Everything you wanted to know about health systems, but were afraid to ask

an interview with Milton Roemer

Professor Milton Roemer of the University of California, Los Angeles is an expert on national health systems around the world. He is also a consultant to the World Health Organisation (WHO). The interview was conducted by Laetitia Rispel of the Critical Health collective around issues of the financing of health care, the different levels of service provision between the private and public sector, and policy decisions around drug lists and personnel.

Q. One of the features of the health care system in South Africa is that we have a large and powerful private sector. In 1987, for example, South Africa spent 5.8% of the gross national product (GNP) on health. Of this, 44% was spent in the private sector which serves only about 20% of the total population. Could you comment on the challenge we face in dealing with the private sector?

MR: The ideal system of health care financing would be that everything be based on taxes which are progressive, so that high income people pay more, and low income people pay less. But that kind of financing has never been achieved, except after many years of financing by insurance. Even in the case of the British and the Swedish and Norwegians, they had many years of insurance before they shifted to relying principally on taxes.

The other way is if you have a revolution, as in Russia, where they organised health services under general taxation. Even in Russia, though, they continued insurance for 20 years from 1917 to 1937, when they unified everything under a

national government tax-supported system.

I think it would be wise to draw up a financing system by insurance which would be politically acceptable. This would require everyone who is employed, any kind of employment - government or private, industry, agriculture or mining - to pay into the insurance system. The insurance would be paid partly by the worker and partly by the employer. The self-employed, for example, shopkeepers and small peddlers, could also pay into the insurance, but they would have to pay for everything since they have no employer. They might be able to get some protection if they earn below a certain income. Then for the low income people, who must always be supported by government revenues, it would be good to have the revenues paid into the insurance system on behalf of the low income people, so that there is not a separate system for the poor.

After many years of compulsory insurance or social insurance, (which I think is a better term) support for medical care and public health, it could take the course which was taken in Great Britain or in Canada. In Canada they had insurance on a province-by-province basis and then gradually each province shifted from insurance (earmarked payments by individuals and employers) to general tax revenues of the province and of the federal government. So after a number of years, the system became essentially tax supported. In Britain it is about 85% from general taxation with a little bit still from insurance.

I think that insurance is a politically acceptable form, because it is earmarked for health and it is payment by both the employer and the employee. Compulsory insurance for every wage earner in South Africa could be controlled by government nationally or by the provinces. The latter could be administratively responsible for collecting insurance contributions and for paying doctors. However, insurance is not the most equitable system. The most equitable system is to have health care paid by general tax revenues.

Financing is important, because it gives you power to do other things. Not that money is every thing, but if you have control over money you can effect how the money is used. For example, more organised services could be provided. So I think it would be wise to first develop National Health Insurance (NHI) and at the same time strengthen the delivery side by organising health centres and polyclinics.

I think the best medical care can be given by teams of personnel working together in health centres. You have a history of wonderful health centres in South Africa, but they were not sufficiently financed by the apartheid government. These primary health care centres that were started back in the 1930s - where doctors, nurses and others worked together - you most probably want more of these, where people can get health care from a team of personnel and not just from a private doctor in a private office which I know is preferred by many upper middle-class people. But this is wasteful and does not necessarily give good quality care.

So I think there should be as much development as possible of organised

The best medical care can be provided by teams of personnel working together in health centres or polyclinics. Photo: Medical Health Project

delivery of general medical care and preventive services by teams of personnel in health centres or what some countries call polyclinics. These health centres or polyclinics could have a number of different specialists, for example, paediatricians, obstetricians/gynaecologists, and maybe sometimes specialists in dental care or psychiatry as well as general practitioners.

Q. In South Africa we face the challenge of dealing with a large private sector. Opinion ranges from those favouring total nationalisation of health care to those in favour of leaving the private sector alone to collapse under the weight of its own limitations. Can you comment?

MR: I guess for some time you may be stuck with hospitals under private auspices, but I don't think the politics of South Africa, from what I know, would permit the new government to take over all the private hospitals as they did in Great Britain. In Britain the government did take over the private hospitals, but that was after 30 years of compulsory insurance. There was a critical situation in the British private hospital system after World War II. Hospitals in debt were taken over by the government. I think, after a certain number of years, the government could take over the hospitals, as they did in Britain and the Scandinavian countries.

Q. Could you comment whether it is possible to avoid a two tier system (that is, a private sector and a public sector providing different quality health care) in South Africa?

MR: A two-tier system is most likely to continue until there is complete integration under a democratic system of government. It would take time to get rid of it. I don't think there is a revolutionary situation in South Africa where power would be seized as in the case of the Bolsheviks in Russia or as in the case of China where a unified system could be established immediately.

Q. Some people in South Africa have suggested some form of centralised policy-making in health care, with decentralised flexible programme development. For many people that conjures images of a centralised bureaucracy. How does one overcome the tension between an overcentralised bureaucracy and too much decentralisation so that overall national priorities can still be devised and implemented?

MR: I have found it very hard to make generalisations, given the situation in different countries. The ideal, it seems to me, is to have a central authority to set standards and to provide money. The money, in the form of grants, should attempt to equalise different local areas which differ in natural resources and wealth. The local authorities should be responsible for implementation. In fact, there seems to be quite a world movement towards decentralisation and government at local level (be it county, municipality or district) being strengthened to be capable of managing all the health services within a local area of say 50 - 100 000 people.

Q: Assume we have NHI in South Africa. We can neither take over the individual private practitioners, nor can we prevent people from going to individual private practitioners. How does one encourage people to go to community health/ primary health care centres?

MR: The answer lies in strengthening the public sector. If you make the public sector attractive, people will be less likely to go to the private sector. Many countries have a dual system of private/public care, but there is an extra price to pay for use of the private sector. Many Latin American countries have social security (similar to NHI), but if a person wants to see a certain private practitioner, because they like the attitude of the doctor or his sense of humour, they can do so, but they have to pay out-of-pocket, whereas they don't in the public sector. That means that the private sector will be used by people with more money. If it is only going to affect 10% of the population, I don't think it is such an inequity.

Gradually that will be reduced I think. As a matter of fact, the experience in the Scandinavian countries has been that, as the public sector has been strengthened with good health care personnel and enough doctors and nurses, more people have used the public sector. Why should they pay more if they can get perfectly good care in the

public sector? In Sweden and Finland, the private sector has almost disappeared, but it is a gradual process.

Q: If national health insurance is implemented more than 200 private medical aid schemes will come to an end. How does one deal with the competing vested interests of this strong private sector lobby?

MR: In Australia there was a period when Australian NHI was carried out through subsidies of the private health insurance companies. Then the law was changed and it was made a government scheme with one big national fund. The private insurance still exists but on a much smaller scale. It only covers child-birth and elective (non urgent) surgery. Perhaps there is a role for private insurance, but only to serve the small percentage who are willing and who can afford to pay twice - taxes or social security and then to pay extra to private insurance for a private room in a hospital instead of a ward with 6-8 people or who want fast access to elective surgery for which there is a waiting list. No matter how many personnel one puts in a public system, the demand is usually high. The waiting lists for hernia and varicose vein operations are long, and people can break through the waiting lists if they have private insurance. The question is, of course, whether it is a serious inequity. Granted it does mean that people with money have a service which is a little better, but if the public system is made strong enough, the private sector gets smaller and smaller.

Q: You have written a lot about personnel issues. There is a lot of debate in South Africa about community health workers (CHWs) as part of the primary health care team. They have mainly been trained and used in rural areas and peri-urban areas. Some people have suggested that programmes should be implemented on a national scale, while others have said that South Africa is a middle-income country and could train higher level health workers.

MR: The use of community health workers with limited training is tricky. I feel they could be abused in a system which is not democratic, for example, when you say that those who live in cities or have enough prestige can see a doctor, but those who are poor and who live in rural areas should go and see a CHW. In my opinion, CHWs should be used in every system but as part of a team. If the team has doctors and professional nurses on it, there could also be CHWs for handling simple problems - not just for rural people but for everybody.

When it comes to a poor country in Africa, for example, Ghana, there are so few doctors, it may be necessary for everybody to be served by CHWs until they can build up an adequate supply of doctors. But these countries should have laws as were passed in Mexico and even Iran, to require that new medical graduates must serve in rural areas. Everyone then has access to at least young doctors, and gradually one can build up the supply. So I think we have to be careful that we don't just supply CHWs in rural

The most important freedom to ensure is that of people's access to medical care, not the freedom of doctors to practice where they like. Photo: Medico Health Project

areas or in slums, on the grounds that we can't get doctors to go there. Doctors should be provided where they are needed. The important freedom to ensure is that of people's access to medical care, not the freedom of doctors to practice where they like. The medical associations usually think that the most important freedom is for doctors to practice in a city where every thing is comfortable.

Q: There is also a debate in South Africa about the method of payment for doctors. Could you comment on the appropriateness of fee-for-service, salaries and capitation forms of payment?

MR: I think the capitation method has a great deal to be said for it, because it gives the doctor the incentive to have more patients choose him or her, and at the same time it does not give extra payment for extra procedures or services. It is interesting that in the Soviet system, one of the corrective actions that the new Minister of Health under Gorbachev is taking, was to introduce capitation payments on top of the salaries that the doctors get in a polyclinic. The doctor gets an additional monthly capitation payment for all the people that choose to be served by that doctor, and this makes the doctor careful to be nice to people.

I think that salaries are reasonable, but they should be elastic, they shouldn't be absolutely fixed. Even with a salary, you can have incentives for diligent work. Combining salaries and capitation has a lot of advantages.

Q: Drugs are another potential cost-saving area in health care. Could you comment firstly on essential drug lists, and secondly on how to deal with the vested interests of the multinational drug companies?

MR: The WHO has been promoting the idea of lists of essential drugs, that is, limiting the number of drugs that may be imported into a country, but only a few countries have adopted it for the total health system. Norway had a strict policy on something like 2000 drugs that could be sold in the country. About 50 countries have developed a list of essential drugs for public facilities. Usually a committee of top physicians and pharmacists selects about 200 - 300 drugs, usually the cheaper generics. That has been a real source of savings. One of the few countries that have done this for all drugs is Bangladesh, and it has achieved even greater savings. It was found that the companies that thought they were going to lose money did not lose money; there was just a trivial change in their profits.

The USA only spends about 8-9% of its national health expenditure on drugs, which is very high of course, whereas in the developing countries, where they have to import drugs, it may be 20 or 30% of national health expenditure. An essential drug policy is particularly important in these countries.

Q: In South Africa, as in the United States most of the pharmacists are in private practice and they run these pharmacies like supermarkets. What kind of role should pharmacists play?

MR: The pharmacy is a useful public resource for health care. I would like to see pharmacists being trained in health education, and maybe doing lab tests in an area, which could be convenient to people. All too often pharmacists are concentrated in cities and there is a shortage in rural areas, just like for other personnel. A demonstration of how the situation can be corrected was in Cuba, where they closed down the pharmacies in cities and built them up in rural areas.

Q: Community participation is one of the key components of the WHO Declaration of Primary Health Care. From your travels around the world, are there any countries where community participation is operative, and what lessons could we learn in South Africa?

MR: I'm afraid there has been much more talk about such participation than action. There are not many countries where citizen groups have played a significant part. One I happen to know about, and they take a lot of pride in it, is Cuba, where committees of consumers - people in the neighbourhood around each of its polyclinics and hospitals - have been organised. I don't know how effectively this has been done in other countries. The average consumer, I guess, even if he or she is a natural leader, feels a little hesitant to give advice on health issues, because they do not feel they know

enough about them. A lot more work needs to be done on community participation, and how citizens can participate in policy making at a local level.