Health Care Study Tour

The FMF organised a fact-finding trip (to study the economics of health care) to the UK and the Czech Republic for five members of the Parliamentary Portfolio Committee on Health from 21 June through 29 June 1998. The group consisted of the following:

**Delegation**

Dr SJ Gous (NP)

Mrs NB Gxowa (ANC)

Dr EE Jassat (ANC)

Mrs FB Marshoff (ANC)

Mrs JN Vilakazi (IFP)

The delegation was accompanied by Ms Rachel Jafta (Economist – Stellenbosch University) and Mr Temba Nolutshungu (Director – FMF).

**Itinerary**

***Mon, 22 June (United Kingdom)***

11h00 Meeting with NERA

(National Economic Research Association)

Mr Daniel Whitaker – Associate Director

Mr Edward Bramley-Harker – Analyst, former economist for Dept of Health

Mr Tom Booer – Special Advisor

Mr Richard Murray – Dept of Health

***Tue, 23 June (United Kingdom)***

08h00 Day at pharmaceutical company

***Wed, 24 June (United Kingdom)***

09h30 Half-day seminar at the IEA

(Institute of Economic Affairs)

Dr Nick Rickman – University of Surrey

Mr Barry Hassell – Independent Healthcare Association

Mr John Spiers – Health Authority Chairperson

Prof Colin Robinson – in the chair

***Fri, 26 June (Czech Republic)***

09h00 Meeting with Mr Tomas Szereghy, Deputy Director, Fakultni Nemocnice Kralovske Vinohrady Hospital

11h00 Presentation and discussion with Mr Mazan and Mr Peter Morallee of MAFS (International Association of Pharmaceutical Companies)

14h00 Presentation and discussion with Prof Robert Holman (former advisor to former Prime Minister Vaclav Klaus) of the Liberalni Institute

**Report by Rachel Jafta**

This report is the result of a study tour undertaken at the invitation of the Free Market Foundation of Southern Africa. The purpose of the study tour was to give the participants the opportunity to meet with people involved in and associated with the Health Care Sectors in the United Kingdom and the Czech Republic. It was hoped that first hand understanding of the issues, mechanisms and policies of the Health Care Systems in these countries could be gained in order to inform the policy debate in South Africa. This is not an academic report but simply a reflection of the valuable insights that I have gained on this tour.

**1 UNITED KINGDOM**

1.1 ***Introduction***

A seminar at the offices of the National Economic Research Associates (NERA) in London and a lunch meeting with an advisor to the Department of Health provided the information for this section. This is further supplemented by the contributions of Dr. Neil Rickman, Department of Economics, University of Surrey, Barry Hassell, Chief Executive of the Independent Health Care Association and John Spiers, Chairman of the Patients’ Association. These latter contributions were made at a seminar arranged by the Institute for Economic Affairs in London.

1.2 ***The National Health Service (NHS) in Britain***

1.2.1 *Background*

This year (1998) marks the fiftieth anniversary of the NHS in Britain. The NHS was introduced in 1948 based on legislation passed in 1946. This system aims to provide comprehensive health care to the whole population according to clinical need and not ability to pay. Soon after the implementation of the system, it became evident that demand far outstripped supply and that is was very difficult to match demand and supply in the absence of a pricing mechanism. The system also did not contain incentives to ensure efficient management and cost effectiveness. Significant reforms were introduced in 1990/91 in an effort to increase efficiency and to introduce some form of competition. This was called the ‘pseudo’- or internal market. This entails a separation of the functions of purchasing and providing care. At the level of hospitals and community units, self-governing NHS trusts were created. Health Authorities’ main function became procuring health care for those within their districts and general practitioners (GPs) were allowed to become fundholders themselves and to procure health care services for their patients. In this manner, the semblance of competition was created.

1.2.2 *Salient features*

Britain has a population of about 58 million people (mid-1991) and spends about 6, 9% of Gross Domestic Product (GDP) on health (1996 figure). The largest share of this spending is tax-funded (87%). The rest comes from Social Insurance (5%), Direct payments (6%) and Private insurance (1%).

Since the system of allocation of resources in the NHS is not based on price, other means of rationing must be used, e.g. waiting lists. Hospital waiting lists have shown a steady increase over time from 752.400 in 1979 to 1 065 400 in 1994.

1.2.3 *The independent health sector*

The problem of waiting lists and limited choice for patients has lead to the growth of a vibrant independent health sector. This sector consists of for profit companies, charities, religious orders, mutual organisations, friendly societies and trade union owned facilities. This sector provides more health and social care beds (443 000) than the NHS and Local Authorities together (356 000). The independent sector also plays a crucial role in providing long term care (85%). In this sector, Private Medical Insurance covers 7 million people. This places a double financial burden on patients since one cannot opt out of the NHS system. In addition, a further 5 million people are covered by a range of Hospital Benefits, Critical Illness, Long term care, Medical Cash Benefits, Sickness and Permanent Health Insurance Products. Under the New Labour government, it seems as if this independent sector will be accepted or at least tolerated and allowed to grow.

1.2.4 *The position of patients*

In discussions at NERA and with the representative from the Department of Health, one came away with the impression that the patients do not feature in any significant way in the power relations between management and the professionals in the NHS. John Spiers, Chairman of the Patients Association, puts the patients’ case most succinctly:

It is sometimes suggested that patients are a third force – alongside professionals and management. Are patients the third force? No, they are definitely not. They are not merely the power or part of the power. They are the purpose.

The Patients’ Association aims to work together with the NHS and local authorities to provide a better service to patients. They undertake to make information available to patients, to enable them to turn that information into knowledge that would help them become responsible consumers of health care. They further intend to relay information from patients to service providers in order to facilitate a better understanding of patients’ needs and preferences.

1.2.5 *Contemporary issues*

The New Labour Government is committed to keep public expenditure under control, yet has pledged more funding to the NHS to reduce waiting lists. This funding is to come partially from a reduction in the bureaucracy in order to promote efficiency. However, a 1997 White Paper on Health introduced new reforms to the system. GP fundholding is to be replaced with primary care groups and contracting between providers and purchasers is to be changed to commissioning (3-year periods). It is doubtful whether these changes would really lead to a reduction in the bureaucracy that would ensure longer-term savings from more efficient operations.

1.2.6 *Innovation and patent protection*

The importance of effective patent protection for firms engaging in Research & Development was greatly underscored by a visit to the R&D facilities of one of Britain’s largest pharmaceutical companies, Smith-Kline Beecham. A first hand appreciation of the capital outlay required to survive in this field was afforded by a tour through the discovery and manufacturing sections of the plant. The Pharmaceutical R&D budget for the company for the 1996 financial year amounted to £ 703 million, compared to the UK Medical Research Council budget of £ 282 million for the 1996/97 financial year. In the absence of effective patent protection, the incentive to spend this money on innovation is severely diminished and the flow of new medicines is consequently curtailed.

**2 THE CZECH REPUBLIC**

2.1 ***Background***

The information used in this section was garnered from a visit to a state hospital in Prague, an interview with its Deputy Director, Dr. Tomas Szereghy, a meeting with the International Association of Pharmaceutical Companies (MAFS) in Prague and a seminar at the Liberalni Institute.

2.2 ***The health care system in the Czech Republic***

The Czech Republic has a population of about 10 million people. Following the changeover from the former communist system of Czechoslovakia and the split of the latter, the Czech Republic embarked on rapid reforms in the socio-economic system, including the system of Health Care. Reforms were aimed at achieving:

* the decentralization and de-monopolization of health facilities,
* multiple health care finance institutions,
* greater choice of health providers for patients,
* greater autonomy for hospitals and doctors,
* more emphasis on ambulatory care rather than inpatient care, and
* strengthening of preventive care.

2.2.1 *The current system*

The Czech Republic spends about 7,6% of GDP (1995) on Health services. Funding comes from compulsory premiums levied on income. These contributions are channeled to an independent General Insurance Fund and several Branch Insurance Funds. The government pays the premiums for the unemployed and the indigent out of tax revenues. Before 1989, the system was funded out of general tax revenue, distributed from national government to regions and districts. Allocations were done on the basis of bed occupancy rates. This process resulted in inefficiencies; for example, it provided an incentive for long hospital stays.

Delivery of health care has not been privatized yet, but hospitals and medical practitioners have much more autonomy under a decentralized system. The government sets guidelines for medicine prices, in consultation with stakeholders such as pharmacies, pharmaceutical firms, etc. The setting of prices are informed by market prices elsewhere, for example in the European Union (the Czech Republic is gearing itself to become a member of the EU).

Evidence was presented that patient satisfaction has generally increased and that the wider patient choice was well supported.

2.2.2 *Current concerns*

The most serious concern remains that of ensuring fair access, while trying to contain costs. Like other European countries, the Czech Republic has to worry about the aging of its population and the larger demands this will put on health care facilities.

**3 CONCLUDING REMARKS**

Various issues present themselves for consideration in the South African debate:

* That South Africa not only has to deal with the problem of matching scarce resources to a growing demand for health care services like any other country, but that our problems are exacerbated by the legacies of unequal treatment in the past;
* Against this background, I understand the South African dilemma to be to try and provide health care to all in a fair and efficient, yet sustainable manner;
* Comparing the demographic and economic statistics of the two countries that we have visited with those of South Africa, it becomes painfully clear that a fully tax-funded health care system for South Africa is not attainable (given the size and age-composition of our population, the relatively small tax base and the state of the economy);
* The previous point suggests that we will have to find a way to retain the private sector funding and provision, yet to make it more accessible and affordable to all. In this regard, a cooperative approach between the private and the public sector is essential;
* To create the environment for our own pharmaceutical industry to grow in a competitive and innovative manner, we have to consider the merits of allowing firms who incur R&D costs to appropriate the benefits of their innovations in an effective patent protection regime.
* Lastly, we need to adopt a vision for South African health care beyond the short to medium term pressures of health care needs. This involves, for example, encouraging individuals to take responsibility for their own health by adopting lifestyles that are health enhancing.

**Conclusion**

The Advocacy Project has been one of the most successful projects ever launched by the FMF. As can be seen from the report, a large volume of work has been done in a very targeted manner, so increasing the impact. Its primary objective has been to inform government about the benefits of economic freedom and what needs to be done to allow economic freedom to prevail in South Africa. As can be expected, there are other agendas at work in the country and every success the FMF has achieved, has been achieved against great odds. Your directors believe that there is good reason to be satisfied with progress to date. Our special thanks go out to the Centre for International Private Enterprise (CIPE), Anglo American & De Beers, Anglovaal, Cementation, Friederich-Naumann-Stiftung (FNS), Mr A Gibbs, Kirchmann-Hurry Construction, Nasionale Pers, Nedcor, Rent A Truck, Rustenburg Wine, Sage Foundation, SmithKline Beecham, Tupperware, USAID and Ingwe Coal, who provided special grants to make it possible for the Foundation to launch and maintain the project.