Working Paper 8-2003

Mapping Health Services Trade in South Africa

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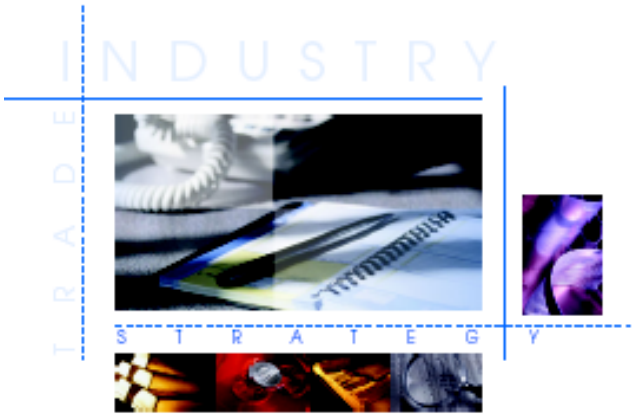

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July 2003

Published 2003
by Trade and Industrial Policy Strategies (TIPS)
P.O. Box 87643, Houghton 2041, Johannesburg, South Africa

Typseset in Futura by DTPworkshop, Johannesburg
Printed and bound in South Africa by Contiprint, Johannesburg

National Library of South Africa

A catalogue record for this book is available from the National Library of South Africa

TIPS Working Paper Series (WP8-2003)
Mapping Health Services Trade in South Africa
by Susan Cleary and Stephen Thomas

ISBN 1-919982-07-8

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ACRONYMS

ANC	African National Congress
BOT	Build Operate Transfer
CPI	Consumer Price Index
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
HPCSA	Health Professions Council of South Africa
MFN	Most Favoured Nation
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
PFI	Private Finance Initiative
PPI	Public-Private Initiative
PPP	Public-Private Partnership
SA	South Africa
SADC	Southern African Development Community
UCT	University of Cape Town
UN	United Nations
UNCTAD	United Nations Conference on Trade and Development
WTO	World Trade Organisation

EXECUTIVE SUMMARY

In South Africa (SA), there is an increasing trend towards trading health services, in both the public and private health sectors, despite minimal formal liberalisation offered by SA under the General Agreement on Trade in Services (GATS). Health-services trade has been occurring in at least three of the four modes of supply: foreign commercial presence, consumption abroad and movement of natural persons.

This paper concentrates on defining regulations in the health sector and determining whether these form barriers to trade or are trade enabling. The paper also provides data on the sector under the categories of human resources, health-care providers and health-care purchasers. It is concluded that policymakers would be wise to exercise due caution when considering trade liberalisation in health services, as the impact on the public sector may not be positive.

GATS offers countries a choice as to which service sectors to liberalise, but also has a built-in agenda to move towards greater liberalisation of world trade in services (World Trade Organisation Secretariat, 1999). It is therefore conceivable that trade in health services will be on the negotiation agenda in future. While this type of trade could be beneficial to certain sectors of the economy, it is not clear what effect this will have on the health system as a whole. While commercial concerns are important, health-services trade should not conflict with the goals of public policy.

This paper starts with an introduction to the levels and trends in financing in the health sector and speculates on their implications for efficiency and equity. Thereafter, a detailed discussion is given of the GATS to understand what is involved in health services liberalisation. Finally, the regulations pertaining to human resources (health professionals), health-care purchasers (for example, medical schemes) and health-care providers (for example, hospitals and clinics) are discussed to determine whether they form barriers to trade.

In conclusion we would argue that the government is wise to hold off on extending liberalisation in the health sector pending further research. Indications are that continued private-sector expansion is neither equitable nor efficient. On the contrary, it may fuel growing inequalities by absorbing ever-greater resources while treating ever-fewer patients.

1. AN INTRODUCTION TO THE HEALTH SECTOR IN SA

This paper undertakes an initial mapping of trade in the health services sector in SA – a largely unmapped territory up to now. After an introduction to overall levels and trends in financing in the health sector, the GATS is discussed in terms of the horizontal commitments, those that apply to all members, and the schedules of commitments that are member specific. A discussion is given of the GATS' distinction of trade by means of 'modes of supply'. While SA is yet to make significant commitments under health services, trade in health services is certainly happening, although it is difficult to estimate the degree without undertaking primary data collection. So this paper mainly focuses on regulations in the health sector that in certain instances may be trade enabling, but in others form barriers to trade.

The SA health sector is analysed under three categories: human resources, health-care providers and health-care purchasers. Basic data on the size of each sector is provided under these categories, which is mainly taken from *National Health Accounts: The Private Sector Report* (Cornell et al, 2001). Detail is given of the regulatory structure under these categories, and the barriers that might be created to imports of health services into SA. Any further information on the types of trade that occur is given where possible.

1.1. The Overall Level of Funds Available for Health Care

The information in this section on the levels and trends of financing of health services in SA is taken from *Health Financing and Expenditure in Post-Apartheid South Africa, 1996/97 – 1998/99* (Doherty et al, 2002), which measured health financing and expenditure changes in the *post-apartheid* period. There are four main sources of finance for health care in SA. Government – whether at national, provincial or local level – allocates to the health sector a portion of the funds it raises from taxes, licences, sales of utilities and other income sources. Employers (including private firms and government-owned enterprises) fund health care for their employees either directly through health services provided at the workplace, or indirectly through contributing to different forms of private insurance. Households contribute to private insurance or pay out-of-pocket for health services. Services are also funded by donors and non-governmental organisations (NGOs).

Table 1 presents the sources of finance for the health sector in 1998/99. The overall level of resources was high and grew rapidly between 1997/98 and 1998/99. In 1998/99, 8.8% of Gross Domestic Product (GDP) was devoted to health care[1]. Given this high level of financing, it is worrying that large sections of the population still experience problems in accessing health services and enjoying quality care.

Table 1: Sources of Finance in the SA Health-Care Sector, 1998/99

Sources of Finance	R-billion (1999/00 Prices)	% Total Sources	Change in % 1997/98 – 1998/99 (%)
Government	31.1	44.2	-4.8
Employers	11.7	16.6	3.4
Households	27.4	39.0	4.5
Donors and NGOs	0.1	0.1	Unknown
Total	**70.2**	**100.0**	**N/a**

[Source: Doherty et al, 2002: ii]

In 1999/2000, private intermediaries controlled the majority of resources (59%). These resources were directed in the interests of those able to pay for their own health care, which was less than one-fifth of the population. So, while the overall level of resources was high, those flowing through the private sector were far more abundant. Increases in funds available to the private sector did not bring extended insurance coverage. On the contrary, the

1 In most of the Organisation for Economic Co-operation and Development (OECD) countries, health-care spending accounts for more than 8% of GDP, compared to 5% in developing countries (WTO Secretariat, 1998).

percentage of people covered by insurance, whether partly or in full, declined. Table 2 shows the different financing intermediaries in SA.

Table 2: Financing Intermediaries in SA, 1998/99

Financing Intermediary	% of Sector
Public Sector	
Central government	9.5
National Department of Health	2.7
Other national departments (Defence, Education, Correctional Services, and Safety and Security)	6.8
Regional government	82.0
Provincial Departments of Health	79.3
Provincial Departments of Works	2.7
Local government	5.6
Statutory Security Schemes	2.8
Worker's Compensation Fund (Receives a levy from employers based on their risk profile and wage bill, and contributes to the costs of health care for injuries sustained at the workplace)	1.6
Road Accident Fund (Receives contributions from a levy on fuel sold by oil companies and provides cover for medical expenses incurred by third parties involved in motor vehicle accidents)	1.2
Government direct expenditures and compensation for health care for employees	0.1
Private sector	
Private health insurance	68.3
Medical schemes (Non-profit associations operated by professional administrators that are essentially for-profit companies – receive premiums from households and employers)	64.8
Health insurance (Offered by life and short-term insurance companies – most policies provide non-indemnity cover for major surgical and hospitalisation costs, i.e. the insurer pays a predetermined amount of money for clearly specified events, rather than reimbursing the actual costs of health care as is the case with medical schemes)	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: Doherty et al, 2002: iii]

1.2. Equity in Health-Care Resource Allocation

In the health sector, the largest equity problem lies in the increasing differentials in resources available to service the poor who are dependent on public-sector care, and higher-income individuals, especially medical scheme beneficiaries. For example, annual expenditure per medical scheme beneficiary rose from 4.7 times that spent by national and provincial departments of health per public-sector dependant in 1996/97, to 5.8 times in 1998/99. In 1998, the proportion of people on medical aid who used a health service in the previous month was 68% higher than for those not on medical aid.

1.3. Efficiency of Resource Use

The annual real growth in expenditure per medical scheme beneficiary was as high as 10% between 1996/97 and 1998/99, compared to 1% for public-sector spending on public-sector dependants. The main driver of cost escalation in the medical schemes sector was private hospitals, which, in 1998/99, consumed 29% of funds. The average annual growth in this expenditure has been 19% between 1996/97 and 1998/99. Private hospital beds more than doubled between 1989 and 1998, and the annual rate of growth between 1989 and 1994 was similar to that from 1994 to 1998, despite the government moratorium placed on the development of new private beds in 1994. The enormous expansion in private hospitals has impacted on the cost of hospital care in the private sector and has also threatened the viability of public hospitals in small towns as skilled personnel seek better remuneration in private settings.

Together, these trends suggest an overall decline in value-for-money in the private sector. Medical scheme administrators need to address the over-utilisation of services promoted by the fee-for-service, third-party payer environment, and demonstrate a commitment to providing low-cost packages.

1.4. The Sustainability of Current Patterns of Resource Mobilisation and Use

While the overall level of resources is likely to continue expanding in the short- to medium-term, most of this expansion is likely to benefit the private sector. The public sector will find itself increasingly constrained in its ability to meet existing needs, let alone new burdens generated by HIV/Aids. Whether private-sector coverage will expand alongside increased funding (or continue to contract) will depend on the impact of new legislation, such as the Medical Schemes Act of 1998 (*discussed below*). If the medical schemes environment is unable – or unwilling – to expand into the upper-lower and lower-middle income markets through offering low-cost packages, the implications could be dire. The state would increasingly have to accommodate those falling out of the medical schemes environment due to spiralling costs in the private sector.

1.5. The Likely Impact of Inward Trade in Health Services

Will growing trade in health services have a negative or positive effect on the provision of health services? Given current trends in the private sector, the impact is unlikely to be positive. For instance, over the past few years, growth in the private sector (particularly in private hospitals) has lead to escalating costs and decreasing medical scheme coverage. This points to worsening efficiency. It is fair to assume that if current trends in growth and cost escalation continued, the private sector would become more inefficient and medical scheme coverage would shrink, thereby dumping more people onto the overstretched public sector. Growth in the private sector is highly unlikely to improve equity in health access unless medical schemes are willing to extend coverage to the upper-lower and lower-middle income markets.

Thus it is likely that inward trade in health services will not enhance efficiency in the private sector, nor will it enhance equity between the public and private sectors.

2. THE GENERAL AGREEMENT ON TRADE IN SERVICES

The General Agreement on Trade in Services, otherwise known as the GATS, identifies 12 basic service sectors (WTO Secretariat, 1999: 12):

1) Business (including professional and computer) services
2) Communication services
3) Construction and related engineering services
4) Distribution services
5) Educational services
6) Environmental services
7) Financial (insurance and banking) services
8) Health-related and social services
9) Tourism and travel-related services
10) Recreational, cultural and sporting services
11) Transport services
12) Other services not included elsewhere

Generally, health services are defined by the United Nations (UN) Provisional Central Product Classification, with health and social services falling under Division 93. This differs from the Services Sectoral Classification List of the GATS (*as shown above*) which members use for scheduling purposes. The GATS splits health services between sector 1: professional services, sector 7: health insurance, and sector 8: hospital-based health services (WTO Secretariat: 1999). To make this clearer, Table 3 provides a list of the various types of health services, along with their Sectoral and UN classification.

As Table 3 below shows, health services fall under GATS 1 and GATS 8. For health services, GATS 1 would mainly be concerned with doctors (for instance) providing services related to their profession. For GATS 8, an example would be health services that are delivered in the hospital setting. Besides the sectors described in Table 3, medical schemes and their administrators are clearly pivotal players in health services trade because of their key role in 'purchasing about two-thirds of health services in the private sector in SA – the remaining one-third is mainly purchased through out-of-pocket payments (Cornell et al, 2001). They also influence the services that are bought through their benefit packages. In GATS terminology, therefore, we are arguing that health services form a part of GATS 1, GATS 7 and GATS 8 because of the strong complementarities that exist between medical services, hospital services and health insurance (which would include medical aid schemes in the SA setting).

The GATS defines four modes of supply:

- Mode 1 is cross-border supply.
- Mode 2 is the consumption of health services abroad.
- Mode 3 is foreign commercial presence or establishment trade.
- Mode 4 is the movement of natural persons.

Table 3: Health and Social Services in the GATS Services Sectoral Classification List and the UN Central Product Classification

GATS Sectoral Classification List	Relevant UN Central Product Classification No.	Definition or Coverage in Central Product Classification
1. BUSINESS SERVICE		
A. Professional Services		
[…]		
h. Medical and dental services	9312	Services chiefly aimed at preventing, diagnosing and treating illness through consultation by individual patients without institutional nursing…
j. Services provided by midwives, nurses, physiotherapists and paramedical personnel	93191	Services such as supervision during pregnancy and childbirth … nursing (without admission) care, advice and prevention for patients at home.
k. Other[a]	n.a.	n.a.
8. HEALTH RELATED AND SOCIAL SERVICES		
A. Hospital Services	9311	Services delivered under the direction of medical doctors chiefly to inpatients aimed at curing, reactivating and/or maintaining the health status…
B. Other Human Health Services	9319 (other than 93191)	Ambulance services; Residential health facilities services other than hospital services; Other human health services n.e.c[b].
C. Other	n.a.	n.a.

[Source: WTO Secretariat, 1998: 22]

Key:
n.a. *Not available*
a *Relates to all professional services, including sub-sectors (a) to (g).*
b *Services in the field of: morphopological or chemical pathology, bacteriology, virology, immunology, etc., and services not elsewhere classified, such as blood collection services.*

A good example of cross-border supply is telemedicine, which is defined as the practice of medical care using interactive audio, visual and data communications (Adams and Kinnon in Unctad[2], 1998). So far, this is mainly used to overcome geographical barriers within individual countries and to improve health care in remote regions.

Consumption of health services abroad may take the form of patients moving from their home country to access treatment in a foreign country. This can happen in a variety of ways between the country groups, and may be driven by a demand for higher quality, lower prices and exotic treatments, or simply a lack of supply in the home country. Another form of consumption of health services abroad can come through the movement of students to access medical training in foreign countries (WTO Secretariat, 1998). This mode of supply is inhibited by the low portability of health insurance or non-recognition of health professionals' qualifications between countries.

[2] United Nations Conference on Trade and Development

The third mode is foreign commercial presence or establishment trade. This could include foreign commercial presence in the hospital operation or management sector, in the health insurance sector, and in the education sector. For many countries, this mode is the most contentious.

The fourth mode is the movement of health professionals. Along with foreign commercial presence, this is a fairly sensitive issue for many countries. It is feared that further liberalisation of this mode may accelerate brain drain, which commonly sees the developing world losing health professionals to the developed world and similarly the less developed world to the developing world. According to Adams and Kinnon (in Unctad, 1998):

> "The loss of health personnel from needy countries to wealthier ones is already a serious problem. If barriers to this type of movement are reduced without an appropriate regulatory framework and/or improvement in working and income conditions in the domestic health system, equity, quality and efficiency will all suffer."

However, under the GATS, the movement of natural persons is defined as being on a temporary basis and not related to permanent citizenship.

According to the WTO Secretariat (1999), the GATS consists of a set of central rules and supplementary agreements – some in the form of annexes to the GATS and others in the form of Ministerial decisions – which deal with issues related to specific sectors. In addition, each WTO member has a schedule of commitments, detailing the sectors in which commitments are offered. Members are given some freedom to choose which sectors to schedule and which to leave unscheduled, although the GATS has a 'built-in' agenda to move towards greater liberalisation.

Part I (Article I) defines the scope and coverage of the GATS. In layman's terms, it applies to all laws, regulations, norms and standards that could affect trade in services. This can include measures of central, provincial and local governments. It also includes non-governmental bodies that exercise powers delegated to them by governments. All services are covered except those "supplied in the exercise of governmental authority" [Article 1:3 (b) and (c)], which are defined as services that are not supplied on a commercial basis or in competition with other service suppliers.

This is a key distinction for trade in health services in SA because of the co-existence of public and private health sectors. It is not clear whether public hospitals may be considered to be in competition with private hospitals, and if GATS 8 were to be scheduled, it is not clear whether this would only affect the private sector and the capacity of government to regulate the private sector (which indirectly affects the public sector), or also directly affect the public sector.

According to the WTO Secretariat (1998: 11):

> "The hospital sector in many countries… is made up of government- and privately owned entities which both operate on a commercial basis, charging the patient or his insurance for the treatment provided… it seems unrealistic in such cases to argue… that no competitive relationship exists between the two groups of suppliers or services."

Hence, free public health services would not come under the GATS, but in the instance that the patient or his medical scheme were charged, this type of public health service would come under the rules of the GATS.

The distinction becomes even more blurred with the advent of public-private initiatives (PPIs) in health. In some forms, these can be defined as government-regulated commercial activity and in other forms as government procurement of services. These would come under the scope of the GATS if the sector were scheduled (WTO Secretariat, 1998 and 1999).

The GATS also defines general obligations, which apply to all members and all services, whether the sectors are scheduled or not. Most-favoured-nation (MFN) treatment states that all nations should be treated equally favourably (Article II) unless an exemption of MFN treatment is established at the time of the signing the agreement. New exemptions can also

be granted through the WTO waiver procedure. In addition, members can depart from MFN treatment in regional trading agreements, although there are rules about how this may work.

Other rules in Part II are intended to ensure that domestic regulations are applied reasonably, objectively and impartially. Applications to supply services must receive a decision within a reasonable period of time. There must also be tribunals or procedures where service suppliers can apply for a review of administrative decisions affecting their trade. Members are encouraged to recognise the educational qualifications of other countries. Governments are allowed to negotiate agreements with other governments for mutual recognition of qualifications, provided other countries with comparable standards are given a chance to join.

Part III of the GATS describes the rules that shape a member's commitment to services trade – known as the schedule of commitments.

Schedules of commitments consist of horizontal and sector-specific commitments. The horizontal section contains entries that apply across all sectors subsequently listed in the schedule. Market access is a negotiated commitment in the specified sectors. However, limitations on market access can be made in the horizontal section. National treatment means that the member does not operate discriminatory measures benefiting domestic services. It is also possible, though relatively difficult, to withdraw commitments that have been given in schedules. It can only be done at least three years after the commitment has entered into force, and at least three months' notice must be given. A price also has to be paid. This is normally settled by negotiation with the WTO member(s) affected by the change and if all goes well, new commitments will be made to offset those withdrawn and to be applied to all members. If there is no settlement, the matter goes to arbitration. If the arbitrator finds that compensation is due, the proposed changes in commitments may not be put into effect until the compensatory adjustments are made. If this is ignored, the affected country can retaliate by withdrawing commitments "substantially equivalent" to the commitments withdrawn by the "offending" country.

Finally, Article XIX states that by no later than January 2000, WTO members will have to enter into new rounds of negotiations with a view to achieving progressively higher levels of liberalisation of services trade. This is the 'built-in agenda' mentioned earlier.

Table 4 presents SA's horizontal and sectoral commitments to health services trade to date. Schedules are divided into two parts. Part I lists the horizontal commitments. These general commitments apply to foreign suppliers of any service that has been scheduled. They do not apply to the sectors that have not been scheduled or that have been scheduled as "unbound". Part II sets out the commitments undertaken for each listed sector or sub-sector. No specific commitments have been undertaken for any sector or sub-sector not listed. In WTO language, "none" means that the scheduling member puts no limitation on market access or national treatment for the foreign supply of that service by the mode concerned. "Unbound" means that the member has undertaken no commitment to liberalise.

Table 4: SA's Schedule of Specific Commitments in GATS relating to Health Services

Modes of Supply:

(1) Cross-border supply **(2) Consumption abroad**
(3) Foreign commercial presence **(4) Presence of natural persons**

Sector or Sub-Sector	Limitations on Market Access	Limitations on National Treatment
I. Horizontal Commitments		
Horizontal Commitments apply to all sectors that have been scheduled	(3) Local borrowing by SA registered companies with a non-resident shareholding of 25 % or more is limited, (4) Unbound (no commitments are offered), except for the temporary presence of up to three years of a number of categories of natural persons. For trade in health services, the relevant category is "professionals" and defined as: "natural persons who are engaged, as part of a services contract negotiated by a juridical person of another Member in the activity at a professional level in a profession set out in Part II, provided such persons possess the necessary academic credentials and professional qualifications, which have been duly recognised, where appropriate, by the professional association in South Africa".	(4) Unbound, except for measures concerning the categories of natural persons referred to in the market access column
II. Sector-specific Commitments		
1. BUSINESS SERVICES A. Professional Services h) Medical and dental services (CPC 9312)	1) None 2) None 3) None 4) Unbound except as indicated in the horizontal section	1) Unbound 2) None 3) None 4) Unbound except as indicated in the horizontal section
j) Services provided by: (i) Midwives and nurses (CPC 93191)	1) Unbound 2) None 3) None 4) Unbound except as indicated in the horizontal section	1) Unbound 2) None 3) None 4) Unbound except as indicated in the horizontal section
j) Services provided by: (ii) Physiotherapists and paramedical personnel	1) Unbound 2) Unbound 3) None 4) Unbound except as indicated in the horizontal section	1) Unbound 2) None 3) None 4) Unbound except as indicated in the horizontal section
7. FINANCIAL SERVICES All Insurance and Insurance Related Services b) Direct non-life insurance (CPC 8129 +)	*1) Unbound* *2) None*	*1) Unbound* *2) None*

[Source: "General Agreement on Trade in Services: South Africa Schedule of Specific Commitments"; 1994]

It is worthwhile going into some detail about what Table 4 means. As explained, horizontal commitments relate to all the scheduled sectors. For health services, the relevant sectors are GATS 1 and GATS 7. GATS 8 of course has not been scheduled. However, in schedules, offers are also made under each mode. If a mode is unbound, nothing is offered and this mode of the particular sector is not subject to horizontal commitments.

What is the implication of horizontal commitments for health services? Foreign companies are not treated as favourably as SA companies if they want to borrow money. Natural persons are not allowed free entry to the country – even for temporary stay – so they are also not treated as favourably as citizens.

What is meant by the sectoral commitments? For medical and dental services (defined as preventing, diagnosing and treating illness through consultation with individual patients) there are no barriers to cross-border supply, consumption abroad and foreign commercial presence. For the movement of natural persons, no liberalisation is offered other than that offered under the general commitments (where certain categories of professionals are allowed to enter the country if they meet certain criteria). In other words, very little liberalisation is offered in medical and dental services since it is mainly traded through the presence of foreign nationals in the consuming country.

Similarly, for the services provided by midwives and nurses, mode 4 is unbound except as in the horizontal section. Interestingly, mode 1 is also unbound, thereby offering no liberalisation in cross-border supply of this service.

For physiotherapists and paramedical personnel, only mode 3 (foreign commercial presence) is liberalised.

Under health insurance, commitments have only been made under mode 2: consumption abroad.

So SA largely retains the discretion to regulate activities in the private health sector. Consumption abroad has been totally liberalised. Similarly, cross-border supply has been mainly liberalised. However, because nothing has been offered for the movement of natural persons under GATS 1, nothing at all under GATS 8, and only consumption abroad for health insurance, it seems safe to say the country has yet to undertake effective commitments to trade in health services.

From a health policy point of view, it makes sense for the government to hold back on health service commitments. The White Paper on the Transformation of the Health System in SA, published in 1997, forms the national health policy statement until the National Health Bill is passed. According to Thomas and Muirhead (2000: 10): “its vision embraces a unified health system where all actors (including the private sector) are co-ordinated in pursuit of the fundamental goal of equity”. It is not clear what effect trade in health services would have on equity and further research is needed. Indeed, if current trends of worsening equity in financing between the public and private sectors are anything to go by, it is possible that increased growth in the private sector through trade would not be positive. The National Health Accounts show that both expenditure in the private sector and the number of hospital beds have grown at more than the inflation rate, even though the number of medical scheme beneficiaries have declined in the last five years. The stark inequities present in the *apartheid* era have not been addressed, and current resource allocation patterns continue to be increasingly skewed toward the rich. It is no surprise that SA has relatively poor health status indicators despite its large funding of health-sector activities (see Thomas & Muirhead, 1999).

3. MAPPING BARRIERS TO TRADE IN THE SA HEALTH SECTOR

According to the WTO Secretariat (1998), three types of domestic regulatory arrangements are significant as they affect the supply and demand of health services. The first is the qualification and licensing requirements for individual health professionals (which mainly correlate to the movement of natural persons). The second is the approval requirements for institutional suppliers such as clinics and hospitals (which mainly correlate to foreign commercial presence) and the third is the rules and practices governing reimbursement under insurance schemes (which can correlate to consumption abroad and foreign commercial

presence). This section outlines these types of regulatory arrangements in the SA setting, under the three categories of human resources, service providers and purchasers. These are analysed with respect to the potential modes of trade relevant to each category and the regulations, and any available data presented.

3.1 Human Resources

The current government perspective regarding health-sector human resources in SA could be summed up by the following:

> "South Africa invests large amounts of public funds in the schooling and tertiary education of health professionals, only to see its efforts to accelerate equitable delivery of quality health services stifled by three forms of professional migration: from rural to urban areas, from the public to the private sector and from South Africa to highly industrialised countries."
> (Health Summit Background Papers, *Human Resources*, 2001: 54).

Human resources include all health professionals involved in delivering health services, which in this category mainly happens via the movement of natural persons – health professionals working abroad on a temporary basis. Although not strictly definable under human resources, temporary residence permits for medical treatment and education (consumption abroad) are also discussed in the section on the Immigration Act.

This section presents data on the number of practitioners in the private sector, the number of foreign health professionals in SA and the annual migration of South Africans abroad. While these data are the best available, they should be interpreted with caution. In addition, the section describes the relevant legislation for the licensing, education and practice of health professionals in SA. It also looks at the options under the newly passed Immigration Act for temporary residence in SA. Finally, it describes the National Department of Health's policy for the recruitment of foreign health professionals in the country, and the policy for the education of foreign students (which is actually defined as consumption abroad, and not as the movement of natural persons).

According to the *National Health Accounts Private Sector Report* (Cornell et al, 2001), there are no accurate data detailing the number of practitioners in the private sector. In the past, registration with professional boards was not compulsory, hence the paucity of data. This has been remedied in the latest legislation, so such data should improve in future. The data that is available varies widely, suggesting that it should be interpreted with caution.

The data presented in Table 5 show estimated total numbers of private-sector practitioners and the proportion of private-sector practitioners relative to the total number of practitioners in the country. These data come from the Board of Healthcare Funders, which provides private-sector practitioners with practice numbers and so has records of them. But the number is most likely overestimated as some private-sector practitioners also work in the public sector.

Table 5: Estimated Private-Sector Health-Care Practitioners, 1998/99

Health Practitioner Category	1998		1999	
	Number in Private Sector	Proportion in Private Sector	Number in Private Sector	Proportion in Private Sector
Doctors	19,935	72.4	20,219	72.6
Dentists	3,868	92.3	3,953	92.6
Pharmacists	8,531	87.8	3,363	76.3
Psychologists	-		3,586	94.2

[Sources: 1998 data from "Health Summit Background Papers", 2001: 59; adapted from van Rensburg, N. "Distribution of human resources". Ch 16: 201-232. In: Crisp N, Ntuli A, eds. South African Health Review*: 1999 Durban: Health Systems Trust, 2000; 1999 data from van Rensburg and van Rensburg (1999) in Cornell et al, 2001: 10.]*

Table 5 shows that a substantial proportion of health-care practitioners work in the private sector. This is particularly noteworthy given that only an estimated 18% of the population is dependent on the private sector (*Health Summit Background Papers*, 2001).

Table 6 presents the annual migration of health professionals from SA in 1998, 1999 and 2000. Over these three years, a total of 293 doctors and specialists left the country – just under 1.5% of the total stock of private-sector doctors in 1999. However, this is not really a meaningful comparison – it would be more useful to know the total number of SA doctors currently practising abroad. Indeed, this figure is highly unlikely to be accurate since the incentives to self-report emigration are very poor.

Dr Steve Reid of the Centre for Health and Social Studies at the University of Natal conducted a survey of Community Service doctors from 1999-2001 (response rate of approximately 75%). He found that the percentage planning to enter Public Service decreased from 42% percent in 1999 to 38% in 2001. The percentage planning to go abroad increased from 34% to 43% over the same period (out of a total of about 1,100 new medical graduates per year). It was also found that 3% to 4% of students leave before their year of Community Service. Because they would be penalised if they returned, it is assumed that they do not intend to come back.

Table 6: International Migration of Health Professionals: 1998, 1999 and 2000

Occupational Category	1998	1999	2000	Total
Allied Health Professionals	55	50	71	176
Dental Professionals	13	12	31	56
Medical Doctors	86	68	89	243
Medical Specialists	19	15	16	50
Nurses	133	117	147	397
Pharmacists	42	39	24	105
Total	348	301	378	1027

[Source: "Health Summit Background Papers", 2001: 59.]

The Health Professions Council, the Pharmacy Council and the Relevant Acts

This section describes the licensing requirements for health professionals in SA. The Health Professions Council of SA (HPCSA) is a statutory body, established in terms of the Health Professions Act 56 of 1974, which continues the activities of the Ciskei Medical Council, the SA Medical and Dental Council, the Transkei Medical Council, and the Interim National Medical and Dental Council of SA. This council was formally established by the Medical, Dental and Supplementary Health Service Professions Amendment Act, which came into effect on 1 March 1998 (Harrison and Qose in Ntuli, 1998).

The Act expanded the powers of the professional boards and required that all persons registering for the first time under the Act must perform a year's remunerated community services. For doctors, compulsory community service began on 1 July 1998, and for dentists in 1999.

To safeguard the public and indirectly the professions, registration in terms of the Act is a prerequisite for practising any of the health professions with which the Council is concerned. Registration confers professional status upon a practitioner and therefore the right to practise his or her chosen profession. (*http://www.hpcsa.co.za/Background/backgrou.htm*).

According to Harrison and Qose in Ntuli (1998), the Pharmacy Amendment Act No 88 of 1998 (to amend the Pharmacy Act of 1974) establishes a permanent Pharmacy Council and contains provisions relating to the licensing of pharmacies, pharmacy education, training and practice. It also removes the restriction that only pharmacists may own pharmacies, but any pharmacy must still be run under the continuous personal supervision of a pharmacist. In addition, any person practising as a pharmacist must be registered as a pharmacist in terms of the Act (must register with the Pharmacy Council). According to the Pharmacy Amendment Act 1 of 2000), any person registering for the first time as a pharmacist is only entitled to registration as a pharmacist on completion of one year of remunerated pharmaceutical

community service in a state institution (Harrison in Crisp and Ntuli, 1999 and Nadasen and Gray in Ntuli et al, 2000):

This brings the pharmacy profession in line with those governed by the Health Professions Act. Foreign professionals do not have to perform community service.

The Immigration Act

The Immigration Act was passed on 30 May 2002, and replaces the Aliens Control Act 96 of 1991.

The passing of this Act was contentious since its work permit clause differs from the original Immigration Bill [B79B-2001]. The Bill relies on a "market-driven technique… centred around a licensing fee to be paid by the employer, leaving the employer to determine the needed foreigners, their job descriptions, qualifications and length of temporary employment" (Buthelezi, 2002). In the Select Committee and Portfolio Committee stages, this was replaced by a quota system. Shortly thereafter, the African National Congress (ANC) tabled a proposal to scrap the quota system and replace it with a labour certification process similar to the one currently employed in the Aliens Control Act. However, insufficient time to amend the Bill meant it was passed with the quota system in place (Buthelezi, 2002; *SA's Immigration Bill becomes law*, 2002).

Quotas will be needed to "delineate the characterising features of each and every category of potentially needed foreign workers, together with a numeric evaluation which can withstand both public and judicial scrutiny" (Buthelezi, 2002).

Constitutionally, this means that the Department of Home Affairs will have to start implementing quotas, but at the same time develop an amendment Bill scrapping them. Minister of Home Affairs, Mangosutho Buthelezi has warned that these amendments would not be developed quickly (Hartley, 2002a and 2002b).

The Immigration Act, No. 13 of 2002

For consumption abroad, two types of temporary residence permits are applicable. These are:

- The study permit, which allows a foreigner to study in SA for a period longer than three months, as long as the foreigner has sufficient means to support himself and to pay his tuition fees.
- The medical treatment permit, which may be issued to a foreigner intending to receive medical treatment in the country for longer than three months as long as the costs of the treatment are borne by the foreigner.

For establishment trade and the movement of natural persons, the following may be applicable:

- A business permit may be issued to a foreigner intending to establish or invest in a business in SA in which he or she may be employed provided that the foreigner invests the prescribed financial or capital contribution in the business. Home Affairs may reduce or waive the capitalisation requirements if the business is prescribed to be in the national interest or under the request of the Department of Trade and Industry.

Other permits that have relevance for the movement of natural persons may include the work permit, which comes in various forms:

1. The quota work permit may be issued to a foreigner who falls within a category determined by the Minister at least annually by notice in the Government Gazette, after consultation with the Ministers of Labour and Trade and Industry. The number of these work permits will not exceed the quota amount.
2. A general work permit may be issued to a foreigner not falling in one of the quota categories if the employer:
   - Satisfies the Department that he or she has been unable to employ a citizen with qualifications equivalent to those of the applicant.
   - The terms and conditions of employment are not inferior to those prevailing for citizens and residents.

3. An exceptional skills work permit may be issued to an individual of exceptional skills or qualifications, as determined by the Department.
4. An intra-company transfer work permit may be issued to a foreigner who is employed abroad by a business operating in the Republic as a branch, affiliate or subsidiary.

Finally, a corporate permit may be issued to a corporate applicant (a juristic person which conducts business, charitable, agricultural or commercial activities in the Republic) to employ foreigners who may conduct work for the corporate applicant. A maximum number of foreigners to be employed via a corporate permit will be determined by the Department in consultation with the Departments of Labour and Trade and Industry.

The Department of Health's Policy on Foreign Recruitment and Education

The Department of Health's policies (2001) create a very real barrier to the movement of natural persons. Employment of any health professionals from developing countries, and particularly from the Southern African Development Community (SADC), will not be supported whether it be to the public or private sector. This section describes the policies of the Department regarding the recruitment of foreign health professionals into the public health sector. Even this creates an indirect barrier to the movement of natural persons, because while the Department will support foreign health professionals in the public sector if a need exists, it states that it will not support the migration of these professionals to the private sector. The Department's policy states that the aim of recruiting foreign health professionals is to bring their skills to underserved (particularly rural) areas of SA, while protecting the rights of SA citizens to employment opportunities. In other words, it will be considered whether a SA citizen can fill the position.

Based on current statistics, the Department argues that the aim of attracting skills to underserved areas is not being met. A greater proportion of foreign health professionals are employed in the urban areas and frequently those initially employed in underserved areas migrate to the cities.

A number of general principles are listed in the report:

1. Health professionals must register with a statutory health professional council.
2. Where there is an adequate supply of trained SA health professionals, recruitment and employment of foreign workers should not occur and applications for permanent residence should not be supported.
3. Recruitment of individual applicants from any developing country, in particular from the SADC, will not be supported.
4. This policy will be subject to the relevant SA laws (Aliens Control Act 96 of 1991, the Refugees Act of 1998, Act 130 of 1998 and the Immigration Act once its regulations have been passed).
5. The Department will not support the migration of a foreign health professional from one employer to another (public/private), between provinces, or who wishes to change his purpose of entry to secure extended stay/employment in SA.
6. Employment will be bound by an employment contract, as it is aimed at addressing a temporary and specific human resource need.
7. Foreign health professionals who obtain registration for the public service will not be allowed to take up employment outside the scope of their registration and employment contracts.
8. Foreign health professionals must submit a written undertaking to return to their countries of origin upon completion of their employment contracts.

Table 7: Country/Continent of Origin and Number/Percentage of Foreign Health Professionals in SA, March 2001

Origin	Number	Percentage
Africa Non-SADC	426	23.5%
Africa – SADC	147	8%
Asia	336	18.5%
Australia	8	0.4%
Canada	5	0.3%
Cuba	396	22%
Eastern Europe	91	5%
England	56	3%
Europe	189	10%
Middle East	6	0.3%
Other	125	7%
South America	12	0.7%
USA	8	0.4%
USSR	9	0.5%
Total	1814	100%

[Source: National Department of Health, 2001: 4-5]

Table 7 provides data on the total number of foreign health professionals in SA and their country or continent of origin. Because of a government-to-government agreement, the highest percentage (from any one country) is from Cuba at 22%. Besides Cuba, most are from Nigeria (154), India (145) and Pakistan (110). Of the 1,814 foreign health professionals, 76% are medical practitioners and 12% medical specialists. This picture is likely to change in future, as health professionals will no longer be recruited from Africa. As Table 7 shows, 31.5% of the foreign doctors in SA are in fact from Africa. It remains to be seen whether this supply of doctors will be forthcoming from other parts of the world. Various sources have shown that African health professionals currently employed in SA are finding it increasingly difficult to renew their work permits.

Table 8 shows the proportion of foreign doctors in the country relative to doctors in the public sector / private sector / in total.

Table 8: Proportion of Foreign Doctors in SA

	Number	Proportion Foreign (%)
Public Sector	7,616	24
Private Sector	19,935	9.1
Total doctors	27,551	6.6

[Source: Numbers of doctors in public sector / private sector and in total is taken from "Health Summit Background Papers", 2001: 59; adapted from van Rensburg in Crisp and Ntuli, 2000.]

For employment in the public sector, the Department contends that it will not entertain applications of individuals from developing countries. In other words, only government-to-government or bilateral agreements will be considered.

Applications from developed countries will, however, be considered if they meet the following criteria:

- Fairly competing for the prospective position, on the condition that no qualified SA citizen has applied for the position.
- Obtaining a written job offer and signing a contractual agreement for employment for a maximum term of three years. If need exists, the Head of Health of the Province can recommend a new contract to be signed.

- Submitting an undertaking in writing to return to the country of origin upon completion of the employment contract.
- Securing suitable registration with a relevant statutory health professional council.
- Complying with the normal statutory requirements for work permits and temporary residence in the Republic.
- Demonstrating professional competence and high ethical standards.
- Fluency in English or at least one of the official languages of SA.
- Working continuously for the same employer.

For specialist or post-graduate training for medical officers (mode 2: consumption abroad and perhaps mode 4: presence of natural persons given that postgraduate training also involves practising) the policy states that preference for post-graduate training will be given to SA citizens and citizens from countries where a government-to-government agreement exists. Applicants from other countries, whether post-graduate or under-graduate, must be sponsored by their respective governments, a donor or an agency. For post-graduate training, a work permit is needed.

The employment of foreign academic health staff should be on a contractual basis and the maximum duration of the job offer must be clearly defined. If the need exists for continued employment of the individual, proper motivation must be given to the Head of Health in the Province.

For under-graduate training, an agreement with SADC ministers has set aside a quota of 100 places for SADC students. Botswana has reserved 15 places, while other SADC countries are still determining the number of students to be sent. These students will be given preference, under the condition that they are fully funded by their governments.

For students from other countries, entrance is also permissible if they are funded. Entrance for all students is conditional, with the contractual undertaking that the student return to his/her home country upon completion of the under-graduate studies[3].

This section has shown that SA has trade-enabling regulations for consumption abroad in relation to under-graduate medical training. However, barriers are put in place to minimise consumption abroad (medical training) becoming the presence of natural persons (after training, the graduate does not return to his or her country of origin). In addition, the laws are not enabling the presence of natural persons in the private health sector.

3.2 Health-Care Providers

Under the GATS, health-care provision includes hospital services (services delivered under the direction of medical doctors chiefly to in-patients aimed at curing, reactivating and/or maintaining health status) and other human health services (such as ambulance services and residential health facilities services other than hospital services and other). Under this category, potential modes of trade could include foreign commercial presence and consumption abroad. The former might occur if foreigners invested in the hospital operation and management sector. The latter might occur if foreigners consumed health services in the private sector.

National Health Accounts data presented in Table 9 indicate that the number of hospital beds in the private sector is substantial and growing.

[3] See HPCSA website – www.hpcsa.co.za – for more information about registration. Provisions are made for foreigners in the registration forms, such as needing further education. However, these parts of the site are not yet operational, and I received no response to my e-mail queries.

Table 9: Total Private Hospital Beds and Annual Growth

Year	1983	1989	1994	1999
Hospital beds	8,220	11,117	16,415	23,706
Annual growth		5.9%	9.5%	8.9%

[Source: Cornell et al, 2001: 7]

Table 9 shows an annual growth rate of 5.9% between 1983 and 1989; 9.5% between 1989 and 1994; and 8.9% between 1994 and 1999. The relatively high growth rate between 1994 and 1999 is particularly interesting, given that the government placed a moratorium on increasing private hospital beds in 1994 to gain time while the policy on the "certificate of need" was developed. Private hospital companies sidestepped the moratorium by building 'step-down facilities' – wards with a full nursing complement but no theatres that are therefore not classified as hospitals.

Although Cornell et al (2001) state that it is difficult to get accurate data on the private sector in SA, the numbers do indicate that the sector is substantial and growing.

Except for the banking and insurance industries, there are no sector-specific restrictions on foreign investment in SA or restrictions on foreign ownership of local companies and businesses, although there are restrictions on the borrowing levels of foreign-controlled companies. (Government consents and approvals are necessary in the insurance industry.) However, while foreigners are not discriminated against, the size of the private health sector is the subject of regulations through the government moratorium and through its proposed policy on the "certificate of need", which will most likely be applied once the National Health Bill is passed. This regulation is aimed at limiting the growth of the private sector and so helping to constrain inequitable health sector development.

The National Health Bill 2001

The National Health Bill is the overarching piece of legislation that enables the establishment of a national health system encompassing public, private and non-governmental providers of health services. According to Sait (2001), this was gazetted for public comment on 9 November 2001. The National Health Department indicated that it would table the Bill in Parliament for processing by June 2002.

Because there is no overarching health legislation, provincial health departments have been initiating their own, leading to a disjointed restructuring process. Any legislation that has been passed in the provincial sphere will have to be adapted to be in line with the national legislation once it is passed.

Although there is not much detail, the Bill does give an indication of the general government policy on the "certificate of need", which provides for the licensing of all health establishments.

The Bill states that:

"Any *person* desiring to -

(a) Establish, modify or acquire a health establishment;

(b) Increase the number of beds or acquire prescribed specialised equipment;

(c) Provide prescribed specialised services; or

(d) Continue operating a health establishment existing at the time of commencement of this Act,

must apply in the prescribed manner to the Director-General for a certificate of need" (s48).

A health establishment is defined as the whole or part of a public or private institution, facility, agency, building or place, whether organised for profit or not, that is operated or designed to provide in-patient or out-patient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, preventative or other health services. The certificate would be valid for no longer than 10 years. Although it is clear that the aim of the certificate is to keep the growth of private-sector health establishments proportional to the 'need' for them, it is not clear from the bill how this will be achieved. One would only get a clear picture of what would

determine a 'need' for a health establishment once the Act is passed and the Regulations promulgated.

In the provincial sphere, the KwaZulu-Natal legislature passed its Health Act in August 2000. It is written largely in enabling language, in other words, it is not detailed but rather indicates what matters in time will be prescribed by regulations. This Act touches on the Certificate of Need, which requires private health facilities to obtain a licence to operate from the province. However, the Hospital Association of SA has described it as not too different from the existing law (Nadasen and Gray in Ntuli et al, 2000).

There is no mention in the National Health Bill of foreign ownership of or investment in private hospitals in SA, and there is no readily accessible data on this issue, although it is clearly happening – as indicated in the media. An example is the recently opened University of Cape Town (UCT) Medical Centre, which is in essence a private wing attached to Grootte Schuur hospital. This was developed through direct investment from Rhon-Klinikum, a German private hospital group. This is also happening in the other direction, with SA-based countries investing abroad. According to the *Business Day,* (2002) Afrox health-care group has non-SA operations in Botswana, Namibia, Zambia, Mozambique and others.

Public-Private Interactions in Health Services

In 1999, the national Health Department established a Public-Private Partnership (PPP) Task Team, and in 2000, a draft report considering 12 different PPP initiatives was released. Four different types of PPPs are being considered:

1. *Purchased services* entail purchasing services to obtain specialised skills or to meet short-term staffing needs, and can include contracts with private hospitals for specialised treatment and diagnostic services.
2. *Outsourcing* is mainly for non-clinical services (for instance outsourcing catering in hospitals), but could include diagnostic services.
3. *Joint ventures* are service partnerships that involve sharing resources between public and private partners with the aim of resulting in increased or higher-quality services or lower costs. This could be on a 'service basis' where clinical and support services are provided by public-sector employees working in the 'private side' of the facility or on a 'lease basis' where the public sector leases space and/or equipment to the private sector and the private partner provides clinical and support services.
4. *Private Finance Initiatives* (PFIs) provide capital funding unavailable in the public sector to build or upgrade public-sector facilities.

The focus is mainly on public hospitals and on leasing out spare-bed capacity, outsourcing support services and PFIs for hospital construction or rehabilitation (Cornell et al, 2001).

The provision of medical and hospital treatment directly through the government and free-of-charge does not come under the rules of the GATS. However, in the SA system there is scope for private activities, and services in government hospitals are not always free of charge. According to the WTO Secretariat (1998: 11):

> "The co-existence of private and public hospitals may raise questions, however, concerning their competitive relationship and the applicability of the GATS: in particular, can public hospitals (and their services) constitute a sector distinct from, and not in competition with, private hospitals (and their services). Given the perceived advantages of private over public hospitals – the absence of waiting periods, use of modern equipment, etc. – the two groups might not be considered to provide 'like' services."

However, the GATS national treatment obligation comes into force if the hospital sector is made up of government- and privately owned entities that operate on a commercial basis and charge the patient or his insurance (as is the case with minimum benefits in SA).

This is especially so in the case of direct private/public sector co-operation. The WTO Secretariat (1998) calls these Build-Operate-Transfer (BOT) arrangements, but they appear to be the same as what is known as PPIs in the SA setting. These arrangements would therefore come under GATS rules if the sector were scheduled in future.

Examples of Trade in Health Services

While data is not available on, for instance, the number of foreign-invested hospital beds in the private sector, it is clear from media reports and other informal sources that foreign investment is happening.

The UCT Medical Centre – a PPP between the Western Cape Provincial Administration, UCT and Rhon-Klinikum AGI, one of Germany's leading private hospital groups – is a key example. It relates to foreign commercial presence and movement of natural persons: the former because the centre is developed in partnership with a German private hospital group, and the latter because employees of the group are involved in the centre's management. According to the brochure, this is "a revolutionary management and operational concept... at costs estimated to be well below that of other private care facilities". It is located in hired vacant space within the Grootte Schuur Hospital complex. It also provides a clinical platform for teaching and clinical research. According to the *Cape Argus* (18 February 2002), the investment by Rohn-Klinikum amounts to R45-million. However, as of 7 August 2002, the private investment in this scheme was transferred to Westcare Hospitals – which means it is no longer a foreign commercial presence.

Grootte Schuur itself is involved in a scheme to treat British patients who need heart operations – a good example of consumption abroad. "The scheme, which is a move to cut the hefty hospital waiting lists in Britain, could see between 500 and 1,000 British patients sent to Grootte Schuur annually for cardiac bypasses alone." The operations would be performed in Grootte Schuur's private wards (Smetherham, March 24 2002) with a 50/50 split of profit between the hospital and the private sector. SA is clearly taking steps to promote the treatment of foreigners in our hospitals.

3.3 Purchasers of Health Services

In the private sector, two-thirds of health services are purchased via medical schemes, while the remaining third is mainly purchased through out-of-pocket payments (McIntyre et al, 1995). This situation leads to a very close relationship between the purchasers (the medical schemes) and health-care providers, and a strong correlation between the services offered on medical scheme benefit packages and the services ultimately purchased. In other words, no discussion of trade in health services would be complete without making reference to the activities of and regulations pertaining to the medical schemes. Medical schemes can be defined as non-profit associations that are funded through contributions from employees and employers. However, their administrative companies operate on a for-profit basis.

Table 10 gives an indication of the coverage of medical schemes as a percentage of the population.

Table 10: Private-Sector Coverage 1996-1998/9 – number of beneficiaries (% of population in brackets)

	1996	1997	1998	1999
Medical schemes	6,862,377 (16.9%)	6,902,697 (16.6%)	6,887,735 (16.3%)	
Health insurance				1,162,875

[Source: Cornell et al, 2001: 17]

Note: There are other sources of coverage such as firms that offer work-place health services. This is particularly common for the mines.

Coverage by health insurance is not included in the sub-total for two reasons. First, it is highly likely to be double counting and secondly, reliable data was only available for 1999. While the table covers those who are covered by 'institutional' financing intermediaries, it should be borne in mind that there are others who may choose to pay out-of-pocket to use private-sector health services. Household surveys indicate that this figure could be as high as 30% of the population. Most of this would be for visiting general practitioners and purchasing over-the-counter medicine.

Although it is difficult to say for sure because of paucity of data, Table 10 shows that at least 16% of the population is covered by medical schemes. An additional 0.7% to 1.3% may be

covered by health insurance (with no medical scheme cover). Thus 17% to 18% are covered through 'institutional' financing – a drop of 4% to 5% since 1992/3.

Table 11 examines the total private-sector expenditure and its rate of growth in nominal terms by financing intermediary, in comparison with the consumer price index. According to Statistics SA, the Consumer Price Index (CPI) was 8.6% for 1997 and 6.9% for 1998. Despite a slight fall in membership (as presented in Table 10) private health expenditure has grown at a rate double that of the CPI. This suggests that utilisation and unit costs have increased considerably. An overall decrease in firms' direct expenditure, particularly for mines, is largely attributable to declining formal sector employment. Trends in households' out-of-pocket expenditure should be interpreted with caution.

Table 11: Private-Sector Expenditure by Financing Intermediary, 1996-98

Financing Intermediary	Expenditure (R-million)			Annual Growth Rate	
	1996	1997	1998	1996-97	1997-98
Insurance/Pre-payment	18,514	22,512	25,158	21.6%	11.8%
Medical schemes	17,769	21,698	24,285	22.1%	11.9%
Health Insurance	410	440	455	7.1%	3.5%
Worker's Compensation	335	374	418	11.7%	11.7%
Firms' direct expenditure	*635*	591	*606*	-7.0%	2.6%
Mining industry	514	462	462	-10.2%	0.1%
Other firms	121	129	144	6.9%	11.6%
Households' out of pocket	5,536	5,377	7,490	-2.8%	39.3%
Medical scheme members	3,847	3,466	5,348	-9.9%	54.3%
Non-scheme members	1,689	1,911	2,142	13.2%	12.1%
Total	24,685	28,480	33,254	15.4%	16.8%
Consumer price inflation				8.6%	6.9%

[Source: Cornell et al, 2001: 22.]

Table 11 indicates that the annual growth rate of expenditure in the private sector exceeds the inflation rate. This is particularly notable given that coverage of the population by medical schemes actually declined over this period. This suggests that the cost of medical care in the private sector is increasing while coverage is shrinking.

Traditionally, medical schemes were community rated. This means that members' contributions were only differentiated on the basis of income and number of dependants. The benefit of community risk rating is that it provides significant cross-subsidisation between high- and low-income earners, between the healthy and ill, and the young and old. However, in 1989, medical schemes were deregulated, allowing for risk rating. Contributions could be adjusted for risk profiles, and risk-rated schemes could attract members with low health risks, while the higher risk members remained in the community-rated schemes. This raised the potential for shrinkage in the industry and for added pressure on the public sector, with some previously covered members with a high health risk being dumped on the public sector (Cornell et al, 2001).

Health insurance is also offered in SA by life and short-term insurance companies. Health insurance is defined to be different from medical scheme business, and therefore does not fall under the jurisdiction of the Medical Schemes Act, but under the Insurance Act and the Financial Services Board. These types of policies provide non-indemnity cover for major surgical and hospitalisation costs. This means that the insurer pays a predetermined amount of money on claims for clearly specified contingencies, rather than reimbursing the actual medical expenses incurred.

Medical schemes have the potential to influence two forms of trade in health services: foreign commercial presence and the movement of patients. The former is said to occur when foreigners enter the market to set up and administer medical schemes. This may also occur

through the avenue of Managed Care. For the movement of patients, SA medical schemes could influence the degree to which South Africans seek health services out of the country. If medical scheme coverage were portable, this type of trade might increase.

Medical Schemes Act No 131 of 1998

Medical schemes are regulated by the Medical Schemes Act of 1998, which came into operation in 1999/2000. According to Pearmain (in Ntuli et al, 2000) some major changes that came about through this amendment were:

- The abolition of compulsory direct payment to providers of services.
- The abolition of the statutory status of the scale of benefits.
- The acquisition by medical schemes of the power to vary benefit levels and structures as they saw fit.
- The acquisition by medical schemes of the capacity to operate pharmacies, hospitals and similar health establishments.

Those who fell out of the system because of the deregulation were forced to access services in the public sector.

To remedy this situation, the new Act introduced compulsory minimum benefits and disallowed discrimination on the basis of age, medical history and health status. Contributions can only be determined on the basis of income level and/or number of dependants.

Schemes may make arrangements for minimum benefits to be provided at public hospitals, but they have to pay for these services (which under the GATS framework might imply that the public sector is in competition with the private sector) at a different rate from non-scheme members in the public sector.

Restricted membership schemes are still allowed, but the restriction is on the basis of employment, former employment in a profession, trade, industry or calling, or by a particular employer or class of employer.

The legislation also attempts to bring administrators and other contractors to medical schemes – such as brokers and managed care organisations – under regulation. Previously, their activities took place in a largely unregulated environment since the application of the previous legislation was confined to medical schemes.

Council for Medical Schemes

The Act also establishes a Council for Medical Schemes. The functions of the Council are to:

- Protect the interests of the members at all times.
- Control and co-ordinate the functioning of medical schemes in a manner that is complementary to the national health policy.
- Make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine.
- Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Act.
- Collect and disseminate information about private health care.

There have been a number of challenges, mainly in an attempt to get around the principle of community as opposed to risk rating. For instance, Discovery Health and Fedsure Health designed and offered hybrid products, which had a baseline medical scheme component but were structured such that meaningful health-care cover could only be obtained if one were to take out allied insurance benefits. Health insurance is not regulated by the Medical Schemes Act, which meant community rating could be avoided.

This demarcation issue led to discussion between the Council for Medical Schemes and the Financial Services Board. It remains to be seen whether there will be a change in the definition of the business of a medical scheme in future.

The Reinsurance issue provided a further challenge to the Act. This is the transfer of part of the hazards or risks that a direct insurer assumes by way of insurance contract or legal provision on behalf of an insured to a reinsurer who has no direct contractual relationship with the insured. This is a sound business practice when correctly applied. However, a report of the Council for Medical Schemes of June 2000 indicated that medical schemes and their members had lost millions of rand each year due to inappropriate reinsurance contracts. This was accomplished in two ways:

1. The scheme takes out reinsurance with its administrative company, which has the insurance licence. The administrator/insurer then reinsures with an outside reinsurer, which includes a profit-share arrangement. The reinsurer often belongs to the same group of companies. The administrator keeps all interest and investment earnings that would have accrued to the scheme.
2. If the administrator has no insurance licence, the scheme contracts directly with a reinsurer who has a profit-sharing arrangement with the administrator.

To prevent this, the Act makes highly specific provisions for the financial arrangements of schemes.

According to Pearmain in Ntuli (2000:192):

The Act stipulates that a medical scheme shall have assets, the aggregate value of which on any day is not less that the aggregate of:

(a) The aggregate value on that day of its liabilities; and

(b) The net assets as may be prescribed.

A further provision states that a medical scheme shall not:

(a) Encumber its assets

(b) Allow its assets to be held by another person on its behalf

(c) Directly or indirectly borrow money; or

(d) By means of suretyship or any other form of personal security, whether under a primary or accessory obligation, give security in relation to obligations between other persons without the prior approval of the Council.

The liabilities of a scheme are statutorily defined as being inclusive of:

(a) The amount which the medical scheme estimates will become payable in respect of claims which have been incurred but not yet submitted; and

(b) The amount which the medical scheme estimates will become payable in respect of claims which have been incurred but not yet submitted; and

(c) The amount standing to the credit of a member's personal savings account.

The Regulations to the Medical Schemes Act of 1998 provide that a scheme must maintain accumulated funds, expressed as a percentage of gross annual contributions for the accounting period under review, of not less than 25%. This is subject to the proviso that this percentage is:

- 10% during the first year.
- 13.5% during the second year.
- 17.5% in the third year.
- Not less that 22% during the fourth year after the regulations have come into operation.

In other words, paying out the bulk of a scheme's financial assets for reinsurance will transgress at least one of these provisions and is a criminal offence.

In 2001, the Medical Schemes Amendment Act No 55 was passed. This Amendment Act sought to tighten up some of the regulations, especially to explicitly prohibit discrimination on the basis of age, further regulate the practice of reinsurance, limit the purposes for which

medical schemes may compensate brokers, and provide for the regulation of their professional conduct.

While these provisions do not discriminate against foreigners, an insider in the industry claims that the regulations have made medical schemes less profitable, which will affect the level of foreign commercial presence.

In conclusion, it is estimated that less than 20% of the population is covered by private institutional financing intermediaries with access to the full range of private-sector health services from primary care to specialist inpatient care. But as many as 30% of non-scheme members may use some private services on an out-of-pocket basis. It is worrying that the proportion of the population covered declined from 1996 to 1998, resulting in an increasing proportion of the population becoming reliant on the public sector for health care, particularly hospital care. Despite the fall in coverage, expenditure grew annually by about 15% between 1996 and 1998.

Managed Care: Linking Providers and Purchasers of Health Services

Managed care refers to any attempt by purchasers to influence the practice and prices of health-care providers. This is American technology which first entered the market in 1994/95 following the amendment of the Medical Schemes Act in 1993. A variety of different services and approaches go under this title, but hospital pre-authorisation and pharmaceutical benefit management appear to be the most commonly implemented interventions in SA. At the time of writing (1998), Soderlund and Schierhout said that there are very few truly integrated provider-insurer entities, and that most have yet to come to grips with the large informational requirements that go with Managed Care.

According to the *Business Times* (2002), the hard-line original model of US managed care has failed to make a meaningful impact in SA. In this model, managed care organisations contract with doctors and specialists. In addition, they seek to ensure that patients visit specialists only when necessary and only see specialists who have signed contracts as preferred providers.

This section has shown that expenditure in the private health sector is growing faster than inflation, while membership of medical schemes has fallen off slightly. The Medical Schemes Act is partially seeking to prevent a further fall in scheme membership, especially for the sickly and aged, by reinstating community rating. Trade in health services would mainly occur via foreign commercial presence in this sector (which is often accompanied by the presence of natural persons) and there is no mention of barriers to investment. In other words, foreigners are treated as favourably as locals. However, because the new legislation impacts on the profitability of the industry, very little investment is actually coming in. A confidential source in the medical scheme / managed care industry says while there are no regulations restricting foreign companies from coming into the managed care or medical scheme industry, managed care is currently not profitable enough to attract investment (constantly performing at under 2% per annum over the four years since entering the market).

4. CONCLUSION

This paper has mapped the current commitments to trade in health services in the GATS, and has provided descriptive data on the number of health professionals (human resources), the number of hospital beds and health-care facilities (health-care providers) and the levels of expenditure in the private sector (health-care purchasers). On the whole, government regulations are the most enabling of consumption abroad and cross-border supply (although there is no information available on whether cross-border supply is actually happening in SA).

SA regulation is least enabling of the presence of natural persons. Foreigners from the developed world are not treated as favourably as citizens, as they have to apply for a work permit. Furthermore, it is the National Department of Health's stated policy not to award work permits to health professionals from any developing countries. On the other hand, there are no explicit barriers to foreign commercial presence, and foreigners are treated similarly to local companies. In addition, it is easier for foreigners to work in SA if they are employed abroad by a foreign company operating in SA. It remains to be seen whether current

regulation in this area actually serves health policy, particularly the ban on health professionals from developing countries.

While regulations are enabling of foreign commercial presence, there are implicit barriers to trade. This is because the government has limited the size and profitability of the sector through the moratorium on hospital beds, the certificate of need policy and the Medical Schemes Act. This means that although foreign commercial presence is allowed, it may not be attracted because of these factors. Much of this regulation can be related back to health-sector policy and the importance of equity and meeting the basic needs of the majority of the population served by the public sector.

We would argue that the government is wise to hold off on extending liberalisation in the health sector pending further research. Indications are that continued private sector expansion is neither equitable nor efficient. On the contrary, it may fuel growing inequalities by absorbing ever-greater resources while treating ever-fewer patients.

APPENDIX

Health Professional Boards

Professional Board	Registrations
Dental Therapy and Oral Hygiene	Dental Therapists Oral Hygienists Student Dental Therapist Student Oral Hygienist
Dietetics	Dietician Supplementary Dietician Student Dietician Student Supplementary Dietician
Environmental Health Officers	Environmental Health Officers Food Inspector Student Environmental Health Officers Student Food Inspector
Emergency Care Personnel	Ambulance Emergency Assistants Basic Ambulance Assistants Emergency Care Assistants Operational Emergency Care Orderlies Paramedics Emergency care assistant Student Ambulance Emergency Assistant Student Paramedic
Medical and Dental	Anaesthetist Assistant Biomedical Engineer Clinical Biochemist Dentist Genetic Counsellor Health Assistant Intern Medical Physicist Medical Practitioner Medical Scientist Student Anaesthetist Assistant Student Biochemical Engineer Student Clinical Biochemist Student Dentist Student Intern Student Medical Physicist Student Medical Practitioner Student Medical Scientist Supplementary Medical Scientist Visiting Student
Medical Technology	Medical Technician Medical Technologist Student Medical Technician Student Medical Technologist Student Supplementary Medical Technician Supplementary Medical Technician

Occupational Therapy and Medical Orthotics/Prosthetics	Arts Therapist Ass. Medical Orth. Prost. & Leatherworker Medical Orthotist and Prosthetist Occupational Therapist Occupational Therapy Assistant Occupational Therapy Technician Orthopaedic Footwear Technician Orthopaedic Technical Assistant Single-medium Therapist (Occupational Therapy) Student Ass. Medical Orth Prost & Leatherworker Student Medical Orthotist and Prosthetist Student Occupational Therapist Student Occupational Therapy Technician Student Orthopaedic Footwear Technician Student Orthopaedic Technical Assistant Student Supplementary Medical Orthotist and Prosthetist Student Supplementary Occupational Therapist Supplementary Medical Orthotist and Prosthetist Supplementary Occupational Therapist
Optometry and Dispensing Opticians	Dispensing Optician Optometrist Orthoptist Student Dispensing Optician Student Optometrist Student Orthoptist Student Supplementary Optical Dispenser Student Supplementary Optometrist Supplementary Optical Dispenser Supplementary Optometrist
Physiotherapy, Podiatry and Biokinetics	Biokineticist Masseur Physiotherapist Physiotherapy Assistant Podiatrist Remedial Gymnast Student Biokineticist Student Masseur Student Physiotherapist Student Physiotherapy Assistant Student Podiatrist Student Remedial Gymnast Student Supplementary Physiotherapist Student Supplementary Podiatrist Supplementary Biokineticist Supplementary Physiotherapist Supplementary Podiatrist
Psychology	Intern Psychologist Psycho-Technician Psychologist Psychometrist Student Intern Psychologist Student Psycho-Technician Student Psychologist Student Psychometrist

Radiology and Clinical Technology	Clinical Technologist Electro-Encephal Technician Radiation Technologist Radiographer Restricted Supp Diag. Radiographer Student Clinical Technologist Student Electro-Encephal Technician Student Radiation Technologist Student Radiographer Student Restricted Supp Diag Radiographer Student Supplementary Diagnostic Radiographer Suppl. Elector-Enceph. Technician Supplementary Clinical Technologist
Speech, Language & Hearing Professions	Audiologist Audiometrician Community Speech and Hearing Workers Hearing and Acoustician Speech and Hearing Correctionist Speech Therapist Speech Therapist and Audiologist Student Audiologist Student Audiometrician Student Community Speech and Hearing Workers Student Hearing Aid Acoustician Student Speech and Hearing Correctionist Student Speech Therapist Student Speech Therapist and Audiologist Student Supplementary Audiologist Student Supplementary Speech Therapist and Audiologist Supplementary Audiologist Supplementary Hearing Aid Acoustician Supplementary Speech Therapist and Audiologist

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