Is there a role for the private sector in SA health care?

Yes, but not in the NHS

By Merrick Zwarenstein

Introduction

In this article I argue that there will be no role for the private sector, as we see it today, in the kind of National Health Service (NHS) needed to answer South Africa's priority health and health care needs.

Definitions

The *"National Health Service"* is the collection of staff, resources and money under the control of the department of health of a democratic government. It will be committed to the Primary Health Care Approach of the World Health Organisation, and will have the goal of meeting priority national health and health care needs first. These priority health needs are likely to be diseases which can be prevented or treated relatively cheaply, and which affect the poorer and disadvantaged classes and groups in the society. Examples are immunisable diseases in children, cervical cancer, AIDS, and occupational illnesses.

The *"private health care sector"* here includes health care providers or companies which provide health care without being under the direct control of the government. The orientation of this care is strongly influenced by the financial interests of the provider, focuses on the individual consultation or care event rather than the person or the community, and will not spontaneously support the PHC approach.

The term *"no role..."* implies both separation from the NHS, and consumption of a small fraction of total national health care resources and expenditure as in the United Kingdom, a country with an NHS, where the private sector is only used by about 15% of the population. Even this group obtain most of their preventive, sophisticated or emergency care from the NHS. Private care is separated from NHS care in the UK.

The present pattern of public and private care sectors

The public sector has widely varying coverage - from urban to rural areas, white to black communities - as well widely varying levels of sophistication - from teaching hospital to rural clinic care. Access is based on one's total household income and accommodation is not luxurious. The private sector is even more unevenly distributed, essentially providing only a luxury service, mainly in urban areas, with a tendency to overtreat, and accessible only to people with money or expensive medical insurance ("medical aid").

The goal: equity, efficiency, effectiveness

We want to move towards an NHS open to the whole population, acceptable to users, accessible financially, nearby, and welcoming, fairly distributed across the country and between all identifiable population subgroups according to health needs, efficiently managed, and applying only those kinds of medical care which are known to work. This NHS would make best use of national health care resources for the population, with a balance of health promotion, caring, and curing.

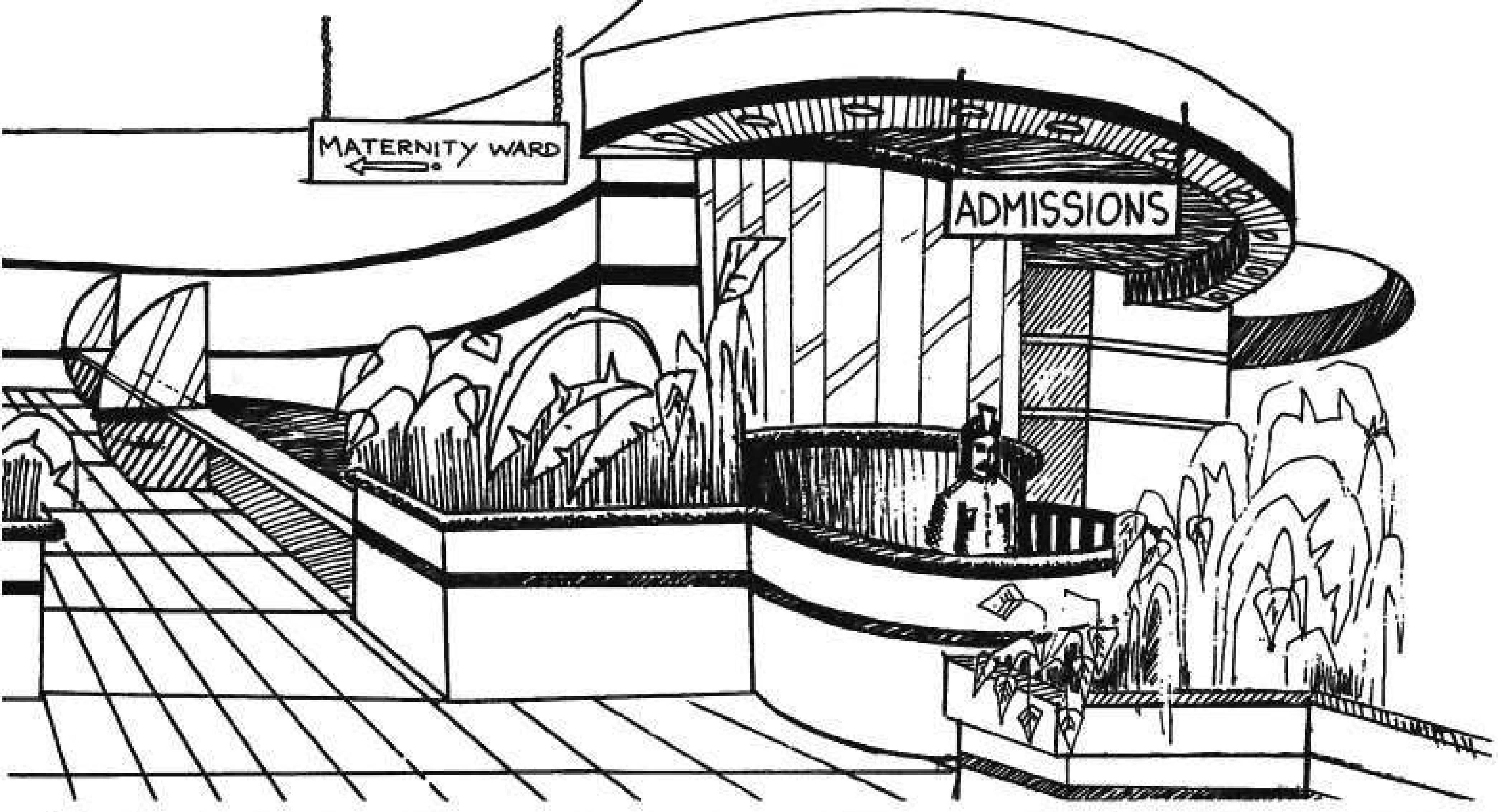
How do we build an NHS?

The political context

The social and political transition in South Africa is occurring over a period of several years, and does not include a wholesale surrender of white controlled assets. Because the existing state and ruling groups are negotiating transition, rather than simply handing over control, there is modest flexibility in political, social, and economic conditions for the new government in dealing with high popular expectations.

Nationalisation

Wholesale nationalisation of private health sector assets, and forced public sector employment of skilled people is not an option. The are in any case many disadvantages in such a strategy - hostility, sabotage, emigration. Since the purpose of the nationalisation is to redistribute



resources and change services to meet priority needs, and since this requires willing providers, frontal confrontation would be self defeating.

Will national health insurance lead to an NHS?

The countries which have moved towards universal entitlement to health care in a unitary national system have, with the exception of Cuba gone via a national health insurance scheme. NHI is a method of financing health care. A government controlled insurer regularly collects money from all employed people and their employers, adds to it money collected by the government from tax, and uses both these amounts to pay health care providers for a negotiated set of health care available as a right to every citizen.

Improvements in the type of services, and distribution and efficiency of health care under this private provider dominated system are through indirect leverage. Control of behaviour of health care providers is obtained through modifications in the amount and form of remuneration. This is more difficult if the PHC approach is the national plan, because its many interdependent programmes will have to be broken down to individual items for negotiation (and perhaps payment). This especially affects doctors, since even in the USA nurses are predominantly salaried employees, and therefore easier to influence directly. Indirect leverage is weak, and may have undesirable side effects. After 15 years of expensive development, insurers in the US have partly controlled overservicing, only to find underservicing emerging as a new route by which the medical companies attain their profit ratios.

Ensuring quality care under an insurance system would be a continuous struggle between the insurer and the providers.

How would a public sector based NHS develop?

Direct control is likely to be the most feasible way to modify the health service to improve its efficiency, effectiveness and coverage.

A public sector NHS, under the control of a democratic government, can plan and implement for national priorities. An NHS with a large private sector will not be able to do this because the private sector elements are not committed to national health priorities and plans and will not accede to them unless they are modified to accord with their special group interests.

I therefore argue that SA should build an NHS from the public sector alone, rather than from a combination of public sector and private sector providers.

Public sector financing of public sector care, direct public sector hiring and direct control over public sector facilities and providers of health care are the basis of effective policy implementation. There are functions where a state wants to implement policy smoothly and directly. Examples are the defence and justice functions, which are never left to the uncertainties of indirect control.

South African health care needs significant improvement. This will be difficult in the absence of smooth and direct control. The NHS would need to develop PHC, with prevention and health promotion activities. The service must use a team approach, with an increased role for both non-doctors and non-professionals. Active community participation and control in local health care would be emphasised.

Improvements in management, morale, resources, and community participation could help keep professional staff, and bring back some of those attracted by the slightly better salaries and working conditions that the private sector has had.

The transition period

South Africa should invest political and financial capital in its NHS in the early years of the new government, coinciding with the period of maximum potential for social interventions.

Patient's experiences of private sector health care have been fairly unhurried, related to minor conditions which seldom reveal the inadequacies of the system, and accompanied by the respectful ear of a skilled doctor whose attention is sharpened by the knowledge of a fee.

Contact with the public sector outpatient service has usually been hurried, production line, and accompanied by the displaced aggression of pressurised staff. Public sector services, which could well use the known efficiencies of appointment systems for outpatients, seldom do, and in the frenzied rush of the crowd, it is not surprising that patient believe the service they receive matches its poor presentation, and is of poor medical quality.

The private health sector should not be closed, nationalised or incorporated into the public sector. On the contrary, aside from medical technical issues, such as safety and quality of care, it should be left almost wholly to its own devices, and the unpredictable nature of the market, entirely separated from the NHS (and from the public subsidies on which it depends). The goal is to limit the growth of the private sector, turning it towards a marginal provider of a small range of luxury services. The desire of some patients to buy private medical services should be respected.

When the presently voracious private sector is brought against its own limitations, when interest groups are fighting with each other over the leaner pickings of an unsubsidised and smaller market, it is likely that individual practitioners and some companies will want to move into or sell out to the public sector.

Until that collapse it is in the best interests of the majority of the population to spend scarce resources of skill, planning ability and money to build up the public sector into an effective, accessible and efficient health care service for all the population who need it.

Strategies for dealing with the private sector

Four active interventions that will affect the private sector come to mind:

Audit and quality control

The country needs to detect, publicise and disallow or at least discourage harmful practices in the private and the public sectors. Examples include unnecessary procedures and inappropriate drug prescriptions. This quality control is likely to be easier in the public than in the private sectors, and the failures in the latter will help to dispel the unchallenged image of infallibility which it carries.

The private sector should not be closed, nationalised, or incorporated into the public sector. It should be left to collapse under the weight of its own limitations.

The medical insurers who will remain should be enabled by the state to police overservicing and conduct other assessments of the private sector providers. As in the United States, this will discourage excessive expenditure in that sector, as well as expose it to the trauma of the real economic world.

Licensing capital investment

The United States licenses the opening of beds and new technology, in both public and private sectors according to need. Successful control over the bed supply, and failure in controlling physician placements and practice explains the mixed picture in the Canadian health economy. South Africa should do the same, including a retrospective review of existing facilities for need.

Removing the tax subsidy

The public purse subsidises private health care via the tax rebate on corporate contributions to medical aid for employees. This rebate could add about 20% to the public sector health budget.

Moving public sector employees off medical aid

Public sector corporations employ about one third of all medical aid members, and therefore provide a large part of the market. These corporations could be required to collaborate with the NHS-to-be to provide public sector health care at the workplace. There are many work sites where the concentration of employees is large enough to supply a full range of public sector services. In appropriate instances, these could be open to the public in the immediate vicinity.

Ending subsidised staff training

Medical and nursing staff are trained with a subsidy from the public purse. It is difficult to make a uniform case for the private sector to repay the cost to the NHS of hiring away a trained person from public sector work, since there is no intention of doing this for other professions or trades. It might be feasible to do this for a period for certain scarce professions, such as nursing. In the longer run the general subsidy could be removed from training, and replaced with bursaries for students who are prepared to pledge themselves to enter public service.

Summary

The NHS South Africa needs can only be built on the foundation of the public sector.

The private sector, especially if strengthened by an influx of national insurance money, will be a growing and uncontrollable sink for money. This money has better uses. The conflict with the private sector needs to be minimised, and conducted from the high moral ground.

More research is needed. We must move beyond rhetoric, to detailed policy proposals with empirical assessments of feasibility. ❑

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The people on this list are not responsible for errors, nor do they necessarily agree with the point of view expressed; this is work in progress, and incomplete. Empirical research on how National Health Insurance or a National Health Service might operate, be financed, controlled or evaluated has hardly begun.

Addendum

This paper reflects my personal opinions and not necessarily those of any organisation of which I may be a member or an employee.