

SOME DEBATES AROUND THE PRIVATIZATION OF HEALTH CARE IN SOUTH AFRICA

by

Max Price

Introduction

The past five years have seen a trend towards the increased privatization of health care in South Africa (SA). Encouraged by a change in government attitudes towards the private sector providers, this trend has also found a following within the professional medical, dental, nursing and pharmacy associations, and, of course, from private hospital owners. What is perhaps more surprising is that it has also drawn support from "middle-class" and working-class blacks and their trade unions. In fact, to a large degree, the recent privatization trend has ridden on the back of increasing black participation in medical schemes (i.e. health insurance).

The trend is significant for a number of reasons. In the short term, it will affect the quantity and quality of health care provided to the bulk of the population dependent on the public-sector services. In the long term, the structural changes which accompany privatization and the interests which come to be vested in that system may present major obstacles to a future, post-apartheid government, should it wish to dismantle the private health system.

Despite its importance, the issue of privatization in SA has, as yet, received little serious analysis. Most of the debate has been rhetorical, with participants taking up extreme positions. The purpose of this paper is, firstly, to document the privatization trend against the background of the economic organization of SA's health services at present. Secondly, the paper analyses the change in government attitudes in favour of privatization, the collaboration with private-sector groupings, and the increasing participation in private-sector health care by blacks, particularly as members of trade unions. In considering why this change in government policy has occurred, I argue that the primary motivation is financial: privatization is seen as a way of easing the state's burden of escalating health care costs.

The third part of the paper examines this question of **whether or not, and under what circumstances, privatization increases the overall level of financing of health care.** This issue warrants serious consideration, not only because it is the basis for the government's present policy; it is also an argument that will confront a future, post-apartheid government. For the competing claims for public funds will probably be greater for a democratic government concerned with the welfare of the masses than it is for the present government, despite the fiscal drain of the present security, military and bureaucratic apparatuses. A future government is unlikely to be able to afford to offer the whole population the level of care which politically powerful black and white communities will be enjoying through the private sector. In fact, even if the public sector offered comparable care to these urban communities alone, this would severely distort the allocation of total public health care resources and might leave the rural masses worse off than when the private sector had existed. Thus it may be that privatization would permit more resources to be allocated to health care in total, and permit public funding to go to those most in need.

However, this paper is not a complete examination of the arguments for and against privatization. In particular, it does not address arguments concerned with economic efficiency, financial efficiency, equity and equality, medical ideology and the balance of preventive and curative care.¹ All of these would have to be

considered along with the consequences for the levels of financing in assessing fully the merits and demerits of privatization.

1. Description of the Economic Organization of Health Services in South Africa²

The 1977 Health Act consolidated the many health related acts of parliament promulgated since 1919.³ The State Health Department (now called the Department of National Health and Population Development) is responsible for overall co-ordination of public services, community health matters such as health education and the control of communicable diseases, family planning, national laboratory services, and the provision of long-term psychiatric services.

The administrations of SA's four provinces (Cape, Natal, Orange Free State, and Transvaal) are responsible for the provision of public hospitals (including out-patient departments, day hospitals, maternity departments) for personal medical care. City and town councils are responsible for environmental hygiene, health promotion and rehabilitation, and for prevention and treatment of communicable diseases. The bantustans⁴ manage their own departments of health, financed out of the central SA state budget.

1.1 The Extent of Private-Sector Health Care in South Africa around 1983⁵

Health policy debates reflect considerable confusion over just what is meant by "privatization" and "private sector". In particular, the literature fails to separate out three distinct components of private health care: (1) the existence of multiple private providers and privately owned facilities; (2) the reimbursement of providers on a fee-for-service basis; and (3) private sources of funds. In the health economics literature, "privatization" may refer to only one of these three components, or to any combination of them.

To assess the extent of private-sector health care, the economic organization of the health sector, therefore, needs to be understood and described in terms to these components. To take "pattern of ownership" first (i.e. who owns and controls providers and facilities): about 50 per cent of doctors are employed in the public sector⁶, the rest being either self-employed or employed by private industry. About 88% of hospital beds are in state-controlled hospitals.

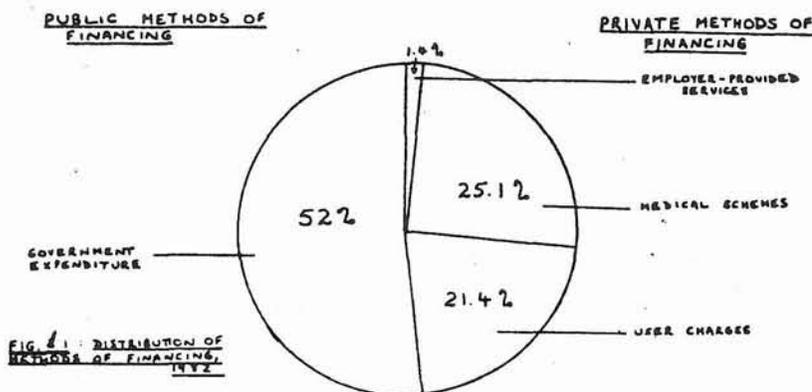
The second component of the economic organization of health services concerns the methods of reimbursement of providers (and facilities). Three methods of reimbursement are commonly found: fee-for-service, salary/fixed budget, and capitation.⁸ Of the 50 per cent of practising doctors in the private sector in SA, most are in private practice, reimbursed on a fee-for-service basis. A few (perhaps 1-2 per cent) would be salaried, employed in the industrial hospitals, and a further few (2-3 per cent) receive capitation fees for looking after the needs of the members of medical benefit schemes. The other 50 per cent of doctors, employed in the public sector, are almost all salaried. Of the privately owned hospitals, most are "for profit", operated on a fee-for-service basis, and the remainder are owned and run by industries for the use of their employees. They do not charge fees-for-service and providers are usually salaried (table 1).

Table 1: Distribution of hospital beds amongst sectors in 1983/4

	Number of beds	Percent
Public	141,210	87.6
Private Industrial	8,614	5.3
Private (fee-for-service)	11,437	7.1
<hr/>		
Total	161,261	100

Source: Calculated from 1985 Hospital & Nursing Yearbook for Southern Africa (Cape Town: H Engelhardt & Co, 1985)

The third component in the economic organization of health services is the methods and sources of financing (figure 1). In 1982, total health care current expenditure amounted to R3,750 million¹⁰, 4.9% of the GNP.¹¹ This had fluctuated between 4.2% and 4.9% of GNP over the previous five years. Of this total expenditure, 52.1% was financed publicly by taxes and deficit financing. (This was about 10% of total public expenditure.) A further 25.1% is spent by medical schemes whose income is largely from employer and employee contributions, though some schemes are also open to individual membership, i.e. voluntary health insurance. Industrial hospitals (i.e. employer-provided health services) accounted for 1.4% of total expenditure.



The remaining 21.4% is raised by means of user-charges¹² to patients. Fees charged at publicly owned facilities are based on a patient's household income and family size. Fees charged by private practitioners and private hospitals may either be at rates determined by the medical schemes or higher, in which case the patient has to make up the difference. Many schemes require the patient to pay 20% of the bill anyway. Data on charitable contributions are lacking. However, such contributions generally fund research, TB centres, first-aid groups and some community health programmes, and are unlikely to contribute more than 1% of total expenditure.

2. Explaining the Privatization Trends

The extension of private-sector health care is evidenced by the following trends. Firstly, over the past five years membership of medical schemes has increased by 20%.¹³ Secondly, although still contributing only a small proportion of the total number of beds, the private hospital industry has grown rapidly, too.¹⁴ These trends have, in turn, been promoted by three major developments: a) a shift in governmental policy in favour of increased private sector participation in health services; b) increased collaboration between the government, the professional associations and private-sector entrepreneurs; and c) the growing power of worker organizations to negotiate, *inter alia*, for improved medical benefits.

a) For most of the 1970s the government seemed to view the provision of health services primarily as an obligation of the state, tolerating the private sector with some suspicion and a good measure of control. In 1974, the government-appointed De Villiers Commission argued that not only was it the State's responsibility to ensure that health services were adequate but, as far as hospital services were concerned, the State should actually provide all such services as far as possible. The report was highly critical of the private hospitals for the unsatisfactory control of patient fees and for competing with public-sector hospitals in a way detrimental to the latter.¹⁵

In terms of the legislation subsequently enacted, new hospitals had to be registered with the Department of Health. Also, the Director-General of the Department and the relevant Provincial authority became the sole judges of whether new private hospitals, extensions to existing private hospitals or changes to facilities within existing private hospitals were necessary.¹⁶

Furthermore, over the preceding decade, government involvement in a number of areas of health care had been increasing, e.g. in the take-over of almost all the rural mission hospitals which were subsequently handed over to the bantustan health departments.¹⁷

Yet, by 1977, government attitudes to the role of the private sector were changing:

(I)t is essential to note that the role of private practitioners forms an integral part of comprehensive health service. ... Every encouragement must be given to the private sector to contribute and expand its share in achieving a comprehensive health service.¹⁸
(Department of Health, 1978¹⁸)

By the 1980s there were frequent statements from government officials calling on the private sector to play a greater role:

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.¹⁹
(Dr M H Ross, Department of Health and Welfare, 1982¹⁹)

It seems clear that the government is now taking the issue of privatization more seriously than ever before. Policies which have been implemented to achieve the greater use of private health services include the increase in fees at government hospitals so that, for some income groups, it is now more expensive to go to public hospitals (e.g. out-patient departments) than to private practitioners.²⁰ An article describing the formation of the Medi-Clinic corporation to set up a chain of private hospitals pointed out that

Medi-Clinic's entry into the hospital field comes at a time when rising costs of treatment at provincial hospitals have encouraged entrepreneurs to develop independent hospitals - to the extent that more than 20 are on the drawing boards or under construction throughout the country.²¹

In another report, the Medi-Clinic managing director said:

Private hospitals have a great future as the government hands over the medical care of everyone but the indigent to the private sector."²²

b) In addition to the change in the government's declared policy towards privatization, there has been active collaboration between the government and various groupings in the private sector. Since 1980, SYNCOM (Pty) Ltd, a private-sector "think-tank" organization, has received several commissions to research the future of health care services in SA, from i a 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 privatization of health care. Out of this four working groups were established which, in February 1986, presented their consolidated "Report to the Department of

Health on Privatisation and Deregulation of Health Care in SA" - hereafter referred to as the Report on Privatization. The main recommendations of this report were that "a strategy of privatisation and deregulation could assist to a great extent in overcoming these challenges" (i.e. rapidly increasing needs and demands).²³

c) Many black trade unions, which have increased dramatically in strength and membership over the last decade, have opted to negotiate for health insurance benefits for their members, for the following reason. The public sector health services are segregated by race. The different hospitals and other facilities are unequally funded and staffed, with whites receiving about 3 to 4 times more public money per capita of the population than blacks, despite the fact that only a small proportion of the white population depends on public-sector services, compared with nearly 90 per cent of the black population.²⁴ Facilities for black patients are grossly overcrowded, while many white hospitals have empty wards. By contrast, most private-sector services are racially integrated, the only criterion for access being ability to pay. It is true that a far higher proportion of whites than blacks can afford private-sector health care: 75 per cent of whites and 5.8 per cent of blacks - 16 per cent of the total population - were covered by some medical insurance in 1983.²⁵ Yet, for those blacks who can gain access to private-sector care, it offers a much higher quality of care than they could obtain through the public sector, and is free of individual discrimination on the basis of race. The systematic legal discrimination along racial lines, which is the hallmark of apartheid, dominates every aspect of life in SA so thoroughly that it is not surprising that those experiencing it daily should see inequality primarily in racial terms. Many who are critical of racial inequality, and many blacks suffering its effects, have been quick to embrace the apparently egalitarian prospects offered by private-sector health services.

As a result, the increase in medical scheme coverage is almost entirely accounted for by the increase in black beneficiaries. Between 1979 and 1983, the number of white medical scheme beneficiaries increased from 3,479,871 to 3,541,846, an increase of 1.8 per cent. Black beneficiaries increased from 909,334 to 1,512,995, an increase of 66.4 per cent.²⁶ This increase in demand for private health care is frequently cited by private hospital owners as a reason for their expansion:

Medi-Clinic expects to benefit from the growing number of patients who are members of medical aid schemes.²⁷

We came onto the scene in 1983 purely for business reasons - we didn't do it for charity. We see the medical services industry as an area of growth.²⁸

The director of another hospital group claimed:

The projections for the future indicate that within 5 years, approximately 60% of the non White population will have some form of medical aid cover, achieving parity with the White population at approximately 95% by the year 2000. With the natural growth of the population, coupled with the growth of that sector of the population covered by health insurance the need for rationalisation and redirection of health care services between the public and the private sector is mandatory.²⁹

Thus, to a large degree, the growth in private-sector health services depends on the growth in the number of people covered by medical insurance. This growth is due largely to the increase in medical schemes membership amongst black employees, a benefit which is, understandably, valued and demanded by workers and their organizations. This is, of course, not independent of government policy since, if the government were to desegregate the public sector hospitals, and lower fees, the relative appeal of private-sector care might be diminished.

There are noteworthy parallels between the three developments described above and certain elements of the broader "reform" strategy pursued by the Government since the late 1970s. These elements include the depoliticization of the reform process, the collaboration between government and the business sector, the shift of various state responsibilities on to the private sector (e.g. housing), and the attempted co-optation of certain groups of urban blacks by improving their immediate living environment and welfare services and by offering them some stake in the capitalist system. Indeed, it has been argued that the privatization trend in health care is quintessentially an aspect of this reformist strategy.³⁰ According to this sort of argument, using health care as an instrument of co-optation requires not only the provision of better quality health care but also racially integrated health services. For the government to accede to this by pouring money into black health services and/or desegregating white hospitals would have been enormously expensive and politically risky (from the point of view of its right-wing support). However, by permitting the private sector services to grow and become racially integrated in order to meet the needs of urban blacks, "reform" could be achieved by "market forces" without the government having explicitly to alter its policies.

This interpretation draws some support from comments made by the business sector in defending its interests in privatization. In the section entitled "Advantages of privatisation/deregulation", the Report on Privatization says:

A big advantage of this is that it again depoliticises the issue since no direct racial or other discrimination will be involved, although of course the available means will largely determine the extent of the choice and equity will be achieved only once access to the earning of appropriate means is open to all.³¹

And, in a seminar sponsored by the Federated Chamber of Industries, organized by SYNCOM, one speaker claimed:

Politically, privatisation could also have a critical effect by replacing political or bureaucratic decisions with routine commercial decisions and so helping to depoliticise important segments of everyday life - and thus help to defuse the current crisis.³²

However, there is little evidence from government sources that such reformist intentions underlie its change of policy towards health service privatization. Indeed, the reformist interpretation of the privatization trend apparently contradicts other features of the state's health care strategies, especially its persistence with the fragmentation of the health services along racial and ethnic lines. The implementation of this policy despite its obvious wastefulness, and in the face of widespread opposition even from government supporters, can only be seen as part of a strategy to build up the credibility of the new ethnic rulers in the tricameral parliament, and of the bantustan authorities.³³ Control of health services is one of the few spheres of government activity which can be devolved to the ethnic authorities without any real loss of power by the central white government. Hence the take-over of almost all the rural mission hospitals, which were then given to the bantustan departments of health, and the dissolution of the provincial councils, with the division of their health service responsibilities between ethnic administrative bodies. Although the financing and functioning of the proposed Regional Services Councils are still unclear, they too would require control over health services in order to boost their power and credibility.

In terms of such a strategy, the state needs to increase, or at least maintain at present levels, control of the health services. Yet privatization, i.e. increasing the proportion of health care provided by individual private providers, necessarily contradicts this strategy. Thus the reformist analysis of health policy on privatization appears to contradict the analysis of policies of fragmentation and increasing control of health services.

Arguably, they reflect confusion and conflict within the state over health policy. Yet, the priority given to the ethnic restructuring of the health services surely detracts from the forcefulness of the reformist analysis. Furthermore, government spokespeople themselves have been emphasizing a more immediate and straightforward reason for encouraging privatization. This is that a combination of factors has caused health costs (for both whites and blacks) to escalate in recent years. These include: an ageing population, urbanization, a more sophisticated and hence demanding population, escalating costs of medical technology, the falling exchange rate, and others. This increase has exceeded the rate of inflation as well as the rate of economic growth, and therefore demands an ever greater proportion of the GNP. If, for various reasons, government cannot cut expenditure in other sectors (e.g. military, administrative) and is unwilling to increase taxation or deficit financing (because of a commitment to monetarist policies), then it cannot increase public expenditure on health, and any increase must come out of private expenditure. Thus:

(C)urtailed 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, 1985³⁴)

(T)he more people placed in a position to afford the services of private practitioners, the less will be the burden on the state ...

(Department of Health³⁵)

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

(Report on Privatization³⁶)

It seems to me that this is, in fact, the most important factor motivating the government's policy of privatization. It is also the solution being promoted in many developing and developed countries facing the same problems - viz, how to increase the overall level of financing for the health sector once the government, for whatever reasons, cannot afford to provide further finance. It is a problem which will, in all likelihood, face a future post-apartheid government in SA. Competing with many other urgent demands - for housing, water and sanitation, education, agricultural development, etc - health care may well rank low on the list of priorities.

It seems relevant, therefore, to address this question: Does privatization offer a way for governments to increase the level of resources devoted to health care?

3. How Does Privatization Affect the Financial Resources Devoted to Health Care?

In the debate on health care financing in SA, privatization 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, 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.) However, if 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 otherwise spent on these individuals. Thus total resources allocated to health services can be increased, and public health expenditure can be concentrated on the poorer communities.³⁷

This type of argument in favour of privatization depends on a number of assumptions which are valid only under certain conditions. The following discussion identifies the conditions under which each assumption would hold, and shows that

these do not pertain in SA at present. It suggests how these conditions would have to change in order for privatization to make economic sense as a means of increasing the total financial resources devoted to health care.

3.1 The First Assumption - that 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 Enquiry³⁸)

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

3.1.1 Tax Concessions. Under corporate tax law, the contributions paid by employers are tax deductible, while contributions paid by individuals are abatements under individual tax provisions. In 1982, medical schemes' income from contributions was approximately 54% of total private health expenditure (26% of total health expenditure³⁹), of which at least one-third is subsidized by the state, i.e. the real cost is 50% more than what employers and employees pay.⁴⁰ This loss of tax revenue (at least R337 million in 1982) was equivalent to 17% of total public sector health expenditure, and more than twice the total amount spent on preventive services.

3.1.2 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 R36,000⁴¹ to R100,000⁴². 937 doctors qualified in 1985, half of whom will eventually work in private practice. This is equivalent to a state subsidy of between R30 and R47 million (up to 2.4% of public expenditure) to the private sector, excluding the costs of postgraduate training.

3.1.3 Subsidized 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.⁴³ Thus the government is subsidizing the non-public sectors.

3.1.4 Other Forms of State Subsidization. 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 costs the government more in subsidies than the government spends on individuals who depend on the publicly funded services.⁴⁴ The subsidy to the private sector, therefore, distorts public sector resource allocation in favour of those who are already the most privileged.

In theory, however, there is no reason why subsidization of the private sector cannot be reduced. The state could quite conceivably withdraw tax concessions; 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 subsidizes other sectors, and the distortive effect this has on public-sector resource allocation.

3.2 The Second Assumption - that only private sector services can raise funds from private sources

The second assumption in the argument that privatization 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 free and unlimited access to health care as a privilege".⁴⁵

Yet this assumption fails to separate, and distinguish between, private ownership of services and private sources of finance. Privatization 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.⁴⁶

The argument in favour of privately owned services may be based on the view that it is likely that more private sources of finance will be mobilized if contributors perceive that they can thereby obtain a better than average service. Privately owned providers may be perceived as offering such a service, and may therefore be necessary as an alternative to the public sector services in order to encourage additional voluntary expenditure. Similarly, some methods of financing, such as compulsory health insurance, may be more acceptable because people perceive some benefits to accrue to them exclusively as a result of their membership. However, there may be ways of offering these additional benefits through the public sector with uniform quality of care. If, as was suggested above, public sector services are charged for, then coverage through risk-sharing schemes could reduce the charges that patients have to pay. Abel-Smith has suggested that "hotel" benefits, such as private rooms, or convenience benefits, such as evening clinics for workers, wider choice of doctors, sick pay, etc, could be explored as alternative incentives to contributors.⁴⁷

3.3 The Third Assumption - that political pressure for public funding will not decrease

The third assumption is that the existence of a private sector would not prejudice 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.

Indeed, as we have seen, the possibility of reducing political pressure to improve the public sector services for blacks is presented, in the current SA debate, as a reason for privatization. The Report on Privatisation (which was also quoted earlier on this) argues:

Crucial decisions on the allocation of scarce resources in a highly sensitive area would shift largely from a central political arena to the market place (depoliticization) (sic)".⁴⁸

It concludes:

There is likely to be an overall saving to the taxpayer.⁴⁹

Yet, this may be one of the greatest dangers of privatization, and 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, then 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 governments were able to devote larger proportions of their expenditure to deprived rural areas.⁵⁰

To summarize, the provision of public sector services may well cost the government more as a result of the shift to private sources of finance and private sector providers. For, firstly, the effect of various subsidies to the private sector may be such that few resources are released. Secondly, those funds which are released may well be diverted towards the most privileged groups anyway. Thirdly, the public sector loses a (potential) source of income as the better-off patients who could afford to pay for their health care move to the private sector providers. And, finally, under the present political economic system, privatization is likely to reduce political pressure from both whites and blacks to provide adequate funding for the public sector services.

However, under a different political and economic system, the total level of financing for health care could be increased by:

- 1) removing subsidies to the private sector - e.g. by abolishing tax abatements, levying an additional tax on private doctors' and nurses' incomes, charging the full costs to patients treated by private doctors in public hospitals, etc.
- 2) using user-charges and other private sources of finance for publicly owned services;

- 3) making special benefits available in public hospitals to patients who can afford user-charges, to encourage them to contribute to risk-sharing schemes and to draw their patronage back to the public sector; and
- 4) developing political and financial mechanisms to prevent any decrease in the proportion of GNP devoted to those dependent on public methods of financing for their health care.

Finally, I wish to re-emphasize that this paper has considered only one aspect of privatization - viz how it affects both the overall level of funding for the health sector and the level and allocation of public funds. It has not considered other issues, such as the trade-offs between level of financing and equality, efficiency, and curative biases - and many others which must be considered in developing a policy for the economic organization of health care in SA, present and future.

- 1 A more complete discussion of the economic arguments relating to the economic organization of health services in SA is presented in M Price, "Health Care Beyond Apartheid: economic issues in the reorganisation of South Africa's health services", MSc dissertation submitted to the London School of Hygiene and Tropical Medicine, 1986.
- 2 Unless otherwise indicated, the data cover the whole of South Africa, including the bantustans. Information is also not separated for the different race groups (as defined by the south African government). Such a breakdown of expenditure and facilities is important, given the racist nature of health policy. However, the analysis here is attempting to identify economic features which would pertain even in the absence of such policies, e.g. in the post-apartheid society.
- 3 Health Act 1977, Government Gazette, May 1977, 143 (63).
- 4 The bantustan or "homeland" policy of the SA government aims at forming independent national states on a tribal basis, within the geographical borders of SA. Four bantustans are nominally "independent" and the other six are "self-governing". All are economically dependent on SA and none has been internationally recognized.
- 5 As a result of various definitional problems, plus the facts that public hospital beds are available to private patients and some doctors work in both the public and private sectors, analysis of the pattern of ownership and methods of reimbursement of providers is complicated. The figures are, consequently, only approximations.
- 6 Medical Association of South Africa Bulletin, S Afr Med J, 1986, 69, p 276.
- 7 Many so-called private hospitals receive up to 90% of their recurrent costs as a subsidy from the state. In this paper these have been treated as public hospitals, since they are operated on fixed budgets, are not "for profit", and their fee structure is determined by provincial regulations.
- 8 If reimbursement is by fee-for-service, the provider's income is directly linked to the services provided. Where providers are paid on a salary basis, or hospitals operated on a fixed budget, income is not related to the quantity or quality of care provided. Capitation methods of reimbursement relate the provider's income to the number of people for whom s/he is responsible, but not to the service provided to each individual.
- 9 This has been calculated on the basis of the annual expenditure by medical benefit schemes on general practitioners' services, as reported in the Registrar of Medical Schemes' 1983 annual report. (Specialist and hospital expenses are paid on a fee-for-service basis.)
- 10 R denotes the rand, the unit of currency. At the current exchange rate, R1 equals £0.28, although the purchasing power would be closer to £0.35 in the UK.
- 11 Most of the information in this paragraph and the next is taken from a paper by M Zwarenstein, R Dorrington, D Budlender, J Frankish, E Thomson & D Bradshaw, "Expenditure on Medical Care in South Africa (1978-1982)". The authors were kind enough to let me see their preliminary results in advance of submission for publication to the S Afr Med J. The original text discusses in detail the problems with the data available. Expenditure on health care in the SA Defence Force, the SA Police, the SA Prisons Service, and the Department of Education and Training have been omitted. Nevertheless, this is, as far as I know, the most recent and accurate estimate of health care expenditure in SA. I have adjusted their figures to include industrial hospitals (i.e. employer-provided health services).
- 12 User charges are payments made by patients directly as a way of financing health care. They are usually paid at the time of use of a service, though they do not have to cover the full cost of the care provided.

- 13 "Healthy Returns", Financial Mail, June 27 1986, p 93. Note: A Spier, of SYNCOM, writes that the growth rate of membership of medical schemes is 6% annually compounded ("Health Care: a sick system", The Star, August 14 1984). I could not find evidence to support such a high estimate. The figure given in the Financial Mail article, of 20% over five years, seems more reasonable.
- 14 See, for example, "Private Hospitals: big operations", Financial Mail, April 11 1986, p 72; "Healthy Returns", Financial Mail, June 27 1986, p 93; "Private Growth", Financial Mail, June 7 1985, p 34.
- 15 Report of the De Villiers Commission of Enquiry into Private Hospitals and Unattached Operating Theatre Units in the Republic of South Africa, September 1974.
- 16 Regulations under the Health Act (63 of 1977) Governing Private Hospitals and Unattached Operating Theatre Units, No R158 of 1 February 1980.
- 17 M Price, "Health Care as an Instrument of Apartheid Policy in South Africa", Journal of Health Policy and Planning, 1986, 1 (2), p 163.
- 18 Guide to the Health Act, Department of Health, 1978. In the Health Plan itself it is suggested that "In order to encourage the rendering of services by private practitioners, health authorities should consider consulting rooms for private practice on a selective basis at certain community centres". Department of Health, National Health Facilities Plan, 1980.
- 19 M H Ross, "Future Provision of Health Services in the RSA", RSA 2000, 1982, 4 (1), p 32.
- 20 Dr Sonnenberg, Opposition spokesman of health in the Cape Provincial Council, said that, as a result of the fee increases, "the ironic situation has been reached that it is cheaper for these poor people to see a private medical doctor", Argus, June 5 1984.
- 21 "Now Rembrandt sets up a chain of private clinics", Sunday Express, December 30 1984.
- 22 "Rembrandt values clinics at R170m", Sunday Times. Business Times, June 29 1986.
- 23 "Privatisation and Deregulation of Health Care in South Africa", consolidated report of the four working groups on privatization and deregulation. Mimeograph: February 1986, p 25.
- 24 C C Jinabhai, H M Coovadia and S S Abdool-Karim, "Socio-Medical Indicators for Monitoring Progress Towards Health-for-All in South Africa", paper presented at the Second Carnegie Inquiry into Poverty and Development in Southern Africa, Cape Town, 1984, p 13.
- 25 Calculated from statistics in Department of Health and Welfare, Annual Report of the Department of Health and Welfare - 1984, p 119.
- 26 Calculated from the Annual Reports of the Department of Health.
- 27 "Healthy Returns", Financial Mail, June 27 1986, p 93.
- 28 Dr Edwin Hertzog, director of Medi-Clinic, Financial Mail, June 7 1985, p 31.
- 29 "Some Thoughts on Health Care Facilities and Services in South Africa with Specific Reference to Private Hospitals", a submission from the Hoffman Hospital Group to the Browne Commission of Enquiry into Health Services in the Republic of SA, undated but post-1982: p 2. The figures presented by Hoffman are not referenced. They certainly do not apply countrywide and were probably calculated for Bellville, an area in the Western Cape where the Hoffman hospitals are based.

- 30 This kind of analysis of health policy has been made, for example, in the following: C De Beer, The South African Disease: apartheid health and health services (Johannesburg: South African Research Service, 1984), Chapter 3; M Price (1986), op.cit. (see note 17), pp 161-62.
- 31 Report on Privatisation and Deregulation in SA (see note 23), p 14.
- 32 "Privatisation likely to ease SA's economic and political woes", Weekend Argus, September 7 1985.
- 33 M Price, M Steinberg and C de Beer, "The New Constitution and Health" in A B Zwi and L D Saunders (eds), Towards Health Care for All, NAMDA Conference, 1985 (Johannesburg: NAMDA, 1985).
- 34 F Retief, "The Strategy", Hospital and Nursing Year Book for Southern Africa 1985 (Cape Town: H Engelhardt & Co, 1985), p 50.
- 35 Guide to the Health Act (Department of Health, 1978).
- 36 Report on Privatisation and Deregulation in SA 1986 (see note 23), p 24.
- 37 See, for example, Abbot's response to Roemer, in M I Roemer, P Abbott, L O Bygren et al, "Private Medical Practice: obstacle to health for all", Round Table Discussion, World Health Forum, 1984, 5, pp 195-210.
- 38 Hoffman Hospital Group (post-1982) (see note 29), p 1.
- 39 Zwarenstein, Dorrington, Budlender, et al, op. cit. (see note 11), p 20.
- 40 For every R1 contributed, 50c is paid by employers, most of whom are companies. The company tax rate is 50%; 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% (the highest rate on the marginal Rand is 50%). Even if all employees are assumed to be on the lowest rate, the effective government subsidy is: $16\% \times 50c = 8c$. Therefore the total minimum subsidy is: $25 + 8 = 33c$ in the rand.
- 41 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 1986 subsidies", i.e. they are not based on calculations of cost.
- 42 "Health Care Costs. Building Bills", Financial Mail, August 17 1984.
- 43 N S Louw (Director of hospital services in the Cape). "Fee for Service and the Right of Practice of Private Practitioners in Provincial Hospitals" in Hospital and Nursing Yearbook for Southern Africa, 1985 (Cape Town: H Engelhardt & Co, 1985), p 41. Note: since 1984, fees at provincial hospitals have increased enormously, and in some provinces patients covered by medical aid are now charged at the standard rates that medical aids are prepared to pay.
- 44 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% 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.
- 45 "Report on Privatisation and Deregulation in SA" (note 23), p 12.
- 46 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 costs privately).

N Prescott and D T Jamison, "Health Sector Finance in China", World Health Statistics Quarterly, 1984, 37 (4), pp 387-402.

On the use of user charges for publicly owned services, see D De Ferranti, "Paying for Health Services in Developing Countries", World Bank Staff Working Papers No 721 (Washington: The World Bank, 1985). Also P Musgrove, "What Should Consumers in Poor Countries Pay for Publicly Provided Health Services?" Soc Sci Med, 1986, 22 (3), pp 329-33.

- 47 B Abel-Smith, "Funding Health for All - Is Insurance the Answer?" World Health Forum, 1986, 7, p 9.
- 48 "Report on Privatisation" (note 23), p 14.
- 49 Ibid., p 24.
- 50 M I and Maeda N Roemer, "Does Social Security Support for Medical Care Weaken Public Health Programmes?" Int J Hlth Serv, 1976, 6, pp 69-78. Also M I Roemer, contribution to "Round Table" discussion on health insurance in Abel-Smith, op. cit. (note 47), pp 26-28.