Does the 'power of the purse' influence the fair distribution of limited resources?

While Taylor and Burns (p. 175, this issue)[1] eloquently describe the objectives of the current legislative reform process, the solutions offered are based largely on existing paradigms. Despite similar approaches, above-CPI increases in medical scheme contributions have been the trend. So-called low-cost products have also been introduced, but have failed to make inroads into the expansion of the private health care market. In fact, the total insured population has decreased over the last year,[2] meaning that growth in these products is likely to have been due to migration of existing members of medical schemes, rather than to attraction of new members.

Suggesting that the private sector has failed poorer and sicker members is not entirely fair because the major portion of the costs associated with health care in the private sector is still borne by the members themselves, despite the tax subsidisation. Patients purchase the care they receive using their own money and by exercising at least some degree of choice. However, the authors' comment that medical schemes are rapidly becoming unaffordable and therefore increasingly inaccessible is valid, but this applies to the distribution of the full-contribution rand and not only the portions spent on the actual delivery of health care. In recent years non-health care costs, which exclude the costs of the increased administrative burden at the point of service, have been one of the main contributors to medical inflation.

The notion of a basic health care package is critical in providing access to care for the greater population and should be supported by the entire industry. However, care should be taken not to throw the proverbial baby out with the bath water by adopting an all-or-nothing approach. For example, there may well be room for re-introduction of standard insurance principles where patients, or consumers, exercise a choice to purchase more than the basic package. Similarly, the definition of affordability should be limited to the cost of the basic health care package and not include what patients elect to purchase in addition to such a package.

Serious consideration should be given to redefining the basic health care package in terms of services, rather than diagnoses. This will not only start to address the debate around the inclusion or non-inclusion of certain diagnoses, but also create a larger focus on preventive as opposed to curative care. For obvious reasons the latter is more costly, and lifestyle-related illnesses in particular have repeatedly been reported as major cost drivers in the medical scheme environment. By the same token HIV/AIDS, for example, should be regarded as a preventable disease.

It is agreed that alternative reimbursement models should form part of the solutions to future health care delivery. However, care should be taken not to create the same pitfalls encountered after the advent of personal savings accounts and day-to-day benefit options by inappropriately allocating risks to parties unable to manage or accept such risks. On the other hand, doctors can share in some of the risks associated with practising their profession, which means that greater consideration should be given to the development of inclusive fee structures, as opposed to global fees. Such fee structures should also empower doctors to decide on the deployment of scarce resources and/or new technology and to make their own clinical decisions without the intervention of clinical risk management programmes, which in more instances than not focus on reimbursement decisions rather than actual clinical interventions. This will obviate the need for managed care organisations, rather than the profession, to develop clinical standards.

It is debatable whether the introduction of prescribed minimum benefits (PMBs) has in fact decreased the burden on public sector resources, mainly because in terms of the Regulations to the Medical Schemes Act 131 of 1998 designated service providers can be identified as opposed to being formally contracted by medical schemes. Hence, a number of schemes are offering limited benefits with regard to PMBs in the private sector, whereafter members have to access further benefits from the public sector, regardless of whether the required resources are available. The net effect of this is the same as the erstwhile dumping of patients, and the future use of public sector facilities will have to take place on a more formalised basis.

Finally, participation in the debate by all stakeholders is unequivocally supported, providing that the playing fields are levelled and the debate based on mutually agreed-upon principles, without the coercive fall-back position currently being employed by elements of the funding industry. The changes required are much more fundamental than a mere transferral of risk from one party to another. We need to think afresh and ensure that all the elements of the private sector remain vibrant and sustainable for the sake of efficient health care delivery to all, rich and poor, sick and healthy.

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1. Taylor B, Burns D. Can medical scheme reform lead to fairer distribution of limited resources? A funder's perspective. *S Afr Med J* 2005; **95**: 175-179.
2. *Council for Medical Schemes Annual Report: 2003/4.*