Choices for a Sustainable Social Health Care

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In this article,[1] I aim to present 12 areas of reflection related to choices with which all social health care[2] systems are confronted. These choices may determine to a substantial extent the satisfaction of the population with the health care system. Moreover, these choices may determine the extent to which the social health care system of a country is seen to be sustainable.

Of course, these choices are to be made within a given context; this context may vary considerably from country to country. It goes without saying that the thoughts and opinions I will present have mainly been inspired by a European context. Yet I aim throughout to add some specific reflections related to the South African context; to do so I have taken the recently adopted *White Paper on a National Health Insurance Policy (White Paper)*[3] as a point of reference.

The reflections I will present are of a rather general nature and cannot but reflect my legal background. I realise that an economist, a medical doctor or a health care manager may emphasise other aspects or identify other areas in which crucial choices are to be made.

Obviously, I shall not put forward the "right choice", but rather weigh some pros and cons various choices may present, allowing each country, each expert to make the most appropriate decisions as to how to organise social health care.[4] Moreover, I shall show even more restraint when discussing a context like the South African one with which I may not be sufficiently acquainted with.

I have defined 12 areas in which fundamental choices have to be made. These areas relate to:

- the territorial organisation of (social) health care;
- the relation between social health care and private health care;
- limits to the availability of health care;
- the universalist character of social health care;

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[1] This article reflects a contribution by the author at a seminar held at Stellenbosch University on 11 April 2018.

[2] "Social health care" means all public (social security) schemes providing entirely or partially (compensation of the cost of) health care in favor of the members of the scheme.

[3] Department of Health *National Health Insurance Policy. Towards universal health coverage* (published in GG 40955 of 30 June 2017).

[4] The seminar contribution was to a large extent based on my earlier article "Asistencia sanitaria, diez áreas de actuación" in *Los retos actuales de la asistencia sanitaria Española en el contexto de la Unión Europea* (Murcia: Ediciones Laborum 2016) 951-962. About the variety of health care systems, see Pieters D *Social security: an introduction to the basic principles* (Alphen aan den Rijn: Kluwer Law International 2006) 85-92.

- in kind or refund based social health care;
- the financing of social health care;
- co-payment by patients and its limits;
- the status and payment of health care providers;
- free choice of health care provider;
- professional responsibility of the health care provider and the “informed consent” of the patient;
- the personal responsibility of the patient for his or her own health; and
- the impact of medical liability.

What follows is a more detailed exploration of each of these 12 areas.

1. TERRITORIAL ORGANISATION OF (SOCIAL) HEALTH CARE

Within Europe, every State has its own health care organisation and system to socially protect against health care costs. Of course there is a free movement of goods and services within the European Union (EU), which may apply to aspects of the organisation of health care and thus somewhat limits the sovereignty of each State. Yet the States remain to a significant extent competent to regulate the provision of health care, the medical and paramedical professions, and medical appliances and pharmaceuticals. There are no plans to unify health care law or social health care for the whole EU.

Furthermore, in a substantial number of federal countries, health care and social health care are within the competence of the federated entities, be it exclusively or in juxtaposition with the federal level. Whereas the principles of health care organisation are to be established at a federal level in Spain and Italy, the further regulation of the area, and administration and financing are within the competence of the autonomous communities, the regions respectively. In addition, in Canada, the provinces enjoy competence in the matter, and in the United Kingdom, Scotland and Northern Ireland have been given competence with regard to social health care.

It is no surprise that health care and social health care are left to the competence of the individual States and often even to the competence of their components, as health care is closely linked to local conditions and possibilities, as well as local preferences. The latter may even pop up in unitary systems, creating problems in these: in Belgium with unitary health care insurance, French speaking patients tend to go directly to specialists or hospitals, and their primary health providers refer more often to clinical laboratories than in Flanders, where the primary health care is used more. There is no policy behind this difference, but simply the preferences of the public and the fact that there is separate medical training in the two parts of the country.

Trying to organise health care and social health care as closely as possible to the patients and medical personnel involved, may conflict however with the principle of equal treatment of all persons within the State. Here choices have to be made: does one adhere to a uniform approach and thus risk neglecting specific preferences or does one accept a diversity reflecting the different wishes and approaches in various regions, but partly give up uniformity within the country?

In the South African *White Paper*, the National Health Insurance policy appears to centralise the social health care policy at a national level, eliminating implicitly the competence of the provinces in the matter. Central hospitals will be transferred to the competence of the national government.[5] When considering that, together with education, health care accounts for more than 75 per cent of the spending of the provinces, the disappearance of the provincial competence may have an important impact, not least for a better performing province like the Western Cape. A secondary, but not unimportant, aspect is the fact that the political responsibility of the provincial policymakers is connected primarily to the two areas of education and health care, whereas a central policy with regard to health care, eg through a National Health Insurance scheme, will politically be evaluated as but one of the many areas of national policy. In a context in which governance of public health care has been linked to real or alleged corruption, it might also be interesting to maintain a variety of policy approaches within the country, in order to be able to compare outcomes and thus see where value for money is best realised. This ultimately could be combined with the maintaining or even strengthening of direct solidarity between the richer and stronger provinces and the poorer and weaker ones.

Let us also observe that the *White Paper* proposes that the National Health Insurance Fund be run by a Board on which relevant experts and representatives of civil society will all be appointed by the State; as such, the Board will not have direct representatives of specific interest groups, such as trade unions.[6]

2. THE RELATION BETWEEN SOCIAL HEALTH CARE AND PRIVATE HEALTH CARE

Most countries in the world will have private medical doctors, private hospitals, private health insurers etc operating alongside the doctors of the social health care system, public hospitals and the national health system or social health care insurance. In some countries, the share of the private sector in the provision of health care may be significant and in others less significant, depending on the reason why patients turn to the private sector. Let us examine the question in more detail in relation to private health insurance schemes.

Private health care insurance may be supplementary. When certain medical goods and services do not form part, implicitly or explicitly, of the social health care package, there will indeed generally be room for free market economics; the services and goods involved can

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[5] *White Paper* paras 10, 170 & 247.

[6] *White Paper* paras 255-256.

then be bought, while they may also be included in a supplemental private health care insurance scheme. The more extensive the package of health care provided by the social health care system, and thus the better the social coverage, the less one will turn to such supplemental health insurance schemes.

The private health care insurance scheme may also be residual; it will then cover the co-payment or user's charges that the patient would normally have to bear him/herself. Evidently, such residual insurance may counteract the goals of the user's charge.[7]

Sometimes special groups of persons (eg certain groups of self-employed persons or persons earning more than a certain amount) may not be covered by the general social health care system or may be covered but given the possibility to opt out of the general system; they are given the option to enter into a substitutive health care insurance scheme. Sometimes this substitutive insurance will be private health care insurance, though quite often it will be offered (additionally or exclusively) by social health care insurers.

When the beneficiaries of the social health care system, eg a national health care system, are subjectively not satisfied with the medical goods and services delivered by that system, they may decide to obtain parallel private health care insurance. In fact, they then buy health care, which is already promised to them by the social health care system. Parallel private health care insurance will often come into existence when significant waiting lists exist in the social health care system or when the quality of the services and goods provided by the latter is considered not to be satisfactory. Yet one has to be cautious and not conclude from the mere existence of a substantial parallel heath care insurance sector that the social health sector is not satisfactory or ill-performing. That may be the case, but is not necessarily so, as one has to distinguish between subjective and objective quality. Indeed, social health care systems, such as the British National Health System, may not have an extremely good reputation, but is objectively not performing badly. Private insurance policies and private providers may cover the most common health problems much better than the social health sector; yet very often they exclude more substantial and costly interventions.

The South African health care system is often labelled a two-tier system:[8] on the one hand the public health care system, in principle providing health care to all, albeit that for the top 10 per cent of the population the social coverage will be reduced to nil as a consequence of a means test; on the other hand there are the so-called medical schemes, financed by employers and workers and providing various schemes of private health care provision, including within these various options of coverage.[9] A prescribed minimum benefit standard should ensure that the privately insured should not be confronted with surprisingly bad coverage.[10] In addition to public health care and medical schemes, there is a third category: people not covered by a medical scheme, and whose incomes disqualify them from the social coverage of the public scheme, pay for health care out of their own pockets.

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[7] More on co-payment by patients and its limits below in part 7 of this article.

[8] *White Paper* paras 58 & 71.

[9] *White Paper* paras 67 & 74.

[10] *White Paper* para 68.

In simple terms we can say that the National Health Insurance scheme, as presented in the *White Paper*, intends to transform the public, social health care system into a universal social health care system, covering the whole population with improved primary health care, hospital based care and emergency care.[11] The private health care policies would progressively change in nature: from a parallel insurance, they would rather become supplementary. All patients would effectively enjoy National Health Insurance and only the extra coverage would have to be provided through the medical schemes; out of pocket payments would be reduced. As the medical schemes would have to cover less care, the contributions for the medical schemes could be drastically reduced; the thus created financial breathing space could allow an increase in personal income tax and a mandatory payroll tax to finance the National Health Insurance scheme. Health insurance would in this way in principle lose its character as an employee benefit.[12]

The *White Paper* also proposes to separate clearly the social coverage of health care by the National Health Insurance scheme and the provision of health care;[13] the National Health Insurance scheme would contract with public and also private providers in order to guarantee the covered health care to be provided to all, and everywhere, in the country. The National Health Insurance Fund would become the single purchaser of and single payer of all health care provided under social health care.[14] It is believed that this monopsonist position would enable the Fund to reduce the costs to be paid to the health care providers.[15]

Still in relation to private health insurance, the *White Paper* announces additional regulation of the medical schemes in order to prohibit low quality benefits and benefit options that limit coverage, predisposing to “catastrophic” health expenditure.[16] The number of schemes will be reduced and only one option per scheme will remain. All schemes covering State employees will in a first stage be consolidated into one scheme, the Government Employee Medical Scheme; in the longer run this will be completely absorbed by the National Health Insurance scheme.[17] The *White Paper*, however, fails to suggest certain crucial regulation, such as, rules to impose a measure of risk pooling between participants and to combat risk selection by the schemes or to include also high cost low frequency interventions in the care packages. All in all, the ambitions to improve the medical schemes are kept modest, perhaps because in the long run they should lose importance; this could be a rather erroneous approach by the *White Paper*, the consequence of which may be long-lasting.

The entire intended reshuffle of responsibilities and tasks between the to be created National Health Insurance scheme (which in a first phase will be quite similar to the public health care scheme as it exists currently) and the current medical schemes, is based on the

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[11] *White Paper* para 102.

[12] *White Paper* para 12.

[13] *White Paper* para 275.

[14] *White Paper* paras 7 & 11.

[15] *White Paper* para 276.

[16] *White Paper* paras 90 & 93.

[17] *White Paper* para 243.

assumption of a substantial increase in the financing of the health care coverage for all. At least part of this additional financing should be made possible by a decrease in the contributions for the medical schemes.[18] But, at the very least, there seems to be a sequential contradiction in this plan: in order to allow for better health care for all, substantial additional funds are required, but these have to proceed from lowering the funding of medical schemes, which would need to cover less, all to occur after the increase of the quantity and quality of the publically provided health care. Moreover, it is repeatedly stressed that government and thus the National Health Insurance scheme will give priority to primary health care and to health care for the more vulnerable segments of the population;[19] this policy option can certainly be understood, but what I cannot see is how this will reduce the need to cover care in the medical schemes, as the latter focus on workers and their families and on hospital and specialist care. Enhancing eg preventive health care in the rural communities may be sorely needed, but it will not reduce what workers will want to have covered in their medical schemes.

Personally, I am of the view that the relation between the public National Health Insurance scheme and private health insurance will have to be reconsidered. Elements of such reconsideration may include measures, such as: eliminating all direct or indirect public subsidising of private health care arrangements; stricter control of price setting by all medical care providers operating both in the public and private health sectors; levying of an earmarked tax upon private health policies and medical schemes in order to co-finance the improvement of the National Health Insurance scheme; levying of special taxes on the income of health care providers providing health care services outside the National Health Insurance scheme, and creation of incentives to stimulate health care providers active in the private sector, to dedicate at least part of their time to servicing the National Health Insurance scheme.

3. LIMITS TO THE AVAILABILITY OF HEALTH CARE

When dealing with social health care, it is important to distinguish the availability of health services and goods in the country from the availability thereof in the social health care system. Let us focus now on the first. If some goods or services are simply not present in the country, the question whether or not to include them in the socially covered package is to a large extent devoid of any meaning.

Which drugs will be allowed into the country? Which physicians will be allowed to practise in the country? Which infrastructure (buildings, medical devices) will be provided? These questions call for a number of crucial decisions; unfortunately, these choices are often being made in a less than transparent way.

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[18] *White Paper* paras 89-90, 93 & 308.

[19] *White Paper* paras 5, 11 & 27.

Let us first discuss the providers, and by way of example, medical doctors. As research shows that the demand for health care is often the product of the offer of health care, it is obviously important to contain that offer. Hence, we see that in a number of EU countries access to medical education, apprenticeships and specialisation are subject to a strict numerus clausus. This raises important questions. How is this maximal number to be determined? What should be the determining factors? In addition, how to avoid that the numerus clausus is established more as a function of limiting the number of competitors for the established health care providers, than by the objective needs of the population?

A similar question can be raised in relation to the drugs to be allowed in the country, whatever their status under social health care may be. Should the criteria for allowing a drug only be its safety and effectiveness, or also include elements, such as, its cost, the presence of better or equivalent alternatives etc?

Moreover, the free movement of goods and services, eg within the EU, may also impact on the relevance of the answers to the previous questions. What good is there in establishing a numerus clausus of health care providers in the country, if patients may call upon the services of a health care provider established in another State? What is the use of limiting the availability of drugs, if you can order any drug via the web?

The lack of transparency in the way choices in health care are made is most prevalent in relation to decisions about the investment in (expensive) health care equipment. Why buy certain equipment (eg a specialised scanner) rather than other equipment (eg a device for distance operations)? What should be the determining factors for such choices? The possible return in the amount of fees charged to utilise the devices? The number of patients that will benefit? The specialisation and the division of tasks between regions or hospitals? Although the choice of equipment may be very influential for the objective quality of the health care, we can establish that in many countries the grounds on which such choices are exercised remain unarticulated. This may be surprising in the light of the attention often paid to competition and procurement law in this area; this attention often seems to push in the direction of acquiring the cheapest equipment, with not so much consideration given to other elements, such as, sustainability, availability of servicing staff, etc.

Sometimes the policy may be to deliberately limit the availability of certain health care services and goods. To fight the so-called “overconsumption” of health care, governments have limited supply eg by introducing limited enrolment (numerus clausus) for medical training, or by the creation of a licence requirement to set up a pharmacy. Let me also mention here a subtler but no less efficient way of limiting the availability of health care services, which consists in allowing waiting lists to emerge. Indeed, certain health care services may be available in the country and covered by social health care/social security, but to actually get the service may take time, sometimes months. Usually governments and social security authorities will present such waiting lists as a “problem” they try to reduce, but in the interest of honesty it often should be recognised that governments and authorities use the phenomenon of waiting lists to limit the availability of the in principle guaranteed services.

The *White Paper* to a large extent seems silent in relation to the choices as to which medical services and goods should be allowed in the country, focussing as it does on the social health care package to be covered by the National Health Insurance scheme. As far as the private health care sector is concerned, only quality criteria seem to play a role in accepting the offer of certain health services or goods. This may seem evident, but on closer scrutiny, may be less so. As long as there is no State policy as to what health services and goods are to be allowed in the country, the gap between what can be offered by the National Health Insurance scheme and what is on offer in the private sector will remain, if not grow, especially as a consequence of the rapid advance of medical technology and science. Consequently, private health care providers and medical services will probably become more expensive as the newer and improved equipment and goods often bear a considerable price tag. This in turn may lead to higher contributions for medical schemes or higher or more out of pocket payments. Do I plead here for only the health services and goods covered by the National Health Insurance scheme to be allowed in the country? Certainly not, as this would substantially downgrade comprehensive health care in the country. However, perhaps the national and/or provincial authorities should have more say in the planning of, especially expensive, new medical equipment even in the purely private health sector. Leaving the private health care sector merely to the laws of economic efficiency and competition is not in line with the general interest; even if at first sight the public authorities do not pay for the private health care.

The *White Paper* focusses on the package of services and goods to be covered by the National Health Insurance scheme. The baseline is a separation of health care provision and the National Health Insurance scheme. The latter purchases the primary health care, the emergency medical services and the hospital based services from the public health care providers and from the private sector, according to the needs.[20] To be able to provide services and goods for the National Health Insurance scheme, the provider has to meet the standards established by the Office of Health Standards Compliance (OHSC); these standards will not so much relate to the intrinsic quality of the services as such, as these remain the province of the professional registration and licensing bodies, but on the health needs of the population and the acceptance by the providers to give specific information and to comply with performance criteria.[21]

The services offered by the National Health Insurance scheme will not be enumerated in a positive or negative list;[22] the only thing we know for certain is that primary health care will

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[20] *White Paper* paras 7 & 12-13.

[21] *White Paper* paras 9, 279-282.

[22] *White Paper* para 114.

be prioritised.[23] Moreover, we can learn from the text of the *White Paper* that, when starting the National Health Insurance scheme, even prioritised services such as obstetrics and gynaecology, paediatrics and trauma services, will not be available everywhere in the country.[24]

4. THE UNIVERSALIST CHARACTER OF SOCIAL HEALTH CARE

Some countries operate a national health care service, which can be used by all inhabitants. Other countries prefer to cover the risk of health care through social insurance, which by itself may be universal or professional. Since health and its correlate of health care are increasingly seen as a fundamental human right, their coverage by the social security system should be universal or ought to aim at being universal. This means, in practice, that when health care is covered by social insurance on a professional basis, its personal scope of application has usually been extended in such a way that the vast majority of the population is indeed covered. Most often not only the worker will be health care insured but also his/her dependants, particularly his/her spouse and children. When the compulsory social health care insurance still leaves people without coverage, often the possibility of voluntary affiliation with the scheme may bring relief. People who still fall beyond the scope of health care insurance will either have to use sufficient means for private insurance, or have to pay for health care out of their own pocket, or will have to rely on health care assistance, which in many countries is part of social assistance generally.

When health care is provided by diverse social insurance systems and by health care assistance rather than by one national health care system covering all inhabitants, one faces the problem of inequality. In general, in continental Europe, it seems unacceptable for the actual availability of important forms of health care to depend on the particular health care system with which one is affiliated. Consequently, the necessary goods and services will be available within health care assistance as well; they will be comparable in both quantity as well as quality to those present in social insurance on a professional basis. It has to be observed though that this approach is not followed in the Anglo-Saxon world.

In spite of the similarity in terms of the supply of health care across continental Europe, the diverse systems may be dissimilar as regards certain modalities, eg on the subject of the “user's charge”. Yet, this user's contribution does not necessarily impact on the equality of supply, at least not when the amount to be borne by the patient still allows him/her to deal financially with - and enjoy the allocation of - the medical goods or services in question. The subject of the user's contribution will be dealt with in more detail below.

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[23] *White Paper* paras 140 & 342.

[24] *White Paper* para 126.

Universal health coverage is the main goal of the *White Paper* initiative; the *White Paper* itself bears as title: “National Health Insurance Policy. Towards universal health coverage”. It is seen as a goal set by the Bill of Rights of the South African Constitution itself, which reads in section 27: “(1) Everyone has the right to have access to – (a) health care services including reproductive health care […] (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.”[25]

The National Health Insurance scheme will pool funds to actively purchase and provide access to quality, affordable personal health care services for all South Africans based on their health needs, irrespective of their socio-economic status, so the *White Paper* states, adding that priority will be given to the most vulnerable groups.[26] The process of introducing the National Health Insurance scheme is multi-dimensional: more and better health care in the package covered by the social health care system, reducing in this way the scope of private health care insurance and medical schemes; but also reaching out to all South Africans even in remote areas and probably also including all South Africans in the social health care system, including those who today as a consequence of means testing are disqualified from social health care coverage. In other words, the National Health Insurance scheme will realise more coverage for more people and, in principle, according to the same standards throughout the country.[27] This ambition is certainly attractive; the question however is whether it is realistic, or rather, what the chances are that these goals may actually be achieved through the proposed reforms. The danger seems present that the focus on primary health care will lead to disinvestment in hospital based care, whilst at the same time the medical schemes will be under increasing pressure as it is the intention to de-link health insurance and employment benefits.

Two more observations. First, the *White Paper* states that internal migrant populations will have to provide prior notice to the National Health Insurance scheme when moving to another place within South Africa.[28] I wonder whether this is realistic; or in other words, what will happen if people do move without first informing the National Health Insurance scheme? Likewise, the *White Paper* is rather vague on the health care to be socially provided to persons illegally residing in the country; they will receive basic health care services, but what that means in comparison with the National Health Insurance package is not defined.

The second observation is of a terminological nature. The *White Paper* speaks of a National Health Insurance scheme. We understand this to mean universal social insurance. However, we can question whether the term is appropriate. Certainly the provider function and social coverage will be separated, but as the *White Paper* itself stresses repeatedly, the National Insurance Fund is to be the single purchaser of the goods and services; as a

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[25] *White Paper* paras 17 & 23.

[26] *White Paper* paras 29-30 & 98.

[27] *White Paper* paras 5-6 & 27.

[28] *White Paper* para 119.

consequence the relation between the patient and the National Health Insurance scheme is not an insurance type relation, but rather that of a patient using the services and goods put at their disposal by a national health system.

5. IN KIND OR REFUND BASED SOCIAL HEALTH CARE

Health care is provided, by or for the social health care system, to the person covered by the system. This person can receive the medical goods or services through a provision in kind, which will generally be the case in a "national health service" system. He/she may also have to pay the full fee for the service or good concerned while the social insurance system guarantees the refund of the expenses incurred. This refund system is supposed to counteract medical over-consumption as it makes the consumer aware of the actual cost of the medical good or service even though he/she can later recover the costs from the social insurance system. However, the refund system poses serious problems when the goods or services are very expensive. Obviously, it is considered unacceptable that a person would not be able to call on services or goods simply because he or she cannot advance the costs. In such cases, the refund system will be abandoned and replaced by the "third party payment" system: the social insurance system, being the third party in the relationship between the consumer and the provider of health care, will directly pay the expenses.

The *White Paper* is clearly opting for an in-kind provision,[29] following in doing so the tradition in South Africa, and as a matter of fact the British tradition. As such, there is nothing wrong in doing so; however, it might be considered that for certain wealthier groups of the population a refund system for certain medical services or goods might be more appropriate, as those groups may also be the ones to over-consume medical services more often. If it is the intention to really incorporate these groups in the coverage of the National Health Insurance scheme, groups that today might be excluded because of means testing, the National Health Insurance scheme could do so through a refund system.

6. THE FINANCING OF SOCIAL HEALTH CARE

Social health care systems, whether they operate via a national health system or through social insurance, need to be financed. Basically, this can be done from general revenue (and the taxes feeding the budget) or through upfront payments dedicated to social health coverage, called social contributions. The approach chosen will often depend on the way social security as such is being organised and financed. In a more Bismarckian or European continental approach, social insurance, including health insurance, are often financed by

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[29] See eg *White Paper* para 102.

contributions paid by the employers and the workers. In a more Beveridgean or Atlantic approach, social health care is most often financed out of the budget. Of course, to the extent that more and more a universalist approach is being followed and the whole population is being covered, the impact of budget financing has increased, or at least, contributions no longer are being levied exclusively on the income from work, but also on other income.

Sometimes co-payments (dealt with in the next part) are also seen as a source of financing (social) health care, but I think it is more correct to label it as a way to reduce the cost of social health care.

Some countries finance their social health care also from earmarked levies, social taxes upon goods or services, which in one way or another are connected with an increased health risk. In a number of European countries, for example, part of the taxes on alcohol and cigarettes go directly to the social health care system; in Belgium, this is also the case regarding a special levy on the insurance premiums for car drivers' civil liability. Even more interesting, is the 10 per cent increase on the premiums for additional private hospital insurance, which is allocated to social health care.

Of course, the earmarked levies upon goods and services increase the prices of these goods, whatever the purchasing power of those who buy them. Therefore, one has to be prudent not to include goods that can be considered essential. Moreover, one has to ensure that in a globalising world, goods and services made more expensive in this way will not simply be replaced by goods and services purchased abroad.

The *White Paper* pays significant attention to the financing of the National Health Insurance scheme,[30] although real figures are absent. The real changes the National Health Insurance scheme will bring and the financial implications of these changes remain unclear. In any event, the *White Paper* states that the ambitious goals of the National Health Insurance scheme will be financed by pooling actual and new sources of funding. The dominant source will be general revenue allocation, supplemented by:

- a 2% payroll tax - I would prefer calling it a social contribution - to be paid by employers and employees; and
- a 2% surcharge on individuals' taxable income.

As the health services of the Road Accident Fund and the Compensation (for Occupational Injuries and Diseases) Fund will be integrated into the National Health Insurance scheme, the corresponding finances will also be pooled with the National Health Insurance Fund.

No VAT or similar charges would be used as they are considered to be regressive.

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[30] *White Paper* chap 7, paras 195-274.

However, the feasibility of the 2% contribution by the labour force and the 2% surcharge upon taxable income, seems related to the success of the National Health Insurance scheme to increase its services in a way that medical schemes need to cover less and can thus lower the contributions they require. I will not repeat what was stated above regarding the lack of (sequential) logic of the *White Paper* in this respect.

The current State contribution to the medical schemes for State employees as well as the tax credits of the Medical Tax Credit will in the long run also be pooled with the National Health Insurance Fund. Whereas the State contribution for the State employees' medical scheme raises questions similar to those in relation to the other medical schemes, the abolition of the Medical Tax Credit seems logical as currently such tax expenditure has a reverse redistributional effect. It is, however, remarkable that the *White Paper* does not explicitly advocate such abolition, probably because it would result in significant resistance.

Moreover, the *White Paper* puts great trust in the ability of the National Insurance Fund, as a single purchaser of goods and services, to negotiate better conditions and prices with the health care providers. It may be that in certain cases this will be realised, but we should not forget that if the ambition is to cover the whole territory with an increased package of social health care, the National Health Insurance Fund, or in reality often the Contracting Unit for Primary Health Care, will face a monopolistic or oligopolistic offer of certain health care services. What options will the National Health Insurance Fund have when confronted with, for example, only one hospital in the region offering the services which according to the national policy should be offered at that level? It is worth noting in this context that today more than 80 per cent of the private hospital beds are in the hands of three major hospital groups.

Several cost effectiveness enhancing measures are also mentioned in the *White Paper*, measures which already could be implemented now, such as, financing hospitals on case load, such as diagnosis related groups (DRGs), or other ways of financing the health care provider (more about this below). Whichever cost improvements will be realised, one should however keep in mind that, if the National Health Insurance scheme has the ambition to be attractive to a broader population, it would have to keep up with the advancement of medical science and technology. In other words, in South Africa just as in the rest of the world it is most likely that the cost of health care will continue to increase in the coming decades.

7. CO-PAYMENT BY PATIENTS AND ITS LIMITS

Both the system of provision (in kind) and the refund system can contain a so-called "co-payment" or "user's charge", a part of the cost (a certain amount per service or good, for instance, or a certain percentage) that must be borne, definitively, by the beneficiary. This contribution is meant to act as a brake on medical over-consumption. However, it is not supposed to lead to the result that people needing a certain service or good, would have to go without these for lack of the means to bear the financial burden of the medical service or good involved. Hence, most systems will provide reductions of, or even exemptions from, the payment of the user's charge in the case of (poor) pensioners, persons suffering from certain diseases, and/or people with a low income in general. Increasingly, the total amount of money to be paid as “user’s charge” by one person (or family) over a certain period of time (eg in one year) is being capped: this maximum “user’s charge” may be fixed at a certain amount or may be established in relation to the income or means of the person (or family) concerned.

The “user’s charge” in itself brings money into the social health care system, or rather reduces the cost of provided health care for the social health care system. However, when the operation of a “user’s charge” also requires social corrections in the form of reductions or exemptions, it is important to weigh the benefit for the system of having “user’s charges” and the cost of operating the corrections. In other words: it may imply a fairly high administrative cost to correct the “user’s charge” system in favour of the poorer segments of the population.

It is to be noted that “user’s charges” have to be distinguished from “franchises”. “Franchises”, in this context, denote the “own-risk-amount” of the social health care system. Per annum (or any other period), the person covered will have to bear all the costs of health care that do not exceed a certain amount; the usual coverage will apply to any amount of costs beyond this limit. Although distinct from “user’s charges”, “franchises” raise similar questions: What about poorer people for whom the “franchise” is already a too high cost? How to operate social corrections?

The *White Paper* seems rather averse to any out-of-pocket payments for health care services and goods.[31] This can be understood by the difficulty some people may have to access needed health care if they have to pay (the price or a certain fraction of the price) for the provided health services or goods.

There certainly is a good case to be made against co-payments or out-of-pocket payments. However, one should also consider that health care providers might like such payments as they provide them with money immediately. If one is thus to ban out-of-pocket or co-payments by patients, it will be important that the health care providers are effectively, regularly and correctly paid what is owed to them by the National Health Insurance scheme. If this is not the case, and no official out-of-pocket or co-payment is established, an appreciable risk that health care providers will pressure the patients to pay them unofficially, or in other words, to pay bribes, will arise.

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[31] *White Paper* para 30(d).

8. THE STATUS AND PAYMENT OF THE HEALTH CARE PROVIDERS

The process of making the supply of health care effectively available to protected people can take different shapes. The social health care system itself may dispose of elements like physicians, paramedics, hospitals and forms of medicine. As such, it can provide the corresponding goods and services to anyone covered by the health care system. When the system covers all inhabitants, it will usually be called a “national health service” system.

However, social health care cannot or may not be able to provide all or some health services or goods. In that case, it has to call on self-employed health care providers, self-employed pharmacists and paramedics, independent health care institutions (in public or private hands) and so on. In such an event, the social health care system will negotiate collective arrangements with the diverse professional organisations representing the providers of health care, the independent institutions of health care, and the like. These agreements may involve such items as tariffs or the ways in which services are paid for; in the absence of such agreements, the government will lay down the necessary rules relative to the distribution of health care. In any case, the legislator always retains the competence to intervene in this respect, e.g. in order to preserve the public interest. The legislator may sometimes also accord a generally binding force on these collective agreements, that is, cause them to be binding on non-members of the contracting organisations as well. Furthermore, there may be cases in which a collective arrangement may not be possible or appropriate and where contracts with individual providers of health care, health care institutions and so on will be necessary. The collective and individual contracts in some instances may exclude other health care providers and/or social insurers from entering into a similar contract; but the law may also expressly require the social insurer/health care provider to conclude analogous contracts with other health care providers/social insurers who would like to do so.

One and the same social health care system can contain elements of both types: some medical goods and services will then be provided by the social health care system itself while others will be provided by third parties. In addition to the physicians in the service of the social health care system, mixed systems of this kind will also make agreements with “recognised” private practitioners.

Health care providers in the service of the social health care system will mostly be remunerated in the form of wages. The private providers of health care integrated into the social health care system will traditionally be paid according to merit, that is, per medical performance. Instead of using fixed sums or performance based payments, one can also work on the basis of a fee per registered patient. Health care institutions can be remunerated either by means of fixed sums or through payments per performance or per patient; in this respect, the number of “beds” will often be taken into account in the calculation of the remuneration as well. For some years now, some social health care systems have been paying health care providers per pathology: a fixed amount is then paid on the basis of the initially diagnosed health disorder. The health care providers concerned are then to deliver all medical services and goods they consider appropriate; the amount they receive not depending upon their therapeutic choices.

Health care providers can also be remunerated through all sorts of combinations of the aforementioned means of payment.

Allow me to make one more general observation with regard to the way health care providers are paid. The way this payment is organised is not without impact on the way the health care providers will behave. There may be less incentive for a medical doctor to see one more patient, when he/she receives a fixed wage only; in such case, the medical doctor however probably will also refrain from needless visits to the patient. Where a medical doctor is compensated for each visit, each intervention, this may motivate him/her, but also induce visits and interventions that are less necessary. I know this is a very delicate issue, but it would be very naive to deny that there is a link between the manner of payment of the health care provider and the way health care is being provided. In this context, I always like to refer to what the practice was in Ancient China; there the medical doctor was paid as long as his potential patients were healthy; once he had to intervene, payment stopped. This sounds weird to our ears, but perhaps paying a general practitioner per visit or act is equally weird?

The *White Paper* pays quite some attention to the ways the National Health Insurance scheme will pay the providers of medical services.[32] At the primary health care level the main mechanism to pay contracted providers will no longer be fee-for-service based, but will be a risk adjusted capitation system with an element of performance based payment. The capitation will be linked to the registered population, the target utilisation and cost levels. Contracted public and private providers are to be paid according to their contract; the latter may include price and volume elements. Moreover, consideration will be given to introduce complementary payments to enhance incentives for providers. Payments for emergency services by private and public providers will be done on the basis of a capped case based fee, where necessary adjusted by reference to the severity of the case. Private specialists will also be paid on a capped case based fee, adjusted for complexity.

Although the *White Paper* goes into detail on the question of how health care providers will be paid, some questions were left open, such as the question whether it would be acceptable to pay differently for the same services according to the place where the services are to be provided, and if so, how to avoid the abuses to which this could lead. To what extent will the National Health Insurance scheme accept that different conditions prevail in the various provinces? Similarly, one can ask if the National Health Insurance Fund will agree to be transparent about the contracts they make with the health care providers who are able to use their monopolistic or quasi-monopolistic position to get better contractual terms.

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[32] *White Paper* paras 90(i) & 286-299.

9. THE FREE CHOICE OF HEALTH CARE PROVIDER

In general, social health care does not guarantee the accessibility of health care to anyone willing to call on one or other service or good. On the contrary, it will merely warrant this to people who effectively need the care, service or good concerned. For that purpose, social health care law will determine arrangements for an accurate assessment of the wanted good or service. As a rule, this assessment will be accorded, first and foremost, to a physician. Medical goods or services that are not "prescribed" by the physician or, putting it differently, that are not allowed according to the assessment procedure, may perhaps be acquired - at their real price - in the private market. However, for reasons of public health, the latter possibility may be restricted.

The choice of the person or institution the patient will effectively call on for medical goods or services may be completely free, be restricted to certain limits, or be completely absent. When health care has been organised on a private basis, freedom of choice will be the more frequent alternative; still, a national health service may also offer a free choice between physicians, paramedics and so on who are in the service of the social health care system. The freedom of choice can also be restricted to a given geographical area or to the health care providers who have entered into a contract with the social health care insurer concerned. Furthermore, the law will sometimes restrict the possibility to swop practitioners, such swop being, for example, only allowed once within a certain period of time.

Two questions emerge when considering the freedom of choice regarding health care providers.

First, what are the pros and cons of free choice regarding a health care provider? Obviously, limiting the choice allows the system to better allocate the necessary means; it, for instance, makes it possible to have the needed health care providers in remote regions as well. Limiting the choice can also cause all providers to have an equivalent work burden or income. The big problem with restricted choice is of course that the provider/patient relationship should be built on mutual trust and that an "imposed" provider may not be readily accepted by the patient.

The second relevant question is: on what basis does the patient make the choice of provider, when he/she has such a choice? There has been relatively little attention paid to this aspect. Of course, one can assume that the patient will choose the health care provider he/she trusts most, as he/she will put his/her own life or health in the hands of that provider. In this regard, many psychological factors may play a role; we shall not discuss them here. The choice of the patient may also be based on the conviction that a certain health care provider, eg a specialist or a hospital, is objectively the best. But how to establish which is the best health care provider? In a number of countries, health authorities may have statistics as to the efficiency and effectiveness of certain health care providers, statistics on the success rates of certain interventions etc. Should these figures be made publically available? Here our first and second questions related to the freedom of choice of health care provider intersect. If data on the objective quality of health care providers is made publically accessible, people may choose the best provider. The logical consequence in a free choice context will be that the favoured medical doctor and/or the preferred hospital will be pressured to take more patients. The other consequence is that the health care providers rating worse in the comparison, will be chosen less often; hence they will lose patients. The danger is that the better doctors and facilities will not be able to maintain the quality they provide, because of pressure to see and care for more patients; the weaker providers will not have the support to improve, as they continuously will have less patients.

The *White Paper* takes the registration of the population at a certain Contracting Unit for Primary Health Care (CUP) as its starting point.[33] There a registered patient can receive primary health care. Should a patient need the services of a specialist or hospital care, he/she will need to be referred by the primary health care providers to certified and accredited hospitals and specialists. Except for acute emergency care, a patient cannot directly, that is without referral, go to a specialist or hospital of the National Health Insurance scheme.[34] The *White Paper* is silent about the freedom of choice at each level, but suggests that no such free choice exists. In order for the National Health Insurance scheme to be more attractive and reduce the medical schemes to a role of supplementing rather than replacing the National Health Insurance scheme, more attention may have to be paid to introducing the possibility to choose the health care provider.

10. PROFESSIONAL RESPONSIBILITY OF THE HEALTH CARE PROVIDER AND THE ‘INFORMED CONSENT’ OF THE PATIENT

Whereas some decades ago, the health care provider, for instance the medical doctor, indisputably was deemed to know best and decided what was the best way to deal with the patient, patients today are often much more emancipated and demand a say in the health care that will be delivered to them. The patient may consult all kinds of medical information on the web and/or may try a second opinion etc.

Then again, the health care provider also is confronted with a multiplicity of information sources. He or she has to continuously update his/her knowledge in the rapidly evolving medical science and techniques.

The health care provider will have to choose the therapeutic track to be followed, but will often not do so alone. He/she will consult with other providers and also with the patient.

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[33] *White Paper* at paras 7 and 103.

[34] *White Paper* at paras 121 and 135.

He/she will also often have to weigh considerations of the public interest, such as the costs for society of the various therapeutic tracks that can be followed. All this makes the delineation of the professional responsibility of the health care provider much more complex than before. He/she might opt for a therapeutic track that may not be his/her first choice, but corresponds better to the wishes of the patient, the views of colleagues or the public interest.

If the patient is given a say in the therapeutic track to be followed, he/she will have to be duly informed about the pros and cons of the various options. Here the professional responsibility of the health care provider pops up again; but there is more: also, other people providing support to the patient may have an important impact upon the final decision. This makes it very important to provide the patient, his/her family and friends, and counsellors (such as representatives of religious organisations assisting the ill) with appropriate information. When the patient consults his/her family members, friends or religious counsellors, these persons need to have access to the appropriate information themselves; moreover, they need to “translate”’ that information in an unbiased way to the patient.

A problem modern societies and their health care providers are confronted with in this respect relates to the cultural diversity of the population. The patient may not master the language of the health care provider; a translator may help in such case. The translator may come in person to assist the patient and his health care provider, or will have to be called and will provide his/her services over the phone. Needless to say, the personal contact between health care provider and patient may suffer from the interposition of the (needed) translator. However, there is more to this problem, as communication is more complex: the words of the patient may be translated correctly, but what the patient wants to convey with these words may be much more difficult to determine. A translator is not sufficient in such case. It is therefore so important that there is always a health care provider available with an understanding of the language and culture of the larger minorities living in a country. Cultural diversity is a challenge very often still underestimated in our health care systems, or only considered when confronted by it in an extreme form.

In most cases, the decision will not be taken by the patient’s family and friends, but by the patient him/herself and the health care provider. Sometimes the health care provider will expressly need the consent, the “informed consent”, of the patient to perform certain medical procedures on the patient. This consent often takes the form of signing a document or a whole bunch of documents, in which information is provided. His/her signing of the relevant paper then confirms his/her “informed consent”. However, is this truly an informed consent: is the information provided understandable by the patient? Are the circumstances in which the document is presented for signing, sometimes just before an operation, allowing a truly free decision? What if a patient would decide at that moment not to sign? We certainly have to caution here against accepting excessive legal formalism: just making a signature cannot always satisfy the requirement of informed consent. However, we have also to ask ourselves whether we do not require such “informed consent” much too frequently;

shouldn't we simply accept that in some cases the medical doctor the patient went to, should make the decision according to his/her professional acumen?

The choices presented in this part of the article have not really been addressed in the *White Paper*. Allow me to make only one remark related to South Africa in this respect. It is obvious that the cultural diversity of the country has certainly to be taken into account when dealing with health care in South Africa. Special efforts to understand the medical needs of patients will include overcoming cultural barriers. The delicate issue of the acceptance or not of traditional healing is not touched upon by the *White Paper* at all, whereas it is not without importance whether or not primary health care contracting units will also contract with traditional healers.

11. THE PERSONAL RESPONSIBILITY OF THE PATIENT FOR HIS/HER OWN HEALTH

Usually social health care systems do not bother about the cause of an illness or accident. When a person needs health care, it is to be provided. When the need for health care can be ascribed to a person's own culpability, his/her entitlement to health care will not, in general, be affected negatively unless, of course, he/she has wilfully acted culpably with a view to claiming medical care, such a situation obviously being quite exceptional. Even the person who attempted (in vain) to commit suicide but remained seriously ill or injured, will be provided with the needed health care.

However, the traditional vision is increasingly coming under pressure. More and more people question the need to cover the costs, or even the provision of health care delivered to persons who did not take their own health seriously. Should there be socially covered long cancer treatment for someone who was in the past already treated for this, but continues to smoke many cigarettes a day? Should there be socially covered heart surgery for the over-weight patient who after the first stroke did not make any effort to lose weight? The examples could be multiplied. The question is: where should the line be drawn? Should we require future patients to have taken part in healthy (eg sport) activities while young? Should we exclude smokers from the benefit of many health care treatments? I think we should in general, notwithstanding extreme exceptions, refrain from linking the right to necessary health care to the hypothetical bad behaviour of the patient, at least if we do not want to end in a medico-totalitarian society. We should not forget: withholding (coverage of) needed health care from a patient is a very heavy sanction … sometimes even a death penalty!

Is this the same as saying we should not confront people with their personal responsibility for their own health? Certainly not. We should favour prevention and preventive health actions, such as, engaging in some sport, having a healthy life style, etc. We can help through social health care by paying for part of the cost of participating in sporting activity, of slimming in a healthy way, etc. Far too often our social health care systems only pay lip service to the idea of prevention, but do very little concrete to stimulate prevention. Compensating not only for curative or rehabilitative health care, but also for prevention, could make the difference.

The *White Paper* shows great awareness of the importance of prevention and includes it as an important component of primary health care.[35] This is crucial. Yet the problem with prevention policies often is that they are focussing more on the means to be invested in preventive actions, than on the actual effectiveness and efficiency of these means. In other words, if prevention is to be prioritised, it should also include a continuous assessment of whether the invested means actually result in the short, medium or long term in good health results.

Preventive measures will have to be rolled out at a local level, but may require national or provincial strategies. Therefore, linking prevention to primary health care may be misleading.

The question remains whether the origin of the need for health care should be taken into consideration. As I have indicated, we are rather opposed to doing so. However, if we consider the importance of emergency medical services required due to violence, one may ask whether criminals falling victim to their criminal activities, eg getting wounded in inter-gang violence or while perpetrating a robbery, should be socially covered by the National Health Insurance scheme. Of course, they will benefit from emergency health care, but should national solidarity be paying for their health care costs? A similar question can be asked when alcohol or drug intoxicated persons are themselves victims of the traffic accidents they cause. It is noteworthy that the *White Paper* mentions traffic accidents and interpersonal violence to be the leading causes of years of life lost according to recent South African Burden of Disease data.[36]

12. THE IMPACT OF MEDICAL LIABILITY

A challenge all health care systems are increasingly confronted with is the professional liability of health care providers. In many European countries, we witness a considerable increase in cases of medical liability: more patients not satisfied with the health care they received turn to lawyers to obtain compensation. Ever-increasing numbers of lawyers have discovered this “new market” of claims. Consequently, medical doctors, hospitals etc. have to take out increasingly costly insurance policies to cover the cost of future damages claims. The premiums for these insurance policies in turn cause the cost of the medical doctor or hospital to increase. In a social health care system, this reflects in rising costs for the whole health care system! If, therefore, we want to contain health care costs, it will be crucial to keep

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[35] *White Paper* para 265.

[36] *White Paper* para 50.

medical liability within reasonable limits. If in the United States most people enjoy a qualitatively poorer health care at a much higher cost than in Europe, this is to a considerable extent due to exorbitantly high premiums for insuring sky-high medical liability claims. This is not the path to follow: thus let us keep medical liability claims reasonable!

The *White Paper* does not address the issue of medical liability as such; it merely observes that "[t]he public's discontent with the quality of services has escalated medico-legal claims in both the public and private sectors, putting enormous strain on the fiscus and healthcare professional. This challenge needs to be adequately addressed within a unified health system, but more so in the public sector."[37] Both for the National Health Insurance to be established, and for the current private and public providers of health care, the issue is important as more liability cases push up the costs of health care. It will however require legislative intervention to limit the medical liabilities.

EPILOGUE

I preferred to sketch in an elementary way some 12 areas in which each social health care system has to make fundamental decisions, rather than to focus upon this or that related legal issue. The choices made in each of these areas are crucial for the sustainability of the health care system and thus also for the wellbeing of the people covered by it. These choices also do not stand alone; they are interconnected. Professional responsibility of the health care provider and informed consent cannot but be related to the issue of personal responsibility of the patient and to the challenge of ever-increasing medical liability claims. The universalist approach is interconnected to the limits of co-payment.

I obviously could continue with my examples. Unfortunately, the discussion about social health care is in most European countries excessively concentrated on the - by the way very real - issue of the need to contain the cost of the social health care system. Yet, what is most important is that we make in each of our countries the choices that suit us best, but taking into account all relevant arguments. Making all decisions depend upon their cost cutting effect not only demonstrates a very narrow vision of the meaning of a health care system as a pure cost factor, but moreover risks resulting in a non-sustainable social health care system and ultimately in very costly results and the relinquishing of the aspiration of a good health care coverage for all!

The latter ambition also prevails in South Africa, but it seems to me that the emphasis here is not so much on the word "good", but on *for all.* Given the context and the history of the country, this is understandable, but one has to note that replacing good health care for some and bad health care for many, with bad health care for all is not the solution either. Maintaining good quality and coverage where it is already present whilst making it available

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[37] *White Paper* para 57.

to all, and increasing quality and coverage where these are lacking will be the challenge. However, with these words, I have definitely started the debate!