Financing health care for all

Is national health insurance the first step?

By Cedric de Beer and Jonny Broomberg

"Political changes in the next few years are likely to produce demands for the development of a health care service more in keeping with the principles of social justice. One urgent problem is the limited resources to meet these demands."

Inequalities in access to health care between white and black, rich and poor and urban and rural communities in South Africa have been well documented in recent years.[1,2,3]

Political changes in the next few years are likely to produce demands for the development of a health care system more in keeping with the principles of social justice. One urgent problem confronting us is the limited resources to meet the consequent explosion in the demand for health care.

In 1987 South Africa spent 5,8% of its Gross National Product (GNP) on health care. Of this, 44% was spent in the private sector which cares for perhaps 20% of the population. The remaining 56% was spent on the care of that 80% of the population dependent on the public sector.[4]

This 56% amounts to 3,2% of the GNP, which is below the WHO (World Health Organisation) minimum target of 5%. The expenditure in the private sector while substantial, does not contribute significantly to meeting the health needs of the population as a whole.

Given that major economic growth is unlikely in the next decade, and that substantial resources need to be diverted to other social priorities, we will soon be facing two uncomfortable challenges: we will have to expand the range and quality of service provided without any significant expansion in resources available to do so; and, as a direct consequence, some way will have to be found to draw those resources currently expended in the private sector, into a carefully constructed system which aims to provide adequate health care for all.

In this article we argue that the implementation of a national health insurance programme would be a significant step towards meeting both these challenges. We suggest that through such a mechanism of centralised control of health financing, privately owned facilities and private practitioners will best be integrated into a national health system.

The case for central funding

Most writers distinguish between private and public sources of finance for health care.[5]

The most important private sources are individual out of pocket payments at the time of service, and contributions to private health insurance.

The two most significant sources of public financing are tax revenue and a centrally regulated system of public health insurance.

A fundamental principle of social justice in health care is that access to care should not be determined by factors such as wealth, race or geographical location. Attempts to fund health care from pri-

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Health care needs are often unaffordable to individuals if they have to pay the full cost of treatment as it occurs. Financing health care through user fees means that many people will not be able to afford the care they require.

Private health insurance has developed to protect individuals from sudden major expenditure. Almost all such private insurance is linked to employment, since the cost is shared by the employer. Where individuals pay the full cost of membership of a medical aid (insurance) scheme, the contributions would be unaffordable to the majority of citizens of South Africa.

Thus private health insurance also offends against the principle of equity on the grounds of affordability, especially in a country such as South Africa where there are large numbers of people without jobs.

Funding health care from private sources is also likely to lead to the development of two separate systems of health care: a luxurious private sector serving the privileged few, and an underfunded public sector providing inferior care for the majority. This leads to an excessive concentration of health care facilities and health care providers in those centres where the private contributors are most densely situated. This has clearly occurred in South Africa.[3]

Administrators of private medical insurance have an interest in excluding high risk patients from membership, since insurance schemes wish to avoid paying the medical bills for high risk patients, in order to keep premiums as low as possible. The result is that higher risk patients can only get care at considerably higher premiums. It is worth noting that risk ratings are being introduced into the South African medical insurance world since the relaxation of certain regulations governing medical aid schemes in October 1989.

Privately funded care almost inevitably pays only for curative health care. There is very little incentive for any individual to pay for preventive measures, in which the social benefits tend to be greater than the benefits to any particular individual. Thus the state is left to subsidise the preventive health care of privately insured individuals.[6] This leads to an unnecessary separation of preventive and curative services.

The existence of multiple private insurance agencies is itself an additional form of fragmentation. It makes it extremely difficult to develop and co-ordinate policies aimed at rationalising the provision of health care. The existence of more than 200 medical aid schemes in South Africa is a case in point.[7] The existence of multiple insurers also adds to overall administrative costs. It must be cheaper to administer funds through a single agency than through 200 different ones.

A single, centrally co-ordinated mechanism paying for health care has the potential to avoid most of these pitfalls, and has some additional advantages.

Where the vast majority of funds for health care are centrally co-ordinated, a two tier health care system is far less likely to develop. Where large disparities in the quality and quantity of care have developed, both regionally and in terms of social class, only a central funding agency will be able to reallocate priorities, and to direct growth financing to underdeveloped areas.

Thus a centrally co-ordinated funding mechanism which is established to finance health care for all has no interest in excluding anyone from access to health care, avoids unnecessary administrative expenses[8] and has the capacity to encourage the integration of curative, preventive and promotive health services within *the same administrative structures.*

Options for central funding

The funds to pay for central funding must come from the general tax revenue available to the government, or from some additional contributory scheme, such as a national health insurance scheme, in

achieve the central control over funding necessary to create a more equitable system of health care?

It appears that there are two possible courses of action:

- Expand tax revenue by several billion rand and pay for all health care out of taxes. This would leave untouched the funds currently paid to the medical aid schemes.
- Find some way to ensure that the money that people are currently paying directly to the private sector, is rather paid into a central state fund.

The other social priorities faced by the state means that raising the additional finances that will be required by the health sector will be very difficult. In this context, it seems obvious to us that the latter course of action should be chosen.

Legislation compelling employers and employees to contribute to a national health insurance scheme would work in much the same way as present contributions to medical aid schemes. The difference is that membership would be compulsory, and payments made to the Department of Health, rather than to the private medical aid societies as at present.

The state would define a fairly comprehensive package of health care that would be available free to all including the unemployed. All health services within the package would be paid for out of the combined tax and health insurance funds.

Thus it seems to us that national health insurance is the logical first step on the road to paying for health care for all.

Clearly the implementation of national health insurance will not guarantee an appropriate and socially equitable health care system. Other major developments are required such as the dismantling of all apartheid structures, the creation of greater administrative efficiency, and a commitment to comprehensive health care with sufficient emphasis on the prevention of disease and the promotion of good health. These prerequisites are beyond the scope of this paper.

What about the private sector?

A basic aim of centralised state funding is the progressive eradication of the two tier health care system. If this is to be achieved, it must not be possible for relatively privileged strata of society to pay for their ordinary health care needs in a system from which others are excluded because they are unable to pay.

In 1987 SA spent 5,8% of its GNP on health. 44% went to the private sector, catering for 20% of the population. The remaining 56% was spent on the care of the 80% dependent on the public sector.

This means, by definition, an end to the medical aid system as we know it. Private health insurance could only be permitted to pay for services not available within the package of care paid for by the national insurance system. The exact process by which the medical aid funds were dismantled, or incorporated into the national health insurance system would need to be negotiated and is also beyond the scope of this paper.

Whatever the desirable end point, health care planners will have to accept the continued existence of private hospitals and private practitioners for the foreseeable future. Without careful regulation, this private sector will perpetuate serious inequalities in the health sector.

The centralisation of funds in the hands of the Department of Health could provide this major mechanism for the effective regulation of private providers of health care. As the sole payer for health care, the department would, for example, be in a strong position to:

- ☆ Bargain with private providers over payment, prescribing patterns, referral and treatment policies, etc.
- ☆ Prevent the private sector from expanding in already well served areas.

Conclusion

The implementation of a statutory national health insurance scheme is a politically feasible way of moving towards greater equity in the health care system. It is a proposal that is likely to be acceptable to a wide range of interests including employers, employees, almost all users of the health service and many health care professionals.

Opposition to the proposal may be expected from the medical schemes and the private hospitals. Some private practitioners, however, would benefit from guaranteed payment for the agreed package of services, through a system substantially simpler than the present network of medical aid schemes. On the other hand, many of the social goals desired by the proponents of nationalisation, may well be achieved through a national health insurance system.

We believe it is an idea worth putting on the agenda for debate, refinement and negotiation. ❑

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