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The Structure and Financing of South African Health Services : Future Options

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DISCUSSION PAPER 118

THE STRUCTURE AND FINANCING OF SOUTH AFRICAN HEALTH SERVICES: FUTURE OPTIONS

by

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ABSTRACT

The current period of fundamental political change in South Africa offers a window of opportunity for the implementation of transformative health policies. The South African health system is presently characterised by considerable fragmentation of health service provision and administration, with associated inefficiencies. There is a wide degree of consensus amongst different political and health-related organisations that this can best be addressed by unifying the myriad of public sector health departments into a single National Health Service. While there would be overall policy formulation, strategic planning and health service coordination at the national level, there would also be significant decentralisation of responsibility to the provincial and district levels.

The major challenge for a future "Government of National Unity" will be to redress the gross inequities in the current health system. It will need to investigate possible ways of resolving the maldistribution of resources between the public and private sectors, to reduce geographical and "racial" disparities in health service provision, and to address the financial barriers to obtaining health care for lower income groups.

As there will be competing claims on the limited resources that will be available to the newly elected democratic government, alternative source of finance for health services are currently being investigated. These include increased excise on tobacco and alcohol products, increased user fees at public sector hospitals for patients who have medical insurance cover, and the possible implementation of a National Health Insurance system. The latter option is supported by many groups in South Africa, and is seen as an important mechanism for addressing the current cost spiral in the private health sector.

There are unlikely to be any easy or short-term solutions to the many problems confronting the South African health system. However, if the political will to achieve a just and equitable health system is sustained, significant gains can be made during this transitional period.

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INTRODUCTION

During this period of fundamental political change in South Africa, the health system in this country will also be transformed. This paper attempts to provide an overview of the current provision and financing of health services in South Africa, and to review some of the options for future restructuring.

The South African health system has a large public sector as well as a substantial and rapidly expanding private health sector. Each of these sectors will be addressed individually in this paper.

The first section outlines the structure of the South African health system, and the second section gives an overview of the resources currently available in each sector. The third section evaluates some of the major equity issues confronting the South African health system, and efficiency problems are addressed in the fourth section.

The final section critically reviews some of the options for future provision and financing of health services under a "Government of National Unity", in relation to the extent to which the alternatives address current equity and efficiency problems. In the case of the private sector, the emphasis is on the "Medical Schemes Amendment Act" which was implemented on 1 January 1994 and provides the framework for significant changes. The focus of discussions around transforming the public sector is the African National Congress' (ANC) "National Health Plan" which was released on 19 January 1994. The reason for focusing on the ANC's plan is twofold; firstly the ANC is likely to be the majority party in the future Government of National Unity and secondly, it is the only party which has developed a substantial and well-documented plan for the future development of South African health services.

1. OVERVIEW OF CURRENT PROVISION AND FINANCING OF SOUTH AFRICAN HEALTH SERVICES

South Africa has a highly fragmented health care system which reflects not only the historical development of health services from colonial times, but also the effect of apartheid ideology. The system will be described in relation to the provision and financing of health services within the public and private sectors.

1.1 Overview of public sector health service provision

A useful way of describing the complex array of health authorities is to categorise them in terms of central, provincial and local government (the first, second and third tiers of government respectively) and to detail the services for which they are responsible.

Until 1993, there were fourteen departments of health at the central government level, namely the Department of National Health and Population Development (DNHPD), the three "own affairs" or "tricameral"[1] departments of health, and the health departments of the ten "homelands"[2] (see Figure 1).

The departments of health in the homelands are responsible for the provision of comprehensive health services to their resident population. The general delivery pattern centres around base hospitals with fixed and mobile satellite clinics.

The DNHPD is primarily responsible for overall health policy formulation and service coordination, control and coordination of the procurement and distribution of medical supplies, and a range of other auxiliary and supportive services. It is also responsible for family planning services and for subsidising local government health departments in rendering preventive primary care services.

The tricameral departments of health were responsible for all health matters considered own affairs for their respective racial groups. This included hospitals and clinics in which more than 95% of the patients came from any one racial group, school medical services, medical services for the indigent, and psychiatric and dental health services.

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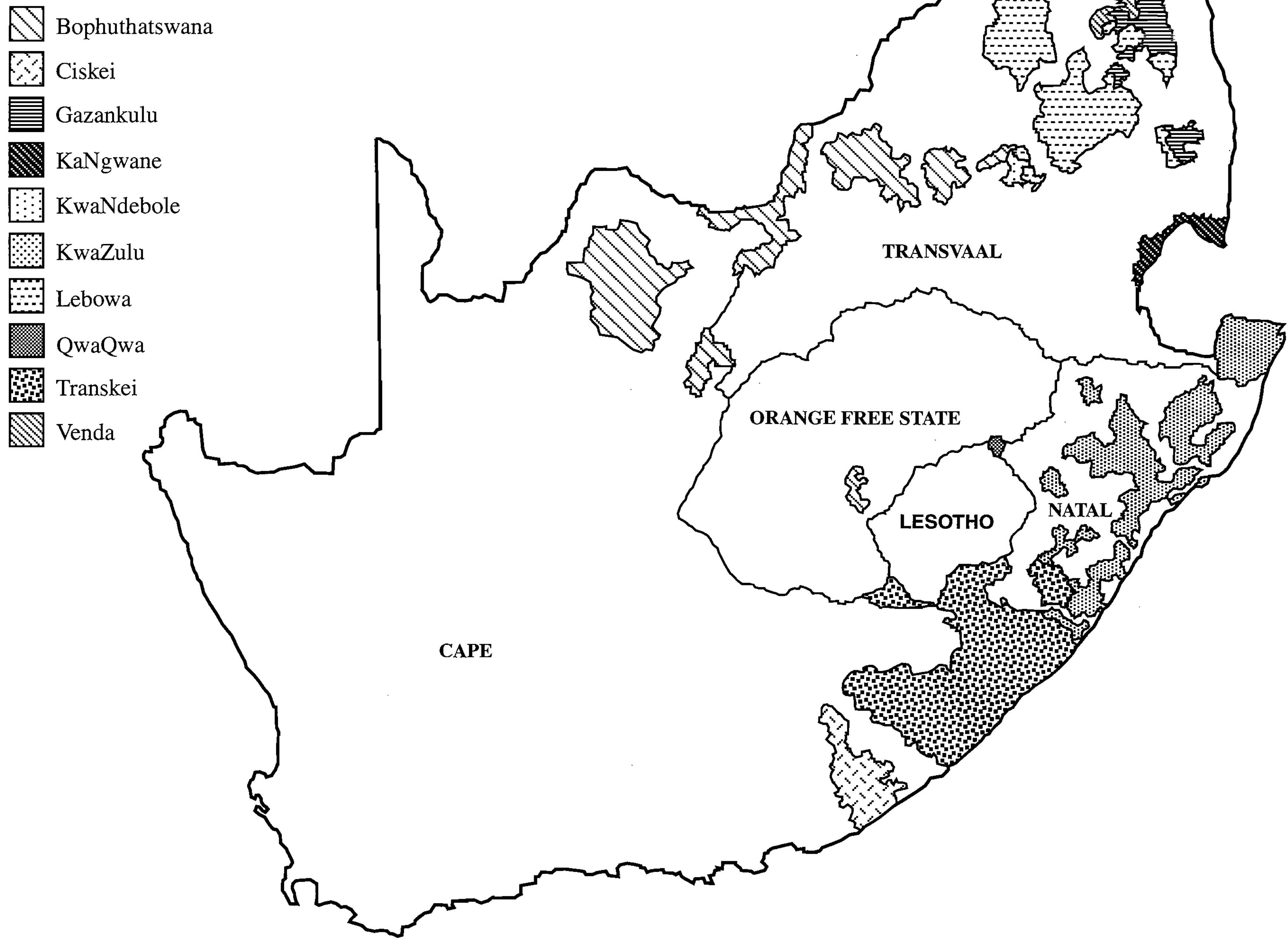
1 In 1983, a new Constitution was enacted which introduced three separate chambers of parliament, namely the House of Assembly for "whites", the House of Delegates for "asians" and the House of Representatives for "coloureds". Each of these chambers were responsible for the administration of the "own affairs" of their particular "racial group". No structure was created for "africans" whose needs were to be regarded as "general affairs"

The use of the terms "african", "asian", "coloured" and "white" indicates a statutory stratification of the South African population in terms of the old Population Registration Act. The use of these terms, however, does not imply the legitimacy of this racist terminology, but is necessary in terms of any discussion of the South African system.

2 Sometimes referred to as "bantustans", these quasi-independent black "ethnic" states were created as part of the apartheid policy to accommodate the African population on 13% of rural areas, thus creating easily controlled labour reserves under the guise of allowing "traditional" subsistence farming.

FIGURE 1: SOUTH AFRICA: PROVINCES AND HOMELANDS PRIOR TO THE 1993 CONSTITUTION BILL



In line with the political transition currently occurring in South Africa, the tricameral parliament has been disbanded and their respective health departments amalgamated with the DNHPD. Their responsibilities relating to hospital services have been devolved to the relevant provincial administrations.

The second tier of government comprises four departments of hospital and health services, one for each of the provincial administrations (Cape, Transvaal, Orange Free State and Natal respectively, as depicted in Figure 1). These departments are largely concerned with the provision of hospital-based services (in- and out-patient care), but also for some primary curative care services. Although much of the responsibility for these services theoretically rests with the DNHPD and the tricameral health departments, almost all of the executive responsibilities for hospital care have been delegated to the provincial administrations.

The third tier of government comprises a complex array of over 400 local authorities, management committees, management boards and regional services councils. Health authorities at local government level are largely responsible for preventive, promotive and rehabilitative services with a particular emphasis on communicable disease control and environmental health services. These services are provided largely from community-based fixed and mobile clinics.

Public sector health services are thus fragmented in a variety of ways. Firstly, there is geographical fragmentation in that each homeland has a separate health department with its own Minister of Health. In addition, the provincial health authorities have a high degree of autonomy which has resulted in differential development of facilities between provinces as well as differences in policies, for example in terms of fee structures. Secondly, there has been fragmentation along racial lines. Until the late 1980's, there were separate hospitals for different race groups, a situation exacerbated by the development of the tricameral system. Finally, there is fragmentation between curative and preventive health care as the provincial and tricameral health departments are responsible for curative care, while local government departments are responsible for preventive and promotive care.

The effect of this fragmentation has been, not surprisingly, a gross lack of coordination in the development of health service infrastructure and inadequate health system planning at the national level. The equity and efficiency implications of this fragmentation and the duplication of health service provision and administration will be discussed in later sections.

1.2 The financing of public sector health services

The primary source of finance for public sector health service provision is general tax revenue[3]. Each of the homelands contributes to the expenditure of their respective health departments from tax revenue raised within its area, while local government institutions contribute from their "rates and taxes" revenue. Approximately 4.5% of the resources required for public sector health service provision are received by central treasury from private sources in the form of user fees[4] (McIntyre 1993).

1.3 Overview of private sector health service provision

South Africa has a substantial and rapidly expanding private sector. There is a range of health personnel who are either in solo or group practice and who are financed from private sources. This includes general medical practitioners[5], dentists and specialists; other personnel registered with the South African Medical and Dental Council (SAMDC) such as chiropractors, homeopaths, naturopaths, osteopaths, dental technicians, dietitians, occupational therapists, physiotherapists, speech therapists, psychologists, and optometrists; as well as a diverse group of personnel who are not registered with the SAMDC such as hypnotherapists and aromatherapists. In addition diviners, herbalists and faith healers constitute a significant group of service providers[6].

In addition to these service providers, the private sector includes the following services:

* Approximately 2,876 retail pharmacies (Pharasi 1992);
* A growing number of Health Maintenance Organisations (HMOs);

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3 In 1993/94, it was estimated that approximately 42% of general tax revenue would be derived from individual income tax, 14% from company and other income tax receipts, 13% from customs and excise duties and 3% from other sources (Department of Finance 1993). In recent years, the use of deficit financing for government expenditure has increased significantly.

4 Fees are levied for in- and out-patient care at the provincial and tricameral health department hospitals and curative primary care facilities, on the basis of income and family size. A narrowly defined category of "indigent" patients are eligible to receive free care. Until recently all fee revenue was returned to central treasury. It may now be retained by the relevant provincial authorities, but budgetary allocations are reduced by the amount of the expected fee revenue.

5 It should be noted that in South Africa, independent practitioners are permitted to dispense the pharmaceutical products that they prescribe. Such practitioners are referred to in this report as "dispensing doctors".

6 Estimates of the number of traditional healers in South Africa vary from 350,000 to 500,000.

* "For-profit" hospitals which provide largely in-patient care on a fee-for-service basis. There were approximately 13,238 beds in these hospitals in 1989 (Broomberg *et al* 1992a);
* Unattached operating theatres or day clinics which provide ambulatory surgical services (the patient is discharged on the day of the operation) on a fee-for-service basis. There were 64 day clinics with 115 theatres and 730 beds in 1991 (Broomberg *et al* 1992a);
* "Non-profit" hospitals, run by various charitable or welfare organisation, which had a total of 916 beds in 1989 (Broomberg *et al* 1992a);
* Contractor hospitals which provide care primarily for long term psychiatric and tuberculosis patients in terms of a per diem payment contract with the state, on a profit-making basis;
* South African National Tuberculosis Association (SANTA) hospitals which provide care for tuberculosis patients on a non-profit basis;
* Province-aided hospitals which are subsidised by the provincial administrations for services provided to non-private patients;
* Industry-specific services which range from the provision of occupational health services to the provision of comprehensive health services such as in the mining industry;
* Charitable and welfare organisations providing a wide range of services such as first aid training and services (e.g. St. John's Ambulance), drug counselling, and hospice care; and
* Non-governmental organisations (NGOs) which are largely involved in the development of community-based primary health care programmes.

1.4 The financing of private sector health services

Medical schemes are the principal financial intermediaries in the private health sector. They are non-profit associations funded primarily by employer and employee contributions. Contributions are related to income levels and the number of dependents. There are different forms of medical schemes ranging from those which provide a relatively comprehensive package of benefits and allow members free choice of service provider, to schemes which offer a restricted benefits package and contract with a specific panel of doctors to provide care for members on a capitation basis. The latter category of schemes generally cater for lower income employees.

Approximately 18.7% of the South African population were covered by medical schemes (including principal members and dependents) in 1991 (McIntyre 1993). There is a significant difference in terms of the racial breakdown of membership with 69% of the

white population covered by medical schemes, 33% of asians, 29% of coloureds and 5% of africans. This is partially a reflection of differences in the employment and income levels between these groups, and of the commitment of employers to provide benefits.

In addition to medical schemes, there are a number of other sources of health care finance in the private sector. In recent years, a number of insurance companies have started offering medical cover, specifically targeting "major medical expenses" such as costs associated with surgical procedures, the treatment of a serious illness, and extended hospitalisation. Those who have opted for medical insurance tend to be young adults in the higher income groups, who are prepared to pay out-of-pocket to use independent practitioners in the private sector, and merely want "catastrophic cover" to ensure that they have access to a private hospital in this event. The growth of medical insurance was promoted by the rapid increased in medical scheme subscriptions over the past decade, and the simultaneous increase in the gap between private providers' fees and the medical schemes' scale of benefits (i.e. the medical schemes' official price list for various medical procedures and treatments).

Another significant source of finance is direct expenditure by individual users of health services, often referred to as out-of-pocket payments. It is useful to distinguish between "schemes-gap" payments and expenditure by "non-scheme members".

The first category includes payments by medical scheme members in the form of co-payments for particular services such as a percentage levy per prescription, payments to cover the difference between the actual cost of a service and the amount paid by the medical scheme, expenditure on goods or services not covered by schemes such as non-prescription medicines, and cash payments to private practitioners once a scheme member exceeds the specified limits (e.g. to continue sessions with a clinical psychologist after the benefit limit per annum is reached).

The second category includes all expenditure on private sector medical goods and services by persons who are not members of medical schemes. This largely refers to medicines purchased at retail pharmacies and from dispensing doctors (see footnote 5), and cash payments to independent practitioners.

Other sources of private sector health care financing include direct payments by industry for occupational and industry-specific health services, fee-for-service payments from the Accident Fund of the Workmen's Compensation Commissioner and the Motor Vehicle

Insurance Fund, and expenditure by welfare, charitable and non-governmental organisations.

2. CURRENT DISTRIBUTION OF HEALTH CARE RESOURCES IN SOUTH AFRICA

This section provides an overview of the resources (facilities, personnel and financial) which are currently available for health service provision in South Africa. It focusses on the distribution of these resources geographically, between levels of care, and between the public and private sectors.

2.1 Distribution of health care facilities

There were 693 hospitals and 158,567 hospital beds in South Africa in 1988 (Chetty 1992). This provides an average of 4.4 hospital beds per 1,000 population. Although this is relatively high by international standards, particularly in relation to underdeveloped countries, there are inequalities in the geographical distribution of hospital beds.

The average number of hospital beds in the homelands is 2.7 per 1,000 population, while the average in the provinces is 5.7 per 1,000 population (Chetty 1993). Geographical maldistribution is also evident in terms of the rural/urban divide. There is an average of 7.1 hospital beds per 1,000 population in the metropolitan areas compared with an average of 4 beds per 1,000 population in non-metropolitan areas. The urban bias is particularly evident in the private sector where more than 94% of "fee-for-service" and charity/welfare hospital beds are in metropolitan areas (Chetty 1993).

In 1988, the majority of hospital beds (71%) were within the public sector, which provides in-patient care for an estimated 80% of the population (i.e. all those who are neither members of medical schemes nor covered by medical insurance) (Chetty 1992). In recent years, there has been a remarkable growth in the private hospital industry in South Africa. Between 1986 and 1990, 31 new private "for-profit" hospitals were established and the number of private hospital beds increased by 61% (Broomberg *et al* 1992b). Thus, there is a growing disparity in the public/private mix of hospital facilities relative to the population that each sector serves.

Hospital care shows a notable bias towards the tertiary sector. In 1988, there were 1.9 general, maternity and acute psychiatric hospital beds per 1,000 population compared with 1.5 tertiary hospital beds per 1,000 population (long-term care hospitals accounted for the remaining 1 bed per 1,000 population) (Chetty 1993).

There were 2,218 public sector community-based primary level care clinics in 1988 (Chetty 1993). This translates into an average of 16,190 people per clinic which is significantly higher than the World Health Organisation's recommendation of 10,000 people per clinic (WHO 1981).

In summary, although South Africa is relatively well-endowed with hospital facilities, there are evident disparities in their distribution on a geographical and sectoral basis, as well as between different levels of care. In contrast, there is an acute shortage of primary level care facilities. It has been estimated that an additional 2,541 clinics will be required by the year 2000 (Chetty 1993).

2.2 Distribution of health care personnel

There is very little accurate information on the distribution of health personnel on a geographical basis. However, data presented in Table 1 indicate that there is a significant maldistribution of personnel between the public and private sectors relative to the population that they serve.

Table 1: Distribution of practising health personnel in the public and private sectors, 1989/90 (percentages in parenthesis)

Category	Public		Private		Total
	No.	%	No.	%	
General practitioners	4 942	(38)	7 947	(62)	12 889
Specialists	1 891	(34)	3 703	(66)	5 595
Superintendents	196	(100)	------------		196
Interns	1 056	(100)	------------		1 056
All doctors	**8 085**	**(41)**	**11 651**	**(59)**	**19 736**
Supplementary health professions	4 187	(40)	6 374	(60)	10 561
Pharmacists	912	(11)	7 350	(89)	8 262
Dentists	228	(7)	2 883	(93)	3 111
All nurses	86 296	(79)	22 940	(21)	109 236

(Source: Rispel and Behr 1992)

While it is known that a growing number of people who are not covered by medical schemes are prepared to pay out-of-pocket for general medical and dental practitioner services, the services of other private sector health personnel (e.g. specialists and nurses working in private hospitals) are usually available only to that segment of the population

(less than 20%) who are covered by medical schemes. This translates into significant disparities in access to health personnel between medical scheme members and the rest of the population. For example, in 1990 there was one dentist for every 137 970 people reliant on the public sector for health care compared with one dentist for every 2 213 people in the private sector.

While the majority of nurses still work in the public sector, the population/nurse ratios have deteriorated from 307 people per nurse in the public sector in 1979 to 368 in 1990, compared with the private sector improvement from 348 people per nurse in 1979 to 265 in 1990.

2.3 Distribution of health care expenditure in South Africa

2.3.1 Public sector health care expenditure

Table 2 summarises the distribution of 1990/91 public sector health care expenditure between the various health departments. Expenditure data for health services provided by the Departments of Police, Prisons and Defence are not included in this analysis. These services are in any event only accessible to an extremely limited population, namely staff, their dependents, and prisoners.

Table 2: Public sector health care expenditure in South Africa (1990/91)

Department	R[7] million	%
DNHPD	553	6.9
Tricameral Health Departments	660	8.2
Provincial Administration Departments	5 145	63.8
Local authorities ("Own contribution")	137	1.7
Homelands	1 568	19.4
TOTAL	8 063	

In 1990/91, public sector health care expenditure was approximately R8 billion. The central government departments of health, i.e. the DNHPD and the tricameral departments, accounted for 15% of this expenditure.

Nearly 64% of public sector health care expenditure was attributable to the departments of hospital and health services of the provincial administrations. The majority of the tricameral and provincial administration health departments' budgets are devoted to

[7] R = Rand, the South African unit of currency. In 1994, £1≈R5.

hospital services (63% and 87% respectively). Teaching hospitals alone accounted for 43% of the expenditure by provincial administration health departments in 1990/91.

This analysis highlights the relative emphasis on curative hospital-based care in South African health services. Approximately 75% of public sector health care expenditure in South Africa (excluding the homelands) is attributable to hospital-based care.

The portion of local authorities' health care expenditure which was financed from their own rates and taxes revenue was R137 million in 1990/91. In addition, certain services (such as the control of communicable diseases and provision of ambulance services) are delivered by the local authorities, but financed by the DNHPD and the provincial administration health departments. These services amounted to R363 million. Thus, while the local authorities' "own contribution" to total public sector health expenditure was only 1.7% in 1990/91, local authorities' overall health expenditure accounted for only 6.2% of total public sector health expenditure. This reflects the relative lack of emphasis on preventive and promotive health services in South Africa.

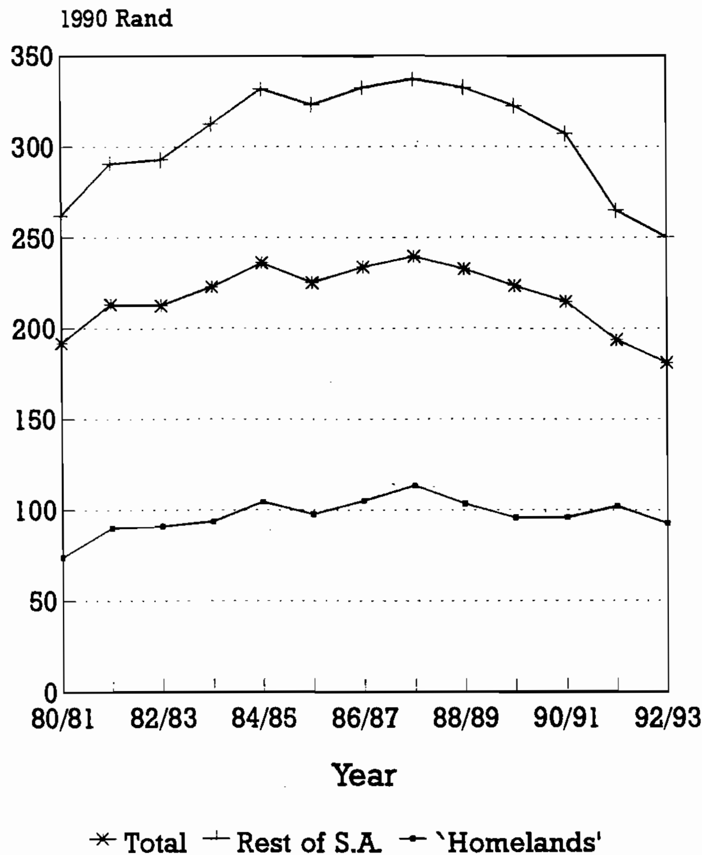
Although an estimated 44% of the South African population resides in the homelands, only 19.4% of public sector health expenditure was attributable to the ten homelands health departments.

Thus, although South Africa devotes a relatively high percentage (11-12%) of the government budget to health services, there are wide disparities in the distribution of these resources. There is an emphasis on hospital-based curative care, particularly at the tertiary level, and few resources are directed to preventive and promotive care.

Figure 2 summarises the major trends in public sector health care expenditure between 1980/81 and 1992/93.

There has been an overall increase in real per capita expenditure within the homelands during the 1980s. In contrast, expenditure in the "rest of South Africa" (i.e. by the DNHPD, and by the tricameral, provincial administrations' and local authorities' departments of health) increased significantly in the early part of the period under review, and then decreased as dramatically from 1987/88. Expenditure was lower in 1992/93 in real per capita terms than in 1980/81 (R250 and R262 respectively).

Figure 2: Real per capita public sector health expenditure



This trend reflects important developments in government policy. It has been pointed out (McIntyre 1991) that a government White Paper on Privatisation and Deregulation published in 1987 (South Africa 1987), called for the "curtailing of public expenditure" and that one of the areas specifically targeted in this regard was the health budget. The substantial decrease in real per capita health care expenditure within the three tiers of South African government since 1987/88, bears testimony to the success of this policy.

The dominant trend during the 1980's was the rapid increase in real per capita expenditure within the three tiers of South African government, particularly by the provincial administration health departments, followed by a policy driven reduction in this expenditure. Despite these decreases, the difference in real per capita expenditure between the homelands and the rest of South Africa remains significant.

2.3.2 Private sector health care expenditure

The only routinely published source of national private sector health care expenditure data is the South African Reserve Bank's (SARB) *estimate* of private consumption expenditure

on medical goods and services. The accuracy of these data has been questioned by a number of researchers (Dorrington and Zwarenstein 1988, McIntyre and Dorrington 1990). An extensive review of private sector health expenditure is currently being conducted, and initial results indicate that the SARB significantly underestimates this expenditure.

However, medical schemes are legally required to submit certain information to the Registrar of Medical Schemes on an annual basis, so data for medical schemes is regarded as reliable and will thus be used in the following analysis.

Private consumption expenditure on health care was estimated by the Reserve Bank at nearly R8.2 billion in 1990/91 (South African Reserve Bank 1992). Approximately R6 billion (73%) of this expenditure was attributable to members of medical schemes (Registrar of Medical Schemes 1993).

Membership contributions to medical schemes amounted to approximately R5,988 million in 1990/91. R5,713 million was paid out in benefits during this year, while administration costs were R347 million. Table 3 indicates the distribution of medical scheme expenditure between various service categories.

Table 3: Distribution of medical schemes expenditure between service categories (1990/91)

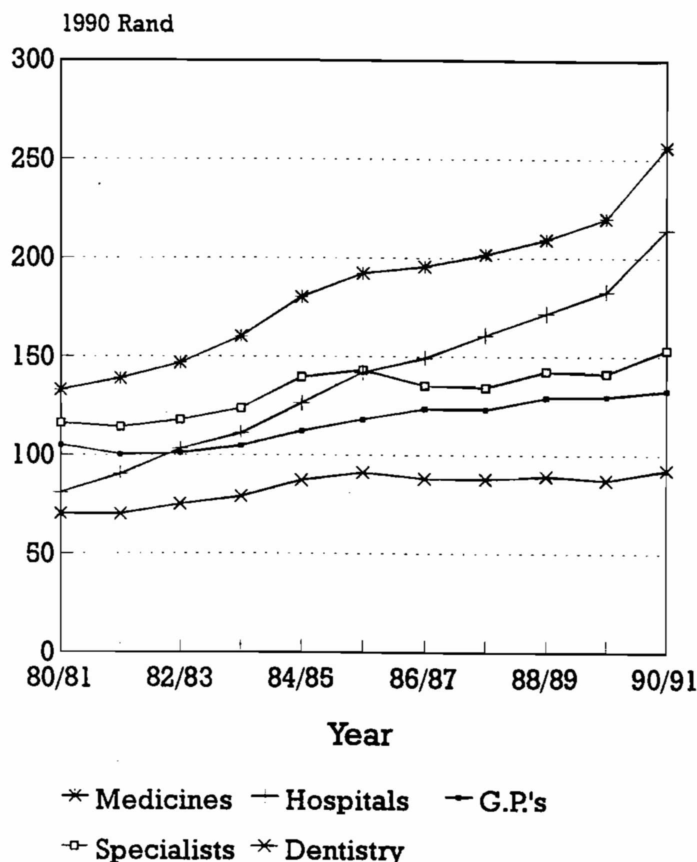
Service category	R million	%
General Practitioners	825	13.6
Specialists	953	15.7
Dentistry	574	9.5
Private hospitals	1 035	17.1
Public hospitals	296	4.9
Medicines	1 592	26.3
Other benefits	438	7.2
TOTAL BENEFIT PAYMENTS	5 713	
Administration costs	347	5.7
TOTAL MEDICAL SCHEME EXPENDITURE	6 060	

Nearly 50% of medical schemes' expenditure in 1990/91 was devoted to hospital care and medicines. Expenditure on general practitioners, specialists and dentists totaled 38.8%. It should be noted that some of the expenditure on medicines is directed to general practitioners who have registered as dispensing doctors.

In terms of guidelines established by the Registrar of Medical Schemes, administration costs should not exceed 10% of a medical scheme's total membership subscriptions. Over the past decade, the proportion of subscriptions expended on scheme administration has never exceeded 7.2%.

There have been some important changes in medical schemes' expenditure patterns over the past decade. Figure 3 depicts trends in real per capita expenditure (i.e. total medical scheme expenditure divided by the number of medical scheme beneficiaries) since 1980/81.

Figure 3: Real per capita medical schemes expenditure



There has been a slight increase in real per capita expenditure on general practitioners (R105 in 1980/81 to R133 in 1990/91), on specialists (R116 to R153) and on dentistry services (R70 to R92).

The significant rise in overall real per capita medical scheme expenditure in the 1980's (from R575 in 1980/81 to R975 in 1990/91) is largely attributable to rapid increases in expenditure on medicines (R133 in 1980/81 to R256 in 1990/91) and on hospitals (R81 to

R214). This represents increases of 93% and 165% respectively in real per capita terms over this decade.

In 1988, the Registrar of Medical Schemes began to report expenditure on private and government hospitals separately. It is particularly significant that real per capita expenditure on public hospitals only increased from R45 in 1988/89 to R48 in 1990/91, while that on private hospitals increased from R127 to R167 (a 31% increase over three years). This extraordinary increase in expenditure mirrors the rapid growth in private hospitals during the 1980's. Broomberg *et al* (1992a) report that the number of beds in private "fee-for-service" hospitals increased by 61% between 1983 and 1990.

In summary, the significant increase in real per capita medical scheme expenditure since 1980/81 was largely attributable to rapid increases in expenditure on pharmaceutical products and private hospitals. Based on the initial findings of the private sector health expenditure review which is based on primary data sources, it is likely that total private sector health expenditure significantly exceeds the SARB estimate of R8.2 billion.

2.3.3 Total health care expenditure in South Africa and the public/private sector mix

Total health care expenditure in South Africa exceeded R16.2 billion in 1990/91. This was equivalent to approximately 6.2% of the Gross National Product (GNP) for that year, compared to 4.3% of GNP in 1980/81 (see Figure 4).

Health care expenditure as a proportion of GNP has been selected by the World Health Organisation (WHO) as one of the economic indicators for monitoring progress in implementing the "Global Strategy for Health for All" (World Health Organization 1988). It is a particularly useful measure for international comparisons, as exchange rate adjustments are obviated and it provides an indication of expenditure on health relative to available economic resources.

However, the major problem with such an indicator is that it not only reflects changes in health expenditure, but is also influenced by fluctuations in GNP. This is illustrated in Figure 4 where the proportion of GNP devoted to public sector health care expenditure increased from 2.2% in 1980/81 to 3.1% in 1990/91 despite real per capita public sector health expenditure remaining relatively constant. In this instance, the decrease in real per capita GNP during this period (of approximately 2.4% per annum) significantly influenced the proportion.

Figure 4: Health care expenditure as a proportion of GNP

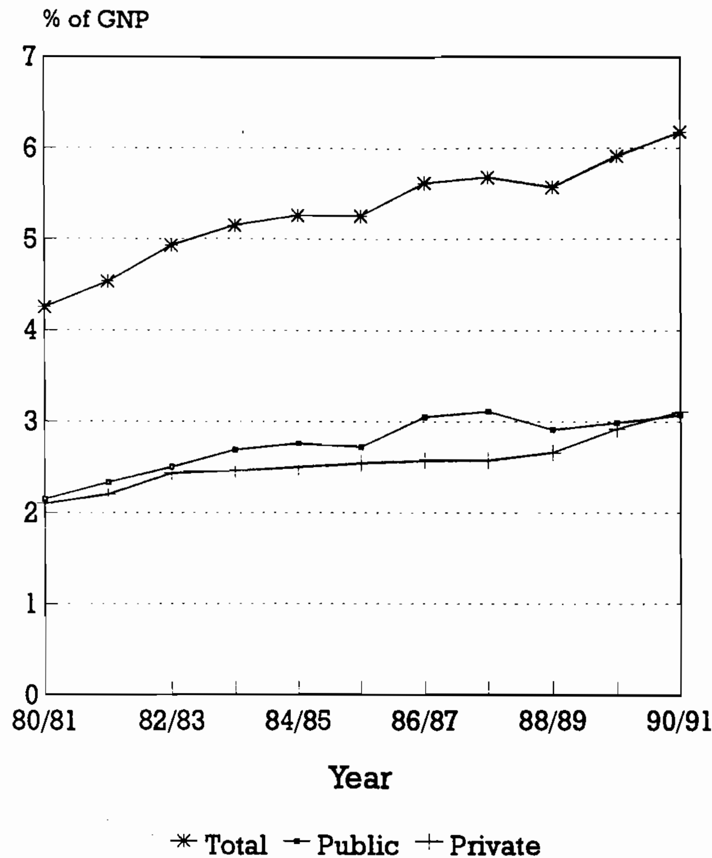


Figure 4 further indicates that by 1990/91, private sector health care expenditure exceeded that in the public sector. As the SARB underestimates private consumption expenditure on health care, it can be stated that the private sector share of health care expenditure exceeds the current estimate of 50.3% based on SARB data.

It is important to note that while at least 50% of health expenditure in South Africa is attributable to the private sector, it only provides health services to an estimated 20% of the population. This results in significant disparities in per capita expenditure. Per capita expenditure on medical scheme members[8] was R975 in 1990/91. If one assumes that this section of the population did not utilise any health services financed from public sources,

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8 The exact proportion of the population covered by the private sector and total private sector expenditure is still to be determined through a national expenditure review. Medical schemes are the major health care financers in the private sector, and a source of reliable data: they are thus used as a proxy to illustrate the private/public sector expenditure disparities in South Africa.

the per capita expenditure on the population reliant on the public sector was R256 in the same year.

3. OVERVIEW OF EQUITY CONSIDERATIONS IN HEALTH CARE PROVISION AND FINANCING IN SOUTH AFRICA

3.1 Disparities in the public/private mix

The data presented above indicate that the private sector has significantly more resources, particularly personnel and financial, than the public sector relative to the populations they serve. A key aspect of the public/private mix equity debate is the acceptability of current state subsidies to the private sector.

These subsidies essentially take two forms. Firstly, employers contribute between 50-100% of their employees' medical scheme subscriptions. As the employers' contributions are tax deductible, potential tax revenues are reduced. Secondly, the training of the vast majority of health personnel is heavily subsidised by the state[9]. Many of these health professionals move to the private sector immediately after graduation.

3.2 Geographical allocation of health care resources

In addition to the maldistribution of health care resources between the public and private sectors, there are also inequities in the distribution of resources within the public sector. Of particular concern is the geographical allocation of public sector health care resources.

A recent study (McIntyre 1994) evaluated the distribution of public sector health care expenditure in terms the provincial boundaries defined in the new *Constitution Bill* (1993). Figure 5 indicates how South Africa will now be divided into 9 provinces as opposed to the previous 4 provinces and 10 homelands (for comparison, see Figure 1).

Table 4 presents the estimates of per capita[10] public sector health care expenditure in South Africa for the year 1991/92.

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9 Some private hospital groups have recently begun training nursing staff.

10 Data are based on the 1991 Population Census. While it is known that there were undercounts in this census, particularly of the African population, this is the only available data source from which to estimate population size in the newly defined provinces. Other sources which adjust for the undercount are only expressed in terms of the old boundaries.

FIGURE 5: SOUTH AFRICA: NEW PROVINCES FOLLOWING THE 1993 CONSTITUTION BILL

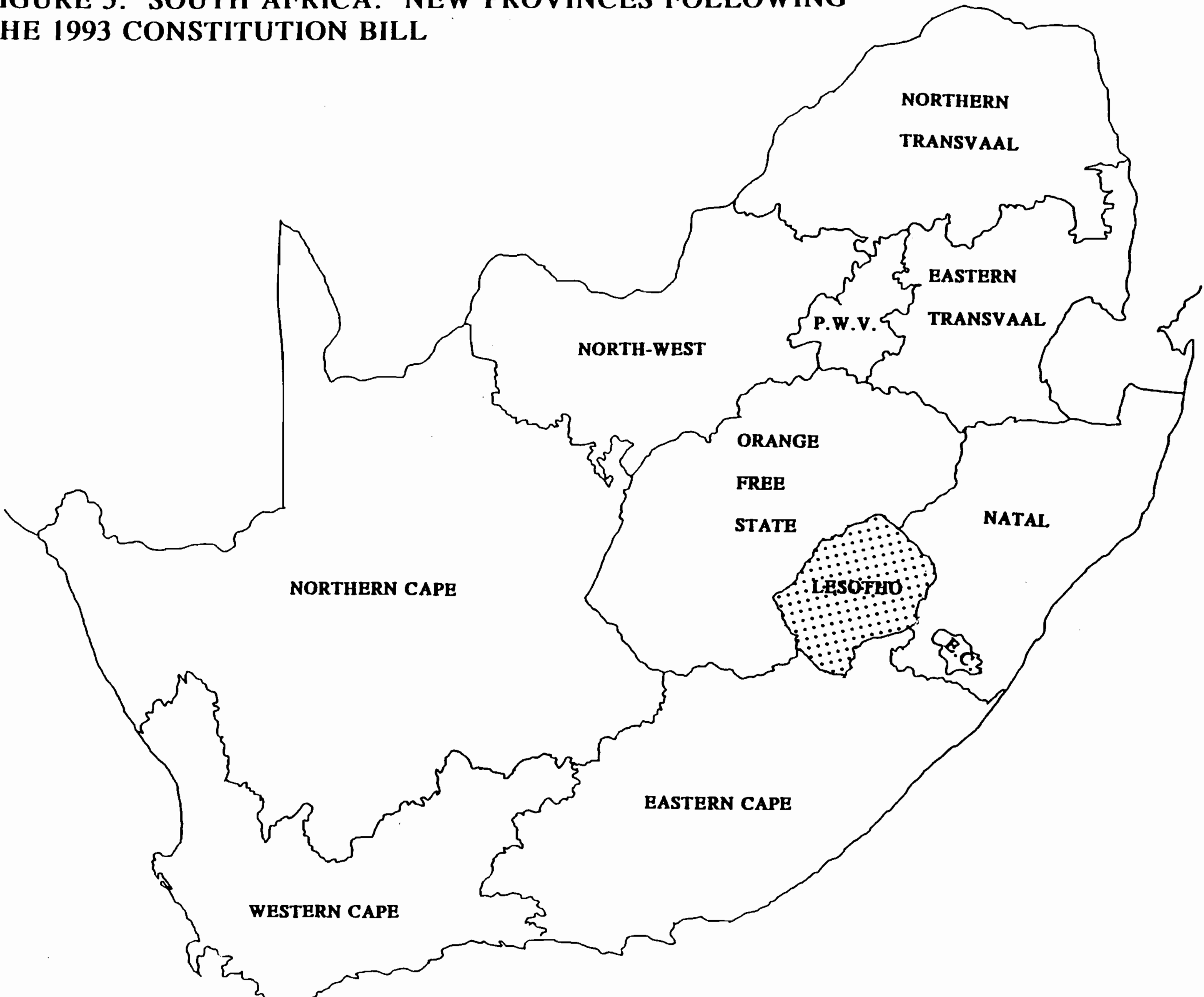


Table 4: Geographical distribution of per capita public sector health care expenditure in South Africa (1991/92)

Province	Per Capita Expenditure (1991/92)
Western Cape	R543.11
PWV	R459.22
Orange Free State	R298.50
Northern Cape	R293.65
Eastern Cape	R249.34
Natal	R234.88
North-West	R154.69
Northern Transvaal	R148.09
Eastern Transvaal	R142.75

With the exception of Natal, those provinces which contain "academic hospitals" (Western Cape, PWV and Orange Free State) have the highest per capita expenditures. Hospitals which are included in "academic complexes" often provide specialist services for a wider population than residents of the particular province in which they are based. For example, as the major hospital performing heart transplants, Groote Schuur serves the entire South African population, and occasionally neighbouring countries. In addition, these hospitals train health professionals who may work in other provinces once qualified. It is therefore useful to make regional comparisons after excluding expenditure on academic hospitals, as presented in Table 5.

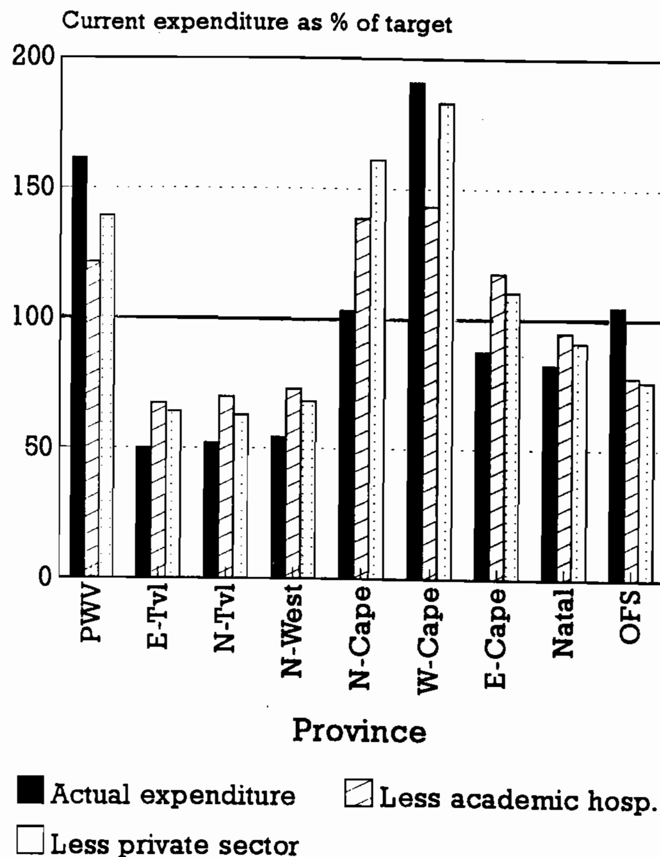
Table 5: Geographical distribution of per capita public sector health care expenditure, excluding expenditure on academic hospitals (1991/92)

Province	Per Capita Expenditure (1991/92)
Western Cape	R303.80
Northern Cape	R293.65
PWV	R257.38
Eastern Cape	R249.34
Natal	R201.29
Orange Free State	R165.17
North-West	R154.69
Northern Transvaal	R148.09
Eastern Transvaal	R142.75

Even with this exclusion, there are significant disparities between the different provinces. The possibility of reducing financial inequities through implementing a resource allocation formula similar to the English RAWP formula (DHSS 1976) has been debated in South Africa in recent years (McIntyre *et al* 1991; McIntyre 1994). While two alternative formulae have been suggested, there are significant difficulties in obtaining accurate data, particularly with regard to morbidity and mortality.

Cooper (1975) has noted that: "In the absence ... of any reliable or accepted indicator of need, per capita equality would appear a more rational goal that the perpetuation of historical chance". Figure 6 illustrates the distance between current expenditure and a hypothetical target expenditure based on equal expenditure per capita in each province. When a province's current allocation is equivalent to its target, the proportion will equal 100%. Proportions exceeding 100% indicate the extent to which a province's current allocation is above the various targets and similarly proportions below 100% indicate the extent to which a province is below target.

Figure 6: Distance from target expenditure



The three bars relate to: actual total current expenditure as a proportion of the target; total expenditure less expenditure on academic hospitals; and current expenditure excluding the academic hospitals at the same time adjusting the population to exclude those within the private sector. Given the size of the private health sector in South Africa (accounting for over 50% of expenditure and covering approximately 20% of the population), per capita public sector expenditure should be based on the population that is primarily reliant on the public sector for health services. This refinement has the effect of increasing the gap between current and target expenditures in those provinces with large metropolitan areas such as the Western Cape and the PWV[11] which tend to have the largest private sector components.

A future democratic government will be under pressure to reduce the disparities in geographical allocation of public sector health care resources. Two additional issues need to be taken into account in the South African redistribution process. Firstly, there are significant differences in the population density between provinces, which will have implications for the relative need for health care resources. For example, the Northern Cape has a population density of 4 people per km^2, and the Western Cape a density of 14 people per km^2, while Natal has a population density of 80 per km^2 and PWV a density of 290 per km^2.

Secondly, as South Africa is undergoing a process of rapid urbanisation, population migration patterns need to be anticipated and taken into account when determining targets. The Urban Foundation has estimated that the proportion of the african population living in metropolitan areas will increase from 35% (8.7 million) in 1985 to 49% (23.6 million) by the year 2010 (Urban Foundation 1990). While the total african population will have doubled in this time, the urban component will have increased by 255%. These migration patterns are likely to affect metropolitan areas in the PWV and Western Cape provinces in particular. If these movements are not taken into account, there is likely to be an excessive shifting of resources to areas where the population is decreasing and away from areas experiencing rapid population growth.

3.3 Racial inequities in access to health services

Another issue of concern in the health sector is that of racial inequities in the access to health services (see footnote number 1). Until the late-1980s, certain facilities were

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11 PWV = the province containing the Pretoria, Witwatersrand and Vereeniging metropolitan complexes.

reserved for the use of specified race groups. While health services are now theoretically open to all races, the historical development of health service infrastructure tended to favour residential areas which are predominantly white. Racial disparities in geographical access to health services thus remain.

In addition, there are financial barriers to access. User fees are charged at all public sector health care facilities, except for certain preventive and promotive services and curative care for infectious diseases. While these fees are income-related and certain patients can be exempted on the basis of means testing, there is growing anecdotal evidence that individuals are deterred from seeking care either because they are unaware of the exemption mechanisms or because of past experience of mistreatment by fees clerks. The indirect costs (such as for transportation) of seeking health care are also substantial for low-income families who tend to have poor geographical access to health services.

While there are disparities in income levels within race groups, income differentials between race groups are significant. It is likely, therefore, that financial barriers to health service access will affect certain groups more than others. The most recent data illustrates this: in 1983, the per capita annual disposable income was R6,242 for whites, R2,289 for asians, R1,630 for coloureds, R1,366 for africans in metropolitan areas and R388 for africans in homeland areas (Wilson and Ramphele 1989).

3.4 The distribution of ill-health

A recent study has highlighted the effect of the "racial" and geographical disparities in access to health services (Sayed *et al* 1994). This study examined the difference in Standardised Mortality Ratios (SMRs) between the various "race groups" in urban[12] and rural areas. The causes of death analysed were based on an abbreviated version of Rutstein's list of causes of death amenable to health care (Rutstein *et al* 1976). Table 6 summarises the major findings of this study. Unfortunately, accurate data are not available for africans living in rural areas.

The crude death rates, based on the list of selected conditions, were 36.41 for urban africans, 28.27 and 39.38 respectively for coloured urban and non-urban dwellers, whereas it was 7.73 and 7.49 for whites. Based on these findings, the researchers concluded that despite the rapid rate of urbanisation the backlog in rural health services provision should not be overlooked (Sayed *et al* 1994).

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12 Defined as areas with predominantly industrial and mining activities and having a population size greater than 30 000.

Table 6: Urban versus non-urban mortality for selected causes, amenable to health care, by race (South Africa, 1984-86)

	SMR, urban	SMR, Non-urban
Tuberculosis		
African	324.97	
Coloured	226.94	406.57
White	8.69	5.86
Cancer of the cervix		
African	247.64	
Coloured	202.24	306.95
White	35.50	36.59
Rheumatic heart disease		
African	140.43	
Coloured	162.40	197.39
White	53.02	46.18
Hypertensive disease		
African	186.32	
Coloured	160.30	207.74
White	45.42	44.54
Acute respiratory disease		
African	121.95	
Coloured	245.39	176.79
White	44.28	62.69
Pneumonia and bronchitis		
African	280.60	
Coloured	179.12	193.66
White	70.39	54.00
Asthma		
African	102.95	
Coloured	194.61	209.63
White	45.00	47.49
Abdominal hernia		
African	218.33	
Coloured	118.11	250.23
White	74.15	79.94

(Source: Sayed *et al* 1994)

As with other African countries, HIV/AIDS will have a major impact on patterns of morbidity and mortality in South Africa. A recent study predicted the spread of the HIV/AIDS epidemic based on an actuarial model (Doyle 1991). The results indicated that if there is no change in sexual behaviour, the epidemic will reach a plateau in about 2010, at which stage 27% of the adult population will be infected. Over 6.4 million people will have been infected with HIV by 2005 and nearly 2.6 million people will have died from AIDS related conditions. As South Africa currently has a relatively high population growth, the epidemic will have the effect of reducing the rate of population growth to 1.2% per annum.

If one assumes that there is a change in sexual behaviour once a significant number of people have died from AIDS, the epidemic curve will reach its plateau in 2005 when about 18% of the adult population will be affected. In this scenario, nearly 4.8 million people will have been infected with HIV by 2005 and more than 2.3 million people will have died from AIDS related conditions. The population would continue to grow at about 1.7% per annum.

3.5 Summary

A future democratic government in South Africa will be faced with demands to address the vast disparities in health status amongst its people. It will need to reduce the geographical and racial disparities in health service provision and address the financial barriers to obtaining health care for lower income groups.

4. OVERVIEW OF EFFICIENCY CONSIDERATIONS IN HEALTH CARE PROVISION AND FINANCING IN SOUTH AFRICA

4.1 Efficiency issues in the public health sector

As highlighted in the first section, a major source of inefficiency in the South African health system is the fragmentation and duplication of health service provision and administration in the public sector. For example, significant resources are being expended on maintaining 11 departments of health at the central government level (reduced from 14 departments in 1993), 4 provincial administration departments of health, and approximately 400 local authority health departments/offices.

This has resulted in a lack of coordination in overall health service planning and the duplication of service provision. There are, for example, hospitals in homelands only a few kilometres away from a provincial hospital, separated by an artificially created border.

Further fragmentation exists in the provision of preventive and curative care at the primary care level. A mother must take her child to a local government clinic for immunisations and other preventive services, but to the provincial day hospital or community health centre for curative care. These facilities are frequently a few blocks apart within the same suburb. Thus, many of the overhead and administration costs for primary care services are duplicated.

In addition, there are few incentives for personnel to contain costs or to allocate resources to patients on the basis of maximising health benefits. This is partially attributable to the lack of information on which clinicians can base decisions, as well as the perverse incentives inherent in historical budgeting. The incentive is to ensure that the entire current budget is expended to guarantee a similar budget allocation for the next year.

Inefficiencies in the public health sector also result from the relative maldistribution of personnel and facilities between different levels of care. As highlighted in section 2.1, there is a significant undersupply of primary level facilities and a relative oversupply at the tertiary level. This has resulted in inappropriate utilisation of tertiary institutions for services which could be provided at the primary level.

There are potential efficiency gains in the collection of user fees. At present, all fee revenue is effectively returned to the central treasury (as the relevant health budgets are reduced by the total expected fee revenue). There is no direct benefit to the facility collecting these fees nor to health services in general, and thus no incentive for collection.

4.2 Efficiency issues in the private health sector

The most serious problem confronting the private sector at present is the uncontrolled cost spiral. This is largely because financing occurs through a fee-for-service third party payer mechanism which creates perverse incentives for both the consumer and the provider. As the consumer faces a zero cost (or relatively low cost if there is a small co-payment), there is the incentive to consume more health services than if the consumer/patient had purchased the service directly. This phenomenon of "moral hazard" is particularly evident in the light of the high, and rapidly increasing, contributions required from medical scheme members at present.

From the provider's perspective, this financing mechanism promotes "supplier-induced demand". A recent South African study compared utilisation of health services in a fee-for-service third party payer medical aid scheme with that in a health maintenance

organisation (HMO) which employed salaried staff. The authors found that medical aid scheme patients visited their doctors 33% more often than their HMO counterparts. Doctors looking after medical aid scheme beneficiaries ordered 133% more radiological procedures and 14% more pathological investigations than those caring for HMO beneficiaries (Broomberg and Price 1990). In addition, primigravid women aged 20-35 years were 50% more likely to have a caesarean section if they were members of a fee-for-service medical aid scheme than if they delivered in a public sector hospital (Price and Broomberg 1990).

These factors have resulted in a significant cost spiral in the medical aid scheme sector. The schemes initially responded to the rapid increase in expenditure, particularly on private hospitals and medicines, by increasing contribution rates. Medical scheme members have faced average annual subscription increases in excess of 23% between 1978 and 1988 (Broomberg *et al* 1990). However, in recent years, benefit payouts have increased more rapidly than subscriptions: they increased by 30.5% between 1988/89 and 1989/90 when subscriptions increased by 25.6%. Between 1989/90 and 1990/91, the increases were 34.6% and 30.7% respectively (McIntyre 1993).

This trend has been met with increased co-payments and the imposition of stricter limits on reimbursements for health services. The Representative Association of Medical Schemes (RAMS) scale of benefits has not increased at the same rate as the charges which the Medical Association of South Africa (MASA) recommends to its members. By 1990, the "MASA price list" was approximately twice that of RAMS, i.e. providers were charging approximately twice what the medical schemes are prepared to pay (Medscheme 1991).

As noted in section 2.3.2, the major areas of rapid increase in expenditure are medicines and private hospitals. Given the low consultation fee which medical schemes cover (relative to the MASA recommendation) and given that there are usually significant bad debts on the co-payment portion of accounts, many general practitioners are starting to dispense pharmaceutical products. In 1990, it was estimated that more than 30% of general practitioners were "dispensing doctors". (Centre for Health Policy 1990) While this is often beneficial for patients, e.g. in "townships" or in rural areas where pharmacies are not readily accessible, further perverse incentives are created where doctors can profit from selling medicines. As the prescription decisions rest entirely with the doctor, the profit motive will result in "supplier-induced demand" for pharmaceutical products.

The increase in expenditure on private hospitals is mirrored by the growth of the private hospital industry (see section 2.3.2 for details). There has been an associated growth in advanced technology within private hospitals, e.g. MRI scanners, purportedly to attract the best specialists. These factors have also contributed to the phenomenon of supplier-induced demand.

Another important factor underlying the crisis in medical schemes is the so-called "actuarial deficit". Medical aid schemes are essentially mutual funds which are based on the principle of cross-subsidisation. This takes two forms: higher income earners subsidise lower income earners; and medical schemes operate on a cash-flow basis with low-claiming members subsidising high-claiming members. The assumption was that there would always be sufficient numbers of high-contributing, lower-claiming ordinary members to cross-subsidise low-contributing, higher-claiming members such as pensioners and widows.

With the rapid escalation in medical scheme subscriptions, the healthy, wealthy members have left the medical schemes. Instead, they have elected to pay out-of-pocket for their infrequent visits to independent practitioners and taken out catastrophic cover with insurance companies to cover hospitalisation costs and medical expenses associated with "dread diseases". The medical insurance industry, although relatively new in South Africa, has been highly successful in "cream skimming".

In response to this actuarial deficit the medical scheme industry has been forced to consider the possibility of moving towards the pre-funding of medical scheme benefits for retired persons (Fourie 1993).

The combined effects of the above factors, has been that the medical scheme industry has had little success in containing the cost spiral. The recent changes in the Medical Schemes Act which attempt to respond to this crisis, and the increasing interest in the possibility of a National Health Insurance scheme are discussed later.

5. OPTIONS FOR THE TRANSFORMATION OF THE SOUTH AFRICAN HEALTH SYSTEM

5.1 Proposed changes to public sector health service provision

The focus in this section is on the National Health Plan recently unveiled by the African National Congress (ANC) (African National Congress 1994). The reason for this focus is

two-fold: firstly, it is widely recognised that the ANC will be the major rôle-player in the future Government of National Unity; and secondly, the ANC is the only political party to have released a detailed health policy document. The ANC is essentially proposing to unify the currently fragmented public health sector into a National Health Service (NHS). The structure of the NHS as proposed by the ANC is summarised below.

In line with international thought and practise in implementing the PHC approach, the strengthening of community services through the development of a District Health System will be central to the restructured NHS. Key elements of this NHS will be:

* the integration of all existing public sector health services, including local authority, homeland, military and prison services, into a single health authority;
* the formation of health structures at the community, district, provincial and national levels; and
* decentralisation of decision-making and control of funds to the lowest possible level compatible with rational planning and the maintenance of good quality care, and in keeping with centrally determined norms and standards.

The backbone of the NHS will be Community Health Centres (CHCs) which will provide comprehensive services including promotive, preventive, curative and rehabilitative care. Each CHC will be responsible for health in its catchment area and, depending on need and resources, will run fixed clinics and send staff to visit health posts in the surrounding areas.

The CHC team will include a full range of health workers. Casualty and maternity services will be available 24 hours a day and other services will include mother and child health care, treatment for minor trauma and locally prevalent diseases, nutrition rehabilitation and support programmes, oral health care, the follow-up treatment and rehabilitation of people with chronic disorders or disabilities, counselling and mental health services, and primary welfare care.

Community Health Workers can play an important role in expanding and improving health services, but their principal role lies in being catalysts for community development.

As previously indicated, the development of health districts will be crucial to the transformation of health care and the decentralised management of the proposed NHS. The country will be divided into about 100 health districts with between 200,000 to 750,000 people per district. Wherever possible, these districts will be coterminous with local authority boundaries. All community level services will fall under a District Health Authority from which they will receive substantial material and logistical support.

Community or District hospitals will be an important component of district health care. They will work closely with the Community Health Centres, and provide in-patient care close to where people live. They will be staffed by a team of full-time workers and will be visited regularly by specialists from the provincial/specialist hospital with which they are linked.

Most specialist hospitals will fall under the Provincial Health Authority. In addition to their role in providing specialist patient care, these hospitals will support primary level health workers through ensuring efficient referral and consultation systems. They will also support and conduct relevant research, and play a significant role in both basic and continuing education and training of all types of health workers.

The National Health Authority will have overall responsibility for the development and provision of health care in South Africa. It will be responsible for policy formulation and strategic planning, as well as the coordination of the operational planning and functions of the overall health system. It will also develop guidelines, norms and standards to apply throughout the health system at all levels. The NHA will allocate the national health budget to the Health Authorities at the provincial (and possibly the district) level. Responsibility for decisions concerning these resources will be decentralised as far as possible, with the important proviso that any decisions that affect the system as a whole must be coordinated at the central level. For example, unilateral decisions by provinces regarding the establishment of advanced treatment facilities, or the biased allocation of resources between levels of service provision, will be proscribed.

Special mention should be made of the place of academic hospitals. While they are regarded as national resources, and are therefore accountable to the NHA, it is proposed that they should be fully integrated into provincial health services in terms of their service role at the tertiary level.

It is not possible to go into much more detail about the structure and functions of the proposed NHS in this paper. It is anticipated that the new structure will result in less bureaucracy than at present, and that it will allow for greater coordination and rational planning on the one hand, whilst encouraging decentralisation of decision-making and responsibility for resources to the lowest possible level on the other.

A further important feature is that the NHS will incorporate mechanisms for the participation of the communities served by it, as well as for participation by private sector

and NGO service providers. The mechanisms for community participation are based on the principles of participatory democracy, allowing communities to elect representatives onto local community health committees. These committees will be represented at all levels of the NHS. In addition, principles of electoral democracy will apply, such as representation from local government structures on the District Health Authority. NGOs and the private sector will be represented at each level on Advisory Bodies to the relevant Health Authorities. In this way, it is ensured that all key stake-holders will have a voice in the restructured NHS.

5.2 Inter-relationship of public and private sectors in providing health care

It is useful to briefly consider the ANC's vision of the role of the private sector. The ANC has stated that it is committed to a mixed economy and that the provision of health care by the private sector will continue to be acknowledged and regulated. Active cooperation between the private and public sectors will be encouraged, with the common goal of improving the health of the nation.

However, a priority will be the strengthening of public sector health services, and in the longer term, the ANC envisages most health care being provided within the public sector. To this end, it will be necessary to create incentives to encourage those health workers who have chosen private practice to return to the public sector. The emphasis will thus be on improving conditions of service and career development structures within the public sector. In addition, private practitioners will be encouraged to work in public clinics, health centres and hospitals on a regular rotational basis.

As the long-term goal will be for most health services to be provided by the public sector, the expansion of the private health sector will be discouraged, and tighter regulations will be applied to the licensing of facilities, practices and equipment. In addition, state subsidies to the private sector will be gradually reduced.

The ANC notes that these proposals are only in the form of broad guidelines at this stage, and that details of how the private sector can play a complementary role to the public sector must be determined in consultation with private sector representatives.

5.3 Financing of public sector health services

As outlined previously, the emphasis will be on gradually building on the existing public sector health service infrastructure, particularly in terms of extending the provision of health care at the primary level and improving conditions of service for public sector health personnel. Given the competing claims on the limited resources that will be

available to the Government of National Unity, it is anticipated that the health budget will not exceed the current level of 11-12 percent of the total budget.

The development of public sector health services will thus have to occur gradually, and clear targets have been set for the next few years which the ANC feels are economically feasible. These developments will clearly require additional resources which can be derived from a number of sources.

Firstly, although the proportion of the total budget devoted to health may not increase, the absolute amount would increase in real terms with time, as the economy and tax revenue grows.

Secondly, the ANC Health Department is recommending significant increases in the excise on tobacco and alcohol products. These resources should be made available for the development of primary health care activities in their broadest sense. It is anticipated that substantial revenue can be derived from this source; with the current levels of excise on tobacco and alcohol products (which are low by international standards), revenue of over 3 billion Rand is generated annually.

It is useful to comment on the proposed increase in excise on these products in more detail. While they are raised in the context of a potential source of revenue for health service provision, the ANC states that the primary motivation for these increases relates to the public health implications of the use and abuse of tobacco and alcohol products.

The adverse health effects arising from consumption of these products have been clearly documented internationally. The single most effective policy to reduce consumption, and hence to improve the health status of the population, is through significant price increases.

There is some concern that excise on these products is a regressive tax, as these products are increasingly being consumed by lower income groups in South Africa. The ANC, however, questions whether it is not more important to address the regressivity of the effects on health status, as it is these lower income groups who will bear the consequences in terms of morbidity and mortality.

The final potential source of increased funding for public sector health care services is that of increased user fees for patients who are covered by some form of health insurance (whether this is through the current medical schemes and medical insurance, or through a National Health Insurance). Many public sector in-patient health facilities are presently

underutilised. The current government policy is to refuse access to public sector facilities by "private patients" apart from exceptional circumstances. It is proposed that patients who are covered by health insurance should be encouraged to use public sector facilities. They would be charged fees that are lower than that of private hospitals, but are nearer to cost-recovery levels than at present. It is acknowledged that the level of utilisation by these patients must be monitored to ensure that patients who are dependent on the state for these services are not "pushed out" of the NHS. It is anticipated that significant additional resources can be generated in this way. Anecdotal evidence of recent experiments in income generation for public sector personnel in academic hospitals support this assumption: current recoveries of approximately R3.5 million per annum are being obtained at some academic hospitals.

It is projected that the current proportion of the total government budget funded from general tax revenue, supplemented by increased excise revenues from tobacco and alcohol products, and increased user fee revenues will permit the future government to maintain the current levels of public sector health service provision, and to develop additional service infrastructure, particularly at the primary care level.

The restructured NHS will provide the same health service package that the current public sector health service provides, with possible rationalisation of certain facilities and services. In addition, all countries are faced with the necessity to "ration" certain health services (particularly at the tertiary level) when faced with limited resources. This will need to be investigated in terms of generally accepted international criteria, as well as in consultation with relevant stake-holders.

A further aspect of the ANC's National Health Plan which relates to the financing of public sector health services is the commitment to the provision of certain forms of health care free at the point of service. This includes: preventive and promotive activities including immunisation and certain screening activities; school health services; ante-natal and delivery services; contraceptive services; nutrition support; and curative care for public health problems including TB and STDs. In addition, certain patient groups will receive free health care, including children under six, pregnant and nursing mothers, the elderly, the disabled and chronically ill (e.g. those with diabetes mellitus and hypertension).

While many of these services are currently provided free of charge, the intention is to broaden their scope to ensure that the most vulnerable groups in society have free access to the health care that they need.

5.4 Discussion of the ANC proposals in the light of current inequities and inefficiencies

It is unlikely that inequities in the public/private mix will be substantially addressed in the short term. A two tier system, with relatively more resources being expended on those receiving services in the private sector, will continue to exist for the foreseeable future. The ANC health department is, however, seriously considering removing the current subsidies on the private sector.

It is currently evaluating the implications of removing tax concessions for medical aid contributions, which would be in line with international experience. The World Bank recommends the removal of such subsidies in its recent World Development Report (World Bank 1993).

Various options are being considered to address the state subsidy on health personnel training. One proposal that has been put forward is that students at tertiary education institutions should be charged the full costs for their education (crude estimates are that medical students currently only cover one tenth of their education costs). These students would then all be offered a full bursary/loan from the state to ensure that candidates from disadvantaged backgrounds are not excluded on financial grounds. Graduates would have the option of working in the public sector for a specified time period or of working elsewhere and repaying the loan. This scheme could also be used to redress the geographical maldistribution of health personnel, e.g. a shorter period of "state bonding" if a graduate works in a rural area.

In its National Health Plan, the ANC has made a commitment to redressing geographical inequities in the distribution of public sector health care resources. The mechanisms for this would be very similar to that outlined in section 3.2. Given the size of the gap between current budgetary allocations and the "equity targets", this redistribution process will occur slowly so as not to jeopardise existing health service infrastructure.

In the last few years, the current government has attempted to shift resources on a geographical basis and has met with significant opposition. One of the key factors has been a lack of consultation with those who would be most significantly affected. These authorities have indicated that they were not given adequate fore-warning of budget decreases and were not given adequate opportunity to express their needs and requirements. In order to overcome similar opposition in the future, a democratic government will need to ensure transparency in their resource allocation deliberations and

engage each of the relevant rôle players in extensive negotiations to elicit support or, at least, to minimise opposition.

The ANC's policy towards user fees is still under review. The current recommendations that key target groups receive free care and that certain services are provided free of charge will address some of the financial barriers to access currently experienced. There is, though, still heated debate about whether or not all public sector primary level services should be provided free at the point of service.

With regard to the racial inequities, there is likely to be a concerted effort on behalf of the new government to address any discrimination in the provision of services. However, much of the public service will remain unchanged in the short term and will continue to reflect aspects of the "apartheid mindset". Vestiges of preferential treatment for certain race groups at the expense of others are likely to continue. There is substantial anecdotal evidence of this occurring after health services were theoretically opened to all groups in the late 1980's.

The intransigence and obstruction of the current health bureaucracy will also have implications for the successful implementation of reconstruction proposals. The obvious analogy is that of Eastern Europe where bureaucrats have covertly, but successfully, strangled restructuring initiatives.

The ANC proposals for restructuring public sector health services will reduce certain of the inefficiencies outlined in section 4.1. As the key component of the restructured NHS will be Community Health Centres which will provide comprehensive health services, the fragmentation and duplication of administration, and provision of preventive and curative services will be removed.

In addition, fragmentation between different health departments will be reduced as there will be a unitary health department with provincial and district authorities. However, some of these potential efficiency gains will be dependent on the final constitutional framework. At present, the constitution has significant elements of federalism and allows for "concurrent" powers for health legislation at the central and provincial government levels. The extent to which the central health department can set the policy framework, national norms and standards and determine the structure of provincial health departments, will influence the extent to which efficiency gains materialise.

It is most unlikely that the new provincial structure will lead to additional bureaucracy as the necessary infrastructure already exists, and may even be excessive.

However, there are four potential areas of expenditure increase inherent in the ANC's plan. Firstly, it is likely that there will be increased administrative expenditure during the transition period, i.e. there may be some duplication of expenditure as new structures are put in place and before the old structures are dismantled. This is unavoidable in any major health sector restructuring and there is agreement amongst all key rôle players that such restructuring should occur. Secondly, the ANC, as the likely major party in the Government of National Unity, will want to appoint certain of its members with experience in health management to a number of key positions. The ANC has already given an undertaking that civil servants will not be retrenched, and there is thus likely to be additional expenditure involved in this "reshuffle".

A third area of expenditure increase associated with the integration of public sector health services into a unified health department is the cost of equalising conditions of service. At present, personnel in the local authorities receive salary packages which can be approximately 40% higher than those for personnel in the provincial, national and homelands health departments. Alternative mechanisms for addressing these disparities are currently being researched, as it is anticipated that this cost of integration will be substantial.

The final area of expected expenditure increase relates to the ANC's commitment to improving conditions of service within the public health sector. The stated objective is to attempt to reverse the brain drain of many medical professionals to the private sector. A major concern in this regard is that the ANC plan does not clearly outline options for "capping" private sector incomes. In the absence of such limits, the costs of attempting to address the public/ private income differential will be substantial.

An area where the ANC proposals could potentially result in efficiency gains is that of user fees. The National Health Plan makes provision for a proportion of fee revenue to be retained by the facility collecting the fees. The rest would be redistributed via the central or provincial health department to other facilities. This would also fulfil certain equity objectives as facilities in lower-income areas are likely to be currently under-resourced and the least likely to raise significant fee revenue.

There are two particular issues which are not yet sufficiently addressed in the ANC plan. First is the issue of providing incentives for cost-effective and efficient utilisation of

resources. There will be improvements in efficiency with the decentralisation of decision-making and resource utilisation to the lowest appropriate level. However, there are no specific proposals on methods to provide incentives for personnel to contain costs and to allocate resources to patients on the basis of maximising health benefits.

The second omission is the lack of a clear statement of intent relating to the future of academic hospitals. Many rôle players have expressed concern about the substantial proportion of the health care budget currently devoted to teaching hospitals (nearly a third of total public sector health expenditure, and 46% of expenditure on public sector hospitals). However, none of these groups has undertaken a rigorous analysis of the future health personnel requirements and the number of academic complexes (medical schools and associated hospitals) that will be necessary to meet future personnel training needs. It seems likely that some degree of rationalisation of academic complexes will be required but this has not, at the time of writing, been adequately addressed.

5.5 Proposed changes to private sector health service provision and financing

5.5.1 The Medical Schemes Amendment Act

In the early 1990's, the medical scheme industry approached the current government with requests to amend the Medical Schemes Act in an attempt to alleviate their financial difficulties. It is not possible to provide a full commentary on the Medical Schemes Amendment Act (1993), which was implemented on 1 January 1994, but a few important aspects are worth mentioning.

Firstly, the proposed changes will allow medical schemes to compete with medical insurers by permitting them to offer diversified packages, and to underwrite and re-insure in order to provide additional cover for their members.

Secondly, the Act allows medical schemes to provide health services in addition to their present financing functions. This will facilitate the introduction of more Health Maintenance Organisations and other forms of Managed Health Care (MHC). MHC options range from schemes in which the financer negotiates lower unit costs or capitation fees with a group of providers (who are selected partly on the basis of their prescribing and referral practises) to schemes which employ their own multidisciplinary teams to provide a specified package of services to members. The primary objective of all MHC options is to achieve better cost containment by changing the perverse incentives of unregulated fee-for-service third party payments.

The amendments will also allow schemes greater "risk-rating" powers. Potential members can now be excluded on grounds of pre-existing conditions and contributions will be more directly linked to individual risk profiles.

A number of concerns have been raised since the implementation of this Act. From the schemes' perspective, a major concern is the detrimental effect of removing gender discrimination. Women can now be the principal member of a scheme with their spouse and children reflected as dependents. Women tend to be in lower income categories and as contributions are income related, contributions for family units will tend to be lower when a woman is the principal member.

From the consumer's perspective, there are grave concerns about the confusing array of benefits packages being marketed. Since the implementation of the Act in early January of this year, there has been a proliferation of new "health care products". Consumer groups have indicated that inadequate information is being provided on which to select between the alternatives on offer. It is becoming increasingly difficult to distinguish between the finer details of different schemes.

This fragmentation of private sector health care financing is also of concern to groups such as RAMS, who are finding it increasingly difficult to coordinate and monitor these developments so as to adequately protect the interests of the public.

There is substantial debate about whether the amendments will in fact adequately address the medical schemes crisis. Some groups argue that the move towards the implementation of managed care principles will strengthen the schemes' capacity to contain costs. For example, if a health service provider charged a scheme member the tariff agreed upon with RAMS, there was direct, guaranteed payment by the relevant scheme to the provider. The amendments abolish this payment system thus allowing the schemes to review utilisation and provision for "appropriateness" and to refuse payment in certain circumstances.

However, the international evidence on MHC is not encouraging. While there appears to be a once-off cost reduction when moving to MHC options, largely resulting from reduced hospitalisation, costs have been shown to increase at the same *rate* within MHC and traditional health care insurance options thereafter (Newhouse 1993). The most significant cost reductions have been experienced in "staff model HMOs" as opposed to Preferred Provider Organisations (PPOs) or Independent Practitioner Associations (IPAs). As the model which is growing the most rapidly in South Africa is that of IPAs, cost-containment efforts may not be as successful as anticipated.

A further concern relates to the extent to which the amendments will affect coverage of the population. With increased risk-rating, the elderly and chronically ill are likely to be excluded from schemes, and become the responsibility of the state sector. Although, in contrast, if cost-containment efforts are successful and contribution levels can be reduced, private medical cover may become more affordable for lower-income groups. However, extension of this coverage is likely to be marginal at best and likely to occur very slowly.

In summary, while the medical schemes were the instigators and chief architects of the recent legislative amendments, there are growing concerns that these changes will not adequately address the financial crisis of the schemes. Increasingly, many of the relevant rôle players are looking at alternative solutions.

5.5.2 A National Health Insurance System

Many key health sector stake holders in South Africa have stated that they are considering the possibility of a National or Social Health Insurance. The ANC makes a brief reference to this topic in its National Health Plan (ANC 1994). The plan states that "It is recommended that a Commission of Enquiry be appointed by the Government of National Unity as a matter of urgency, to look at the current crisis in the medical aid sector and to consider alternatives such as a compulsory social insurance system for all formal sector employees and their dependents. The commission would consult all interested parties, including employer, labour, professional, medical aid, and health insurance organisations".

It is useful to consider some of the thinking behind this proposal. The ANC has indicated that it is unconvinced that the Medical Schemes Amendment Act will resolve the crisis in the medical schemes adequately. A number of groups have suggested that a National Health Insurance may be a solution to some of the current difficulties faced by the medical schemes. The ANC feels that there are a number of unanswered questions about such a system, for example, the revenue that it would generate and the basic package of care that could be covered from these funds. Most importantly, the ANC has stated that it feels that this is not an option which one group should be evaluating in isolation. There are many who would be affected by this proposal and they should all be actively involved in these deliberations.

If after such an evaluation it is decided that a National Health Insurance (NHI) should be instituted in South Africa, it is likely that the NHI will initially cover only formal sector employees and their dependents. It could gradually be extended to other groups, as is the international trend. An NHI could be structured in a number of different ways: e.g. there

could be a single NHI with other groups merely offering "top-up" insurance to cover those services not included in the basic package; or the current medical schemes and insurers could continue to be the financial intermediaries, with some pooling of resources and redistribution in terms of relative risk profiles, along the lines of the German model.

The state is likely to play an influential role in such an NHI in terms of enabling and regulatory legislation. This would necessitate the following legislation:
1)Compulsory membership for all formal sector employees;
2)Contributions to be based on community risk profiles and to be income-related;
3)Any exclusion of "high-risk" members to be illegal;
4)Specification of the minimum service package that each scheme must cover; and
5)Provision for the pooling of risk if current medical schemes form the basis of the NHI.

To date there has been very little specific debate about the components of the "essential package of care". However, it seems likely to include relatively comprehensive care at the primary level and certain hospitalisation costs in public sector hospitals. Members will need "top-up insurance" or will have to make out-of-pocket payments if they wish to use private for-profit hospitals.

There has also been minimal debate about when an NHI could be implemented. The ANC has proposed that the Commission should be established by July/August of this year. Given that there are substantive issues relating to the NHI option that have not been researched and that extensive consultation should occur, the ANC proposed that the Commission should report within a year. There has been pressure from various quarters to speed up this process. For example RAMS, in a critique of the ANC's health plan, recommended that an essential package of services be researched and negotiated with providers during March 1994. They further recommend that a "pilot" NHI in which the existing "... medical schemes will be used to fund and administer a basic/essential package for all in formal employment" should be implemented on a "voluntary basis" by 15 April 1994, i.e. two weeks before the new Government of National Unity is elected. (Magennis 1994)

International experience has indicated that implementation of an NHI could take 5-10 years (Personal communication: Professor Alan Maynard). Haste will not only cause cost inflation but will result in inadequate consultation with those who would be most seriously affected by these developments. There would be particular concern about exacerbating the current emigration of health professionals if private sector providers feel unduly threatened or undermined by an NHI.

As the ANC has made a commitment to extensive consultation and "transparency" in its decision-making, it is unlikely that an NHI will be adopted until its feasibility and acceptability has been fully researched.

6. SUMMARY AND CONCLUSIONS

A future democratic government in South Africa will inherit a health care system that is fragmented, beset with inefficiencies and highly inequitable. It will be under substantial pressure to act decisively to redress these inequities and to be seen to be making an impact on the health status of previously disadvantaged groups. This will have to be achieved largely within the constraints of the existing health budget and with covert opposition from some "apartheid mindset" bureaucrats who will remain within the civil service for the foreseeable future. Additional resources may be raised from increased excise on tobacco and alcohol, and higher user fees at public sector hospitals for those covered by some form of medical insurance.

The public health sector is likely to be restructured into a unitary health department with provincial and district health authorities. There will be significant decentralisation of decision-making relating to service provision and resource allocation. The emphasis will be on developing additional primary level service infrastructure, particularly in those areas which have been historically under-resourced.

With regard to the private sector, it seems likely that a Social or National Health Insurance will be the financing mechanism within the near future. Certain independent practitioners, particularly general medical and dental practitioners, are unlikely to be adversely affected by this development. However, the livelihood of specialists working in the private sector may be more precarious, depending on the services covered in the "essential benefits package". The private for-profit hospitals are likely to be entirely dependent on "top-up insurance" beneficiaries, as it is likely that only public sector hospitalisation costs will be included in such a package.

Although the African National Congress has produced a draft National Health Plan, there is a need to secure the support of other key stake-holders to facilitate its implementation. In addition, urgent attention should be given to more substantive planning to address some of the worst inequities and inefficiencies in the current health system. There are unlikely to be any easy or short-term solutions, but there is substantial good will amongst the people of South Africa. If the political will to achieve a just and equitable health system is sustained, there is every chance of success.

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