Abstracts of papers by Max Price during Takemi Fellowship, 1994/5

1 Should health insurance contributions be tax deductible? A political and economic analysis.
In Press as monograph published by the Centre for Health Policy, Johannesburg, 1995.

The tax concessions on employer contributions to medical aids have attracted much attention due to protagonists of a strong public sector viewing them as a subsidy to the private health sector. This study examines critically the views of the major stakeholders in health care funding and provision, and offers an economic and political analysis and some concrete policy solutions.

There is probably a loss of tax revenue in the region of R1,5 to R2,3 billion in 1994, which amounts 11-17% of the 1994 public health budget. However, the range could be as wide as R235 million to R2,6 billion. The concessions are inequitable and probably distort the private market for health care. The removal of the subsidy would be unlikely to affect the public sector but could reduce private sector use and income by up to 25% depending on elasticities of demand. However, the revenue generated by removing the tax concession would probably not be allocated to benefit the public health sector. In addition, if removing the concession coincides with the introduction of mandatory medical aid cover, this would present an enormous burden on employers and low income medical aid members, with consequent opposition. We therefore recommend a revenue neutral restructuring of the concession in a way that addresses the equity and efficiency concerns.

2 Some reflections on the changing role of Progressive Policy Groups in S.A.: experiences from the Centre for Health Policy.
To be published in *Transformation,* August 1995.

This paper documents some personal observations of the changing role and relations of a policy research unit from the late 1980s (the apartheid era) through the transition period (1990-94) to the first year of post-apartheid democracy (1994-1995). At a more general level, this is a case study illustrating how the relationship with "policy makers" affects the behaviour of academics whose work relates to public policy. Paradoxically, in our new post apartheid roles and relations, progressive policy groups may be more constrained than we were in the apartheid period. For the changed environment has altered not only the relationship with policy makers from antagonists to allies, but, perhaps more importantly, has changed the types of knowledge we need to generate, the use of that knowledge, the audiences we address, the time constraints within which we conduct research, the sources of funding, and, closely linked to funding, the power relationships between policy makers and researchers.

The paper suggests ways in which policy oriented intellectuals and institutions will need to adapt to the new context of legitimate government, but will also need to challenge the state's inclination to monopolize the policy studies arena.

3 Proposals on regulation of the private sector as part of health financing reform in South Africa.

In considering national funding strategies for the health sector, it is necessary to examine the functioning of private sources of funding (primarily medical aids) for several reasons. A key principle of the funding strategy is that those who can afford to finance their own health care should continue to do so. Even if using public services, particularly hospitals, costs for such services should be recovered from those who have regular incomes and can afford to insure themselves. This insurance, particularly for hospital services, will largely occur through the medical aid system.

The long term sustainability of the medical aid system and its affordability or low income workers has been seriously jeopardised by recent deregulation with consequent selection against high risk patients, risk rating, failure to cover dependents and the loss of cross-subsidisation across income groups, age groups and degrees of ill-health.

This paper focuses on regulation of the medical aid and health insurance system to ensure appropriate cross-subsidisation and extension of cover. However, affordability also depends on cost-containment in the provider sector. This can be facilitated by regulations on the "supply side" - i.e. regulation of hospitals, pharmacies and doctors.

4 Child nutrition in Lesotho: results from a national household survey.

In 1988 and 1989 a child nutrition survey of 9900 children under the age of 5 years, was conducted in Lesotho. The results showed that the overall level of stunting (percentage < -2 Z-scores height for age) was 23.9%, 3.9% were wasted (< -2 Z-scores weight for height), and 12.7% were underweight (< -2 Z-scores weight for age). Levels of stunting were higher in rural than urban areas (24.8% and 17.3%) as were levels of underweight. There was however not a significant difference between rural and urban regions for wasting (3.9% and 4.1%). The levels of stunting also increased with age, starting at 12% in the under 1 year age group, and reaching 29.4% in the 48-59 month interval. There was no significant difference in the percent wasted between genders, but an interesting result was the significant difference that appeared between genders for stunting (22.6% in females, 25.2% in males). Another interesting result was the decreasing trend in the weight based measures of malnutrition from the cold month of June (1st round data) to the hot, rainy month of February (3rd round data). The levels of malnutrition varied between the districts, with some districts having rates twice that of others.

5 An analysis of resource allocation to community and hospital services in homeland health wards.

Also published as: PRICE M. *An analysis of resource allocation to community and hospital services in homeland health wards*. Technical Report #10. South African Health Expenditure Review. Health Systems Trust, Durban, 1995.

The cost structures of three homeland health districts (KaNgwane, Ciskei and Kwazulu) have been studied in detail using a cost accounting approach. Capital and recurrent costs were analyzed and expenditure was categorised in a number of ways including: hospital versus non-hospital expenditure; primary health care versus secondary care; and components of primary care were disaggregated into environmental health, ambulance services, clinic services, out-patient department and maternity services.

Annualized capital costs account for 2 to 10 percent of total costs but do not affect the distribution into other categories. Non-hospital spending (i.e. fixed and mobile clinics, outreach services and environmental health) accounts for 1/3 of spending in Ciskei, 26.5% in KaNgwane, and 9.3% in Kwazulu. Defining primary care more broadly to include OPD services and some maternity services delivered within the hospital, as well as a portion of nurse training, clinic related ambulance services and relevant hospital overheads, spending on PHC increases to 56% in Ciskei, 44% in KaNgwane and 33% in Kwazulu.

One of the objectives of these studies is to develop a method for estimating the proportion of total district expenditure in the homelands (as collected through ReHMIS) that is spent on non-hospital services. To do this a model was developed which uses the distribution of registered nurses between hospital and community services to predict the distribution of expenditure.

6 Financing health care in South Africa: Social or National health insurance (not yet completed at time of writing).

The new government in S.A. inherited a health system characterised by inequality between public and private sectors, urban/rural inequality within the public sector, and a skewed allocation of public sector resources towards tertiary care in metropolitan areas. Committed to goals of improving equity and of strengthening primary health care and ensuring universal access to a basic package of services, the new department of health is nevertheless constrained by a fiscal policy that is unlikely to increase government spending on health. Two competing models have been proposed, viz. social health insurance, with mandatory contributions linked to increased benefits for contributors; and national health insurance which would grant the whole population equal access to primary care services. These models are discussed and compared in terms of the values underpinning them, the goals they are designed to achieve, and the economic and political constraints which affect their feasibility. A third model is proposed which tolerates some inequality between contributors and non-contributors, but which attempts to reduce that inequality at the level of primary care services through a transfer of funds

from private health insurance to the publicly funded primary care.