Van die Redaksie/Editorial

Understanding the global context of urbanisation and health in South Africa

The process of urbanisation is profoundly related to socio-cultural and political change. South Africa has seen various waves of urbanisation: initially that associated with British settlers, then Afrikaner urbanisation in the 1930s, Asian urbanisation in the 1950s, particularly rapid urbanisation of the coloured population during the 1960s and, at present, accelerated black urbanisation. This process has been complicated by legislation designed, at least in part, to control urbanisation. Parts of the coloured population of Cape Town were moved from formal old housing in the inner city to new, but often inferior, housing in Mitchell's Plain and other areas. The black population has also, until recently, been prevented from moving to urban centres by influx control laws.

Despite measures to prevent it, urbanisation in developing countries occurs during economic recession and is largely unplanned and uncontrolled; it thus results in deteriorating health conditions in growing peri-urban slums. However, efforts aimed at preventing urbanisation can be redirected to improve urban conditions. Urban residents have greater potential for upward social mobility than their rural counterparts owing to better access to jobs, education and health services.[1] Clearly, the provision of services in the urban areas, where demand is concentrated, is more cost-effective than distributing scarce resources thinly throughout the country. There is a strong relationship between poverty and population growth rates, so improving the income of the poorest members of the community is critical to influencing population growth. However, in order to achieve this, urbanising families must be integrated into the urban economy and not isolated on the peri-urban fringe.[1] Some efforts in this direction are evident from recent deregulation of many trading practices in order to encourage growth of the informal economic sector.

The World Health Assembly first discussed the challenge of urbanisation to public health in 1967.[2] In 1984 a new programme on environmental health in rural and urban development and housing served as the focal point for the World Health Organisation in responding to this challenge. The WHO seeks to relate health to comprehensive social and economic development and to improve the health of the city environment and its inhabitants. Urbanisation has now become a major focus for WHO programmes examining the relationship between health and the urban environment.[3-6]

A WHO Expert Committee on Environmental Health in Urban Development met in Geneva from 17 to 30 April 1990. Since then the organisation has recognised that: (*i*) in most countries the health of urban dwellers is at increasing risk from social and physical factors in the environment; (*ii*) urban health problems are most severe in developing countries; (*iii*) improvements in health depend on changes in both the physical and social environments of cities and the supporting rural areas; (*iv*) in virtually all cities inadequate measures have been taken to protect and promote the health of groups at special risk; and (*v*) prevalent constraints that have impeded changes include fragmented social and administrative structures, inequitable development policies, over-centralised government policies, and inadequate or fluctuating support for social services. In developing and industrialised countries alike there is an intense need to reconsider the concept of integrated approaches to the design and planning of healthy cities and towns.

In 1987 the South African Department of National Health and Population Development asked the South African Medical Research Council (MRC) to set up a national programme to assess the impact of urbanisation on health and to identify means of alleviating adverse effects. Since then the MRC's Centre for Epidemiological Research in Southern Africa (CERSA) has initiated a wide range of research projects to examine the current and likely future impact of urbanisation on health.[7] This undertaking was far too large to be tackled by a single institution so the programme involves collaborative studies with most universities, several health services (particularly local authorities), non-governmental organisations and research groups. All the studies are geared towards providing information for the design and evaluation of appropriate interventions. This issue of the *SAMJ* contains, in the main, the descriptive components of some of these studies and is timed to coincide with a World Health Assembly meeting to be held in Geneva in May this year. With the exception of Nigeria,[8] few African countries have systematically investigated the health issues surrounding urbanisation. South Africa both has the infrastructure for excellent research and is experiencing rapidly changing sociopolitical conditions that contribute to rapid urbanisation.

Certain disease categories are related to poverty (measles, diarrhoea and malnutrition), while others relate to industrialisation and pollution (lead in inner cities) and consumer patterns (particularly smoking), as well as social and political instability (trauma, particularly interpersonal violence). Specific risk groups, such as children, women and the elderly, have been examined and the research covers various physical, environmental and social factors important to health (see von Schirnding and Aucamp, p. 414).

Three studies have examined measles prevention (Coetzee *et al.* p. 440, Berry *et al.* p. 433, and Yach *et al.* p. 437) and these consistently point to a need for integration of curative and preventive health services. New arrivals in the city have much poorer vaccination coverage than long-term residents and even intensive vaccination campaigns failed to achieve adequate herd immunity. There is an urgent need for targeted interventions among specific risk groups, such as new arrivals and children born at home.

Two studies (Byarugaba p. 448 and Le Roux and Le Roux p. 500) demonstrated slightly better nutritional status among children in urban areas but with some notable exceptions in the poorest areas. Byarugaba examined several aspects of the GOBI-FFF interventions and found poor knowledge of the correct formula for oral rehydration solutions. However, he makes the important observation that where commercially prepared sachets are being distributed by the clinics, such knowledge may be irrelevant. This shows the necessity for tailoring health education messages to the specific local circumstances.

Two very different studies ('Birth to Ten' p. 449, and the SACLA Community Health Worker project p. 504) emphasise the need for participatory methodology for effective research in community health. Both these studies involved the service providers (in the one official health authorities and in the other a non-governmental organisation) in processes of data gathering and evaluation. 'Ownership' of the data leads to much greater potential for implementation of the results. The 'Birth to Ten' study and one examining mortality data (Van der Merwe *et al.* p. 419) also demonstrated the inadequacy of much routinely collected data. The participation of the authorities in this research has led to a very positive response to the deficiencies of the routine data and measures are already underway to address the problems.

Among the specific risk groups examined are women and the elderly. One study (Cooper *et al.* pp. 423 and 428) describes the women of Khayelitsha as experiencing 'quadruple oppression . . . on the basis of race, social class, gender and as new arrivals in an urban environment'. Gillis *et al.* (p. 490) confirm this in their report, which shows very high prevalences of psychological stress and depression, particularly in elderly women, in new arrivals to the city compared with those in a more established suburb. Stress and depression are probably risk factors contributing to the high rates of traumatic injury resulting from interpersonal violence reported in the study of trauma in Johannesburg and Soweto (Butchart *et al.* pp. 466 and 472).

The first study of risk factors for coronary heart disease in the South African black population (Steyn *et al.* p. 480) shows that there is still time to prevent an epidemic of ischaemic heart disease and coronary heart disease in blacks. The present prevalence of risk factors in black men is about half that in the white, coloured and Asian populations. This finding highlights the need for health promotion efforts in schools to encourage adopting a healthy lifestyle and community health education campaigns to improve awareness of available hypertension screening services.

The key to sustained urban health improvement is, firstly, long-term intersectoral planning involving health professionals, engineers, and housing developers. In addition, community mobilisation and participation provide the most important human dimension to the success of living in the urban environment. Involvement of communities in new ways of adapting community health worker programmes to urban pressures (as seen in the SACLA project, Mathews *et al.* p. 504) are important innovations for the future. Health service use is the third response to the problem. Here the need is clearly to improve access to primary health care, integrate existing preventive and curative services (demonstrated in the missed opportunities for measles immunisation study, Yach *et al.* p. 437), and develop new models of urban primary health care.

Finally, if we hope to reduce smoking rates (identified as an existing problem in the lung cancer (Haldenwang p. 461 and the BRISK study p. 480) articles, we need to restrain certain commercial activities (such as tobacco advertising) and encourage new commercial and social marketing strategies for disseminating information on health (as seen in the AIDS prevention project, p. 496).

The tide of urbanisation cannot be stemmed and it demands a re-evaluation of health care priorities. Appropriate primary health care facilities have to be developed for new conurbations while secondary and tertiary care should also be maintained in the correct mix.

A radical rethink of priorities is necessary both in resource allocation and in health care education. Epidemiologists, community physicians and skilled health care administrators must be provided to enable authorities to plan, organise and operate health services in the most efficient and effective way against a background of limited resources. The epidemiologist, in particular, has the appropriate skills to make a major contribution but there are insufficient properly trained epidemiologists. One might well ask whether the seven medical schools in this country should not be giving more emphasis to epidemiology and community health in their curricula.

Overall there is a need for the better use and integration of all community resources, be they non-governmental, governmental or private sector. Can we meet this challenge?

Derek Yach
John Seager
George Watermeyer

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Urbanisation and environmental health

Rapid urbanisation is associated with an ever-increasing need for adequate housing and basic environmental health services, as well as appropriate epidemiological evaluation of the impact on health of key environmental factors associated with urban development. Environmental determinants of health associated with urbanisation relate to both communicable diseases (for example availability of safe water, sanitation facilities, waste disposal facilities, overcrowding, poor personal hygiene) and to non-communicable diseases (environmental pollution, physical factors relating to housing, transport, land-use and settlement patterns).

Peri-urban settlements in South Africa (already vulnerable with respect to their risks for nutritional and infectious diseases) are subject to environmental health hazards of both rapid urbanisation and industrialisation. Not only do peri-urban informal settlements often lack basic amenities, such as water, sanitation and waste disposal facilities, but they are often more exposed to dust, chemical pollution (both from nearby industry and domestic cooking and heating), and noise. The Bhopal disaster in 1984 was a stark reminder of the additional hazards to health arising from environmental pollution, accidental leaks of toxic gases and spills and explosions at industrial sites adjacent to low-income residential areas.[1]

In this edition of the *SAMJ*, results from a national sample of the urban coloured population of South Africa reveal that a significant proportion of people do not have access to amenities such as reticulated water or flush

toilets. Both these aspects were found to be risk factors for diarrhoea in young children (von Schirnding *et al.* p. 457). Limited information exists for the black population, although data reported here from a sample of black people living in the Cape Peninsula indicate that only around 50% of people live in formal housing, with the rest living in shacks or tents (Steyn *et al.* p. 480). A similar percentage have access to reticulated water inside their homes. In the unplanned informal (or squatter) areas the virtual total lack of sanitation facilities and solid waste disposal services, and the scarcity of pure water, is a matter of grave concern. It is imperative to solve this problem before a major epidemic strikes.

Also reported in this issue of the *SAMJ*, the type of fuel used in the home has been found to be a risk factor for certain respiratory symptoms in urban coloured children (von Schirnding *et al.* p. 457). While millions of children world-wide die each year from acute respiratory infections (ARI), many more suffer acute and chronic morbidity. In parts of Africa, ARI accounts for a quarter to one-third of deaths in young children, and is the main reason for utilising the health services.[2] In South Africa mortality rates for ARI among coloured infants are significantly higher than those of whites, and in some urban areas (where rates are generally higher than in rural areas) there is evidence that ARI is becoming an even more important cause of death than diarrhoea.[3]

In spite of attempts by the authorities to monitor air pollution, there is a dearth of information on prevailing pollution levels and respiratory illness rates in the black urban townships. Yet the black townships are among the most severely polluted environments in which South Africans live, owing to the inefficient combustion of coal in domestic stoves. Poor dispersion conditions in the winter months complicate and aggravate this problem. In contrast to the developed countries where indoor air pollution problems of current concern relate for example to the presence of radon gas and formaldehyde in homes, here factors related to the use of fossil fuels in cooking and heating homes may give rise to respiratory problems and contribute to chronic lung disease. Women and children are most likely to be exposed to health hazards in the domestic environment, owing to the amount of time spent in and around the home.

A further problem relating to the urban environment concerns 'inner-city decay', which is associated with factors related to deteriorating and dilapidated housing, and inadequate environmental amenities.[4] Infants and young children living in the inner cities may in some circumstances be particularly susceptible to ill-health and disease due to their inherent vulnerability, impoverished living conditions, and lack of parental supervision and recreational facilities. This is illustrated in this issue of the *SAMJ* in a study of factors associated with environmental lead exposure in inner-city children (von Schirnding *et al.* p. 456). Previous studies in South Africa have demonstrated that children living in urban areas have a higher incidence of raised blood lead levels than other children.[5,6] Part of the reason for this is that children are more exposed in inner-city areas to heavily trafficked roads and petrol-derived lead aerosols. However, low-level lead exposure is multifactorial, and socially disadvantaged children living in dusty homes in a poor state of repair are at increased risk (for example due to flaking of lead-based paints and soldered joints in water reticulation systems). The extent to which social and environmental risk factors interact in exacerbating risk needs further attention in environmental health studies.

With rapid urbanisation, the potential for inner-city decay to worsen is likely. While housing can protect against the elements and provide security, it is evident that under adverse conditions it may also be a source of considerable ill-health. The health sector needs to be more involved in housing and settlement planning, as well as in the siting of industries in relation to existing or planned residential areas. In this respect, there is a need for co-ordinated action by various sectors relating to housing, health, environmental protection, transportation, planning and education.[4] The community's perceptions and evaluation of their needs are vital to promoting and implementing successful intervention programmes, as is illustrated in the article (Mathews *et al.* p. 504) relating to the evaluation of a peri-urban community health worker project in the western Cape.

Y. E. R. von Schirnding
P. J. Aucamp

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The future of medical schemes in South Africa — towards national insurance or the American nightmare?

The first few months of this year produced fresh evidence of the crisis facing the private health sector in South Africa. There has been yet another round of the now familiar battle over fees between the medical schemes, represented by the Representative Association of Medical Schemes (RAMS), and the Medical Association of South Africa (MASA), representing doctors in private practice. At the same time, most schemes have announced major increases in contribution rates for 1991, in many cases up to 30%.

These developments leave all parties dissatisfied; for existing (and potential) members of schemes, and for their employers, the rapidly rising costs make private health care increasingly unaffordable. For the medical schemes, these same cost pressures place tight limits on their ability to obtain new membership; and for the providers (doctors and others), there is an ever-widening gap between their demands and what RAMS will pay.

This crisis has produced a flurry of activity in recent

months. The Competition Board announced a major investigation into medical schemes, and has released a 'working document' (reflecting the views of the Directorate rather than of the Board itself),[1] which may have dramatic implications for private health care in South Africa. Some important changes to the Medical Schemes Act have recently been gazetted,[2,3] and the Minister of National Health has recently hinted that further major changes to the Act may be forthcoming.[4] The likelihood of major changes is confirmed by the fact that the Central Council for Medical Schemes has appointed a committee to work on the redrafting of the Medical Schemes Act.

The apparent flexibility and willingness of the major parties to investigate alternatives is superficially impressive. The responses are comprehensive; they cover both the relationship between the medical schemes and their members, and that between the medical schemes and the providers of services. However, analysis of these responses indicates that all have a fundamental problem in common; they all fail to recognise that this crisis is an *inevitable* result of the present structure of the private health sector, and that an effective long-term solution will require substantial structural change. Instead, all the proposed solutions are aimed at short-term relief, and amount to little more than tinkering with the present structure. As this analysis will show, not only will these proposals fail to solve the problems that occasioned them, but they are likely to severely aggravate the crisis.

Until September 1989, the most basic principles of social insurance, those of risk sharing, cross-subsidisation and equal access to a comprehensive package of health services,[5] were guaranteed by the provisions of the Medical Schemes Act.[6] After the promulgation of amendments on 15 September 1989,[2] however, these principles are directly threatened. Whereas in the past schemes were allowed to determine contributions only on the basis of family size and income, they are now able to take into account such factors as previous claims experience and age (both of which affect the risk that the member presents to the scheme), as well as other factors.

This opens the way for schemes to begin to 'risk rate' their members. Those who are low risks, the young and healthy, will be offered comprehensive packages at very cheap rates. Schemes will compete with each other to 'skim off' these good risks. This will fracture the risk sharing pool, and eliminate the cross-subsidisation from good-risk groups to bad-risk groups (the elderly and the sick). As a result, the elderly, or those who are or have been ill, will have to bear the full costs of their insurance. This will take health insurance well beyond the reach of many of these people. Pensioners, who may have contributed all their lives, and even those among the employed who are at high-risk, may find themselves uninsurable. This is precisely the situation in the USA, where this kind of competition between health insurance companies has meant that 37 million Americans, many of them earning a decent living, are unable to afford health insurance.[7]

In theory, these changes may benefit some schemes in the short term, allowing them to retain or even expand membership, despite rising costs. But the consequences of massive cost escalation for a significant proportion of their members have clearly deterred most schemes. To date, relatively few have taken advantage of the legislative changes by offering differentiated packages based on risk, or by offering no-claim bonuses, although recent evidence suggests that these practices may be on the increase (R. Speedie, Executive Director, RAMS — personal communication).

However, new changes, some already enacted, and others now possibly in the pipeline, will bring this scenario much closer. The Act specifies a minimum range of benefits that schemes must offer, as well as minimum (R100) and maximum amounts (not more than the 'Scale of Benefits') that can be paid for each service covered. A recent announcement by the Registrar of Medical Schemes[3] allows schemes to request permission to pay more than the Scale of Benefits should they choose to.

One of the findings in the working document of the Competition Board is that the system of specifying a minimum range of benefits, and of minimum payments, is a restrictive practice which limits competition. The working document also describes as restrictive the present limitation on non-medical schemes (such as insurance companies) from doing the business of a medical scheme, and on medical schemes from doing other business such as offering short-term insurance.

It is quite possible that all of these restrictions will be eliminated from the Act in the forthcoming changes hinted at by the Minister. This will allow insurance companies directly into the medical scheme market (at present they are only able to offer cash payments to individuals instead of meeting their medical expenses directly). It also opens the way for an infinite range of medical scheme 'packages'. In order to survive the competition from insurance companies, who will not hesitate to 'risk rate' and to 'skim off' the good risks in pursuit of clients, medical schemes will be forced to engage in the same practices. This might suit the young, the healthy, and the well-off, but it will be a disaster for everyone else.

The medical scheme system is also under threat on the question of the relationship between the medical schemes and the providers of services. Another pillar of the medical scheme system has been Section 32 of the Medical Schemes Act, which mandates direct payment by medical schemes to providers who charge within the Scale of Benefits.

One of the submissions from RAMS to the Competition Board was that this 'guarantee' of direct payment should be abolished. It argued this on the basis that the present system induces unwarranted utilisation of services by patients (since they receive services free at the point of service when practitioners are paid directly by the schemes). Whether or not this is true, the effect of abolition would presumably be to strengthen the bargaining power of individual schemes, which would then be free to negotiate direct payment with individual practitioners in return for concessions that they might demand.

There appears to be some disagreement within RAMS, with some schemes supporting the proposal, and others opposing it. The Board's working document argues that the guarantee is 'under suspicion' of being a restrictive practice. It is possible, then, that the guarantee may go, along with the other changes to the Act discussed here.

This, too, would be disastrous for the medical scheme system. This guarantee of payment has had three profoundly positive effects, all of which would be lost if it were abolished. Firstly, it has meant that a sizeable number of private practitioners have chosen to charge their patients at 'scale', rather than cope with the bad debts that are inevitable without direct payment. An estimate by a large medical scheme administrator put the percentage of all charges by general practitioners to its members which are at 'scale' at 86,6% overall in 1989. In the case of claims submitted by black members (i.e. Africans, coloureds and Indians) approximately 99% of GP charges were at scale, whereas for white members, the equivalent figure was 82% (Medscheme Medical Administrators — personal communication).

Secondly, it has allowed members of schemes to obtain much of their health care free at the point of service from 'contracted-in' practitioners. This is clearly crucial for thousands of patients who do not always have cash in hand when they need health care.

Abolishing the guarantee would mean that practitioners would no longer have any reason to stick to the Scale of Benefits. This would lead to far higher charges for services in many cases. It would also mean that, except where especially negotiated, large numbers of scheme members would, for the

first time, be faced with significant out-of-pocket payments for essential care from general practitioners and other practitioners.

A third effect of the guarantee has been that it has provided the major reason for the existence of a co-ordinating body of medical schemes, as exists in RAMS. Without the guarantee, the scale would become little more than a guide to fees. In a bid to gain competitive advantage, individual medical schemes would begin to negotiate fees and conditions of payment directly with practitioners. Instead of the present system of co-ordinated payers, we would move to a fragmented, multiple-payer system.

Doctors may well perceive the present system to be uncoordinated and fragmented. However, the extent to which RAMS and the Scale of Benefits function as a co-ordinating mechanism will become very clear once doctors are confronted with the prospect of negotiating separate agreements on fees and terms of payment with hundreds of individual schemes and insurance companies.

This would have extremely problematic consequences for both the medical schemes and the providers. Medical schemes would lose the bargaining power that derives from the collective purchaser function that RAMS performs. They would also lose the ability to co-ordinate fees. This would lead to enormous increases in administrative costs for the schemes. For providers, too, the costs of negotiating fees with, and collecting payment from, innumerable payers would increase dramatically.

The result will be a chaotic shambles of different fees and arrangements, negotiated between the 250 schemes[8] and the approximately 11 000 private practitioners,[9] as well as all other private health care providers (hospitals, other health professionals) who are also governed by the Scale of Benefits. This will take us very close to the situation in the USA, in which administrative costs of health insurance, as well as of providers, are far higher than those in Canada, with its single-payer system — the National Health Insurance system — or in Britain with its National Health Service.[10]

Another change to the Act, suggested by some of the medical schemes who have opposed the abolition of the guarantee, is that the level of guaranteed payment should be reduced from its present 100% of scale to a lower level, say 70% (this is the official position of the Southern African Association of Medical Schemes — SAAM, which represents over 600 000 members of schemes (K. P. C. Hollis, Chairman, SAAM — personal communication)). This would mean that providers who charged at the Scale of Benefits would receive 70% of the charge directly from the medical scheme, and would have to collect the remaining 30% from the patient. This proposal is also defended on the ground that it will reduce unnecessary use of services by patients.

This proposal, however, also threatens the fabric of the system. The long-term deterrent effect of increased out-of-pocket costs of health care on utilisation has not been clearly established;[11] and the necessity for out-of-pocket payments may deprive many scheme members of necessary health care when it is needed most. For the providers too, having to collect a part payment for every visit would increase the administrative load and the risk of bad debts, and would undermine their willingness to adhere to the Scale of Benefits.

All of these proposals, then, would create more problems than they would solve. They retain the worst aspects of the present system — fee-for-service payment and the third-party payer arrangements;[12] at the same time they threaten to destroy the only good aspects of the system — the administrative efficiency and bargaining power of a co-ordinated payer system, access to a comprehensive package of care largely free at the point of service, and risk sharing and cross-subsidisation between members.

Aside from the massive increases in administrative costs throughout the system, one of the major effects of these changes will be to leave large numbers of medical scheme members with inadequate cover. They will thus come to rely more heavily than in the past on the public health sector. Ironically, this will defeat what was the major aim of the government's privatisation strategy — that the private sector should remove some of the burden of health care from the state. But this should give the opponents of privatisation no relief. The private health sector is not about to wither away. Instead, if these changes are legislated, it will have found a way to extract as great, or even greater, a share of total health expenditure for itself (its current share is 46,7%[13]), while taking on progressively less of the burden of providing health care for the population.

In its submissions to the Competition Board, the government argues that it will oppose any changes that increase its share of the health care burden. It is to be hoped that it realises that all of the changes analysed here will have precisely that effect, and that if it allows such changes, it will be creating precisely the situation it is hoping to avoid.

What is considered an appropriate response to the current crisis in the private health sector will clearly depend on one's perspective about the future role of the private health sector in the health care system in general. Three broad positions can be defined here. The first is that the private sector should have as small a role as possible (and that maximal resources should go into building the public sector).[14] Another commonly held position is that the private health sector should continue to coexist alongside a rationalised, strengthened public sector. The third, which colleagues and I have proposed elsewhere,[15] is that public and private *provision* of health care should be integrated within a public financing mechanism, such as a national health insurance system. This latter option could of course coexist with either of the other two. In our view, its major effect would be to enhance public sector provision and ensure that what remained of private provision was equitable and cost-effective.

I have argued here that current developments in the private health sector will not bring the first scenario any closer. Only major legislative change, such as elimination of subsidies to private health care, and even legislative elimination of private practice, would achieve this end. The measures needed to attain the second or third scenarios are almost the opposite of what is happening at present. The collective purchasing power, negotiating ability and co-ordination functions of the medical schemes should be strengthened. Access to comprehensive packages at minimal out-of-pocket cost should be extended rather than limited. So should risk sharing and cross-subsidisation.

At a minimum, this will require retention of the guarantee of payment at 100% of the Scale of Benefits, retention of the minimum (and ideally the maximum) range of benefits, a reversal of legislation that makes 'risk rating' a possibility, and preventing of the insurance companies from directly entering the medical scheme market.

It would also be greatly assisted by deregulation of health care providers. For example, rules preventing group practice and limiting the employment of doctors should be done away with. This would create a situation in which a strengthened co-ordinated payer could use its purchasing power to negotiate the best possible deal for consumers with both individual and group practices, and with managed care structures such as preferred provider organisations or health maintenance organisations. In such a situation, the possibility of more than one Scale of Benefits, with direct incentives for cost-effective managed care structures, could also be investigated.

These developments would allow for a private health sector to exist alongside the public sector. While I would argue that this scenario is undesirable, not least because the private sector seriously undermines the public sector, at least it will achieve

some measure of cost-effective care for the money spent in the private sector. More importantly, these developments would facilitate the emergence of some form of national health insurance system. The co-ordinated payer system, already in place, could be extended to cover the whole population; and this new single payer would be able to negotiate, on behalf of all citizens, with a mix of competing public and deregulated private providers so as to achieve a package of decent quality care at an affordable cost.

What happens to medical schemes in the next year will be crucial. If things continue as they are, those who are at present covered by schemes will soon find themselves in the local version of the American health care nightmare. On the other hand, timeous and appropriate intervention may avoid this, and may in fact allow the medical scheme system to begin to make a contribution to the health care of *all* South Africans.

Jonathan Broomberg

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