# Health Care Beyond Apartheid

## Economic Issues in Reorganisation of South Africa's Health Services

**max price**

*The consequences of apartheid for health policy in South Africa are profound. Racial differences in health status and the allocation of health care reflect the inequalities of power and wealth produced by the political economy of apartheid. Furthermore, health policy is itself instrumental in furthering apartheid goals. It might be tempting then, to rely on the demise of apartheid and subsequent democratic redistribution of power and wealth to redress the fundamental inequalities in the provision of health care. Yet, as has been seen in Zimbabwe for example, radical political change is not sufficient in itself fully to transform the health services. Likewise in South Africa, it will require more than the mere removal of apartheid policies to attain health for all. This article analyses the economic organisation of health services in SA, so as to identify various structural obstacles to the provision of health care for all, which could well survive the demise of apartheid. The article analyses the proposed options for reorganising the economic structure of the health services to decide whether they make economic sense and to indicate the likely consequences of particular choices. It does not assess the political possibility of their implementation.*

*The article is abstracted from the author's Master's dissertation to the London School of Hygine and Tropical Medicine, published in full in* ***Critical Health****, March 1987.*

IN 1944, in South Africa (SA) the Gluckman commission proposed the establishment of a comprehensive national health service. Few of the commission's recommendations were implemented. However, while not committed to the principle of a national health service, the Nationalist government steadily increased its control over the health services during the 1960s and 1970s. Since the late 1970s the trend has turned towards greater privatisation. This has recently been accelerated by the state's current fiscal crisis, combined with escalating health care costs. There are also strategic political and ideological reasons for the change in the state's policy towards increasing the number of people who use private sector providers. This trend has been supported by various private sector organisations, think-tanks, companies and professionals. On the other hand, there is also a growing concern about the inadequacy of the present health services amongst some professionals and political organisations, many of whom have called for the establishment of a national health service. Thus the debate on the choices to be made regarding how the health services should be financed, has again flourished.

Not surprisingly, it is often emotive, and positions are taken primarily because they are in line with the broader ideologies of the authors. But more importantly, when economic arguments are marshalled, they are frequently confused. Choices are crudely defined, since the options of 'privatisation' and 'nationalisation' are presented as if they were each a single uniform phenomenon. On closer examination however, it will be seen that the nature of each is more complex, and defined by a range of possible combinations rather than one essential feature. The choices in the economic reorganisation of the health services, therefore, comprise a series of options which should be examined discretely.

The effects of the system of apartheid on health and health care have been extensively researched and debated. These studies have focussed largely on those aspects of the health services that fall under direct government control — viz. the public health sector. There has been very little research or debate on the health service as a whole and in particular, its economic structure. Recently, however, this debate has flourished.

Although for most of the 1970s the government seemed to view the provision of health services primarily as an obligation of the state, and seemed to tolerate the private sector with some suspicion and a good measure of control, the recession and fiscal crises of the late 1970s and 1980s have resulted in a dramatic shift of attitude:

> Curtailed by the lack of resources, especially financial, .... a more active process of privatisation of health services is indicated. Dr. Francois Retief, Director General of the Department of Health and Welfare, 1985. [2]
>
> We will have to guard against being compelled to move away from the free market system. (The Minister of Health and Welfare in parliament, March 1984.) [3]
>
> Health authorities must not be seen as an infinite source of health facilities and medical care. More people should be able to make use of private health facilities as their economic circumstances improve. (Dr. M.H. Ross, Department of Health and Welfare, 1982.) [4]

The government appointed the Browne Commission of Enquiry into the Health Services in the Republic of South Africa in the early 1980s. Although it has recently submitted its report, this is not yet published at the time of writing. Since 1980, SYNCOM (PTY) Ltd, a private sector 'think-tank' organisation, has received several commissions to research the future of health care services in SA from the Pharmaceutical Society of SA (PSSA) and the Health Strategy Group (HSG). The HSG is composed of the Medical Association of SA, the Dental Association of

SA, the Chemical Manufacturers Association of SA PSSA, the Propriety Association of SA, the Representative Association of Private Hospitals, and the SA Nursing Association. In August 1985, the department of health convened a meeting at which representatives of the HSG, industry, academia and the public sector deliberated on the options for privatisation of health care. Out of this, four working groups were established which presented their consolidated report in February 1986.[5]

Between August 1985 and June 1986, the South African Medical Journal (SAMJ) carried 14 letters, an editorial and an opinion column on the subject of whether or not a National Health Service (NHS) would be appropriate for S A. So the future economic organisation of health services in South Africa is very much on the agenda.

**The 'Ideological' Arguments**

Much of the debate simply reflects participants' vested interests and ideological tendencies, with little attempt to explore the consequences of proposals honestly and rationally. For example, one opponent of NHS, in a letter to the South African Medical Journal (SAMJ), claimed, "They (the advocates of NHS) are simply advocating socialism", as if that were sufficient reason for his opposition. Far more disturbing though, is the following allegation by SYNCOM about a report it prepared for the HSG in 1982 (known as the SYNCOM III report): "The draft to the final report contained chapters on the future role of the Associated Health Service Professions, on the changing scientific paradigm, and on the need to shift the incentive in health care from the curative aspects to primary health care with emphasis on life styles and prevention... It was unfortunate that most of these chapters and observations had to be deleted, since they were perceived to clash with vested interests."[7] And, on the other side of the debate: "In our view, the right to health implies provision of health services which are free, ...."[8] There may be good reasons why some or all people should not have to pay for health care at the point of service, but this has to be argued and the consequences examined, and certainly does not derive automatically from the premise that health is a right.

The examples of these arguments which follow are given in order to illustrate my contention that they are confused because of the analytic approach they adopt. The substance of the arguments will only be assessed later, since the point here is only to justify the presentation of an alternative analytic framework.

Although presented with many minor variations, most of the arguments for privatisation are covered in the report of the four working groups on privatisation and deregulation, and may be summarised as follows:

1. As the demand for health care, and health care costs escalate, the government and taxpayer will not be able to afford the health care bill. Privatisation reduces the costs to the state of health care because:

(a) Privatisation shifts this burden from the public sector to private individuals. The implication is that because private health care is not provided free, patients have to pay for it and therefore they carry the costs, not the government.

(b) If people have to pay for health care, the tendency to overuse health services can be reduced considerably.

(c) Since all parties are agreed that a minimum level of health care must be provided for the indigent, the aged, the chronically ill etc, where necessary the government should subsidise the individual, not the institution. This is claimed to be cheaper for the government because private providers in a competitive market are more efficient than bureaucratically controlled, non-competitive public providers.

2. Privatisation permits a range of levels of health care to be offered by providers. This not only increases consumers' choice of provider, it also permits discrimination, or rationing of health care along non-racial lines, thus depoliticising the issue.

3. People attach more value to services for which they have to pay.

Argument 1(a) is concerned with the possibility of raising funds by making private individuals pay to use health services, thus easing the burden on the state. Yet, hospitals do not have to be privately owned, nor do doctors have to be in private practice for this to occur, since such charges could quite conceivably be made for publicly owned services. Thus this argument relates to methods of paying for health services (public versus private sources of funds), not the pattern of ownership of services (the provision of services by private, independent health workers and facilities).

Arguments 1(b) and 3 are concerned with reducing the demand on the health services, using fees as a disincentive to patients so that they do not use the services 'unnecessarily'. These incentive effects on demand for health care depend on the use of user charges, third party systems of payment and other factors all related to the methods of financing health care, not the pattern of ownership of health services. For example, if patients have 100 per cent health insurance, then there is much evidence that their demand for health care increases, regardless of whether they are being treated in the private or public health sectors.

Just as public facilities can charge for their services, public funding can be used to pay private providers, as is suggested in argument 1(c). This argument is obviously concerned with a different sense of privatisation, viz, multiple private owners of health services rather than private sources of funds.

Argument 2 is about rationing scarce resources and the consequences for equity. Privatisation here refers to a particular pattern of ownership, viz., multiple providers; a particular method of financing, viz., private payment via

'user charges' or voluntary health insurance; and a particular form of remuneration of providers, viz., on a fee-for-service basis. Only with such a combination can the quantity and quality of service be varied according to how much a patient is willing to pay.

Much of the confusion in the debate on privatisation results from the failure to separate out three distinct aspects of privatisation: (1) private sources of funds; (2) payment of providers on a fee-for-service basis; and (3) private ownership of services. More generally, it is necessary analytically to recognise three distinct components in the economic organisation of any particular health service. These components are: (1) Methods of financing health services, i.e. how funds are raised to pay for health services; (2) Methods of remuneration of providers; and (3) Patterns of ownership of the health services.

When we turn to the international literature to throw some light on the debate about the economic organisation of health services, we find similar confusions arising from the same analytic failure to disaggregate the components of the economic organisation of health care as was found in the South African debate. Two examples are examined here to illustrate this.

**Debate About Private Practice**

In an article entitled 'Private Medical Practice: Obstacle to Health For All' Roemer identifies the following problems associated with private practice: (1) perverse incentives leading to unnecessary investigation and treatment, and escalating health service costs; (2) inequity resulting from the inability of lower income patients to afford fees to cover treatment costs; and (3) maldistribution of medical manpower caused by doctors' attempting to maximise their income by moving to areas where demand is high, i.e. where there are large numbers of people who can afford private medical fees.[9]

But are these problems endemic to private practice or do they apply to a particular form of private practice? If the latter, how can we identify what it is precisely about that form so that it can be selectively altered? I will take the problems Roemer identifies in turn.

1. The problem of perverse incentives and escalating costs arises because, in the health care market, the supplier is an important determinant of demand and therefore perfect competition fails. This problem may be aggravated when the provider is reimbursed on a fee-for-service basis, such that the more expensive the investigations and treatment, the more the provider benefits. As I will show later if private practitioners were paid on a capitation basis, whether by the patient directly or by the government or other third party, the perverse incentives would disappear although ownership of the services would remain private. In other words, the problem needs to be analysed by focussing on the method of remuneration of the provider since this is not inherent in the pattern of ownership (i.e. private practice).

2. Unequal access to health care due to inability to afford fees is mainly a problem for poor people who do not participate in any risk sharing scheme. In Western Europe, where 90 per cent to 100 per cent of the population are covered by social security, the inability of the poor to afford the fees of private health care is largely solved. (This is not to say, of course, that non-fee costs, utilisation, quality of care or distribution of burden of financing is equitable.) Again, the point here is that the criterion in this discussion, equity, relates specifically to the method of financing, rather than to the institution of 'private practice'.

3. The maldistribution of doctors in favour of the urban rich again depends primarily on the method of financing. For example, if private, self-employed doctors were paid an adequate fee-for-service by the government on behalf of the poor (i.e. by subsidising the individual), they might move to areas where they could maximise the number of patients per doctor. This could produce a reasonable distribution of doctors. The maldistribution of private practitioners is more accurately attributable to whether private or public sources of finance are used, than to how they are reimbursed, or the pattern of ownership.

Thus we can only make sense of Roemer's criticisms, given a strict definition of 'private practice' as entailing self-employed providers, dependent on fee-for-service for their income, where the fees are paid by patients with no risk sharing arrangements or third party payment systems. Roemer probably intended this definition. However, as the responses to his article exemplify[9], others may not accept such a strict definition and the different meanings of 'private practice' (e.g. direct payment by private individuals, competing privately owned practitioners, etc.) are one source of confusion in the debate. Yet this could be readily overcome by making one's definition explicit.

The more serious criticism though, is that the discussion fails to recognise that the economic organisation of health care (in this case, private practice) has three analytically distinct components viz. financing, remuneration and patterns of ownership. The failure to disaggregate the institution into its component parts masks the fact that judgements made about the institution as a whole, are in fact the result of judgements about one or other component of the institution. It is this failure to apply evaluative criteria to the separate components individually that results in much of the confusion that surrounds debates about the pros and cons of different ways of organising health services.

One way in which authors frequently deal with the conceptual difficulties that arise, is by apparently restricting their discussion to the first component — the financing of health services. However, their failure to identify the other two components often results in the de facto inclusion of the latter under a discussion of 'financing',

and the same confusion recurs. Zschock, for example, categorised the possible ways of financing health services as follows:

(a) Public and quasi-public sources — general tax revenues; deficit financing (including foreign loans); sales tax revenues; social insurance; lotteries and betting.

(b) Private sources direct financing of health care by employers; private health insurance; charitable contributions (including foreign grants in aid); direct household expenditures for health; communal self-help.[10]

Although these categories appear to relate only to financing, the discussion that follows this classification suggests otherwise. For example, with respect to general tax revenues, Zschock argues that "to increase significantly the proportion of general tax revenues allocated to health care ... would imply a movement towards increased socialisation of the health sector by providing free or low cost health care services for most or all members of society."[11] Yet there is no necesary connection between the extent of government funding (a financing issue) and the socialisation of the health sector (which concerns patterns of ownership, if socialisation means the extent to which health workers are employed by the state). Public funding very frequently goes to the private sector directly as fees (e.g. Medicare in the US), or as subsidies to social security, or as capitation fees to GPs. The methods of remuneration, the patterns of ownership of the health services and the various combinations of financing methods are all separate questions.

Social insurance or social security is another example of confused debate. Some authors do attempt to distinguish different forms which social security systems might take, e.g. direct (employing health workers and owning facilities) and indirect (paying independent private practitioners and facilities), multiple or single providers. [12,13,14] Abel-Smith makes the point that the many problems attributed to health insurance are not intrinsic to health insurance as a system of financing services, but to other associated features — e.g. in Europe, the fee-for-service remuneration system, and in Latin America, the separation from the ministry of health and the competition among the many social security schemes for scarce personnel.[15] Thus analysing social security as a method or source of financing is confusing unless the point is to show that very little can be said that is true of social security systems in general. Once again, the analysis would be facilitated by disaggregating the three components.

### An Alternative Framework

The left hand column of table 1 sets out an alternative framework for the analysis of the economic organisation of health services. This has firstly been divided into its three component parts. Secondly, within each component a number of possible methods are identified. The methods within any component are not mutually exclusive, and frequently occur together in the same organisational form. For example, private health insurance may require co-payment and thus the method of financing includes user charges. For the sake of continuity with the conventional taxonomies, the table attempts to indicate the links between the categories used in this analysis and conventional categories (in the right hand column). Also in the right hand column are the institutional forms which usually manifest the particular method of financing, or remumeration, or pattern of ownership.

### Increasing Finances For Health Care

In the debate on health care financing in SA, privatisation has most frequently been supported on the basis of the claim that it will result in more funds being made available for health care. The argument, typical of that common in the international literature, usually runs something like this: The level of resources that a government can raise and devote to health services will always be less than is required to meet the health needs of the whole population. (Indeed, even if the whole GNP were allocated to health, this would not meet the total needs). If, however, there are individuals or groups of individuals who are willing to pay more for better health services than can be provided through the public health sector, this should be encouraged because it can release the public funds spent on these individuals. Thus total resources allocated to health services can be increased, and public health expenditure can be concentrated on the poorer members of society.

This type of argument in favour of privatisation depends on a number of assumptions which are only valid under certain conditions. The following discussion identifies the conditions under which each assumption would hold, and shows that these do not obtain in SA at present. It suggests how these conditions would have to change in order for privatisation to make economic sense as a means of increasing the total financial resources devoted to health care.

### First Assumption: Public and Private Methods of Financing are Independent

The first assumption is that the increased expenditure by other sectors (private individuals, medical schemes, employer- provided services) releases public expenditure that would have been spent on the beneficiaries of those sectors. Thus, for example,

> (The private sector) is self-perpetuating and independent of government finance. ... (it) is therefore not to be considered a drain on public funds. (Submission from Hoffman Hospital Group to the Browne Commission Enquiry.

> (P)rivatisation of health services ... would lead to considerable savings in terms of demands made on

**Table 1 : Three Components in Economic Organisation of Health Services and Available Options**

| Components of health service organisation and options within each component | Conventional categories and Institutional form usually taken |
|---|---|
| **A. Methods of Financing:** | |
| **Public Methods of Financing:** | |
| Taxes - General | Income, company, property taxes |
| - Sales tax, import/export duties | Sales tax, tariffs and duties |
| - Charging out costs to those who generate them | Motor vehicle licences and compulsory third party insurance |
| | Taxes on tobacco, alcohol |
| | Workmen's compensation contributions from employers |
| Deficit financing | Deficit financing and foreign loans |
| Foreign Aid grants (bilateral/multilateral) | Foreign Aid grants (bilateral/multilateral) |
| Lotteries and betting | Lotteries and betting |
| **Public, Quasi-public or Private Financing Methods:** | |
| Employer & employee contributions (other than general taxes) | Direct provision of, or payment for health services by employer |
| | Payroll taxes |
| | -National health insurance |
| | -Social security, compulsory health insurance |
| | -Private health insurance |
| | Charges related to generation of costs |
| | eg. workmen's compensation |
| **Private Methods of Financing:** | |
| Charitable contributions | Frequently from wealthy families, firms, religious groups |
| Private health insurance | Private health insurance |
| | Direct household expenditure |
| User charges | Direct household expenditures— for treatment and drugs etc. |
| | Co-payments — proportion of total costs, deductibles, excess above ceilings, for excluded benefits |
| **B. Reinmbursement of Providers** | |
| Fee-for-service | Private practice |
| | "Indirect " social security (eg as found commonly in Western Europe) |
| | Private health insurance |
| | Direct household expenditures |
| Capitation /pre-payment fees | Health maintenance organisations |
| | National Health Service "contract arrangements" with GPs (eg Britain) |
| | Community based/cooperative financing (eg Brigade level health care, China) |
| Salaried/budget allocation | Government provided health services |
| | "Direct" social security systems (eg as found commonly in Latin America) |
| | Employer provided health services |
| Others eg. bonus systems, merit award | |
| **C. Patterns of Ownership** | |
| Predominantly public owned health service (other sectors very small) | eg National Health Service (UK), small private sector, small or no quasi-public sector. |
| Multiple sectors, Many private providers as well as public and quasi-public sectors | Public sector as well as one or more social security schemes and/or employer providers and/or self employed practitioners |
| Community owned health services | Community financing [16] |

the central coffers (Report on Privatisation and Deregulation of Health Care in S. A., 1986 — hereafter referred to as the Report on Privatisation.)

However, the private sector is not, at present, "self - perpetuating and independent of government finance." For, the public sector subsidises the private sector in numerous ways.

***Tax concessions:*** Under corporate tax law, the contributions paid by employers are tax deductible, and the contributions paid by individuals are abatements under individual tax provisions. In 1982, medical schemes' income from contributions was approximately 54 per cent of total private health expenditure (26 per cent of total health expenditure) of which at least one-third is subsidised by the state, i.e. the real cost is 50 per cent more than what employers and employees pay. [17] This loss of tax r ue (at least R337 million in 1982), was equivalent to 1 er cent of total public sector health expenditure, and more than twice the total amount spent on preventive ser. ices.

***Subsidies For Medical Education:*** The major share of the costs of medical education is borne by the public sector. This is a form of 'human capital' investment by the state. When the doctor is employed in the public sector, it may be assumed that his/her salary undervalues his/her output by an amount equivalent to the return to the state on its investment. When a doctor is either self-employed or employed by another sector, the additional value accrues to him/her and to his/her patients. This value is an effective subsidy to those sectors from the public sector.

Estimates of the cost to the state of the undergraduate training of a doctor vary from R36, 000 [18] to R100, 000. [19] 937 doctors qualified in 1985, half of whom will eventually work in private practice. This is equivalent to a state subsidy of R47 million (2.4 per cent of public expenditure) to the private sector, excluding the costs of post-graduates' training.

***Subsidised Use of Public Facilities:*** Publicly financed facilities are usually available to private sector patients (especially for sophisticated tertiary care), but also frequently for routine care under private doctors. Most patients requiring emergency admission are admitted to public hospitals regardless of their income and whether or not they are covered by medical aid. These patients are charged at less than the running costs of maintaining the beds (i.e. ward costs), let alone the full costs of investigation and treatment. In 1984/5, in the Cape, the average daily cost for an in-patient at a teaching hospital was R130.14, for which the maximum fee of R45.00 was charged. (In provincial non-teaching hospitals the costs and maximum fees were R55.45 and R36.00 respectively.) [20] Thus the government is subsidising the non-public sectors.

***Other Forms of State Subsidisation:*** The government, as one of the largest employers' pays employer's contributions so that its own employees will have medical aid coverage, and be able to use the private sector providers. Many other forms of subsidy would be too complicated to measure — e.g. the costs of training nurses and other health workers, the cost of research, drug testing and control, and other parts of the health service infrastructure which benefit private sector, and public sector patients alike.

Thus it is not at all clear that the private sector does indeed release public resources for use on services for those who cannot afford private health care.

It is likely that the individual who uses the private sector providers costs the government more in subsidies than is spent by the government on individuals who depend on the publicly funded services. [21] The subsidy to the private sector therefore, distorts public sector resource allocation in favour of those who are already the most privileged. However, there is no theoretical reason why subsidisation of the private sector cannot be reduced.

The state could quite conceivably withdraw tax concesions; it could charge private patients the full cost for the use of public facilities; doctors who leave the public sector could be obliged to pay an additional tax on their earnings, etc. Withdrawing all subsidies may raise the costs of private health care so high that demand is transferred to the public sector. The costs of meeting this demand may therefore reduce the net savings to the state.

Nevertheless, the assumption that other sectors release public resources which can be directed to higher priority services, often ignores the many ways in which the public sector subsidises other sectors, and the distortive effects this has on public sector resource allocation.

**Second Assumption: Only Private Sector Services Can Raise Funds from Private Sources.**

The second assumption in the argument that privatisation increases total funding for health services, is that publicly owned services are financed from public sources of funds, and privately owned services, from private sources which would not otherwise come into the health sector. As the Report on Privatisation expressed it, "Privatisation seems to imply a shift towards health as a personal responsibility and feel and unlimited access to health care as a privilege."

Yet this assumption fails to separate, and distinguish between, private ownership of services and private sources of finance. Privatisation of ownership is only one way of getting private individuals to finance their own health care. For, user charges can be a method of financing public sector providers just as it is for the fee-for-service providers. Publicly owned services need not be financed entirely from taxation, but can draw on other methods of financing as well, e.g. social security, health insurance and user charges.[22]

**Third Assumption: Political Pressure for Public Funding Will Not Decrease.**

The third assumption is that the existence of a private sector would not inhibit or depress the amount raised by public methods of financing and allocated to health care. Yet, in the presence of other methods of financing from private sources, and alternative private providers, it is likely that the people with political influence (usually the relatively wealthy, urban dwellers with regular employment), will not be dependent on the publicly financed services. There is a strong chance, therefore, that they would not lobby either for increasing the tax effort or for allocating a greater proportion of public expenditure to the health services.

Thus privatisation has been seen as a way of offering urban middle-class blacks access to racially integrated medical care of better quality than is available in the public sector. This has been motivated precisely by the belief that it defuses the political pressure from this articulate group to improve public health services for blacks in general, which would be extremely expensive. And as the Report on Privatisation concludes, "There is likely to be an overall saving to the taxpayer." Yet this may be one of the greatest dangers of privatisation, and may result in little increase in the total resources allocated to health care, and a decline in public sources of finance for the health services.

It is possible, though, that if a future democratic government were committed to providing the best public service the country could afford, that the existence of the private sector would not reduce the political pressure for raising public finances, and therefore total finances could be increased by permitting other sectors to operate and raise funds. Roemer's research in Latin America, for example, suggested that there was no decrease in the allocation of public funds to health services with the growth of the social security systems there. The overall level of resources available was indeed increased, and he argues that money that would otherwise have been spent on the costly and inefficient private health sector (if it had been spent on health at all) was channelled into the more efficient social security sector. At the same time, governments were able to devote larger proportions of their expenditure to deprived rural areas.[23]

The economic organisation of the health services should ensure that, for any given total expenditure, the health outcome is maximised. The concept of 'efficiency' encompasses both (1) financial efficiency and (2) economic efficiency.

## Financial Efficiency

Financial efficiency is a measure of the proportion of total expenditure that is spent in the direct 'production' of health care. If system 'A' produces the same output of health care as system 'B' but at lower cost, then 'A' is more efficient, financially, than 'B'.

With respect to methods of financing, financial efficiency refers to the difference between the gross and net yields of a particular method of financing. This relates primarily to the cost of administering the collection and allocation of funds. Other measures sometimes considered are the difference between actual and hypothetical gross yields and reliability or stability of a source.

The protagonists of privatisation claim that public methods of financing are financially inefficient. For example, in its conclusion, the Report on Privatisation and Deregulation in SA claims that, with privatisation, "more funds would be available for the direct delivery function through a reduction in regulations, interventions and central decision-making".

Yet there seems to be little evidence to support this. The government spends 0.34 per cent of tax revenues on tax collection, and 0.9 per cent of public health expenditures administering financial allocations to the health services.[24] Most medical schemes, on the other hand, spend between 6 per cent and 10 per cent of their income from contributions on administration, i.e. calculating and collecting contributions and processing claims. [25] There are also numerous examples of overcharging by private hospitals, since it is difficult for medical schemes to check the bills and there is little incentive for patients to check them, even if they are informed enough to do so. This reduces the efficiency of this method of financing, since it results in more being spent with no increase in output.

This evidence is compatible with the findings of two recent international health care expenditure surveys. Commenting on them, Navarro concluded that western industrialised countries with the greatest government funding and administration of health services have the greatest population coverage and the lowest administrative costs.[26]

There are no estimates of the costs of collecting user charges either in the public or private sectors. However the relative costs will largely depend on whether the user charges are flat rates, or are related to the costs of providers (as with fee-for-service providers). This will therefore be covered in the next section (on the efficiency of different methods of remuneration).

(a) Private fee-for-service hospitals: Many of the arguments presented in the South African literature in favour of privatisation, are based on the belief that competitive providers motivated by profit and dependent on fee-for-service for their income, are financially more efficient than non-profit, government-owned services where facilities have fixed budgets. These arguments also reflect a faith in the power of the free market to prevent higher costs and excessive profits being passed on to the consumer in higher prices.

A criticism frequently made about the financial management of public sector hospitals is that "public hospitals in South Africa do not operate on a true costing system and

nobody actually knows what it costs ... to keep a patient." This criticism is valid. However, it does not follow from this that these hospitals are managed inefficiently, and the lack of cost data means that no accurate comparisons have been made. There is therefore no good evidence to suggest that private hospitals are more cost effective than public hospitals.

Indeed, one might expect the reverse. For, firstly, there can be little doubt that the flat rate fees charged by public sector facilities, even when applied on some sort of means tested basis, are cheaper to administer than the user charges in the fee-for-service sector. For, in the latter, the need to calculate charges for each item (drug, investigation, use of equipment etc.) for each patient individually, makes billing complicated and costly.[27]

Secondly, most of the hospitals which operate on a fee-for-service basis are profit making enterprises. As the director of one of the Rembrandt group of hospitals said, "We came onto the scene in 1983 purely for business reason — we didn't do it for charity. We see the medical services industry as an area of growth." [28] The profit obviously accounts for some of the difference between the gross expenditure on health in the private sector, and the net amount actually spent on activities which improve health.

At a fairly crude level of analysis, there is considerable evidence suggesting that fee-for-service hospitals are more expensive for less output. Comparisons are hazardous because one is not comparing like with like. For example, the costs per patient-day in public hospitals may include the costs of training personnel, of treatment, drugs, etc, but generally exclude capital expenditure, while for fee-for-service hospitals, ward costs exclude medicines and treatment, but include amortisation of capital expenditure. There is usually no training of medical staff in private hospitals. The quality of care and of the 'hotel' functions may differ. Furthermore, many of the most expensive treatments are available only or mainly in public hospitals (e.g. cardiac surgery, neonatal intensive care) because these are not covered by most medical schemes, or they are not profitable. The following comparisons must therefore be treated with due caution, though the order of difference seems so large that it is doubtful that the direction would be altered by the net effect of these biases.

In the Cape, the Groote Schuur teaching hospitals had an estimated daily average cost per unit of R108.37, and an average for all Cape provincial and aided hospitals of R63.43. In the Transvaal, in 1983/4, the median cost per patient day of 69 provincial and provincial-aided hospitals was R63.27. [29] Compared with this, fee-for-service hospitals are estimated to cost R100 per patient per day for ward costs alone (hotel and nursing services), before the costs of any doctors fees, theatre costs, investigations, drugs etc. are added. [30] On the other hand, in some private sector industrial hospitals, which are non-profit, with salaried health workers, and which do not have to compete with other providers (as employees are obliged to use the services provided), the average cost per patient day in 1984 was R30.61, inclusive of all drugs and treatment. [31]

**Table 2 : Comparative Costs of Specific Curative Health Services in Public and Private Sectors 1984.**

| | Cost to Cape Provincial Administration | Cost to private patient at medical aid rates |
|---|---|---|
| GP Visit | R 10.00(a) | R 39.50(b) |
| Obstetric Confinement | R 567.00(c) | R 850.00(d) |
| Herniorraphy (5 day stay) | R420.00(e) | R 990.00(d) |
| Pneumonia (5 day stay) | R 420.00(e) | R 700.00(d) |

*Notes:*

a. Cost per patient seen at Cape Peninsula Day Hospital includes investigation, minor procedures, day theatre cases, district nursing and medicines.

b. GP visit and average medical aid pharmaceutical cost of R30 per patient.

c Cost per confinement at Peninsula Maternity Hospital, including complicated obstertrical cases and neonatal ICU facilities.

d. Uncomplicated normal medical aid patient.

e. Cost to the Cape Provincial Administration of a 5 day stay in Victoria hospital (a non-teaching hospital).

*(Source*: Frankish J, Thomson E, Budlender D, Zwarenstein M, Dorrington R, Bradshaw D. *Privatisation of Health Services— Who Benefits?* Unpublished. 1986.)

A more comparable and accurate analysis of costs in the public and fee-for-service sectors has been made by Frankish et al (Table 2).

In the light of the above, it is interesting to note the findings of a recent study in the United States, which compared the differences in the economic performance of matched pairs of 'for-profit' and 'not-for-profit' hospitals. While there were no significant differences in patient-care costs, the total charges and net revenues per case were both significantly higher in the 'for-profit' hospitals due to higher administrative overhead costs. The author concluded that 'for-profit' hospitals generated higher profits through more aggressive pricing practices rather than higher operating efficiencies. [32]

The imperfections of the market, in the case of health care, have been frequently discussed in the literature [33] and cannot be reviewed here. It may be concluded, however, that the evidence available suggests that the profit motive, and the competition of multiple fee-for-service private hospitals are no guarantee of greater financial efficiency. Indeed, such an economic structure is probably less efficient.

(b) *Effects of Methods of Remuneration on Efficient Use of Personnel Resources:* Doctors in SA have jealously guarded their monopoly over the right to diagnose and treat, and 'primary health care nurses' have only been allowed to perform a limited range of tasks in certain prescribed circumstances. There is adequate evidence from all over the world that, in both developing and developed countries, other health workers can perform many of these functions at lower training and salary costs. Yet South Africa's present inefficient system will not change as long as doctors earn more for seeing patients themselves, as occurs in a fee-for-service system. If, for example, doctors were paid a capitation fee, then it would be in their economic interests to employ cheaper health workers to perform the tasks for which they are competent, so that their own more expensive skills could be used more efficiently, while covering a much larger population.

**Effect on Financial Efficiency of a Multi-sector Pattern of Ownership.**

(a) *Wage inflation:* The competition between sectors for fixed resources forces up wages in both the public and private sectors. Comparing salaries of professionals in the public sector in 1984, the median salary (before tax) of male doctors was 26 per cent higher than engineers, 39 per cent higher than lawyers, but only 4.5 per cent less than doctors in the private sector. [34] As one private hospital managing director said, "We just take a lead from the government hospitals. When they increase their rates we simply add a bit more on to get the staff." [35] This is unrelated to productivity, and hence is purely inflationary and is financially inefficient.

(b) *Duplication and Economies of Scale:* In 1974, the de Villiers Commission found that there was a lack of planning, especially between provincial and private hospitals — an excess of beds had been provided in certain urban areas, resulting in too low a rate of occupancy in provincial hospitals as well as private hospitals. [36] But this is not merely the result of poor coordination. It is the inevitable consequence of access to different providers being restricted to different groups in the population (the rich and the poor) when these groups overlap geographically. Thus there will be many areas where both public and private facilities overlap merely because they are not open to all the people who live near them. If this results in the failure to achieve economies of scale, then average costs are high, and the arrangement is financially inefficient.

## Economic Efficiency

Economic efficiency, as opposed to financial efficiency, is concerned with the allocation of resources in socially optimal ways. The reality of finite resources means that more of health care entails less of something else, and within the health sector, more of one type of health care means less of another. Optimal economic efficiency occurs when the marginal rand produces equal benefit, no matter where in the economy it is spent. In a free market, the price mechanism may equilibrate supply and demand in a way that reflects individuals' relative evaluation of alternative combinations of resource allocation. However, in the health care market, the price mechanism fails to achieve economic efficiency for several reasons: the presence of monopolistic providers (e.g. doctors); consumers are not well-informed and have difficulty choosing between alternatives; providers influence consumption more than consumers; there are significant externalities such that the social benefits exceed the sum of the individual benefits (and therefore willingness to pay); and unequal income distribution results in monetary prices reflecting different marginal utilities at different income levels. [37]

Consequently, other mechanisms are needed (some of which may also use prices as signals to providers and consumers) to promote efficient resource allocation. Broadly speaking, these mechanisms act either on the providers to influence the supply of health services, or on the consumers, to influence the demand for health care.

The efficient allocation of resources therefore, depends inter alia on: (1) The ability to control allocation on the supply side — determined largely by the pattern of ownership of the services. (2) The ability to control demand for health services, i.e. to limit demand for each kind of service to levels that are socially optimal — dependent on the methods of financing and remuneration.

There can be little doubt about the economic inefficiency of resource allocation in a country where heart transplants are being performed while the vast majority of the population suffers from vaccine preventable diseases. This failure to allocate resources to where they will achieve the greatest health improvements for the maximum number of people, occurs because the economic agent, the decision maker, is split into parts with independent allocation systems. The result is that the benefits and opportunity costs of a given allocation are borne by different parts of the system. Put another way, even when the marginal rand spent by different parts of the system produces highly unequal benefits, no transfer of resources occurs between the separate parts of the system, in favour of those sectors where they could produce a greater marginal benefit.

The present system prevents the optimal allocation of resources in two ways. The first is the racial and geographic fragmentation of the public health service and the division of control over total health care spending between many sectors (government, medical schemes, employers, private individuals). The other is, of course, the control of public health services, by an undemocratic minority government. For such a government, the present policy may be 'rational' in the sense that it serves the interests of that government. Thus even if there was a single authority controlling all health resource allocation,

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in the absence of a democratic government, health policy would be unlikely to benefit the maximum number of people.

Yet, assuming that in the future there is adequate democratic control over public health expenditure, if private expenditure is significant, it will continue to produce inefficiencies since private individuals do not suffer the opportunity costs of withdrawing trained personnel and technology from the public sector. The effects on the public sector could be minimised, though, by removing any subsidy to the private sector. Then, if private individuals were willing to carry the full cost of, say, haemodialysis, public sector resources would not be diverted and the optimal allocation of public expenditure need not be reduced (although the economic efficiency of *total* expenditure would still be suboptimal).

The determinants of demand for health services are multiple and complex. Financial incentives are clearly only one group of determinants. Furthermore, it is difficult to say what the appropriate level of provision for any particular service is. However, in terms of economic efficiency, the quantity provided is optimal when it costs what society is willing to spend on it, i.e. the value society places on it relative to other possible uses of those resources.

When the economic organisation of the health services does not have adequate mechanisms for limiting demand to the level for which resources have been allocated, demand will exceed its optimal level, drawing in more resources and resulting in economically inefficient resource allocation. This also means that cost escalation cannot be controlled.

*(a) Economic Efficiency and Methods of Financing:* Third party methods of payment frequently result in economic inefficiencies and cost escalation. If individuals had to pay the true marginal costs of medical care, they would allocate their resources according to how they valued each, which would ideally reflect the relative cost-benefit of each. A collection of individuals, in the form say, of the state (ministry of health), or an insurance group, should allocate their collective resources the same way. However, having paid their insurance contributions, individuals who no longer have to sacrifice more in the short term for demanding more expensive curative care, will demand more than the value of that care to them (the problem of 'moral hazard'). Assuming, for this example, that the provider faced no financial incentives either to provide or withold treatment,(s)he will attempt to do what is best for the patient personally. To serve the patient's interests well,(s)he will administer additional care as long as there is some net benefit to the patient.

Yet this may be excessive from society's point of view since the same resources could have achieved greater overall welfare had they been used for some other purpose. In the long term, costs will escalate, with aggravated distortions and growing economic inefficiency.

*(b) Economic Efficiency and Methods of Remuneration —Problem of Perverse Incentives:* In the example above, it was assumed that the provider was interested only in what was best for the patient. However, given firstly, that the provider is the main determinant of demand for investigation and treatment, and for secondary and tertiary care, and secondly, that the patient can afford almost any fees either personally or through risk sharing arrangements, the fee-for-service system offers financial incentives to the provider to perform more investigations and treatment than are necessary or justifiable. This is the problem of "perverse incentives."[38] In Brazil, for example, doctors and hospitals receive the highest fees from private patients, slightly lower fees for patients on social security, and the lowest for indigent patients (paid by the government). The rates of caesarian section in primiparous women in 1981 were 75 per cent in private patients, 40 per cent in insured patients and less than 25 per cent in indigent patients.[39]

Usually the interests of the income maximising practitioner will not be in conflict with those of the patient — the marginal investigation may indeed increase the certainty of diagnosis. Furthermore, other non-financial incentives such as status, career advancement, medical ethical principles and regard by peers may protect the patient's interests. However, all these incentives work in the same direction as the financial incentives, encouraging the doctor to 'do more' rather than less, with little regard to the economic costs to society. Thus the system of fee-for-service remuneration aggravates the problem of efficient resource allocation and results in the dramatic cost escalation.

By contrast, the incentive effects of remuneration by salaries and capitation fees do not have the 'perverse' effects that occur with fee-for-service, with its consequences for cost escalation and economic efficiency. In prepaid (capitation) group practices the providers undertake to cover part or all the costs of treatment that a patient may require during the next year (or other period of time). This creates financial incentives not only to keep patients healthy in the first place, but also to limit unnecessary or excessively expensive tests, drugs, referrals etc. Saward and Fleming, for example, have shown that prepaid group practices can be more cost-effective than fee-for-service systems, largely because of lower hospitalisation rates.[40]

In S.A, as in most other countries, per capita expenditure on health care has escalated in real terms. One source (in the Report on Privatisation) estimates that real per capita expenditure by the state increased by 13.5 percent from 1975/6 to 1984/5 (i.e. 1.4 per cent annually, compounded). On the other hand, average Medical Aid premiums (which approximate per capita expenditure by medical schemes) have increased 500 per cent from 1975 to 1986 compared with an inflation rate of 387 per cent over the same period

(a real annual increase of 2.3 per cent compounded), i.e. more than 1.6 times the per capita rate of increase of public expenditure. [41]

Another source puts the increase in total (public and private) real expenditure on health (not per capita) at 26.5 per cent from 1978 to 1982 (or about 6 per cent annually compounded). Over the same period medical schemes' total real expenditure increased by 31.3 per cent (or 7 per cent annually compounded). Some of the factors that have contributed to cost escalation over the decade have been demographic changes e.g. aging white population, urbanisation of blacks, increasing income and sophistication of patients, increased coverage by medical aids (membership has been increasing by about 20 per cent in five years), increased provision of services, increasing costs of high technology equipment combined with a falling exchange rate, recession and poverty. All these trends are likely to continue. The economic organisation of health services ought to be able to contain costs at appropriate levels. Yet, there is evidence that in both the private sector and public sectors, the structure aggravates cost escalation and does not provide mechanisms for its control.

An increase in expenditure on health care is not in itself a bad thing, especially since the proportion of the GNP devoted to health care is relatively low (4.9 per cent), compared with most industrialised countries. Yet the following quotes indicate that, in the private sector at least, the cost escalation is due to the inability to limit demand to socially optimal levels i.e. to growing economic inefficiency.

In 1985, John Erntzen, chairman of the Representative Association of Medical Aid Schemes of S.A. (RAMS), said that as a result of increased claims: medical aid schemes throughout the country are on the brink of collapse ... (T)here is evidence that doctors are offering more services, often unnecessary, to make a living. ... RAMS has also found that doctors charge more and offer less services at any given consultation. ... (T)he man-in-the-street also insisted on a lot of treatment because he felt he was entitled to it because of his medical aid membership. [42]

He also claimed that, while medical tariffs in 1984 were an average of 4.4 per cent higher than in 1983: (y)et we have found that our claims costs for 1984 rose much higher than this: up 19 per cent on 1983 for general practitioners and 25 per cent for specialists. This can only suggest that more services are being performed (per beneficiary). Those doctors who rely on medical schemes for their income see our members on average 25 per cent more than those doctors contracted out." (Tony Leveton, executive chairman of Affiliated Medical Administrators [43].

And, in the Report to the Department of Health on Privatisation and Deregulation in SA, it is claimed that the "disproportionate increase (in private medical expenditure) can most likely be ascribed to an overuse of health care facilities in the private sector due to the present structure of Medical Aid Schemes".

These are exactly the obstacles to economic efficiency that are created by the inability to contain excess demand due to the moral hazard problem of third party methods of payment, and the perverse incentives effect when suppliers who influence demand are reimbursed on a fee-for-service basis.

This report to the department of health recognised that "the present triangular arrangement (consumer-provider-funder) is highly inflationary" and that, in such a system, "with state subsidy to individuals, the results could be disastrous." Yet its answer was that, " to overcome this, prepaid cover for health care should be market-oriented," so that people could attain the kind ofcover they require. But this is a *non sequitur*. For, no amount of market orientation will alter the inflationary triangular arrangement. The report goes on to say that the members of the four working groups that produced the report could reach no agreement because of strong vested intreests", and that this "requires much further detailed study once the principle has been accepted." (One might have thought that such a study should precede acceptance!)

Thus, on the one hand, they are unable to accept the logic of their own arguments because the conclusions would conflict with"strong vested interests". On the other hand, since they refuse to question their assumptions about the efficiency of private sector health care, any observed inefficiencies in the present system are regarded as the indications that further privatisation is required. As we have seen, the real problems are the fee-for-service method of remuneration and the dependency on health insurance as a method of finance.

These are not the only obstacles to limiting demand to socially optimal levels. Any mechanism that lowers fees below their marginal cost may result in `excess' demand. And, as was suggested above, even when there are no perverse incentives (such as with salaried doctors), supplier induced demand, and hence costs, are difficult to control. These latter problems occur in the present structure of the public sector, since the doctor does not have to carry the costs of the quantity of care (s)he provides, and the opportunity costs of such care frequently exceed the marginal benefits. However, in the public sector, where total expenditure is constrained by a predetermined budget, suitable management mechanisms could be developed to control the supply of services and thus control costs.

Any changes in the economic organisation of health services designed to meet the objective of greater economic efficiency, must clearly move *away* from these methods of financing and remuneration by introducing selective user charges; by reinbursing providers on a capitation fee or salary basis; and by making providers bear some of the cost of the demand they induce. In the public sector, manage-

ment systems will be required to ensure that resources are directed towards those communities and types of health care that produce the highest marginal benefit.

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17. For every R1 contributed, 50c is paid by employers, most of whom are companies. The company tax rate is 50 per cent, thus the company effectively pays only 25c and the government pays the other 25c (through loss of tax revenue). The employee pays the other 50c. The lowest rate of individual taxation is 16 per cent (the highest rate on the marginal Rand is 50 per cent). Even if all employees are assumed to be on the lowest rate, the effective government subsidy is: 16percent X 50c = 8c. Therefore the total minimum subsidy is: 25 + 8 = 33c in the rand.
18. Calculated from figures given in reply to a question in the House of Assembly. *Hansard* February 27, 1986, column 256. "The estimates are based on the subsidy formula used for calculating the 1986subsidies" i.e. they are not based on calculations of cost.
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21. The total value of these government subsidies, divided by the number of people who benefit from them (approximately 20 per cent of the population who use the private sector providers), is likely to be more than per capita public sector health expenditure. The tax concessions alone, which equal at least 17 per cent of the public health budget, benefit only about 16 per cent of the population (the proportion covered by medical schemes). If the whole public sector health budget were distributed evenly over the whole population; the per capita expenditure would be less than the amount of the tax subsidy to private sector users.
22. The Chinese system comes fairly close to this arrangement. At secondary and tertiary levels of care, there is only one sector providing care and this is charged for. The methods of financing used to pay these charges depend on whether the patient is a government employee, a commune or brigade worker, a factory worker, a dependant of a worker, or not covered by any risk sharing arrangement in which case (s)he must carry the full cost privately. Prescott N & Jamison D T. Health Sector Finance in China. *World Health Statistics Quarterly*, 1984, 37(4): pp387 - 402.

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43. *Financial Mail* November 29, 1985, op.cit. pp 37

*Continued from page no. 2)*

other than what was already being written about. We were in no competition with fraternal journals which were focussing on these issues. And most of the ongoing debate on the three issues, whether in the mainstream or in the alternative press were themselves major contributions to the radical critique of health. There was another perhaps more important reason. For all of us on the collective the ***RJH*** was the second or third area of activity. That is all of us at different levels with different groups were already very much involved with these issues. The other forums, such as the **medico friend circle, the All India Drug Action Network, The Health Services Association and the West Bengal Drug Action Forum, Kishore Bharati,** women's groups and others, were putting in a tremendous effort to generate a public debate on critical problems in these areas. By tacit consent we decided to put our energies into these for a rather than in brin out substantial material in the ***RJH.***

What now? Do we still feel that the journal can fulfill a need? Have we contributed to the development of a marxist debate on health care? Certainly things have changed much since we began. For one thing the last four years have seen an upswing in the interest in and awareness of health issues. Interestingly the three issues we mentioned above have been both a cause and consequence of the changing situation. During this period we have also seen a large number of health periodicals, some occasional, some regular, emerge. Also, publications encompassing a broader canvass of social analyses have begun to devote more space to health issues.

We do not attempt here to answer these questions. Because we really have no means of evaluating the ***RJH*** qualitatively. We invite you, our readers new and old, to give us your feedback. Because after all the whole point in starting this journal was so that it could provide a forum for participating in the evolution of a radical, marxist critique of health. In the meanwhile we will continue to do our bit as best as we can.

So here comes a fifth year of ***RJH!***

**Padma Prakash**