RAISING THE PRICE OF PROVINCIAL HEALTH CARE: UNWISE AND UNFAIR?

In this paper, John Frankish and Merrick Zwarenstein from the NAMDA Tariff Group look at the rise in fees for medical services. This paper focuses on the medical service fees in the areas of the big cities which fall under the Cape and the Transvaal Provincial Administrations.

In looking at the rise in fees, it turns out that it is higher than the general rate of inflation.

The new tariff fees do take income and family size into account; but still, they put poorer patients at a disadvantage, and the price of health care would prevent many people from getting the medical care that they need.

In this way, the Provincial Administrations are not fulfilling their duty and their obligation to provide medical services to all who need them, at a price that people can afford.

This paper would, further, like to make some suggestions on how to improve the situation, so that the Provincial Administrations can carry out their tasks more fully and fairly.

Provincial Health Care Services in the Past

The provincial departments of hospital services always used to be responsible for providing curative health services to people in lower income groups. The Health Act of 1977 for the first time makes this a legal obligation. The provincial authorities have to provide for "personal health services". A "personal health service" is defined as any health service for examining and treating any person's physical or mental condition which

needs attention. The law does not specifically say that such services are to be provided for low income patients. But, in the past, provincial authorities and private medical services always had an agreement to lay down an income limit for patients to be treated in provincial health care. This agreement prevented competition between provincial and private health services for patients able to afford private, unsubsidised health care.

Conditions for appropriate provincial health care

If the provincial authorities are to fulfil their obligations to provide curative health services, they must not only have the facilities for medical care (such as hospitals, clinics, medical staff, facilities for examining, diagnosing, and treating patients, drugs, etc.); but they must also make sure that people in need of medical care can have access to the health care services.

The Tariff Fee Increases

Outpatient fees at the provincial hospitals in the Cape and Transvaal were increased greatly in April 1984 - in the Cape by 50% for all income groups and in the Transvaal by up to 250% for certain income groups.

Despite those very large increases, provincial authorities say that medical treatment is still accessible to all, because patients who cannot afford medical treatment can appeal to have their fees reduced. But if one looks at the fee increases more closely, it becomes clear that it is the average patient, rather than the exceptional patient, who cannot afford the fees of the provincial hospitals. According to official figures for 1980, more than half of Soweto households earn less than R300 per month. In the Cape Peninsula working class townships, the average income lies between R150 and R290 per month.

Results of the Increases

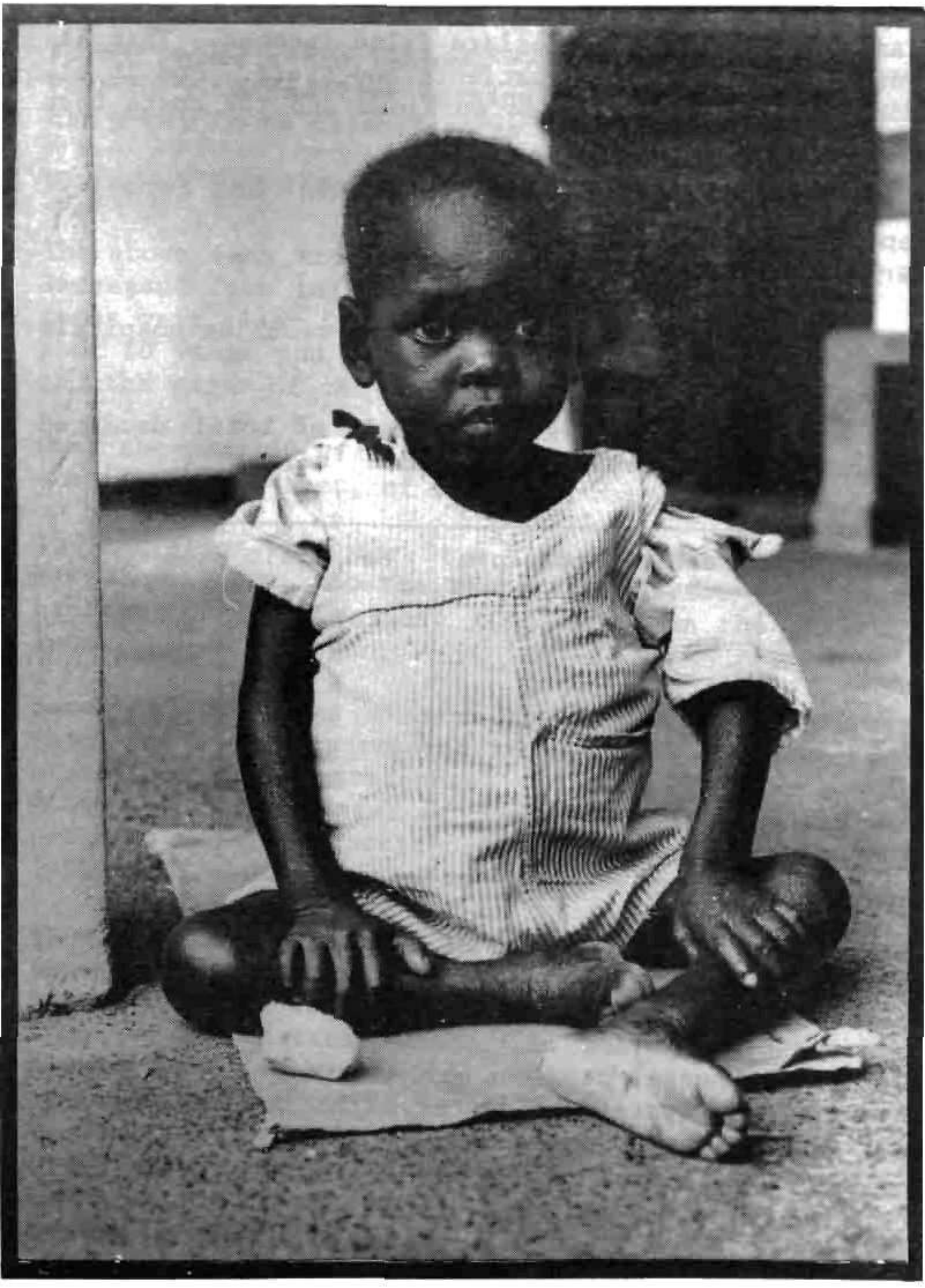
After the fees were increased last year, many patients could not afford to pay for medical treatment. As a result, the number of patients seeking medical treatment has gone down. The provincial authorities have not released any figures on this; but doctors in provincial health services confirm this drop in patient numbers.

There are many patients with chronic illesses such as hypertension, diabetes, asthma, and epilepsy who have stopped coming to hospitals regularly for follow-up treatment and medication. Now they often only come for treatment when their condition is completely out of control, or has become so bad that they do not have any other option but to come back for treatment. After they have been treated, they do not come back for regular check-ups.

The number of patients coming for dressings has also gone down. Meanwhile, it is very important for them to come to hospitals for getting wounds, chronic ulcers, burns, etc. dressed.

What is most disturbing is the fact that patients who have suffered from an acute illness hesitate to come back for follow-up visits, because they are charged for that return visit. So, for instance, it is uncommon today to have a child return for a Heaf reading, because patients are charged full rates even for that. Also, people hesitate to return for hydration checks, for circulation checks after they have had a Plaster of Paris cast, for follow-up of middle ear or of urinary tract infections in children, of pneumonia and jaundice, of anaemia, and so on. And as a doctor or health worker, it is difficult even to make a decision whether to ask a mother to return with her malnourished child when one knows that she cannot afford food for the family, let alone the costs of another hospital visit.

Apart from these immediate problems, the new fee structures have had other results which cannot be pinpointed so easily. The new fee structures have generally had



Child suffering from Marasmus and TB

the effect of undermining the relationships between hospital staff and patients. Many patients, for instance, feel forced to declare false incomes. This has caused embarrassment to patients and staff. And it has increased the bureaucratic workload and the costs that go with it.

Cape Provincial Administration Tariff Structures

The present outpatient tariff at non-teaching hospitals in the Cape is as follows:

Fees are payable on a sliding scale of total declared family income irrespective of family size:

Family income p.m.	Fee/visit
R 0- 50	R 1
R 50-100	R 3
R100-200	R 6
R200-300	R12
R300-400	R14
R400-500	R15
R500-600	R17
over R600	R18

Patients pay for a maximum of two visits per calendar month. Visits thereafter during that calendar month are free.

Patients on social pensions are seen free. (Unemployed patients on private pensions or with incomes less than that social pension are charged.)

Patients earning more than R600 a month are classified as private and are asked to go to a private doctor. (This ceiling was, in fact, R240 at the time of the tariff increases on 1 April 1984, and was increased on 3 August 1984 after representations to the authorities.)

Accounts are levied for any amount owed of R12 or more (including accounts from previous visits.)

Formal appeals can be made to have accounts reduced. Persons from families earning more than R600 per month can apply to be classified as hospital patients.

Fee Rises and Inflation

The above fees are very high. The true burden of the increased fees falls on low income patients. This becomes very clear if one looks at the increases over the past 10 years and relates these to the inflation rate and the wages of the average patient.

Over the past 10 years, there has been an increase, for each income bracket, of 500%.

The inflation rate for Cape Town over the same period was about 300%. So the hospital fees for each income bracket increased almost 60% more than the inflation rate.

Secondly, the rate of increase in subsidised hospital fees needs to be compared to the rate of increase in private general practioners' consultation fees as approved by the Minister of Health over the same 10 year period. General practitioners' fees increased by only 140% - well below the inflation rate for that period.

At one stage (during the period 1977-1979), the private fees were, in fact, increased by more than the inflation rate. But this increase was followed by such an outcry from private patients (who, in most cases, have the necessary political muscle), that the law was changed to give the Minister of Health final say over increases in the private tariff. He has never, since then, granted an increase more than the prevailing inflation rate.

Bracket Creep

So far we have considered only the fee increases for each income bracket over the past 10 years. This, unfortu-

nately, shows only part of the real fee increase which has taken place. The major effect of the fee increases is hidden in the so-called "bracket creep". While the fee for each income bracket has been increased (supposedly to take account of inflation), no corresponding adjustments have been made to the income brackets themselves. This means that patients find themselves moving up through the income brackets as their wages increase with inflation (but not with spending power), and so they find themselves in even higher fee brackets.

Other Problems

There are also other problems in the present fee structure which need to be mentioned.

Patients in the lower income brackets are asked to pay relatively more than patients in the upper income brackets. It would be more fair if all income brackets would pay roughly the same proportion of their income, or that the scales be weighted in favour of the lower income brackets.

The Cape Provincial Administration encourages patients to make use mainly of day hospitals. But patients who attend and pay at a day hospital and are then referred to a teaching hospital, are expected to pay a full fee yet again at the teaching hospital. This double fee can hardly encourage anyone to go to a day hospital first.

The Transvaal Provincial Administration Tariff Structures

The NAMDA Transvaal tariff study group has prepared a similar analysis focusing on the inpatient services of the Soweto Primary Health Care Clinics and Baragwanath Hospital which are run by the Transvaal Provincial Hospital Services.

"Computed Incomes"

In the Transvaal, the tariff category for a patient is decided on the basis of the computed income. This is

derived by dividing the total annual income by the number of family members plus one, for instance:
Five family members, total income per year - R2400
Computed income = R2400 6 (5 family members + 1) = R400

The method of adding one to the family size discriminates against larger families, tending to categorise them in higher fee brackets.

For instance: Two families, with the same income per person per month, but different in size, will have a different computed income and will often pay different tariffs.

Table: Family Size and Computed Income

Family Size	Annual Income	Income/ Person/ Month	Computed Income	Tariff/ Outpatient Visit	Class
2	R1800	R75	R600	R2.00	H4
4	R3600	R75	R720	R7.00	H5

Present Out-Patient Tariffs and Tariff Categories

There are four common paying categories, namely H3, H4, H5, and P3. Other categories are less common - these include social pensioners, persons with certain rare diseases, scholars from school clinics, long serving staff and patients whose fees are paid from other sources, such as Workmen's Compensation Act patients, prisoners, and so on. The present fees and tariff categories are as follows:

Current Tariff

Tariff Class	Computed Income(in Rands)	Outpatient Tariff Per Visit	Inpatient Tariff
H3	R 0-R 480	R 2.00	R10/admission
H4	R 480-R 600	R 2.00	R15/admission
H5	R 600-R1250	R 7.00	R20/day
P3	R1250 plus	R20.00	R45/day

Tariffs as a Proportion of Income

These tariffs take a large bite from the monthly income of patients who seek provincial medical care, particularly those in the lower income groups.

For example: A family of five with an annual income of R4800 (R80 per person per month) is classified H5. If two children each need one visit, and one return visit to a hospital doctor, the total cost is R28.00. That is 7% of that family's income. In addition, one child may be admitted to hospital for five days. In that case, at R20.oo per day in hospital, a further 25% of the monthly income is spent on medical care.

Comparison of Cape and Transvaal Provincial Administration Fee Structure

It is difficult to directly compare the fee structure of the Transvaal and the Cape Provincial Administrations; for the income brackets are different for the Transvaal and the Cape respectively. The Transvaal income brackets take into account family size, while the Cape income brackets do not do so. But if we take the family size to be five, we can compare the fees that patients from such families have to pay:

Income/month	Cape Fee	Transvaal Fee
R 0-R 50	R 1	R 2
R 50-R100	R 3	R 2
R100-R200	R 6	R 2
R200-R300	R12	R 2
R300-R400	R14	R 7
R400-R500	R15	R 7
R500-R600	R17	R 7
over R600	R18	R20

In both provices, fees have increased above the inflation rate.

In the Transvaal, an attempt has been made to adjust for bracket creep. This is the main reason why fees are so unequal between the two provinces. But the overall picture shows the totally arbitrary standards for setting fees. This calls for a nationally determined fee structure.

Why were the fees raised? - Refuting the myths

It has been argued that the tariffs could be raised because people are able to pay more. This would mean that real income rises have matched the 300% to 700% real rise in tariffs over the last 10 years. But studies have shown that this is not true. In the last few years, most household incomes have gone down in real terms. This can be expected to get worse in the current depression.

Another reason for raising the tariffs is the assumption that more Africans are members of medical aids, and that therefore people can afford the higher fees. But, in fact, only a very tiny proportion of Soweto residents are on medical aid. This is therefore no justification for raising the fees. The medical aids of which they are members often make people pay a part of the bill, and the patient usually has to pay an initial amount.

It has also been argued that many patients have factory health services provided by their employers. This, too, is only true for a small number of Soweto residents. In any case, these services are not always staffed by a doctor. These services are available to workers only, not to their dependants.The factory health services are closed outside of factory hours.

The health authorities have argued further, that many patients have switched to private general practitioners. There is no evidence to show that this includes all or even most of the patients who can no longer afford provincial health services. The fees range from R7 to R15 at the dispensing doctors whom most lower income patients would use. Therefore many of these patients are not able to afford this fee either. General practitioners usually do their best, but they cannot do investigations, or give patients expensive drugs for hypertension, diabetes, asthma, or other chronic illnesses.

The private profit sector cannot provide affordable health care to low income groups in the same way that the Primary Health Care clinics or Day Hospitals can. Therefore raising the tariffs and lowering the number of patients in the provincial sector is a contradicition, not a transfer of health services.

Even though the state might, in the short term, save money by raising the tariffs, it will not be able to cut down expenses in the long run. It will be overcome by the hidden economic and social costs of delayed medical attention for unnecessarily complicated illnesses.

Officials of the state health services say that those who use the service should pay for it. In 1983, only 6% of the total costs of the Transvaal health service was recovered in fees. Administration officials estimate that the fee increase of 1984 will pay for 9% of the overall costs of the health services. Does this estimate take into account the fall off in attendance, which lies anywhere between 8 and 80%? Does it take into account that there are going to be many more cases of se-

rious illnesses, because people cannot afford to get medical care as often and as early on in illness as they need it? And even if state health officials do take these things into account, is the extra burden of death and disease on low income groups worth the drop from 94% to 91% in the state subsidy?

Conclusion

The medical services are putting up barriers to keep patients out - to discourage people from using the services. In this way, they hope to reduce costs. They do this without considering the health of the patients, or their legal obligation to provide adequate medical care for those who need it and cannot afford to buy it privately. As a result, those in greatest need, those who are least able to afford illness, or health care, are affected most.

There are four reasons why the Provincial Administrations are doing this:

Firstly, there is a clear central government policy to reduce state expenditure, particularly social welfare expenditure.

Secondly, there is an unfounded belief that the private profit sector can provide for basic needs of low income groups.

Thirdly, the state is out of touch with the plight of the majority of the people, who do not have democratic control over state actions.

Fourthly, the state has no commitment to plan for the rational allocation of resources to priority health needs first.

Suggestions for Alternatives

The NAMDA tariff group would like to make the following suggestions, with the aim of encouraging patients to attend hospitals and clinics early in illness, and come for follow-up visits.

The first suggestion would be to reduce outpatient tariffs. NAMDA proposes a nominal outpatient fee for all patients from low-income groups. But the authorities are unlikely to put this into effect immediately. Realising this, NAMDA offers the following scheme for immediate national implementation:

Annual Income per household member	Proposed Fee/ Outpatient Visit
R 0-R 600	R 1
R 600-R1100	R 3
R1100-R1500	R 6
R1500-R1800	R10
over R1800	R15

The proposed fee structure would make for a progressively increasing fee as a proportion of income. It would also bring fees, both in the Cape and in Transvaal, more into line with inflationary trends since 1974.

In determining the tariff class, the household size shoud be taken into account fully. For the Transvaal, this means that the definition of "dependant" should be widened. "Dependants" should include unemployed adults dependent on that household, unofficial forster children, and rural non-resident dependants. All such people draw on the family income, and this should be taken into account when setting payment categories. For the Cape, the whole concept of household size should be introduced.

The cost of return visits should be lowered. The maximum number of visits paid for in a calendar month by any patient should be reduced from the Transvaal's present five to the Cape's two. Patients returning for results of tests or referred from a peripheral centre to a central hospital should not pay again. In general, doctors and sisters providing care should be entitled to issue free return cards to patients in need of follow up for a single acute illness episode. Patients with sexually transmitted diseases should not pay when returning for treatment; contacts should be treated a a low or nominal fee. Sufferers from chronic diseases, a list of which should be prepared and recognised nationally, should be charged a low or nominal fee for regular visits; those patients who are stable should be allowed three months' supply of medication.

NAMDA believes that people will willingly pay fees that they can afford and that they had a part in determining, for decent, polite health care. A reasonable fee structure will increase clinic incomes, improve relations in the health services, reduce the clerical and social work load, and also reduce misrepresentation, frustration, and authoritarianism. Most important, it will ensure that people seek care early rather than too late.

This article has been prepared in the belief that an issue as important as fees should be debated openly in the health service and in the communities served.

NAMDA therefore urges the health authorities to consult with legitimate community representatives, and with patients and staff.

While recognising increasing health service costs, NAMDA does not believe that these should be paid for with hardship and even more death and disease.

This article was adapted from a paper presented by Merrick Zwarenstein and John Frankish to the NAMDA Conference "Towards Health Care for All", January 1985