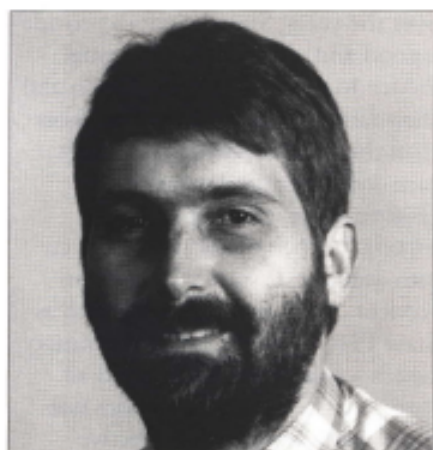


Managed Health Care based on the Relationship between People and their Health Professionals — Dr Neil Heard



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Neil Heard qualified as a medical practitioner in 1981. He spent about 10 years in various African state services, working in surgery, obstetrics, community health and paediatrics. Dr Heard is currently a General Practitioner in Claremont, Cape. He is also a participant in, and originator of a direct contracting managed primary care network, that uses a point of service (POS) format to facilitate patient choice. He is interested in the achievement of health for all and the functional integration of health services to this end.

Summary

This article is intended to help evoke more focused management in private primary care, in a changing economic environment. It is intended for private general practitioners, but may be of interest to anyone who is involved in the delivery of health services.

Context:

Change in the Health Budget

Change in Tax

Change in GDP

Change in Medical Aid Membership

Overall effect in financing care

Pathways for primary care

Pathways for total care

Synergy of these with PHC based policy.

Certain well-documented macro-economic trends have put financial pressure on South African Health services. These are described in this article. The poor growth potential for State primary care and National Health Insurance (NHI) is presented. The decline in conventional medical aids and the impact on general practice of independent practitioner associations (IPAs) and other bodies which are linked to declining systems, is discussed. New options for private care are discussed with some of their experiences. The integration of these options with PHC based policy is presented.

S Afr Fam Pract 1993; 14:449-56

KEYWORDS

Primary Health Care;
Changing Economic System;
Patient Participation.

'South Africa does not have a health service ... but it does have a complex and developed medical service'.¹ This could apply to any country in the world, whose 'health' services are determined by a medical or treatment model. Things are changing however, and the change is being fuelled by financial constraints and a changing National and premeditated New World Economic Order,⁶ setting social justice as the priority.

Funds available for State Health Services have decreased

The State health service is funded by the health budget, which is raised from taxes. Figure 1 shows what has happened to the South African health budget from 1985 until 1993. Actual spending has not changed much,^{2,5,30} but the real amount spent has decreased significantly, due to the flight of capital from South Africa in the 1980s, causing a 50% depreciation in the value of the Rand,³ and to inflation causing a 10% to 15% annual decrease in the real value of the Rand. Thus, in 1993, the fund available for State health services is about 1/2 of what it was in 1985 (Figure 2). Severe cuts in health service delivery, such as curtailed services, point of service charges, semi-privatisation, and cut-backs on staff privileges have happened. Some relief has come from integration of services, and the huge growth in the work of non-governmental organisations (Figure 3)⁴. Expenditure on primary health care (PHC) of which primary care is a small part has remained at 5% of the health budget.² The tiny State expenditure on primary care, has

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decreased over the years, despite an increase in demand through population growth, increasing unemployment, and a changing official theoretical approach to care based on PHC. Expenditure on State hospital services and administration which is 95% of the health budget,² has declined by about 50% in real terms, since 1985. It is therefore difficult to pay for more primary care from the hospital budget. If anything, State tertiary care (hospitals) needs to be expanded to cover rural and lesser urban areas more effectively.⁹

Medical Aid mediated private care is stagnant

Private medical aid membership is increasing by 0,9% pa,¹⁴ but when

corrected from population growth, there is a net decrease of about 2% pa in the percentage of the South African population who are served by the private sector (Figure 4).

A macro-economic view of hospital services (Figure 7) is taken from data about the private and public services.^{2,8,10} Private hospitals appear to be nearly 3 times less cost effective on a population basis than State facilities. There is a need to evaluate the financial management of private hospitals if they are to become a community resource. Private hospitals appear to be a wasteful resource for a cash strapped economy. The given State bed cost per day is comprehensive, and the private fee is for the bed only. Despite the huge fall in their funding

over the years, State hospitals provide a good and cost effective essential service to most of the population and their funding cannot be cut by more than the natural attrition. Primary care data from the same sources, (Figure 8) reveals disparity, especially when medication is taken into account. Private primary care services cost 3 to 5 times as much as State PHC services, of which primary care is a small part. The quality of care is not equal, and this does not only reflect a more cost effective State service, because State primary care is poor and, through no fault of the service providers, it is undignified, because of long queues, bureaucratic procedures, inadequate facilities, lack of privacy, and inconsistent care.

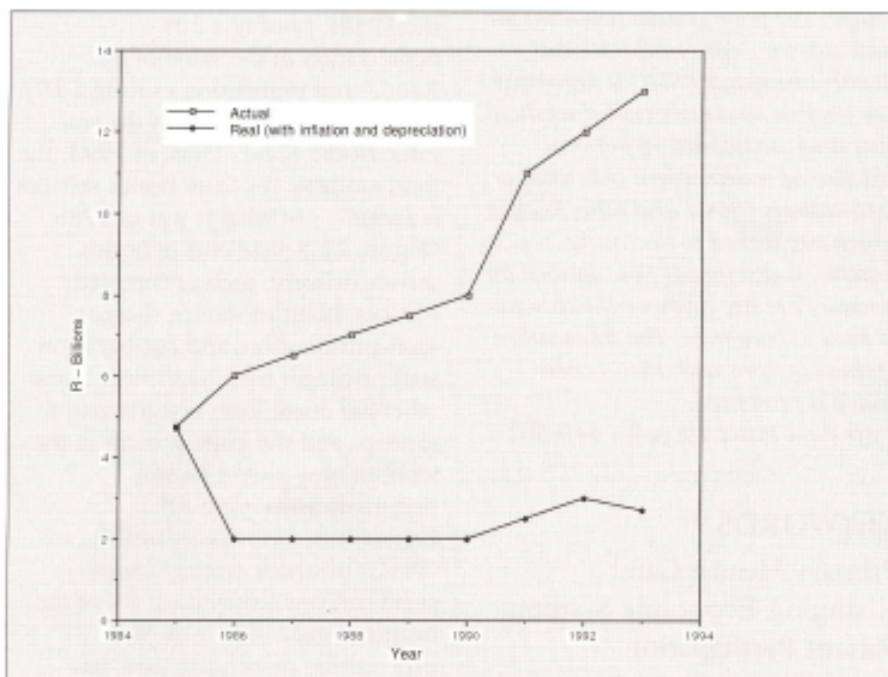
The economic problems facing the health service are:

- 1) Per capita GDP in South Africa is decreasing.
- 2) The State health service is diminishing.
- 3) The private health service is diminishing.
- 4) The population is growing.
- 5) Tax is increasing.

Therefore the current care paradigm cannot be pursued further. State health care cannot be improved, because funding has crashed, and attempts to redistribute it are not viable. The formulation of a new paradigm requires an improvement in private care, which must fulfil the following requirements:

- 1) It must be cheaper by far (70 to 90% less than present costs).

Figure 1. Changes in the South African Health Budget 1985-1993.^{2,5,30}



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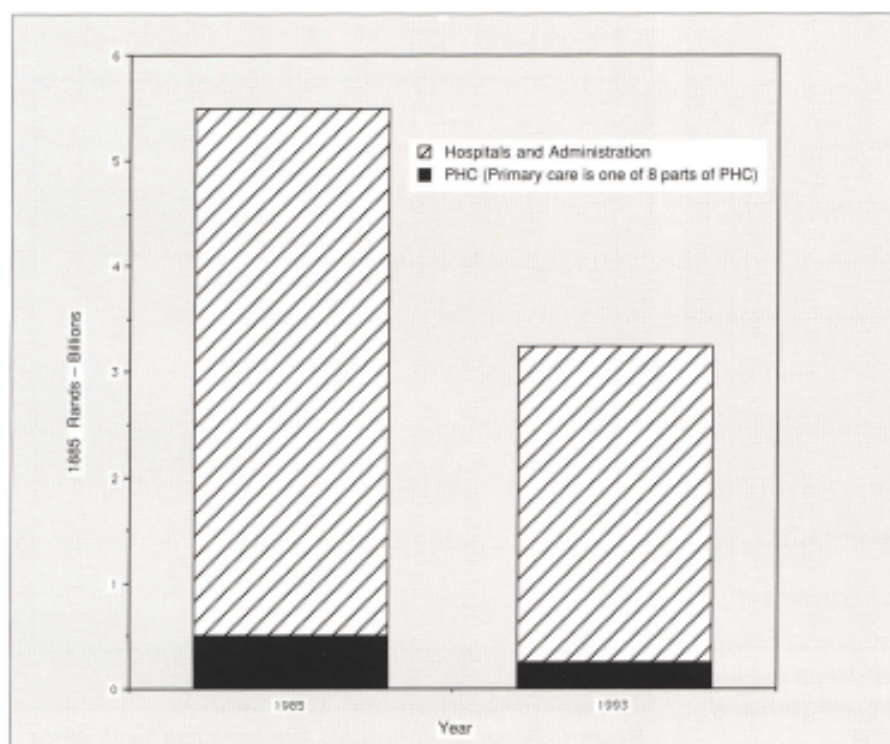


Figure 2. The Health Budget

- 2) It must be equitable and dignified.
- 3) It must have a vested interest in health, and as such it must be synergistic with current and future PHC based health policy, and current State services.

These requirements are substantiated by review of South African demographic facts. At least fifteen percent of the population is unemployed.¹⁵ They cannot access unsubsidised private services. According to Cosatu, quoting Cornell (UCT), ninety two percent of the employed population earn less than R1000 per month.⁹ These could access private services that meet the cited requirements. Only 4% of

employed Black people currently afford private medical aid,¹⁷ and this percentage is decreasing. This demonstrates the limited scope of Independent Practitioner Associations (IPAs) that are linked to the existence of private medical aids.

Managed care options

NHI is a form of managed care, in that such systems, involve registration, use consumer premiums, management protocols, restricted or controlled formularies and preferred providers. It has been proposed that an NHI fund, to pay for private care be set up.²² Tax has doubled since 1985 and is now about one third of Gross Domestic Product (GDP)

Figure 5.7 The current annual cost of private care⁸ for 20% of the population is R8 billion. Can taxpayers afford NHI on this scale when other social and health demands are obvious? A compounding factor to such a proposal is that per capita GDP is decreasing (Figure 6).¹¹ Whilst it is a good idea, NHI may not be viable at present, because State health expenditure, whether financed by tax, fee per service or NHI levy, has reached a maximum, and the distribution of the health budget within the State service is difficult to change because of the 60% fall in real funding since 1985. This concurs with the COSATU view⁹ that there will not be a significant long term increase in the health budget. Notwithstanding this, linkage of private health workers to the public system through NHI, may not be welcomed by the health workers, if the contract extends beyond mere financing.

Changes in the financial management of private care are occurring. One change is the advent of comprehensive health maintenance organisations (HMOs). Capitation based HMOs, which are the cheapest to run will decrease the consumer premium for care by 30%.¹⁸ This means that a medical aid premium of R400pm will decrease to R280pm. This 'best case' situation may help the few who are on medical aid but does not serve the needs of the majority who earn less than R1000 per month.¹⁵ This casts doubt on the relevance of various foreign inspired, comprehensive managed care systems^{11,27} to South Africa. Whilst

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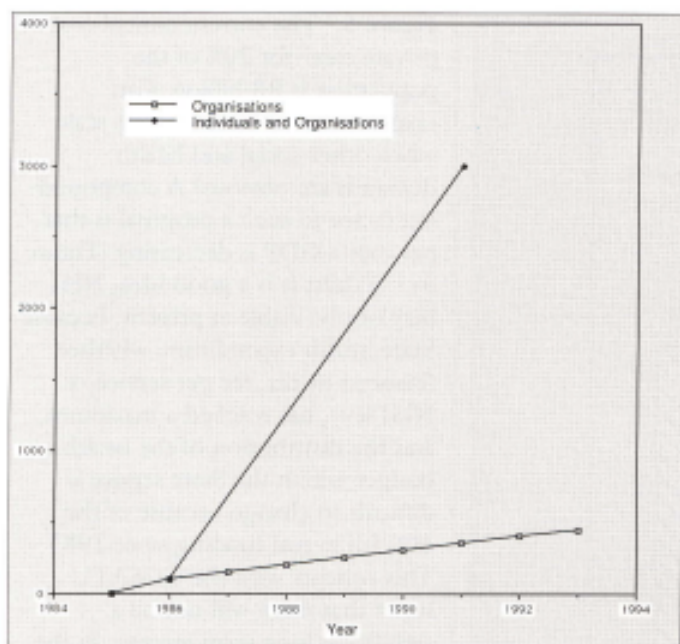


Figure 3. Growth in the mailing list of the Health for All Resource Service 1985-1993, as an index of growth in the contribution of nongovernmental Organisations to health services

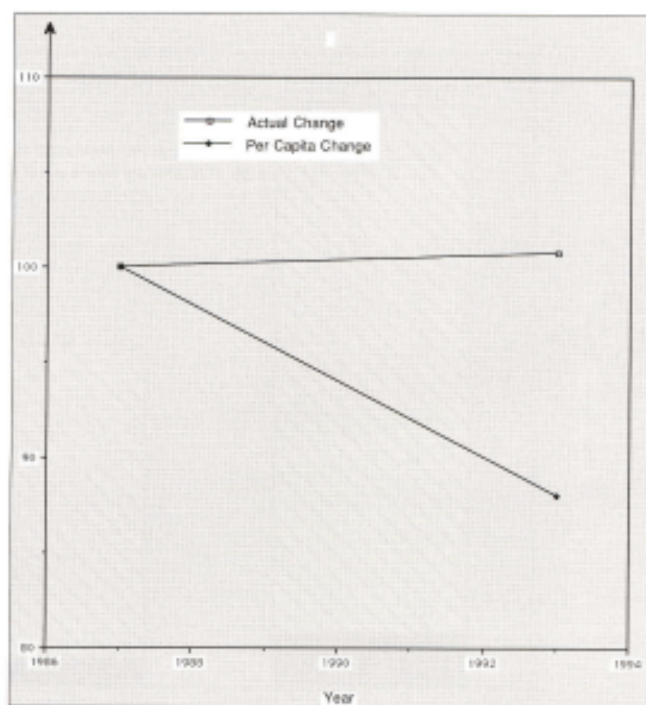


Figure 4 Change in Medical Aid Membership in South Africa 1987=100% (Venter R)

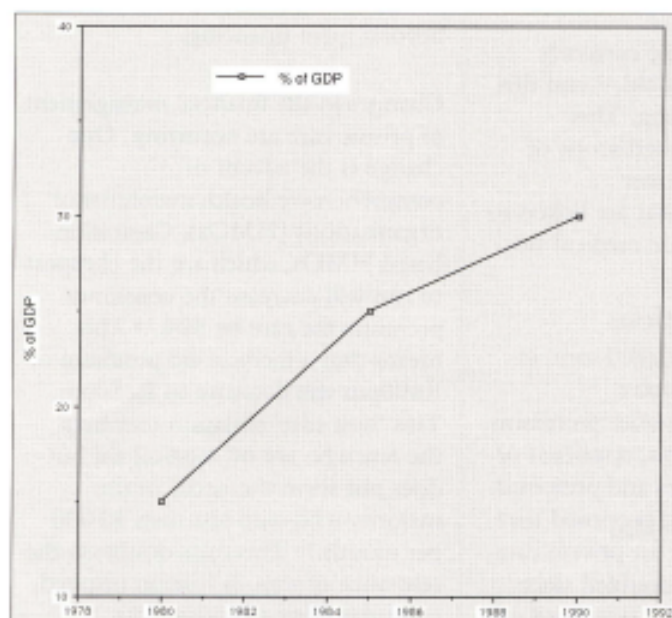


Figure 5. Tax and Government expenditure as a percentage of GDP

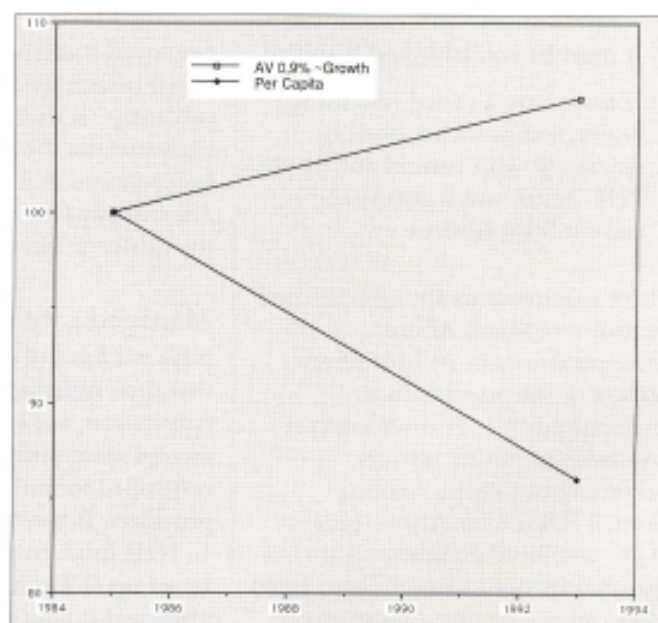


Figure 6. Change in Gross National Product (GNP)¹¹

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	State	Private
Beds	34 500	13 500
Bias	Medical	Surgery
%of State or Private Budget	95%	21%
Cost per Bed per day	R603	R340
Cost/bed/day/head of population served	0,0024c	0,0068c

Figure 7. Health Service Macroeconomics — Hospital Care (State and Private)

care needs to be managed, comprehensive HMO type managed care, which includes private tertiary care, is as limited in usefulness to South Africa as it is limited in access to South Africans, because private tertiary care is inefficient as a community model however it is presented. Support of such models in the USA requires the health budget to be 12% of GDP. In South Africa and most of the Third World, the health budget is 3,5% to 6% of GDP. This means that one would expect an individual who earns R1000 per month to pay R35 to R60 per month for care, and not R250 or even R180. Two managed care schemes, with premiums in the latter range closed in the Western Cape in recent months.¹²

IPAs are being set up.^{20,26} The principal behind these business entities is the formation of fronts by service providers to negotiate with the health financiers (mostly medical

aids) and consumers, to protect income on a fee per service basis. Such IPAs are useful whilst medical aids exist in their present form, but they do not contribute to the achievement of Health for All. Their modus operandi erects a barrier between doctor and patient, without serving the cause of health or the wellbeing of the majority of South Africans. IPAs operate in the diminishing medical aid environment and as such cannot be seen as part of a paradigm shift in the provision of care. The 'market' in which they have elected to operate is crumbling.^{14,16} If private care is to retain relevance then its true market must be the community as a whole.

Primary Health Care

PHC has no set definition, although that which is common to most situations is presented, and set out in Figure 9.¹⁹ The cornerstone is participation of people in the management of their own health.¹³ PHC based central health policy is the essential ingredient of presently evolving and future health policy.^{21,22} Despite this, expenditure on State hospitals will continue to consume most of the budget, because they are there and have a powerful academic lobby group. State primary care services will remain poor and underfunded, because there is no more money. Private hospitals are inefficient as a community resource, and a greater private community service contribution can be made by primary care physicians. High technology has no effect on health care parameters such as mortality and morbidity, and secondary and tertiary

care have a marginal effect, when they are supportive of primary care.¹⁰ Good primary care reduces the need for secondary and tertiary care, and thus improves the quality of whatever services are available (McKoenen).¹⁰

The responsibilities of primary care physicians may be summarised as:

- The delivery of primary care that can reach most people.
- To work with systems that improve access and dignity.
- To work with systems that are synergistic with other services and PHC based central policy.

Primary care is the interface of the health service with the public, and the fact that private primary care has been too expensive and State primary care has been too poor, have limited access and dignity and denied primary care physicians the opportunity to meet the cited responsibilities adequately. Direct contract primary²⁵ care offers a chance for private primary care physicians to meet these

Figure 8. Health Service Macroeconomics Primary Care (State and Private)

	State	Private
% of State or Private budget used	6%	16%*
Rands per day used (Millions)	1,095	3,506
*39% if medication is included		

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PHC	FPS	Direct Contract
Promotion of Nutrition	No	Yes
Maternal and child care including family planning	Partial	Yes
Provision of adequate water supply	No	No
Provision of basic sanitation	No	No
Immunisation against major infectious diseases	Partial	Partial
Prevention and control of locally endemic diseases	No	Yes
Education concerning prevalent health problems and their prevention and control	Yes	Yes
First Contact Care	Yes	Yes

Figure 9. Aspects of PHC routinely^(*) covered by Fee Per Service (FPS) and direct contract primary care

* Remunerated in private practice

innovative technology such as the point of service format and network model.²³ This approach is also synergistic with emerging private benefit funds which offer a range of more comprehensive care choices (Figure 10). Unlike conventional benefit funds, which pool the resources of members to defray the medical costs for any one of them, usually in favour of a preferred provider group, the emerging funds exist as personal savings accounts, in which cross subsidisation of one member by another does not occur. The savings account may exist on its own, or in combination with a limited medical aid. There are 3 such funds registered at present,²⁴ and others which are adaptations of present medical aids and insurance.²⁸ All 3 of the registered savings funds are inaccessible to the majority of South Africans. Two of them, Bensure and Clinisure, are linked to

responsibilities (Figure 8). This approach to primary care is based on the relationship between doctor and patient. It renders the advantages of private care, such as privacy, dignity and patient time-effectiveness accessible to all who earn more than R400.00 per month. Thus direct contract primary care can reach about 80% of people who are not currently served by the private sector, because the service is radically cheaper than medical aid. Direct contract primary care has a vested interest in health, is optimally synergistic with PHC based central policy (Figure.9) and pays the service provider at a rate higher than the current medical aid scale of benefits.²³ Patient choice is enhanced when it is combined with other

	Savings Fund	Traditional Medical Benefit Fund
Contribution	Employer and/or employee	Employer and/or employee
Membership	Membership number is not critical and one member is sufficient	Large membership is required usually from a group with a common link such as a union or employer
Format	Individual savings tapped for benefits by contract debit order or fee per service	cross subsidisation within the membership to defray the claim of any member
Benefit	Benefits based on each member's preference, savings and health. Health benefits are as important as medical benefits because savings accrue from being healthy	Standard benefits according to rules, usually medical benefits as opposed to health benefits

Figure 10. Benefit Funds based on Personal Savings

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Age		20	25	30	40	50	60
Contribution		Low	Intermediate	High	High	High	Low
Preferred Benefits	Wellness contract	—————→					
	Primary Care contract			—————→			
	Primary Care fee per service	—————→					
	Tertiary Care insurance			—————→			
	Withdrawal of accrued benefits					—————→	

Figure 11. The use of a Savings Fund

compulsory hospital or tertiary insurance cover, which is too expensive to make them into practical options for lower paid people. The third fund, Botshelo, does not link compulsory insurance and could be financially accessible if it were not for the R20.00 per month administration fee per member, caused by a linkage to a computer network and smart card technology. Savings funds are more useful as an option for small employer/ee groups, where the group lacks the numbers to form a conventional benefit fund. Figure 11 shows how these funds can work to provide affordable care based on individual needs, which change throughout life.

Many traditional medical benefit funds exist, and serve the needs of large numbers of mid and lower income employees, where they have a common link, such as the union or employer. Usually the services of these funds are limited to a preferred provider organisation or limited in other ways. One fund which is not so limited is that of a factory in Paarl.²⁹ This fund has been operative since 1965. The worker contribution is less

than R20 per month and the fund is able to pay out of pocket for any medical intervention relating to the members. This situation is possible, given time, adequate wellness education, and a large and changing membership who do not accrue benefits after they leave the fund. It is difficult for these funds to cover dependants and pensioners. Individuals or small employer/ee groups do not have access to such funds and may find personal savings funds with linked services such as direct primary care, dental, wellness or pharmacy contracts more viable, if they require consistent day to day private care, combining this with state services or insurance for tertiary care.²⁵ There should be more functional integration between State and Private practice care.

Conclusion

Two of the main changes facing private care are the adoption of PHC based central policy, and the need to provide a service which is synergistic with this and which is financially realistic for most South Africans. Both are essential to the achievement of health for all. Care needs to be

managed, but this is not synonymous with adopting imported managed care models, or models that include expensive tertiary services. An interim opportunity to meet these changes may be provided by combining the most cost efficient services from State and private care. In essence this means focusing on managed primary care in the private sector, such as that facilitated by direct contracting, and developing greater synergy with the State tertiary care and PHC. State services need to be built up, and, given a fixed sum available for all services, a realistic source of revenue for this purpose could be from the diversion of funds from private tertiary care into the State sector.

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Acknowledgement

I would like to thank Dr Warwick Charlton of Health South Medical Resources for reviewing this article.