Affordability through accountability: Prospects for community-based health care in South Africa

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The main emphasis in the overarching programme as well as in the subprogrammes is on aspects of affordability, accountability and appropriateness in the field of social security and the provision of social services.

This report is based on an investigation into the attitudes and perceptions of samples of health care consumers and physicians on the matter of health care, and more particularly, health care reform.

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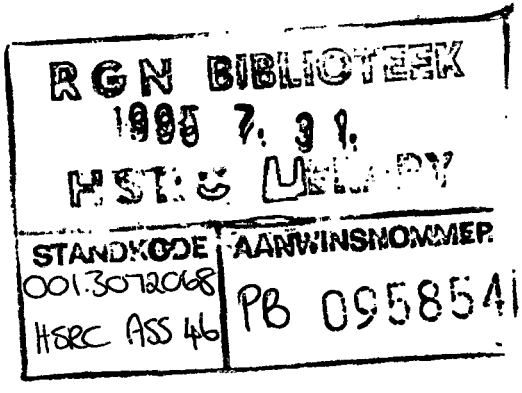


Ekserp

Die stygende finansiële koste van gesondheidsorg het 'n katastrofiese impak op sowel staatsbesteding in Suid-Afrika as op die huishoudelike begrotings van individuele verbruikers. Weens histories-gevestigde, sosiaal ekonomiese en politieke samelewingsrealiteite is daar onvermydelik 'n bykomende sosiale dimensie gekenmerk deur diskriminasie, uitsluiting en ontbering in die gesondheidsektor, en dit dryf die behoefte aan wesenlike, progressiewe gesondheidsorghervorming in Suid-Afrika op die spits. Die probleem blyk grootliks in die struktuur van 'n pluralistiese sorgsisteem geleë te wees, en wel in dié opsig dat beginsels, prioriteite en praktyke van gesondheidsorg wat inherent is aan die samestellende sektore van so 'n sisteem, afsonderlik en in wisselwerking met mekaar, tot dramatiese finansiële en sosiale kostestygings aanleiding gee. Belange wat mettertyd in hierdie pluralistiese sisteem gevestig raak, lei boonop tot weerstand teen hervorming. Dit verwater progressiewe hervormingsinisiatiewe telkens tot oppervlakkige, reformistiese ingrepe wat hoogstens tydelike verligting vir geïsoleerde, dringende krisisse bring.

In hierdie studie word die motivering vir 'n gemeenskapsgebaseerde sorgmodel as oplossing vir die krisis in Suid-Afrikaanse gesondheidsorg in 'n breedvoerige teoretiese argument voorgehou. Ooreenkomstig heersende oriëntasies, strukture en praktyke in Suid-Afrikaanse gesondheidsorg behels die implementering van so 'n sorgmodel egter in vele opsigte 'n radikale breuk met die *status quo* en kom dit reëlreg teen gevestigde belange en behoudende kragte in die bestaande sisteem te staan. 'n Empiriese ondersoek na die houdings en persepsies wat gesondheidsorgverbruikers, asook geneeshere in Bloemfontein en Mangaung aangaande gesondheidsorg en -hervorming handhaaf, bevestig dat die eensydige en outokratiese implementering van 'n gemeenskapsgebaseerde sorgmodel om verskeie redes weerstand vanuit talle oorde sal ontlok. 'n Onderhandelde skikking waarvolgens die beginsels van 'n gemeenskapsgebaseerde sorgmodel op kreatiewe wyse en tot wedersydse bevrediging van en aanvaarding deur verbruikers sowel as verskaffers van gesondheidsorg in 'n bekostigbare sisteem geïntegreer kan word, blyk eerder die aangewese weg tot progressiewe hervorming te wees. In 'n onderhandelingsforum moet daar dus, waar en sover moontlik, konkrete beslag aan die beginsels van 'n gemeenskapsgebaseerde sorgmodel in die beplanning, organisasie en finansiering van 'n bekostigbare gesondheidsorgsisteem vir Suid-Afrika gegee word.

Abstract

The rising cost of health care has a catastrophic impact both on state expenditure in South Africa and the household budgets of individual consumers. The historically determined socio-economic and political realities of South African society inevitably introduce an additional social dimension of discrimination, exclusion and deprivation into the health sector, bringing to a head the need for fundamental, progressive health care reform in this country. The problem of rising costs seems largely attributable to the structure of a pluralistic care system — and specifically to the way in which the principles, priorities and practices of health care inherent in the component sectors of such a system contribute, jointly and severally, to dramatic escalations in the financial and social cost of health care. In addition, various interests gradually become vested in this pluralistic system, rendering it resistant to reform and resulting in the continuous reduction of progressive reform initiatives to superficial interventions which at best bring temporary relief for isolated, intolerable crises.

In this study, a detailed argument in favour of a community-based approach towards health care as a solution for the crisis in South African health care is presented. In terms of prevailing principles, priorities and practices in South African health care, the implementation of such an approach implies a radical deviation from the *status quo*. As such, it can be expected to meet with direct opposition from vested interests and conservative powers in the current system. The results of an empirical investigation into the attitudes and perceptions prevailing among consumers of health care and physicians in Bloemfontein and Mangaung regarding health care and reform, confirm that the unilateral and autocratic implementation of a community-based approach towards health care will not be tolerated, for various reasons. Progressive reform should rather be achieved through negotiated settlements in which the principles of a community-based approach towards health care can be integrated into a new, affordable system in a creative manner and to the mutual satisfaction of consumers and providers of health care alike. The principles of a community-based approach towards health care should, where possible, lay the foundation for the planning, organisation and financing of an affordable health care system in South Africa.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

METHODOLOGY AND RESEARCH DESIGN

1. Initiative for the study

Some years ago, concern about escalating government expenditure on social services, including public health care provision, saw the Human Sciences Research Council launch a comprehensive investigation into the creation of an affordable dispensation for social provision in South Africa. On behalf of the Co-operative HSRC programme: Affordable Social Provision, the Department of Sociology at the University of the Orange Free State investigated certain facets of community-based health care as a model for affordable health care provision in South Africa. It was assumed that community participation and involvement in health care, as well as resource development on the community level and the devolution of responsibility regarding the planning, management and provision of health care to the community level, could contribute much towards the affordability of care. This subproject offers a macroperspective on community-based health care as a comprehensive, integrated policy model or strategy for affordable health care provision, as well as on the problems accompanying its implementation in South Africa.

2. Research problem

In 1978, the World Health Organisation (WHO) issued a statement (the so-called Alma Ata-Statement) which led to a world-wide revival of interest in primary health care. In accordance with a comprehensive definition of health as a condition of total well-being and the optimal functioning of body, mind and society, the conviction is expressed in this statement that community development in general, and particularly the provision of environmental, primary, preventive and community health care services, can contribute significantly towards the improvement of the health status of the world population. However, the condition is that these processes be accompanied by the stimulation and encouragement of community participation, involvement and deliberation on all appropriate levels of planning, management and provision (*cf.* Coovadia, 1991:2; WHO/UNICEF, 1978). The ideal of Health for All by the year 2000 originated in this context. Apart from accessibility, availability and acceptability, the affordability of health care was expressly singled out as a principle of this ideal. Fundamental to this ideal is the aim of providing effective, appropriate health care of the highest possible standard at the lowest possible cost according to

the actual health needs of diverse communities. In a broader perspective, the ultimate aim is to cultivate and stimulate appropriate priorities and orientations regarding disease, health and health care through a community based approach in order to accomplish equity, equality and justice in health care. As such, community-based health care constitutes a unique model of organising, planning, financing and providing health care within which the interests and needs of smaller, diverse communities can be accommodated in an organised manner.

In South Africa, such an approach directly opposes many orientations, principles, priorities and practices which historically determined, and still dominate, the health care system. It also implies drastic changes to the organisational context in which professional health services are currently rendered. Siler-Wells (1987:821) emphasises that such a re-orientation implies far-reaching reforms indeed: "... reform entails shifting the focus of the health care system from a predominant emphasis on care and cure of the sick (viewed here as a negative health policy), to a positive-health policy focus of promoting and maintaining good health ... Achieving national health system reform involves changing the direction of national health policy, and changing behaviors throughout the entire health sector, including government, providers and consumers."

It can be expected that vested interests in the *status quo* will necessarily have to be challenged in the process. These interests have impeded the attainability and feasibility of community-based health care to such an extent that no real or visible shift of emphasis in this direction has yet occurred in the South African health care system. The research problem to be addressed in this study relates to the problems created by health care consumers' and providers' resistance to the organisational reconstruction of the health care system according to the principles and practices of community-based care. The purpose of the study follows from this.

3. Purpose of the study

Many of the assumptions underlying the belief that community-based health care constitutes an affordable model of health care provision are based on over simplified conceptions of the real causes and manifestations of unaffordability in South African health care. In addition, confusion prevails regarding the concept, nature and implications of a community based care model. Arguments in favour of such a model are often also inexplicit as to the ways in which the model can contribute to the resolution of the complex problem of unaffordability. Consequently, community-based health care is indeed being dealt with irresponsibly and little heed is paid to the full extent and potential impact thereof. Furthermore, questions and problems

relating to the implementation of a community-based health care model have so far largely been left unaddressed or even deliberately avoided. By analysing the concept and principles of community-based health care and then investigating certain problems relating to the implementation of a community-based care model in South Africa, this study is particularly aimed at addressing the aforementioned omissions in the study of health care reform.

More specifically the theoretical aims of this study are to:

(i) analyse critically and comprehensively the problem of unaffordability of South African health care on the basis of cause and manifestation in order to illustrate the complexity and extent thereof;

(ii) clarify the concept of community-based health care, analyse the basic principles thereof and enunciate the practical implications of its implementation for health care in South Africa;

(iii) reflect critically on the appropriateness and feasibility/practicability of community-based health care as an affordable model of health care provision in South Africa.

These analyses will clearly show that community-based health care is based on principles and practices that are foreign to modern, Western, clinically oriented and hospital-based medicine. For doctors and patients alike, the idea of a community-based health care system for South Africa would be acceptable to greater or lesser degrees. The question of the acceptability of and receptiveness to the principles, practices and implications of community-based health care is addressed in an empirical investigation involving these two groups. The purpose of this empirical investigation was to determine the extent to which doctors as providers of health care, on the one hand, and health care consumers, on the other hand, are receptive to alternative health care orientations, practices and structures, and to establish to what extent and in what ways their attitudes and perceptions can be accommodated in a community-based care model. The purpose of the empirical investigation was thus to elucidate certain problems relating to the implementation of a community-based model of health care in South Africa.

In short, this study has a dual purpose: firstly, to clarify the nature and rationale of community-based health care theoretically within the context of affordability, and secondly to illustrate by means of empirical information certain problems relating to the implementation of a community-based model of health care — which inevitably influences the practicability thereof.

4. Design of the empirical investigation

Several methodological problems occurred in the empirical investigation into the receptiveness of a community-based model of health care among doctors and consumers of health care in Bloemfontein. These problems had to be carefully accounted for in the research design. The most important research decisions are justified in the next section (Par. 4.1).

4.1 Sampling and data collection: Consumers of health care in Bloemfontein and Mangaung

As a result of the maldistribution of opportunities and prosperity in society as a whole, and specifically on account of the maldistribution of health insurance, the consumers of health care in South Africa can be divided into two distinct consumer populations whose frames of reference regarding health care are based on their experience of divergent care systems (health care realities).

Viewed separately, the maldistribution of health insurance reveals that the 20,1% of the South African population, who were members of medical schemes in 1989, was made up of 57% whites, 22,6% blacks, 15,4% coloureds and 5,2% Asians. According to total population figures for the various groups, this means that about 70% of all whites in South Africa have health insurance, as against 33,3% of all Asians, 29,5% of all coloureds and only 6,5% of all blacks (Van Rensburg, Fourie & Pretorius, 1992: 226-228). On the one hand, it appears that whites in particular, on account of their membership of medical schemes, should find the private health sector more accessible than other population groups. Consequently, it can be assumed that private health care services constitute the basis of their impressions and perceptions regarding health care in South Africa. On the other hand, the vast majority of non-whites appear to be dependent on public health care provision. Therefore, their impressions, attitudes and perceptions regarding health care should mainly reflect their experience of public health care services in South Africa.

For the purposes of representation and generalisation, the consumer population involved in the survey is stratified according to the variable "population group". By including consumers from both the white and black populations[1] in the survey, the range of variation resulting from differential frames of reference and perceptions

1. For the sake of economy, reference is made in the text to "consumer populations" or "black/white" populations. Keep in mind, however, that unless otherwise stated, these references relate only to the population of white health care consumers in Bloemfontein and the population of black health care consumers in Manguang.

regarding health care was broadened as far as possible. Consequently, research results are representative of the attitudes and perceptions of consumer populations from both the private and the public health sectors in South Africa.

In view of the fact that the survey was limited to the Bloemfontein area, the inhabitants of Bloemfontein itself and those of the black township, Mangaung, were identified as the population strata. Then a process of multistage cluster sampling from each of these strata took place: From a list of all 47 neighbourhoods in Bloemfontein, and all 17 sub-areas of Mangaung, twelve neighbourhoods and six sub-areas respectively were selected randomly and proportionately according to size. From chronological lists of residential stand numbers for all these selected neighbourhoods and sub-areas, twelve stand numbers (ten preferential and two reserve stand numbers) per neighbourhood, and 20 stand numbers (15 preferential and five reserve stand numbers) from every sub-area were selected according to simple random sampling. Selected stand numbers were marked clearly on maps of the various neighbourhoods and sub-areas (preferential stand numbers in red and reserve stand numbers in blue) so that interviewers could easily identify calling points with the aid of these maps. It was thus envisaged that interviews would be conducted with at least 120 households in both Bloemfontein and Mangaung. With the withdrawal of one white interviewer from the survey, interviews were eventually conducted at 110 households in Bloemfontein and 120 in Mangaung.

With the aid of information which the interviewers themselves had to complete on a page attached to each interview schedule (the address where the interview took place, the date and time of interviewing and, if possible, a telephone number at which the respondent could be contacted) 40 randomly selected black and white respondents were telephoned or visited in order to verify the reliability of the interviewers and, by implication, of the data obtained. Interviewers reassured respondents that this information was merely required for control purposes and that it would in no way be used to identify them or jeopardise confidentiality. All selected white control respondents confirmed that interviews were in fact conducted as specified. These controls however, cast suspicion on the reliability of a particular black interviewer and it was decided not to process the seven schedules which this interviewer claimed to have completed. Because of unreliable data and interviews being refused or prematurely terminated, 104 interview schedules of white respondents and 112 of black respondents were eventually suitable for further processing.

4.2 Realisation and description of sample: Consumers of health care in Bloemfontein and Mangaung

In order to determine the extent to which the sample was representative of the total consumer population in this study, the sample was analysed in terms of certain crucial variables. Of decisive importance for the interpretation of information in this survey was the extent to which the sample was compiled according to population group, socio-economic status and membership of medical schemes. Of lesser importance was its composition according to age, gender and politico-ideological orientation.

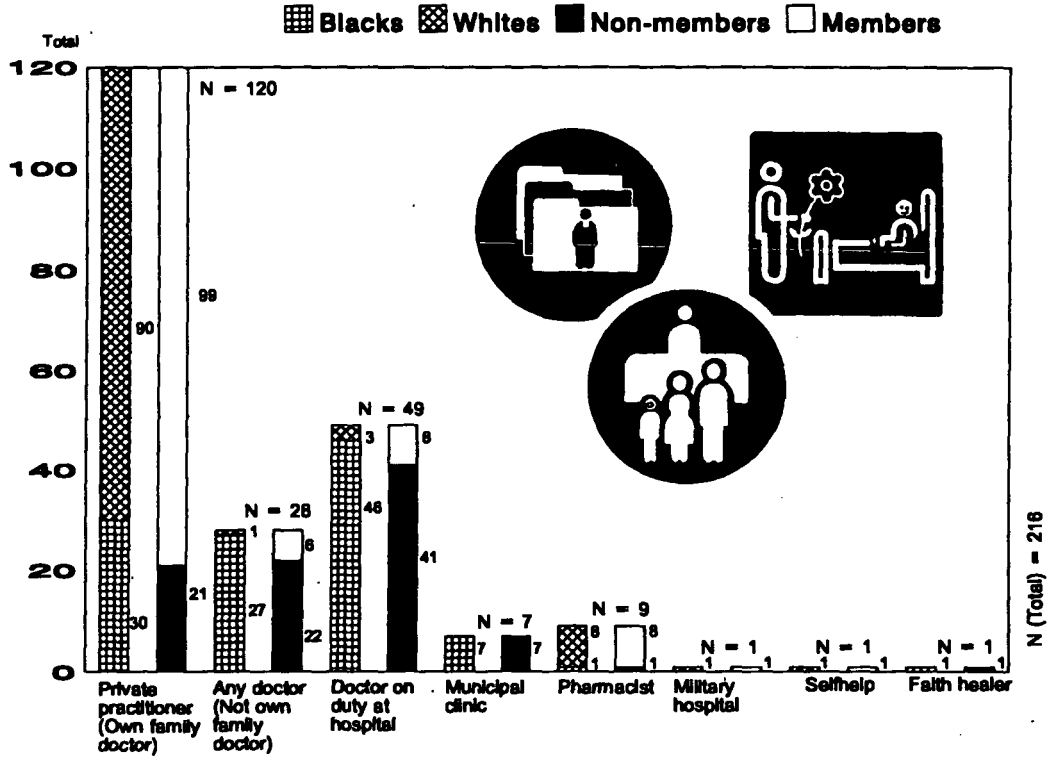
4.2.1 *Frame of reference concerning health care*

In the light of socio-economic and political realities in South African society, the population group and socio-economic status of a particular household, as well as membership of medical schemes, are the most important variables determining accessibility to health care services. Consequently, these variables are basic to respondents' frames of reference concerning health care in South Africa, as well as to their impressions, perceptions and attitudes in this regard. For the purpose of data interpretation it is essential to take into consideration the frame of reference and socio-economic circumstances from which respondents interpreted survey questions. In terms of the realisation of the sample according to socio-economic status and membership of medical schemes, the original rationale for the stratification of the sample according to the population groups of respondents seems to be justified. In the sample, the mutual relationship of these three variables manifested itself as follows:

Numbers which were filled in on interview schedules before the survey commenced and which had to be adapted after unreliable and incomplete schedules had been removed, indicated that the sample consisted of 104 white and 112 black respondents. Although not proportionately according to the national population composition, blacks are slightly better represented in the group than whites. However, the explanatory value of this variable lies in its indication of respondents' frames of reference regarding certain health care realities. According to the sample statistics, 90,4% of all the white respondents had health insurance, as against 26% of all the black respondents.[2] This variation is reflected clearly in respondents' indication of their first point of referral in the care of illness (*cf.* **Figure 1**).

2. Most of those respondents who had health insurance (57%) were members of *exempted schemes*. These schemes mainly provided insurance for employees in the public service and were exempt from reporting to the Registrar of Medical Schemes. The remaining 43% of respondents who had health insurance were members of *registered medical schemes*. These were schemes which private-sector employers implement for their employees. They were legally forced to report to the Registrar of Medical Schemes annually.

Figure 1: First line of care: Variation according to population group and medical scheme membership



As Figure 1 shows, 87% of the white respondents referred to a private practitioner (i.e. family doctor) first for medical care. White respondents' experience of individual care in a personal care context will therefore form the frame of reference for their interpretation of survey questions. By contrast, the vast majority of black respondents (71% — i.e. approximately the same percentage as of blacks who did not have health insurance) based their attitudes and perceptions regarding health care on the services provided at public hospitals and clinics. Note that the proportion of blacks who did have health insurance, namely 26% equalled that of black respondents who indicated a private practitioner as first referral for medical care. Therefore, it can be accepted that the attitudes and perceptions of (mainly white) respondents who do have health insurance, provided a valid account of the private health sector in South Africa, while those of non-insured (mainly black) respondents in the group under study reflected on the public sector. Interpretations/ explanations of the variation of consumers' attitudes and perceptions regarding

matters relating to health care and health care reform, indeed seem to lie with the relationship between population group and membership of medical schemes (which, in turn, is indicative of respondents' frames of reference regarding health care).

4.2.2 *Socio-economic status*

Together with respondents' membership of medical schemes, the socio-economic status of a particular household was indicative of the degree to which respondents perceived themselves as being able to provide for their health needs; it was also a determinant of the nature, range and quality of health care accessible.

The monthly expendable income of households involved in this study varied between R100 and R12 000. The term "expendable income" indicates the amount available to a particular household for the provision of its everyday needs. It was operationalised by asking respondents what the **total** monthly income (from **all** sources and **after** deductions) of the particular household was. The incomes of **all** members of the household who contributed towards the domestic budget were taken into account. The average expendable income of white households involved in the survey (R3 965) was much higher than that of black households (R1 340).

The already unfavourable financial position of black households as compared with white households was rendered even more gloomy when factors such as the size and composition of black households were taken into account. As for the influence of the size of a household on the socio-economic status of that household, it was clear that many more people were reliant on the relatively low monthly expendable income of the black households than on the relatively high monthly expendable income of the white households. The number of dependents on the monthly expendable income of a particular household in this survey varied from 1 (in the case of single persons) to 12.[3] In black households an average of 4,5 people were reliant on a relatively low monthly expendable income, as against an average of 3,1 dependent on the relatively high monthly expendable income of white households. As a result, the average expendable income per member of a black household in Mangaung amounted to R358, as compared with R1 345 per member of a white household in Bloemfontein.

3. In the case of single black respondents, it was interesting to note that such respondents often indicated that a part of their income was allocated towards the provision of basic needs of friends and family living elsewhere. It can be assumed that some of these respondents were males who had been forced to seek employment in the urban area of Bloemfontein, yet who still provided financially for their families who remained on farms in the vicinity or in the homelands.

An aggravating factor in the socio-economic status of blacks was the fact that far more black households than white households suffered the negative consequences of family disruption. Single-parent families were far more common in the black than in the white populations of this study (40 against 11). This suggests that black households, especially, are financially reliant on the (often uncertain income and/or goodwill) of a single breadwinner. By contrast, most white households seemed to enjoy the financial security provided by a fixed and regular income (often the combined incomes of husband and wife in dual-career families) as well as the physical presence of a breadwinner. Also, the disrupting financial consequences that a live-in grandparent had on a household budget was a phenomenon peculiar to the black households involved in this study.

These objective, relatively crude indicators of socio-economic status were reflected in respondents' subjective experience of their socio-economic circumstances. The relationship between respondents' population groups and their responses to a question in which they were asked to compare their own financial position with that of most other people, is presented in **Table 1.**

Table 1: Relationship between population group and subjective experience of relative financial deprivation

POPULATION GROUP		Experience of own financial position compared with that of most other people			
		BETTER	THE SAME	WORSE	ROW TOTAL
WHITE	N	19	70	15	104
	Row %	18,3	67,3	14,4	48,1%
	Column %	67,9	49,3	32,6	
BLACK	N	9	72	31	112
	Row %	8,0	64,3	27,7	51,9%
	Column %	32,1	50,7	67,4	
COLUMN TOTAL		28	142	46	216
		13,0%	65,7%	21,3%	100%

χ^2 = 8,9
v = 2
α = 0,011
Uncertainty coefficient = 0,02

As Table 1 reveals, significantly more blacks than whites indicated that they perceived their own financial situation as less favourable than that of most other people. The uncertainty coefficient of 0,02 indicated that the researcher's uncertainty

about the correct prediction of respondents' experience of their own financial position decreased by 2% if the respondent's population group was known to the researcher. The population group of respondents was therefore not a particularly strong or reliable indicator of their experience of relative financial deprivation. Although significant, the relationship depicted in Table 1 is not particularly strong.

Together with the direct, significant relationship between respondents' monthly income and their subjective experience of their socio-economic status compared with that of most others, this confirms and supports the conclusion that blacks, because of both real financial incapacity and the experience of relative financial deprivation, should be especially aware of and sensitive towards financial obstacles and considerations of cost in health care. This conclusion was consistently confirmed by the inferential analyses of survey data.

4.2.3 *Gender*

Although the variables of age, gender and politico-ideological conviction were operationalised in this survey, they can at most be applied for explanatory purposes where the biographical details of individual respondents are relevant to the interpretation of information. For analytical purposes, this study placed more emphasis on details relating to households rather than to individuals as such. For this reason, the relative underrepresentation of male respondents in the sample is not considered particularly problematic. This is merely the result of the fact that interviews could be conducted with any adult respondent who was sufficiently informed about the health, and matters relating to the health insurance, of a particular household in order to provide reliable responses to interview questions. In general, women were more available, accessible and willing to provide the necessary information.

4.2.4 *Age*

The particular explanatory value of the respondents' age lay in the indication it gave of the phases the respondents were in with regard to their careers and the establishment of their families, as well as of their health status in general. In this survey, the respondents' ages varied between 21 and 86 years, while the sample average was 44 years. The average age of the black respondents (42 years) was somewhat lower than that of the white respondents (46 years). For purposes of inferential data processing, respondents were divided into three age categories:

- ☐ *Young adults* (between the ages of 21 and 42 years). These people were in the process of establishing or just beginning to develop their careers and

families. In general, they experienced few serious or chronic health problems. Half the sample (50%) fell in this category.

- ☐ *Adults* (between the ages of 43 and 65 years). These people had established their careers and families. During this phase an increase in health risks and accompanying problems generally occurred and an increased awareness of health-related matters emerged. In total, 90 respondents (41,7% of the sample) fell in this category.
- ☐ *The aged* (between the ages of 66 and 86 years). The financial impact of retirement, and often also an increase in serious or chronic diseases during this phase, could mean that persons in this category would be especially aware of the affordability, availability, accessibility and reachability of health services and facilities. A total of 18 respondents (8,3% of the sample) fell into this category.

Statistical analyses of survey data indicate that respondents' age, according to this division of categories, did not significantly influence their attitudes and perceptions regarding health care and health reform.

4.2.5 *Politico-ideological conviction*

The fact that health care is a matter of dispute in the political arena inevitably politicises the issue of health care and health care reform in South Africa. Politics is therefore also a forum through which consumers' attitudes, perceptions and awareness of the health care reality in South Africa are influenced. Within this context, the political convictions of respondents should be taken into account in the framework for the interpretation of survey results.

The relationship between respondents' population group and the political party/ movement with which they could best associate in terms of policy and standpoint, is shown in **Table 2**. The table shows that the sample was representative of a wide spectrum of political convictions. However, the non-response rate of 23,6% indicated that this was a sensitive and/or confusing question. According to the information in Table 2, the African National Congress enjoyed the most political support in this sample (specifically among the blacks), followed by the National Party (with support mainly from the whites), the Conservative Party (exclusively white support), the Pan Africanist Congress (exclusively black support) and the Inkatha Freedom Party (also with exclusively black support).

Table 2: Description of the relationship between population group and political association

POPULATION GROUP		POLITICAL ASSOCIATION						
		AWB/ CP	NP/ DP	ANC	PAC	IFP	NO RE-SPONSE	ROW TOTAL
WHITE	N	20	61	1	0	0	22	104
	Row %	19,2	58,6	1	0	0	21,2	48,1%
	Column %	100	96,8	1,4	0	0	43,1	
BLACK	N	0	2	70	8	3	29	112
	Row %	0	1,8	62,5	7,1	2,7	25,9	51,9%
	Column %	0	3,2	98,6	100	100	56,9	
COLUMN TOTAL		20	63	71	8	3	51	216
		9,3%	29,2%	32,8%	3,7%	1,4%	23,6%	100%

In view of the uncertain and highly changeable political situation in South Africa, these results indicate at most that respondents should be aware of and sensitive towards matters in which racial distinction and racial discrimination are at stake. This awareness should relate to the degree to which and the manner in which these issues are emphasised in the agendas of various political parties or movements. In general, it can be expected that political parties or movements with overwhelming black support would exert themselves for the elimination of disparities and for wide-ranging upliftment. Moderate, reconciliation-orientated parties with mainly white support should be similarly directed. As far as political parties and movements with rightist convictions (enjoying mainly white support) are concerned, a spirit of conservatism and the desire to protect the advantageous position of whites in the current social order are strongly emphasised. From a political point of view, as far as health care is specifically concerned, most respondents can be expected to aspire towards the standard and quality of care reserved for the advantaged clientele of the private sector as an ideal health care dispensation. Because of the wide range of variation of this variable and the relatively small sample to which the survey data applied, the statistical requirements of certain procedures could not be met. Consequently, the degree to which this political aspiration measures up to socio-economic realities could not be further investigated.

4.2.6 *Summary: Realisation of consumer sample*

As far as critical variables are concerned, the sample can be regarded as sufficiently representative of the population of health care consumers in Bloemfontein and Mangaung at the time of the survey to justify the generalisation of sample data, with an acceptable measure of validity and reliability, to the population concerned. However, because of the realisation of the sample in terms of gender, age and politico-ideological conviction it should be taken into account that, where these latter variables are crucial to the interpretation and explanation of data, the results reflect mainly the attitudes and perceptions of young adult, female and relatively liberally oriented respondents at the beginning of the 1990s.

4.3 Sampling and data collection: Physicians

The providers of health care (which in this study included only doctors) are likewise a heterogeneous population. Therefore, certain diversities necessarily had to be accounted for in the sample of doctors so that a representative version of their attitudes and perceptions regarding health care could be obtained.

In view of the fact that 50% of all registered doctors in South Africa are employed in the public sector and the other 50% are in the private sector (Van Rensburg, Fourie & Pretorius, 1992:256), it can be logically concluded that doctors' experiences and views of the health care situation in South Africa — i.e. the current problems in South African health care and the solutions to these — will vary according to their sector of employment. In order to account for this critical variation, the sample of doctors was compiled from both the population of private practitioners in Bloemfontein (comprising the list of 160 general practitioners and medical specialists listed in the Bloemfontein telephone directory) and the medical doctors and specialists on the combined staff of the Free State Provincial Administration and the Faculty of Medicine at the UOFS (which totalled 128 at the time of sampling). From a combined alphabetical list of these populations, a random sample of 90 doctors was systematically selected. Questionnaires were mailed to the practice or office addresses of selected doctors.

Since the response rate of postal surveys is generally low, the selected sample was deliberately selected relatively large in comparison with the size of the population. Also, a follow-up strategy was followed in order to maximise the response rate. By means of control numbers applied to each questionnaire before mailing, respondents whose completed questionnaires were received could be marked off on the sample list. After ten working days those respondents who had not returned their questionnaires were phoned and reminded. Nine completed

questionnaires were received in reaction to these first reminder calls. During these conversations, four respondents indicated that their addresses had recently changed and that they had not received questionnaires. Questionnaires were thereupon mailed to their new addresses. One week after the first reminder calls, those respondents who had still not replied, were contacted again. Another five questionnaires were received after these second reminder calls. Several respondents indicated that they did not intend completing the questionnaire. Their names were also marked off on the sample list and they received no further reminder calls. Eventually, 33 completed questionnaires were received, which brought the response rate of this survey to 36,6%.[4]

4.4 Realisation and description of sample: Physicians

In relation to the size of the population, the 33 questionnaires that were received could be regarded as representative of the population of physicians in Bloemfontein at the time. The same applies to the composition of the sample in terms of gender, age and working experience. The gender composition of the sample largely concurred with that of the total South African physician corps (*cf.* Central Statistical Services, 1987:20; Van Rensburg, Fourie & Pretorius, 1992:253; Zwarenstein, Youngleson & Botha, 1989:106). The national ratio (1987/88) was 11,5 female physicians (including specialists) per 100 male physicians, while 12% of the sample in this study were female physicians.

The average age of respondents was 49,5 years (the youngest and oldest were respectively 31 and 60 years old). The working experience of respondents varied between seven and 44 years and came to an average of 23 years. Most of the respondents (13 in total, or 39,4% of the sample) had undergone their medical training during the 1970s, while nine (27,3%) completed their studies during the 1960s, eight (24,2%) during the 1950s and late 1940s, and three during the 1980s.

In view of the fact that this survey was about physicians' experience of health care in South Africa and many survey questions required fundamental knowledge and expertise based on the practicalities of health care in this country, the researchers were of the opinion that in terms of gender, age and working experience the sample could give valid and reliable opinions on behalf of the population of physicians in Bloemfontein.

4. Volmink *et al.* (1992) obtained a response rate of 67,4% in their survey among private practitioners in South Africa by launching the survey on a lottery principle. Eight gold Kruger Rands were available for eight lucky respondents who returned their completed questionnaires to the researchers.

Because of the particular over- and underrepresentations in this sample (which could be ascribed to the poor response rate of private practitioners rather than to the design of the sample as such) the attitudes, perceptions and opinions of physicians in this survey were mainly representative of Afrikaans-speaking specialists trained at "White", Afrikaans universities and at the time attached to the Universitas-National-Pelonomi training hospital complex. Of the 33 respondents, eight (24%) were *bona fide* private practitioners, while 25 (76%) were attached to the Faculty of Medicine at the University of the Orange Free State. In addition, it should be mentioned that many physicians attached to the Faculty of Medicine worked as specialists in specific departments. This explains why the specialist:general practitioner ratio in this sample was 5,6:1, as against the national ratio of 1:2,7 (or 37:100) (Van Rensburg, Fourie & Pretorius, 1992:263).

A further noticeable imbalance in the composition of the sample (which could be ascribed to the restriction of the survey to physicians in Bloemfontein) is the fact that only four (12%) of the respondents indicated that English was their home language and general medium of conversation, while 29 (88%) indicated Afrikaans as their mother tongue. The greater majority of the respondents (31 in total) had received their medical training at Afrikaans universities — among others the University of Pretoria (20), the University of the Orange Free State (7), and the University of Stellenbosch (4). Only two respondents had undergone their medical training at English universities — one each at the Universities of the Witwatersrand and Cape Town. One has to bear in mind that English universities are generally associated with a more liberal academic tradition than Afrikaans universities. With regard to medical training in particular, primary and community health care are more highly esteemed at English universities, while the elitist-conservative tradition at Afrikaans universities contributes to an enduring emphasis in medical curricula on curative, specialised and hospital-based care. The interpretation of research results will definitely have to account for these imbalances in the composition of the sample, especially since Volmink *et al.* (1992:2) found in their survey among private practitioners in South Africa that the university at which respondents received their training was crucial to their attitudes and perceptions regarding issues currently at the centre of the reform debate in South African health care. Their conclusion was that graduates of white, Afrikaans-medium universities were strongly in favour of a privately funded and fee-for-service oriented system. Those who qualified at black universities, on the other hand, favoured public funding with less emphasis on fee-for-service. White, English-language university graduates, while expressing a preference for fee-for-service remuneration, were less enthusiastic about private funding, favouring a mixed approach (private and public) instead.

4.5 Data analysis and interpretation

The SAS data-processing package was used to analyse survey data. Dependent variables were operationalised mainly on an interval level so that parametrical data-processing techniques could be used for inferential purposes as far as possible. T-test analyses for independent groups were carried out in instances where the independent variable had only two categories, whereas one-way analyses of variance were used for independent variables which had three categories. Relations between variables were tested throughout on the 0,05 (5%) level of significance. Non-parametrical data-processing techniques were used mainly for the initial exploration, systematisation and description of survey data. A serious problem concerning the processing of data in this study relates to the relatively small samples included in the survey. Valuable exploratory data-processing techniques, for instance PATH-analyses, could not be carried out because of the limited size of the samples. Although the categories of dependent variables were combined and reduced as far as possible when subjected to non-parametrical data-processing techniques, in many cases Chi-square analyses could not be interpreted inferentially because of the high incidence of empty cells and cells with cell frequencies of fewer than five in the contingency tables. This limitation applies especially to the interpretation of survey data relating to physicians.

The findings of this study are presented in three sections. Each section begins with a theoretical review of a particular aspect of the research problem. The first section (Chapter 2) entails an analysis of the causes, extent and manifestation of the problem of unaffordability in South African health care. This is followed by a description — and a comparison of — how the consumers of health care on the one hand, and the physicians on the other hand, experienced and viewed the matter of the affordability of health care.

The second section (Chapter 3) centres on community-based health care as a solution to the problem of unaffordability in South African health care. In this section, a theoretical review of the concept, principles, requirements and implications of community-based health care is followed by an analysis of the acceptability of opposing policy frameworks respectively more and less accommodating of a community-based approach to health care, to consumers of health care and to physicians.

In the third section (Chapter 4) some problems relating to the implementation of a community-based health care system in South Africa are addressed in terms of research results. In particular, the attitudes and perceptions of physicians and consumers with regard to alternative principles and practices of health care will be

analysed with the aim of identifying obstacles in the way of a community-based care model for South Africa.

The fourth and last section (Chapter 5) entails an attempt to integrate into a tentative explanatory framework the attitudes, opinions and perception which consumers of health care and physicians maintain about certain policy options for health reform, with their ideologically founded life and world perspectives as well as with their concrete experience of certain realities of South African society and health care.

CHAPTER 2

ESCALATING COSTS AND UNAFFORDABILITY OF HEALTH CARE IN SOUTH AFRICA: CAUSES, EXTENT AND MANIFESTATION OF THE PROBLEM

The rising cost and increasing unaffordability of health care in South Africa is a complex problem closely associated with the current structure of the South African health care system and its prevailing orientations, priorities and practices. Furthermore it encompasses far more than the actual financial transfers between consumers and providers of health care; it is symptomatic of the deeply rooted, complex and multi-dimensional problems which underlie the South African health care system and which manifest themselves both financially and socially.

1. Causes and extent of the problem

There are many and varied causes for the problem of unaffordable health care. However, a systematic unravelling of this complex web of causality provides valuable insight into the problem of unaffordable health care in South Africa and contributes significantly to the generation of informed, workable solutions to the problem.

In the first place the composition of the South African population is characterised by its complexity. Consequently a variety of health needs of different population groups with divergent and, above all, continuously changing demographic and epidemiological profiles have to be catered for.[5] The prevention, treatment and rehabilitation of such a variety of diseases and ailments obviously make great demands on the financial resources for health care provision.

In the second place, the composition of the South African health care system — consisting of equally established public and private sectors each of which is in essence a fully fledged, independent health care system with its own administrative and organisational structure, a distinctive financing mechanism and its own network of provision — unmistakably contributes towards the rising cost of health care. The

5. See Van Rensburg, Fourie and Pretorius (1992:95-197) for a complete and recent demographic and epidemiological profile of the South African population, with specific reference to the divergent health needs arising among the different population groups.

independence of the sectors is emphasised by the absence of either a common policy commitment or any co-ordination and systematisation as far as a mutually integrating mission of health care provision is concerned. This fuels the increasing cost and unaffordability of health care in South Africa in the following three ways:

(i) The maintenance and operation of two separate, independent subsystems lead to the unnecessary division and consequently to the squandering of available resources. This leads to a high measure of non-beneficial health expenditure, which means that available financial resources are expended inefficiently on the maintenance of the structure of the system instead of on health care as such.

(ii) In the private sector the cost spiral in health care is founded upon and instigated by interaction among the following factors:

- ☐ *Consumer ignorance,* which means that patients are knowingly and unknowingly reliant upon the clinical decision-making power of autonomous private practitioners or institutions. The consumer seldom questions either the clinical decisions made by the care provider or, by implication, the cost thereof (*cf.* Mechanic, 1972:19; Naylor, 1987:673; Price, 1987:38; 1988a:708).

- ☐ An emphasis on the *financial incentive for care provision* which leads to a particularly strong profit-orientation among care providers. This fosters a financially indifferent approach towards clinical decision-making, over-treatment and excessive prescription, as well as excessive and inappropriate specialisation and inappropriate technological advancement in the field of health care (*cf.* Fourie, 1989:135; Kunnes, in Solomon, 1973:21).

- ☐ The fact that, on account of their clinical and professional autonomy, private practitioners and institutions can generate, regulate and even artificially stimulate the demand for their services. This phenomenon is known as *supplier-induced demand* (*cf.* Benatar, 1990:445; Maynard, 1986:1163; Price, 1987:38; Rosen, 1989:457). Broomberg and Price (1990:130) indicate the financial implications thereof: "The critical role of health care providers in the generation and containment of health sector costs has long been recognised ... Doctors act as gatekeepers to virtually the entire health care system. Their decisions determine when a patient should be admitted to hospital, what investigations and procedures should be undertaken, and what drugs should be prescribed. Aside from the direct cost of their services, doctors themselves therefore have a major impact on expenditure throughout the remainder of the health sector. Some estimates put this share at 70-80% of total health expenditure."

- ☐ The system of *third-party financing*, which encourages consumers to make high and even unrealistic demands on care providers, on the one hand, while rendering providers indifferent as to the financial implications of clinical decision-making, on the other. Both these consequences lead to the over-utilisation and misuse of funds (*cf.* Broomberg & Price, 1990:130; Gear, 1990:123). An investigation by the International Federation of Health Funds revealed that South Africans were among the highest claimants in the world (Registrar of Medical Schemes, 1991:9-10), while Naylor (1988:1160) refers to the finding by the Bureau of Investigation into Medical Schemes (1984) that fraud by doctors and dentists (in the form of multiple claims for the same procedure, the padding of accounts and claims for services not provided), amounts to R15—R20m per year.
- ☐ The *inability and/or reluctance* of medical schemes and insurance agencies to *control and limit claims and payments* effectively (*cf.* Naylor, 1988:1164).

Segall (1983:1953) identifies the following relationship among the abovementioned contributing factors to the cost spiral in the private health sector: "Private medicine is exclusively clinical and has no relation with the public health and social measures necessary for health improvement. In addition, when finance is available, it exhibits a tendency towards excessive curative interventions and expensive styles of practice. The interpolation of the commercial relationship in medicine turns health care into a marketed commodity, which leads to a technocratic approach to health, and to many practices which may not be effective, are certainly not cost-effective" (*cf.* Price, 1988:709).

Private health care has indeed become an expensive commodity. For example, members of all types of medical schemes in South Africa had to contend with fee increases of at least 13% per annum, which means that members of medical schemes paid nine times as much for health insurance in 1988 as they did in 1978. In this decade, the increase in the cost of health insurance was more than twice the increase in the inflation rate (Broomberg, De Beer & Price, 1990:139; *cf.* Benatar, 1991:33; Centre for Health Policy, 1990:2; Naylor, 1988:1160; Van Rensburg, Fourie & Pretorius, 1992:231). In the meantime, this mechanism of health care financing leads to various forms of exploitation and transgression which cost the consumer dearly. While membership premiums constantly rise, medical schemes spend a continuously decreasing percentage of their income on benefits for their members (*cf.* Dorrington & Zwarenstein, 1988:46; Registrar of Medical Schemes, 1988 Annexure 1:3 and 6:4; 1989, 1990 and 1991 Annexure 8:4-5, 1989:3). In view of the fact that the administrative expenditure of medical schemes is decreasing at the same time,

continual and excessive increases in membership premiums can be regarded with suspicion.

Cost increases in the private health sector directly affect the members of medical schemes and their employers, and indirectly affect the state. Medical schemes simply do not possess the necessary bargaining power to keep the professional fees of physicians within affordable limits — an inability for which members of medical schemes and their employers are paying dearly. At the same time, the state loses on its tax income the amount that employers spend on the subsidisation of their employees' health insurance (in 1988 this amount was calculated at around R1,5 billion) (*cf.* Centre for Health Policy, 1990:2; Van Rensburg, Fourie & Pretorius, 1992: 232). It is often forgotten that the state subsidises so-called private patients in various ways, for instance as far as their treatment in academic and public hospitals is concerned. At the same time, many "public" tuberculosis and psychiatric patients are treated at great cost in private hospitals, though at public expense.

State subsidisation of private health care deprives the public sector of valuable financial resources and drains the public health budget at the expense of a growing clientele which is entirely dependent on public health services. Therefore, the rising cost of private health care could not only further diminish already inflation-eroded household budgets, but could also contribute subtly and indirectly to the state's inability to perform its welfare function regarding health care provision.

(iii) In the public sector the following causes of rising costs can be identified:

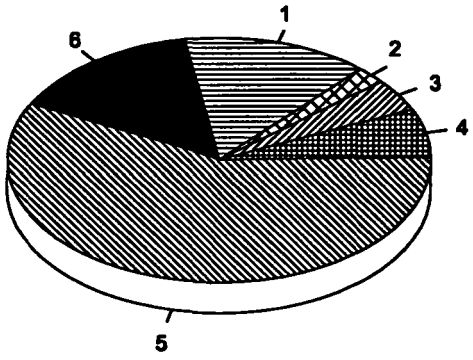
- ☐ An increase in the demand for public health care created by an overflow of consumers who have recourse to the public health sector because of dramatic increases in the cost of health insurance.
- ☐ An increase in the demand for public health care created by the high natural growth rate of the population groups and sectors dependent on public services.
- ☐ The unsystematic and undiscerning application of funds, as well as inefficient expenditure and the squandering of available resources on and by the administration of public health services.

In South Africa, the fragmentation of health services has for years deliberately been taken to extremes for political reasons. The financial waste this has created is particularly regrettable (*cf.* Cooper *et al.*, 1985:710; Taylor & Klopper, 1987:802; Van Rensburg, Fourie & Pretorius, 1992:207-217). For example, McIntyre and Dorrington (1990:128) indicated that the implementation of the 1983 Constitution, which institutionalised "own" and "general" affairs together with three

additional health departments at central government level, led to an increase of 5% in real annual expenditure on health care administration. In the same vein, Kelly (1988:117) calculated that the distinction between "own" and "general" affairs brought about the duplication of services and facilities at a cost of almost R800 million per annum, while Savage (in De Beer, 1988b:9) pointed to the fact that 12c out of every rand spent in the public health sector went towards the "administration of apartheid" (*cf.* Cooper *et al.*, 1989:2-3). The futility of this management style lies in the fact that "... the duplication of everything from administrative structures to stationery, the multiplication of ministerial motor cars, the need for extra staff and the existence of three separate structures to co ordinate between all the fragments of the health service must cost the tax payer several million rand per year, *with no benefits in terms of additional services*" (own emphasis) (Centre for the Study of Health Policy, 1988:9).

Apart from blatant squandering, the inefficient expenditure of available resources is also an everyday occurrence in the public sector. The clearest indication thereof is to be found in the particularly high level of state financing of health expenditure by provincial administrations when compared with the level of state financing of health expenditure by other government bodies (*cf.* **Figure 2**).

Figure 2: Proportional allocation of financial resources in the public health sector in South Africa, 1987/88



1. Department of National Health and Population Development 14,2% (R749 m)
2. Own Affairs Administrations 2,2% (R118 m)
3. Local Authorities 4,3% (R225 m)
4. Other State Departments 7,5% (R399 m)
5. Provincial Administrations 57,3% (R3 029 m)
6. Self-governing and Independent States 14,4% (R762 m)

Source: Department of National Health and Population Development, 1991:36-37

Although provincial health expenditure has decreased in proportion to total public health expenditure since 1975, it still constituted about 60% of the public health care budget in 1987/88 (as against 72% in 1975-76) (*cf.* Department of National Health and Population Development, 1991: 36-37; McIntyre & Dorrington, 1990:126; Van Rensburg, Fourie & Pretorius, 1992:211-212). Indeed, the Browne Commission (Republic of South Africa, 1986a:136) attributed the increase in total public health expenditure to the exceptionally high level of health expenditure by provincial administrations, and remarked that the real per capita increase of the latter was much faster than and out of proportion to that of the budget administered by the Department of National Health and Population Development (*cf.* McIntyre & Dorrington, 1990:127). The transfer of several executive responsibilities to provincial administrations in 1987 and 1988 strengthened their mandate for an even greater claim to public funds. Relative to other public institutions, the provincial administrations were thus left in a particularly powerful bargaining position for funds (*cf.* De Beer, Buch & Mavrandonis, 1988:40 & 45; McIntyre & Dorrington, 1990:127; Republic of South Africa, 1990/91:40 & 153). The inevitable implication is that curative, institutional health care provision by the public sector (which is the executive responsibility of provincial administrations) is receiving disproportionately more funds than basic, primary and preventive health care. Because of this expenditure, the substantive and real needs for care in several communities and population sectors remain unaddressed.

2. Manifestation of the problem

A striking illustration that inflation is endemic to a pluralistic care system is found in Wildavsky's (1977:109) "Law of Medical Cost". This law states that "... medical costs rise to equal the sum of all private insurance and government subsidy", which means that the cost of health care in a pluralistic system will rise in relation to consumers' ability and willingness to pay for it, on the one hand, and the state's ability to finance and subsidise it, on the other. As has been explained, the coincidence of several circumstances and factors in each of the sectors leads to substantial increases in the cost of health care, while the unique interaction between the sectors instigates a culminating cycle of cost increase. In current terms, South Africa is indeed spending more and more money on health care. From 1980/81 to 1989/90 South Africa's total health expenditure as a percentage of the country's Gross National Product increased from 4,3% to 6,4% (*cf.* Central Statistical Services, 1990:21.5; Department of National Health and Population Development, 1988:16; 1991:75-76; Engelhardt, 1989:60; Republic of South Africa, 1986b:17; Zwarenstein

et al, 1988:31-32). However, it is important to note that between 1975/76 and 1984/85 health expenditure in the private sector increased almost twice as fast as health expenditure in the public sector (Naylor, 1987:674). More recently, real per capita health expenditure in the public sector — as measured against 1985 price indices — has revealed an annual average increase of 3,6% since 1988. In the private sector, it increased by 5,9% from 1987/88 to 1988/89, and by 10,7% in the following year (Department of National Health and Population Development, 1991:76).

The difference between the two sectors in per capita health expenditure in 1987, i.e. R159 in the public sector, as against R555 in the private sector, and the more rapid increase in expenditure in the private sector, have specific implications for health and health care which cannot be calculated or expressed in financial terms. On the one hand this indicates an expansion in the range and quality of service in the private sector, where more money is available for satisfying the curative health needs of mainly white, urban and personally paying clientele. On the other hand, the declining rate of state expenditure on health care necessarily indicates a deterioration in the range and quality of services for the growing public sector clientele — mainly non-whites with an increased demand and need for ever more comprehensive care (Van Rensburg, Fourie & Pretorius, 1992:205; *cf.* De Beer & Broomberg, 1990:144-145). Between the two sectors, more comprehensive and deep-cutting inequalities with class and racial connotations become increasingly evident. This necessarily creates the impression of a first-world, first-class private sector reserved for first-class citizens, as against a third-world, inferior and second-rate public sector reserved for second-class citizens. Inevitably, the social cost of such a system, as measured by the experience of relative deprivation, discrimination and frustration, is very high.

From the preceding exposition, the conclusion inevitably follows that the current South African health care system is financially and socially unaffordable. Therefore, throughout this study, the problem of unaffordability is conceptualised in both financial and social terms and related as such to arguments concerning solutions to the problem of unaffordability.

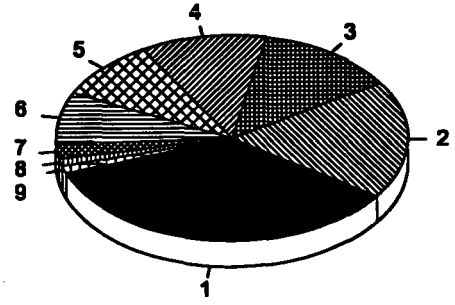
2.1 Unaffordability of South African health care: Physicians' perspective

The results of the survey conducted among physicians in Bloemfontein on this issue indicate that they have a mainly financial view of the problem of unaffordability. The social dimensions of the problem figure less prominently in this conception — indeed, they seem to be deliberately denied or depreciated. This conclusion is based on physicians' response to a question enquiring what they regard as the *three* main

problems/deficiencies of South African health care, as well as the response to a supplementary question included in the questionnaire to elucidate and qualify the earlier question.

Figure 3 contains a summary of the responses to the question relating to physicians' identification of the three main problems in South African health care.

Figure 3: Problems in South African health care: Physicians' perspectives



Problem	Frequency of occurrence in combination of problems
1. Escalating cost of health care	30
2. Fragmentation of the health care system in terms of organisation and service provision	16
3. Insufficient resources	11
4. Effective health care provision for the underprivileged	10
5. Third-party financing of health care	8
6. Increasing state intervention	7
7. Increasing claim of private sector to public facilities	2
8. Incompetent minister of National Health and Population Development	1
9. Deterioration of academic medicine	

According to the information in Figure 3, it would appear that physicians in Bloemfontein regard the increasing cost of health care as the main problem of South African health care. This fixation on the financial cost of health care seems to be a reflection of physicians' unilateral concern about their own financial position. As will be indicated presently, most physicians do identify the cost of health care as a problem consumers have to contend with. Nevertheless, they do not regard it as a fundamental obstacle as far as consumers' access to the health care system is concerned.

In this survey, physicians who entered the profession with preconceptions about its profitability (15 of the 20 such respondents) indicated that they were disillusioned and that medicine was not as profitable a career as they had expected it to be. Furthermore, 30 respondents (91% of the sample) indicated that the financial position of physicians has deteriorated, even drastically so, during the past five

years. This pessimism about their own financial position appears to predominate physicians' perception of the problems afflicting South African health care. In a study by Fredericks, Mundy and Kosa (1974:53), physicians' attitudes towards health care provision for the indigent were taken to be indicative of their social conscience. Should the same apply to this study, the rating of this particular issue indicates that concerns about immediate financial or economic problems seem to crowd out the social conscience of physicians in Bloemfontein.

Physicians' perceptions and views of the degree to which consumers are faced with various problems in the South African health care system are summarised in **Table 3.**

Table 3: Financial and social costs of health care: Physicians' perspective on consumers' problems

PROPOSITION	Agree		Undecided/ Neutral		Do not agree	
	N	%	N	%	N	%
1. Access to professional health care is becoming financially more difficult for the average South African to obtain	23	70	1	3	9	27
2. In South Africa, a person's financial ability determines the quality of care he can lay claim to	8	24	2	6	23	70
3. In South Africa, the colour of a person's skin determines the quality of care he receives	1	33	5	15	17	52

Concerning the impact of escalating costs on the consumer, the information in Table 3 indicates that 70% of the physicians in this sample were of the opinion that professional health care was becoming too expensive for the average South African. Their responses to a supplementary question relating to their views of the main causes for the non-utilisation of health care (which by implication would also indicate their views regarding factors influencing the accessibility of the health care system) are very informative in this regard. According to these responses, the physicians did not regard the unaffordability of health care as a fundamental cause for the non-utilisation of health services. Only eight physicians (24%) were of the opinion that unaffordability restrains consumers from making use of health services

according to their needs, as against 13 (40%) who ascribed non-utilisation to consumers' ignorance regarding the appropriate utilisation of health services. This indicates that physicians would blame the non-utilisation of health care on the consumer (the phenomenon of victim-blaming) rather than admit that consumers are vulnerable to problems stemming from the characteristics, processes and practices of the system as such. (Of the remaining 12 respondents, six ascribed non-utilisation to the unavailability of services and six to the inaccessibility thereof.)

The information in Table 3 further indicates that the physicians denied and failed to appreciate the differential degree to which various population groups and sectors were exposed to the effect of cost escalation in the health sector. Some 52% of the physicians in this sample denied that financial ability was a crucial factor determining the quality of health care to which the consumer could lay claim. Many more (70% of the sample) also denied that a person's ethnicity was of fundamental importance in this regard.[6] Thus, the physicians neglected three realities of South African health care, viz.

- ☐ the significant connection between a health care consumer's population group and socio-economic status, which implies that whites have access to more and better health care resources than blacks;
- ☐ the inequitable distribution of health insurance, which further benefits whites, particularly in relation to health care, and
- ☐ the fact that financial considerations deny many consumers access not only to the private sector but even to the most basic health care.

From the physicians' very favourable evaluation of the degree to which the South African health care system effectively addressed the health needs of the whole South African population, it was clear that they viewed the problem of rising costs in the health sector in isolation from the complex societal issue. The question relating to this issue had been carefully formulated in the questionnaire to include the then self-governing and independent states. In spite of this reference to the homelands, a very high proportion of the physicians (36% of the sample) believed that between 75% and 100% of the whole South African population received effective services in terms

6. Interestingly enough, 15% of the respondents gave a neutral/unsure response to the statement relating to financial discrimination, as against only 6% to the statement implying racial discrimination. Along with the higher percentage of negative responses to the latter statement, this indicates that physicians do have some insight into the discrepancies in the nature and quality of health care in terms of the financial standing of consumers. However, it also indicates their unwillingness to allow that these discrepancies are also influenced by race and colour.

of the existing system. When one considers the inequitable distribution of health insurance and health services in South Africa, and particularly the still very desperate health care situation in the previous homelands (which housed roughly 44% of the whole South African population in 1985), this result indicates an over-favourable evaluation of the South African health care situation. Even the 42% of the sample which felt that the existing health care system effectively served about half of the population would seem to have based their evaluation on the narrow frame of reference of the middle and upper classes.

In sum, physicians in Bloemfontein seemed to have only a limited understanding of the financial aspects of the problem of rising costs and the unaffordability of health care. The fact that the problem permeates other aspects of society where it assumes discriminatory undertones of class, race and colour, does not seem to have penetrated their perception of the problem.

2.2 Unaffordability of South African health care: The perspective of consumers

In contrast to the physicians, who conceptualised the problem of unaffordable health care in a very narrow financial sense and seemed unaware of its ramifications in other areas and levels of social association, the residents of Bloemfontein and Mangaung (the consumer population of this study) were well aware of both the financial and the social dimensions of unaffordability in South African health care.

The degree of consumer dissatisfaction with the existing health system was clear from the acknowledgement of 86,1% of the sample that there was a crisis in South African health care. In itself, this result is not significant, because it gives no indication of the conception and experience of the so-called crisis. However, analyses of the responses to supplementary and qualifying questions revealed that various consumer groups conceptualised and experienced the crisis in South African health care in accordance with their differential experience of certain social and health care realities. Inferential analyses of research data indicate that this variation is explicable mainly in terms of respondents' population group and membership of medical schemes. Note that these two variables were themselves also significantly related. By implication, most of the variation in the consumers' perception and experience of the crisis in South African health care was elucidated by reference to the sector of service (public or private) on which they relied. The socio-economic status of the respondents and their subjective experience of relative deprivation in this regard, as well as their financial ability to overcome health crises, were less significant in this explanatory framework. Owing to the limited size of the sample,

the role played by respondents' political convictions in their perception and experience of the South African health care issue could not be analysed inferentially.

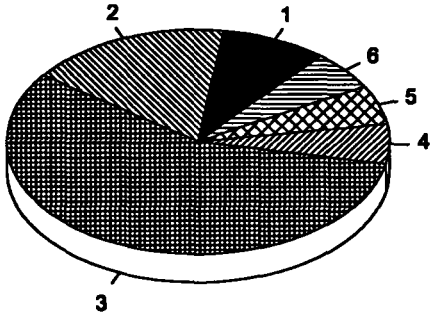
Blacks appeared to be significantly more aware than whites that South African health care is in a crisis situation. The same is true of uninsured consumers as against insured consumers. As will be shown by further analysis, these results reflect negatively on the public health sector and indicate a basic dissatisfaction with both the social and financial cost of health care among the public sector clientele. By contrast, the perception held by white, insured consumers (the private sector clientele) of the crisis in South African health care focuses more specifically on rising financial costs and the increasing unaffordability of health care.

2.2.1 *Financial cost as critical consideration in consumers' perception of health care problems*

A first important and insightful variation in the consumers' perception and experience of the crisis in South African health care relates to their experience of the financial cost of health care. Most respondents (84,3% of the total group under investigation) agreed that it was "nowadays too expensive to go to the doctor". However, this result must be interpreted within the framework of the pluralistic health care system in South Africa. For insured consumers, financial costs refer mainly to the cost of health insurance, as well as extra payments on certain services, prescriptions and prostheses. For the non-insured consumer it refers to the levy on curative services provided by public care institutions or the full fee of private practitioners and care institutions.

Views on the cost of health insurance of the respondents who indicated that they did have health insurance are presented in **Figure 4.**

Figure 4: Cost of health insurance in relation to benefits: The views of respondents with membership in medical schemes



	N	
1. Exorbitant	11	(8,94%)
2. Expensive	21	(17,07%)
3. Reasonable	70	(56,91%)
4. Inexpensive	7	(5,69%)
5. Very inexpensive	7	(5,69%)
6. Cannot judge	7	(5,69%)

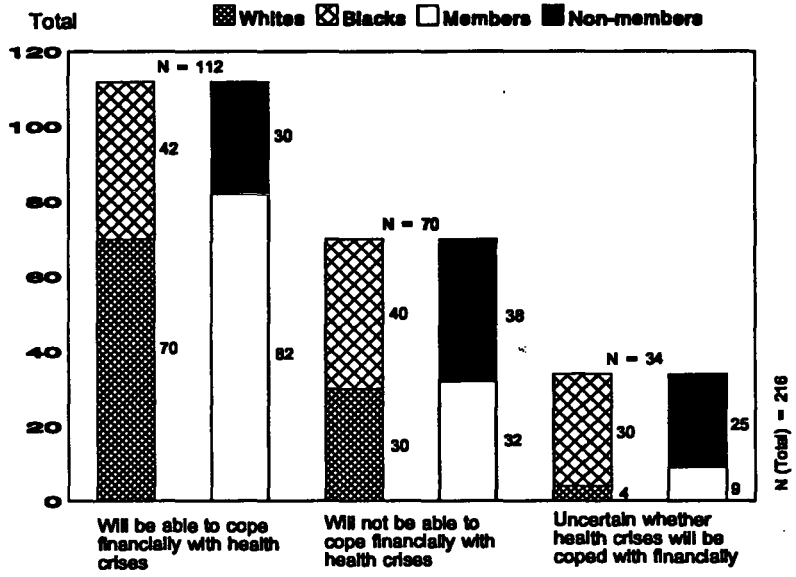
Note: N = 123 (93 respondents did not have health insurance)

According to Figure 4 it appears that the consumers who did have health insurance (mostly whites) were generally satisfied with the cost of this insurance as such, considering the coverage and protection it provided. Most of the respondents who had health insurance (70, or 57%, of the 123) were of the opinion that their health insurance premiums were reasonable in comparison with the benefits offered. The data show that the insurance of insured respondents in most cases covered the medical expenses of the member and his dependants. As far as specific expenses were concerned, most respondents' insurance offered partial payment of consultation fees and prescribed medicine, while hospital expenses were in most instances fully covered. Apart from this proportion of insured respondents who felt that health insurance was financially speaking a reasonable transaction, as well as those seven respondents who did not want to comment in this regard, more of the remaining insured respondents (32, or 26% of the 123 respondents concerned) were of the opinion that health insurance was an expensive or even exorbitantly expensive transaction than were of the opinion that it was a cheap or very cheap transaction (14, or 11,4%, of the 123). The conclusion that follows is that most of the respondents who had health insurance did not, in view of the coverage and protection it provided, view the cost of that insurance as problematic in itself. These respondents seemed to hold the opinion that health insurance still provided an affordable alternative for the direct payment of medical expenses, despite dramatic increases in membership premiums in recent years. Therefore, these respondents regarded the *health care services* (consultation fees, medication, hospital costs, etc.), rather than *health insurance,* as unaffordable.

As far as non-insured respondents (mostly blacks) were concerned, the statement that "it is nowadays too expensive to go to the doctor" reflected concretely on consultation fees and fixed tariffs at the point of and at the time of service rendering. For these respondents the direct, though unpredictable and immediate impact of medical expenses on household budgets seemed to bring financial catastrophy; and among *them,* more than among the others, insecurity and anxiety arose regarding the ability to cope financially with serious health crises. The relationships between, respectively, respondents' population group and membership in medical schemes, and their perception of their financial ability to overcome a serious health crisis is depicted in **Figure 5.**[7]

7. The figure is regarded as a suitable visual representation of the results. Note, however, that the inferential Chi-square analyses to both relevant relationships produced significant probability ratios of 0,00 and uncertainty coefficients of 0,07.

Figure 5: Consumers' perceptions of their ability to cope financially with a health crisis: Variation according to population group and medical scheme membership



As the data in Figure 5 show, significantly more black and uninsured respondents than white and insured respondents indicated that they could not cope financially with a health crisis. On the one hand, this result reflects the more favourable socio-economic position of the white, insured clientele as well as the security offered in the case of large-scale expenses by the accumulated reserves of a health insurance fund. On the other hand, the uncertainty and extreme vulnerability of the black, uninsured consumer is also visible. It is important to note that the respondents' socio-economic status (as indicated by the average monthly income of a specific household) and their subjective experience of their financial circumstances serve to explain the responses to this question. A significant Chi-square probability of 0,001 in the relationship between the respondents' monthly income and their perception of their financial ability to overcome a health crisis, along with a Gamma-value of -0,4 and an uncertainty coefficient of 0,04, indicated that the confidence in one's financial ability to overcome a health crisis increased proportionally with the increase in monthly income. The same is true of the respondents' subjective experience of their financial circumstances: the better the consumers considered their circumstances to be in comparison with those of others, the greater their confidence in their financial ability

to overcome a health crisis. (The probability of the Chi-square value in this regard was 0,000, while the uncertainty coefficient of 0,05 indicated that the subjective experience of financial circumstances actually exerted a stronger influence than real monthly income on the consumers' perception of their financial ability to overcome a health crisis.) The mutually significant relationships between the respondents' population groups, their membership of medical schemes, their socio-economic status and their subjective experience of relative deprivation was clearly shown in their perception of their financial ability to overcome a health crisis. In particular, the extreme vulnerability of black respondents (who do not usually have health insurance and cannot make much allowance for direct medical costs and expenses out of their limited monthly income) was stressed.

Across the spectrum, therefore, consumers were worried and dissatisfied about the high cost of health care. Black consumers, in particular, were aware of their financial inability to provide for their health needs. Although most of the white consumers also considered the cost of health care to be high, health insurance gave them sufficient confidence in their ability to provide for their health needs. The burden of the cost of this insurance is apparently not as important as the knowledge that it will protect them from health expenses in general, and particularly from sudden and/or catastrophic expenses and dramatic increases in costs.

2.2.2 *Social cost as critical consideration in consumers' perception of health care problems*

A further variation in consumers' perception of the health crisis in South Africa relates to their experience of quality differences and discrimination in the context of care. In general, consumers appear to be satisfied with the quality of health care in the context of personal care. Most of the respondents (70% of the sample) indicated that they had no complaints about the quality of service provided by physicians. The result of a closer investigation of the relationships between consumers' population group and membership of medical schemes, on the one hand, and their experience of quality differences and discrimination in the health sector, on the other hand, are summarised in **Table 4.**[8]

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8. This and other similar tables contain summaries of the results of *T-tests for independent groups*. Statistically, the use of this data processing technique requires that the independent variable has only two independent categories, whereas the dependent variable must be operationalised on at least an interval level of measurement. In this table, the average counts of responses to statements (items) on a five-point attitude-index of whites and non-whites, as well as insured and non-insured consumers of health care are compared. Values were attributed to the categories of the dependent variable as follows: 1 = strongly agree; 2 = agree; 3 = undecided/neutral; 4 = do not agree; 5 = definitely do not agree. Note that the T-test for independent groups is especially sensitive

Table 4: T-test of consumers' experience of the quality of health care: The role of population group and medical scheme membership

DEPENDENT VARIABLES	Group	N	Average	F-value	2-way probability of F	*Separate variance estimate*		
						T-value	Df	2-way probability
I cannot complain about the quality of service I receive from doctors	Whites	104	1,29	1,74	0,005	-4,29	205,93	0,000
	Blacks	112	1,76					
	Members of medical schemes	123	1,35	1,58	0,019	-3,7	169,33	0,000
	Non-members of medical schemes	93	1,78					
In South Africa, the colour of a person's skin determines the quality of care he receives	Whites	104	2,11	1,76	0,004	5,78	191,11	0,000
	Blacks	112	1,44					
	Members of medical schemes	123	1,96	1,65	0,012	4,03	212,64	0,000
	Non-members of medical schemes	93	1,50					

From Table 4, it appears that black and uninsured respondents were significantly more dissatisfied with the quality of care received than whites and insured respondents. Furthermore, the impression that the quality of care was determined by the patient's colour was held mainly by black and uninsured respondents. These responses indicate by implication consumers' awareness and experience of real

for the tenability of the parametrical assumption of homogeneity (that is the equalness of variances of score distributions of which the average are compared). Should this assumption hold in a given comparison of score distributions, the result of the relation which is calculated on the basis of a separate variance estimate must be interpreted. The procedure for a T-test for independent groups includes an F-test for the homogeneity of variances. The significance thereof indicates whether the results of the pooled or those of the separate variance estimates must be interpreted. Should the significance of F > than the chosen level of significance (in this instance 0,05), the null hypothesis which states that the variances of the score distributions which are here brought into relation are equal, is accepted. The T-value based on the pooled variance estimate will therefore be interpreted. Should the significance of F < than 0,05 the null hypothesis is related in favour of the alternative hypothesis which states that the variances of the score distributions differ significantly. In such an instance, the T-value based on the separate variance estimate is interpreted.

differences in quality between the public and private health sectors. Specifically, the mainly black, uninsured clientele of the public sector were significantly more negative than the largely white, insured clientele of the private sector with regard to the aspect of the quality of care.

An analysis of the responses to an unstructured question about the consumers' reasons for dissatisfaction and unhappiness concerning the provision of service provides clarification in this regard. The complaints of white respondents related mainly to the general problems associated with free-market health care. The high fees charged by private hospitals, the high cost of medicine and of medical services generally, were the main points made. Twelve of the 26 complaints listed by white respondents were of this nature, while the two complaints in respect of incomplete medical insurance cover might also be considered in this light. Comparatively few complaints from white respondents had to do with the quality of health care. The six complaints listed in this regard were indicative of a lack of interest, dedication and personal care which respondents perceived in particular among physicians and hospital staff.

By contrast, most complaints of black respondents related to the issues characteristic of socialised or state medicine. Long waiting times at service points, overloaded facilities, impersonal service and hospital staff's negative attitude towards patients were the major reasons for dissatisfaction. Sixteen complaints referred specifically to the inconvenience of long waiting times at hospitals and clinics. The next major source of dissatisfaction appeared to be the behaviour of hospital staff and nurses in particular. The following responses were typical of the 13 complaints listed in this regard: "Nurses are careless, they have a negative attitude towards patients", and: "Once the nurses know you they will treat you well, but if they don't know you they become negative and scold you as if you were a fool." Nine other complaints revealed dissatisfaction with impersonal, uninterested treatment amounting to merely "processing" the patients. A typical example reads: "I once visited a doctor and told him I had a pain in the chest. Without examining me he gave pain tablets, but the pain went on. I went to the other doctor who diagnosed TB." Interestingly enough, only two black respondents complained about the high cost of health care in response to this question.

2.2.3 *Consumers' perceptions of unaffordability: A summary*

From the survey data it can be concluded that white, insured health care consumers in Bloemfontein perceived and experienced the crisis in South African health care as relating to the high and increasing cost of medical services and medication. Although they generally regarded the cost of health insurance as reasonable, these

consumers became increasingly concerned about the gap between the medical aid tariff of fees and the tariffs actually charged for consultations, treatment and medication. It was the increase in these direct payments, like automatic excess payments on certain services, medications and prostheses, that was apparently the greatest source of concern for the white, insured consumer. Problems relating to the provision of services and the behaviour of health staff, which would indicate dissatisfaction with the quality of health care, did not figure prominently in these consumers' perceptions of the crisis in South African health care.

Although the high and still rising financial cost of health care was an equal source of concern and dissatisfaction for the black, uninsured consumer, the survey data also indicated a real dissatisfaction with aspects of the service and quality of health care in this sector of the consumer population. For these consumers, the inferior quality of service, indicative of the social cost of health care, was a crisis in itself, apart from the financial cost of care.

From the consumer's point of view, the issue of unaffordability in South African health care is a real problem in both financial and social terms. The survey data confirm that household budgets were increasingly pressurised by rising financial costs owing to tariff increases and expensive but incomplete insurance cover. This was particularly true among the largely white, insured clientele of the private health sector. The available information also confirmed that consumers experienced real differences in the quality of care and treatment offered by the public and the private health sectors; the largely black, uninsured clientele of the public health sector gave clear evidence of this in the survey. With respect to the reporting of quality differences in health care, Wildavsky's (1977:105-106) comment on the role played by differential frames of reference in the experience of a particular health care situation is very relevant: "Opinions about the family doctor ... are formed from personal experience. The 'system', on the other hand, is an abstract entity — and here people may well imitate the attitude of those interested and vocal elites who insist the system is in a crisis" (*cf.* Calnan, 1988:927-928). This comment is only partially applicable to the present survey, however, since the qualitative information, in particular, indicated that the perception of the health care crisis held by consumers in the public sector was fully justified by their concrete experience of inferior quality of service.

In view of the lack of an all-embracing vision of the various dimensions of unaffordability in South African health care, as well as the incomplete insight into the complex mutual relationships between the causes and manifestations thereof and, above all, in the absence of the political will and ability to acknowledge and address the nature of the problem, the financial and social costs of health care are

escalating to undesirable and unprecedented levels. From the discussion it is clear that this complex problem will not respond to instant, ill-considered or patchwork solutions. Rather, simultaneous solutions must be sought for both the financial and social unaffordability of health care. This would include relief for both state and household budgets, but also the fundamental acknowledgement of the consumer's right to affordable, efficient, humane treatment in the health sector.

CHAPTER 3

COMMUNITY-BASED HEALTH CARE: AN APPROPRIATE MODEL FOR AFFORDABLE HEALTH CARE PROVISION IN SOUTH AFRICA

Solutions to the dual issue of unaffordability in South African health care require both the promotion of economic and financial efficiency in the health sector and the single-minded pursuit of equal social entitlement to health care. The question arises as to whether a community-based approach to health care could make health care financially affordable, while also promoting equality, justice and fairness.

The justification for a community-based model of health care is to be found in the degree to which it can offer solutions to the complex problem of rising financial costs in the health sector, on the one hand, and oppose the various manifestations of social disadvantage in the health care system, on the other.

It has already been explained that, for the purpose of this study, community-based health care is defined as a comprehensive approach to health care and an all-embracing strategy for health care provision. As such, it relies on specific principles and assumptions and has certain implications for the planning, organisation, provision and financing of health care. An exposition and evaluation of these principles, assumptions and implications, in accordance with the degree to which they may be able to promote the financial and social affordability of health care in South Africa, will now be given.

1. Community-based health care: Conceptual elucidation

Conceptually, community-based health care amounts to a fusion of the primary health care approach and the ideal of health for all. Although Zwarenstein and Barron (1992:1)[9] do not refer to the concept of community-based health care as such, they summarise its essence in saying: "The goal of most governments world wide is to strive for ... Health for All, a concept which commits them to seeking an equitable and acceptable approach to attaining a level of health for all people within their borders which allows full participation in the life of the community and society.

9. Zwarenstein and Barron (1992:10-13) offer various conceptual definitions of community involvement and participation in health care, and also elaborate on functional aspects thereof within the broader context of primary health care provision.

Health services are to be directed to achieving Health for All using the PHC [Primary Health Care] approach. The PHC approach is a comprehensive national strategy for health, based on principles of equity and affordability, effectiveness and acceptability, participation and efficiency" (*cf.* Department of National Health and Population Development, 1989:23). The crucial conceptual quality of community-based health care, distinguishing it from primary health care and "health for all", is the pertinent inclusion of reference to community involvement and participation, i.e. the principle of community empowerment and democratisation in its definition (*cf.* Segall, 1983:1947). As such, the renewed interest in and emphasis on community-based health care is a purposeful attempt to implement a principle or assumption whose merit has long been recognised. As early as 1970, for instance, Freidson (1970:212) commented that" ... if the health services of the future are to be organized more economically, fairly, and 'rationally' than they have been in the past, the only thing that can save them from accelerating the emerging crisis in the human quality of care is the concomitant strengthening of the circumstances that permit the patient to have direct impact on the care he receives" (*cf.* Mechanic, 1972:48; Mji & Vallabhjee, 1990:122).

2. Principles and practice of community-based health care

Several crucial guiding principles and assumptions which play a role in the realisation of a community-based care system are implicit in its definition. The following are among the most important:

- ☐ *Appropriateness and relevance:* This implies that a clear connection, co-ordination and balance must exist or be created between the type of services and facilities available in a specific community and the needs of that community.
- ☐ *Acceptability:* Health services and facilities must be personally and socio-culturally acceptable to their clientele. Factors such as the developmental and educational standards of specific communities, as well as diverse cultural views and convictions concerning health, disease and health care must therefore be taken into account and respected in the provision of care.
- ☐ *Accessibility:* Obstacles in the way of needs-based access to health care — whether geographical, financial, cultural or political — must be eliminated if possible.
- ☐ *Affordability:* Nobody should be refused the right to basic care because of financial constraints. At the same time, the cost of health care should not be allowed to exhaust any household or state budget.

- ☐ *Adaptability and flexibility:* The continually changing health requirements of the clientele necessitate regular evaluation of the care provided in terms of all the above criteria. The provision of care must be consistently adapted to and synchronised with the altering circumstances of various communities and their changing care requirements.

If these principles were applied to the practice of health care provision in South Africa, community-based health care would amount to the provision of

- ☐ effective, appropriate health services and facilities
- ☐ of the highest possible standard and quality
- ☐ at the lowest possible cost
- ☐ in accordance with the actual health requirements and demand for health care of the
- ☐ broad South African population
- ☐ in all its diversity.

The implementation of these principles in the practice of community-based health care would require considerable adaptation and alteration to existing structures, processes and practices of South African health care. In outline, this would amount to the following:

2.1 Community-based health care planning

The provision of community-based health care depends on the diverse, different needs and demands for health care which exist within a complex clientele. Thus it requires a planning process which is sensitive to the specific needs of the entire clientele and flexible enough to accommodate these needs suitably in the provision of care. This necessarily implies the devolution of health care planning to the level of the community and the direction of care provision to the needs, abilities and circumstances of smaller communities. Dodds (1992:12) explains the underlying justification for a community-based planning process as follows: "Since the aspirations of any particular group or sector have no logical or legitimate precedence over those of any other, the only *just* way in which to achieve alignment of ends and means is through *interactive participation in choice (i.e. decision-making), responsibility (i.e. implementation) and accountability (i.e. evaluation).*"

For the purposes of community-based health care planning, communities are defined as social groupings with relatively comparable geographical, socio-economic and socio-cultural circumstances, relatively uniform demographic and epidemiolo-

gical profiles and relatively homogenous health requirements — and not, as is currently the case, as complex social groupings which coincidentally exist within specified provincial, political or national boundaries. With specific reference to the organisational co-ordination of community-based health care planning within the broader context of a local government system, Zwarenstein and Barron (1992:III) are of the opinion that "[t]he present ethnic boundaries should be replaced by more organic socio-economic and topographical boundaries, drawing coherent economically functional units together as administrative districts. Rationality and accountability necessitate that the health district boundaries match those of other local administrative structures."

Health provision planning must thus occur in accordance with the specific **need** for care, as established from measurable, observable indicators of sickness and health in a specific community. The provision of care must also take into account the **demand** for care, in accordance with various communities' specific socio-cultural frames of reference, i.e. their culturally unique views and perceptions of sickness, health and care, as well as their demographic and economic circumstances, including their particular conception of affordability, acceptability and appropriateness. In this way community-based health care planning leads to financial savings by means of the elimination of any unnecessary, inappropriate or unacceptable provision of service.

The democratisation of the planning process also allows for the implementation of the principle of equity, since equal provision is made for persons with similar health needs, as well as for persons equally exposed to health risks (*cf.* De Beer, 1988b:5; Klopper *et al.*, 1989:209). Tannen (1980:128-129) explains the underlying advantage of this planning process as follows: "Population-based planning is a process which determines health needs and establishes resource requirements based upon an assessment of the risk levels and health status of a given population. The determination of need is derived solely from attributes of the population, initially ignoring all existing resources... By basing its analysis on the subsets of the population and their risk levels rather than on the resource structure, population-based planning facilitates the identification of the social, economic and environmental problems which predispose a population to high risk of disease... It facilitates health maintenance by targeting preventive and health care programs directly at high-risk populations and appears more capable of orienting the health care system toward promotion, prevention and primary care activities." It is clear that community-based health care planning involves a radical reversal of health planning in South Africa; the current "... process of imposition from above ... will indeed have to be replaced by a process of ... consultation from the bottom up ..."

(Centre for Health Policy, 1990:20). This is the only way in which the fundamental assumption of community-based health care, namely community participation and involvement, can be practically implemented.

2.2 A unifying national health policy

Although community-based health care planning occurs on a regionalised, democratic basis, this process must nevertheless take place in an orderly fashion within an appropriate, unifying and guiding policy framework. As Zwarenstein and Barron (1992:8) correctly point out, the function of such a policy framework is, on the one hand, to see that the implementation of the principle of local autonomy does not disintegrate into anarchy and, on the other hand, to prevent the supportive, guiding process from degenerating into rigid, bureaucratic prescriptiveness. Community-based planning and centralised policy formulation are not mutually exclusive processes. A central co-ordinating body is necessary only to ensure the uniform implementation of policy principles by local authorities. This would prevent autonomous regional authorities from promoting their own interests on the grounds of their own interpretation and distortion of policy principles and thus creating inter-regional inequities which could undermine the move towards equality and justice (*cf.* Klopper *et al.*, 1989:209). Central policy formulation does not thus mean rigid, authoritarian control. Rather, it implies a management model by means of which autonomous local executive bodies can be made **socially accountable** to the communities they represent as well as **politically and financially accountable** to a central controlling body. As Dodds (1992:11) remarks, central policy formulation and control relate more to functional co-ordination than to the exercise of control *per se*: "Functional alignment on a national scale is not necessarily in conflict with regional or local needs and aims, but means that the latter should contribute toward the overall development process in an appropriate manner, not working against the larger system of which it is part. This would require ongoing debate and interaction between different levels and amongst different components of society, so that mutual understanding can lead to a shared development culture" (*cf.* De Beer, 1988a:72).

A representative authority or body with the required mandate, credibility, expertise and political will to bring about progressive reform in South African health care would necessarily have to be in control of the formulation and implementation of such a pro-active health policy. However, this ideal is rendered impossible by the existing system of health care financing in South Africa. The specific interests which have developed over time around private and public financing methods and mechanisms aim at opposing ideals with respect to the provision of health care.

These interests and ideals cannot be reconciled in a guiding policy without subjecting the present system of health care financing in South Africa to drastic reform. This reform should be aimed at giving a single authority the mandate to implement the principles and practices of community-based health care in South Africa — regardless of the established interests, priorities and practices which may be threatened thereby.

2.3 Financing a community-based health care system

A representative authority or body charged with creating a community-based care system by means of pro-active policy formulation is faced with a special challenge. It will have to create a favourable climate for the establishment of a community-based health care model by replacing the current financial, political and professional profit-motives by more collective, egalitarian, even altruistic and humanitarian motivation. In the process of reform, various established professional, political and financial interests — which have been responsible for so much distortion, disparity and discrimination in South African health care — will have to be questioned and effectively opposed. Wolinsky (1988:67) correctly points out that the mandate for this is to be found in control over the funds for and financing of health care: "It should become clear that the way to control the health care delivery system is to regulate the flow of money into and within the system ... Therefore, if you want to control the system, you must control the purse strings."

The consolidation of all available financial resources for the provision of health care in South Africa and the administration of such a collective fund by a reliable, representative, impartial or democratic financing agent would thus seem to be further conditions and requirements for community-based health care. Viewed in this light, the financing of health care becomes a public matter, with the funds for health care provision being generated and collected from the clientele in accordance with the limits of affordability, and then allocated and distributed to various communities in accordance with the principles of equality and justice, with primary consideration for the needs, requirements and health risks involved.

The ideal would be to have a single authority or body responsible for national policy formulation and the financing of health care. In this way, the various principles of community-based care (appropriateness, acceptability, accessibility, affordability and adaptability) could best be co-ordinated. The absence from this central body of any commercial aim or financial interest in health care provision is the essential factor in the successful implementation of a community-based care system. Dodds (1992:14) explains the essence of this conviction: "We need a

process that focuses on what people want and not on eliminating what they don't want ... Such a process is one of interactive, participative national development planning, and should be conducted with the aid of facilitators who don't have a stake in the system short of seeing it succeed." Community-based health care provision is indeed an unselfish enterprise in the best interest of the community which it serves. Personal financial, professional or political interests are incompatible with its fundamental principles and assumptions.

On close examination, community-based health care thus involves the devolution and promotion of power and involvement regarding the planning, organisation, management and financing of health care to the level of the community, and may also be viewed as the democratisation of health care. The legitimacy of a community-based health care system is thus by definition to be found in the acceptance and endorsement thereof by the whole population or clientele. This implies that only a system which remains accountable to its clientele in terms of well-defined criteria such as affordability, appropriateness, acceptability and accessibility will be legitimate. The legitimacy of the system will be ratified by its continued financing from a collective fund. On every level of planning, management and provision, such a system will thus be impelled by accountability towards financial efficiency and savings. Since **need**, rather than financial status, race or geographical situation, will be used as the criterion determining provision and accessibility in the health sector, community-based health care will obviously lead to the levelling or elimination of inequity, disadvantage and discrimination on various levels of social association. In the final analysis, community-based health care offers an affordable alternative — in both financial and social terms — to the existing health care system in South Africa.

CHAPTER 4

PROBLEMS RELATING TO THE IMPLEMENTATION OF COMMUNITY-BASED HEALTH CARE IN SOUTH AFRICA

The classification of various forms of health care reform according to their feasibility by Renaud (1975:568-569) confirms that reform along the lines of the principles and requirements of a community-based care model is very difficult to implement, and particularly so in a country like South Africa: "A third possible avenue for the improvement of health through state actions is ultimately only possible in socialist societies, although some minor changes can realistically be expected within capitalist economies. It involves the implementation of an altogether different approach to health, disease and medicine: in brief, the decommodification of health needs, leading to a more direct and intense preoccupation with the social conditions giving rise to disease. Specifically, it involves the development of a new medical knowledge based on what has been called an 'ecological' approach, the elimination of the monopoly of the medical profession over the definition and cure of illnesses, the elimination of private property in skills, training and credentials, and a reversal in the actual trends in the allocation of resources towards therapy and prevention ..." The implementation of a community-based health care system indeed has far-reaching implications and involves radical change as far as the current principles and practices of health care in South Africa are concerned. This study will concentrate on the following aspects:

1. Implementing a community-based health care model in South Africa: Implications for the physician

The reform of the South African health care system in accordance with the principles and requirements of a community-based care model clearly has major practical implications for the organisation, planning, financing and provision of health care. The implementation of collective financing measures implies the demise of private health care financing, while the implementation of an alternative system for the payment of physicians often (though not necessarily) spells the end of the fee-for-service system. For physicians in the public sector, of course, collective financing measures and salaried provision of service is nothing new. However, all physicians will have to accept increased external control over professional matters (as

CHAPTER 4

PROBLEMS RELATING TO THE IMPLEMENTATION OF COMMUNITY-BASED HEALTH CARE IN SOUTH AFRICA

The classification of various forms of health care reform according to their feasibility by Renaud (1975:568-569) confirms that reform along the lines of the principles and requirements of a community-based care model is very difficult to implement, and particularly so in a country like South Africa: "A third possible avenue for the improvement of health through state actions is ultimately only possible in socialist societies, although some minor changes can realistically be expected within capitalist economies. It involves the implementation of an altogether different approach to health, disease and medicine: in brief, the decommodification of health needs, leading to a more direct and intense preoccupation with the social conditions giving rise to disease. Specifically, it involves the development of a new medical knowledge based on what has been called an 'ecological' approach, the elimination of the monopoly of the medical profession over the definition and cure of illnesses, the elimination of private property in skills, training and credentials, and a reversal in the actual trends in the allocation of resources towards therapy and prevention ..." The implementation of a community-based health care system indeed has far-reaching implications and involves radical change as far as the current principles and practices of health care in South Africa are concerned. This study will concentrate on the following aspects:

1. Implementing a community-based health care model in South Africa: Implications for the physician

The reform of the South African health care system in accordance with the principles and requirements of a community-based care model clearly has major practical implications for the organisation, planning, financing and provision of health care. The implementation of collective financing measures implies the demise of private health care financing, while the implementation of an alternative system for the payment of physicians often (though not necessarily) spells the end of the fee-for-service system. For physicians in the public sector, of course, collective financing measures and salaried provision of service is nothing new. However, all physicians will have to accept increased external control over professional matters (as

established and implemented by a central planning and financing agent in terms of a national health policy). Such control measures will not undermine a physician's clinical authority and autonomy, but will lessen and limit physicians' influence on and dominance of macro-aspects of organisation and policy formulation in the health sector. In the implementation of the British National Health Service, which is generally regarded as the prototype of a collectively financed, centrally regulated health care system in a capitalist society, physicians did retain their autonomy in the context of clinical care, but..." they have increasingly had to cede ground to government and to 'administrators' over issues of policy and resource allocation" (Horobin, 1983:91-92). For the physicians, thus, the implementation of a community-based care model has major implications concerning their involvement in the **conditions** of service provision and the issue of professional accountability to society at large.

2. Implementing a community-based health care model in South Africa: Effects on the consumer

For health care consumers in the private sector, these health care reforms will mean the end of health insurance, as well as the end of their claim to certain benefits and privileges associated with buying power in the private health sector. The existing clientele of the public sector, however, will experience these reforms as the equalisation of access to the health care system for all consumers, regardless of race or membership of a medical fund. As Van Rensburg, Fourie and Pretorius (1992:383) correctly point out, the universalisation of care benefits within an integrated system will eliminate discrimination against consumers on the basis of income, race, or any other consideration. Consumers will enjoy equal access to integrated facilities according to their need for care.

3. Receptiveness to alternative policy orientations: A *modus operandi* for empirical surveys among physicians and health care consumers

The reform of the South African health care system in accordance with a community-based care model will have the greatest effect upon private practitioners and the clientele of the private sector.[10] Physicians and consumers of health care,

10. For the purpose of this survey the discussion of the disadvantages associated with the establishment of a community-based health care system in South Africa is limited to these interest groups. A wider perspective might argue that the implementation of the principles and practices of a community-based care model involve real disadvantages for all individuals and institutions

jointly and severally, can thus be expected to exhibit varying degrees of receptivity towards alternative reform strategies in South African health care. In this survey, the receptivity of physicians and consumers towards reform alternatives was determined by means of their attitudes towards various system variables of two distinctive policy orientations. Their objections and anticipated opposition to specific reform initiatives were then deduced, and the problems of the implementation of community-based health care were thus reconstructed from the perspectives of both physicians and consumers.

The first Likert index determined respondents' attitudes to and perceptions of the provision of health care within a largely collectively financed, centrally regulated care system (in essence a welfare dispensation). The specific system variables operationalised in this index related to the collective financing of health care by means of tax revenue, the free provision of services and salaried physicians. Within this framework, the most important prerequisites for the implementation of a community-based care model were presented to respondents. It must be stressed that only the essence of an ideal scenario of health care provision within a collectively financed, centrally regulated system was sketched for the respondents. Against this background certain statements relating to health care and health care provision were presented to respondents who had to respond within the given frame of reference. In the first index, the responses indicate the degree to which respondents found the essential conditions of a community-based care model acceptable or unacceptable. The prospects of the implementation of a community-based care model could thus be deduced from the index.

A second Likert index presented an indication of the attitudes towards and perceptions of physicians and consumers of health care in respect of health care provision in a privately financed system where market principles and the medical profession regulate the supply and price of health care (i.e. a largely free-market system). In this scenario the system variables highlighted as the essence of the respondents' frame of reference were health care as a commodity, private financing of and payment for health care and the system of fee-for-service remuneration for physicians. Note that the system variables in the respective scenarios were directly opposed, so that respondents could not be confused or uncertain about the essential principles according to which they had to interpret the items in the index. For the

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with a primarily financial interest in the existing care system. Apart from private practitioners, who could experience such a step as a threat to their income levels and their professional autonomy, the interests of companies running private hospitals and clinics, as well as the pharmaceutical industry and, of course, the whole health insurance industry could well be threatened (*cf.* Van Rensburg, Fourie & Pretorius, 1992:395).

purposes of interpretation, responses to items in the different indices serve to supplement and elucidate one another. By implication, positive attitudes in one index reflect negatively on the principles and practices operationalised in the other index. From the specific combinations of attitudes, preferences and perceptions of physicians and consumers, their receptivity towards alternative health care principles and practices and, by implication, the problems associated with the implementation of a community-based health care system could be deduced.

4. Collective financing and central control *versus* the free market and entrepreneurship in health care: An attitude survey among physicians in Bloemfontein

To obtain a global impression of the Bloemfontein physicians' attitude in respect of these contrasting policy frameworks, the average of each respondent's scores on the items comprising the respective indices was calculated. Certain responses were recoded in order to synchronise the values of responses in terms of scores on a five-point attitude scale in such a way that low scores consistently indicated a negative attitude and high scores a positive attitude. By implication, the lowest average score which respondents could rate on an index, indicating a very negative attitude towards a specific policy orientation, was 1. The highest average score obtainable was 5. Average scores approaching 5 thus indicated a more positive attitude towards a specific policy orientation.

The conclusion that physicians in Bloemfontein preferred the principles and practices of a largely free-market system to collective financing and central control (the essential principles or prerequisites of a community-based care model) was based on the following comparison of the distribution of average scores on items in the respective indices:

The average of the score distribution reflecting the physicians' attitude towards collective financing and central control (by implication, community-based health care), along with the median and mode of this distribution, was far lower than the average, median and mode of the score distribution reflecting the physicians' attitude towards free-market health care. As a whole, the distribution of average attitude scores on the community-based index tended towards the lower extreme of the scale, which indicated a preponderance of negative attitude scores on the individual items in the index. The distribution of attitude scores on the free-market index approached the higher extreme of 5, indicating a preponderance of positive attitude scores. Note, too, that the difference between the lowest average score obtained on the community-based index (1,38) and the lowest potential score of 1

was far less than the difference between the highest score obtained on this index (3,85) and the highest potential score of 5. The opposite was true in respect of the free-market index: the difference between the lowest average score obtained (1,5) and the lowest potential score of 1 was far greater than that between the highest average score obtained (4,6) and the highest potential score of 5.

Analyses of the responses to individual items in the respective indices provided more specific indications of the preferences and aversions underlying the physicians' attitudes towards a collectively financed, centrally regulated care system, on the one hand, and a free-market health care system, on the other.

4.1 Prospects for a community-based health care system in South Africa: A summary of the physicians' perspectives

A summary of the index operationalising the physicians' attitudes towards and perceptions of specific system variables of collectively financed, centrally regulated health care is given in **Table 5.**

Table 5: Physicians' attitudes and perceptions regarding collectively financed, centrally regulated health care

SYSTEM VARIABLE	Agree		Undecided/ Neutral		Do not agree	
	N	%	N	%	N	%
1. The individual will unlearn taking responsibility for his own welfare	23	70	3	9	7	21
2. The patient does not pay directly for medical services and will therefore make unreasonable therapeutical demands on the physician	26	79	4	12	3	9
3. The financial ability of the individual patient need not be considered during clinical decision making, which will lead to insensitivity of physicians towards the cost of therapeutical intervention	18	55	3	9	12	36
4. People who do not deserve it, will benefit from such a system	18	55	6	18	9	27
5. It is a very fair system of health care provision	7	21	4	12	22	67
6. Physicians will have to sacrifice much in terms of income should such a system be implemented	22	67	9	27	2	6
7. The implementation of such a system will deprive physicians of their motivation to work	25	76	2	6	6	18
8. Interest in medicine as a career will decline if such a system is implemented	24	73	3	9	6	18
9. Within such a system the physician will be deprived of his clinical autonomy	15	45	2	6	16	49
10. Such a system will deprive physicians of their social prestige	13	39	6	18	14	43
11. Relief from the administrative demands of a private practice will allow physicians more time for patient care	5	15	3	9	25	76
12. Physicians will experience relief from the financial concerns and uncertainties accompanying private practice	12	36	6	18	15	45
13. The implementation of such a system will lead to the large-scale emigration of physicians	24	73	4	12	5	15
14. As a physician I shall support such a system if the clinical autonomy of the medical profession can be guaranteed	12	36	4	12	17	52

As far as the effect of collective financing and central control of health care on the consumer is concerned, the data of Table 5 indicate that most physicians in Bloemfontein envisaged its having a negative effect upon consumers' willingness and ability to accept responsibility for their own welfare. Because services would be provided free of charge, patients would make unreasonable therapeutic demands on the physician. And physicians, in all likelihood, would fulfil these demands, since the buying power of the patient would place no limits on clinical decision-making. In this regard, 18 of the 33 respondents (55% of the sample) indicated that, in their opinion, collective financing and free provision of health care could lead to insensitivity and indifference towards the cost of therapeutic intervention. Physicians were also of the opinion that the benefit of free health care could be too widely distributed, in the sense that all individuals, regardless of their contribution towards a collective health financing fund, would have an equal claim on scarce health care resources. For the physicians, the universalisation of health care benefits by means of the elimination of buying power as the criterion determining access does not in itself imply a more just health care dispensation. In the survey, 22 of the 33 physicians (67% of the sample) indicated that the introduction of collective financing and central control measures in the health sector would not necessarily lead to an equitable system of health care provision. The perception of equity appears to be connected to the claim on health care resources in accordance with contributions to a collective financing fund. According to this view, buying power should be the basis for and the criterion determining justice in a collectively financed care system. It should not be replaced by need as the criterion determining access to free health services.

The data of Table 5 also reveal the implications envisaged by the physicians in a system of collective financing and central control in the health sector. Most of the physicians were negative or concerned about the extent to which the implementation of these measures could lead to a decrease in their income, as well as about the negative effect which the removal of the financial incentive for service provision could have on the professional motivation of physicians, on interest in medicine as a career and, inevitably, on the standard of South African health care. By comparison, fewer physicians indicated concern about the extent to which their autonomy in terms of clinical decision-making, or their social status and prestige would be affected by the implementation of these measures. Most of the physicians felt that collective financing and central control would not relieve the financial worries and uncertainties associated with private practice. Nor was it felt that physicians would be able to devote more time to patient care once they were relieved of the administration and management of private practices.

As a whole, these responses reflect negatively on the physicians' receptivity towards the policy measures and strategies by means of which a community-based care system would have to be established in South Africa. It is particularly disturbing to note that most of the respondents (73% of those involved in this survey) envisaged the large-scale emigration of physicians as their likely resistance to the implementation of such measures.[11] Even if the maintenance of their present income and clinical autonomy were guaranteed, most of the physicians in Bloemfontein would not be in favour of the implementation of collective financing and central control measures in the health sector.

An unstructured question about the physicians' objections to the implementation of these measures in the South African health care system aimed at greater clarity and a deeper understanding of their responses to the previous structured items. The greater proportion of the physicians (27, or 82% of the sample) responded. Their objections confirmed their concern about the repressive effect of the implementation of collective financing and central control measures on their professional enthusiasm and motivation, as well as its necessarily deleterious influence on the standard and quality of health care. The physicians correctly envisaged that, with the implementation of collective financing and central control measures, the role of personal financial profit as an incentive for the provision of services would be at an end ("private income as incentive would disappear") and that their professional autonomy would be questioned and limited in various ways. This was shown by objections such as: "The physician is denied the choice of prescribing quality medication", or "There must be choice in a national system — all physicians must be able to choose the type of service they wish to provide, e.g. curative, community or preventive", or "The family doctor or general practitioner is ignored. No state system can plan sensibly without family doctors."

Inevitably, these measures were also associated with the British National Health Service, and in the wider context with socialism; much reference is made to the disadvantages and faults of both. Specific criticism included bureaucratic red-tape, the overuse or abuse of services and resources, long waiting lists, and the repression of personal initiative. Telling comments included: "Standards will be lowered; entrepreneurship will be eliminated; there are major defects in such systems elsewhere" and "Any free service will be abused — people must pay for services,

11. Although 72,2% of the physicians involved in this survey were of the opinion that the implementation of collective financing and central control measures in the South African health care system would lead to the large-scale emigration of physicians, only 12 (36,4%) indicated in response to a supplementary question that, under such conditions, they themselves would consider emigration. This indicates that the threat of emigration is to a certain extent being abused by physicians as a counter to certain reform initiatives in South African health care.

otherwise they are not appreciated, and doctors must be remunerated according to merit, otherwise they won't work." The general impression of the physicians concerning the implementation of collective financing and central control measures was encapsulated in the following two responses: "Dilution and demotivation of the medical profession under a pathetic administrative bureaucracy" and "Socialist — autocratic — lowering of standards". Note the similarity between these results and the findings of Ugalde (1979:109). He came to the conclusion that physicians in Colombia were not against the principle of collective financing and central control as such, but rather feared the bureaucratic control of the medical profession by an unqualified and inefficient civil service ("... the bureaucratisation of the profession under an incompetent and inefficient civil service ...").

The physicians thus irrevocably associated the implementation of collective financing and central control measures with the removal of financial incentives for achievement and the provision of service, as well as with major restrictions on their autonomy, which, in their opinion, would necessarily lead to a lowering of standards and quality in the South African health care system. By implication, this means that a collectively financed, centrally regulated care system could not offer the incentives (specifically, financial enrichment, professional autonomy, free input into the conditions of service provision, and freedom of initiative) required to encourage physicians to provide excellent service.

4.2 Review of physicians' attitudes and perceptions regarding free-market health care

Table 6 provides a summary of the physicians' responses to statements associated with the nature and principles of free-market health care.

From the survey data summarised in this table the following conclusions can be drawn about the physicians' attitudes towards and perceptions of free-market health care. As far as the situation of the consumer was concerned, the physicians acknowledged that the uninformed patient in a mainly free-market system could be exploited and that such a system was inherently unfair towards the financially less well-off clientele. However, most of the physicians did not envisage themselves putting personal gain above the interests of their patients in such a system, or purposely exploiting the benefits of such a system for their own gain. Although they therefore acknowledged the inherent disadvantages of the system, they did not seem to be as willing to admit their own role in the negative effects of such a system. In all probability this was also the reason why most of the physicians did not regard the provision of health care in a free-market system as inherently discriminatory.

Table 6: Physicians' attitudes and perceptions regarding free-market health care

SYSTEM VARIABLES	Agree		Undecided/ Neutral		Do not agree	
	N	%	N	%	N	%
1. Such a system will lead to the exploitation of uninformed patients	15	46	5	15	13	39
2. Free-market health care is inherently unfair towards financially underprivileged patients	15	46	7	21	11	33
3. Physicians will put their own economic gain above the interests of their patients	7	21	4	12	22	67
4. Physicians will easily exploit such a system by claiming fees for services not actually rendered	12	36	3	9	18	55
5. Health care provision in a free-market system is inherently discriminating	8	24	6	18	19	58
6. Physicians are best equipped for the task of national health care planning	20	61	3	9	10	30
7. The medical profession will welcome the state's withdrawal from the health sector	20	61	8	24	5	15
8. Patients who pay directly for medical services will be more judicious in the utilisation thereof than those who receive it free of charge	28	85	4	12	1	3
9. The quality of service in a free-market system will be superior to that in a collectively financed, centrally planned system	22	67	4	12	7	21
10. Most physicians will welcome the implementation of a free-market system	23	70	7	21	3	9
11. A free-market system is only feasible in as far as most people can afford health insurance or the direct payment of medical services	24	73	3	9	6	18

With regard to the position of the physician and the medical profession in a mainly free-market system, most of the physicians seemed to think that such a system would allow them clinical autonomy — specifically in the light of the scaling-down of state involvement in the health sector. In the same positive strain, physicians in Bloemfontein felt that patients would make more judicial use of medical services in a free-market system because they would be paying for these services. They also thought that the quality of service provision in a free-market system would generally be better than that in a collectively financed, centrally regulated system. Most of the physicians would welcome the implementation of a largely free-market health care system in South Africa.

The physicians were also realistic enough to understand that a free-market health care system could only be implemented if the majority of people had health insurance or could afford the direct cost of medical services. In response to an unstructured question about the physicians' objections to the implementation of

such a system, the associated costs and the fact that the system would always be inaccessible to certain consumers because of financial considerations were consistently mentioned. Another important source of objection was the controlling and even manipulative role which third party financing agents (insurance companies and medical schemes) could assume. The physicians experienced this as a real threat to and undermining of their professional autonomy. Concern was also voiced about the disadvantages of a free-market system for academic medicine, as well as about the unequal distribution of medical services, facilities and labour which characterise free-market health care because it tends to be concentrated in areas with a relatively high *per capita* income and around an insured clientele. Although the statement that, in a free-market system, physicians might put their own financial gain above the interests of patients, did appear in the structured index, it was also specifically mentioned in response to the unstructured question as an objection to the implementation of a free-market health care system.

Physicians therefore acknowledged that financial and economic limitations were serious restrictions on the implementation of a free-market health care system in South Africa, and that the consumer could be very vulnerable in such a system. Concern was also felt about the degree to which, in a free-market system, financing agents threatened the professional autonomy of physicians.

In general, it appeared as if the disadvantages of collective financing and central control in the health sector were more important to physicians than those of a free-market health care system. The complete result of four items in which the physicians used individual criteria to indicate a definite preference of one or other system is given in **Table 7.**

Table 7: Collectively financed, centrally regulated health care *versus* free-market health care: Physicians' preferences according to certain critical considerations

CRITICAL CONSIDERATIONS	A: Free-market health care		B: Collectively financed, centrally regulated health care		C: Combination of A and B	
	N	%	N	%	N	%
1. Which system best complies with your conception of justice?	7	21	3	9	23	70
2. Which system has the most potential for solving current problems in South African health care?	6	18	4	12	23	70
3. Which system will best promote a sensitivity towards costs and savings?	9	27	5	15	19	58
4. Within which system would you as a physician prefer to practise?	9	27	5	15	19	58

The data in Table 7 indicate that the physicians still saw a combination of systems (a pluralistic system, therefore) as the most appropriate model for health care provision in South Africa. Where choices were made between the two systems, the physicians seemed consistently to prefer free-market health care. Most of the physicians indicated that, as opposed to a collectively financed, centrally regulated system, they considered a free-market health care system to be a fair, cost-effective and appropriate solution to the problems of the existing South African health care dispensation. More physicians indicated a preference for practising in a free-market system, than in a collectively financed, centrally regulated system.[12] In response to an unstructured question, many physicians proposed solutions to the perennial problem of consumers unable to afford private health care. They suggested either a lower, state-subsidised tariff for such consumers, or the training of semiprofessional health workers for the provision of health care to underprivileged consumers, or even that such consumers could "pay" for their health care by means of community service.

It therefore appears that the physicians attempted to reach a compromise with the recognised disadvantages, dangers and temptations of the free-market system by means of concessions based on their professional morality and personal integrity. Thus, strict ethical codes of conduct and high moral standards were seen to offer the consumer sufficient protection from the potential disadvantages of free-market health care. In so far as each physician respects ethical codes of conduct and maintains high personal moral standards (as individual respondents in this survey confirmed), the demonstrated disadvantages of free-market health care are thus regarded as the unfortunate confluence of abstract system effects in which neither the individual physician nor the medical profession plays any part. At the same time, the physician enjoys the benefits, privileges and liberties of a free (in this sense,

12. In a national survey of general practitioners in South Africa only 20% of the sample were in favour of collective financing of health care (Volmink *et al.*, 1992:6). More specifically, the researchers note that "[a]fter controlling for university background, sex, age, location and GP qualification, we found that the university at which a respondent's basic degree was obtained was the only independent predictor of attitudes to the funding of health care. Considerable divergence was demonstrated between the views of graduates of White, Afrikaans universities on the one hand, who favoured a privately funded and fee-for-service orientated system and those of respondents who qualified at Black universities, who preferred public funding with less emphasis on fee-for-service" (Volmink *et al.*, 1992:11). In the survey of Bloemfontein physicians, no respondents had graduated at black universities, while graduates of English universities were also underrepresented. This must definitely be taken into account in interpreting the data obtained in this survey. In this respect, see also the findings of an investigation into receptivity towards alternative methods of remuneration conducted by Pineault, Contandriopoulos and Fournier (1985:427) among physicians in Quebec.

uncontrolled and unregulated) health care market. In this context, Reuschemeyer (1983:41) notes appropriately: "Individually and, in association, collectively, the professions 'strike a bargain with society' in which they exchange competence and integrity against the trust of client and community, relative freedom from lay supervision and interference, protection against unqualified competition as well as substantial remuneration and higher social status." In fact, this demonstrates the insensitivity of physicians towards the social good in health care. The question arises: to what extent do physicians' professional and financial interests and personal gain still dominate the planning, financing and provision of health care in this country, to the detriment of the interests of consumers?

5. Community-based health care *versus* free-market health care: Attitude surveys among consumers in Bloemfontein and Mangaung

The same method used to establish the attitudes and perceptions of Bloemfontein physicians with regard to the abovementioned contrasting policy frameworks was used, with the same motivation, in the attitude survey among residents of Bloemfontein and Mangaung. Items in the indices were, however, adapted and reformulated to take cognisance of the consumers' knowledge and frame of reference in relation to health care. Care was taken to ensure that attitudes would be established in relation to system variables and principles corresponding with those in the population of physicians.

From the distribution of the respondents' average scores on all the items in the respective indices, there appeared to be greater receptivity towards a collectively financed, centrally regulated health care system than towards a free-market system among health care consumers — especially when compared with the physicians. On the Likert index in which attitude scores were allocated to various aspects of a collectively financed, centrally regulated system, the scores were relatively evenly distributed between a minimum of 1,43 and a maximum of 4, around an average of 2,65, a median of 2,64 and a mode of 2,43. On the whole, the distribution therefore tended towards the lower end of a continuum stretching from 1 to 5. This indicates a predominance of positive attitude scores on the various items in the index. On the index for free-market health care, scores varied between a minimum of 1,64 and a maximum of 4,36. These scores were also relatively evenly distributed around an average of 2,9, a median of 2,82 and a mode of 2,54. It must be noted, however, that the synchronisation of scale or index scores allocated to positive and negative statements required that certain scores be recoded, and that all attitude scores on the relevant index be interpreted accor-dingly. After recoding, low scores on the index for free-market health care indicated a predominantly negative attitude towards this

system as a whole. Further analyses of the responses to individual items in the respective indices indicated to what extent different system variables were more or less acceptable to respondents. This also provided clarification and explanation of certain attitudes towards various aspects of the contrasting policy orientations included in this study.

The respondents' evaluations appeared to be much more positive in the case of a collectively financed, centrally regulated care system than in the case of a free-market system. Most of the respondents (69% of the sample) thought that the former — as described to them by the interviewer in terms of **scenario A** on the interview schedule — was a good system of health care. A total of 64% of the sample would have no objection to the implementation of such a system in South Africa. (Note that respondents who responded neutral/uncertain to the questions in this regard were consistently excluded from these calculations.) According to 26% of the sample, collectively financed, centrally regulated health care would not be an acceptable system; 27% felt, moreover, that it should never be implemented in South Africa. Concerning the evaluation of a free-market health care system — as described to respondents by interviewers in terms of **scenario B** on the schedule — far fewer respondents (44% of the sample) were of the opinion that it was a good system; 46% would have no objection to its implementation in South Africa. For a small majority of respondents (46% of the sample), however, it was an unacceptable system, and according to 43% it should never be implemented in South Africa. It is interesting to note that white and black consumers differed significantly in their attitudes to the respective policy orientations or systems. The variation in consumers' attitudes towards collectively financed, centrally regulated health care, on the one hand, and free-market health care, on the other, is summarised in **Table 8.**

The data in this table may be interpreted as follows: While the blacks were significantly more in favour of collectively financed, centrally regulated health care, the whites were significantly more positively disposed towards a free-market system. Likewise, the relationship between the respondents' population groups and their membership of medical schemes was reflected in these attitudes, since respondents without health insurance were significantly more in favour of collective financing and central regulation than those with health insurance. According to the survey data, consumers' attitudes towards the two policy alternatives did not seem to be influenced by their socio-economic status, their subjective experience of this status, or their politico-ideological orientation.

However, these results may well suggest that respondents involuntarily had a more positive attitude towards principles and practices corresponding to their prevailing frame of reference in relation to health care. Alternative principles and

Table 8: Collectively financed, centrally regulated *versus* free-market health care: The role of population group and medical scheme membership in consumers' opinions

DEPENDENT VARIABLE	Group	N	Average	F-value	2-way probability of F	*Pooled variance estimate*		
						T-value	Df	2-way probability
Collectively financed, centrally regulated health care is a good system of health care provision	Whites	104	2,58	1,07	0,739	2,83	213	0,005
	Blacks	112	2,08					
	Members of medical schemes	123	2,64	1,05	0,795	4,14	212	0,000
	Non-members of medical schemes	93	1,92					
A free-market system is a good system of health care provision	Whites	104	2,85	1,01	0,938	-2,15	212	0,033
	Blacks	112	3,20					
	Members of medical schemes	123	2,79	1,02	0,938	-3,69	211	0,000
	Non-members of medical schemes	93	3,37					

practices automatically met with a negative response owing to ignorance or incomprehension. Yet, these results may show that, after careful thought about their own positions *vis-à-vis* the advantages and disadvantages of alternative principles and practices in health care, the respondents were able to express a considered preference for one or the other option. In the preference of the whites for a free-market system, the quality and personal nature of service were apparently more important than the cost of private health care. The blacks, by contrast, apparently knowing that free-market health care was financially inaccessible to them, saw their needs and interests as being better served by a collectively financed, centrally regulated system.

5.1 Collective financing and the free provision of health care: A review and analysis of consumers' opinions

From the respondents' reactions to individual items in the respective indices, the equity and affordability of collectively financed health care seemed to be a major factor disposing consumers positively towards the system. Most of the respondents,

regardless of population group, membership of medical schemes, socio-economic status or politico-ideological convictions, were of the opinion that the implementation of collective financing and central control measures would make the system more accessible to the underprivileged, and thus contribute to a more just health care dispensation. A total of 93% of respondents thought that the implementation of collective financing and central control measures would make the health care system accessible to those currently without medical care because of financial considerations. For 77% of the respondents, such a dispensation was just in so far as it eliminated buying power and personal prosperity as criteria determining the nature and quality of care. As far as affordability was concerned, most of the respondents (67% of the sample) thought that a collectively financed system would remove their financial concerns regarding health care. As the data in **Table 9** indicate, however, significantly more black and uninsured respondents were of this opinion than white or insured respondents.

Table 9: Affordability of health care: The role of population group and medical scheme membership in consumers' opinions regarding collective financing

DEPENDENT VARIABLE	Group	N	Average	F-value	2-way probability of F	*Pooled variance estimate*		
						T-value	Df	2-way probability
The implementation of collective financing measures in the health sector will relieve my financial concerns about health care	Whites	104	2,5	1,42	0,073	2,34	213	0,020
	Blacks	112	2,1					
	Members of medical schemes	123	2,5	1,21	0,335	3,24	213	0,001
	Non-members of medical schemes	93	2,0					

The interpretation of the data in Table 9 may indicate that black, uninsured respondents considered the payments levied on public services to be a real obstacle in their access to the health care system and that they would welcome the reduction or total abolition of such payments. Because of their receptivity towards collective financing measures in place thereof (see Table 8), the black, uninsured respondents were also more accepting than the white, insured respondents of a crucial condition and basic principle of community-based health care. This difference can probably best be explained in terms of the white respondents' insistence that all South

Africans should make a contribution to the taxes which finance health care. The data in **Table 10** indicate that the whites reacted significantly more positively to the statement that a collectively financed, centrally regulated health care system would have to be based on a foundation of broader taxation than was the case at the time of the survey.

Table 10: The relationship between population group and consumer opinion about the collective financing of health care from tax revenues

DEPENDENT VARIABLE	Group	N	Ave-rage	F-value	2-way proba-bility of F	*Pooled variance estimate*		
						T-value	Df	2-way proba-bility
Collective financing measures and free provision of health care can be implemented if all South Africans pay their fair share of income tax	Whites	104	2,0	1,38	0,102	-2,73	214	0,007
	Blacks	112	2,4					

Whites in South Africa contribute proportionally more than blacks to the state coffers by means of income tax, and it appears that they would feel aggrieved if funds to which they had made the largest contribution were to be used without distinction for the financing of health care for the population of South Africa at large. This conclusion is supported by the predominantly confirmatory response (received from 66% of the sample and from more — though not significantly more — white, insured respondents than black, uninsured respondents) to the statement that the implementation of collective financing measures and the provision of free health care could advantage the undeserving. If collective financing methods are to form a component of health care reform in South Africa, this aspect will have to be carefully taken into account. The generation of funds to finance a community-based health care system will have to pass the test of equity and fairness according to the specific consumer perceptions thereof. Sources supplementing income tax, or completely alternative sources for extending or broadening the financial basis, such as the levying of additional sales tax on certain consumer items or the legalisation of lotteries, for example, could be considered for this purpose.

Another aspect of health care financing in a community-based care system, where the respondents' population group and membership of medical schemes did influence their attitudes, was the perception of significantly more white, insured respondents than black, uninsured respondents that, in a collectively financed, centrally regulated care system, physicians would not be able to enrich themselves financially to the detriment of patients. (T-test analyses of these relationships for independent groups produced significant results.) Consumers thus seemed to expect collective financing measures almost automatically to offer protection from both the dramatic increase in health care costs and the exploitation of the free-market.

Certain disadvantages of collectively financed health care were purposely presented to respondents in certain index statements (items). Most respondents reacted negatively to these items. Nevertheless, there were noticeable contrasts and variations in these responses which provided valuable insights into the respondents' consideration and evaluation of this policy orientation. While most of the physicians indicated that collective financing and central control measures would undermine their initiative and incentive to provide excellent service, only 40% of all consumers thought this would be the case. The significant majority of these were white, insured respondents. (The two-way probability of the T-value based on the combined variance estimate was 0,00.) In the same way, a significant majority of those 78 respondents (36% of the sample) who were concerned that physicians would lose interest in their patients if the system of private payment were abolished were white, insured respondents. It might be argued as a possible explanation that the black, uninsured respondents accepted the public care context as the standard frame of reference for the quality of health care and were therefore largely indifferent towards these statements. However, it was white, insured consumers who associated the high standard of personal service with the fact that the physician was dependent on his patients for his income — a mechanism of quality control which is threatened by the collective financing of health care and which would be taken away from white, insured consumers along with their rights and privileges relating to buying power.

The only disadvantage or danger implicit in collective financing and free provision of health care identified by consumers was that it could lead to the over-utilisation of health services. Although most respondents (73% of the sample) would not intentionally neglect their own health in the knowledge that health care was provided free of charge, 60% were nevertheless concerned that the abolition of direct payment could lead to overuse of services, as people could seek professional assistance too easily or in the case of trivial problems.

5.2 Free-market health care: A review and analysis of consumers' opinions

In the distribution of respondents' average scores on items in the index for free-market health care, attitudes were seen to tend slightly towards the negative. From analyses of responses to individual items, the preponderance of negative attitude scores appeared to be based largely on the black, uninsured respondents' experience of the unfairness, exploitation and discrimination associated with free-market health care.

In general, the respondents appeared to feel that they could benefit very little from the full implementation of a free-market health care system. Indeed, most of the respondents (56% of the sample) felt that greater privatisation of health care would only be to the advantage of physicians. For 51% of the sample, the exploitation of patients by physicians in a free-market system gave real cause for concern. Because of the fact that 8% of the sample responded neutrally or with uncertainty to this statement, this 51% was a considerably higher figure than the 41% who did not consider exploitation to be a real danger in a free-market health care system. It appears, however, as if the respondents were hesitant to attribute this concern simply to physicians' profit motive. An analysis of the response to a statement which indicates consumers' perception of the possibility of exploitation is reflected in **Table 11.**

Table 11: Exploitation of the patient in a free-market health care system: The role of population group and medical scheme membership in consumers' opinions

DEPENDENT VARIABLE	Group	N	Average	F-value	2-way probability of F	*Pooled variance estimate*		
						T-value	Df	2-way probability
Patients will not know whether the services they pay for, were actually rendered	Whites	104	2,9	1,13	0,529	2,36	214	0,02
	Blacks	112	2,5					
	Members of medical schemes	123	2,9	1.23	0,307	2,46	214	0,015
	Non-members of medical schemes	93	2,5					

The data in Table 11 indicate that significantly more black and uninsured respondents than white and insured respondents were afraid of exploitation and would not know when they might be paying the doctor for a service never rendered by him. On the other hand, this indicates a greater degree of acknowledgement of their ignorance with relation to health care matters among blacks than among whites. However, it also indicates that health insurance, which is usually regarded as an accumulated, maximally utilisable reserve, can cause insured respondents to become indifferent towards aspects such as the exploitation and abuse of the system. There was far more concern about exploitation and abuse among the black, uninsured respondents who were paying directly for health care.

A further consideration figuring prominently in the consumers' negative perceptions of free-market health care was its inherently discriminatory nature, and specifically the very vulnerable position of the financially underprivileged in such a system. Most of the respondents (66% of the sample, regardless of population group, membership of medical schemes or socio-economic status) agreed that health care provision in a free-market system was inherently discriminatory. In response to a statement specifically relating discrimination to buying power or personal prosperity, by far the majority of the respondents (79% of the sample), regardless of population group, membership of medical schemes or socio-economic status, also agreed that a free-market health care system was unfair to the financially underprivileged.

On the positive side, 61% of the sample were of the opinion that greater privatisation of health care would teach people to look after their health better, while 70% felt that physicians would show more interest in their patients if they were directly dependent on those patients for their income. In the respondents' general impression of a free-market health care system, however, the disadvantages of exploitation and discrimination appeared to count for more than these positive aspects. According to the conceptualisation of this study, the consumers thus appeared to experience both the financial costs of free-market health care and its social effects — other forms of exclusion and discrimination — as problematic. It was the realisation of these real disadvantages which disposed most consumers more favourably towards a collectively financed, centrally regulated system as the appropriate policy alternative for South Africa. In response to the question asking which of the given scenarios they would prefer to see implemented in South Africa, 136 respondents (64% of the sample and significantly more black, uninsured respondents than white, insured respondents) were in favour of a collectively financed, centrally regulated system, as against 77 respondents (36%) who preferred a free-market system. In the final analysis, a significant majority of consumers in this

survey thus saw their best interests, as far as health care was concerned, as lying with the principles and practices of community-based health care rather than free-market health care. Although the population group of consumers did play a significant role, this result broadly supported that of Levine (1984) who, in the light of respondents' reactions to contrasting value orientations (principles such as market orientation or social orientation, public welfare or medical efficiency, and autocracy or democracy) came to the conclusion that, "... contrary to what most mainstream philosophers and some Marxists exert, dominant values exhibit at least a tendential bias favoring socialism ..." (Levine quoted in Van Parijs, 1986:773).

CHAPTER 5

RECEPTIVITY TOWARDS ALTERNATIVE REFORM STRATEGIES IN SOUTH AFRICAN HEALTH CARE: A FRAMEWORK FOR INTERPRETATION AND EXPLANATION

Any attempt to explain the attitudes and perceptions of physicians and consumers in respect of alternative policy orientations towards the reform of the South African health care system leads inevitably to those values and norms which underlie a specific ethos of health care and view of health care matters. In the final analysis, the differential receptivity of physicians and consumers (jointly and severally) towards alternative reform strategies appears to result from their irreconcilable aspirations, interests and convictions with regard to health care. In this final section, certain aspects of the ethos and orientation of physicians and consumers towards health care are analysed, with the intention of demonstrating in what ways and to what extent specific reform initiatives run counter to prevailing values, norms and interests, and are experienced as an obstacle in the way of aspirations.

1. The moral dilemma of physicians: Community-based health care *versus* personal interest

Previous studies have shown that the factors underlying the attitudes and perceptions of physicians in respect of health care and health care reform are:

- ☐ symbolic attitudes (actually their politico-ideological philosophy of life and view of the world),
- ☐ objective personal interest (financial incentives and maximum financial reward for clinical services), and
- ☐ subjective personal interest (maintenance of autonomy in affairs relating to both the content and the conditions of service provision[13]) (*cf.* Fredericks, Mundy & Kosa, 1974; Globerman, 1990; Goldman, 1974; Pineault,

13. By means of an aggressive process of professionalisation, the medical profession has extended the limitations of its autonomy beyond the generation, reproduction and application of knowledge in the context of clinical care (i.e. the **content** component of medical service), to include the **conditions** of service provision (i.e. input into the macro-organisational aspects of health care planning, financing and provision) (*cf.* Anderson, in Jaco, 1972:285). While the autonomy of all

Contandrioupolous & Fournier, 1985; Sudit, 1988; Umeh *et al.*, 1986; Yishai, 1982: 286-287[14]).

From the perspective of the physician the problems surrounding the implementation of community-based health care amount to the fundamental conflict between moral and ethical values and convictions, on the one hand, and subjective and objective personal interests, on the other. Although there was a receptivity towards certain critical requirements for the implementation of a community-based health care system among physicians, this apparently did not lead to a sense of liability for the actual implementation of such a system. Realising that the implementation of a community-based system would require certain re-orientations and sacrifices which would have a direct impact on their established financial, professional and political interests in the prevailing system of care, the protection and preservation of these interests appeared to be more important to them than their sense of moral liability towards the broader social interest.

It is noteworthy that most of the physicians in this survey (28, or 85% of the sample) were prepared to acknowledge the principle of health care as a basic human right. However, the concept of the right to health care may confound the interpretation of this item. In accordance with this study's conceptual definition of community-based health care, the acknowledgement of health care as a basic human right implies the universalisation of health care benefits by abolishing and eliminating all measures which limit the needs-based claim to health care resources (*cf.* Navarro, 1989:890). The concept as a whole thus implies the provision of health care in accordance with the actual health needs of consumers, regardless of their financial situation, race, gender or any other distinguishing characteristic. By contrast, the physicians' interpretation of the right to health care appeared to be

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professions with respect to the content of service provision must be acknowledged and respected, the medical profession's claim to autonomy with regard to the conditions of service provision may justifiably be considered unusual, and thus questionable. Freidson (1970:25) notes critically: "Above all, qualifying all else, is my contention that both past and present evidence and experience do not support the justice of the profession's claim for autonomy in organizing the way it presents care ... [W]e cannot rely solely on the profession and its own system of self-regulation to provide a responsible system of care ... [I]t should be clear that some kind of legal, administrative, or bureaucratic system is needed to provide an organized set of requirements that stimulates the profession to provide responsible care and the political and economic support to sustain such care."

14. In these studies the validity of the various variables used to operationalise constructs such as "symbolic attitudes", "subjective personal interest" and "objective personal interest" was verified. Several of these items were included in the measuring instrument used in the survey of Bloemfontein physicians, with slight amendments to the wording to make these items relevant within the South African context.

limited to the provision of a basic minimum level of care as a component of the state's welfare function.[15] Related aspects of the physicians' ethos and orientation in respect of health care must therefore be interpreted in the light of their limited conception of the right to health care.

In the introduction to the previous section it was noted that the implementation of a community-based health care system is particularly problematic in capitalist societies, since the principles of community-based health care are in many respects opposed to, or even irreconcilable with a free-market ideology based on the principles of individualism, *laissez-faire*, market justice and entrepreneurship (*cf.* Van Rensburg, Fourie & Pretorius, 1992:371). In a comment on health care in the United States which is equally valid in the South African context, Tannen (1980:118) puts this problem neatly into perspective: "Surely medical ideology is shaped and determined by many different forces and is not dictated by any one class, but of the many variations and different organizational forms possible, it is no accident that the prevailing form of medical practice ... today is largely compatible with the capitalist mode of production and its social relations. It would be highly unlikely for the medical system in this country to foster ideas relating to the social origins of disease, collective responsibility for health, democratization of medical skills, or community control of medical facilities. These concepts run counter to the prevailing values of the rest of society" (*cf.* Battistella & Smith, 1974:707; Lindblom, 1979:520-521; Navarro, 1976b:454; 1983:184; 1989:889; Price, 1987:48-49; Roemer & Roemer, 1982:112; Van Rensburg, Fourie & Pretorius, 1992:397). The results of selected items in the survey of physicians in Bloemfontein, as summarised in **Table 12**, confirm this unfavourable prospect for a community-based health care system owing to the irreconcilability of the prevailing ethos and value-orientation of the physicians with regard to health care, on the one hand, and the principles and prerequisites for the implementation of a community-based health care system, on the other.

15. In the operationalisation of their national survey of general practitioners in South Africa, Volmink *et al.* (1992:6) distinguished between an all-embracing and more limited concept of the right to health care and came to the conclusion that "[t]here was strong support for the notion of health care as a right for all, with most being in favour of access to some basic level of health care for all and two-thirds supporting comprehensive health care for all citizens".

Table 12: Ideology *versus* practice: Elucidation of contradictions in the physician's moral dilemma

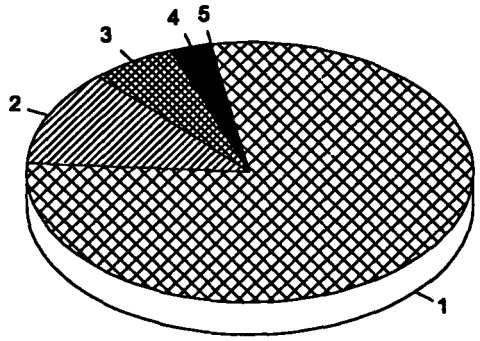
STATEMENT	Agree		Undecided/ Neutral		Do not agree	
	N	%	N	%	N	%
1. Health care is a basic human right	28	85	2	6	3	9
2. Physicians have a moral responsibility towards those who cannot afford their services	21	64	1	3	11	33
3. Health care is a commodity similar to food and clothing; there can be no claim to obtaining it free of charge	19	58	4	12	10	30
4. People who can and want to pay for private health care should not be denied such care	29	88	4	12	0	0
5. The state is responsible for health care provision to the underprivileged	30	91	3	9	0	0
6. Physicians should be compelled to settle in areas where the need for their services is greatest	4	12	4	12	25	76
7. Physicians should be free to settle where they can obtain maximum financial gain for their services	22	67	5	15	6	18
8. The provision of medical care is a professional matter which cannot be subjected to state control	17	52	7	21	9	27
9. The state cannot afford to compensate physicians according to their knowledge and experience	27	82	1	3	5	15
10. The main responsibility of physicians is the provision of care to the individual patient	29	88	1	3	3	9
11. The state must ensure that health care is distributed fairly in society	11	33	6	18	16	49
12. Their qualifications and expertise entitle physicians to social esteem	12	36	9	27	12	36

From the data in Table 12 it appears that the physicians were playing their part in the practice of health care provision in the midst of serious conflicts between their personal and professional interest, on the one hand, and their moral and social liability on the other. Although the physicians did acknowledge health care as a basic human right on an abstract, moral or ethical level of discussion, and also perceived themselves to have some degree of moral liability towards the underprivileged, the results of this survey indicated a strong contrasting orientation as far as their concept of the practice of health care and their own role in the provision thereof is concerned. Just as Sudit (1988:382), in her survey of medical students in the United States, had come to the conclusion that ideological views of health care were not necessarily a manifestation or rationalisation of the personal interest of physicians, the results of this survey identified a fundamental opposition

between ideology and personal interest. This disproves the important Marxist postulate that ideology and personal interest are difficult to separate or distinguish in a relatively homogenous population. In this respect, and in direct contrast to the idea of health care as a basic human right, most of the physicians regard health care as a commodity which can be exchanged in a free-market. This view is borne out in the support of most of the physicians (29, or 88% of the sample) for the preservation of private health care. The conflict lies in the fact that the implementation of the principle of health care as a basic human right cannot be left to the working of market forces and an autonomous profession; health care cannot at one and the same time be acknowledged as a basic human right and exchanged as a consumer item in an unregulated market (*cf.* Gallie, in Maynard, 1986:1161; Ginzberg, 1987:132; Globerman, 1990:14; Gray & Osterweis, 1986:543-544; Roemer & Roemer, 1982:126). In fact, it requires the large-scale limitation of free-market forces and professional dominance of the health sector. The practical implications of this are, of course, unacceptable to the medical profession.

In similar fashion, the physicians' acknowledgement of a moral liability towards the underprivileged was contradicted by the opinion held by most of the physicians in this survey that the state was responsible for the provision of health care for the underprivileged. For further clarification of this aspect of the physicians' sense of their social liability, their preferences in respect of service provision in various care contexts, as depicted in **Figure 6**, are particularly relevant.

Figure 6: Physicians' preferences with regard to alternative contexts of work



	N	%
1. Lecturing/Research in a training hospital	26	79
2. Private practice in an urban area	4	12
3. Limited private practice	2	6
4. Private practice in a rural area	1	3
5. Community health centre in a black township	0	0

The data in Figure 6 contain little to confirm or support the physicians' initial moral conscience with regard to the underprivileged. No physician wanted to become involved with the provision of service at a community health care centre in a black residential area. In fact (possibly because of the composition of the sample) most respondents revealed a distinct preference for teaching and/or research posts at training hospitals. Private practices in urban and rural areas, as well as limited private practice (a recent concession to physicians in academic life), were also preferred to the provision of service to an underprivileged or non-white clientele. Thus, when physicians were faced with the reality of life and the practical implications of moral pronouncements, personal interest seemed to overcome their moral conscience (*cf.* Fredericks, Mundy & Kosa, 1974:52-53). According to Savage (1979:148) a real examination of conscience is required of South African physicians in this regard: "While it may be inevitable within the existing organisation of South African medicine that doctors ... cluster into areas where richer practices amongst the affluent and more ancillary services are to be found, and where professional advancement is more possible, the medical profession must question whether the implicit transmission of and ethic whereby medicine among blacks and in rural areas is devaluated can continue to be supported." Referring to items 6 to 12 in Table 12 it is clear that the physicians associated certain financial benefits and professional liberties, as well as their influence on and input into areas by means of which these benefits and liberties could be promoted and protected, with health care provision in the private sector. It appears that they would not give up these benefits, liberties and inputs (i.e. their objective and subjective personal interests) or submit themselves to central control and collective financing measures in order to implement the principles of community-based health care.

From this point of view, physicians' protection of the principles of a free-market in health care, with the awareness that this ensures the preservation and promotion of their own financial, professional and political interests, would hinder the implementation of a community-based health care system in South Africa. Given their strong input into matters of health care organisation and policy formulation on the macro-level, physicians have always succeeded in effectively opposing the implementation of measures intended to promote community-based health care and reducing these measures to minor alterations and adaptations to intolerably problematic priorities and practices.[16] With reference to the South African situation it should be mentioned that the recommendations of the National Health Services

16. Gorz (in Waitzkin, 1983:42) explains the politico-ideological dynamics underlying such a reformist reform process as follows: "'Reformist reforms' provide small material improvements

Commission of 1944 (the so-called Gluckman Commission), as well as those of the Vos, Loram, Collie and Browne Commissions, have largely faded into oblivion, while numerous superficial amendments to the Medical Schemes Act (No. 72 of 1967) and continual alterations to the method of establishing the tariffs for private health services have pacified the physicians' sense of moral liability (*cf.* Broomberg, 1991:416; De Beer, 1985:59; Republic of South Africa, 1925, 1928, 1936, 1944, 1986b; Van Rensburg, Fourie & Pretorius, 1992:60-64, 74-76, 218-224).

The question arises as to whether the self-directed motivation of physicians justifies the preservation of certain problematic structures and practices in South African health care. The key question to be considered in this regard is whether autonomous decision-making and professional autonomy in terms of private interests can contribute in any meaningful way to the solution of the South African health care problem, or whether the solution is rather to be found in comprehensive economic planning in terms of a democratic settlement of societal needs (*cf.* May, 1986:1786; Vilikazi, 1984:4). This question can only be addressed and answered by evaluating the social interest against the interest of the profession.

2. Social interests in health care: What is required?

The key aspect of consumers' opinions and perceptions of health care financing and payment for health care are summarised in **Table 13.**

while leaving intact current political and economic structures. These reforms may reduce discontent for periods of time, while helping to preserve the system in its present form. A reformist reform is one which subordinates objectives to the criteria of rationality and practicability of a given system and policy ... [I]t rejects those objectives and demands — however deep the need for them — which are incompatible with the preservation of the system" (*cf.* Lindblom, 1979:522).

Table 13: Financial transfers in health care: Consumers' opinions according to population group and medical scheme membership

DEPENDENT VARIABLE	Group	N	Average	F-Value	2-way probability of F	*Pooled variance estimate*		
						T-value	Df	2-way probability
1. One can never pay too much for the maintenance and recovery of one's health	Whites	104	1,56	1,10	0,632	-4,60	214	0,000
	Blacks	112	2,10					
	Members of medical schemes	123	1,74	1,02	0,910	-2,05	214	0,042
	Non-members of medical schemes	93	2,01					
2. Health care is a commodity similar to food and clothing — if you need it, you must pay for it	Whites	104	1,14	3,17	0,000	*Separate variance estimate*		
	Blacks	112	1,64			-5,02	177	0,000
	Members of medical schemes	123	1,30	1,50	0,037	-2,02	173	0,045
	Non-members of medical schemes	93	1,50					
3. One cannot help falling ill, therefore it is unfair to pay for health care	Whites	104	2,80	2,32	0,000	7,48	193	0,000
	Blacks	112	1,90					
	Members of medical schemes	123	2,70	1,62	0,013	6,25	168	0,000
	Non-members of medical schemes	93	1,90					
4. The private sector must be retained for those who want to pay for private care	Whites	104	2,40	1,83	0,002	-1,96	204	0,050
	Blacks	112	2,70					
	Members of medical schemes	123	2,10	-1,10	0,619	*Pooled variance estimate*		
	Non-members of medical schemes	93	3,30			-8,00	214	0,000

In broad outline, the data in Table 13 indicate that the consumers rated their health high in financial terms. Most of the consumers (55% of the total sample, but significantly more white and insured respondents than black and uninsured respondents) were of the opinion that one could never pay too highly for the maintenance and recovery of one's health. This response should be interpreted in a figurative sense, since the responses to related and clarifying items indicated that the consumers did believe that financial limits should be set for the maintenance, protection and recovery of health, so that physicians could not enrich themselves unduly and consumers would not have to go without health care because of financial considerations.

It appears that most of the respondents had no objection to paying for health care. Referring to items 2, 3 and 4 in Table 13 it is clear that, of the total number of

respondents indicated, consistently and significantly more white and insured consumers than black and uninsured consumers

- ☐ saw health care as a commodity to be paid for (altogether 78%);
- ☐ considered payments for health care to be justified, despite the universality of the need for care (the fact that illness cannot be helped) (altogether 64%);
- ☐ argued for the preservation of private care for those willing to pay for it (altogether 65%).

From additional interview questions it appeared that, regardless of population group, socio-economic status or membership of medical schemes, by far the majority of the consumers (96% of the sample) were of the opinion that nobody should have to go without health care because of lack of financial means. Similarly, most of the respondents (88% of the sample) felt that nobody should be denied the right to health care because of financial considerations, and also that physicians did not have the right to refuse treatment to patients unable to pay for it (also 88% of the sample). The consumers' view of solutions to the dilemma of providing affordable, universally accessible health care are given in **Table 14**. In this regard, most of the consumers proposed limiting the remuneration of physicians as well as providing state assistance for the underprivileged.

Table 14: Measures for and principles of affordable health care provision: Consumers' perspectives

STATEMENT	Agree		Undecided/ Neutral		Do not agree	
	N	%	N	%	N	%
1. By the nature of their work physicians can never be paid too much	63	29	27	13	126	58
2. On the basis of their knowledge of how to cure illness, physicians deserve to be esteemed	169	78	17	8	30	14
3. Because of their long and difficult training, physicians are entitled to a higher incomer than other people	77	36	7	3	132	61
4. Physicians should be employed by the state rather than work in private practice	105	49	18	8	93	43
5. The state is responsible for the provision of health care to those who cannot pay for their own medical expenses	189	88	9	4	18	8

Referring to Table 14, most of the consumers (57% of the sample) felt that neither physicians' knowledge and ability to cure disease, nor the long and difficult process of medical training to attain this knowledge, justifies their claim to unusually high remuneration. The majority of the consumers (49% of the sample, including a significant majority of black, uninsured respondents[17]) believed that the incorporation of medical service provision into a state-controlled system would be instrumental in limiting physicians' claim to an above-average income. In addition, most of the respondents (88% of the sample) irrevocably confirmed the welfare responsibility of the state to provide health care to the underprivileged.

Although the consumers indicated their receptivity toward the principles of community-based health care, a comprehension of and sensitivity towards the following prerequisites and preferences would have to be demonstrated, from the consumers' perspective:

Earlier conclusions indicated that consumers did not object to the use of tax revenue for the purposes of health care provision, provided that everyone with a claim to health care resources contributed to such a collective fund. Survey data also indicated that consumers associated direct payments of a physician with the right to quality care and personal attention. With the implementation of collective financing measures, provision could be made for this by clearly specifying the nature and size of the contribution made by consumers to the collective health financing fund, as well as distinguishing this contribution from other tax payments. This would not only maintain the principle of direct payment for health care, but also extend the right to quality care and personal attention to every contributor to the collective fund. As far as the administration of a collective health financing fund and the allocation of such funds are concerned, consumers appeared to be concerned mainly about the exercise of effective and responsible control in order to prevent service providers from unduly enriching themselves.

17. T-test analyses of the respective relationships between the respondents' population group and membership of medical schemes, and their attitude towards state control over the medical profession indicated a significant difference in attitude between white and black respondents and between insured and uninsured respondents, in both analyses. (The two-way probability of the T-values based on the combined variance estimates was in all cases 0,00.) The average score obtained by the respective groups on the relevant index indicated that blacks and uninsured consumers were consistently more in favour of state control over the medical profession than whites and insured consumers were.

3. Professional and social interests: A juxtaposition

From the foregoing discussion, the problems of implementing community-based health care in South Africa appear to derive, on the one hand, from an awareness that free-market principles do not promote or accommodate a community-based care orientation and, on the other hand, from the fact that some of the principles and requirements of a community-based care orientation are unacceptable to physicians as well as to certain consumer groups and sectors. On the one hand, collective financing and central control of health care are in themselves unacceptable to physicians; they put a high premium on the professional autonomy, financial prosperity and decisive input into health care matters which they enjoy in a free-market system. Consumers, on the other hand, are more receptive to collective financing and central control measures; indeed, they see these as providing protection from the "tyranny" of an uncontrolled private sector (*cf.* Van Rensburg, 1989:24; Lee, 1987:98). Wildavsky (1977:11) effectively explains the fundamental dilemma associated with this conflict: "If money is a barrier to medicine, the system is discriminatory. If money is no barrier, the system gets overcrowded. If everyone is insured, costs rise to the level of insurance. If many remain underinsured, their income drops to the level of whatever medical disaster befalls them. Inability to break out of this bind has made the politics of health policy pathological." Indeed, pathology is evident in the manner in which this dilemma has gradually manifested itself in South Africa's pluralistic care system — a system in which interests on both sides are only partially serviced and problems only partially or temporarily solved. In the final analysis, nobody is willing or able to take full responsibility for the existing problems or for providing a solution (*cf.* Roemer & Roemer, 1982:124; Wildavsky, 1977:121).

It is thus precisely this pluralistic dispensation and artificial division which is at the root of the intolerable problems of South African health care, and for which a solution is now necessarily sought in integration. This reform initiative cannot be thwarted by old-fashioned, rigid ideas regarding collective financing and central control. The many and varied forms of the essential principles and prerequisites of a community-based care system world-wide provide sufficient motivation to approach the implementation of such a system in South African health care in a new and creative way (*cf.* De Beer & Broomberg, 1990:146; Elling, 1974:265-267). The choices and alternatives do not have to be limited either to a narrow, bureaucratic model or to a free-market model. Rather, the principles of both models can be combined into a model which will be progressively able to respond to the actual needs and demand for health care in a meaningful, fair, efficient and affordable way.

It is, however, clear that the solution to the reform dilemma is to be found in the fundamental principles of community-based health care. The democratic principle can be applied to good effect in the settlement of apparently irreconcilable conflicts in the process of health care reform.

4. Health care reform in South Africa: *Quo Vadis?*

Community-based health care is by definition aimed at the democratisation of decision-making about matters affecting the planning, financing and provision of health care. One-sided decision-making about the reform or alteration of any of these aspects is thus excluded in principle. According to this approach, health care reform is a democratic process in which differing interests must be evaluated and a satisfactory settlement found in the implementation of mutually acceptable reform measures and strategies. The survey data in this study confirm that a balance between equally fundamental preferences for collective financing and central control of the health sector, on the one hand, and for the free play of market forces, on the other, will not be easy to establish (*cf.* Mechanic, 1972:26-27; Wildavsky, 1977:120-121).

Referring to the results of this survey, it is clear that the one-sided implementation of a community-based care approach would threaten the interests of physicians and, to a lesser extent, in certain respects also those of the existing private sector clientele. This would naturally evoke resistance from these areas. However, if these interests were prioritised, and the principles and practices of free-market health care were aimed at, not only the existing clientele of the public sector, but also increasingly those of the private sector would have to pay the literal and figurative price. Still, the apparent irreconcilability of conflicting interests cannot be allowed to justify the maintenance of the *status quo*. That would amount to allowing the medical profession to maintain its unique alliance with the government[18] and its controlling influence on the conditions of medical service provision within the framework of a capitalist means of production and free-market ideology — to the real disadvantage of the broader consumer interest. As Ugalde (1979:109) remarks,

18. The so-called alliance between the capitalist state (as an institution) and the medical profession is based on their mutual endeavour to protect and preserve the capitalist means of production as the foundation of social organisation. Both sides understand that this is the crucial prerequisite for the medical profession's privilege of providing services in a privately financed, unregulated system of care, on the one hand, and for the government's retention of its political mandate and legitimacy, on the other (*cf.* Fourie, 1992:7; Navarro, 1976a & b; 1980; 1982; 1983; 1986; 1989; Waitzkin, 1983).

the medical profession within a free-market system tends to degenerate into a money aristocracy which manipulates policy decisions through its close alliance with the state and thus denies the community's claim to health care as a basic human right (*cf.* Buch & De Beer, 1988:4-5; De Swaan, 1989:1166; Krause, 1975:604; Navarro, 1976a:205-206; Waitzkin, 1983:55-56).

By contrast, the principle of democracy demands that the inequitable matrix of power existing between physicians and consumers of health care must be brought into equilibrium so that their needs and claims can be fairly and impartially considered and evaluated in the interest of health care provision that is efficient, appropriate, affordable and acceptable. In this way, the currently one-sided process of health care reform in South Africa could at least be steered in the direction of a democratic settlement, and physicians and consumers could negotiate on an equal footing for real reform, whether directly or by means of arbitration (*cf.* Gear, 1990:124). In the light of the results of this survey, the following key issues would need to be clarified in such a forum:

- ☐ The establishment of a fair mechanism for the financing of health care, with the principle of payment for service being retained, partly so that consumers could still rely on this principle in their claim on quality service, but also in order to prevent any over-utilisation or abuse of health services;
- ☐ consideration of a remuneration system for physicians which would be affordable but still provide the necessary incentives for service excellence as well as a basis for competition, in order to stimulate quality in the health sector;
- ☐ planning for a strategy whereby an appropriate balance could be struck between the orientation towards curative care and secondary, institutional care, on the one hand, and the orientation towards preventive care and primary, community-based provision of services, on the other. The shift of emphasis to a socially accountable, positive health approach is not aimed at the demise of well-established, quality curative care networks, but rather at providing a fair balance between disease care and the bio-medical, technocratic model of care, on the one hand, and health care and the socio-demographic, ecological care model, on the other (*cf.* Allan & Hall, 1988:33; Evans & Stoddard, 1990:1355-1363; Siler-Wells, 1987:830);
- ☐ the establishment and maintenance of the necessary liaison and communication channels along with appropriate information systems in order to facilitate community participation in and influence on health care, and

- identification of the appropriate way in which to constitute a central co-ordinating or controlling body for health care, and a manner in which this body should perform its task.

Even these initial steps in the direction of community-based health care will require a large degree of sacrifice and adjustment, since they will involve the entry of lay people into the professional and political arena and the questioning of many structures and processes which have come into being as ideological concessions during the historical relationship between the government and the profession (*cf.* Freidson, 1970:212-213; Tannen, 1980:123-124). It is, however, high time to break out of the vicious cycle of reformism in which the alliance between the state and the medical profession has trapped the process of health care reform in South Africa. New structures and processes must be created to oppose the established, self-directional professional, financial and political interests in the South African health care system, in order to render the process of health care reform socially accountable. By means of democracy and diplomacy, the problems of financial and social unaffordability can be settled and a community-based health care system can be established within a capitalist society, provided that this pro-active, democratic planning process is accompanied by a genuine political will and a real attempt to implement the judicious distribution and utilisation of resources — with complete cognisance of and provision for the financial implications of these reforms.

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