Editorial/Van die Redaksie

Achieving health care for all

South Africa stands on the brink of major social and political changes. Whatever the uncertainties of the moment, it is certain that we are moving towards a time when all South Africans will participate as equals in the political processes and decision-making structures that govern our lives.

These changes will inevitably have consequences in all sectors of society. Health care, and the institutions and professions that provide health care, will not be untouched.

The end of apartheid must bring with it the end of segregation and racial discrimination in health care. Indeed, we would do well to remove all discriminatory practices from the health sector even before a new government forces us to do so.

However, opening facilities to all is the beginning and not the end of the challenges that we face. The first and fundamental challenge is an economic one. In this issue of the *SAMJ* McIntyre and Dorrington[1] demonstrate how starkly unequal is the allocation of resources for health care to white and black, rich and poor and urban and rural populations. Their figures also demonstrate that South Africa cannot afford to provide health care for all in the way it currently provides health care for the white population in the private sector.

We face the dual challenges of eliminating these disparities and of making better use of available resources in order to upgrade the care available to the poor, rather than compromising the quality of care provided to the privileged few. It is these challenges that have led us to focus primarily on economic issues in this edition of the *Journal*.

However, too narrow a focus on economics carries with it the danger that we will ignore other critical policy issues affecting the health sector. No informed observer would care to deny the existence of a deepening crisis in both the private and public health sectors in South Africa.

The private sector as we know it is in danger of pricing itself out of the market, and the system of fee-for-service care and guaranteed third-party payments are major factors contributing to a cost spiral that far outstrips the general rate of inflation.[2,3]

The crisis in the public sector is of a somewhat different nature. Drug costs are reasonably well controlled, and there are not the same incentives to provide surplus service. However, there is clear evidence that the fragmentation of health services leads not only to administrative waste, but also to the inefficient use of resources and to many cost-effective services not being supplied because they fall between the different authorities providing preventive or curative services.[4] In addition the public sector, with about 3,3% of the GNP to spend, simply does not have the resources to provide adequate care to all. Finally, management in public sector services is constrained by excessive bureaucratic regulation.

The responses to these crises have been typical of the partisan and parochial defence of vested interests that has characterised the health sector to date. The medical aid schemes, private practitioners, hospitals and the pharmaceutical industry have all acted primarily in their own economic interests. One example is the recent legislative changes, long lobbied for by the medical scheme movement, that give medical schemes greater flexibility in the packages they provide, and in setting contribution rates. Rather than act to contain costs, the schemes have acted primarily to maintain their market. The net effect of the resulting changes will be that decent coverage for care in this sector will become increasingly unaffordable for the average earner.[3]

In the case of the public sector crisis, the Government's response has, until recently, been to further promote privatisation as a means of unburdening itself of its vital responsibilities.

These observations bring us to the second critical challenge, that of creating democratic and effective channels for the development of a sound and equitable health care policy for the country. The obstacles to this are numerous. There is as yet no evidence of willingness on the part of any of the major actors to move beyond tinkering with minor aspects of either public or private health care. There has always been a virtually complete absence of democracy in the policy-making process. Finally, there is a drastic lack of detailed information necessary for rational health policy development.

All these obstacles must be addressed as a matter of urgency; professional, commercial and other groups must learn to move beyond their vested interests. Real democracy must become part of the process of health policy formulation. This means that both the Government and the private sector must begin to do more than pay lip-service to the concept of consultation with the communities whose interests they claim to serve. Lastly, and equally urgently, we need to embark on ambitious policy-orientated research programmes that will provide the information base on which policy can be formulated.

The political climate, the inherent failings in the present systems of health care delivery, and the moral imperative to provide adequate care for all, combine to demand a serious reappraisal of the health care system in South Africa. What is needed is an ambitious plan to meet defined objectives, and then a process of negotiation to ensure that the legitimate needs of all parties are met. The complete restructuring of health care in South Africa, as part of a process of more general social change, should be seen as an exciting challenge that awaits us, rather than a threat to be avoided at all costs. The time to meet that challenge is right now.

Cedric de Beer
Jonathan Broomberg

1. McIntyre DE, Dorrington RE. Trends in the distribution of South African health care expenditure. *S Afr Med J* 1990; **78:** 125-129 (this issue).
2. Broomberg J, Price M. The impact of the fee-for-service reimbursement system on the utilisation of health services. Part I: A review of the determinants of doctors' practice patterns. *S Afr Med J* 1990; **78:** 130-132 (this issue).
3. Broomberg J, De Beer C, Price MR. The private health sector in South Africa — current trends and future developments. *S Afr Med J* 1990; **78:** 139-142 (this issue).
4. IJsselmuiden CB, De Beer C. Reducing health care costs — potential and limitations of local authority health services. *S Afr Med J* 1990; **78:** 161-164 (this issue).

A time to choose

Never before in South African medicine has there been such intense and widespread interest in health policy, nor so many misgivings expressed as to where we may be heading in the provision of health care in the country. The quality of and the ethical basis for the services that are presently provided have come under intense scrutiny. It is now widely acknowledged that a comprehensive system for the provision of health care must be created that is both efficient and affordable, as well as morally defensible. Any reasonable commentator will acknowledge that among many of the country's doctors, nurses, pharmacists, dentists and health administrators there is a commitment to these objectives, and that at the same time we have a considerable distance yet to cover.

There are several reasons for this new urgency. It is prompted by the contracting resources available for health. It also reflects the political debate in the country which addresses, as never before, issues of equitable distribution of resources and influence among all South Africans. It is a manifestation of the misgivings of many concerning resource allocation in health, the declining status of the teaching hospitals, the inability to provide adequately for curative and preventive health at community level, and the need to meet up to the country's official decision to align with the World Health Organisation objective of 'Health for all by the year 2000'. Moreover, there has been a decline in the morale of health professionals, and unedifying public bickering between doctors and pharmacists. A plea for a comprehensive health service has come from various quarters. All this indicates a widely felt need for change in the present dispensation.

Government and progressive health workers alike have in recent times identified the principles which should guide our health services: availability and accessibility of facilities and personnel; effectiveness of the programmes, including cost-effectiveness; and acceptability to those who are affected. This must be achieved according to standards of medicine which are universally recognised, and in a manner that is just for everyone. This cannot be done without broad negotiation and consultation, which includes those who are affected (the public). It is at last understood that the fragmentation of health services on racial lines has been unsuccessful and prohibitively expensive, and that this cannot be further sustained or morally defended.

Policy-makers considering the future form of our health services will take note that South Africa currently spends between 5,5% and 5,9% of the GNP on health, and there is little prospect in the foreseeable future of this being substantially increased. In the United Kingdom the entire national health service takes up slightly less than 7% of the GNP. This is a comparatively small difference, given the differences in the breadth of health cover offered in the two countries. Whatever policy may be decided upon for this country, it must — for unarguable reasons — be race-free, and conducted by a single government department. Special care will be required to protect and develop access of the elderly to health care, and to ensure that people are not devastated by the financial consequences of serious illness. Furthermore, if the flourishing tradition of South African medicine is to be maintained and strengthened, general practice, the pharmaceutical industry and academic hospitals will need to be developed.

In the various articles included in this issue of the Journal a number of important and challenging points are made that call for the attention of those who plan an enlightened health policy for South Africa. (It does not necessarily follow that all the points have been adequately substantiated, but they certainly merit careful consideration and follow-up.) These include:

1. Private practice may generate excessive medical attention, with 'supplier-induced demand' leading to over-utilisation of health services and excessive investigation and treatment. This has been shown in a well-documented example of surgical intervention by caesarean section (Price and Broomberg, p. 136). In a comparison of a local health maintenance organisation with health services in medical aid schemes, it was found that medical aid patients sought the services of general practitioners 36% and specialists 18% more than in the health maintenance organisation, and that 133% more radiological procedures were performed in the former (Broomberg and Price, p. 133).

2. Local health authorities providing comprehensive health services are likely to cost less than the present system of divided curative and preventive care. The expenses incurred by the dichotomy of promotive and curative services in South Africa are unnecessary and can be significantly reduced.

3. Restructuring of private health care is essential if inflation in health costs in this sector over the past 11 years is to be curtailed. An argument for 'managed care structures' is put forward which needs to be examined critically, in comparison with the benefits of health maintenance organisations and with more traditional systems.

4. Health care will remain prohibitively expensive until such time as there is a resolution of the adverse political, social, economic and ethical issues that impact on health in this country, and the issue of poverty is energetically addressed.

5. 'Privatisation' of health services will not relieve the South African health burden. [The proportion of the public supported by medical aid schemes was 17,6% in 1983 and 16,9% in 1987 (the decline was mainly due to the reduced number of whites covered by medical aid), and it is unlikely that this figure will exceed 20% in the future.]

6. There is evidence that in some systems the salaried payment of health workers may not produce adequate incentives to maintain good quality of health care.

7. In 1988 the weighted average per capita expenditure on blacks compared with whites was 1:4:3. Extrapolated per capita, 13 - 14% of the GNP goes to whites and 3,35% to blacks by proportion. The WHO target is 5%.

8. A comprehensive planning strategy by dedicated manpower has become essential if a detailed health plan with prospects of success is to be developed in accordance with accepted ethical and humanitarian considerations (Kane-Berman and Taylor, p. 154).

9. Since health costs in the public sector are predominantly accounted for by personnel (60%), consumables (27%), equipment (7%) and operating expenses (4%), meaningful savings can only be achieved if there is reduced spending on the first two items.

10. The present two-tier health system provides luxurious curative care in the private sector for a privileged and affluent few and under-funded public sector support for the majority of the population. There is a concentration of facilities, doctors and pharmacists in cities, where most private contributors are situated. But private funds only pay for curative health care. The State remains with the bill for preventive health services for all citizens.

11. Health care reform in this country can only be achieved *pari passu* with improvements in education, social security, infrastructural development and job creation.

Several articles in this series refer to medicines. Medicines occupy an important position in the formulation of health policy. Besides being the single most expensive consumable item (and in the private sector the most expensive health item overall), they also represent a vital resource, provided that