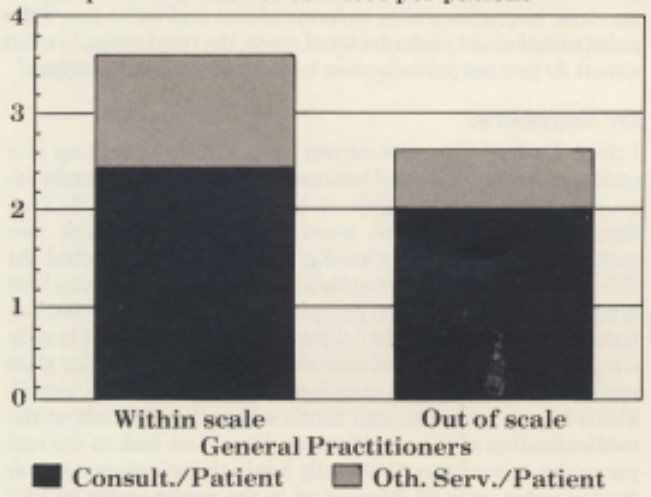
Forum - The free market in medicine

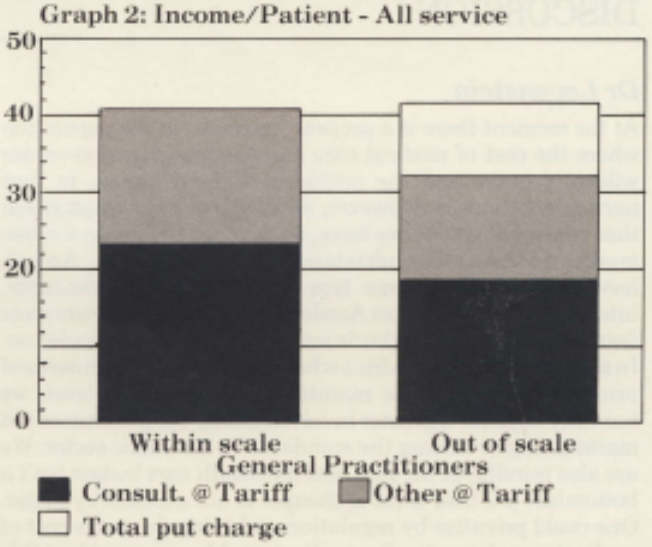
From the talks and discussions at the Forum on 14 April 1986, held at the 5th GP Congress in Johannesburg.

The panel consisted of Dr J H Levenstein (Chairman, SA Academy of Family Practice/ Primary Care), Dr F P Retief (Direct General, National Health and Population Development), Mr A M Leveton (Chairman, Affiliated Medical Administrators), Dr H Snyckers (President, PCMA), Dr D R Gurnell (Chairman, National General Practitioners Group), Dr G Davie (Executive Committee, National General Practitioners Group), Dr N C H Stott (General Practitioner, UK) and Prof René de Smet (State University in Ghent).

Graph 1: Number of services per patient



Graph 2: Income/Patient - All service



A M Leveton

Graph 1 - *Number of services per patient*

A sample surveyed in 1985 of general practitioners' services over a period of approximately 6 months is represented. The sample excluded all services rendered by dispensing doctors recognised by Affiliated Medical Administrators.

Total services surveyed amounted to 760 000 of which 526 000 were charged at the scale of benefits and 234 000 were charged in excess of the scale of benefits; 464 000 of these services were general practitioners' consultations.

Patients who received consultations at the scale of benefits received an average of 2,47 consultations.

Patients who were charged in excess of the scale of benefits received an average of 1,99 consultations. This means that the general practitioners, at the scale of benefits, performed 24,12% more consultations per patient than their contracted out counterparts.

When one looks at all services performed by general practitioners, contracted in practitioners rendered 3,61 services per patient compared with 2,62 services for the contracted-out, i.e. the contracted-in practitioners rendered 39,79% more services than the contracted out practitioners.

Taking into account frequency of consultations - the cost at a 100% of tariff to medical aid is R23,28 for the contracted-in practitioners and R18,77 for the contracted-out practitioners.

Contracted-out practitioners' average private charge for these equivalent services is R27,57.

Looking at the income per patient of all general practitioners' services - contracted-in practitioners at tariff earned R40,72 per patient whilst contracted-out practitioners' total charges averaged R41,43. These figures support my view that doctors work to a pre-determined level of income which they achieve by either doing more services or charging more for the individual service.

At 100% of tariff the contracted-out practitioners only cost the Medical Aid Society R32,36 - leaving the patient to pay a extra R9,07.

1. My view is that the guaranteed fee for service payments lead to over-utilisation and over-servicing. The graphs support this fact.

2. When setting fees the Medical Aid Schemes must take into account the total cost, or in other words the total income for practitioners. This is a combination of the price of the services, multiplied by the frequency at which the service is performed. The 1985 position shows that whereas general practitioners' costs, as a

result of the tariff increase in July 1984, should only have increased by a little over 8%, the actual increase in their income was nearly 20%. The extra increase was derived by performing more services.

3. Fee for service as a means of provider payment has internationally and locally proven to be the wrong vehicle for cost containment or cost-effective medicine. This position is even more aggravated when coupled to a guaranteed payment to the practitioner. Until the compulsory guarantee of payment is scrapped and replaced by voluntary guarantee, costs will continue to escalate.
4. With the anticipated urbanisation of blacks over the next decade or so, systems other than guaranteed fee for services systems have to be developed.
5. If privatisation is to take place and the provision and financing of medical services is to be an economic proposition for the employer and the man in the street, then extensive deregulation under both the Medical, Dental and Supplementary Health Services Act and the Medical Schemes Act is to take place.

DISCUSSION

Dr Levenstein

At the moment there is a projected increase in the population where the cost of medical care has far outstripped even our wildest fantasy and the problems that are innate in that particular situation. However, all speakers have emphasised that whatever system we have, one cannot really have a free market system as we understand free market system. And all have spoken about some type of containment, standards, intervention, etc. From an Academy point of view, we are most fearful in regard to standards and with whatever is decided on. In a situation in South Africa where we believe the standards of primary care should be maintained at a specific level, we honestly hope for a greater involvement by the government in maintaining or raising the standards in the public sector. We are also mindful of the fact that the health care budget isn't a bottomless pit; that what is cheaper is not necessarily better. One could privatise by regulation and bring down the cost of medical care dramatically, as illustrated by our president this morning. By allowing antibiotics to be dispensed or anti-hypertensives to be dispensed by pharmacists or if you want to decrease the cost even more, by supermarkets. So one has to be extremely wary in this very delicate and difficult balance, which none of the speakers pretended is an easy balance to maintain.

Leveton:

Chairman, we have been nationalised. My view is that the health insurance movement was nationalised when the Medical Schemes Act came into being. The only thing is that the national health scheme has no cost to the government, and I say that without any offense. We had absolutely no flexibility in terms of that Act and I think the medical aid schemes would seek the regulation very vigorously because at the moment, as we see it, those people who can afford to pay the contribution – that is virtually any employed white, a growing number of black employed – are subject to a national health insurance set-up.

Question:

Is a system such as a national health system where a doctor is paid a fee per patient per year by the state, a feasibility for SA?

Dr Retief:

That loaded question of course is the basis of the whole discussion here today. All I can say is that at this stage a system such as that, according to preliminary investigations, and calculations on our behalf, is not an economical feasibility. The country cannot pay for such a service. Even if it disregards all ethical, theoretical, professional consideration in this regard, it is not a feasible proposition from a financial point of view.

Chairman:

There was, in fact another question asking why SA has a thousand medical aids while the USA has only three?

Mr Leveton:

I would like to comment. The reason we have so many, and we have approximately 240 registered funds, and a large number of unregistered funds, is historic in that there is no flexibility. Now, if the Act that binds us, was deregulated or to a large extent – which allowed us to run a number of different benefit packages, a number of different contribution structures within the same plan, we would have no need for all these small, individual schemes. I believe there are 80 registered schemes with less than 1 000 subscribers.

The root cause of that, I think is in an extremely rigid approach from the authorities, nothing else. They would disappear on their own accord if they were free to do the things we wanted to do.

We've heard now from Dr Retief about national health care services' impracticability in terms of cost and we've heard the point raised about underdoctored areas, the rural areas, to what extent do you see privatisation helping us with our problem?

Dr Snyckers:

I think Dr Retief is quite correct in that the whole thing is a question of economics and because of all the other demands the country cannot afford a national health care scheme of the kind that one would perhaps want to envisage. I think you mentioned that the costs have gone totally out of control. At this point it's perhaps not quite as terrible as one expects, that is up to 84/85. We find that as a percentage of GDP the cost has gone up from about 4,9 to 5,4 percent and normally it is only when it reaches a figure of something like 6½% that you start really having to draw on taxation moneys; in America we talk about 10 or 11 percent, and that's where they talk about the medicalisation of the state budget. Also, if we look at the real per capita expenditure, that really has in the private sector over the ten years up to 84/85 gone up in the public sector by 13% and in the private sector by about 9% in real terms, if you discount inflation. I think we must just get back to basics, but I think the demand of population growth, urbanisation and the qualitative demands that are going to be made, for various political and socio-political reasons on the system, where everybody will expect the opportunity to at least have access to similar quality service, it's just going to break the system if we carry on as we are now. Now I think what we're really talking about is that by changing the emphasis to subsidising the individual institution, and also linking that to perhaps being in process which will take too long to explain, but you will be able to weed out those people who are presently making use of the free market system, who should not be making use of the free system by freeing the medical aids to become market-orientated. You'll make that system as cost-effective as possible, so the scarce resources will then be spread a little further. That's really what it boils down to. As far as the rural areas are concerned the state will, and Dr. Retief has mentioned it, be responsible for a large proportion of our people for a long, long time. A figure I didn't mention – unemployment – is expected to reach 2½ million in the year 1987 and possibly 5 million in the year 2000, which we just can't afford. The solution to the whole thing basically, is proper economic growth, and creation of jobs, and at the moment we're heading in the opposite direction. But the state will then be able to have some money, once you've taken off the people who make use of the system that shouldn't be making use of the system to possibly establish facilities and hand them over to the private sector to run, or even find that the private sector can put up

health care centres as envisaged in the national health facility schemes themselves, and run them in the rural areas. But it's really a question of putting the money where it's most needed, and making both the public sector and the private sector's facilities as cost-effective as possible. Without wanting to insult anybody in the public sector, the private sector works more efficiently because of the competitive nature of the system.

Chairman:

Would you like to comment on that, Nigel? Do you think your people work less sufficiently than our GPs in the private sector?

Dr Stott:

I think it's significant that most of the discussions so far has made the assumption that we can identify quite clearly the things we're paying for. We've not talked at all, so far, about health of the population. We haven't talked at all about whether as individual practitioners, we have any responsibility at all, for promoting health in the people we look after for the cronic or acute illnesses. And I doubt whether a nationalised system or a free market system will solve that one until, within our ethics, within our system of approaching medical care, we feel responsible for a number of illnesses occurring in the community, and that we are acountable for that, and to central government or whoever the body is going to be. That could either come with the level of professional standards, or it's something that must be planned and budgeted for. But it's very easy to talk about market forces when one is dealing with procedural work, when one is dealing with the treatment of acute illnesses. But in fact that is a very small proportion of the overall problem we face in this country. And that's why I submit that a lot of our debate is sketched around the central issue of health this morning.

Chairman:

Would anyone on the panel like to comment on what Dr Stott has said? All that we have heard up to now is mostly from the point of view of the doctor, but we can also consider it from the point of view of the community.

Dr De Smet:

Diseases are rising everywhere and we have to take measures to eliminate this problem. To make as good use of all resources it is necessary in our opinion. In the free market system, the patient can go to whatever doctor he likes, he doesn't come to the doctor most suited to his problem. So we are in favour of the two tier system where the first tier should be managed by general practitioners, and that also only paients who need more specialised care can have access to the specialist. I think that in one or another kind of nationalisation this can be managed in a better way. But on the other hand I think that it is not the system but it is the people who are working in the system that make the value of each system and whatever system you have, free market or nationalisation. Abuses are possible in each system, and looking around we see that there are good doctors and not-so-good doctors and very good doctors, but it is the same, I think, in every system. Another point is, that in a free market system you don't exactly know for whom you are responsible, and this I think is how it can be difficult to take preventive measures for your patients. A patient comes to you only when he is sick and you cure him. That's good, but I think more and more we should be preventive-minded. This is more easily possible in a structured system.

Chairman:

There is fragmentation of health service as carried out and envisaged by central government. Surely this is very costly and counter-productive and could in itself lead to the breakdown of health services: You can't blame the present chaos on no money in he future, with regard to fragmentation of health service.

Dr Retief:

Mr Chairman, firstly I'd like to go on record saying that my Department's views with regard to the future health service in this country is that we do not want to see greater fragmentation in the health service. But when I say this, we have to be very careful by what it means because the present health service system in this country is a heavily fragmented one. None of us as we sit here today, really know what the new health service system is going to look like. I think some of us have a fairly good idea. This is a decision which we hope will be finalised in the next couple of weeks, perhaps a month. Now I said this so often in the last six months that I must be right sooner or later. But whatever happens, I think the ideal would be to see to it, that it is a less fragmentated system. I don't know whether you are aware of the fact that at present about 15 different health authorities budget separately for health matters and health services in this country. They liaise voluntarily, but the law doesn't force them to do so. Now this system must be improved on. And I think I would like to leave it at that for now.

Dr Stott:

I think I'd like to draw some comparisons with elsewhere as well. When governments face escalating costs, as is certainly happening in the UK, some of the ways in which they can start to save costs, is to divide and rule and by introducing market forces especially in the free market sector. Nurses can compete with doctors. Fringe medicine competes as well. Specialists compete with generalists and opening its freemarket forces, actually can be very cost-effective from the government's point of view. What it does to health is another matter completely.

Question:

On what basis does the state, or anyone else for that matter, decide that health care - especially access to health care - is a right or a privilege?

Dr Snyckers:

I don't think the state decides whether it's a right or a privilege. It is a fundamental concept. Now I think the WHO's concepts of health for all by 2000, which states that health is a right for everybody not a privilege, is certainly not going to produce health care for all by the year 2000. It just doesn't work. It certainly doesn't even work in developing countries where it has been found that an individual should contribute in some form or another towards his own health care. That means even in the rural areas he might trade in kind, he might bring you a chicken or an egg to pay for the service. That is except for the totally indigent.

Of course they will have to be provided for by the state so it's not a question of the state deciding one way or the other, or anybody deciding. It's a basic concept that if you build up a system, that is what you must have in mind, and whoever can pay, should pay to the maximum of their abilities, which will also put a brake on over-usage, because once it's free and you've paid your medical aid, then you are going to make maximum use of the system.

Dr Stott:

I think the whole concept of health being a right, is a very difficult one. It will be a truism to say that with all rights go responsibilities and those responsibilities are first of all to recognise that the public does not actually consume health. The public should not be looked upon purely as consumers of health resources, they should surely be looked upon as producers of health, to a certain extent, and therefore we all have a responsibility for and in health maintenance. Our second responsibility is to finance the health services as they are and our third responsibility is the political responsibility for the marginalized or indigent in our society, and whether we like it or not, we in this room, are a very privileged group, in the planning of health services. And with that responsibility and with that privilege goes the fact that have to do the opposite of what my colleague suggested. We must provide care and support and health services for those who are indigent and can't pay and I don't see how we can escape from that.

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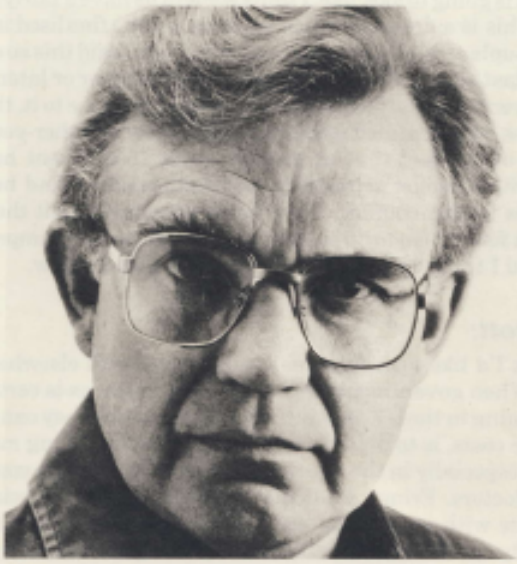

Dr G Davie

To me the whole question of medical ethics is diametrically opposed to the ethics of business. Especially to the free market system which seems to say: everyone for himself and let the devil take the hindmost!

In our case the "hindmost" accounts for the remainder when, as Dr Snyckers has pointed out, 18% of the population of our country is excluded.

I therefore do not think that any of the discussions about the free market system pertains to the Republic's needs. The idealistic doctor-patient relationship has no meaning in our setting. The individual whom we have to consider also does not necessarily believe that he has to take responsibility for his own health. I think that he expects health care to be visited upon him by the gods and the rulers of the country.

If we want to give adequate health care to these people, how are we going to set about the problem? We are not going to deal with a sophisticated people, who can readily accept responsibility for their health, for at least the next thirty years.

In a previous discussion, Dr Retief mentioned that privatisation leads to cheaper management of the tuberculous patient. That is cheaper than the state's expenditure in this regard. Did he also mean better, or did he just mean cheaper? Cheaper can always be managed if there is someone making a profit, but this does not often benefit the patient.

Someone else also asked why the MASA did not favour the concept of the HMO (Health Maintenance Organisation). The reason is very simple. In the HMOs which we investigated there was no saving except for a reduction in hospital bed occupancy.

What should we offer the patients in our country in the immediate future? If we give them clinics with sound medical scope, we will probably do them more good than handing them cards entitling them to medical services. Mr Leveton has pointed out how incomes can be inflated by over-servicing people who belong to just such a scheme.

Is a National Health system cheaper for general practitioner services? Are the patients getting a worse service than we hope to offer them? They may spend less time with their doctor, but is their basic intelligent care worse than in countries where National Health services are not to be found?

I have always been haunted by the concept discussed by George B Shaw in his 'Doctor's Dilemma'. He mentions the case of a surgeon whose daughter is soon to be married with all that entails financially. If this surgeon has to choose between amputating only the foot or above the knee in an ailing patient, the latter procedure being more remunerative, would his own financial predicament influence his decision?

D R Gurnell

As we have experts here in the fields of hospitalisation, group practice and pharmacy, I will confine my remarks to the more personal level of the doctor/patient relationship.

The prime moving force behind all human endeavour is self-gratification, whether this gratification takes the form of self-esteem, the promise of future rewards or pecuniary gain, the driving force does not change. Because the rewards are related to the quality of the endeavour there exists an incentive to achieve excellence. It is for this reason that I believe a fee for service in a free market system will give rise to the best medical care. In a system of socialised medicine the rewards in the form of a fixed remuneration are the same for both excellence and hard work as they are for slovenliness.

However, before we rush blindly into a free market we must ask ourselves what it in fact implies. For the market to be truly free there must be unrestricted entry for both the users and the suppliers, and

therefore any form of licensing would negate the basic principle of a *free* market.

The argument against licensing is that the patient would be protected by the common law pertaining to fraud, in other words someone claiming to have the knowledge and the expertise required would be committing an offence if he did not have that expertise, and the patient could then sue for damages. But, ask yourself, is there really any way that one can be compensated for loss of health or in fact loss of life itself. Must not the unsuspecting be protected from charlatans before the damaged is inflicted?

Then there is the question of advertising that would allow the patient to shop around for the best price? How can you shop around of you do not even know what is wrong with you? How do you establish the quality of the service if there is no standard?

Very often a patient is too ill to even be in a position to make a choice. For example, the accident victim could be presented with a bill for services from the free market doctor for treatment given when the patient was not in a position to shop around. What would prevent that supplier from charging an exorbitant fee?

We are continually being told that South Africa is both a First and a Third World country – let us not bluff ourselves – we live in a Third World country and in this Third World country there are individuals who have succeeded in raising their own small world to the level of the First World countries.

Ninety per cent of our people are medically speaking very ignorant of their own bodies and their own health, so how can they be expected to be able to select what would be in their own best interests. For example, the connotations of the word 'doctor' could mean anything from the most highly trained super specialist to a witchdoctor.

I believe that the free market, based on a fee for service, is the most cost-effective means of supplying the highest quality of medical care. There is also no room for guaranteed payment.

There will have to be safeguards for the user. These could take the form of registration of suppliers who conform to certain standards and only these persons would be entitled to use the term 'doctor', so that the user is in no doubt as to the training that the provider of medical service has received. Suppliers of alternative medicine would be obliged to signify exactly what they were marketing. In this way the supplier market would be free for anyone to enter, but he would have to specify his field. Furthermore, if there is to be any form of state or charity support then it should take the form of individual support with the principle of a fee for service being rigidly maintained. Only in this can we hope to maintain high standards.

And the cost? The main cost of health care lies in good housing, sanitation, nutrition and water supply. These costs tend not to have the visibility as do personal medical costs.