

**POLICY OPTIONS FOR HEALTH CARE PROVISIONING FOR
UNIFORMED SECURITY FORCE MEMBERS**

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A research report submitted to the Faculty of Management,
University of the Witwatersrand, in partial fulfilment of the
requirements for the degree of Master of Management (in the
field of Public and Development Management).

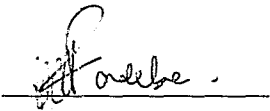
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ABSTRACT

This research report examines problems faced in health care provisioning for members of the Defence department (based on public sector lines), and Safety and Security and Correctional Services departments (based on private sector lines). This provisioning is entirely financed by Government. The aim is to determine the most viable solutions to the specific health service delivery problems confronting these departments that will meet public health objectives. Data was collected from primary and secondary sources and interviews were conducted. Main findings indicated that increasing costs made private health care provision unsustainable. Downsizing of the defence force has resulted in under utilisation of health facilities. Recommendations are made for a public-private health care mix at the primary level and public provisioning at secondary and tertiary levels combined with members' contributions for dependants. The active participation of providers and users as well as political will is needed for successful implementation.

DECLARATION

I declare that this report is my own, unaided work. It is submitted in partial fulfilment of the requirements of the degree of Master of Management (in the field of Public and Development Management) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University

A handwritten signature in black ink, appearing to read 'Mokhehi Radebe', is written over a horizontal line.

Mokhehi Radebe

28 July, 1999

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Chapter 1 INTRODUCTION

1.1 Background

The challenge facing health care delivery in South Africa is to find sustainable ways of addressing medical and public health needs of all people in the country, particularly the majority of disadvantaged people. Debates rage about the “best” model with different views advocating private or public sector approaches or a combination of both.

Both private and public sectors are well developed in the country and combined they provide a wide range of facilities and services. But weaknesses in both sectors undermine the overall impact on public health objectives so that optimal health delivery to the majority of the people has not yet been achieved.

It is important to identify the strengths and weaknesses of the different health delivery approaches and to develop policy options that build on the strengths of both systems.

This paper intends to contribute to the debate by focusing on the different Government security departments namely, Defence (DOD), Safety and Security and Correctional Services and their contrasting approaches to health care coverage and delivery of services to their members. This will be examined according to the following public health objectives: equity in access, efficiency, acceptability and sustainability. These objectives will be further discussed in the literature review in this paper.

Qualifying members from the DOD and their dependants receive free health care mainly from publicly owned, not-for-profit institutions run by the DOD. Serving members of the DOD do not make a contribution for their health cover (except for a contribution for a minimum of ten years for health care coverage on retirement) as it

is entirely financed out of the Defence budget. (Department of Public Service and Admin, 1998)

This service grew to unprecedented proportions during the “bush war” in Angola and Namibia. The end of South Africa’s active involvement in wars outside of its borders and the relative peace experienced internally and amongst its neighbours resulted in the need to cut defence spending. Cawthra (1995) points out that defence spending has declined by 60% in real terms from 1989 to 1994. This has led to the cutting of services and has resulted in a major problem of the underutilisation of health facilities in the Department of Defence.

Different solutions have been proposed. The ANC National Conference, held in Mafikeng in December 1997, proposed that the Department of National Health take over the under-utilised SAMHS facilities (ANC, 1998). There are discussions within the DOD about making 1 Military Hospital in Thaba Tshwane a specialist referral hospital for gunshot wounds. The DOD has also been in discussion with the Ministries of Safety and Security and Correctional Services for potential collaboration but no definitive options have been agreed to.

On the other hand, members from the Departments of Safety and Security and Correctional Services and their dependants receive free health cover with services delivered mainly by privately owned, for-profit institutions. Health cover is provided through the Polmed medical scheme and Medkor medical scheme and is free for members and their dependants as it is financed entirely from their respective Departments’ budgets except for a small contribution by members in the form of a co-payment or ‘medical scheme gap’ at the point of service. (Department of Public Service and Admin, 98)

One of the problems faced by the health coverage of Safety and Security and Correctional Services departments is the high rise in the cost of private health cover in South Africa. A leading member of the Standing Committee on Safety and Security points out in an interview (February 1999) that the Committee finds the amount spent on health cover by the police to be excessive. The South African Police Services (SAPS) has been instructed by this Committee to investigate which of the following measures will be appropriate to lessen the burden of the cover from the state:

- a. Increase the level of contributions by police members through higher co-payment charges
- b. Shift health coverage to public health institutions or the military health services

The Ministry of Correctional Services also provides medical care for prisoners through contracted medical practitioners in the prisons. Hospitalisation of prisoners is mainly done in private institutions. According to the Department over R9 million is spent per annum for treatment of prisoners in private hospitals (The National Assembly Portfolio Committee on Health, 96:26).

A former General in the South African Military Health Services highlighted in an interview (December 1998) the rationale for free health care services for serving members of security forces:

- a) The state has an obligation to provide adequate care to those who are prepared to lay their lives down in defence of its people
- b) Because of the high probability of injury faced by security force members any private health insurance premiums would be unaffordable.

Although the lives and limbs of both retirees and dependants of serving Police and Correctional Services, and Defence Force members are not exposed to the same

dangers as actual serving members, they receive the same health benefits from the State.

The challenge facing the departments is how to provide equitable health care and acceptable service in a sustainable manner given decreasing budgets.

1.2 Research Problem

To analyse and compare the health delivery approaches of the Departments of Defence, Safety and Security and Correctional Services in terms of the public health objectives (equity in access, efficiency, acceptance and sustainability).

To then identify policy options that will enhance the strengths of contrasting approaches for the greater benefit of the members.

Because Safety and Security and Correctional Services have adopted mainly a private sector model while Defence has adopted a public health sector model, the issues confronting these departments cannot be considered in isolation from the wider health service provision in the country. Therefore the lessons learned from the policy review to be undertaken in this paper will

- firstly, inform the debate on whether public provisioning of health care to the members of the Defence Force or private provisioning of health care services to members of the Department of Safety and Security is preferable
- secondly, help to identify policies that would deal with the under utilisation of the South African Medical Health Services (SAMHS) facilities and the spiralling costs of health cover to the Police and Correctional Services
- thirdly, contribute to achieving the stated public health objectives of the Government

1.3 Limitation of Research

It is difficult to estimate "true costs" of health care services. There are major deficiencies in the availability, quality and comparability of data as often for the three approaches data is not systematically collected from the services, is not readily made public and is therefore not comparable. In relation to the DOD, a leading member in the Defence Secretariat pointed out in an interview that SANDF-related data is inadequate and there is a need for a more focused and systematic costing of health care provision by SAMHS. The data, therefore, presently available must be treated with caution (Interview, December 1998). Data related to the cost of police health services also has to be treated with caution because it has been provided from documents by different sources and the categories of expenditure are different from those of the DOD.

Services offered by the health services are not identical. The SAMHS, for example, offers a number of services that are not covered by the medical scheme run by the Department of Safety and Security e.g. veterinary services, VIP treatment, operational support to police and combat forces. This limits comparison. Commenting on the unavailability of data, Van der Heever (1994:7) stated: "The inadequate availability and distribution of regular, up-to-date and useful standardised data by medical schemes and hospitals appears to run counter to the public interest."

This research report does not include an economic analysis of the cost of the services provided; however, reference to the economic effects of the cost will be made where appropriate. Available monetary expenditures and revenues will be examined and there will be a simple analysis of how much money is taken from tax payers to care for members and their dependants and for what purposes. This examination, however, will give some insight into the issues related to the policy process in South Africa and will identify issues and questions to be studied in a full costing or economic analysis.

Due to time constraints, an assessment of the quality of services rendered and its acceptance to both the providers and members was not done.

A number of Ministries are currently undertaking studies to optimise the government's coverage of health care to the security forces. Any major policy announcement done after 30 November 1998 will be ignored in the research report.

It was intended to include in this report a comparison of Medkor, which is the health insurance providing cover for employees of the Department of Correctional Services, and for prisoners. Data could only be obtained from a single source but it is assumed that as a private medical aid scheme, Medkor will exhibit similar trends as Polmed.

1.4 Structure of this Report

This paper intends to add to the debate about optimal health care provision by introducing key issues and presenting a model for evaluating health delivery approaches in terms of public health policy objectives. In Chapter One, background to and context of the issues, as well as introduction to and limitations of the research are presented.

The literature review in Chapter Two presents and analyses the major debates internally and nationally about appropriate health care provision. Specifically, the analytical model that will be used in this study is presented and the criteria to be used to evaluate the impact on health care policy objectives are discussed in detail. These criteria relate to equity, efficiency, acceptability and sustainability. The specific context of health care provision in South Africa is discussed and issues and lessons learned from other countries are highlighted.

The research methodology is presented in Chapter 3. As this research is based on an analysis and comparison of three health approaches, it is essentially of a qualitative nature with no need for quantitative instruments or a survey methodology.

The paper reviews in detail (in Chapters 4 and 5) the two differing approaches to health care provision in South Africa as exemplified by the public service of South African Medical Health Services of the Defence Force (Chapter 4) and the private sector medical aid schemes of the Police and Correctional Services (Chapter 5). An analysis of secondary data and information is presented and discussed.

In Chapter 6 the data is interpreted by specifically comparing expenditure between the two models. Each approach is reviewed and strengths, weaknesses and overall impact on health objectives are highlighted. A policy framework is then proposed that will build on the strengths of each model. Obstacles affecting successful implementation of the proposed policy are identified.

The conclusions are summarised in Chapter 7 and additional research questions are identified.

Chapter 2 LITERATURE REVIEW

2.1 Summary

This chapter sets the framework for health policy analysis by examining the debates around private and public provision of health care services and presenting the analytical model used by B. McPake and J. Kutzin (1997) of evaluating effects of health sector reforms prepared for the World Health Organization¹. The specific context in South Africa is highlighted and the research focus comparing health services provided by the South African Police Services and the South African Medical Services is described.

2.2 Background

Health policy is aimed at achieving a single or multiple objectives. These objectives may be of a political, economic or public health nature (McPake and Kutzin, 1997). In this report, economic objectives will be referred to as they impact on public health objectives. Although political objectives play a central role in health sector reforms, this is especially the case in South Africa during this period of transformation where the government is engaged in correcting past injustices. This paper will mainly focus on public health objectives.

2.3 Public Health Policy Objectives

In order to assess the appropriateness of any policy tool including health care provision for achieving health policy objectives, McPake and Kutzin, (1997) recommend that one must first define these policy objectives explicitly and identify the main obstacles to achieving them. These policy objectives may be defined as improving health status equity, efficiency, acceptability/quality (to both the providers and users) and sustainability. They further define these policy objectives.

¹ A similar framework was used by an International Seminar on Sustainable Health Care Financing held in Johannesburg from June 23-28 1996, sponsored by the World Bank

Equity is multidimensional. It refers to

(a) *Equity in the receipt of care* which implies that access to and use of services of an acceptable level of quality is based on medical need irrespective of an individual's ability to pay.

(b) *Equity in access* which relates to the historical distribution of health service across regions, between urban and rural areas and between public and private sectors. Kutzin points out that "although analysis of equity issues usually involves comparisons across income groups, other aspects of possible inequities (e.g. difference in the receipt of care relative to need by gender, age, ethnicity, etc.) should be considered as well". . In South Africa, equity in access, particularly between urban and rural areas and between provinces is an issue in the context of health sector reform.

Efficiency is also multidimensional:

(a) *Allocative efficiency* within the health sector refers to the extent to which sectoral resources are distributed to their most cost-effective uses. Allocative efficiency is also a relevant concept for assessing the size of the health sector in the national economy. Thus, policies can affect allocative efficiency by causing shifts in the distribution of resources within the health sector or between the health sector and the rest of the economy (issues of financial sustainability arise in this context).

(b) *Technical efficiency* is a narrower concept. It refers to the management and use of resources that have already been allocated within the sector. Analyses of technical efficiency try to determine if services are produced at lowest cost possible for a given allocation of resources and thus often focus on the extent to which poor management practices or inappropriate incentives generate waste.

(c) *Administrative efficiency* is concerned with the costs of managing the health system (WHO 1993). Ability to administer the health system efficiently is also an important element of institutional sustainability.

Acceptability/quality of service refers to the readiness of providers and members to use the health system that is of acceptable quality.

Sustainability is defined by Gilson (1996) as "generating sufficient resources to enable continued and improved provision of health care for a growing population". She points out that achieving sustainability requires capacities to

- Secure sufficient resources to enable improvements in the effectiveness of health care
- Use resources effectively and efficiently to meet health needs
- Perform these functions on a continuous basis
- Perform these functions with minimum external inputs

The South African Government is attempting to redress the effects of apartheid which systematically denied equal access to health services while simultaneously creating a costly and inefficient system -- one for whites, the other for blacks -- that was administered by nine different health departments. The total South African health budget was R30 billion or 8.5% of the GDP in 1992/93. This is a relatively high allocation to health for a developing country; however, South Africa's overall health indicators reflect a high level of morbidity and mortality from preventable diseases. The apparent contradiction is due to the public policies of the previous government (South African Health Review, 96).

Because of this historical context, health sector reforms in South Africa will centre around issues of *equity* and *efficiency*, which ultimately have an impact on the other public health objectives of acceptability, quality of service and sustainability. The ANC policy framework, Reconstruction and Development Programme (RDP) which was adopted as government's policy indicated five key programmes for the RDP that has, among others, the programme for *meeting basic needs*. Health care is included as one of the basic needs that needs to be met by a democratic government. The Programme states that "reconstruction in the health sector will involve the complete transformation of the entire delivery system" (The RDP, 1994:43).

The Ministry of Health has developed the following set of more specific objectives

- 1) To unify fragmented health services at all levels into a comprehensive and integrated national health service
- 2) To promote equity, accessibility and utilisation of health services

- 3) To extend the availability and ensure the apparatus of health services
- 4) To develop health promotion activities
- 5) To develop the human resources available in the health sector
- 6) To foster community participation across the health sector
- 7) To improve planning of the health sector and monitoring of health status and health service Department of Health (1997: 14-16)

At the same time, there are pressures from the Government's Growth, Employment and Redistribution (GEAR) policy which aims at restricted government spending. For example, in the 1996/7 budget, the RDP allocation for the clinic building programme was R65m in contrast to the R327m proposed by the National Committee of Enquiry (Health Expenditure Review 1996).

Budgetary constraints are one of the main obstacles to achieving public health policy objectives. This phenomenon is not only affecting South Africa. As observed by Kutzin (1997: 3) "the principal problem identified by most countries is simply a shortage of government budgetary resources for health care relative to an increasing demand and need for care".

In an attempt to contain costs all developed and many developing countries are implementing systems to lessen the burden of expenses of illness. These systems range from the provision of free health care by the government to regulating private health care through legislation. (Palmer & Short, 1989: 53).

2.4 Delivery of basic social services

Barker (1996) argues that in the Alma Ata Declaration adopted by the World Health Organisation in 1978, it was seen as the duty of governments to provide primary health care; however, during the past decade, the dominance of the state in the provisioning of basic social services has increasingly come under attack. As Mwabu, Ugaz and White (1998) point out "the welfarist or traditional approach, that accords prominence to the state as provider and funder of quasi-public or 'merit' goods such as

education and healthcare, is being challenged by the neo-liberal approach. The latter advocates slimming down the role of government to providing those services only for the very poor. It holds that the private sector, by relying on price mechanisms, could achieve more efficient allocation of resources.”

2.5 Delivery of health care services

Budget cuts are also a problem for the health sector. As pointed out by McPake and Kutzin (1997), “health systems in developing and transitional countries have been subjected to a variety of pressures and have undergone changes in recent years”. They argue that these changes involve amongst others, the fundamental reorientation of health systems including re-examining the overall structure and organisation of provision of health services; and the ideological orientation of health systems. “The term ‘health sector reform’ has been coined to reflect the new context”. [McPake and Kutzin, 1997:1]

2.5.1 Privatisation of Health Care

In line with recent neo-liberal arguments, Shaw and Griffin (1995) argue for private provision of health in curative services, which is seen as a *private benefit*. According to this argument, the state’s resources would be freed up to provide primary health care services to the poor. The state’s role would be regulation or the creation of an enabling environment for the private sector.

2.5.2 Critique of Privatisation of Health Care

This process of privatising health care has come under increasing criticism. As Robinson (1998) notes, private provision has had benefits like in the education sector in Chile. He points out, however, that there are some services, like preventative health care where the private sector is neither willing nor capable of intervening.

In a study in South Africa on provision of hospital services by the government or contracting out, Broomberg and Mills (1998) found that while private hospitals were more efficient, the cost of contracted out hospital services was more to the government than providing the service. The cost effectiveness of the private hospitals was largely due to more efficient use of staff.

The high costs are as the result of the contracts which were drawn up by lawyers representing private hospitals. The conditions end up favourably for the private hospitals. It is interesting to note that the study did not find marked differences in the quality of care delivered at both hospitals.

The efficiency of public hospitals is clearly affected by overutilisation (e.g. Chris Hani Baragwanath Hospital) or underutilisation (e.g. Edenvale Hospital which the Gauteng Health Department had to close). Moreover a hospital audit commissioned by the Department of Health found that a third of all public hospitals in the country will need to be replaced due to the neglect they suffered under the previous apartheid government (Department of Health, 1998)

The efficiency of private hospitals is also open to question. The appropriateness of the treatment in private hospitals is debatable due to patients who receive treatment and end up in the public hospitals when their medical aid schemes cannot cover the treatment. (Valentine and McIntyre 1994)

Barker (1996) cautions against accepting as common wisdom the efficiency of the private sector in the delivery of health care services as the arguments for privatisation are in line with a much wider shift towards neo-liberal political views. On the claim that the public sector is inefficient, she concludes: "Because it (this claim) is made so often, people come to believe it, but there is little evidence to support this" (Barker, 1996:154). Practice has shown that more than in any other sector, the health sector

has been characterised by market failures. Hammer (1997) argues that pervasive market failures are an essential feature of the health sector.

In assessing arguments for privatisation of health care, Price and de Beer (1989) make the following observations:

- The argument that by having those who can afford pay for health services thus freeing government resources for the care of the poor overlooks the fact that firstly, the government subsidises the private health sector particularly in the training of health workers. Secondly the affluent are influential in the society so when they do not use public facilities, pressure on the state to provide quality services will decline.
- The argument that the private sector will provide the services cheaply is based on the assumption that competition among service providers leads to financial efficiency. This argument is flawed because there are no perfect market conditions in health care.

Price and de Beer (1989) conclude that "the arguments in favour of privatisation are at best inconclusive; at worst, incorrect".

One of the institutions that has become involved in health policies of developing countries is the World Bank. Werner and Sanders (1997: 103) describe the involvement of the World Bank in the health policy of developing countries as "the World Bank's take-over of health policy planning". They sketch the history of the World Bank and the International Monetary Fund (IMF) from their inception in 1945, to the mid 1980s when criticism was levelled against policies linked to structural adjustment programmes from these institutions.

As part of the effort to reposition itself, the World Bank started getting increasingly involved in developing countries' health care policy through lending to the health sector. In 1993, the World Bank's agenda on health care policy was spelled out in the *World Development Report* [WDR] and is entitled "Investing in Health".

According to Werner and Sanders (1997), the report acknowledged the links between poverty and ill health. They criticise the three-pronged policy approach to health reforms from the World Bank as follows:

1. **"Foster an enabling environment for households to improve health"** is a return to "trickle down" development. Policies for economic growth must take priority. Family health will improve when household income starts to rise.
2. **"Improve government spending in health"** means trimming government spending by moving from comprehensive service provision to a number of narrow vertically planned programs, selected on the grounds of cost-effectiveness: in other words, a *new brand of selective primary health care*. It also means user charges which require disadvantaged families to cover the costs of their own health care despite the fact that for many it will prohibit the use of health care services.²
- 3) **"Facilitate involvement by the private sector"** means turning over to private, profit-making doctors and businesses most of those government services that used to provide free or subsidised care to the poor ... in other words, *privatisation of most medical and health services*: thus pricing many interventions beyond the reach of those in greatest need.

² Murray et al (1994: 182) further criticises the focus on cost effectiveness on two accounts: "first, cost effectiveness analysis of health interventions, which are more often than not disease specific, tends to neglect the role of the health system in delivering these interventions Second, there is a potential for considerable confusion, including in the WAR, on the policy choice that should be informed by cost-effectiveness analysis."

Murray et al (1994) point out that through this report, the World Bank has promoted the concept of using cost-effectiveness of health sector interventions and the burden of disease of health problems to develop essential packages of clinical and preventative care. They add: “In brief, estimates of the current burden of diseases are combined with a cost-effectiveness rank list of interventions, to derive packages of services that, for a given budget, will purchase the largest improvement in health as measured by DALYs [disability-adjusted life years]” (Murray, Kreuer and Whary, 1994: 182).

2.5.3 Alternative Approaches

The editorial of the Seminar on Sustainable Health Care Financing (1996) held in Johannesburg noted that private-public collaboration is one of the ways to effect health sector reforms. It defined private-public mix as “formal or informal cooperation between the public and private (voluntary and for-profit) sectors in the provision and/or financing of health care services.”

Robinson (1998) further argues for a new “welfare pluralism” where private sector institutions and the government participates with individuals and communities in the provision of services. This approach places the people at the centre of change. As explained by Chambers (1983:44) “pluralism recognises multiple causation, multiple objectives, and multiple interventions.”

The UNICEF-facilitated Bamako Initiative reflects this alternative approach by emphasising the crucial role of community participation and management of health resources. As stated by Gilson (1994) the “model sees community participation in management as the critical mechanism for ensuring that revenues are used in ways that address the persistent quality weaknesses of primary care, and that the health system is accountable to the users of health care”.

2.5.4 Managed Health Care Model

Managed health care is presented as a solution to private health sector problems. Medscheme defines Managed Health Care as “a collective term for health care management processes and/or services whose goals are the delivery of affordable, accessible, quality health care. These health care management processes are based on the application of standard business practices to the delivery of health care in a free-market setting. It is important to note that Managed Health Care is about management processes and is independent of the health care structure or organisation in which it takes place.” (Medscheme 1997). It further points out that any managed health care model has four basic elements: a fund, purchasers, providers and a management organisation. It concludes that “it is important to note that Managed Health Care is about management processes and is independent of the health care structure or organisation in which it takes place.”

Schiff (1996) highlights fundamental problems of managed health care from the experience in the United States. These problems are proposed as managed health care solutions to problems facing the medical aid scheme for the Police.

Confusion and waste. A frequent patient complaint with fee-for-service medicine was the fragmentation of care, with too many specialists who knew too little about the whole patient. Managed care, however, confuses restricting care with co-ordinating care. Primary care physicians' relationships with patients and specialists are repeatedly disrupted. Patients with a definable disease risk being "carved out" to an asthma, diabetes or a schizophrenia "disease management" factory. Physicians dealing with armies of corporate utilization managers spend millions of hours chasing approvals, correcting inappropriate denials and dealing with conflicting formularies, all of which leads to skyrocketing administrative costs. As each plan develops its own electronic medical records, billions of dollars are wasted on incompatible information systems.

Eroded trust. Primary care needs to be structured to preserve the physician's role as a trusted patient advocate. How can patients feel reassured by their physician's decision not to order a CT scan for a headache when they know he is being paid to deny the test? Turning patients and physicians into adversaries generates intense antagonisms that undermine the trust needed for health care to work.

Disgruntled patients, harassed doctors. Because most patients and providers have been forced into managed care arrangements under duress, exam rooms are increasingly filled with angry patients and stressed physicians. Knowing that they lose money every time a patient walks into their office makes physicians loathe sick patients. When you combine this with doctors' frustrations over inability to choose treatments and make clinical judgements, a decline in compassion and communication is inevitable.

Disempowered patients. Restricting patients' options takes away their strongest quality leverage—choice. The business ethic makes managed care organizations accountable to corporate stockholders, not the public or patients. It's hard for a patient—much less a physician—to go head-to-head with these increasingly powerful organizations.

Wrong incentives. While managed care advocates correctly point out that fee-for-service medicine has more than its share of abuses and incentives to overtreat, capitation is not simply an inverted fee-for-service system. It is more akin to an illegal kickback arrangement. Giving financial rewards to physicians who order or deny tests and referrals allows bribes to influence their decision-making.

Gatekeeping. Gipe (1994) notes that in the United States “the HMOs have assumed that contracting with primary care physicians will result in the gatekeeping that is necessary to control costs, despite the absence of data to support this conclusion.” He argues that the greatest costs occur in the hospitals particularly in ICUs where primary care physicians have no influence.

2.6 Private and public sector health expenditure in South Africa

According to the Department of Health, in 1992/93 about 38.7 per cent of total health expenditure was funded from public sector sources while 60.8 per cent was from private sector sources. “Despite these substantial resources within the private sector, only an estimated 23 per cent of South Africans have some degree of access to private health care on a regular basis.”(Department of Health, Restructuring of The National Health System For Universal Primary Health Care, 1996).

In comparing public and private sector health expenditure, van den Heever (1994) shows that between 1982 and 1992 private sector real per capita expenditure has more than doubled while public sector real per capita expenditure has remained stable. He argues that in the past there have been few incentives to contain costs in the private sector. According to the South African Health Review (1996) the total expenditure on health care is projected to increase to just over 9.2% of GDP by the year 2000/01.

The majority of this increase would be attributable to the continued cost spiral in the private health sector. It points out that one of the major contributory factors to this cost spiral is the prevailing fee-for-service reimbursement mechanism by third-party payers, which encourages "supplier-induced demand" and excessive utilisation by patients. According to Gilson (1996), supplier-induced phenomenon arises when patients rely on health providers for information about their needs and demands for services. She contends that this is not necessarily harmful because an important function of providers is to inform patients about their condition and the available treatment options. The potential for costly and possibly harmful overuse of services exists where providers benefit financially from the treatment they recommend and provide. Supplier-induced demand is the reason why fee-for-service reimbursement causes cost escalation. As stated by Gates (1996) "autonomous, provider-directed care with fee-for-service reimbursement combined with expensive medical technology and an overabundance of providers has led to increasing medical costs".

ANC health policy (A National Health Plan for South Africa: 71) stated that "the cost spiral within the private sector can largely be attributed to expenditure on drugs and private hospitals." According to Valentine and McIntyre (1994), "the major challenges facing the private health sector are to contain the rapid cost spiral and extend access to private sector resources to a larger proportion of the population."

Public sector spending has largely been to fund curative hospital-based services. According to Valentine and McIntyre (1994) “acute care hospitals spent over 76 percent of total recurrent public health expenditure in 1992/93. Academic and other tertiary hospitals alone accounted for 44 percent of total recurrent public health expenditure, while non-hospital primary care services accounted for only 11 percent”. The government has set as its priority reorienting public health services towards universal primary health care.

2.7 Private Health Care in South Africa: Historical Background

The first private practice was set up by a medical practitioner in the Cape in 1657. By 1818 the first civil hospital was established. Industrialisation of South Africa followed the discovery of diamonds, and later gold and this meant large concentrations of urban population which was accompanied by the arrival of private medical practitioners and the establishment of other private hospitals.(RAMS, 1997)

By the 1940s the notion that only a state-run and state-financed health system was appropriate had wide support in South Africa. As pointed out by Price and de Beer (1989) this was still the government position in the early 1970s. By 1977, however, this position had changed with the Department of Health (as quoted in Price and de Beer, 1989:29) stating that “ It is essential to note the role of private practitioners forms an integral part of comprehensive health service Every encouragement must be given to the private sector to contribute and expand its share in achieving a comprehensive health service.”

They further point out that this development was due to

- Firstly, the rise of monetarist theories that advocated minimal government involvement in the economy
- Secondly, reduced government funding for services

- Thirdly, political motivation related to the government's reform of Apartheid policies: 'middle class' blacks were to have integrated health services with whites in private health facilities without the then government taking responsibility for that integration (Price and de Beer, 1989).

2.8 Health Insurance

A key mechanism in the provision of private health care is health insurance which can be defined "as an arrangement in which contributions are made by or on behalf of individuals or groups of individuals (members) to a purchasing institution (i.e. a fund). The fund is responsible for purchasing covered services from providers (It is possible for the fund and the provider to be the same entity) on behalf of the new members of the scheme". For the members to be effectively insured implies both financial protection and access to desirable services (Kutzin, 97).

Using this definition of health insurance, Polmed is a health insurance scheme as the central government contributes on behalf of members of the police services to a purchasing institution to purchase services from providers. The SAMHS can also be considered a health insurance scheme as again the government contributes on behalf of the members of the DoD to a fund to purchase services from providers. In this case, however, the SAMHS is also the provider of services. There are other parts of the SAMHS that cannot be classified as a health insurance; i.e. the specialised units such as 7 Medical Battalion Group, the Institute of Aviation Medicine and the Institute of Maritime Medicine.

Shaw and Griffin (1995: 146) highlight three problems that can undermine health insurance plans:

Adverse selection -- when people with a high probability of a health loss systematically join an insurance plan -- thus predominating its membership --

while those with a low probability of a loss do not join. For example, some people may be more afflicted with a chronic illness than others, or may work in occupations with high risk of injury.

Moral hazard -- when people may take advantage of their membership in a health insurance plan by using services more frequently than had they not been members. Should this happen frequently, the insurance plan will incur a loss and lose its economic viability.

Cost escalation -- physicians can promote cost escalation by providing more elaborate treatment than required, with little resistance from clients who have little to lose, because their insurance plan pays the bill.

Moreover, in developing countries, insurance companies face several unique problems that contribute to cost escalation. Insurance adds what is called a *loading cost* to the cost of medical care. The loading cost includes administrative costs, sales costs or commissions, and profits of the insurance system. As these loading costs increase, they diminish the value of insurance to the consumer and make it less likely that insurance will be a viable alternative to accepting catastrophic risks.

2.9 Health Insurance in South Africa

The first private health insurance was established by De Beers Consolidated Mines for its employees in 1880. Many other industries created similar schemes for their own employees. The schemes mainly covered white employees and their families. After the Second World War, there was unprecedented expansion in the health insurance industry as the economy entered a period of growth. There were, however, neither standards nor accountability structures for the industry nor was there any framework for regulation. By the late 1960s, the government passed the Medical Schemes Act 72 of 1967 with the aim of regulating the private health insurance industry. Under this Act medical schemes had to be registered. The Central Council for Medical Schemes was established as the statutory controlling body for registered medical schemes. (RAMS, 1997)

The Act defined two forms of schemes; namely, *medical aid schemes* and *medical benefit schemes*.³ With medical aid schemes, members and dependants could see any health provider of their choice. Medical benefit schemes, however, either employed or directly contracted with health providers. The Act also guaranteed payment to the health providers by the schemes. (Valentine & McIntyre, 1994)

The decades that followed the passing of the 1967 Medical Schemes Act witnessed a phenomenal rise in the private health sector in South Africa. By 1983, there were 206 medical aid and 22 medical benefit schemes. But the situation had greatly changed by the 1990s: by 1992, there was a 20% decrease in medical aid schemes and a 14% decrease in medical benefit schemes. In 1993, the Medical Aid Amendment Act stopped guaranteed payment of service providers and removed the distinction between medical aid and medical benefit schemes. (Valentine & McIntyre 1994)

Medical schemes are all supposed to be non-profit; yet, as Valentine and McIntyre (1994: 4) point out:

“an entire industry functions to process the claims including medical scheme administrators and script processing organisations. They charge an administrative fee within which they can make a profit”.

By comparing South African Reserve Bank estimates with a detailed analysis of the private health sector in 1992, Valentine and McIntyre estimate that approximately R4b went to investments, administrative costs and financial intermediaries. Only R450m went to public providers.

The proposed National Health Insurance Bill aims at redirecting health care expenditure to the public health sector. The result would be improved allocative efficiency in health spending.

³ As well, the Act exempted certain schemes from its provision, particularly those established under legislation relating to the railways, harbours, police, defence, prisons and national intelligence.

One of the major problems facing the private health sector is increasing costs (*The Saturday Star*, July 19, 1997). This increase in private health care expenditure has been more than the rate of inflation (Department of Health, Restructuring of The National Health System For Universal Primary Health Care, 1996). Increased private health care costs, Valentine and McIntyre (1995), point out, have led to "increasing questions about whether the private sector provides good value for money."

For example, there was a 47% increase in private hospital beds from 1983-1994 (Valentine and McIntyre: 22). This correlated with an increased payment from medical aid schemes to private hospitals (219.89% increase from 1988-92). McIntyre makes the point that this figure includes a complex variety of items including GP and specialist services, medicines, theatre and ward costs and "hotel" costs. This makes it difficult to know the true costs of hospital services according to level of care. It follows that cases which should be handled in a primary health care setting will be seen in an institution providing a more costly level of care.

2.10 Public sector health service

The Department of National Health identifies the following as some of the most pressing problems affecting delivery of services in the public sector:

"In summary, the public sector faces the challenge of attempting to improve access to basic primary care services for those who currently do not have access to such care, while at the same time trying to redress historical inequities in the distribution of health care resources between and within provinces. This must be achieved within the constraints of a limited budget which is currently derived mainly from general tax revenue" (Department of Health, Restructuring of The

National Health System For Universal Primary Health Care,
1996:3)

The SAMHS as a public sector organisation is faced with similar problems. Almost all its health facilities are located in previously white areas as the service was mainly meant for serving military members who were white. However, it is also faced with the unique problem of under utilisation of its hospital facilities. For instance, the flagship of SAMHS hospitals, 1 Military Hospital located at Thaba Tshwane in Pretoria, has a bed occupancy of about 52 per cent. According to Barnum and Kutzin as quoted in the National Health Expenditure Review: "Hospitals are usually designed to operate most efficiently at an occupancy of 85-90 per cent; at lower activity their unit costs rise...."

2.11 Historical background to military health services

Little is known about traditional African warfare and even less about the health matters of those armies. By and large, documented military history appears to start after the 15th century.

In South Africa, the Union Defence Force was established by legislation passed in 1912, after the formation of the Union of South Africa in 1910. This legislation also made provision for the establishment of the South African Medical Corps (SAMC) (Military Information Bureau, 1983). The establishment of SAMC and the regulations governing its organisation was officially gazetted on 3 December 1913. Maj. P. G. Stock was appointed as the staff officer to command the SAMC. The SAMC comprised the Cape, Natal, and Transvaal Medical Corps. Van Jaarsveldt (Military Information Bureau, 1983) points out that the planning, organisation and training of the SAMC was done with the help of the Royal Army Medical Corps (RAMC) whose units were still in South Africa following the Anglo Boer War. The beginning of the SAMC is summed up by the then Surgeon General Lt Gen Niewoudt's words: "The

initial growth of the South African Medical Service, however, was exceptionally slow mainly because it was accorded a lower priority within the Union Defence Force than for instance the development of the Artillery Corps. In fact, to begin with the South African Medical Service did not even enjoy independent status, falling under the auspices of the Department of Public Health” (Military Information Bureau, 1983).

In between the two World Wars, in 1922, Maj. H. Porteous was sent to South Africa from Britain, to establish a medical corps in the SA Air Force (Military Information Bureau, 1983). In 1959 the SAMC was renamed the South African Medical Service (SAMS). The SA Navy established a Medical Corps in 1960. Due to conscription under Apartheid, there was an unprecedented growth of the South African Defence Force including the Medical Corps in the 1960s. The three medical corps, the Army, Navy and the Air Force, were, however, under the respective combat force they supported. In 1970, one Surgeon General was appointed to head the Army, Air Force and Navy Medical Corps. C. R. Cockcroft was promoted to the rank level of Lt Gen, and was appointed to head this service. Thus the SADF’s SAMS which began with a head at the rank level of major in 1913, had grown in a period of more than five decades to be headed by a Lt Gen.

Lt Gen Cockcroft was to oversee a number of structural changes in the SAMS. Two additional posts of deputy surgeon general - operational medical services and medical support, on major general level were introduced in 1975. This was particularly necessitated by the involvement of the SADF in the Angolan civil war in 1975, as the SAMS had to medically support the fighting forces.

In 1979, the SAMS became an independent arm of service in the Defence Force. The Surgeon General was Lt Gen N. J. Nieuwoudt who had taken over from Lt Gen

Cockcroft in 1977. The SAMS growth continued unabated in the 1980s. In 1982, the present 1 Mil Hospital was officially opened by the then Prime Minister P. W. Botha.

2.12 Experience From Other Countries

Walt (1996: 95) observed “whatever the strength of the military, it is common that, as a sector, it provides health care for its own personnel and families.”

2.12.1 The United States Armed Forces

The US armed forces military health system is headed by the Assistant Secretary of Defence for Health Affairs, and the Surgeon generals of the Army, Navy, and Air Force. Health delivery is through a form of managed care called TRICARE system. According to the Office of the Assistant Secretary of Defence for Health Affairs “TRICARE brings together the health care resources of each of the military services and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support military operations”.

The following are eligible to enrol in TRICARE: “All active duty members in the seven uniformed services: Army, Navy, Air Force, Marines, Coast Guard, National Oceanic and Atmospheric Administration (NOAA) and Public Health Service (PHS), as well as their CHAMPUS⁴-eligible family members, CHAMPUS-eligible retired military, their family members and survivors as well as active duty family members and retirees and their family members who are under age 65, Medicare eligible because of a disability, and enrolled in Medicare Part B.” There are seven categories of priorities for space for treatment at military health facilities. These range from

⁴ In 1966, Congress passed the Military Medical Act (Public Law 89-614) which resulted in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). It directed DoD to develop an option for military retirees and family members that would be “the equivalent of the Federal Employees' Health Benefit Plan's (FEHBP) Blue Cross Blue Shield-High Benefits Option”.

serving uniformed services members receiving first priority to former active duty women who were pregnant at the time of discharge who make up the seventh and final priority

Active duty members receive free health care in military health facilities. In the TRICARE programme family members of active members pay up to a maximum of \$1000 and retirees for up to \$7500 per year in total out-of-pocket costs for covered medical services. Members who qualify for military health services but do not enrol in any of the TRICARE options receive treatment for free in military facilities on a space available basis. Members enrolled in the TRICARE programme receive health care services in the designated geographic military health facilities and if they live outside those geographic areas then they are attended to by designated private health care providers.

Dr. Stephen Joseph, assistant secretary of defence for health affairs, in a speech to the DoD TRICARE Convention, Washington, Jan. 22, 1996 identifies issues facing the military health system as the rising health costs on the one hand and having to support smaller, flexible, mobile, and highly technical fighting forces on the other. He further points out that as a quick fix solution to these issues there are suggestions “to privatise or outsource those military functions which can be most easily accomplished by the civilian sector. It is this line of thinking that leads to suggestions for severely scaling back the military health services system -- manpower, infrastructure and dollars. We have been successful thus far in articulating the inseparability of our everyday health care delivery responsibilities from our operational support responsibilities and therefore, establishing the requirement for a very robust military health care delivery system.”

Described by James D. Staton, Executive Director of AFSA (the Air Force enlisted organisation) in a statement entitled *Congress Must Address The State Of Military Health Care -- Now!*, March 6, 1997

Critics of the TRICARE system argue that this system is a breach of the promise by the DoD to provide health care for a lifetime to members and dependants of serving military personnel. AFSA, an organisation for US Air Force personnel, argues for “legislation to: Continue full funding of the Military Health Services System (MHSS) to guarantee lifetime, affordable, quality health care for the total force, with full access to care regardless of rank, age, gender, health status or location -- to include all eligible family members”.

2.12.2 Lessons Learnt from the American System

- There is an inseparability of delivering day-to-day health care from operational support responsibilities
- However military health facilities are primarily for active serving members
- Contributions are required for health cover for family members of active duty members
- Contributions are required by retirees
- There will be resistance from retirees who expect a free service
- There is a dependence on a private-public mix of providers

2.12.3 The United Kingdom

The United Kingdom military health services do not cater for retired members of the armed forces or dependants of serving members. These categories are covered by the National Health Insurance system. Active serving members are taxed like all citizens, thereby contributing to the National Health Insurance. The military health service only caters for support of the fighting forces. This policy means that members of the military health service have to be operationally deployable at all times. The Army, Air Force and Navy components of the health services are attached to those fighting forces. Procurement of medicines and equipment, and hospital services are centralised. There is one military hospital in the United Kingdom. Previously, there were also military wards attached to public hospitals. The practices was stopped due

to contractual problems that favoured the public health system. (Interview with a member of the British Military and Training Team in South Africa, 1998).

2.12.4 Lessons Learnt from the British System

- The existence of a National Health Insurance system makes it unnecessary for dependants of serving personnel to receive health coverage from the military.
- Serving members contribute to health cover of dependants as they pay tax like all citizens
- Serving members' day-to-day and operational support health care needs are rendered by the military organisation.
- Attaching military wards to public hospitals provided the contracts are properly done.

2.12.5 Algeria

Serving members of the military contribute 7% of their salaries for health cover. Dependants are also covered by the military health services. Delivery of care is done in military facilities and public hospitals. The private health sector is weak as private practice was only allowed in 1998. (Interview, 1999)

2.12.6 Namibia

Free health care is provided by the Military Health Service to serving members and their dependants. However, the Military Health Service is not yet well developed. This has resulted in members of the military voluntarily subscribing to the government medical scheme. The members on the government medical scheme are able to be attended to in the private sector for non-work related injuries or illnesses. Work related injuries, even when referred to the private sector, are fully paid for by the Ministry of Defence (Interview, 1999)

2.13 Conclusion

This chapter has identified the relevant policy objectives for reviewing the private and public health services in South Africa. The debates about such provision are highlighted and the analytical framework to be used has been presented. Specific issues related to private and public health care provision in South Africa are highlighted.

Chapter 3 RESEARCH PROPOSITIONS AND METHODOLOGY

3.1 Introduction

This study is based on a qualitative policy review rather than quantitative research methodology. Two organisations have been chosen for a detailed study because of the differing approaches they use and the contrasting lessons that can be drawn from their experience. The South African Medical Health Services (SAMHS) is based on the model of a publicly owned and financed approach to health care provision while the South African Police Services (SAPS) utilises a private health care sector approach. Understanding in greater detail the specific issues confronting these organisations can inform the broader debate in South Africa.

3.2 Methodology

The background, structure and approach of each organisation is described in detail. This information is derived from interviews and publications on the history of SAMHS and SAPS medical support. Data for the current SAMHS facilities and services is derived from DOD public documents. Where gaps exist, internal SAMHS publications are used. Data for Police Services is obtained from the Parliamentary Committee on Safety and Security. Secondary sources of data from previously published research are also consulted. Unstructured interviews are conducted with the main role players from the SAMHS, Department of Safety and Security and offices from foreign Defence forces in South Africa.

The criteria for analysis, i.e. the criteria of impact on the public health policy objectives, are introduced and defined / operationalised. These are:

- equity in access according to income, geography, age and gender
- efficiency in allocation, technical and administrative aspects
- acceptability to users and to providers

- sustainability of the service in the long run

An analysis is then undertaken of each service according to the established criteria for the various models

A comparison of the two services is made on the basis of the given criteria and a qualitative analysis is undertaken of the overall impact. This is undertaken in order to identify the optimum public-private sector mix in the delivery of services to uniformed members of the security services.

Recommendations are made based on the comparison that has been undertaken and a policy framework is proposed.

Obstacles to the successful implementation of the model are identified.

Chapter 4 THE SOUTH AFRICAN MILITARY HEALTH SERVICES (SAMHS)

4.1 Summary

This chapter discusses the rationale and organisation of health services in the South African National Defence Force. An overview of the organisation, facilities and health services provided by the SAMHS is presented including a breakdown of the budget and expenditure. In particular, the health delivery is examined, including the extent of consultations, hospitalisation and drug prescriptions. After presenting the comparison, the SAMHS' performance is reviewed against the public health objectives.

4.2 Introduction: Why a Military Health Service

Military health services grew out of the realisation that the prevention or control of disease and the treatment of the wounded greatly reduced mortality and contributed to sustainment of numbers and morale of fighting forces. In the past, more soldiers died from diseases than through combat. For example, during the United States civil war, 364,000 soldiers died on the Union side; a third were killed or died of wounds and two-thirds died of disease. The situation has improved over time: about 15 percent of the wounded died in the civil War; about 8 percent in World War I; about 4 percent in World War II and about 2 percent in the Korean War. [Pertinent Facts About the Civil War]

As long as military forces go to war, there will be casualties. As pointed out by Supreme Headquarters Allied Powers Europe (1993) "the history of modern conventional ground operations has demonstrated a remarkable consistency in battle casualty patterns and rates. The patterns indicate a deep internal coherence across the spectrum of major operational scenario types, and it would be reasonable to assume that these patterns will recur in future conventional conflicts." It must be pointed out

that in peace support operations, casualty rates will be reduced, and casualty patterns differ from conventional war patterns.

The White Paper on Defence, approved by the Parliament of South Africa in 1996, recognises that there is no military threat against the Republic of South Africa in the short to medium term. However, the possibility of the country being involved in peace operations and in other areas of armed conflict cannot be ruled out. The recent events in Lesotho with Operational Boleas and the statements by government officials of peace support operations in the Great Lakes Region points to this. There is therefore need for a military health service that will be capable of handling public health problems and battle casualties arising from military operations that South Africa may be involved in. As Abbate (1998) points out after the end of the cold war, peace missions have entered what is termed 'second generation peace missions' from traditional peace keeping to a multidimensional peace operations that "...seek to help belligerents' transition to a lasting peace by addressing the underlying causes of conflict."

As parties to peace missions, there will be a need to handle the injured and infirm of the conflicting / warring members, and possibly their own caught up in crossfire as prescribed by international humanitarian law. The four Geneva Conventions of 1949 extend protection to the following persons in times of armed conflict:

- Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field
- Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea
- Convention (III) relative to the Treatment of Prisoners of War
- Convention (IV) relative to the Protection of Civilian Persons in time of War

(<http://www.tufts.edu/departments/fletcher/multi/texts/BH241.txt>, 14/10/98)

Neo-colonialism in Africa has ignited modern conflicts characterised by fratricidal fights pitting one group against another, often with the usage of child soldiers. The result is huge numbers of civilian casualties and displaced persons. These conflicts are usually in countries where infrastructure, including that of delivering health services, has collapsed (Stewart, 1998). As stated in Art. 56 of the Geneva Conventions -Convention (IV): “To the fullest extent of the means available to it, the public Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health and hygiene in the occupied territory, with particular reference to the adoption and application of the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. Medical personnel of all categories shall be allowed to carry out their duties.”
(<http://www.tufts.edu/departments/fletcher/multi/texts/BIH241.txt>, 14/10/98)

4.3 Background

In preparation for a democratic South Africa, the Transitional Executive Council (TEC) formed the TEC Sub Committee on Defence, with day-to-day negotiations on defence matters conducted by the Joint Military Co-ordinating Council (JMCC). The SAMS was formed as a result of these negotiations by the integration of the medical components of the seven military forces [SADF, MK, APLA, Transkei, Ciskei, Bophuthatswana and Venda armed services] that existed in South Africa in 1994. Its mission, as approved by the JMCC in February 1994, was “to provide and ensure, as part of the RSA government’s Southern African strategy, a military health service that is guaranteed, comprehensive, self supporting at all relevant times and places to ensure the physical, psychological and social well being of the entire military community and approved clientele.” (SAMS Strategy, 94).

The SAMS was renamed the South African Military Health Services (SAMHS) in 1998 and is presently headed by Lt Gen D. T. Masuku. As stated in the Defence

Review (1998), “the SAMHS provides comprehensive medical, psychological and social services within the Department of Defence (DoD) and makes many of its services available to the families of the DoD members including non-military personnel. The Defence Review further provides that “the SAMHS should provide medical services wherever possible through its own facilities and capabilities referring patients to provincial hospitals where it cannot render appropriate service, or in some cases to private facilities where provincial hospitals do not have the necessary facilities.” The net effect is that serving members, retired members, widows and dependants of the Defence Force receive free medical attention from SAMHS facilities and/or become referred to other institutions if SAMHS facilities cannot provide the service.

4.4 Organisation of South African Medical Health Services

The SAMHS organisational structure is undergoing change in line with the transformation process in the DoD. The transformed structure will still consist of 20 statutory disciplines and 13 Staff Departments. The SAMHS health coverage, as stated in the Department of Defence’s annual report (1997) is through nine geographical regions called Medical Commands. These are the Western Province Medical Command, Eastern Province Medical Command, Natal Medical Command, Orange Free State Medical Command, Gauteng Medical Command, North Western Medical Command, Eastern Transvaal Medical Command, Far North Medical Command and the Northern Cape Medical Command. Each Medical Command is headed by an Officer Commanding who reports directly to the Surgeon General. The Chiefs of the various Staff Departments and the Statutory Directors at the SAMHS headquarters level are responsible for the vertical co-ordination of their respective functions between the SAMHS and the different Medical Commands and the Specialist Units.

The SAMHS specialist units render a countrywide service and therefore are under the

direct command of the SAMHS headquarters. These units are 1 Military Hospital, SAMHS Academy, 7 Medical Battalion Group, Medical Command Post Army Battle School, Medical Base Depot, the SAMHS Technical Support unit, the Institute for Aviation Medicine, Institute for Maritime Medicine and the Military Psychology Institute.

4.4.1 Health facilities

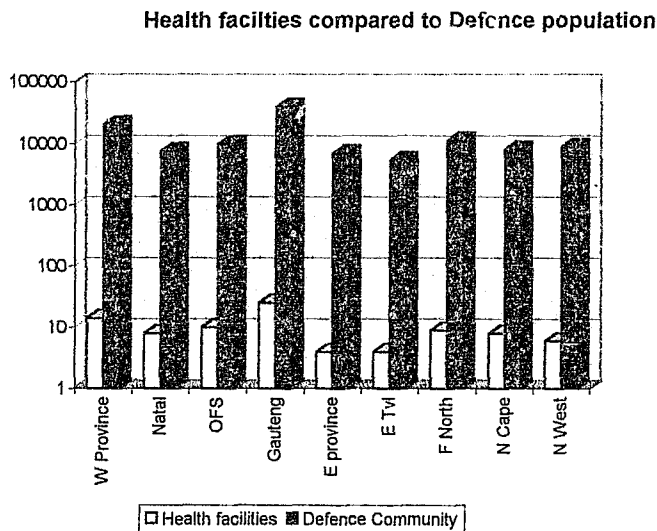
The SAMHS has the following public health facilities : 3 Military Hospitals, 5 Military Base Hospitals (MBH), 34 Sickbays, and 43 Military Medical Clinics. Other health care provisioning facilities include the 4 Specialised units (7 Medical Battalion Group, Institute for Aviation Medicine, Institute for Maritime Medicine and the Military Psychology Institute). The distribution of these facilities per medical command is indicated in Table 1.

1 Military Hospital is a tertiary referral institution, while 2 and 3 Military Hospitals are secondary hospitals. Military Base Hospitals (MBH) are primary health care facilities with approximately 40 beds and facilities for minor surgery. Sickbays are primary health care facilities with an overnight holding capacity for patients of approximately 10 beds and are usually staffed by doctors, nurses and operational emergency care orderlies. In cases where Permanent Force doctors are not available then use is made of sessional civilian doctors. Military Medical Clinics (MMC) are primary health care facilities that attend only to day patients and are usually staffed by nurses.

The distribution of SAMHS health facilities reveals interesting considerations by the previous apartheid government (see Fig 1). Gauteng and Western Province commands being the economically most important provinces have the largest defence populations and health facilities. The Eastern Province command has the same number of facilities as Eastern Transvaal despite having a higher number of Defence

community members. The Eastern Cape is formed mainly by the former Bantustans of the Transkei and Ciskei. The pattern follows the historical distribution of health resources between the former 'white' and 'black' South Africa. The Eastern Transvaal had until recently a Military Base Hospital at Hoedspruit Air Force base as the command was important against attacks from the Eastern borders. The three commands Far North, North West, and Northern Cape have been important in the conduct of the bush war in Angola and Namibia. However, although the highest number of deployed soldiers in peace time are in the Natal province, this is not reflected in the health facilities available as they are the same as in the relatively calm Northern Cape command.

Figure 1



Source: Epidemiology Department, SAMHS HQ 1997

The number of SAMHS facilities has been reduced in line with the closure of SA Army

Army bases and other military installations (See table 2 for a comparison of facilities available in August 96 and April 97). The hardest hit with reductions in facilities are those that served the previous so-called independent states of Transkei, Ciskei, Venda and Bophuthatswana. The announced retrenchments of Army personnel will lead to further closures of bases which will include Military Health facilities.

4.5 The SAMHS Budget

The amount voted for medical support in the DOD for 94/95 stood at R899,925 m. See Table 3. This was due to extra allocation for the expected rise in health care cost because of the integration of members from the TVBC and non statutory forces. According to the document SAMS Strategy (1994) the extra amounts requested during the JMMC talks for the SAMS were: R136m for personnel, R162m for logistics and professional services, R5m for main medical equipment, R1m for medical equipment for sickbays making a total of R305m. A total of R85m was allocated for integration. Van Heerden (1994) was critical of the extra allocation arguing that since the SAMHS had an extra capacity it does not need extra funds to cater for an increased coverage.

The SAMHS expenditure for the financial years 94/95, 95/96 and 96/97 is outlined in table 3.

Table 3 SAMHS expenditure for the financial years 94/95, 95/96 and 96/97

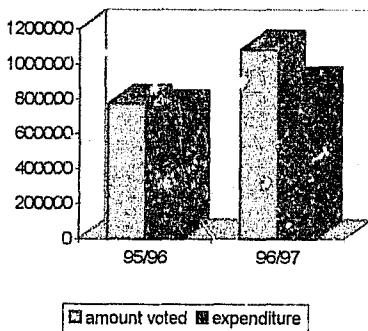
Fin Year	Amount Voted	Expenditure in R'000
94/95	R899 925	R624 200
95/96	R771 745	R739 406
96/97	R1 080 895	R873 111

Sources: DOD Annual Report FY 94/95
DOD Annual Report FY 1997

There has been underspending by the DoD on the amounts voted in the Defence budget. In 94/95, 95/96 and 96/97 financial years, the underspending amounted to 11%, 3.7% and 3.10% of the budget respective to the total defence budget. The SAMHS under expenditure for the financial year 95/96 and 96/97 was 4.2% and 19.22% respectively (See fig 2). According to the DoD annual report for 1997, "The surplus can be attributed mainly to integration costs for which the allocated budget proved to be in excess of the requirement. This was due to the fact that fewer than the expected number of members reported for the integration as well as the fact that the process took longer than initially anticipated. In addition, the surplus can also be attributed to normal requirements to roll over funds in respect of unpaid orders to the next financial year." It would appear that Van Heerden's point is valid that the SAMHS is able to absorb an increased patient load without huge increases in its budget because of its spare capacity.

Figure 2

Fig 1. Amount voted for the SAMHS vs Expenditure



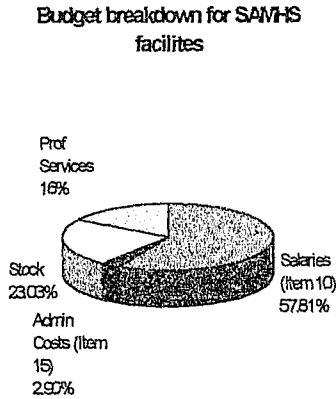
The breakdown per activity for the financial year 94/94 is as noted in table 4. This table indicates that:

- The biggest single item on the budget is dedicated to the SAMHS health facilities i.e. the hospitals, sickbays and MMCs.
- The support to the Correctional Services and the South African Police Services is for services rendered at SAMHS institutions, however payment is deposited directly to the state coffers.
- The medical continuation fund is the health insurance for retired members of the defence force who had contributed a nominal fee of R100 a month for a minimum of 10 years. The SAMHS supports this fund from its budget as the health care costs for retirees increases as they age.
- Operational duties refer to citizen force members who are deployed operationally.

The budget for the SAMHS health facilities can be further broken down as noted in table 5. The table indicates that the SAMHS spent more than half of its budget on salaries (see fig 3).

More than half of the personnel are supporting staff and not health professionals. The transformation process in the DoD will centralise common support functions like common logistics thereby reducing the duplication of support staff across the four arms of service.

Figure 3



Source: SAMHS Information System, 1997

The budget for the SAMHS stock can be broken down as in Table 6. This table shows that medical stock accounts for the largest single item accounting for 81% of the expenditure of this item.

The budget for professional services can be broken down as in table 7. Expenditure for private medical services accounts for 51% of the money spent for this item. Referral to private medical services occurs where SAMHS facilities or expertise are not available and in emergency situations.

Salaries, medical stock and private medical services are the cost drivers for the SAMHS budget. Measures directed at controlling these items can further reduce the cost of provision of health services by the SAMHS.

4.6 SAMHS Beneficiaries

Active uniformed members of the defence force and their dependants qualify for free health care from the SAMHS. Dependants of married women in uniform have recently

recently won a court case to have health coverage by the SAMHS. Retired members of the permanent force who had contributed R100 a month to the medical continuation fund for a minimum of ten years also qualify for free health care. There are an estimated 326,486 beneficiaries covered by the same (Estimate from figures from Department of Public Service and Admin, 1998).

4.7 Delivery Of Health Care Services

4.7.1 Nursing services

In the SAMHS, nurses form 50.1% of all health professionals. The ratio of nurses to patients in the 3 hospitals is 1:5 in general wards. Section 38A nurses are the main health care providers in sickbays and MMCs. The 1998 nursing statistics show that the SAMHS had a total of 1 565 nurses including student nurses of which 77% are uniformed and 13% are civilians i.e. 1 386 and 179 respectively. The number of nurses can be broken down into:

• Registered nurses	742
• Staff nurses	376
• Assistant nurses	110
• Student nurses	337
Total	1565

4.7.2 Medical doctors

The SAMHS report for the financial year 96/97 put the total number of medical doctors employed by the SAMHS at 491. These could be broken down into the following categories:

• Permanent Force	164
• Civilian Full time	118
• Post graduate trainees	<u>59</u>
Sub Total full time medical doctors	341

• Sessional doctors	<u>150</u>
Total	491

4.7.3 Ancillary health services

Ancillary health services comprise 10 statutory occupational groups which is broken down as follows:

• Occupational therapy	39
• Biokinetics	39
• Physiotherapy	46
• Medical technology	46
• Clinical technology	12
• Orthotics and Prosthetics	10
• Radiography	60
• Speech therapy and Audiology	10
• Optometry	0
• Podiatry	1

In the past three years, statistics for consultations by the SAMHS personnel were as noted in table 8. Consultations are done mainly by medical doctors and nurses.

Ancillary health workers also have consultations including psychologists and social workers. Medical officers are having more consultations than Sec 38 A nurses when it should have been the reverse, as nurses are supposed to screen patients before they are seen by medical doctors. The decline in the number of consultations by medical officers combined with an increase in the number of consultations by nurses and Operational Emergency Care Orderlies (OECOs) is an indication that principles of primary health care in terms of level of care are beginning to take root in the SAMHS.

The SAMHS report for 97 attributes the decline in ancillary workers consultations to financial constraints. The report concludes that “the impact of this is

- (1) a shortage of personnel
- (2) the imperative of the SAMS to concentrate on the provision of essential services, and
- (3) limiting service rendering to own facilities as far as possible.”

4.7.4 Hospitalisation

Statistics for hospitalisation in the SAMHS institutions in the past three years are as noted in table 9.

Surgical operations in the SAMHS in the same period were as noted in table 10.

Table 11 presents prescriptions issued in the SAMHS in the past two years. The pharmaceutical bill for pensioners is the highest for all categories. This will continue to increase even after the transformation process and reduction in the total DcD personnel as any Permanent Force member who had contributed to the medical continuation fund for a minimum of ten years is guaranteed health coverage by the SAMHS until death. The SAMHS had to support the medical continuation fund from its budget due to an increase in medical costs. In the year 1994/1995 this support from the SAMHS budget amounted to R25m.

The SAMHS expenditure on prescribed medicines amounted to 5.94% of the SAMHS expenditure for the year 1996/1997. The average items per prescriptions for the same year is 2.7. The SAMHS prescribing patterns are therefore within the accepted international standards. The savings and prescribing patterns however, can be further improved if a formulary of an essential drug list was to be adopted.

4.8 Analysis of SAMHS Services in Relation to Health Policy Objectives

4.8.1 Equity Issues

Equity in receipt of care -- the majority of facilities are located in the formerly white urban areas and thus are physically inaccessible to the majority of people, particularly families of defence force members living in townships and rural areas.

Secondly, the location of military facilities in the former bantustans was mainly for political reasons -- to give semblance of independence and not for security reasons. The rationalisation of Defence force facilities has resulted in the closure of many facilities, including health facilities. The closure of these health facilities, especially in the former bantustans impacts negatively on those dependants of the serving members who are in the main women and children.

Equity in financing of care: The SAMHS requires a permanent force member to contribute a monthly sum of R100 to the Medical Continuation Fund while employed. If payment has been made for a minimum of ten years the member and his/her dependants (including children up to 21) can continue to enjoy medical benefits. A permanent force member who terminates service before the mandatory ten years does not receive continued care nor does s/he receive compensation from the contributions due. In reality, therefore, a permanent force member who terminates services before ten years subsidises those who will continue with medical benefits. Those who work longer than the 10 years continue to subsidise those who terminate in their 10th year.

4.8.2 Efficiency Issues

Allocative Efficiency

SAMHS money which is from public revenues is directed into

- the provision of service (preventative as well as curative care)
- infrastructure (equipment purchased remains public property; e.g. R3.5million in 1995)
- knowledge and expertise (training of personnel, specialised services such as aviation and maritime medicine)

- national disaster operations and international peacekeeping efforts. The ability of military health services to mobilise at short notice with its skills in the handling of logistics and with support from the Air Force, Army and Navy has made them important role players in disaster situations even in countries where civilian disaster organisations are well established.

Technical efficiency

There is no optimal use of the SAMHS secondary and tertiary facilities as demonstrated by the percentage of bed occupancy in 1 Military Hospital. The adoption of some managed care principles in terms of referred patients to the private sector and the adoption of a forumulary will increase technical efficiency.

There is administrative infrastructure in place. During 1998, the financial section has been “demilitarised” and now reports directly to the Secretary of Defence in order to delink the section from direct military control. According to the previous Surgeon General, services to other government departments could be provided because of excess administrative capacity and because the service is located in all nine provinces (Interview, 1998)

4.8.3 Sustainability

There are concerns about the sustainability given the fact that currently SAMHS remains a service for mainly the military population and this population is declining given the ‘peace dividend’ in Southern Africa. This leads to facilities and services not being fully utilised thereby raising the unit costs of providing services in those facilities.

4.9 Conclusion

The South African Medical Health Services evolved out of a need to address health

issues of the military personnel in the country. The former SAMS was specifically influenced by the war in Southern Africa, particularly in Namibia and Angola. Future services will also be determined by the potential involvement in other countries in the sub-continent, particularly around peacekeeping operations which will include rendering services to the civilian populations.

Extensive resources have been invested in building up facilities and services throughout the country. Medical staff have been trained and provision has been planned for military personnel including retirement needs. The SAMHS approach has started to incorporate an increasing focus on primary health care and this has resulted in a changing deployment of personnel and greater dependence on nurses rather than doctors. Thus, the model reflects very much the priorities of the national health strategy.

Chapter 5 HEALTH CARE SERVICES FOR THE SOUTH AFRICAN POLICE SERVICES (SAPS) AND CORRECTIONAL SERVICES

5.1 Summary

The evolution of Polmed, the health insurance used for police members is reviewed. This chapter will also look at Medkor. Available data is presented and discussed and the general trends are analysed in relation to the health policy objectives of equity, efficiency, acceptability and sustainability.

5.2 Medical Services for the South African Police Services

5.2.1 Historical Background

Prior to 1981, members of the former South African Police (SAP) had primary health care services rendered by district surgeons. Secondary care was delivered mainly in state hospitals and in private hospitals. The Department of Health budgeted and paid for services delivered by district surgeons on a fee-for-service basis as well as for services provided at state hospitals. Services delivered at private hospitals were budgeted and paid for by the Department of Police. (Department of Public Services and Admin 1998).

This system ended in 1981 when Cabinet decided to start a health insurance scheme for members of the SAP and their families. Polmed Medical Aid Scheme was instituted with Medihelp as the administrators. This change in policy was attributed to the poor service rendered to the police by district surgeons and provincial hospitals (Department of Public Services and Admin, 1998). It is important to note that this change happened in the period when the district surgeon system was inundated with cases from the township violence that engulfed South Africa, beginning with the uprisings in Soweto 1976. It also coincided with the period identified by Price and de Beer when the then government clearly intended to encourage the expansion of the private health care sector. (Price and de Beer, 1989)

5.2.2 Polmed

Since 1981, delivery of primary health care services has mainly been through a network of independent private service providers. Service providers are remunerated on the scale of benefits rates (Department of Public Services and Admin 1998). In 1992 the police, faced with a shrinking budget, announced the cutting of certain privileges enjoyed by police members that included payment to police for medical services rendered when they were off duty. (*Beeld*, 01/04/92)

In 1994, after the first democratic elections, the South African Police Services [SAPS] was formed by the amalgamation of the former South African Police Force and the former homeland police forces. The South African Police Force's medical scheme Polmed as the largest medical scheme of the integrating forces was intended to absorb the increased membership. (Interview with member from Portfolio Committee on Safety and Security, 1998). This increased membership resulted in increased expenses (SAFSURE 1997).

In 1994, Medihelp attempted to contain costs by signing contracts with individual GPs for direct payment. This move was rejected by the providers (Polmed workshop 1997). Eventually a breakthrough in the deadlock between doctors and Medihelp was reached in 1995. A new contractual relationship was agreed upon. Medihelp no longer insisted on contracts before direct payments to the doctors. (*Beeld* 04/03/95).

SAFSURE on 1 April 1995 was appointed as the managed care consultants for Polmed. SAFSURE is a managed care consulting firm with links to the US-based Johnson & Johnson Health Management Institute. It was independent of the administrator (then Medihelp) and the corporate body -- Polmed itself.

A number of changes were introduced that included amongst others, Polmed being re-allocated from SAPS finance to SAPS human resources. There were also new budgeting procedures. In 1997 Polmed ended its 16 year association with Medihelp and Medscheme was appointed the new administrator after it had won a State Tender to administer Polmed.

A Polmed task team was appointed by the National Commissioner of Police in 1997 to identify various cost-cutting mechanisms over the short, medium and long term. The task team includes SAFSURE. Disease management programmes that included psychiatric care, cholesterol and HIV/AIDS were identified as part of the short-term actions for Polmed and asthma and diabetes as medium-term actions.

Overserving and underutilisation of services does not contribute to better health outcomes. Denying services to a member in order to raise a health care company's profits cannot be in the interest of the member. SAFSURE's proposal for gate-keeping through GPs will result in patients being denied treatment in order to increase profits.

Managed care when first introduced by Medihelp was not accepted by providers. Police Unions also added their voice during the Polmed workshop. As most medical aid schemes adopt managed care principles, health care providers are forced to accept managed care and the result will be a situation similar to the one described by Schiff in Chapter 2 of this report. (1996).

Notwithstanding the changes to Polmed, with SAFSURE as managed care consultants and Medscheme as the administrators, the budgetary challenges facing the medical scheme continued.

Polmed's expenditure exceeded the amount awarded as can be seen in Table 12. The difference continues to grow each year.

Table 12
Polmed's Amount Awarded and Expenditure 94/95, 95/96 and 96/97

Year	Amount Awarded ¹ Rm	Expenditure in Rm ²	Difference in Rm
94/95	702	711.4	-9.4
95/96	966.1	981.8	-15.7
96/97	1025.4	1044.6	-19.2

Source: 1. Department of Public Service and Admin

2. SAFSURE

Membership. The membership of Polmed has also been increasing over the years without corresponding provision for the membership increases. In 1994 an extra ± 7500 members were added to the Polmed Medical Scheme consisting of 1500 pensioners and 6000 married women.

The largest increases were in 1995 with 20,400 new police members and 600 civilians joining Polmed after the amalgamation of all the Police forces that had existed in the country. During the apartheid era, the members of the homeland police forces belonged to Bonitas Medical Aid Scheme because they were not allowed to join Polmed. Most of the members opted to remain with Bonitas after the formation of SAPS in 1994. By 1997, Bonitas was owed about R24 million which they claimed from the SAPS. The SAP deducted the contributions from the salaries of the members concerned as the new regulations stipulated that all had to belong to Polmed. The Police affected were not keen to join Polmed as they argued that it was "financially embattled" (*The Saturday Star*, 21/06/97) but by 1997, 8000 members from Bonitas, Polprised and Hosmed became members of Polmed. By the end of 1997, the Police Services consisted of 136,448 members. A member of the Portfolio

Committee on Safety and Security indicated that many members from the former KwaZulu homeland are refusing to join Polmed as their present medical scheme includes non-health benefits like burial insurance. (Interview 1998).

When Medscheme began administering Polmed, it created a new database and re-registered members. During this process, about 10,000 members who were getting benefits from Polmed could not be traced. There was also close monitoring of claims profiles by service providers. Another strategy by SAFSURE to reduce costs has been to educate members about medical schemes. There are an estimated 376,148 beneficiaries in Polmed (Estimates based on figures from the Department of Public Service and Admin, 98).

General Practitioners. The proportion of expenditure to GPs by Polmed is high. This underscores the need for strict control of expenditure for this category of providers. SAFSURE unlike Medihelp which contracted to individual GPs proposes contracting with networks of GPs as a means of cost cutting: a pilot project has been instituted in the Cape. The contracted GPs will give a 15% discount on medicines. SAFSURE also intends to redefine chronic medication programme (SAFSURE Report, 1997).

Table 13 Proportionate Utilisation / Expenditure by Polmed 1996/97

	Expenditure R'000	Percentage of Total
G.P.	321,450	31.1%
Specialists	166,091	15.9%
Dental	82,523	7.9%
Hospital	265,328	25.4%
Medicine	130,575	12.5%
Optometry	29,249	2.8%
Auxiliary	47,007	4.5%

Source: Report on Polmed Workshop, Appendix B "Presentation by Safsure"

Hospitals. Hospitals expenditure constitutes the second largest cost to Polmed with almost the same proportion of expenditure as in the general private insurance industry.

It should be noted that the Polmed figures do not differentiate between private and public hospitals. According to data collected in 1992 by Valentine and McIntyre (1994) on Polmed, Transmed and Medkor, only 3.8% of the total of 26.9% expenditure to hospitals went to public hospitals. It is clear that the majority of funds spent by private medical schemes on hospital care is directed towards private rather than public hospitals.

The SAFSURE plan for controlling hospital costs consists of auditing accounts, pre-certification programmes and disease management.

Specialists. Specialists account for 15% of the expenditure. In order to contain costs SAFSURE's plan is to have gate-keeping through GP networks. (SAFSURE Report 1997). This follows the trend used in other managed care situations (Gipe 1994).

5.3 Analysis of SAPS services in relation to Health Policy Objectives

5.3.1 Equity Issues

Equity in access.

Currently access related to income is generally equitable. Polmed introduced co-payments in the late 1980s for non-work related health problems but the payments are currently low -- R10 for each consultation and 10% of each prescription. These fees are not a deterrent to excess use of health care facilities and services. Safsure has recommended that co-payment fees be raised. If a substantially higher flat rate is

were to be introduced, lower-paid members would be discriminated against and this would likely raise issues of the acceptability of Polmed as the health carer.

This issue is inherent in private health insurance schemes and high co-payments inevitably have adverse effects on equity. Participants in the Interregional Consultation in Health Insurance Reform held in the Republic of Korea in 1995 noted that equity impacts of health insurance are of two types: equity in financing and equity in the provision of services. While the impact on efficiency varies, there are predictable patterns that depend on the way providers, particularly doctors, are paid. Experience of participants points to the fact that where providers are paid on a fee-for-service basis, costs are high and constantly increasing as providers over charge and some are prone to fraud. The participants observed that “it seems virtually impossible to prevent some perverse incentives arising from a fee-for-service payment system”.

The structure of Polmed was conducive to abuse as members did not contribute financially and were entitled to receive unlimited free medical care from any medical practitioner of their choice. By the mid 1980s, allegations of fraud by service providers against Polmed had already surfaced. A pharmacist was alleged to have committed fraud against Polmed between 1984 and 1985. He successfully appealed against the conviction by a lower court in the Cape High Court in 1988 (Die Burger, 14/07/88).

Allegations of fraud by some members of the SAP and some health care providers has continued to plague Polmed. Examples of fraudulent cases are given in a report to the press by the national police human resources management spokesman, Strini Govender, as reported in the *Sunday Argus*, May 24/25 1997. SAFSURE (1997) presents examples of a Durban optometrist who prescribed 10 spectacles to a family of five in two weeks.

Co-payments for certain benefits is proposed by SAFSURE (1997) as a solution to this problem as it attempts to contain patients' demands. Raising user payments in Polmed, however, would ultimately have a negative impact on access because members would have to pay the increased costs out of their own pocket.

The SAPS model, however, does ensure geographical accessibility to service. The members of the police services are to be found in almost every part of the country and they can be catered for because of Polmed's reliance on GPs in rural areas and townships for primary care. Police members and their families based in urban centres, however, have access to more health workers than their rural counterparts. This is due to the fact that most health workers are based in urban areas (South African Health review, 1996).

Issues of access related to gender, ethnicity, age need to be studied in more detail to determine the impact of the SAPS model. In terms of gender, wives living in rural areas and townships do have access to health care through the use of private GPs.

5.3.2 Acceptability / Quality of care

No direct statistics are available; nor was a survey of members undertaken for this paper. The numerous examples of fraud that have been uncovered, however, suggest that there are incidents of procedures being undertaken for profit not related to the need of the patient. As an example a KwaZulu general practitioner does routine sonars of the eye. He justifies the practice by saying that he receives too little money for ordinary consultation (SAFSURE, 1997).

5.3.3 Efficiency Issues

Allocative Efficiency

SAPS contributes through Polmed over R1 billion from state revenues to the private health care sector. This is strictly for fee-for-service payments and does not include any investment in infrastructure etc. The focus is on curative and not preventative services (Any preventative measures such as annual pap smears are done purely on the initiative of the individual GP) and as can be seen from the critique of for-profit services, many procedures are actively discouraged.

Efficiency -- technical

No figures are available on unit costs. There are, however, administrative costs to SAFSURE as the managed care insurance consultant and to Medscheme as administrator. This is paid on a capitation (or amount per member) basis.

5.3.4 Sustainability

This is an issue for SAPS due to declining budgets, increasing membership and spiralling private sector health care costs. An additional area of concern is the cost of providing health care to pensioners. Polmed does provide this service but at a cost of R1.26 billion [SAFSURE quotation]. Generally pensioner care is very costly and this greatly affects sustainability.

An option to balance income and expenditure is to raise the level of co-payment rates. Although this will affect equity in financing issues, it should be mentioned that raising fees is part of international managed care model to try and control demand. Figures show, however, that this move didn't reduce usage by Polmed members. Personal experience as a GP in the townships has shown that the Polmed members refuse to pay their portion and demand that practitioners reclaim the full amount by adding extra charges to claims.

Another option to contain costs is to closely monitor the claims by providers and investigate high claims as proposed by Safsure and Medscheme. The problem here is

the difficulty in achieving convictions given the reluctance of users to corroborate the claims against the owners. This relates to the issue of moral hazard related to private health insurance -- the patients feel entitled to unlimited use of health care services once their fees are paid.

While Polmed is not for-profit health insurance, the consultants, SAFSURE, and the administrators, Medscheme, are for-profit organisations. The need to save on costs for Polmed is fulfilled through the use of strategies applied in for profit managed care organisations. Given, however, that the recommendations by SAFSURE and implemented by Medscheme have not fundamentally reduced the problems faced by Polmed, it is necessary to question how long Polmed can survive in its present form. SAFSURE (1997) believes Polmed is a viable medical scheme provided it implements managed health care principles. Business against crime (1997) also believes given time through managed health care principles Polmed will survive.

Although the model ensures greater geographic access to its members, the model is unable to deliver in terms of equity and efficiency when discussed in the broader context of managed health care models. The trend indicates an ever-increasing spiral of costs that does not appear able to be contained.

5.4 Medkor

Medkor was established in 1980 to provide health cover for members of the Correctional Services. Cabinet approved that the serving or retired members of Correctional Services and their dependants would not contribute to the medical scheme as the scheme will be funded entirely from state coffers (Dept of Public Service and Admin, 1998).

Delivery of service is through any registered medical practitioner. Members pay the first R10 per consultation at the point of service and an extra 10% per prescription (Department of Public Service and Admin, 1998). The total number of participants in the Medkor is 28,725 with an estimated 91,446 beneficiaries. (Dept of Public Service and Admin, 1998).

5.4.1 Budget

The budget for Medkor for the years 1995/96 and 1996/97 increased by 26% and 18% respectively.

Table 14 Budget for Correctional Services

Financial Year	Budget	% Increase
1994/95	190 453 307	
1995/96	257 738 989	26%
1996/97	317 789 592	18%

Source: Dept of Public Service and Admin (1998)

Prisoners are catered for by a number of health professionals. Van Heerden (1995: 346) points out that “district surgeons never challenged the notion that doctors who work in prisons were subject to clearance by the security police, at least, apparently, until 1992 ... This raises serious questions about the independence of district surgeons and their declared allegiance to prisoner-patients. Doctors will need to assess the ethical implications of these past actions and omissions if they wish to build a strong code of moral conduct for future prison health care.”

Hospitalisation of prisoners is mainly in private hospitals. Private health care for prisoners was estimated at over R9 million per annum (National Assembly Portfolio Committee on Health, 1996).

5.4.2 Containment of Costs

In an attempt to contain costs, MEDKOR has instituted the following measures:

Consultations:

- are restricted to a total of 12 consultations per year per person
- a R10 payment by the member per consultation

Prescriptions:

- a 10% extra payment per prescription with a minimum of R5 per prescription by the member
- contract with Medicredit which is 20% cheaper per script than general pharmacies
- a list of disapproved items like cosmetics was updated

Dental:

- contract with Mobident -- a dental group that gives a 15% discount on the RAMS scale of benefit tariff
- a restriction of R6000 per financial year placed on certain dental work

Opticians:

- contract with networks of opticians to give a 20% discount on scale of benefit tariffs

Hospitalisation:

- no member is allowed to make use of private hospitals
- contracts have been entered into with private hospitals which levy only scale of benefit tariff
- members encouraged to make use of military hospitals

General:

- managed health care principles applied to chronically ill patients
- investigation into abuse/fraud carried out against providers and members. Several service contracts with providers have been suspended. Rules of MEDKOR now provide that a member who abuses the medical scheme will have benefits suspended

Medkor, like Polmed, is faced with large increases that affect the private health sector. In an attempt to contain costs managed health care principles have been introduced. The same results as has been analysed for Polmed can be expected.

Cachalia (National Assembly Portfolio Committee on Health, 1996) describes as outrageous the cost of private health care to prisoners. Prisoner health care, however, is part of a wider problem. As pointed out by Van Heerden (1995), the “White Paper on Correctional Services in the new South Africa ... deals mainly with general aspects of prison management and, as in the past, fails to identify several matters of medical concern”. She calls for the professionals and the Department of Health to relook at health care for prisoners.

5.5 Conclusion

Private health insurance for the Police and Correctional services has been rising in keeping with the spiralling of health costs in the private health care sector. Many of the issues confronting the Polmed health insurance scheme mirror the broader problems confronting the private health care sector.

Geographic access is the most important benefit of delivery of health care services to members of the Dept of Safety and Security and Correctional Services.

Managed care is seen as a solution to private health care. Experience from the United States points to flaws in a number of assumptions made by the managed health care model.

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Chapter 6 INTERPRETATION AND RECOMMENDATIONS

6.1 Summary

In this chapter, a general comparison of the expenditure of the two services is done and the differing impact on health policy objectives between the SAMHS and SAPS approaches to providing medical care is summarised in table format. Thereafter general conclusions are drawn and a policy framework is proposed to build on the strengths of each model. Further obstructions are identified that will also have to be addressed for the policy to be successfully implemented.

6.2 Comparison of Expenditure

Comparison of expenditure per beneficiary for the year 1996/97 shows no difference between the SAMHS and Polmed expenditures. While the SAMHS expenditure will be higher due to costs budgeted by other Departments (e.g. Department of Public Works constructs and maintains government building), the SAMHS remains an asset to the State due to other activities that it carries out and are difficult to quantify (e.g. readiness to participate in disaster situations).

Table 15

Comparison of expenditure per Beneficiary fin year 1996/97

Service	Estimated Beneficiaries	Total Expenditure in R million	expenditure per beneficiary
Polmed	376 148	1044.6	2800
SAMHS	326 486	873 111	2700

6.3 Comparative Impact on Health Care Objectives

The different provision of services by DOD and Safety and Security Departments is reviewed against the achievement of public health objectives and conclusions are drawn on the appropriateness of each approach. This is summarised in Table 16.

Table 16
Impact on Health Care Objectives: Comparison of SAMHS and SAPS
Approaches

Policy Objective	SAMHS Approach	SAPS Approach	Conclusions
Equity in Access			
1. Income	<p>Small monthly fee to the Medical Continuation Fund for a minimum of 10 years.</p> <p><i>Strength</i> -- Fee has minimum impact on user's income.</p> <p><i>Weakness</i> --- a. When member stops working for SANDF prior to 10 years' service, contributions are lost. b. Potential inequitable impact on income if contributions are raised and everyone pays the same contribution.</p>	<p>No fee but small co-payment required at the point of service</p> <p><i>Strength</i> -- The co-payment up until now has remained very small</p> <p><i>Weakness</i> --- a. Co-payment at the point of service adversely affects households with the lowest income. b. Raising of co-payments to curb abuse will adversely affect members with low incomes.</p>	<p>Overall, SAMHS provides the greatest potential for equity in access related to income. Due to the uncontrolled spiralling of costs in private health care sector, there could be a continual raising of co-payment levels. Increased contributions under SAMHS could be more controlled.</p>
2. Geography	<p>Facilities only in areas where the SANDF have units.</p> <p><i>Strength</i> -- Facilities always accessible to principal member even in the most remote areas.</p> <p><i>Weakness</i> -- Historical distribution of facilities means that the facilities are not accessible to the majority of the disadvantaged population. Some</p>	<p>Private practitioners all over the country can be used</p> <p><i>Strength</i> -- There are more facilities available in most areas and to most communities.</p> <p><i>Weakness</i> -- There are not enough medical practitioners in rural areas while there is an over supply in the urban areas</p>	<p>Overall, SAPS provides better geographic access</p>

Policy Objective	SAMHS Approach	SAPS Approach	Conclusions
	current facilities are also being closed		
3. Gender and Age	<p>Dependants of serving members majority of which are women and children living far from SAMHS facilities receive no special arrangement.</p> <p><i>Strength</i> -- Coverage is available for spouses and children without having to pay.</p> <p><i>Weakness</i> -- Members and dependants are restricted to available facilities which are not readily available to the majority of disadvantaged communities</p>	<p>Dependants of serving members receive care where private practitioners are available.</p> <p><i>Strength</i> -- Access to health services is more accessible throughout most disadvantaged communities.</p> <p><i>Weakness</i> -- Cost of co-payment fee for low income households can be high, particularly for rural communities</p>	Overall, SAPS provides greater access to women and children.
Efficiency			
1. Allocative	<p>SAMHS is a public sector organisation; thus, all funds allocated remain in the public domain.</p> <p><i>Strength</i> -- The investment helps to build much needed infrastructure and expertise in the public sector as well as provide direct services.</p> <p><i>Weakness</i> -- Currently, only SANDF members and their families have access to these services.</p>	<p>The entire SAPS budget is used to buy services medical from the private sector.</p> <p><i>Strength</i>--By outsourcing medical services the SAPS can attend to its core function more efficiently.</p> <p><i>Weakness</i> -- Funds are drained away on a fee-for-service basis to the private health care sector which caters for a small percentage of the overall South African population</p>	SAMHS contributes more to allocative efficiency in the country because resources are kept in the public sector, which then caters for the majority of the people.
2. Technical	Members are attended to mainly at SAMHS	No data available on unit costs.	Despite the overall efficiency of individual private sector

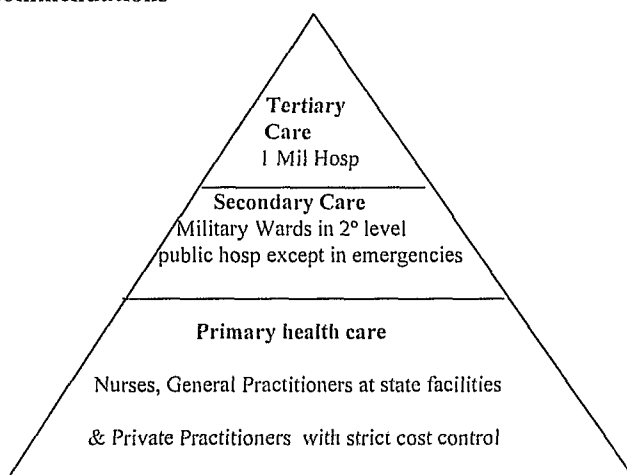
Policy Objective	SAMHS Approach	SAPS Approach	Conclusions
	<p>facilities</p> <p><i>Strength</i> -- There is potential technical efficiency if infrastructure and resources are used by greater numbers of people.</p> <p><i>Weakness</i> -- There is current low technical efficiency given the underutilisation of available facilities</p>	<p><i>Strength</i> -- Some research, however, [e.g. Broomberg & Mills (1998)] has indicated that private sector hospitals do have lower unit costs.</p> <p><i>Weakness</i> -- The same researchers [Broomberg & Mills (1998)] also noted that governments find that given contract costs, there is no overall saving.</p>	<p>hospitals, the benefits do not accrue to the government when outsourcing these services. If SAMHS could increase its utilisation of available facilities, its unit costs would decrease thereby increasing the allocative efficiency of its units.</p>
3. Administrative	<p>The SAMHS is a national organisation which has regional representation along provincial lines.</p> <p><i>Strength</i> -- The administrative infrastructure is in place to administer the system.</p> <p><i>Weakness</i> -- The infrastructure is under-utilised and thus costly.</p>	<p>Medical care is administered by a private medical administration company</p> <p><i>Strength</i> -- By outsourcing the administrative functions, private sector institutions can concentrate on their core functions of providing medical care.</p> <p><i>Weakness</i> -- There is no control over administrative costs as they are the responsibility of a third party.</p>	<p>Overall, SAMHS has greater administrative efficiency</p>
Acceptability	<p>Most providers join the SAMHS to further their careers.. No research was done to test acceptability by users</p> <p><i>Strength</i> -- For</p>	<p>Providers are presently faced with uncertainty due to changes in legislation and the advent of managed care.</p> <p><i>Strength</i> -- At primary</p>	<p>No conclusive evidence on acceptability was collected; however, the SAPS approach can be assumed to be more acceptable to users because there is more choice than with the SAMHS approach. On the other hand, the SAMHS</p>

Policy Objective	SAMHS Approach	SAPS Approach	Conclusions
	<p>providers, there is a guarantee of employment and contracts including opportunities for furthering their careers.</p> <p><i>Weakness</i> -- No choice is available for receivers of care and this can result in problems of acceptability</p>	<p>care level there is increased user acceptability to receivers of care because they can go to their GP of choice.</p> <p><i>Weakness</i> -- With increased use of the managed care option, this is now being restricted to a specified network of GPs. There is also increased insecurity for individual health providers in the private health sector.</p>	<p>approach appears to be more acceptable to the providers given the security of employment and career prospects.</p>
Sustainability	<p>Despite budget cuts the SAMHS budget is still guaranteed.</p> <p><i>Strength</i> -- Improvement in the numbers of users will increase sustainability.</p> <p><i>Weakness</i> -- Presently the SAMHS faces declining budgets and declining membership which increases costs of running the service.</p>	<p>The government still provides the SAPS budget for medical care although the amount provided is less than the amount requested.</p> <p><i>Strength</i> -- Currently, Government is committed to providing SAPS budget for health care.</p> <p><i>Weakness</i> -- SAPS faces ever-increasing private health care sector costs over which it has no control.</p>	<p>With the current structures and modalities, the long-term sustainability of both approaches is in question. However, SAMHS has the potential to achieve real sustainability if it can increase its number of users.</p>

The strengths of the SAPS approach is greater geographical access and choice for recipients of care at the primary care level. SAMHS strengths include greater equity in access in relation to income, greater allocative and administrative efficiency.

Although the private sector hospitals that are used for secondary and tertiary level care operate at greater technical efficiency, the contract costs in using these facilities is likely to be high. If access to SAMHS facilities were broadened so that optimal bed occupancy rates were achieved, their technical efficiency would also improve. This would also maximise the allocative efficiency of the SAMHS given that all other objectives except sustainability were also in place.

6.4 Recommendations



It is recommended that a policy on DoD, Security and Safety and Correctional Services health care reform encompass the following elements:

Decentralisation of primary care through a network of private GPs

Amalgamate the SAPS and DoD health care provision so that the base consists of in-house primary health care nurses and clinics where the concentration of users is sufficient to support a sustainable service. Where there is not a sufficient concentration, a network of private GPs should be contracted to work at the primary care level.

Elimination of the use of private medical aid administrators

Medscheme acts as a costly 'middleman'. Use the administrative and financial infrastructure of the SAMHS to administer the health service along public sector health insurance lines.

Centralisation of secondary and tertiary level care

Concentrate these levels of service in SAMHS facilities except for exceptional cases; i.e. emergencies. The two military hospitals in Bloemfontein and Cape Town should be closed as they cannot provide secondary level care for all the members of the three departments in the country. Secondary level hospital wards should be built adjacent to secondary level hospitals in all the provinces. This will ensure that expertise and equipment already available in the Provinces are not duplicated in the SAMHS facilities. The SAMHS will be able to tap on to existing Ministry of Health's (MOH) public health expertise and infrastructure and the same will be true for the (MOH). Security for hospitalised prisoners will be adequately dealt with by the SAMHS in these wards.

Tertiary care will be provided at 1 Military Hospital in Pretoria as is the case at present.

Strict control of costs

Control of costs relating to payments to private GPs should be strictly monitored. It is essential to build in community participation into the model by having continuous dialogue between the receivers, providers and administrators of the health care system. This is needed in order to develop a sustainable service for the security services.

Contributions for Dependents.

It is recommended that serving members should contribute for the health coverage of their dependants.

6.5 Impact of the recommendations on Public Health Objectives

6.5.1 Equity issues

Access related to *income* will not be an issue for all serving members as they will not pay for their health coverage. Contributions for health coverage of dependants, and retired or discharged members will have to be calculated on an equitable basis depending on one's income. There will need to be further studies on how much money will be raised by these contributions for decisions to be taken on its usage.

This recommendation may be strongly resisted by members of the three departments as the practice of non contributions is seen as part of the employment benefits. The participation of the employees and their organisations in the decision making process will help to avoid costly industrial disputes that may arise from such a decision.

Geographic access for dependants of members of the Defence Force will be increased particularly in those rural areas where GPs are available and sickbays are not viable. This is important mainly of *women* and *children* who live in rural areas. Geographic access for primary health care services for members of the Departments of Safety and Security and Correctional Services will not be affected.

6.5.2 Acceptability / Quality of care

The acceptability or quality of care of these recommendations to the employees and providers will need to be researched further. The loss of 'hotel services' provided in private hospitals for Polmed and Medkor members may become an issue for

contention by those members. Again full participation by the members in the decisions taken will be crucial.

6.5.3 Efficiency Issues

The recommended approach places an appropriate public-private sector mix in the delivery of health care services in the three departments contributing to the overall *allocative efficiency* in the health care sector.

The increase in the utilisation of the SAMHS facilities will contribute to *technical efficiency*. The provision of secondary care in SAMHS facilities will contribute to the efficiency of funds allocated for health coverage of health care services to members of the Departments of Safety and Security and Correctional Services.

6.5.4 Sustainability

The pooling of the present health budgets for the DOD, Departments of Safety and Security and Correctional Services combined with changes in the health care delivery system will ensure sustainability of the health care programmes of these departments.

6.6 Additional Issues

Apart from the logical reasoning of the model that has been presented, it is imperative that the country maintain at all times a well-trained military health service capable of supporting military operations. In between periods of conflict, the facilities and personnel need to be put to productive use for the benefit of the whole country. Thus this proposed model best meets this obligation.

6.7 Obstacles to Implementing this Reform

Thomason (1997) points out that the problem with implementation of health sector reforms has been that analysts assume that when presented with a rational tool that:

1. governments will adopt recommended policies,

2. institutional capacity exists to implement the reforms,
3. communities will want to use the proposed package of services, and
4. the reforms will achieve the objectives they were designed to achieve.

The implication of this policy will depend largely on the political will and the respective departments. It is beyond the scope of this paper to be able to comment definitely on this issue.

The non-involvement of the members and providers will also result in non-acceptance thereby negatively affecting implementation.

6.8 Conclusion

The South African Medical Health Services evolved out of a need to address health issues of the military personnel in the country. The SAMS was specifically influenced by the war in Southern Africa, particularly in Namibia and Angola. Future services will also be determined by the potential involvement in other countries in the sub-continent, particularly around peacekeeping operations which will include rendering services to the civilian populations.

Extensive resources have been invested in building up facilities and services throughout the country. Medical staff have been trained and provision has been planned for military personnel including retirement needs. The SAMHS approach has started to incorporate an increasing focus on primary health care and this has resulted in a changing deployment of personnel and greater dependence on nurses rather than doctors. Thus, the model reflects very much the priorities of the national health strategy.

The facilities and services are not fully utilised, however, and benefits could be maximised by opening up the facilities more to the public health services in the country such as has been discussed earlier in the paper.

Chapter 7 Conclusions

7.1 Conclusions

This paper is an initial research into health care provisioning by the public and private sectors in the South African setting. Two services (SAMHS and SAPS) were reviewed in depth in order to give greater insight into the issues confronting both sectors.

The services' background, structure and functions were described in detail. Their performance was analysed, particularly as it impacts on health policy objectives of equity, efficiency, acceptability and sustainability. The analysis clearly shows that neither approach is currently meeting all health policy objectives.

SAPS' dependence on private GPs provides greater geographic and gender/age access to its members, particularly to those living in disadvantaged communities in rural areas because SAMHS facilities are heavily concentrated in formerly white areas. At the same time, SAPS members are in danger of facing ever-increasing co-payments in the face of spiralling private sector health costs.

Overall, allocative efficiency of SAMHS is greater given the retention of facilities in the public sector. The efficiency of its institutions could increase if overall utilisation of facilities increased. Individual private sector institutions currently tend to operate with greater levels of efficiency; however, the overall cost to government of using the facilities through payment of private medical aid schemes means that the saving does not accrue to government. SAMHS has the infrastructure in place to administer health provision along public sector lines, particularly at the secondary and tertiary levels.

No conclusive evidence was presented about acceptability of services because no stakeholder surveys were undertaken. A general analysis of acceptability, however, suggests that while the SAPS model offers greater choice, and by inference greater acceptability, to users, the SAMHS model provides greater employment security and career development prospects for health providers. This highlights the need to develop new models with the active participation of stakeholders.

Currently neither approach is sustainable: SAMHS facilities are under-utilised and concentrated in certain geographical areas while SAPS faces ever increasing medical scheme costs.

This report proposes a system of health care provision for members of the Departments of Defence, Safety and Security and Correctional Services based on a model with three levels of care along with a strict referral process in order to meet objectives of public health policy. This particular model will build on the strengths of both the public and private sector. Members of the Defence Force, Safety and Security and Correctional Services Departments will have to be active participants in the proposed system including making contributions to the health care of their dependants.

Cost containment of the services delivered by the private sector is crucial, without which sustainable services cannot be provided. At the same time the managerial capacity of the public sector (SAMHS) should be strengthened for more efficient delivery of services.

7.2 Additional Recommendations

This study has highlighted the issue of access to information. The two services studied were considered part of the security community by the previous government (van Heerden, 1995). This resulted in any information related to the departments

being classified information and therefore not readily available. It is in the interest of open democracy, better governance and effective policy-making for analysts and researchers to be able to access this information. Health care for non operational members is of public interest.

Additional research is needed to quantify the costs of health care provisioning by the DOD that will include the cost of building construction and maintenance. The lessons learned will be vital for the overall health sector reforms by providing a more detailed insight into what is feasible and what is desirable.

This research report has also highlighted a need for further research into issues around policy implementation processes. Although concern from different quarters has been raised about health care provisioning in the departments mentioned (for instance, the investigation by Department of Public Service and Administration 1998, the Polmed workshop, discussions between SAMHS, Correctional Services and SAPS and concerns raised by the Portfolio Committee on Safety and Security about Polmed) no major changes have been implemented in the health care funding and provisioning for the three departments.

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APPENDIX

TABLES

Table 1. Distribution of SAMHS public health facilities

Facility	WP	Natal	OFS	Gauteng	EP	ETVL	FN	NC	NW	Total
Hospital	1		1	1						3
MBH	1						2		2	5
Sickbay	4	6	2	5	2	4	4	6	1	34
MMC	7	2	7	17	2		3	2	3	43
MPH				1						1
IAM				1						1
IMM	1									1
TOTAL	14	8	10	25	4	4	9	8	6	

Source: Epidemiology Department, SAMHS HQ 1997

Table 2 Reduction in military health facilities

Year	WP	Natal	OFS	Gauteng	EP	ETVL	FN	NC	NW
1996	17	8	11	27	11	4	13	9	12
1997	14	8	10	20	4	4	9	8	6
% Difference	18	-	9	26	36	-	31	11	50

Source: Epidemiology Department, SAMHS HQ, 97

Table 4 Breakdown of expenditure per Departmental activity

Activity	Amount in R million
SAMHS health facilities	590.2
Correctional and Police Services	5
Support for Med Cont Fund	25
Operational duties	1
Maritime Med Services	1
Aviation Med	2
Total	624.2

Table 5 Budget for SAMHS health facilities.

Activity	Amount in R'000
Salaries (item 10)	359000
Admin costs (item 15)	18000
Stock (item 20)	116200
Professional Services (item 35)	97000
Total	590200

Table 6 SAMHS Stock

Stock (Item 20)	Cost in R million
Medical Stock	R 94
Transport	R 9
Clothing	R 6
Photocopiers rental	R1.5
Fuel	R 2
Medical gases	R 1.7
Construction Material	R 2
Total	R 116.2

Source: SAMHS Information System, 1997

Table 7 Breakdown of SAMHS Professional services budget

Professional services (Item 35)	Cost in R million
Private Medical Services	R 49.5
Computer Services	R 38
Vehicle Maintenance	R 6
Med Equip Maintenance	R 3.5
Total	R 97.00

Source: SAMHS Information System, 1997

Table 8 Statistics for consultations by SAMHS personnel

Service provider	Consultations in 94/95	Consultations in 95/96	Consultations in 96/97
Medical Officers	572 186	589 373	579 722
Specialists	98 993	88 156	92 546
Sec 38 A nurses	330 584	377 397	426 025
OECOs	62 647	65 044	95 207
Ancillary workers	141 418	119 545	114 110

Source: SAMHS Information System, 1997

Table 9 Statistics for hospitalisation in SAMHS institutions

	Fiscal year 94/95	Fiscal year 95/96	Fiscal year 96/97
No of in-patient days	176 222.19	173 194.38	177 991.88
Ave. in patient days	4.7	4.7	4.8
No of Lab tests	444 156	813 294	827 532
No of x ray exposures	287 920	293 982	279 550

Source: DOD Annual Report FY 94/95, 95/96 and 97

Table 10 Statistics for surgical operations in SAMHS

	Fiscal year 94/95	Fiscal year 95/96	Fiscal year 96/97
No of operations	14 584	13 767	14 832
Operations per duration			
< 30 min	8 188	7 779	8 458
Between 30-60 min	3 934	3 657	3 954
Between 60-80 min	950	892	932
> 80 min	1 512	1 439	1 488

Source: DOD Annual Report FY 94/95, 95/96 and 97

Table 11 Prescriptions Issued in SAMHS

	1995/1996		1996/1997		Cost of pres items
	No of pres	No of pres items	No of pres	No of pres items	
Permanent Force	464579	1134148	481895	1196136	16137124.92
National Service	1899	4206	1776	3993	37884.88
Citizen Force	9216	22372	7973	20070	270134.12
Auxiliary fighting force	103	222	75	164	2583.66
Aux Non fighting force	3750	9769	2299	6102	85038.39
Volunteers	14626	34606	7864	18818	215805.74
Dependants (PF members)	318677	822258	299299	767784	12245233.33
Vp (pensioners)	190639	665476	232688	781007	20801324.11
Police Services	3376	8103	2656	6333	137307.20
Civilians	1521	4136	4092	10247	176211.06
Peace Keeping Force	38	85	5	10	81.04
Correctional Services	520	1262	633	1455	42614.41
Other (Attaches, VIPs)	38530	95771	43370	121129	1768609.85
Total	1047474	2802414	1084625	2933248	51919952.71

Source: SAMHS Information System, 1997

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