Committee of enquiry into National Health Insurance
Memorandum on funding of medical services

Effie Schultz 22 February 1995.

Definitions

Since health is dependent on more than preventive medicine and medical care, action on/for health is the responsibility of all sectors in government and not only of the medical services. My proposal on funding is predicated on this understanding and uses Victor Sidel's concept of social medicine[1] which identifies the pre-requisites for health as:

1 social well-being
the attainment and maintenance of the socio-economic conditions necessary for health

2 public health
the advocacy and implementation of measures to protect and promote health, and to prevent disease in communities and in the nation as a whole;

3 medical services which consists of:
preventive medicine - the protection and promotion of health, and the prevention of disease in individuals and families;

4 medical care - the provision of diagnostic and therapeutic services for sick individuals and families.

I do not therefore use the terms, health care and primary health care. The following definitions are used to distinguish between levels of medical services:

i	primary care	first contact medical service
ii	tertiary care	high-tech specialist medical service
iii	secondary care	the space between.

Academic medicine is concerned with the whole of social medicine.

Multi-sectoral local authority action for health

Social medicine which embraces every sector of public life should be funded and administered as an integrated whole. Because medical services are part of social medicine, there should not be separate hierarchical medical service sectors. These and vertical medical programmes may not be effective. The conclusions of a Canadian study of anti-natal care would probably also apply to AIDS and TB control programmes, to family planning, and to well-baby clinics, etc. They write:

> After 2 decades of observational studies the evidence for a beneficial effect of early and frequent prenatal care on birthweight remains ambiguous. .... [T]he findings of this study do not support the proposition that the route to moderating socio-economic inequities in birthweight is through improved access to conventional prenatal care.[2]

There should be one body to fund, provide, administer, and monitor medical services for all people, irrespective of age, gender, medical condition, health status, or income as part of an accountable, transparent, participatory, and coordinated multi-sectoral service. Money derived from the different sectors should be pooled. Goal-directed expenditure should be integrated to meet multi-sectoral needs. Local government is the appropriate body for these functions because it is already looking after the other components of social medicine such as water and energy, transport and traffic control, parks and recreation, sanitation, refuse removal, protection of the environment, and even housing. Academic medicine and medical research should also be the responsibility of local government. Separate district health structures as subsets of provincial health departments should not be set up. As Costa Gazidis wrote about the ANC Health Plan:

> The district health authorities will be unnecessary once the new local authorities are in place - locally elected, accountable directly to the community, designed for inter-sectoral cooperation, ... [3]

The polarisation within the medical sector between primary, secondary, and tertiary care, between medical service, training, and research, and between the different sectors in local government would fall away. There are other advantages also, as reported from the WHO inter-regional seminar on rural medical services in China in 1982:

> The method used to finance health care can be an important instrument of policy by facilitating the objectives of decentralisation, involvement of the people, and self-reliance within a health care system. It affects:
>
> [a] the distribution of resources;

[b] the social acceptability and economic efficiency of the services offered;
[c] the ease of administering services;
[d] the capacity of the health care system to finance its growth. [4]

The role of central and provincial government

Central government should allocate the necessary money to the local authorities via the provincial governments or directly according to the future constitutional dispensation. In order to ensure fair distribution the central government should take into account not only local needs but also local resources. A poor community with many sick people and an inadequate infrastructure will obviously need more money than a rich community with a better infrastructure and a better health profile.

Central government should not have any executive responsibilities for medical services but should set standards, define policy, and regulate practice through a system of controls, standards and guidelines.

Provincial governments should monitor the performance of local authorities and how they handle their resources, acting as the people's advocate, protector and ombuds-person. The relationship between local authorities should be mediated by provincial governments.

S/he who pays the piper, calls the tune

While the local authorities are dependent on the central government for their funds, they should be primarily accountable to their constituency. Their right to exercise financial control of all local sectors should be guaranteed by statute. As noted in the conclusions of the inter-regional seminar:

> [Decentralisation] has to be initiated by national policies, supported by the necessary legislation or equivalent instruments and implemented by strategies that:
>
> [a] ensure that resources generated locally are used to build up and maintain, to the maximum degree possible, local health services [and health status]
>
> [b] allocate government resources to subsidise local health services when the communities concerned lack sufficient resources, thus putting social solidarity into practice by overcoming gross regional and local disparities.[5]

Prioritising medical interventions

All people should have equal access to every component of social medicine that society can afford. This implies a system of medical service rationing based on priority setting – a dynamic public process which communities and their governments, not health professionals or administrators, should define up-front and periodically review as is done in Oregon, USA.[6] The type of medical condition, the nature of the medical intervention, the level of care, whether provided publicly or privately, the appropriate service sector/s, and the amount of money to be paid for each intervention should be specified. Because communities' needs, resources, and health status differ, local decisions and lists are absolutely essential. The impossible task of determining what constitutes global basic medical service requirements is side-stepped.

Hidden costs

The cost of medical service to the individual is more than just paying to see a health professional or paying for special tests, medicines, or even for admission to hospital. Transport to and from a service point has to be paid for. Time lost and somebody to help at home or at work while the sick person is away costs money. The pain and suffering of a sick or disabled person and the hurt of bereavement is priceless. These hidden personal costs as well as the direct and indirect financial and social costs to the community of ill-health should be entered into cost-effective equations. This may only be possible at a local level.

How to save money

The best way to reduce direct medical service costs is to secure, maintain, and protect people' health. These costs can however also be reduced by good house-keeping, as when the following apply:

patients:	informed, compliant, involved;
staff:	appropriately qualified, job satisfaction;
policy:	continuity of care, family and area-based service;
facilities:	appropriate, functional, simple, looked after;
medicines:	limited list, generic prescription, not imported;
service:	appropriate level, structured, efficient, respectful;
admin:	efficient, participatory, accountable.

Accountable local government that controls how money is obtained and spent could ensure that good care is provided, money is not squandered, and maladministration and corruption are minimised.

Source of money for medical services

Local authority funds for all its activities including medical services should be obtained from central government from general and targeted taxes. This money should be supplemented by rates, proceeds from the sale of services including medical services, interest on investments, donations, loans, grants, as well as by a medical insurance fund.

All money-earners should be compelled to subscribe to an interest-bearing insurance fund collected and administered by the local authority. Employers should contribute towards the premiums paid by their employees. The state should subsidise, to the extent necessary, the insurance premiums of the poor whether gainfully employed or not. Premiums should be means-related. There should be no-claim bonuses. The payment of premiums could be tax-rebated and could stop at an agreed age. At death funeral expenses should be paid from the fund and the balance of the money should be paid into the deceased's estate.

Such an insurance package helps to put the onus on individuals to be responsible for all cost-benefit decisions on their own health. It undermines the perverse incentives associated with third party payers. All citizens are obliged and helped to invest money to cover the costs of future medical services. There is no need for cross-subsidisation.

Providers, purchasers and payers

All levels of medical services can be provided by the local authority, by the private sector, or by both together in joint ventures. The local authority should also be able to contract out services to private providers. The private sector should operate on a non-profit basis.

The insurance fund should purchase medical services on behalf of its members from the appropriate provider/s according to the local currently applicable rationing protocol and should pay the specified amount to the service provider. If the required service is not available within the resident's local authority, the insurance fund should purchase the service on behalf of the resident from a source in another local authority. If the resident however wishes to purchase a service from a private provider or from another local authority despite the service being available at her/his local authority, s/he would be personally responsible for the costs involved and will not be reimbursed from the insurance fund. If a service not on the rationing protocol is wanted, or if the listed refund does not completely cover the costs, the person seeking the service would again be personally responsible for full or part-payment respectively. It could however be possible for members of the medical insurance fund to borrow money against their own policy to pay for such eventualities.

The Institute for Public Policy Research in the United Kingdom has recently also proposed that local authorities should purchase medical services on behalf of their residents.[7] As Anna Coote a research fellow at the Institute, writes:

> Health would thus become part of the bigger plan, to include social services, housing, transport and other things provided locally.[8]

This system of payment for medical services is a modification of one used in Singapore where it works well[9]. It has been suggested that such a system is only likely to be effective within a small population like in Singapore. I think that local municipal areas may be a good size too.

Local authorities, non-governmental, and non-profit private sector bodies should separately and/or jointly provide and support academic institutions for health professional/worker training and for health-related research. The provinces and the central state should subsidise the establishment and running of these institutions. These institutions should also be encouraged to raise supplementary finance. Student fees and research budgets could be funded by local, provincial, and central government and privately with grants, loans, and service contracts, etc.

Conclusion

A paradigm shift from the bio-medical approach to health to the social approach is needed. Medical service funding should be considered as a part of a comprehensive action on/for health in the context of the new constitution and the reconstruction and development programme that the country has embarked upon. Planning and decision-making should not be undertaken by so-called experts. Separate committees examining separate aspects of medical services cannot provide long-term options.

I therefore recommend a public commission of enquiry into social medicine with enough time for submissions to be extensively canvassed, prepared, presented, and debated. Until such time as the recommendations in the commission's report have been accepted by the people through their legislatures, no restructuring should take place.

References

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[3] Costa Gazidis. The ANC National Health Plan [letter]. South African Medical Journal. 1994. **84**: 226.

[4] Conclusions of the Seminar. Primary Health Care: The Chinese Experience. Report of an Inter-regional Seminar. WHO Geneva 1983. p 80.

[5] Conclusions of the Seminar. ibid. p 76.

[6] Gail McBride. News & Political Review: Oregon revises health care priorities. BMJ. 1991. **302**: 549.

[7] Stephen Harrison and David J Hunter. Rationing Health Care. Institute for Public Policy Research. 1994.

[8] Anna Coote. Unhealthy Britain, New Statesman & Society, 14 October 1994, p 30.

[9] World Health Forum. 1987. **8**, p 101-104.