Privatisation of South African health services — are the underlying assumptions correct?

C. D. NAYLOR

Summary

Six key assumptions made by proponents of privatisation are critically appraised in the light of Canadian, US and UK studies. 'Counter' assumptions, equally credible, are: (i) the economic behaviour of the health-care market does not correspond to the idealised rules of the free market nor, given the nature of health care as a 'public good', should it do so; (ii) national health-care systems with a heavy emphasis on private insurance are as or more costly than universal public systems; (iii) private for-profit hospitals do not usually enjoy any cost-efficiency advantages over public hospitals; (iv) subsidising individuals to purchase private care carries a risk of adding administrative costs, fueling the inflationary spiral in health care, and reducing public accountability of tax money; (v) user-fees and co-insurance will not deter over-utilisation without penalising and reducing legitimate use of health services; and (vi) savings from privatisation are unlikely except for the more affluent citizens of the RSA who will carry a slightly reduced tax burden — all others will pay more and may be deterred from seeking necessary care.

The concept of privatisation of health services has been endorsed in South African government statements, in certain recommendations of the Commission of Inquiry into Health Services (hereafter the Browne Commission), and in a 1986 report from four working groups of the Health Strategy Association. Conversely, arguments by prominent academics for a UK-style National Health Service (NHS) have been rejected by the Minister of National Health and Population Development. In the RSA, as elsewhere, exponents of privatisation and critics of 'socialised medicine' make various efficiency-related assumptions to support their case. Canadian, UK and USA evidence is reviewed to show that six of these assumptions are incorrect.

1. The 'invisible hand' of the market place is the best method of allocating all goods and services, including health care

Free-market economies produce and deliver a wide range of consumer goods and services with impressive efficiency. However, leading Canadian and US health economists have pointed out that classic free-market theories correspond poorly with the special circumstances of the medical market place. The free market relies on the consumer's ability to decide which combination of goods and services best meets his or her needs and desires within given income-constraints. In health care, the information gap between consumers and providers and the uncertainties associated with illness impede this decision process. Price competition is limited by the adoption of standard fee schedules. Licensing and certification procedures for providers represent another departure from the free-market model. Training of providers, in fact, is regulated and subsidised by the public sector, and the link between consumer demand and the rate of 'production' of providers is therefore tenuous.

Neoconservatives in North America and South Africa have criticised licensing laws and traditional medical ethics for introducing market distortions and promoting provider interests. However, these provisions are found in virtually every political and social system, and can be linked to two imperatives: (i) anti-competitive and anti-commercial features of medical ethics promote scientific and professional collaboration between doctors, and also help to create a psychological climate for doctor-patient interaction that is beneficial to both parties; and (ii) public health consequences of 'free trade' in medical care have been deemed unacceptable. The application of classic economic theory further founders on the proxy consumer role of doctors. Because of consumer uncertainty and information gaps, clinicians become, in essence, purchasing agents for their patients, ordering drugs, hospital days, consultations, diagnostic tests, and so forth. A private fee-for-service system does encourage the practitioner to be efficient in office and time management, but offers no direct incentive for the doctor qua purchasing agent to minimise the expenses incurred by the patient.

To some extent, perverse incentives apply. In a fee-for-service system, the doctor has a financial interest in the patient, and notwithstanding the sound ethical and technical basis of most practices, Canadian data suggest that these incentives affect provider behaviour. Controversy continues in economic circles about the extent to which doctors and dentists determine the demand for their own services. In any case, North American and UK studies show that the amount of surgery varies with the number of surgeons and how they are paid, and similar variations in other supplier-influenced services have been demonstrated.

Health-care insurance itself distorts the free market. Insurance allows the 'magic of averages' to spread the financial risks of illness over a larger group, but most private insurers act primarily as clearing-houses for accounts. By pooling funds and altering price signalling at point of service, insurance releases pent-up consumer demand, creates more scope for provider-controlled practice expansion, and pushes overall costs up in a spiral of rising utilisation, premiums, and tariffs. In these respects, there are clear differences in the economic impact of medical insurance opposed to life assurance or fire insurance.

Lastly, health care is commonly thought of as a 'public good', i.e. basic needs are to be met for all citizens. This ethical tenet has been reflected both in promises of free services for the poor in medical codes from the Hippocratics onwards, and in the inter-
national movement towards universal state-administered healthcare systems. These universal systems have altered the traditional inverse relationship between income and consumption of medical services. For example, the UK's NHS has had levelling effects on the distribution of curative and palliative services, even though class-related discrepancies in consumption of preventive services persist. In Canada, the disadvantages were already covered by public programmes, but universal health insurance still led to a significant increase in utilisation by the poor in all provinces studied.

In short, the theoretical free-market mechanism is seriously distorted by the realities of the health-care marketplace. These distortions undermine the efficiency advantages conventionally attributable to private enterprise. Moreover, the societal goal that health care be allocated as a 'public good' constitutes a specific and important drawback to distribution of services by the 'invisible hand'.

2. Universal public systems are more costly and less efficient than multilayered private/public systems

From a cost containment perspective, the British NHS is a model of frugality. The UK spends only 6.4% of its gross national product (GNP) on health care, about 90% through the public sector. Since the GNP is much lower than that in the USA, the actual per capita cost in 1984 was 27% of US expenditure. UK national health status indices do not differ significantly from those in the USA.

Despite recent changes, the US system relies primarily on private insurance plans similar to South African medical aid schemes. In the 1960s, public insurance programmes — Medicare — for the elderly and Medicaid for the elderly and poor respectively, were also implemented. This approach has led to the most costly system in the world: the USA now spends about 11% of its GNP on health care, 45% through government channels. Adjusted for per capita GNP, the USA spends at least 20% more per citizen than Canada, yet falls short of Canada on all major health status indicators.

Because of escalating costs, there have been several interesting trends in US health care. Multispecialty group practices, usually funded on a capitation basis with salaried providers, have grown rapidly and now cover 25 million people. Known as health maintenance organisations (HMOs), these agencies are similar in some respects to the medical benefit schemes operated by the South African parastatals. HMOs achieve savings on the order of 25% compared with standard fee-for-service practices, largely by reducing hospital utilisation. Employers and insurance companies are forming both HMOs and preferred-provider organisations (PPOs) that contract with practitioners and hospitals to achieve fixed, lower rates. Investor-owned health care corporations have also taken a more active role in the last two decades. These new forms of 'managed care' encroach more on clinical freedom than the universal, 'socialised' system in Canada.

Proponents of a private-sector solution to the USA's health-care problems envisage vertical integration occurring as large corporations buy up hospitals and laboratories, hire professionals as employees, and implement cost- and quality-control programmes. US critics of corporate-mediated rationalisation of health care contend that: (i) the profit motive of these corporations will force medical employees to abandon their traditional role as patient advocates; and (ii) private-sector rationalisation will not alter the fact that 30 million Americans do not even have health insurance.

Thus far, these new trends have had only a small influence on US health-care costs. In 1985 health spending rose 8.9%, compared with an inflation rate of 3.2%; in 1986, the respective figures were 7.7% and 1.1%.

In the Canadian system, universal public insurance applies for basic medical and hospital services. Funding is largely from general tax revenues, and private insurance applies only for services not insured by the public plans. Most doctors are in fee-for-service private practice, but are paid exclusively by the provincial authorities; contracting out is not allowed. Tariff negotiations have often been acrimonious, but relative incomes of practitioners have been maintained. Overall health-care expenditure amounts to 8.5% of the Canadian GNP, 70% of which flows through the public sector. Cost-containment was acceptable in the 1970s, but recent inflationary trends have prompted a search for improved efficiency. Organised medicine has called for demand-side controls such as user-fees, while many health economists have espoused supply-side rationalisation, including capped funding of medical practice on the pattern of US HMOs.

Public systems succeed in cost control by substituting central budgetary discipline for the lack of market discipline in private insurance-based systems. Indeed, as exemplified by rationing of technologies in the NHS, the public sector may be excessively frugal. Lengthy waiting lists for elective surgery in NHS hospitals have made supplementary private insurance attractive, and a combined programme of deregulation and government incentives contributed to a remarkable expansion in private medicine in the UK between 1979 and 1981. Enrolment growth rates have since plummeted due to poor cost control. Private insurance premiums rose by 61% on average between 1981 and 1983, while the retail price index rose only 14% in the same period. Public sector spending has climbed much more slowly.

In 1985, South Africa spent about 5.4% of its GNP on health care, of which about 60% flowed through public-sector channels. The working groups of the Health Strategy Association have reported that real per capita expenditure on health care by all levels of the South African government increased by 13.5% between 1975/6 and 1984/5, while real per capita expenditure in the private sector increased by only 9% in the same period. However, this analytical approach is inadequate. Public and private sector expenses are not equally distributed between white and non-white groups. The latter have a higher rate of population growth, and are also much less likely to incur private medical expenses (Table I). Population-weighted averages adjusted for growth rates and proportional consumption of private services should have been used in all calculations, and would tend to reverse this ratio.

<table>
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<tr>
<th>TABLE I. PERTINENT GOVERNMENT STATISTICS* 1985</th>
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<tr>
<td>Black</td>
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<tr>
<td>Population breakdown</td>
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<tr>
<td>(% of total)</td>
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<tr>
<td>Household</td>
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<td>income (R/yr)</td>
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<tr>
<td>Infant mortality/1,000 live births</td>
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<tr>
<td>Private insurance (of each group covered)</td>
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*Derived from preliminary 1985 census data, and excluding Transkei, Ciskei, Bophuthatswana, and Venda.

More important still, private sector expenses included other areas such as health education, research expenses, and health and welfare organisations. The real per capita expenditure on these other items declined by 28.9% while real per capita expenditures for private medical care per se rose by 29.5%. Hence, even without proportional consumption allowances, private sector expenses rose over twice as much as public sector expenses.

What of administrative waste? A 1980 report on the Canadian public insurance system included that administrative costs would be four times higher after privatisation. A more recent US analysis indicated that in administrative costs alone, the Canadian system could save the USA $29.2 billion a year or 8.2% of total health expenditures, while the NHS would reduce overheads by $38.4 billion or 10.1% of the health budget.

The difference lies in the billions of separate items that must be accounted for and collected by about 1,100 private insurers in the USA. In the UK, although NHS dentists are paid on a fee-for-service basis, general practitioners receive fees only for special services, and otherwise are paid an annual capitation fee scaled to...
the number of patients on their 'lists'. Specialists are salaried, and direct hospital charges are not levied. Paperwork is minimised.

The Canadian system has slightly higher administrative costs than the UK partly because doctors are paid on a separate fee-per-item-of-service basis. However, accounts from each practitioner are marked on special cards, sent in bundles direct to the provincial administration, and paid with lump-sum cheques covering several weeks' billings. Definite economies are realised, and savings will increase as doctors move to computerised billing systems. Also, block budgets for hospitals are belatedly replacing per diem allowances based on numbers of beds and occupancy rates, thereby reducing accounting costs and perverse incentives. About 95% of gross operating revenues come from block grants in some provinces, and actual bills sent by the hospital to patients are restricted largely to extra charges for private and semiprivate rooms.

The average overhead of South African medical aid schemes was only 5.8% of total contribution income in 1984,66 lower than either investor-owned or Blue Cross schemes in the USA. However, to underscore one of the hidden costs of privatisation, imagine the administrative nightmare of preparing itemised accounts for scores of private insurers for all inpatient and outpatient services delivered at Baragwanath Hospital in a year.

On the general issue of system-wide efficiency, it is intuitively obvious that privatisation can do next to nothing to improve health care in the 'homelands',64,65 may further fragment services in urban areas, and will not address the unmet need of many black South Africans for basic, community-centred primary preventive services. The growth of the private hospital industry, in particular, may pull resources in the opposite direction — i.e. towards technology-intensive, curative/palliative services for affluent urbanites. As suggested by Canadian66 and UK67 experience, even a public system organised on egalitarian principles is unlikely to eliminate totally the race- and class-related discrepancies in various morbidity and mortality indices that have frequently concerned South African doctors.68 None the less, it is only since the advent of a universal public system that Canada has moved ahead of the USA in basic population indices of health status.68 Which tends to reduce the likelihood of early discharge and render certain hidden expenses, but educational overheads and professional salaries are included, as are other items that are charged over and above private-hospital room fees, i.e. drug costs, theatre charges, and bills for professional services. As in the UK, case-mix and patient-profile factors must be considered,69 and tend to drive per diem costs higher in the public sector. It therefore seems most improbable that large-scale privatisation could lead to cost savings in the provincial hospital system — a view also accepted by the Browne Commission.64 Such gross balancing of comparative costs, moreover, does not begin to weigh the benefits from teaching and research activities in public hospitals.

On the other hand, equity and efficiency would clearly be enhanced if the public sector were to allocate beds on the basis of need rather than race (Table I). It has also been suggested that the provincial institutions have sacrificed some flexibility and on-site efficiency through too much central control (Professor M. McGregor, 5 January 1987 — personal communication). This has been blamed in part for problems with recruitment of nursing staff in the teaching hospitals (Professor McGregor).66 As noted in the SAMJ,66 one policy option might be to decentralise public administration by adopting a system of quasi-autonomous public hospitals, owned and run as private non-profit corporations with strong community and professional representation on the board of directors. General performance criteria could be set by government, which would also provide basic block-funding. The hospitals otherwise would have wide administrative latitude. Such an arrangement has worked reasonably well in Canada; it may or may not be appropriate in the RSA.

### Table II. Percentage Provincial Hospital Occupancy Rates, 1984

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<thead>
<tr>
<th>Transvaal</th>
<th>Cape</th>
<th>OFS</th>
<th>Natal</th>
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<tr>
<td>White</td>
<td>59.9</td>
<td>58.7</td>
<td>49.0</td>
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<tr>
<td>Others</td>
<td>102.6</td>
<td>102.6</td>
<td>91.4</td>
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4. Direct charges in the form of user fees and co-insurance reduce abuse of prepaid health services

Financial deterrents should theoretically increase consumer discretion and curb abuse, but this assumes an ability on the part of consumers to make complex judgements under emotional and physical strain. Since the doctor serves as the consumer's proxy for most large expenditures, many Canadian health economists have favoured supply-side rationalisation over demand-side deterents that run the risk of penalising the disadvantaged to achieve comparatively smaller savings.67 In the Canadian province of Saskatchewan, temporary imposition of user fees in the 1960s deterred the poor and elderly, while middle-class people made more demands on the doctor. Interestingly, there was also a rise in supplier-initiated services and a shift to more expensive billings as doctors responded to lower consumer-initiated demand. No savings were achieved, and the net effect was to redistribute income and services away from the disadvantaged.68,69 Two academic reviews of the international evidence have since concluded that user-fees are an inequitable and inefficient means of cost-control.67,70 and recent federal legislation has all but banned user-charges.
A controlled trial by the Rand Corporation in the USA demonstrated that income-scaled cost-sharing reduced overall utilisation of health services. For the South African private sector, the complex issue of co-insurance and user-fees was reviewed in the Sixth Interim Report of the Rand Corporation. It found that 90.1% of the 'free' care group — a desirable reduction. But for serious symptoms, the proportions were 17.9% and 23.2% respectively — an undesirable deterrent effect highlighting the problems of inadequate consumer information. Who began the study with the lowest incomes and lowest health status had serious symptoms more often if assigned to a cost-sharing plan, and over time, free care led to a significant comparative reduction in prevalence of serious symptoms. Hospital utilisation by the cost-sharing group was significantly lower than the 'free' care cohort. However, the rate of inappropriate utilisation was the same, proving that people in the cost-sharing group were also deterred from receiving necessary hospital services.

In South African provincial hospitals, user-charges are scaled to income but are less extensive than in the Rand experiment. A deterrent effect from the 1984 increase in user-fees in the Cape Province is none of the less suggested by an observational study that found a 92.2% decrement in overall attendance at Baptist Lavis Day Hospital in the 9 months after the charges rose. There was also a significant drop in attendance for follow-up of asthma, hypertension and diabetes among patients paying user fees over R5.00. Home follow-up of this group revealed a striking increase in compliance. The net effect of higher user-fees was therefore to drive costs up for this subgroup.

For the South African private sector, the complex issue of co-insurance and user-fees was reviewed in the Sixth Interim Report of the Browne Commission. It is hard to fault the committee's observation that there is no system to deter those 'guilty' of overutilisation without penalising the 'innocent'. In fact, a Canadian survey of general practitioners showed no particular consensus on what actually constitutes overutilisation or abuse of medical services. The Browne Commission set aside this committee's recommendation to report in favour of removing the legal requirement for minimum benefits by registered schemes. The intent was to allow more cost-sharing policies to be offered. In response, the Government White Paper reaffirmed that insurance to a minimum of 80% of the statutory tariffs should be paid by the medical aid schemes. The reason is obvious, and reflects another problem with privatisation. If consumers purchase policies with large deductibles to obtain reduced premiums and then incur significant costs, they are likely to turn to the public sector for care. The net result will be to undermine the contributions base of private insurance, and transfer costs back to the public sector.

5. It is more efficient to subsidise private people than public institutions

The concept of subsidising citizens so that they may obtain health services in the private market was endorsed by the Browne Commission and by the working groups of the Health Strategy Association. Since it seems unlikely that the private sector is actually more cost-efficient than the public sector, the rationale for a subsidies programme is flawed. The low overheads of South African medical aid schemes reflect efficiency at processing accounts, but premiums imposed on several measures of health status among enrollees. On the other hand, treatment of myopia and hypertension was adversely affected, and reservations were expressed about the study's validity for detection of other deleterious outcomes. The utilisation data have been challenged because the design not only excluded the very young and the elderly, but also capped annual co-insurance expenses for low-income subjects at not more than 5% of disposable income — an unrealistic condition in a deregulated market.

Another report from the Rand group, which looked at emergency department utilisation specifically, showed that the number of visits for 'less urgent' diagnoses fell 47% with co-insurance. However, utilisation for 'more urgent' diagnoses such as asthma and urinary tract infections also fell, by 64% and 49% respectively. Furthermore, the percentage of visits leading to hospitalisation fell by 33% in the co-insurance group. This indicates that cost sharing deterred both needless casualty department visits and many individuals with illnesses severe enough to warrant hospital admission.

Subsequent analyses have also shown mixed results. Among the cost-sharing group with minor symptoms, 6.3% saw a doctor compared with 9.0% in the 'free' care group — a desirable reduction. But for serious symptoms, the proportions were 17.9% and 23.2% respectively — an undesirable deterrent effect highlighting the problems of inadequate consumer information. Who began the study with the lowest incomes and lowest health status had serious symptoms more often if assigned to a cost-sharing plan, and over time, free care led to a significant comparative reduction in prevalence of serious symptoms. Hospital utilisation by the cost-sharing group was significantly lower than the 'free' care cohort. However, the rate of inappropriate utilisation was the same, proving that people in the cost-sharing group were also deterred from receiving necessary hospital services.

6. Privatisation will reduce the burden on the treasury and taxpayers, and depoliticise health care

Proponents of privatisation emphasise the importance of reducing the amount of 'public money' devoted to health care. On one level, the distinction between 'public' and 'private' money is spurious. If a private hospital is believed to provide employment and constitute a reasonable use of society's working capital, then the same can be said for a public hospital. Conversely, if there is concern to limit expenditure on health care and maximise efficiency, then the private sector must face the same constraints as the public sector.

In North America, the implicit promise of tax savings from privatisation would simply be misleading for the average taxpayer. Canadians pay higher amounts of tax towards health care costs than Americans. However, to achieve comparable first-dollar coverage, a US family pays considerably more when the costs of health-care taxes and private-insurance premiums are combined. The US private-insurance system also leads to a direct burden for employers: comparable health-care costs at the Ford-Motor Company are 6 times higher than one of its major Japanese competitors. Thus, the issue is not 'public v. private' money but rather how to distribute equitably the burden of health-care costs.

In South Africa, adjusted for numbers of economically active persons, the average household income for non-whites in 1985 was R426,185/ month; for whites, it was R1 956,00, or 4.6 times higher. Weighing 1982 figures for provincial hospitals with over 95% beds for whites against those with over 95% beds for non-whites, the white/non-white ratios of average costs per bed-day were 4.1:1, 2.6:1, and 4.1:1 for community, district and academic hospitals respectively. For outpatient visits, divided the same way, the ratios were 2.3:1, 2.3:1, and 2.6:1. These rough figures suggest that public-sector health expenditures are far from egalitarian, and embody only a limited amount of income redistribution downwards. Any programme of privatisation that has as its goal the reduction of public funding of health care will reduce any redistributive elements in the current system, and constitute a net transfer of disposable income back to the more affluent members of South African society. So, far from depoliticising health care such a programme could become a major political grievance for lower-income citizens.

Conclusion

Between 1980 and 1985, the number of white beneficiaries of private insurance as a percentage of the population remained virtually constant, while the number of black, coloured, and
Asian beneficiaries grew substantially. Continued growth in private-sector insurance can be expected under current arrangements if incomes rise and cost-control is successful. The concept of privatisation to accelerate this trend has been endorsed by influential persons and groups. However, the above review has drawn on Canadian, US and UK data to challenge six key assumptions made by advocates of privatisation programmes and critiques of public medical-care systems.

The South African literature on health policy contains many proposals for positive change within the extant private and public sectors. Assuming that broad principles derived from international evidence are applicable to the RSA, it may well be that intra-sectoral policy options merit more serious consideration than most trans-sectoral privatisation plans mooted thus far.

REFERENCES

Summary

The historic origins of the medical and pharmaceutical professions, since the dawn of civilisation, are briefly reviewed. The development of these professions in Great Britain as a prototype of the European situation over the past 3 centuries is traced, with emphasis on the developing strife between apothecaries and physicians. The corresponding situation in South Africa over the period 1652 - 1840 is then reviewed. The first Commission of Inquiry into health matters at the Cape, appointed by the British after their occupation of the region in 1806, was precipitated by complaints regarding unsatisfactory services rendered by apothecaries and medical practitioners. Health services were subsequently regulated by way of two Medical Proclamations in 1807, one Medical Proclamation in 1823 and a Medical Ordinance in 1830. According to this legislation apothecaries in Cape Town were not allowed to treat patients, and doctors were not allowed to sell medicines — but due to a shortage of rural practitioners, apothecaries and doctors were allowed to supplement each other in the country districts.

Die huidige onenigheid tussen resepterende geneesheer en apteker — 'n historiese oorsig

Deel I. Tot 1840

F. P. RETIEF

Die huidige onenigheid tussen resepterende geneesheer en apteker in Suid-Afrika (Afb. 1) het reeds aan die begin van die vorige eeu sy ontstaan gehad. Ten einde die wese van hierdie onverkwiklike broedertwis tussen twee belangrike gesondheidsberoepse beter te begryp is dit egter nodig om die ontwikkelingsgang van aptekerswese en geneeskunde veel verder terug te volg.

Voorgeskiedenis

Algemeen

Daar is getuens dat die oorbewensings van Mesopotamie en Egipte reeds 5000 jaar gelede wetlik voorsien het vir onderskeibare beroepse van helers en medisyneverkopers.1 Alhoewel sekere outeurs voel dat die woord farmasie in die oud-Egiptiese woord ph-ar-maki (waarborg van veiligheid) sy ontstaan het,1 kom dit meer waarskynlik van die Grieks, pharmakon, wat oorspronklik 'magiese kuur' beteken het.2 Tydens die klassieke beskawings van Griekeland en Rome verdwyn die onderskeid tussen geneesheer en medisynevervaar-