AFRICAN AIDS CRISIS: IMPLICATIONS FROM THE RISE OF MANAGED CARE IN SOUTH AFRICA

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I. INTRODUCTION

In the tradition of tobacco and pesticides, U.S. corporations are exporting to third-world countries—in the form of managed care—products and practices that have come under heavy criticism domestically.¹

Health care costs associated with the unyielding AIDS ² epidemic are strangling an already suppressed South African economy. In the wake of this unyielding financial crisis, managed care systems, based primarily on U.S. models, have moved in.³ The problem is circular. With AIDS draining the economy through healthcare costs, there is less money to budget for prevention. While not an all-inclusive solution, managed care’s cost-containing methods will help reduce healthcare expenditures, thereby enabling more economic resources to treat current AIDS patients.⁴ More importantly, the economy is also freed to increase budgeting on prevention aimed at reducing future cases.

Managed care, however, has its shortcomings. A tension exists between managed care’s emphasis on cost-cutting and a patient’s right to quality of care. The result is a need for legislative regulation. South Africa recently met that need with the Medical Schemes Act (hereinafter Act).⁵ While the Act is

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¹ Waitzkin et al., How the United States Exports Managed Care to Third World Countries, MONTHLY REVIEW, May 1, 2000, at 21.


³ See generally Waitzkin, supra note 1.

⁴ See Kerry Hall, Managed Care Spanning the Globe; United HealthCare of North Carolina Executives are Sharing Secrets of Success—And Even a Song—With Sister Company in the Philippines, NEWS & RECORD (Greensboro N.C.), Dec. 3, 2000, at E1.

⁵ Medical Schemes Act, South Africa (Ad No. 138 of 1998).
new legislation for South Africa, it closely resembles various American models developed over the last few decades.

This Note seeks to compare the Act to these American models with an eye towards possible changes and other recommendations for South Africa in light of its AIDS crisis. The background section describes the effect of AIDS on South Africa and the particularities of South Africa that managed care must take into account. Additionally, this section describes the financial effect of the AIDS epidemic on South Africa and the general role managed care plays in suppressing that rise. The result is an economy better able to afford prevention and stop the cycle. The analysis section will examine whether South Africa's aim for universal health is an attainable goal given AIDS' impact on a suppressed economy. It further analyzes the impact managed care may have on this goal and need to regulate this Medusa's head of healthcare. This will involve exploring what legislative regulations South Africa recently promulgated under its Medical Schemes Act and comparing those regulations to the American model they closely resemble. This Note, however, will also argue that South Africa needs to be cautious of over regulating and should consider letting market conditions control certain aspects of the healthcare agenda.

II. BACKGROUND

A. South Africa's AIDS Problem Generally

The statistical effect of AIDS in South Africa is staggering. In 1999, 250,000 people died in South Africa from AIDS-related illnesses. At the end of 1999, an estimated 4.2 million adults and children were living with HIV and AIDS. This comprises approximately twenty percent of the adult population. These percentages continue to progress as South Africa has one of the highest growth rates of HIV in the world.

7 See id.
8 See id.
9 See David Benjamin Snyder, South Africa's Medicines and Related Substances Control Amendment Act: A Spoonful of Sugar or a Bitter Pill to Swallow?, 18 DICK J. INT'L L. 175, 176 (1999). See also Charles W. Henderson, Envoy Says U.S. Not a "Puppet" of Drug Companies, AIDS WKLY. PLUS, Aug. 16, 1999, available in 1999 WL 10041285 (stating "South Africa has one of the fastest growing rates of (HIV/AIDS) in sub-Saharan Africa, estimated at 1,500 new
Unlike the United States, where AIDS epidemiology still runs primarily along a homosexual and intravenous drug user line, South Africa has a heterosexual crisis with women comprising over half of those infected with HIV.\textsuperscript{10} Given the large number of women infected, perinatal\textsuperscript{11} transmission encompasses a more significant mode of transmission than in the United States.\textsuperscript{12} Another source of HIV infection is through blood transfusions.\textsuperscript{13} While not a primary source of infection in the western nations, blood transfusions remain a considerable problem for South Africa because blood is not routinely screened for the virus.\textsuperscript{14}

\textbf{B. Financial Concerns of AIDS Impact}

Given the wide range of associated illnesses and long-term medical care/costs that results from such, the AIDS crisis creates economic quicksand for South Africa's already sinking economy. Moreover, in light of AIDS' long latency period, an expected rise in AIDS cases is anticipated and, therefore, the economic impact may be even more staggering than expected. The problem invariably feeds on itself. With AIDS depleting financial resources, less money is available for educational programs and pharmaceuticals to delay its growth.

While HIV has been controlled, to a large extent, in the United States by pharmaceuticals like the antiviral drug Zidovudine (AZT),\textsuperscript{15} these drugs remain financially out of reach for most South Africans. In 1997, South Africa attempted to assist its enormous population of HIV and AIDS patients.\textsuperscript{16} Working with a realization that it did not have the economic resources to

\textsuperscript{10} See generally WHO, supra note 6.
\textsuperscript{11} See MOSBY'S, supra note 2, at 1192 (defining perinatal as "pertaining to the time and process of giving birth or being born").
\textsuperscript{12} See PRICE & WILSON, supra note 2, at 175 (commenting "because pediatric AIDS is predominately a reflection of prenatal or perinatal infection (vertical transmission), as the rate of HIV infection in women rises, more infants will acquire HIV."); Bartschi, supra note 2, at 174.
\textsuperscript{13} See Bartschi, supra note 2.
\textsuperscript{14} Id.
\textsuperscript{15} See MOSBY'S, supra note 2, at 20 (stating "[t]reatment consists primarily of combined chemotherapy to counteract the opportunistic diseases. Although there is no known cure for an HIV infection, the antiviral drug zidovudine [AZT] has been shown to reduce the progress of the disease and prolong the lives of patients. Alternative antiviral drugs include didanosine (ddi) and zalcitabine (ddc)[."]
\textsuperscript{16} See Snyder, supra note 9.
afford AZT and other AIDS drugs, South Africa passed a law to give its AIDS infected population greater access to AIDS drug treatment. The most controversial aspects of the law are two provisions aimed at lowering the price of AIDS drugs. The first provision involves “parallel importing,” which allows “the import of commercial drugs from third world countries where they are available at a lower cost.” The second provision involves compulsory licensing, allowing local pharmaceutical companies to make generic versions of the AIDS drugs. Given its enormous HIV/AIDS population, and pharmaceutical aid financially out of reach, “the government called its actions necessary and legal.”

South Africa, charged with intellectual property violations, has since relented. Pharmaceutical companies, however, have agreed to lower the price of their AIDS drugs in South Africa in an effort to avoid backlash that could damage their intellectual property rights. However, even if anti-AIDS medicines were ten percent of the current prices, the annual cost to South Africa would total half of the government’s total health care expenditure.

Treating this enormous AIDS epidemic creates disparaging results to the South African economy. The costs of HIV/AIDS is creating a financial disaster predicted to reduce medical scheme reserves, making health care unaffordable. HIV/AIDS related costs accounted for approximately ten percent of the total spent on health care costs in the insurance industry in South

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17 Id.
18 See Steven Lee Myers, South Africa and U.S. End Dispute Over Drugs, N.Y. TIMES, Sept. 18, 1999, at A8; see also Snyder, supra note 9; Henderson, supra note 9.
19 See U.S. Dispute, supra note 18. “Despite many efforts to harmonize and increase intellectual property protection around the world, there still exists a significant number of countries that permit parallel imports. As a result, companies that sell their products abroad may experience increased competition from their own goods.” Id. at A8; Snyder, supra note 9, at 180-82.
20 See U.S. Dispute, supra note 18. Snyder, supra note 9, at 179-83.
22 U.S. Dispute, supra note 18, at A8.
24 See id.
26 See id.
Africa.  

This percentage will likely increase to forty percent within the next ten years.

III. MANAGED CARE'S MOVE INTO SOUTH AFRICA TO CONTROL SPIRALING HEALTH COSTS

A. Entrance of Managed Care and the Need to Adapt to South Africa Generally

Due to AIDS' unyielding drain on South Africa's economy, managed care entered to contain healthcare costs. The move to managed care has been viewed by many as negative, but it may play a role in enabling the South African economy to afford AIDS care and, more importantly, AIDS prevention. After thriving for years, managed care is at the point of saturation in the United States. With prospects in Europe limited, the managed care corporations now turn their sights onto third-world countries. Much of the criticism comes from foreign physician participants, as HMOs are as hated by foreign doctors just as much as their American counterparts. However, managed care in South Africa is likely to stay. Therefore, attention must be focused on how to better managed care's impact on South Africa both internally and through the legal structures.

Given managed care's unstoppable stream into South Africa, attention needs to be placed on more than learning from the changes that have taken or need to take place in America. HMOs must also place an emphasis on taking the intricacies of South Africa into consideration. Healthcare systems in different countries are too diverse for managed care companies to simply replicate abroad what they do at home. Managed care needs to take

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27 See David Jackson, Survey-Managed Health Care Now its Time to Deliver Benefits, BUS. TIMES (South Africa), May 21, 2000, at 25.
28 See id.
29 See Waiztkin, supra note 1, at 21.
30 See id. at 21; Medicine for Export, THE ECONOMIST (U.S. Edition), Mar. 7, 1998, at 26 (“Whereas premiums paid to managed-care firms in America have levelled [sic] off since 1994, private medical spending abroad is growing.”).
31 See Waiztkin, supra note 1, at 21.
33 Dr. Tony Pope, CEO of Netcare-owned Clinical Partners states that “the underlying reason for failure was that funders adopted an American concepts without due regard for South African circumstances.” David Jackson, Integrated Approach to Manage Costs, BUS. TIMES (South Africa), May 21, 2000, at 24.
34 See Medicine for Export, supra note 30, at 26; see also Hall, Spanning the Globe, supra
knowledge from the American experience and apply it to local conditions, but American companies can assist countries like South Africa to "introduce new money-saving strategies." As one health economist states, "The [United States] has developed the managed care model further than any other nation. That's why they (other countries) look to us."

B. Specific Adaptations Managed Care Companies Must Make Changes Internally to Succeed

South Africa's situation, in particular, entails many intricacies for managed care to work around. For example, there is a disparaging socio-economic difference between its black majority and its white minority, a result of years of apartheid, a lack of a skills base to implement a managed skills plan and the relatively few doctors in proportion to its population. These intricacies attributed to the demise of some managed care companies attempts to move into South Africa. Managed care in South Africa is currently at a crossroads. After faltering for the first few years, only a handful of managed care elements have been incorporated in South Africa successfully. Managed care "has been plagued by fragmentation among role players, hostility from provider groups and an initial lack of quality clinical data on which to base health care decisions and strategies." For these reasons, managed care

note 4, at E1 (quoting the CEO of UnitedHealthcare of North Carolina, Frank Mascia as stating, that "[its] amazing to design benefits for different cultures regarding health care, seeing what fits and does not.").

35 See Medicine for Export, supra note 30, at 26.
36 Hall, Spanning the Globe, supra note 4, at E1.
37 See id.
38 See id.
39 See Laura B. Benko, High Interest Rate: South Africa's Experience with MSAs is Worlds Apart from America's, MOD. HEALTHCARE, Nov. 13, 2000, at 38 (stating that managed care has failed to take shape in South Africa because "doctors are relatively scarce . . ., they tend to organize themselves into group practices and associations to maximize their bargaining clout, making it nearly impossible for insurers to force them into risk-bearing agreements.").
40 See Spanning, supra note 4 (stating "[n]ot all U.S. endeavors abroad have proven successful. UnitedHealth's first foray was in South Africa. It no longer operates a health plan in that country.").
41 See David Jackson, Survey—Managed Health Care—Now it's Time to Deliver Benefits, BUS. TIMES (South Africa), May 21, 2000, at 19.
42 See id.
43 Id. at 19.
groups failed in making a significant impact on the overall health care industry.44

Due to their mishandling of AIDS related cases, medical schemes face the daunting task of determining how to take the future costs of AIDS into consideration.45 The previous tactics make it difficult to get an accurate figure for retrospective calculations.46 There is no question, however, that it will be expensive. As previously noted, approximately ten percent of the total benefits are paid out for HIV treatment47 causing South African managed care companies, like Medscheme; to estimate that it will incur its heaviest financial burden from AIDS-related expenses.48

Regardless of the negative image, managed care still has something to offer to other countries.49 Specifically, managed care may prove invaluable to South Africa and its AIDS plague with its emphasis on preventative medicine and primary care.50 Managed care may also help the spiraling health costs by monitoring the appropriateness of treatment and promoting efficiency, quality and cost effectiveness of the health care industry.51 Managed care, however, needs to be regulatory to ensure patient rights.

IV. ANALYSIS

A. Health Care as a Universal Right

Given the AIDS crisis in South Africa and the resulting increase in healthcare needs, the question of what the government’s role should be remains. Fortunately, South Africa views its people’s need for health care as a right to which all should be entitled. South Africa, however, will have to work out practical aspects of this aspiration in light of the drain that AIDS has, and will continue to place, on its economy.

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44 See id.
45 See Survey, supra note 27, at 25.
46 See id.
47 See id.
48 See id.
49 See Hall, Spanning the Globe, supra note 4, at El (stating that “skyrocketing medical costs and aging populations have sent governments—and private entrepreneurs—looking for new strategies to cope. And foreign eyes are increasingly turning to the United States.”).
50 See Medicine for Export, infra note 30, at 26.
51 See id.
Health care is a basic human right incorporated in the World Health Organization (WHO) Constitution. Yet, "[d]espite the proclamation in 1946 of the fundamental human right to health in the WHO Constitution and the efforts of the WHO to achieve 'health for all,' health conditions greatly differ between developed and developing countries[,]" like South Africa. South Africa incorporated the WHO's universal right to health in its new constitution. The 1996 South African Constitution's Bill of Rights reads in clause (1) of Article 26, that everyone has a right to healthcare and states in clause 3 of Article 27 that no one may be denied emergency medical treatment.

Healthcare may be a universal right, but, as one commentator stated, "if the right to health covers everything, then it means nothing." To have a constitutional right to health, one's country must first have the economic resources to support it. South Africa, in its strained economic condition, has already begun to interpret its constitution's "right to health" clauses narrowly. The Constitutional Court of South Africa rejected a broad reading of the right to emergency health that provided for ongoing treatment of chronic illnesses, a label AIDS is sure to carry.

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54 See S. AFR. CONST., ch. 2 (Bill of Rights), art. 27.
   27.(1) Everyone has the right to have access to—
   a. health care services, including reproductive health care; . . .
   (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive [realization] of each of these rights.
   (3) No one may be refused emergency medical treatment
   Id.
55 Fidler, supra note 53, at 214.
56 See id. at 213-14.
58 Steiner, supra note 57, at 31.
   Such a construction would make it 'substantially more difficult' for the state to meet its primary obligation under clauses (1) and (2) to provide health care to 'everyone' within its available resources. It would reduce the resources available to the state for purposes of preventative health care and treatment
The Constitutional Court, in *Soobramoney v. Minister of Health*, determined that the appellant, who required kidney dialysis, did not fall within the emergency criteria of the constitution. Rather, appellant’s case involved an ongoing state of affairs that could not be protected through clause 3, stating “[n]o one may be refused medical emergency treatment.” Thus, the appellant’s situation fell within clause (1), the general right to health care clause. Unfortunately, that clause is further defined by clause (2) of Article 27. Clause (2) states the state “must take reasonable legislative and other measures, within its available resources, to achieve the progressive legislation.” The court recognized the Department of Health budget was overspent, with resources depleted in all renal clinics. Consequently, the state was forced into making “agonizing choices” about who should receive treatment.

Constitutional Court President Chaskalson, in stating the opinion of the court, referenced to the preamble of South Africa’s constitution which captures the aspiration to a society based on “social justice and fundamental human rights” and the desire to “improve the quality of life of all citizens.” The court observed that “obligations imposed on the state with respect to these social rights were dependent on available resources, and that the circumstances of South Africa, an ‘unqualified obligation’ to meet health care and other needs ‘would not presently be capable of being fulfilled.’”

In confronting the over-stretched health care budget, the court recognizes that South Africa has other priorities that must be faced in light of its economic resources. The court stressed that the state “must ‘manage its limited resources’ in order to address the claims of the many people in need of access to health care, housing, and social security, all aspects of the right to human life.” The problem with funding their altruistic right to health care is systemic. Despite the determination that the right to health care involves an

of curable diseases [i.e. AIDS].

See id.

59 See Soobramoney, 1997 (12) BCLR 1696 (SA).

60 S. AFR. CONST. ch. 2 (Bill of Rights), art. 27, clause (3).

61 S. AFR. CONST. ch. 2, art. 27, clause (3) (emphasis added).

62 See Steiner, supra note 57, at 32.

63 Id. at 32.

64 S. AFR. CONST. preamble.

65 Soobramoney, 1997 (12) BCLR 1696 (SA), at ¶ 11.

66 Steiner, supra note 57, at 32. See also Scott Burris, *Law as a Structural Factor in the Spread of Communicable Disease*, 36 Hous. L. Rev. 1755, 1776 (describing how human rights could be used to help prevent the spread of HIV).

67 See Steiner, supra note 57, at 33.
individual right instead of just a policy goal, the realization that it cannot be done independently of the system still confronts the country.\textsuperscript{68} Under this realization, the court acknowledged that a "holistic approach" must be adopted which focuses on "the larger needs of society rather than focus on the specific needs of particular individuals within society."\textsuperscript{69} As a result, the future of AIDS victims' constitutional right to health will be subject to a cautious judicial interpretation of the constitution owing to "institutional incapacity."\textsuperscript{70}

Since South Africa does not have the available resources to adequately treat its AIDS/HIV patients, it must decide how to allocate its funds. When determining where resources should be allocated, the South African government must account for all its needs. As horrific as the AIDS epidemic is, it would be short-sighted to focus all of South Africa's limited resources solely on that one problem. With a stronger economy, South Africa will be able to better afford preventative medicine (including AZT), prevention/education programs, and the costly long-term care that will eventually be needed for those infected with HIV. Part of making the economy stronger and better equipped to handle rising healthcare costs will encompass making the health industry more efficient. Helping meet this challenge is the introduction of managed care into South Africa.

V. MANAGED CARE'S ROLE IN CONTROLLING COSTS: COMPARING AN AMERICAN MODEL

A. Regulations of Managed Care: An American Model

1. General

Considering the rising need of health care secondary to the AIDS crisis and the economic unfeasibility of the state providing health care at all, South Africa has been primed for a change in its health care structure. Consequently, managed care has entered aiming to decrease health care costs and possibly help restrain the rise of AIDS in the private industry. Due to the incentive to provide as little care as possible, however, managed care requires legislative regulation to protect patients' rights.

In writing the \textit{White Paper For the Transformation of the Health System in South Africa}, the South African Department of Health (DOH) recognized the

\textsuperscript{68} See id.
\textsuperscript{69} See id.
\textsuperscript{70} Soobramoney, 1997 (12) BCLR 1696 (SA), at 91 ¶ 5.8.
importance of regulating the public and private sector. However, the DOH acknowledged the need to learn from other countries’ attempts at regulating. Specifically noted was the importance of learning “lessons from failures in the implementation of regulatory framework in many countries.”

With this in mind, the DOH set forth the regulations promulgated under the Medical Schemes Reserve Act.

America has a long history of regulating managed care dating all the way back to the early nineteen-seventies. This long history makes America a resourceful model to compare to the new South African legislation. While in many respects the Act resembles established American models, South Africa has combined some approaches and either avoided or not considered others. Given managed care’s importance to helping the AIDS suppressed economy of South Africa, an examination of these differences should be made, focusing on what changes may be appropriate.

Under its new constitution, South Africa appears to have a similar general legislative structure to America. South Africa is divided into nine provinces, each granted the power to create its own legislative body and law. The South African Constitution specifies areas of concurrent national and provincial legislative competence, including health services. The constitution, however, as the supreme law of South Africa, states that if there are conflicting laws of a stature requiring uniformity, national legislation prevails. When South Africa enacted the Medical Schemes Act, it left nothing to doubt. Chapter 2 of the Act states: “Application of Act.—(1) If any conflict, relating to the matters dealt within this Act, arises between this Act and the provisions of any

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72 See id.
73 Id. at 3.10.5.1.
74 Regulations in Terms of the Medical Schemes Act, 1998 (Ad No. 131 of 1998) (S. Afr.). See also Legislative Updates—Regulations in Terms of the Medical Schemes Act, 1998 (Feb. 9, 2001), at http://www.hst.org.za/pphc/phila/legis/1999/medact.htm (the line between a scheme and insurance in generally is blurred and to the criticism of some, the Act did not clarify the difference). See id.
75 See A. Enthoven & S. Singer, Markets and Collective Action in Regulating Managed Care, HEALTH AFFAIRS 26-32 (1997).
76 Barry R. Furrow et al., HEALTH LAW CASES, MATERIALS AND PROBLEMS 799 (3d ed. 1997).
77 See S. AFR. CONST. sch. 4, pt. XX (Functional Areas of Concurrent National and Provincial Legislative Competence).
78 See id.
79 See S. AFR. CONST., preamble.
80 See S. AFR. CONST. § 146.(2)(a)-(e).
other law save the Constitution or any Act expressly amending this Act, the provisions of this Act shall prevail.” Consequently, it would seem that provinces are free to regulate health services, a concurrent area, but it may not conflict with the Medical Schemes Act. How this may play out remains to be seen.

Giving provinces the freedom to regulate health care concurrently may produce innovative legislation, as seen with American states’ regulations on managed care. It may also, however, like America, produce a litany of jurisprudence attempting to parcel out what is preempted. It is recommended that when South Africa’s Department of Health appointed council meets to review and modify the Act, they have an eye toward possible problems with preemption. For example, if South Africa purposely left out an “any willing provider” clause, as discussed later, then the Act should specify that Provinces cannot create the same.

2. Initial American Regulations

The initial stages of legislative responses to managed care in the United States were on the federal level. In the beginning, managed care was viewed positively. It came in a time in which deregulation and market force theories for healthcare held a greater respect and healthcare costs were escalating. Nearly three decades ago, in 1973, Congress adopted a federal statute to encourage the viability of HMOs. The Health Maintenance Organization Act of 1973 establishes federal recognition of HMOs and initially gave federally qualified HMOs substantial advantages over non-qualified HMOs. Specifically, it requires employee benefit plans to use qualified HMOs in certain circumstances. Much of the growth of HMOs can be traced back to the incentives found in that initial act. The good, however, did not come without

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83 See Regulations in Terms of the Medical Schemes Act at Annexure A (Ad No. 131 of 1998) (S. Afr.) (stating the appointed council is to meet every two years to evaluate the regulations).
84 See Singer, supra note 75.
86 See Furrow, supra note 76, at 800; Pengram v. Herdrich, 120 S. Ct. 2143, at 2156-57 (“The Health Maintenance Organization Act of 1973... allowed the formulation of HMOs that assume financial risks for the provision of health care services...”).
the bad; there were also substantial burdens imposed on federally qualified HMOs, and today, most HMOs do not seek federal qualification.87

Because of the federal government’s desire to advance managed care and managed care’s inherent tendency to self-regulate, legislative regulation was initially lacking.88 States’ regulations of managed care were of a traditional nature, based on reporting, disclosure, credentialing, and due process requirements.89 However, the view of managed care soured over time, with one survey by the Kaiser Family Foundation and Harvard University indicating that fifty-one percent of those surveyed believing managed care has lowered the quality of healthcare.90 The result has been legislative regulation at unprecedented rates.91 These measures tend to be narrowly aimed and reactionary with no plan manifested, just a general anti-managed care proclivity.92 It is this new slate of legislation that South Africa’s Act closely resembles.

3. Regulation of Managed Care Insolvency

One of the biggest concerns, and therefore a point of regulation, is HMOs solvency. If an HMO folds, there remain patients who continue to expect care, providers who expect compensation and employers who have rights against the HMO that may conflict with other creditors.93 Some states address this problem by either adopting statutory requirements or authorizing insurance commissioners to take actions to assure the financial stability of HMOs.94 Some of the statutory requirements include “restricted reserves, net worth requirements and strict accounting standards and reporting requirements.”95 Another possible approach establishes a state or federal HMO guaranty fund

87 See id.
88 See Alice A. Noble & Troyen A. Brennan, The Stages of Managed Care Regulation: Developing Better Rules, 24 J. HEALTH POL. POL’Y & L. 1275, 1278-80 (Dec. 1999) (stating “states have passed legislation at unprecedented rates aimed at ameliorating physician and consumer dissatisfaction.”).
89 See id. at 1280.
90 See R. Blendon et al., Understanding the Managed Care Backlash, HEALTH AFFAIRS 80-94 (1998).
91 See T. Miller, Managed Care Regulation: In the Laboratory of the States, 228 JAMA 13, 1102 (1997).
92 See Stages, supra note 88.
93 See FURROW, supra note 76, at 801.
94 See id.
95 Id. at 801 (stating also that “[r]eserve and net worth requirements are often quite low, however, particularly when compared to those required of other health insurers.”).
mandating HMOs to contribute to these funds.\textsuperscript{96} Funds assets become an available means to protect members if an individual HMO should fail.\textsuperscript{97} However, the guaranty fund approach can be seen as sounding a dangerous resemblance to the Savings and Loan crisis: giving incentives to poorly managed funds and creating problems for well-managed funds.\textsuperscript{98}

An Illinois statute illustrates a third approach where all provider contracts shall contain a "hold-harmless" clause.\textsuperscript{99} This clause states:

The provider agrees that in no event, including but not limited to nonpayment by the organization of amounts due the hospital provider under this contract, insolvency of the organization or any breach of this contract by the organization, shall the hospital provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from or have any recourse against, the enrollee, persons acting on the enrollee's behalf (other than the organization), the employer or group contract holder for services provided pursuant to this contract except for the payment of applicable co-payments or deductibles for services covered by the organization or fees for services not covered by the organization.\textsuperscript{100}

This statute places the risk squarely on the provider. If, for any reason, the insurance company does not pay the provider, the provider is precluded from seeking payment from the insured. While seemingly harsh to the providers, the obvious rationale is that they are in a better position to insure against the risk. If the doctors do not believe the company to be solvent or reputable, they can choose not contract with that company.

South Africa created a combination of the first and third approach. To ensure HMO solvency, chapter 8 of the Act, Accumulated Funds and Assets, mandates medical schemes to maintain at all times accumulated funds of not less than twenty-five percent of gross contributions within five years of the

\textsuperscript{96} See id.

\textsuperscript{97} See id.

\textsuperscript{98} See FURROW, supra note 76, at 801 (citing to Charles Underwood & Randall Luecke, The HMO Industry, and What Should We Learn from the S & L Crisis, 7 HEALTH MATRIX 41 (1990)).


\textsuperscript{100} Ill. Comp. Stat. 125/2-8 (2001).
Act's enactment. Schemes are given five years to reach this requirement and are given transitional percentages the first four years. The Act also requires a membership base of 6000. This ensures that risk is adequately spread and the schemes are less likely to become insolvent due to an unexpected percentage of patients that require large volumes of care. South Africa also incorporates the Illinois approach. A Chapter 5 provision of the Act states that a scheme's contract with a provider must "specifically provide that no member or dependent of a member may be held liable by the participating provider for any sums owed by the medical scheme or any other person."

These provisions may play an important role in South Africa. Medical Schemes may likely become insolvent from increased AIDS costs. Many of the beneficiaries left without a medical scheme would, therefore, be AIDS patients, the group least likely to afford paying medical bills. Given the severity of the disease, they will likely become jobless and require extensive treatment. Also, if the beneficiary is deceased, then the surviving spouse and children are unlikely to afford the deceased's medical bills. They have lost an income earner. As a result of the Act, the risk is placed on the doctor who is likely more informed and financially solvent. As previously noted, doctors are generally in a better position to assess the solvency of a medical scheme and whether they should contract with the scheme.

4. Patient's Bill of Rights

An important societal concern about HMOs, as mentioned, is how the incentives to providers provided by HMOs affect the availability and quality of care received by plan beneficiaries. With this in mind, many American states have enacted some form of a patient's bill of rights mandating what benefits insurance policies must cover. State laws often contain mandates prescribing what the insurance policies will cover. By 1989, state govern-

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102 See Welcome, supra note 101.
103 See id.
104 Regulations in Terms of the Medical Schemes Act (Ad. No. 131 of 1998), ch. 5 (Provision of Managed Health Care), § 15 (Conditions for Providing Managed Health Care), pt. 2.
105 See Furrow, supra at 76, at 802.
106 Texas is considered one of the most beneficiary friendly. See id.
107 See Furrow, supra note 76.
ments had, by one estimate, "imposed 732 mandates requiring that insurers cover certain providers, benefits, or insureds." The most common coverage mandate requires coverage of specified providers if they would pay for the same services if provided by a doctor. Mandated benefits include alcoholism, mental health and maternity services.

While many states' bill of rights are, in some circumstances, rendered moot in the United States from federal preemption, South Africa had the insight to include a fairly extensive section of minimum benefits at the national level. In the United States, employers who self fund their health plans are protected from their state's patient's bill of rights. This protection comes under the "deemer" clause in the Employee Retirement and Income Security Act (ERISA). This has expansive implications because much of health insurance today is provided through the employer and self insuring is on the rise.

In contrast, the South African national government has provided for a list of minimum benefits a scheme must provide for all members. The benefits are organized into general classes, such as cardiac and maternal, and then into more specific diagnoses within that class. A prescribed treatment follows each diagnosis. For example, in the Brain and Nervous System section in Annexure A, under the diagnosis "Benign and Malignant Brain Tumours, Treatable," the minimum treatment is listed as "Medical and Surgical Management, Which Includes Radiation Therapy.'

108 Id.
109 See id. (stating "[a]s of 1991 forty-eight jurisdictions required equal coverage of optometrists, forty-six of chiropractors, forty-two of dentists, forty-two of psychologists, thirty-nine of podiatrists, and thirty-two of nurse practitioners.").
110 See id. (noting that some states have begun to respond to criticism of mandated benefits and have begun to allow exceptions for small employers).
112 See Regulations of the Medical Schemes Act (Ad No. 131 of 1998) (S. Afr.).
115 See generally FURROW, supra note 76, at 815-24.
116 See Regulations in Terms of the Medical Schemes Act (Ad No. 131 of 1998) (s. Afr.) ch. 3.1 (Contributions and Benefits).
117 See Regulations in Terms of Medical Schemes Act (Ad No. 131 of 1998) (S. Afr.).
118 Id.
Problems will most likely arise, however, in the lack of specificity of the treatments listed. In the United States, for example, under Newborn's Protection Act a group plan may not limit hospitalization to less than forty-eight hours for a normal delivery. For cesarean deliveries, coverage for at least ninety-six hours of hospitalization is mandated. Under South Africa's minimum benefits for maternity, however, treatment is only specified as delivery. While the Department of Health likely had some notion of the quality expected, without a greater degree of demarcation, schemes are free to provide the absolute minimum in delivery care. Thus, increased specificity will better protect patients' rights. Fortunately, South Africa's Department of Health reviews all prescribed minimum benefits every two years. The minimum benefits are to be evaluated in terms of medical schemes' viability and affordability to members, cost effectiveness and health policy developments.

The mandated benefits are especially important to AIDS patients in their need of long term, expensive treatment. Medical schemes' early responses to the AIDS crisis was to "bob and weave," attempting to avoid picking up the bill for the costs of AIDS. The "catalyst" for change came in the Act. Prior to the Act, medical schemes in South Africa employed two primary methods to contain the costs associated with their HIV-positive members. Their first

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120 See 29 U.S.C.A. § 1185.
122 See Regulations in Terms of the Medical Schemes Act (Ad. No. 131 of 1998), Annexure A, Pregnancy and Childbirth—Code 52N (stating "Diagnosis: Pregnancy; Treatment: Antenatal and Obstetric Care Necessitating [Hospitalization], including delivery.").
124 The review shall involve the Department of Health, the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives. [These] reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of:

i. inconsistencies or flaws in current regulation;
ii. the cost effectiveness of health technologies or interventions;
iii. consistency with developments in health policy; and
iv. the impact on medical scheme viability and its affordability to Members.

Regulations/Medical Schemes Act, at Annexure A.
125 See David Jackson, Survey—Managed Health Care—Call for Sharp Focus on AIDS, BUS. TIME (South Africa), May 21, 2000, at 23.
126 See id.
tactic was to use underwriting to protect the gates.\textsuperscript{127} Through this mechanism, medical schemes were able to assess the member patient's risk prior to her admission.\textsuperscript{128} This enabled adverse selection where the medical scheme could require an HIV test and then deny membership based on perceived risk, or it could adjust contributions in correlation with risk profile.\textsuperscript{129}

Their second method was tartaric exclusion.\textsuperscript{130} If a medical scheme was not able to keep an HIV-positive patient out through the aforementioned underwriting method, then it could make her policy contain low enough limits to be practically useless given the patient's condition.\textsuperscript{131} The Act, however, now requires medical schemes to identify AIDS treatment as a "minimum benefit that private medical schemes are obliged to cover, but only if provided in hospital."\textsuperscript{132}

5. Gag Clause Statutes

Fears of economic motives driving managed care companies have also driven the enactment of anti-gag clause statutes in the United States.\textsuperscript{133} Gag clauses seek to restrict the physician from informing the patient of all appropriate medical options available to them: specifically those not covered by the insured's health plan.\textsuperscript{134} Most states have now banned such clauses and federal law prohibits the use of gag clauses in Medicaid and Medicare contracts.\textsuperscript{135} Additionally, in \textit{Weiss v. Cigna}, the Southern District of New York held that a gag clause constitutes a breach of fiduciary duty under ERISA.\textsuperscript{136}

In South Africa, the Regulations specifically states that "[a] medical scheme shall not enter into any arrangement where a provider of a relevant health service is forbidden in any manner from informing patients of the care they require, including various treatment options, and whether in the provider's view, such care is medically necessary and appropriate."\textsuperscript{137} The

\textsuperscript{127} See id.
\textsuperscript{128} See id.
\textsuperscript{129} See id.
\textsuperscript{130} See id.
\textsuperscript{131} \textit{Focus}, supra note 125, at 23.
\textsuperscript{132} See id.
\textsuperscript{133} See \textit{Stages}, supra note 88, at 1285.
\textsuperscript{134} See id.
\textsuperscript{135} See id.
\textsuperscript{137} Regulations in Terms of the Medical Schemes Act (Ad No. 131 of 1998) (S. Afr.) ch 5 (Provisions of Managed Health Care), § 15 (Conditions for Providing Managed Health Care),
Regulations further state that a healthcare provider may not be terminated for: (1) expressing disagreement with the denial or limit of a benefit (2) assisting a member to seek reconsideration of such denial or limit, and (3) discussing any aspect of the patient's condition, treatment, or alternatives whether covered under the scheme or not.\(^\text{138}\) Placing more flesh to this regulation, the Act also requires that, if a scheme terminates an arrangement with a physician, the reasons must be stated.\(^\text{139}\) The physician is also given a right to request a hearing with an impartial panel.\(^\text{140}\) This regulation instills an important right to AIDS patients in South Africa. The regulation would enable a physician to consult the AIDS patients on all available treatment options including the more expensive options like anti-viral pharmaceutical intervention.

6. *Any Willing Provider*

America has also seen the rise of "any willing provider" statutes.\(^\text{141}\) These statutes state generally that managed care companies must take in any physician who is willing to abide by the company's conditions to membership.\(^\text{142}\) The rationale behind this statue is the fear that managed care will shut out providers who treat their patients too well.\(^\text{143}\) Over half of the states have some form of an any willing provider statute, but many have limited the application to select providers such as pharmacies.\(^\text{144}\) Louisiana provides a typical example of a general any willing provider clause:

No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of his license.\(^\text{145}\)

However, these type of statutes may prevent managed care companies in their primary goal of controlling health care costs, specifically through the

\(^\text{139}\) See Regulation's/Medical Schemes Act (Ad No. 131 of 1998) (S. Afr.), ch. 5, § 15, pt. 6(a).
\(^\text{140}\) See id. at pt. 6(a).
\(^\text{141}\) See FURROW, supra note 76, at 803.
\(^\text{142}\) See id.
\(^\text{143}\) See id.
\(^\text{144}\) See id.
\(^\text{145}\) LA. REV. STAT. ANN. § 40:2202(c) (2000).
ability to select physicians that are cost conscious. Many see a movement away from any willing provider statutes to a more focused physician de-selection statutes. This regulates the provider/managed care company relationship, access to standards for acceptance into the network and reasons for termination. Unfortunately, these statutes often lack requiring reasons for nonrenewals and an opportunity for physicians to appeal.

South Africa’s Act does not include an “any willing provider” section. While this may be from legislative oversight, it may have also been a result of the criticism previously noted. South Africa instead has a form of physician de-selection. As noted in the gag clause section, the Act requires medical schemes to give reasons for terminating an arrangement with a physician and gives the physician an opportunity to appeal. However, like the American counterpart, there are no regulations requiring reasons for non-renewal or an opportunity to appeal the non-renewal.

If South Africa did not include an “any willing provider” regulation because such a regulation interferes with managing costs, then the South African DOH should expressly prohibit such a regulation. This avoids the preemption problems noted earlier. Additionally, if the de-selection clause was created to protect against physicians retaliation, this purpose would be better served by requiring “for cause” non-renewals. Such a requirement may create evidentiary problems for schemes trying to keep a doctor out that should be kept out. However, it may also keep schemes from not renewing physicians for bad causes such as adequately informing patients of their treatment options.

7. Managed Care Liability

A possible regulation for South Africa to consider is whether, and to what extent, managed care companies should be amenable to lawsuits. In many U.S. states, managed care companies remain virtually insulated. In most

146 See Stages, supra note 88, at 1285.
147 See id. at 1285.
148 See id. (stating that Maine is the only state which includes these requirements).
149 Regulations in Terms of the Medical Schemes Act (S. Afr.).
151 See id.
152 This regulation is void from the Act, and there appears to be no other legislative work addressing this issue.
153 See Stages, supra note 88, at 1293.
states, under the "corporate practice of medicine doctrine," health plans cannot practice medicine and consequently can not be sued for medical decisions. However, some states have enacted legislation abrogating the corporate practice of medicine doctrine. A Missouri statute simply allows for the suit, leaving it to the judiciary to decide what type of claims may be brought and what is the legal standard of care. A Texas statute goes an additional step and creates a new cause of action "when a plan fails to use 'ordinary care' in denying or delaying payment for care recommended by a physician or other provider." The statute appears to allow suit against the company for "health care treatment decisions" and for the acts of its employees and agents in their coverage decisions and delivery of care.

South Africa, it appears, has not addressed this issue legislatively. This may be an important statute for AIDS patients. AIDS' expensive and unrelenting nature inherently conflicts with managed care's cost saving focus. The ability to sue a medical scheme may better protect an AIDS patient's rights to quality care through a deterrence effect.

8. Emergency Medical Treatment

America's right to emergency medical treatment comes from Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA requires that any hospital that has an emergency room and accepts Medicare patients must not deny emergency medical treatment. A two-step analysis is required. There must be appropriate medical screening and treatment to the point of stabilization. However, hospitals are often conflicted between this requirement and managed care's requirement for pre-authorization. Some states, like Maryland, have recognized this dilemma and have required the

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154 See id.
155 See id.
156 See id. (citing Mo. H.B. 335, repealing Rev. St. Mo. § 345.505.3, adding § 345.627).
157 See Stages, supra note 88, at 1293.
159 Stages, supra note 88, at 1293.
160 See id.; see Texas Health Care Act, supra note 158.
161 Emergency Medical Treatment and Active Labor Act, § 1867(f), as amended, 42 U.S.C.A. § 1395dd(f).
163 See FURROW, supra note 76, at 761-63.
164 See id. at 772.
insurance company to reimburse the hospital if the care was required by EMTALA.\footnote{See Md. Code Health § 15-103(b)(1); FURROW supra note 76, at 772.}

South Africa, in its new constitution, sets forth the right to emergency medical treatment for all its citizens.\footnote{S. AFR. CON. ch. 2 (Bill of Rights), art. 27, clause (3).} Additionally, members of a medical scheme have an additional protection of their emergency care rights through the Act. The Act specifies that a scheme may not require pre-authorization before the initiation of treatment for an emergency condition.\footnote{See Regulations in Terms of the Medical Schemes Act (Ad No. 131 of 1998) (S. Afr.), ch. 5 (Provision of Managed Health Care), § 15 (Conditions for Providing Managed Health Care), pt. 11 (stating “[a] medical scheme may not prohibit, or enter into an arrangement that prohibits the initiation of appropriate intervention by a provider prior to receiving authorization from the medical scheme or any other party, where a person suffers from a condition that requires immediate medical or surgical intervention.”) (emphasis added).} South African hospitals, consequently, do not have any conflicting requirements with managed care’s need for pre-authorization. This right, however, has already been narrowly defined as secondary to South Africa’s depleted economy.\footnote{See Soobramoney, 12 BCLR at 1696 (1997).} As stated previously in Soobramoney, the claimant’s renal condition was construed an ongoing state of affairs and not, therefore, an emergency. Under that reasoning, AIDS would likely be treated in the same manner.

9. Additional Regulations

In the United States, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry’s proposed a Consumer Bill of Rights and Responsibilities draft that includes other regulations considered on the national level.\footnote{Vickie Yates Brown & Barbara Reid Hartung, Managed Care at the Crossroads: Can Manage Care Organizations Survive Government Regulation?, 7 ANNALS HEALTH L. 25 (1998).} The Commission was charged with advising then President Clinton “on changes occurring in the health care system and recommend[ing] such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system.”\footnote{See id. (quoting Advisory Comm’n on Consumer Protection and Quality in the Health Care Indus., Consumer Bill of Rights and Responsibilities (Aug. 21, 1999) http://www.hcqualitycommission.gov/cbomr.} Some of the additional rights stated in this proposed draft include confidentiality of health information and complaints and appeals.\footnote{See id. While these have not}
yet been realized in the United States, South Africa had the insight to include them in its Act.

Section 15(9) of chapter 5 in the Act provides, "[a]ny information pertaining to the diagnosis, treatment or health of any member of a medical scheme or of any dependent of such member must be treated as confidential." The Act goes on to state in 15(10) that this right to privacy includes disclosures by the provider to any other provider. Additionally, the Act provides a member with the right to appeal any decision of the review panel.

The confidentiality clause is an important right for AIDS patients. While South Africa has other legislative acts to protect against discrimination, these acts have not afforded sufficient protection. The Act, in protecting their confidentiality, protects beneficiaries from this discrimination. As a consequence, beneficiaries may be more open to testing, thereby working to prevent the future spread of the disease.

B. The Need to Balance Regulations with Market Control

While South Africa has acted legislatively in the Medical Schemes Act and additional regulations exist to facilitate its dealings with managed care, a balance must be struck with letting the market control. The success of non-regulation has been seen in the success of Medical Savings Accounts (MSAs). Thus, while South Africa may gain from the experience that the United States has had with managed care, the United States may also learn a

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173 Regulations in Terms of the Medical Schemes Act (Ad No. 131 of 1998) (S. Afr.), ch. 5 (Provision of Managed Care), § 15 (Conditions for Providing Managed Health Care), pt. 10 (A medical scheme must have access to any treatment records held by the provider and other information pertaining to the diagnosis, treatment and health status of the member in terms of the arrangement, but such information may not be disclosed by the provider to any other person without written consent from the member, unless such disclosure is in terms of any legislation) (emphasis added). See id.

174 See id.

175 See, e.g., Employment Equity Act 55 of 1998 No. 19, 370.


valuable lesson from South Africa. Sometimes less regulation is the best regulation.178

With South Africa under the regime of Nelson Mandela, it "enjoyed perhaps the freest market for health in the world."179 Health insurance was deregulated in South Africa in 1994, making way for every type of healthcare currently available in America including HMOs, PPOs, and MSAs.180 Tax authorities then gave MSAs a favorable tax ruling making employers' contributions to MSA's under the same tax break as payments of third-party premiums.181 This ruling put MSAs on level playing fields with the other forms of health coverage and the results have been incredible with MSAs taking over half the market in only six years.182

Whereas MSAs have flourished in South Africa, they have faltered in the Untied States.183 Among the reasons for its demise here domestically is availability.184 Concerned with MSAs only benefiting the young and healthy and encouraging others to hold back on needed care, the Health Insurance Portability and Accountability Act of 1996 made MSAs available solely to self-employed individuals and employers of fifty or less.185 While it is true that younger, and presumably healthier, families have enjoyed the cuts in outpatient spending, households headed by seniors in South Africa have also enjoyed a significant reduction.186 Also disproved is the notion that MSA holders would deny themselves primary care in a fashion that would lead to higher hospitalization costs.187

Other differences that account for the success in South Africa are more choices with fewer government restrictions and greater flexibility.188 Americans may only contribute up to sixty-five percent of their deductible whereas a South African has no limits to the amount of her contribution with many choosing to deposit one hundred percent of the deductible to avoid

178 See id. (stating that in South Africa, "a unique environment of deregulation has fostered a boom in MSAs even as U.S.-style managed care has failed to make inroads.").
179 Benko, supra note 39, at 38; see Albertson, supra note 177 ("Under the regime of Nelson Mandela in the 1990's, South Africa conducted a unique and interesting experiment in the market for private insurance.").
180 See Benko, supra note 39.
181 See id. at 38.
182 See id.
183 See Benko, supra note 39, at 38.
184 Id.
185 See id.
186 See id.
187 See id.
188 See Benko, supra note 39, at 38.
"paying a large portion of the bill in the event of a medical emergency."

Additionally, in America, either the employee or the employer can make contributions, but not both. In South Africa, both can. Not being under a rigid tax code like the United States, MSAs have been able to innovate in South Africa to produce a dynamic product. Their success has been astounding. The average member spends about half as much on outpatient services.

VI. CONCLUSION

Plagued by AIDS and faced with an economy that cannot support its constitutional right to medical care, South Africa needs reformation of its healthcare system. Managed care's presence in South Africa will help control spiraling healthcare costs and in turn enable the economy to treat AIDS patients. This can be accomplished by making healthcare delivery more cost effective through efforts aimed at preventing wastage and fraud and abuse, increasing the efficiency of providers, and emphasizing primary care as a means of gate-keeping. Managed care also assists lowering the rising healthcare costs by decreasing AIDS through its focus on prevention.

Managed care, however, is not without its flaws and must be regulated to ensure patient rights. South Africa recognized this need in its Department of Health White Paper and realized it through the Act. While encompassing

189 Id. at 38; see also Albertson, supra note 177 (further expanding on the differences between American and South African deductible regulations: "whereas a U.S.-type MSA plan has an across-the-board deductible covering all medical services, South African MSA plans typically have varying deductibles." A plan may have no deductible for hospital care because there is usually little choice in the matter, whereas there is there is a high deductible for outpatient care: a high discretion area that may make patients think twice about spending their money).

190 See Benko, supra note 39, at 38.

191 See id.

192 See id.

193 See Albertson, supra note 177.

194 See generally Soobramoney, 12 BCLR 1696 (1997).

195 For example, providers are less likely to provide unnecessary treatment for the patient under a managed care capitated payment plan. Under the traditional fee for service, providers were under an incentive to order as much and as expensive treatment as possible. See Medicine for Export, supra note 30.

196 Prevention remains economically advantageous to managed care because preventative measures are less costly then treatment. See id.

broad regulations similar to those in America, the Act may benefit from some modifications and additions. Such changes include a higher degree of specificity for the minimum benefit’s treatment listing and additional legislation outlining managed care’s liability to patients. Finally, South Africa may also consider adding an “any willing provider” regulation to the Act if South Africa has not already considered and rejected such a regulation.

When the Department of Health reevaluates these regulations in 2002, consideration should not only be focused on the inclusion of additional regulations. As seen with the success of medical savings accounts, letting the market control may bring forth some of the most innovative and effective approaches to healthcare. This need was recognized by the Department of Health in its White Paper and should not be discarded.

While managed care has its role in South Africa, healthcare costs will continue to escalate unless the incidence of AIDS is stifled. This is going to require more than managed care’s focus prevention and cost cutting. While managed care may affect the economy overall through its portion of the healthcare market, its effect on AIDS will likely be limited to those who have insurance. Consequently, the government must focus its resources on preventing AIDS among all citizens. Ultimately, this will require expansive cultural changes including empowering women, educating on safe sex and educating on sterile medical techniques, even for traditional practices.

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198 See Regulations in Terms of the Medical Schemes Act (Ad No. 131 of 1998) (S. Afr.), at Annexure A.

199 “[A] central weakness in the regulatory framework has been the tendency to lay down rigid regulations about what the private sector can and cannot do. It is important that government creates appropriate incentives and disincentive [sic] (carrot stick approach), to encourage appropriate behavior.” White Paper for the Transformation of the Health System in South Africa (South Africa), 3.10.(5.1) (1997).