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).

Dr F P Retief

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It is government policy that there should be privatisation in the health care sector. This will enable the private sector to bear its full responsibility in freeing the resources of the State for optimal performance in those sectors which must remain its responsibility.

For this ideal to be achieved in an orderly fashion to the benefit of all our peoples, careful spadework is necessary. A joint task group under chairmanship of my Department and involving the State and the private sector has been investigating this issue since September last year. A preliminary report has just been released, and is being studied. Without quoting from the report I wish to highlight at random a number of realities:

- The State must continue paying the health care bill of those who are unable to bear the cost themselves.
- The State must not be expected to subsidise the private sector outside its own sphere of responsibility. The corollary is that where State responsibilities are privatised (as may well happen), the cost of such a service must not increase.
- We have to ensure that the quality of our health care service improves steadily from present levels. There should thus be constantly increasing coverage to ensure an adequate level of care for all.
- The private sector must have its profits, but it is also quite essential that constant attention be paid to the containment of costs, which have an uncanny way of escalating out of proportion to benefits obtained. Peer review and control is the ideal, but if the profession does not succeed with reasonable cost containment, the State may be compelled to intervene on behalf of the patient.
- The definition of "reasonable costs" will always be difficult, and cost containment without due regard for maintenance of minimum acceptable standards and quality of service will always be unacceptable. The State must thus develop and retain a monitoring function to ensure an equitable situation – and must do so without alienating the health professions in the private sector.
- At the same time the State could well emulate some of private sector's proven cost-reducing ploys. Presently approximately 40% of this Department's chronic psychiatric and TB patients are cared for by private enterprise at a cost considerably lower than the State could achieve.
- Whatever the mode of financing and regulating of services, we in the public sector will need to give special attention to those who are particularly vulnerable, namely the aged, the disabled and the indigent.
- The concept of ultimate State support by way of subsidisation of the individual rather than the health care institution, has merit, but its practical implications will first have to be evaluated very carefully. The same goes for concepts such as health maintenance organisations. We live in a developing country in Africa – not in Europe or North America.
- The greater the use of high technology medicine in the private sector the more we have to give attention to costs. The big capital outlay on expensive equipment demands that it has to be used frequently to cover its cost. If the owner of the equipment also prescribes investigations or treatment which will

utilise (and thus pay off) his equipment he may find himself in a difficult ethical position. I see an increasing role for the general practitioner as the patient's advocate in helping the patient to decide if certain procedures are necessary, or in helping the patient to interpret and evaluate his hospital bills before payment.

- The same principle holds for private hospitals where rapid turnover surgical patients are economically better propositions than long-term medical, psychiatric or paediatric patients. Who should run the admissions office?

Dr H Snyckers

Dr H Snyckers

At the outset it must be understood that the "Free Market", i.e. a market without restrictions or regulations, regulated purely by market forces, is an ideal or a concept which does not exist anywhere in the world, so what we should be talking about is a "*freer* market in medicine", a market in which there is more involvement by private enterprise.

In the year 1984/85 approximately R5,5 billion was spent on health care in the RSA. Of this the public sector accounted for about 60 percent. There thus appears to be quite some scope for increased private sector involvement and what we are actually talking about today is increased privatisation and deregulation of the health care market.

The question then arises whether this is desirable and feasible in the South African situation.

There are obviously many, many aspects to this but it is not possible to cover all these now. I will therefore concentrate at this stage on the financial aspects – and even here I will have to be very brief.

When looking at the desirability or need for such a movement we need to look at both the current situation and likely future developments, and here we have to start with demographics.

Group	1980	2000	2020
Asians	794	1 108	1 345
Coloureds	2 554	3 601	4 443
Whites	4 364	5 817	6 652
Blacks			
(high)	15 892	34 913	55 700
(low)		33 718	46 125
TOTAL			
(high)	23 604	45 439	68 140
(low)		44 244	58 565

TABLE 1 – Population growth per population group (millions)

From the year 1980 to 2000 and looking at the age composition of our population we find that among both the white and the black population the proportion of those requiring support will increase in relation to that part of the population earning income.

The growth and age distribution of our population will lead to increased demands for scarce financial resources, demands for job creation, the raising of per capita income, capital formation in plant and infrastructure, health services, education, housing, energy, water supply and social infrastructure in addition to the continuing requirements for the country's defence.

If we look at the process of urbanisation and population redistribution we find that this adds even more pressure.

	1985		1990		2000		2020	
	%	million	%	million	%	million	%	million
Coloureds	81	2,26	84	2,58	91	3,28	95	4,22
Asians	92	0,82	93	0,90	93	1,05	95	1,28
Whites	91	4,39	93	4,80	95	5,53	95	6,32
Blacks								
(high)	47	11,14	57	15,45	75	26,18	85	47,35
(low)		11,14		15,45		25,28		39,19
TOTAL								
(high)		18,61		23,73		36,04		59,17
(low)		18,61		23,73		35,14		51,01

TABLE 2 – For the total population

Table 2 shows the picture from 1985 to the year 2020, where particularly the percentage of blacks becoming urbanised increases from 47 to 85 percent or from 11 million to 39 or 47 million.

Two other important factors influencing the financial viability of comprehensive heatlh care services regardless of who renders the service, are income and its distribution, and the levels of employment or unemployment. In both areas we have and will continue to have serious problems.

At the same time government expenditure is already high and rising at an alarming rate.

Continuation of health care provision under these circumstances and under the present dispensation and task distribution will lead to the collapse of the system under the combined demand/cost escalations.

It is my considered opinion that a strategy of privatisation, be it partial or complete, in many areas of health care delivery will not only be desirable but *essential* in assisting and solving many of the problems.

At this stage it is not possible to determine the exact extent of privatisation to take place, nor to produce an exact timetable for the process but only to map out the direction in which the process should go.

Certain basic *premises* have to be made and for this purpose due consideration should be given to the fact that because of our population composition, geographical and income spread, a significant proportion of the inhabitants of South Africa are not part of the cash economy and that this situation may indeed remain so for a long time to come.

Basic principles

- *Subsidisation of the individual rather than the funding of the institution*
- *Levying of user charges*
- *Restructuring of medical aid schemes*
- *Promotion of responsible self-medication*

Whether privatisation takes place or not, to prevent the health care bill from going completely out of control, the following premises must be accepted:

1. the individual is responsible for his or her own health
2. access to unlimited free health care is a privilege and not a right
3. there must be one system and not two or more.

Next, four basic *principles* must be adopted for any health care strategy in South Africa to be successful.

1. The subsidisation of the individual rather than the funding of the institution. The level of state subsidisation would be tied to the level of income or taxation paid by the individual.
2. The levying of user charges.
3. The restructuring of medical aid schemes. The present structure produces a tendency to over-usage of the health care delivery system. A more market orientated system must be developed. The medical aid schemes must be allowed to offer a variety of cover with appropriate package premiums; such packages could include, inter-alia
   a) first rand cover (as at present)
   b) co-payment
   c) co-insurance
   d) catastrophic cover only
   e) no-claim bonuses
   f) other patient and provider incentives for the maintenance of good health
4. The promotion of responsible self-medication.

Considering all this, we have developed a suggested model. Before considering such a model you have to look at the present model of health service provision which looks something like this:

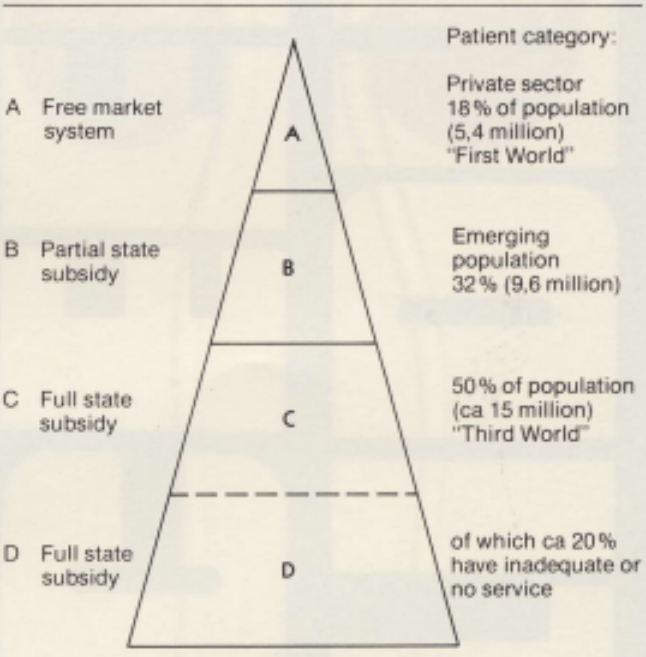

Figure 1: Present private/public sector health services breakdown

We see that only about 18 per cent of the population is presently looked after in the private sector.

A generalised model for the responsibility of the funding of health care for the total population would look as in figure 1 on page 243.

This model is applicable to all sections of the South African population, and where the patient fits into the scheme of things is determined by his or her income. The C and D category patient would be funded by the state, regardless of who delivers the service, but by way of the subsidisation of the individual. In the B category the state part of the funding could be done by way of tax incentives and we see that this will lead increasingly to the "free market" model where employer and employee share the cost of health care funding.

When we refer to *minimum* care it must be stressed that this does not mean *substandard* services, but the the provision of *optimal* health services *considering the available resources.*

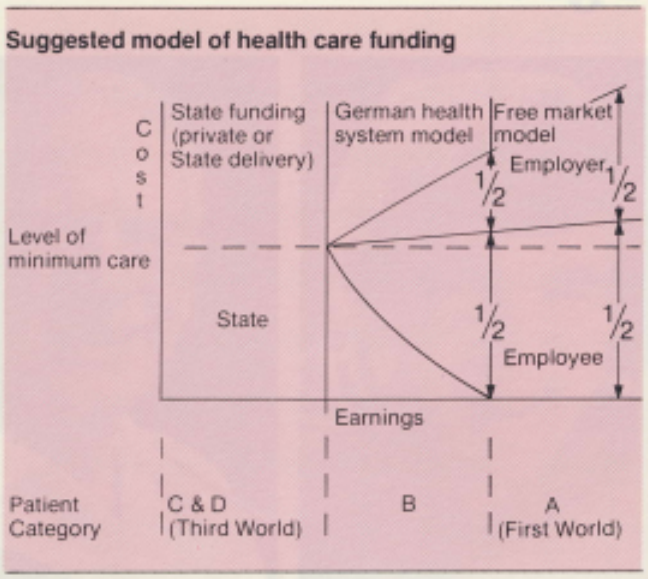

Figure 2:
A generalised model for the responsibility for funding of health care for the total population and taking the above population make-up into account.

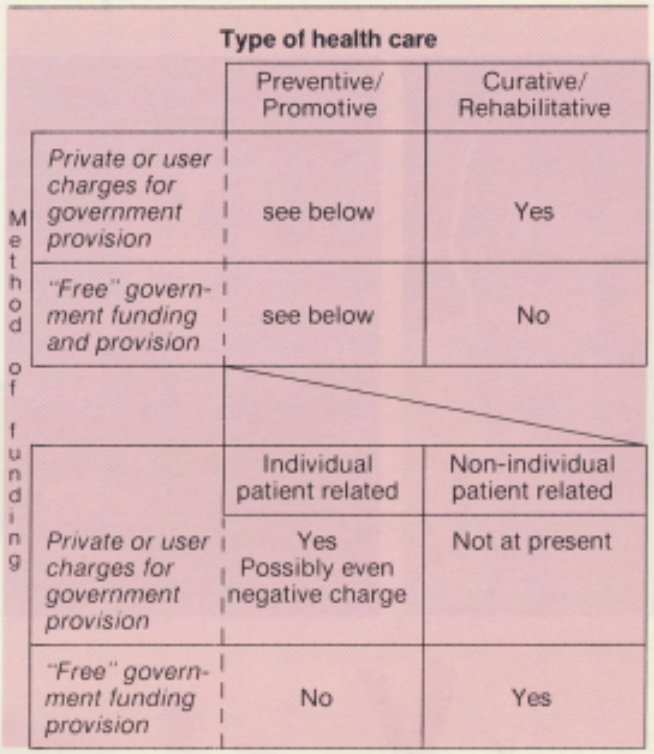

Figure 3: Proposed funding of health care in South Africa

Another way of looking at the possible funding of health care is shown in figure 3:

By applying this model, curative and rehabilitative health care can become part of the private sector or be fully charged for in the case of government provision. When it comes to preventive and promotive health care *individual patient-related* health care can again become part of private sector provision, whilst *non-individual patient-related* health care (e.g. the provision of safe water, sewerage, etc) presently probably not.

There are many possible methods of privatisation, but time does not allow me to go into detail now.

Summary

It can be said that there are many advantages to the process of privatisation and deregulation of health care; to name a few:

★ the inflationary pressure on excessive rise in government spending would ease off considerably

★ the tendency to overuse of health care services can be reduced

★ crucial decisions on the allocation of scarce resources in a highly sensitive area would shift largely from a central political arena to the market place – depoliticisation

★ racial differentiations would be replaced by economic differentiation above agreed minimum standards

★ higher efficiencies are encouraged in a competitive system through rewards and incentives

★ more funds would be available for the direct delivery function through reduction in regulations, intervention and central decisionmaking, and

★ there is likely to be an overall saving to the taxpayer.

Conclusion

I believe if this strategy is accepted and to be further developed and implemented it is essential that there is full and ongoing consultation at the highest level between the public and private sector and that a *permanent, joint health policy/planning committee* with the requisite authority and funding be established to do this.