

The Government aims to make a universal subsidy contribution on behalf of the indigent and poor to this fund to provide for their services. To effectively realise the objective of universal healthcare for all, a number of reforms have to be undertaken, which should include regulatory, financing, health service delivery and complementary reforms.

Steps in the development of the NHI system require reaching consensus on matters relating to the Basic Benefits Package (Essential Healthcare Package), the structure of the National Health Fund (NHF) **and the role of private funders and providers** [my emphasis added]

With regard to the Basic Benefits Package, one of the key components of adopting an NHI system is defining the set of healthcare services that individuals and households would be covered for and how much it would cost the State to provide these services to the national population.

In terms of the structure of the NHF, there is a need for public stakeholder engagement on the exact form that the proposed fund would take.

The role of private funders and providers is also important. **The private health sector in South Africa holds a huge share of the country's national health resources, human and financial [my emphasis].** There is a need to engage with stakeholders on the best way the NHI system would draw on the resources in the private sector for the benefit of the national population – not just those with private health insurance. There is also a need to resolve the role of private funders, as well as medical schemes in an NHI environment.

During the Medium Term Expenditure Framework (MTEF) period 2009 to 2012, the department aims to continue working towards the design of a NHI system for South Africa that promotes health-system integration and ensure universal access for all South Africans.

In November 2009, the Minister of Health, Dr Aaron Motsoaledi, announced the appointment of a 25-member committee to advise him on an implementation plan for the NHI system' (Bhaktawar 2010: 290,291).

The role of Non-governmental organisations (NGO's) continues to be a crucial one as it extends form national level, through provincial structures to small local organisations rooted in local communities. They bring 'different qualities to the healthcare network' (Bhaktawar 2010: 294).

4.1.2 The Minister of Health

The Minister has the responsibility for the provision of overall health care in South Africa and is ultimately responsible for all medical schemes (Veliotes 1991: Appendix C1).

4.1.3 The Council for Medical Schemes

This is a statutory body representing all major stakeholders of the healthcare industry. Members are appointed by the Minister of Health. The Registrar is the Executive officer of the Council. The Council falls under the jurisdiction of the Department of Health and Population development (Dry 1994: 15).

In terms of Section 7 of the Medical Schemes Act 131 of 1998 the key functions of the Council are as follows (Annual Report 2001: 5)

- i) To protect the interests of beneficiaries (of medical schemes) at all times

- ii) To coordinate the functioning of medical schemes in a manner consistent with national health policy
- iii) To measure quality of care provided by schemes and to make recommendations to the Minister
- iv) To investigate and, as far as possible, resolve complaints raised by beneficiaries of schemes
- v) To collect and disseminate information about private health care; and
- vi) To advise the Minister on any matters concerning medical schemes

The main aims of the Medical Schemes Council are:

- i) Securing an appropriate level of protection for beneficiaries of medical schemes and the public
- ii) Promoting awareness and understanding of the medical schemes environment by beneficiaries and the public
- iii) Strengthening the regulatory framework in a complex and dynamic environment
- iv) Developing capacity within our staff to ensure effective, proportionate and fair regulation.

4.1.4 Medical Aid Administrators

Historically, employer groups registered their own medical aid schemes in compliance with the Act. They deducted medical aid contributions from their employees. Members or contributors appointed a Board of Trustees. An administrator of the fund was appointed to administer these funds on behalf of the employer, in return for a fee. Their services would include the verification and payment to service providers. Funds were not reinsured, therefore self-insured by the employer.

Most schemes therefore contracted out the administration of the scheme to professional medical aid administration companies. These administration companies invested large amounts in their infrastructure such as branch networks, computer systems and specialist employees. Their services typically include the collection of contributions from members and the processing and payment of claims. In addition they provide advice to the management committees on specialist issues as well as secretarial, accounting and investment issues.

Administrators need to be accredited by the Council of Medical Schemes (CMS).

In 1982, the annual income of medical schemes amounted to R883 million. In 1989 this amounted to R4.5 billion of which R3.9 billion was paid out in benefits (Report of Registrar 1990:8). Veliotes attributes this increase to ‘spiralling costs in the health care industry’ (1991: 26). This amounted to 20 percent per annum medical inflation. Essop quotes Robbins (1998: 35): ‘by 1992 third party health funding had mushroomed to an 11 billion rand industry which services some 20 percent of the population.’ Administrator fees were derived as a percentage of contributions or a fixed fee per member. In 1992, this amounted to 5.3 percent of contributions or R6.89 per person (Dry 1994:20). Since the introduction of the Medical Schemes Act in 2000 ‘the majority of schemes enjoyed operating surpluses with total operating surplus rising from R170 million to R1,1 billion in 2002’ – excluding an increase in net investment income by R82 million (Jekwa 2006: 24).

Medscheme – an example of an Administrator

Medscheme was founded by Keith Hollis in 1971. It has since developed into one of the largest medical aid administrators in South Africa. ‘Medscheme has been at the forefront of developments within the South African healthcare industry for over thirty seven years and is an integrated medical scheme administrator and health risk manager’ (Medscheme 2010: 1).

The company was acquired by Lethimvula Investments Limited in September 2006 and is now 73 percent black owned. It has diversified into three core businesses: healthcare administration, health risk solutions and financial services. These integrated services are provided to medical schemes, corporate clients and individuals. Medscheme have two million medical fund members and beneficiaries covered by blue chip client medical funds (Medscheme 2010: 1).

Their services in 2010 included Market-leading integrated medical scheme administration services; Managed care and health risk management solutions that set the industry standard; Innovative disease and wellness management programs; Best practice HIV/AIDS disease management services; Holistic health risk assessment and wellness programs; Extensive value-added reporting and Board of Trustees support; Negotiation of healthcare services on a collective and individual basis; Customized individual life, group life and investment products and services. (Medscheme 2010: 1)

4.1.5 Medical Practitioners

The period up to 1990 witnessed the breakaway of certain sectors to form their own professional bodies. In 1993, doctors had to become members of the South African Medical and Dental Council or alternatively could volunteer to become members of their official mouthpiece, the Medical Association of South Africa (MASA) (Ward 1993: 12). Since 2001 medical professionals and their services exist under the statutory control of the Medical and Dental Professions Board which forms part of the Health Professionals Council of South Africa (HPCSA). The latter is an independent body responsible for setting standards for registration, training of health professionals, public protection and disciplinary measures for breach of professional conduct. It also advises the Minister of Health on matters referred to the Board (Van Rensburg 2004: 324). The role of the HPCSA is to be a coordinating and advisory body to its affiliated professional boards – 12 in total.

In 1950, the number of medical practitioners (including specialists) amounted to 5 703, with a doctor to population ratio of 1:2 185. The number increased to 19 912 in 1970 (ratio 1:1 845) and to 26 452 in 1994 servicing a population of 39 534 575. By the year 2000, the number of doctors had increased to 29 788, so had the population to 43 647 260 (Van Rensburg 2004: 319, 328). This represents a doctor to population ratio of 1:1 465 which shows an improvement over the decades. It should be noted, however that the distribution of doctors is mainly centred in urban areas and that many are in private practice which services the private sector only.

The South African Medical Association (SAMA) is a professional association representing the interests of the majority of doctors in South Africa with the objectives to:

1. promote the integrity and image of the medical profession
2. develop medical leadership and skills
3. promote doctors with knowledge relevant to the demands of medical practice
4. promote medical education, research and academic excellence
5. encourage involvement in health promotion and education
6. influence the health care environment to meet the needs and expectations of the community by promoting improvements to health reform, policy and legislation (Van Rensburg 2004: 327).

4.1.6 Pharmaceutical Industry

In 1807, pharmacists could register with the Supreme Medical Committee. In 1891 this changed to the Pharmacy Board, then the South African Pharmacy Board and now in 2010 the Pharmacy Act 88 of 1997 regulates the professional and pharmacists register with the South African Pharmacy Council.

Traditionally, pharmacists were at the top of the public sector health professional shortfall list, even more so in rural areas. This has improved from a private/public proportion in 1990 of 84:16 to 74:26 in 1998. Numbers have increased from 3 627 in 1998 to 10 506 in 2000 (De Klerk 2004: 342).

Jekwa contends that the second largest cost-driver of private healthcare in 2003 was expenditure on outpatient medicine. Although hospital dispensaries had increased at a greater rate than those dispensed by doctors and pharmacists, medicines dispensed by pharmacists still comprise the largest portion of medicinal expenditure (Jekwa 2006: 30).

4.1.7 Nurses

In 1905, the first South African based nursing association, the Natal Nursing Association, was formed. In 1915 trained nurses were joined into one professional body South African Trained Nurses' Association – however it was voluntary and reserved for whites only. By 1928 nurses were granted representation on the South African Medical and Dental Council (SAMDC). Black nurses got recognition in 1932 with the formation of the Association of Trained Bantu Nurses. The Nursing Act 45 (of 1944) introduced the South African Nursing Council (SANC) and the South African Nursing Association (SANA), which consolidated control within its own ranks. Registration was along non-racial lines however this was reversed in terms of the Nursing Amendment Act 69 (of 1957), when membership in SANC was reserved for whites only. The Nursing Amendment Act (1972) compelled registration of all persons practising nursing, although racial disparities remained.

In the late 1970's black nurses were excluded by the introduction of homelands and separate nursing councils for each homeland. Membership of SANA was restricted to within South African boundaries only. Collective bargaining for nurses in the private sector was introduced in the late 1980's by SANA as well as attempts to obtain recognition as a personnel association in the public sector. Black nurses joined health organisations that openly challenged the apartheid state on health issues and a trend to join trade unions to protect their service conditions and professional interests emerged. In 1992, all references to race were eliminated and in terms of the Nursing Amendment Act 5 (of 1995) the separate professional councils of the past dismantled. The new SANC was officially instituted in 1998 in terms of the Nursing Amendment Act 19 (of 1997). The Democratic Nurses'

Organisation of South Africa (DENOSA) came into existence after the first democratic election among nurses in 1997. As of 2004, nurses freely associated in the public and private sectors with worker organisations of their choice (Van Rensburg 2004: 331-336).

Most nurses are employed in the public sector, and mainly in the provincial health services and municipal health services. The number of registered nurses has increased from 24 096 in 1960 (excluding the homelands) to 93 030 in 2000. In 2000 all category nurses to population equalled 1:255 (Van Rensburg 2004: 338).

4.1.8 Board of Healthcare Funders of SA (source BHCF)

This is a section 21 company representing 90 percent of the private medical schemes in Southern Africa. Membership is voluntary and fees are calculated on the size of membership. It exists:-

- a. To be a platform that converges medical schemes
- b. To co-ordinate shared knowledge and standards
- c. To be a voice for the Industry, taking action on behalf thereof
- d. To advocate and meaningfully interact with policy makers and regulators in the industry

The Hospital Association of South Africa (HASA) represents the interests of the private hospital industry and is the collective bargaining body. At the end of 2002 due to an impasse between HSA and BHCF, hospitals negotiated tariffs direct with medical schemes, bypassing the BHCF (Jekwa 2006: 30). In May 2004, the enabling section of the Medicines and Related Substance Amendment Act came into effect after finalization of the Pricing Committee. These regulations were expected to curtail the increases in medicine prices and therefore medical inflation. Discovery Health expected a reduction of R4 billion or 40 percent off the medical scheme industry's annual drug bill. Medscheme expected a 10-20 percent reduction (Yekwa 2006: 32).

Regulation of the private sector is effected through the Council for Medical Schemes. Safety quality and effectiveness of medicines is controlled by the Medicines Control Council. The Health Professionals Council of SA (HPCSA) is a statutory body for health-service professionals as well as the South African Dental Technicians Council, the South African Nursing Council, the South African Pharmacy Council and the Allied Health Professions Council of SA (AHPCSA).

4.1.9 *Financing intermediaries*

The following table shows the structure of the private funding sector, as depicted by Van Rensburg:

Table 45

Private Medical Funding Sector: Financing Intermediaries

Financing Intermediary	Percentage of Sector
Private Health Insurance	68.3
Medical Schemes	64.8
Health Insurance	3.5
Households' out-of-pocket payments made directly to public or private health services	30.1
Private firms' direct expenditure on workplace health services	1.6

Source: Van Rensburg (2004: 387) adapted from Doherty

Health Insurance

Just as the term “medical aid” had evolved since the early 1800’s, the term ‘insurance’ has progressed since earlier times. Even during the 1960’s the Reinach and Snyman Commissions make extensive reference to assurance companies – in

the form of Old Mutual and Sansom. Insurance Companies registered in terms of the Long- and Short-term Insurance Acts of 1998 had been involved in providing medical aid as a method of private health funding. Innovative products were provided by these companies such as hospital- and dread disease policies and top-up programmes, commencing in the 1990's. The issue of the 'business of a medical scheme' has become a contentious legal issue which continues today.

Medical Schemes

Historically *Medical Aid Schemes* and *Medical Benefit Schemes* were defined in terms of the Medical Schemes Act 72 of 1967, however this was changed in terms of the Medical Schemes Amendment Act 23 of 1993. This brought significant change to the definition of 'medical scheme' see the insertion of paragraph c) (Harrison 2008: 5):

'Medical scheme' means a scheme established with the object of making provision for-

- a) the obtaining [free of charge] by members thereof and by dependants of such members, or any service; [or]
- b) the granting of assistance to members thereof in defraying expenditure incurred by them in connection with the rendering of any service; or
- c) the rendering of a service to members thereof or to dependants of such members, either by the scheme itself or by any supplier of a service of group of suppliers of a service in association with or in terms of an agreement with a scheme.

There are two main categories of medical schemes:

- a. Registered medical schemes
- b. Bargaining council schemes (previously referred to as exempt schemes)

Registered medical schemes fall under full regulatory control of the Act. Registered schemes can be further broken down into restricted (or closed) schemes and open schemes. Restricted schemes typically belong to the employer or industry that set them up, therefore belong exclusively to that organisation. Open schemes are open to the general public. In 1990, beneficiaries were evenly distributed amongst these schemes, however registered beneficiaries belonging to open schemes has increased to 68 percent in 2001 (Annual Report 2001: 27).

Bargaining council schemes are granted exemption from certain provisions of the Act as they are not able to comply fully with certain provisions of the Act, such as prescribed minimum benefits. According to Doherty and McLeod (2002: 44) historically these included those covering the police force, correctional services, defence force and schemes created before the Medical Schemes Act (of 1967). In 2001 the total number of Bargaining Council schemes reporting to the registrar was only eight, servicing 3.7 percent of the total beneficiaries (Annual Report 2001: 27)

‘Open and close schemes’ refer to membership boundaries of the schemes. Members of a closed scheme belong to a particular organisation whereas an open scheme has no such restriction (Veliotis 1991: Appendix 1). Medical Aid Schemes are non-profit organisations, (NPOs) however profits are made through the administration process, rather through the offering of add-ons. The profits are accrued to the shareholders in the Administration Companies.

‘The private medical-aid scheme industry is regulated by the Council of Medical Schemes (in terms of the Medical Schemes Act 131 of 1998). The Council is funded mainly through levies charged on the industry in terms of the Council for Medical Schemes Levies Act, 2000 (Act 58 of 2000).

In September 2009, there were 112 medical schemes. The total number of principal members of registered medical schemes increased by 6 percent from 3 178 127 at 31 December 2007 to 3 366 383 at September 2008.

The number of beneficiaries increased by 4.6 percent from 7 578 040 in 2007 to 7 823 137 in 2008. The total gross contribution for all medical schemes amounted to R55,5 billion for the period ended 30 September 2008, 1.2 percent lower than the budget of R56,2 billion for the same period. The gross contributions per average beneficiary per month was for the period ended 30 September 2008, an increase of 9 percent compared to the previous year. Gross relevant healthcare per average beneficiary per month was about R722 for the period ended 30 September 2008.

Tariffs for admission to private and provincial hospitals differ. Cost differences also exist between various provincial hospitals, depending on the facilities offered. Provincial hospital patients pay for examinations and treatment on a sliding scale in accordance with their income and number of dependants. If families are unable to bear the cost in terms of the standard means test, patients are classified as 'hospital patients'. Their treatment is then partly or entirely financed by the particular provincial government or the health authorities of the administration concerned.

Provincial hospitals offer treatment to patients with medical aid cover, charging a tariff designed to recover the full cost of treatment. This private rate is generally lower than the rate charged by private hospitals. The Medical Schemes Amendment Act 55 of 2001 improves the regulatory capacity of the Registrar for Medical Schemes and regulates reinsurance.

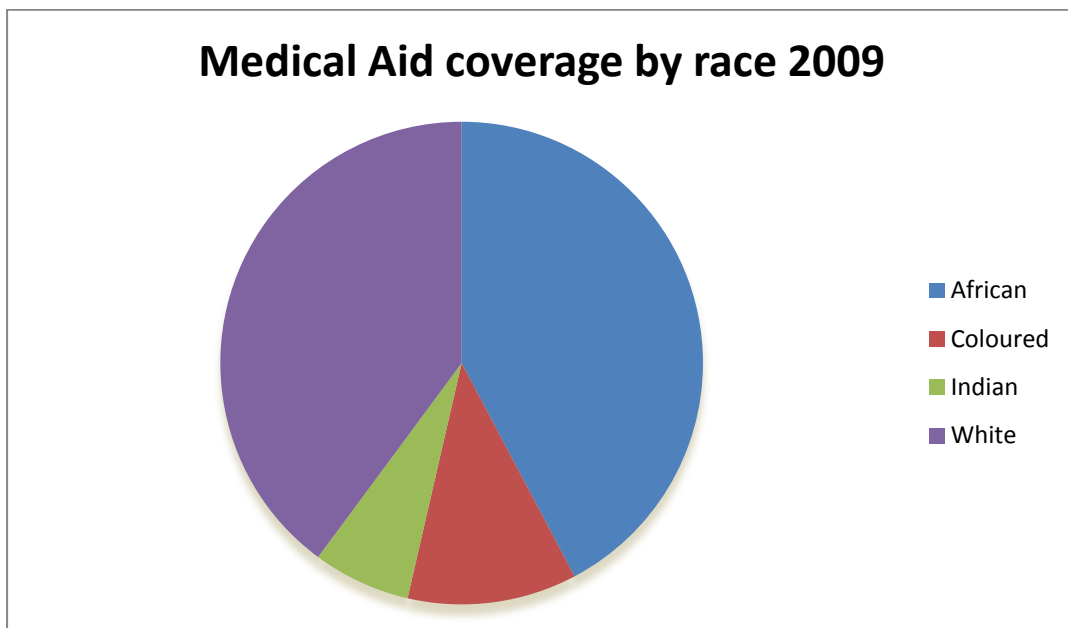
The Medical Schemes Amendment Act 55 of 2001:

- Provides improved protection for members in addressing the problem area of medical insurance, revisiting the provision of waiting periods, and specifically protecting patients against discrimination on grounds of age
- Promotes efficient administration and good governance of medical schemes by insisting on the independence of individuals in certain key positions

- Introducing mechanisms to address problematic practices in the marketing of medical schemes and brokerage of service
- Minimum benefits are also prescribed (Bhaktawar 2010: 290)

The tables below confirm that racial inequalities in private medical funding continued into the year 2010.

Diagram 46
Medical Aid coverage by Race 2009



Source: Kane-Berman (2010: 508)

To summarise, the total population in 2009/10 equalled 49 035 000. Persons covered by medical aids totalled 8 293 000 versus the number of persons not covered equalled 40 743 000. The population growth declined to 1.4 percent in 2001-2006 and is projected to be 0.04 percent by 2031 (Van Rensburg 2004: 175). Physicians are 0.8 per 1000 [public sector people to doctor 4 571:1] versus Denmark 3,2 and United Kingdom 2,2 and United States 2,7 (Survey 2009: 517). The ratio of people to Nurses in the public sector equals 1018:1. In terms of the National Health Budget the total health expenditure estimates for 2011/12 equals R23 708 million (Kane-Berman 2010: 504)

The split between public and private expenditure is detailed below. Although 8 percent of GDP is spent on healthcare, which is in line with world norms, it is unequally distributed in favour of the private sector.

Table 47

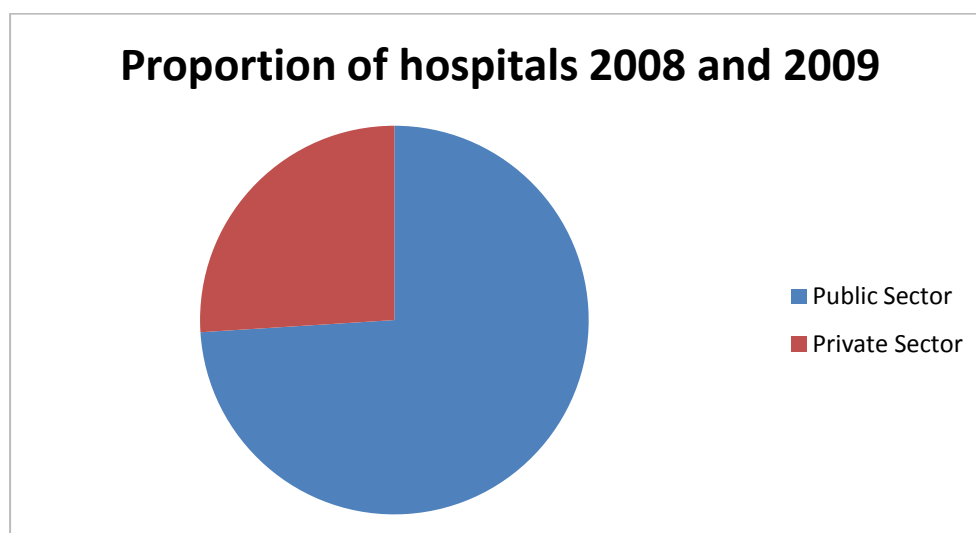
Health expenditure, GDP and per capita spending, 2006

2006	Public Health Expenditure as a % of Total Health Expenditure	Out-of-pocket expenditure as a % of total private expenditure	Total Health Expenditure as a % of GDP	Per capita health expenditure PPS\$
Ghana	34.2%	77.8%	5.1%	214
South Africa	37.7%	17.5%	8%	1 100
UK	87.3%	91.7%	8.2%	4 259
USA	45.8%	23.5%	15.3%	6 719
Botswana	76.5%	27.5%	7.1%	1 054

Source Kane-Berman (2010: 505) extract

Diagram 48

Proportion of hospitals, private and public sectors 2008 and 2009



Source: Statistics 2009/10: 519

This Chapter concludes with a summary of private health funding as it was in 2010:

The Council of Medical Schemes Annual Report 2010-2011 statistics conclude this chapter. There were 100 registered medical schemes in South Africa at the end of 2010. The number of schemes had declined from 144 in 2000 and 110 in 2009. This was attributed mainly to consolidations, amalgamations and liquidations, the latter both voluntary and involuntary. The prevailing economic circumstances in the medical schemes industry is cited as the prime reason for the decline.

Gross contribution income for medical schemes increased by 13.7% to R96.5 billion which represented an increase of 11,3% from the previous year. Total benefits per average beneficiary per month increased 7% from R800 in 2009 to R856 in 2010. Total membership totalled 8,315,718, an increase of 3.8% (Council of Medical Schemes Annual report press release).

CHAPTER 5: CONCLUSION

The origins and evolution of private health funding was examined in this dissertation. The objective was to set out the historical developments up to the current private health funding position. Having done so, this dissertation provides a basis for future research.

From the arrival of the Dutch in the Cape ‘medical aid’ was provided by the only employer at the Cape, the VOC. Occupational health was therefore the first form of private health care funded by employers as an operational expense. During the British era’s hospitals were provided on a voluntary basis. Private patients were usually treated at home for a fee or admitted to hospital where a fee was payable for those who could afford payment. This *status quo* continued to the late 1800’s when friendly societies were registered and medical aid provided, in accordance with employment conditions, directly relating to the discovery of diamonds, and later, gold. Large mining companies provided hospitals to all their employees, regardless of race.

The State was the largest provider of hospital institutions. Private patients could use these facilities and pay an out-of-pocket fee or be reimbursed via medical societies, if they could afford to do so. This trend continued into the 1970’s. The study shows that during this decade, accurate quantification of private healthcare funding was not possible.

This study is incomplete without an explanation of the dual models of health funding found in South Africa. In this context, the study included many references to public and other sources of health funding. It was demonstrated that the earlier models of private and public funding existed alongside each other and played a supplementary, rather than divergent, role in applying limited resources to unlimited needs.

Chapter two detailed the chronological development of the medical history of South Africa and the early Dutch, British and Batavian influences. External effects were detailed, with its aim to explain the anomalies between public and private health funding. This dissertation has demonstrated that the nature and extent of health sector reform is reliant on its historical foundations, with due consideration to cultural-, economic-and social organisation.

The concept of National Health Insurance was initiated in 1935 (See Collie Commission). The dissertation had shown the efforts by various interest groups in providing adequate medical assistance and advice to the entire population however the State and political influences steered the private health funding model to the large industry it is today. Reluctance by the State to include blacks in any forms of private funding schemes from the early 20th century was demonstrated. This explains the historical domination of whites in the private health funding structure.

Although every effort has been made to reflect a comprehensive study of the evolution of private health funding, it is felt that there is scope for further research on this subject. The influence of the Medical Association of South Africa [MASA] on the development of private funding has been reflected in great detail. However, the role of the State in terms of social and economic policies was not conclusively dealt with. Parliamentary debates and legislative changes would assist in this regard.

The study of the provision of medical aid in South Africa's public sector, particularly in terms of white public servants in the early 1900's, has not been included in this dissertation. It is felt that a direct link between this subject and the development of private health funding in the corresponding period would be found. Journals and an unpublished paper written by Verhoef on Medihelp should support this view.

Many more Commissions of Enquiry were encountered but not reported upon i.e. De Villiers, Broomberg and Social Security Committee (1943).

It is known that third parties, such as administrators and insurance companies had played a major role in supporting the development of private health funding. These influences are not comprehensively dealt with in terms of this dissertation. A full history on selected administrators and medical schemes, including financial information, will provide further insight. The passing of the MSA and its effects on medical schemes in terms of for example solvency ratio's had not been fully investigated. The relationship between solvency margins, administration expenditure and inflation had not been fully illustrated. The last decade was not comprehensively reported upon.

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APPENDICES

Appendix 1: SOUTH AFRICAN MONETARY SYSTEMS

The Dissertation refers to various different monetary terms in the seventeenth and eighteenth century, which makes it difficult to interpret in terms of South African Rand. This is a rough monetary guide only and the entire section is extracted from Muller as sourced below:

	<i>Dutch money</i> Value in Stuiwers	<i>English money</i> Value in Pounds, shillings and pence	<i>South African</i> <i>money</i> Value in Rands and cents
stuiwer	1	1d	5/6 c
Dubbeltjie (‘double’ stuiwer)	2	2d	1.66c
Cape guilder (<i>f</i>)	16	1s 4d	13.3c
skelling	6	6d	5c
Dutch guilder	20	1s 8d	16.66c
Cape rix-dollar (rd)	48	4s	40c

Source: Muller 1984: 584

The following will show the reduction in purchasing power. Between 1690 and 1750 a Cape sheep would cost average 1.5 to 7.5 guilders each. Between 1834 and 1835 it rose to 4d per pound. In 1903 it was 9.5d per pound (Muller 1984: 584).

An explanation of the currency below:

From 1825 to 31 May 1961 the South African currency was measured in the same unit as the British currency i.e. pounds, shilling and pence (12 pence = 1 shilling, 20 shillings = £1.

A South African currency was introduced in 1961 when it became a Republic, with Rand and Cents ($R1=100c$); the initial rate of exchange against sterling set at $R2 = £1$ (Feinstein, 2005:xx).

APPENDIX 2: SOUTH AFRICAN POPULATION STATISTICS

‘By 1694, there were 573 farmers at the Cape and by 1707 their number had increased to more than 1 600 as compared to the stationary number remaining in the Company’s employ’ (Burrows 1958: 39). In 1715, after the 1713 smallpox epidemic, a Cape census shows the 2 598 Europeans and 2 185 slaves. In 1812, the population shows 14 623 Europeans and 17 780 slaves and non-Europeans. The period until 1817 shows mostly growth in the population, not due to immigration, but to natural births of the burghers or freemen. The Colonial Office circular 23 of 1890 shows the population of the Cape Colony in 1825 to be 118 125. This is projected in 1891 to be 956 485. Separation of population statistics into races formally commenced in 1848 (Laidler and Gelfand 1971:33, 40, 114, 467). The first national population census for South Africa in 1904, recorded the country’s total population as 5 176 000 people. In 1925, (estimated on 1921 census) the South African population totalled 7 407 932. This comprised of 1 637 472 Europeans; 5 034 563 Africans; 172 577 Asiatic and 563 320 mixed and other coloured races (Annual Report 1927: 8). In 1927, the Department was headed by the Minister of Health. By 1985 the population (inclusive of the TBVC homelands) totalled 32 million comprising of Asian 0,9, Black 23,5 Coloured 2,8 and White 4,8 (Browne Commission report 9 (1986: 11). By 1989, the total population was 30 million people of which whites comprised 16.5 percent and blacks 69.9 percent (Registrar of Medical Schemes, 1990, Annexure 8). By 2001, the population was 44.7 million (Van Rensburg 2004: 175). The total population in 2009/10 was 49 035 000.

APPENDIX 3: GROSS DOMESTIC PRODUCT

The Gross National Product is a rough gauge to determine the share of national resources allocated to health care. The Gross National Product of South Africa is one of the highest in Africa but wealth is unevenly distributed toward the Europeans. Table 47 below shows the growth in public and private expenditure, depicted as a percentage of GNP over the decades where significant disparities are shown between public and private health funding:

Table 47

Health Care Expenditure as a percentage of GNP: 1959-1998

Year	Expenditure R000 000		Percentage of GNP		
	Public Sector	Private Sector	Public Sector	Private Sector	Total Percentage
1959/60	96	93	2.1	2.1	4.2
1969/70	242	234	1.9	1.9	3.8
1974/75	515	378	2.1	1.5	3.6
1986	5 196.6	4 019	3.3	2.6	5.9
1987*					5.8
1988*					
1992/93**		18 240			8.5
1998/9***	31 100	39 200			8.8

Sources:

Westcott et al 1979: 14, 121* McIntyre and Dorrington 1990: 126

** Broomberg 1995: S2

*** Van Rensburg et al 2004: 380 In 1998/99 at 1999/2000 prices

Note: Westcott: Public Expenditure sourced from Controller and Auditor General Reports from Central Government and the provinces; Private Expenditure from South African Statistics 1976. (Note: private expenditure does not include expenditure on industrial hospitals.) The McIntyre statistic includes -homelands and excludes Namibia