

# Financing health care for all — is national health insurance the first step?

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## Summary

Political changes are likely to lead to demands for a more equitable health care system. It will be necessary to pay for more health care for more people without a substantial increase in the resources available. If a substantial proportion of the funds continue to come from private sources, then inequity in access to and the distribution of health care is inevitable. Consequently, it is argued that this can best be achieved if the resources that are available to pay for health care are controlled by a single, centralised co-ordinating body. It is suggested that it will be more feasible to generate sufficient funds under central control through taxation supplemented by a national health insurance scheme, rather than through simply expanding the contribution to health care that comes out of general tax revenue. Given that private ownership of health care facilities and services is likely to continue for the foreseeable future, central control of the funding of health care will make it possible to regulate the private sector, and bring it into a national health plan to provide health care for all.

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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.<sup>1-3</sup>

Political changes in the next few years are likely to produce twin demands from the first 'post-apartheid' government and from previously disenfranchised communities, for the development of a health care system more in keeping with the principles of social justice.

We need to address urgently the question of where we will find the resources to meet the consequent explosion in the demand for health care.

Elsewhere in this issue McIntyre and Dorrington<sup>4</sup> point to some salient facts on health care expenditure that should inform this discussion. In 1987 South Africa spent 5,8% of its gross national product 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.

In effect South Africa spends 3,2% of its gross national product (GNP) on public sector health care, which is below the World Health Organisation's 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. Indeed, if South Africa were to pay for health care for all citizens with the extravagance that the private sector lavishes on its customers, the country would need to spend about 13% of the GNP on health care, which is an unattainable and probably undesirable goal.

Given that major economic growth is unlikely in the next decade, and that substantial resources need to be diverted to

improving education, housing, infrastructural development and job creation, we will soon be facing two uncomfortable challenges: firstly, we will have to expand the range and quality of services provided without any significant expansion in resources available to do so; secondly, and as a direct consequence, some way will have to be found to draw those resources currently expended almost without regulation in the private sector, into a carefully constructed strategy to provide adequate quality 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 begin by putting the case for centralised control of the finances available to pay for health care. We go on to argue that the best way to achieve this in the present South African context is through the implementation of a national health insurance programme. Finally, we suggest that through such a mechanism privately owned facilities and private practitioners could best be integrated into a national health system directed at attaining greater equity in access to health care.

## The case for central funding

Most writers distinguish between private and public sources of finance for health care.<sup>5</sup>

The most important private sources are individual out-of-pocket payments at the time of service, and contributions to private health insurance or other private medical schemes such as health maintenance organisations.

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

It has been popular in recent years to argue that as far as possible health care should be privately paid for.<sup>6</sup>

Fundamental to the attainment of social justice in health care is the principle that access to care should not be determined by such contingent factors as wealth, race or geographical location. Attempts to fund health care from private sources are likely to contravene this principle of equity.

Health care needs are random and unpredictable in individuals and families, and often unaffordable to individuals if they have to pay the full cost of treatment as it occurs. Attempts to finance health care through user fees create the likelihood that many people will not be able to receive the care they require, because they cannot afford the charges.

Private health insurance has developed to protect individuals from sudden major expenditure. It is a form of risk-sharing in which the well contribute to the costs of providing care for the sick, on the basis that should they become sick themselves, the costs of their care will in turn be covered by all those who are members of the insurance scheme.

Almost all such private insurance is linked to employment, as the employer generally pays a substantial proportion of the member's contribution. Where individuals pay the full cost of membership of a medical insurance scheme, the contributions are so high that the majority of citizens would be unable to afford them. Private health insurance as a major source of financing therefore 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.

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There are other equally fundamental reasons why funding health care from private sources leads to inequalities in access to care.

Firstly, private sources only pay for the health care of the individuals who contribute. This is likely to lead to the development of two separate systems of health care: a luxurious and overendowed private sector serving the privileged few, and an underfunded public sector providing inferior care for the majority of the population. In turn, 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.<sup>3</sup>

Secondly, administrators of private medical insurance have an interest in excluding high-risk patients from membership. This occurs either because the insurance scheme is run by a profit-making body that does not wish to pay the medical bills for high-risk patients, or because they wish to keep premiums as low as possible. In the USA this had led to the practice of insurance agencies competing for the lowest risk patients, who they take on at preferential rates.<sup>7</sup> The result is that higher risk patients can only get care at considerably higher premiums. Equity is discarded as each person seeking insurance is 'risk-rated' and the lowest risks are 'skimmed off', and any subsidy from the well to the ill, from the young to the old or from the wealthy to the poor is lost in the process.

It is worth noting that risk-rating is being introduced into the South African medical insurance world since the relaxation of certain regulations governing medical aid schemes in August 1989.

A third problem with privately funded care is that it almost inevitably pays only for curative health care. There is very little incentive for any individual to pay for preventive measures such as immunisation, in which the social benefits tend to be greater and more visible than the benefits to any particular individual. The state is therefore left to subsidise the preventive health care of privately insured individuals.<sup>8</sup> This leads to an unnecessary separation of preventive and curative services, when current wisdom is that a single network of institutions should provide comprehensive care.

Finally, 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.<sup>9</sup> The competition between them, and the consequent fear of losing custom to competitors, is one of the fundamental reasons why the medical aid schemes have not been able to encourage doctors to implement policies of generic prescribing, or to control some of the obviously unnecessary expenses associated with the private hospital sector.

In addition, the logic of economies of scale suggests that the existence of multiple insurers 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. Certainly, where large disparities in the quality and quantity of care have developed, both regionally and in terms of social class, it seems self-evident that only a central funding agency will be able to re-allocate priorities, and to direct growth financing to underdeveloped areas.

In addition, a centrally co-ordinated funding mechanism established to finance health care for all has no interest in excluding anyone from access to health care, avoids unnecessary

administrative expenses<sup>10</sup> and has the capacity to encourage the integration of curative, preventive and promotive health services within the same administrative structures.<sup>11</sup>

Later in this paper we will suggest that substantial private ownership of health care facilities will be with us for some time to come. We argue that this creates another incentive for moving rapidly towards central control over the financing of these facilities.

## 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. The most common such scheme is a national health insurance scheme, in which those in formal employ are compelled by law to contribute to a national fund. Employees' contributions may be matched by employers. The money thus raised may be administered as a separate fund to pay the health care of contributors, or it may be pooled with other sources of revenue and used to pay for the health care of all.

At a certain level of abstraction, the differences between these two systems begin to blur. On the one hand, compulsory health insurance is simply a form of payroll tax shared between employers and employees. In a situation of near full employment almost everyone will be contributing, and the only difference between this and other forms of tax is that it is earmarked to pay for health care. On the other hand, in some health insurance systems the state pays, out of general tax revenue, the contributions of those who are unable to pay for themselves.

None the less, the systems are identifiably different, and their relative merits are argued persuasively by their respective proponents.<sup>12-15</sup>

Those who support taxation as the major source of central funding argue that, from the point of view of efficiency, no additional structures are needed to raise or administer the funds. Tax revenue remains directly under the political control of central and local government structures which are more directly accountable to the people served.

The critics of national health insurance point to insurance systems in which the funds generated are controlled by departments of labour, thus fragmenting health services, or by some administrative structure that is not politically accountable.

It is argued further that because health insurance contributions in developing countries come largely from an employed urban elite, they pay for health care in which undue emphasis is put on curative care, resources are focused in urban areas, and a two-tier system often develops with far better care available to those who contribute to the insurance system.

It is therefore argued that a health service funded almost exclusively from tax revenue, and open to all citizens equally, is the neatest, the most equitable and probably the most efficient way to pay for health care.

The proponents of national health insurance argue that it is the most politically acceptable way to mobilise additional funds to pay for health care. In developing countries there is usually a low ceiling on revenue that can be raised from income tax. Other forms of taxation such as sales tax tend to be regressive, penalising the poor more than the wealthy. It is easier, so the argument goes, to convince the relatively well-off to make additional payments earmarked specifically for health care, than to increase income tax to pay for expanded health services.

In addition, these earmarked funds are relatively well protected against any impulse to cut funding for health care in times of economic recession.

Finally, the proponents of national health insurance argue that no matter how desirable it is for health care to be funded

by taxation, all tax-based systems have in fact evolved out of health insurance schemes. Therefore, health insurance becomes a necessary stage in the transition from privately funded to tax-funded systems.

The arguments on both sides have their merits. The choice of system must therefore be influenced by the context in which a decision has to be made, rather than by any theoretical advantage of one system of funding over another.

### The South African context

We began by suggesting that it is unlikely that South Africa will be able to spend much more than 6% of its GNP on health care, and went on to infer that it would be desirable if almost all these resources were controlled by a central co-ordinating body. Yet the reality facing us is that almost half of the funds available to pay for health care currently come from private sources, and pay for the private care of a small, privileged élite.

The question facing us is: *How do we 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: (i) 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; and (ii) find some way to ensure that the money that people are currently paying directly to the private sector, particularly in medical aid contributions, is rather paid into a central State fund.

As noted in the introduction, any South African government committed to social development is going to be met with demands for increased spending in education, social security, infrastructural development and job creation. It seems highly unlikely that it will be possible to nearly double government expenditure on health care while also meeting these other important social needs.

The alternative is to pass legislation compelling employers and employees to contribute to a national health insurance scheme. This 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.

At the same time it would be necessary for the State to define a fairly comprehensive package of health care that would be available free to all. All health services within the package would be paid for out of the combined tax and health insurance funds.

The specific nature of the package of services provided would have to be determined by the resources available. Commonly excluded under such schemes are specialist dental services, cosmetic surgery, and even non-emergency ambulance services. In Australia, the health insurance system will pay for medical services received in private hospitals, but users of these hospitals have to pay their own 'hotel costs'.<sup>16,17</sup>

The development of such a national health insurance scheme would not establish equity in health care immediately. Apartheid and the unfettered growth of the private sector have created enormous imbalances in the distribution of health facilities and of doctors and nurses. These will take years to redress. However, as the State gains control over extra funds so it would become possible to ensure that resources for capital development are directed to underserved areas, and incentives are created to encourage medical and other staff to work in those areas.

It therefore 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.

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 (and we do not wish here to enter the debate about whether all health services should be owned by the State), health care planners will have to accept the continued existence of private hospitals and private practitioners for the foreseeable future. As this private sector has contributed significantly to inequalities in the past, so without careful regulation it will help to perpetuate these inequalities in the future.

The centralisation of funds in the hands of the Department of Health would provide the major mechanism for the effective regulation of private providers of health care.

As the sole payer for health care, the department would be in a strong position to: (i) bargain with private providers over rates and types of payment — it would be possible over time to replace the 'perverse incentive' associated with fee-for-service care<sup>18,19</sup> with more appropriate forms of payment; (ii) encourage generic prescribing, which would result in substantial savings on drug expenditure; (iii) ensure access to specialist care only after referral from an appropriate level; and (iv) prevent the private sector from expanding in already well-served areas, as such expansion contributes to growing inequalities in access to care.

This achievement of greater efficiencies in the private sector would be accompanied by the removal of the inequalities presently inherent in private health care. In terms of the national insurance system, the State would pay the full costs of an agreed package of care in any appropriate facility, whether privately or publicly owned.

### Conclusion

The implementation of a statutory national health insurance scheme seems like 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 aid schemes and the private hospitals. In addition, some private practitioners may perceive a threat to their income levels and clinical independence. Opposition may also come from groups committed to more direct nationalisation of the private sector.

Much of the opposition may be misplaced. For example, private practitioners would benefit from guaranteed payment for the agreed package of services, through a system substan-

tially 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 achievable through a national health insurance system.

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

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