



CENTRE FOR DEVELOPMENT AND ENTERPRISE  
Informing South African Policy

# REFORMING HEALTHCARE IN SOUTH AFRICA



What role for the private sector?

CDE Research no 18

The Centre for Development and Enterprise is one of South Africa's leading development think-tanks, focusing on vital national development issues and their relationship to economic growth and democratic consolidation. Through examining South African realities and international experience, CDE formulates practical policy proposals for addressing major social and economic challenges. It has a special interest in the role of business and markets in development.

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## What role for the private sector?

November 2011

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CDE Research Reports convey the findings of major research projects undertaken by the Centre for Development and Enterprise.

Series editor: Ann Bernstein

This report summarises the results of a CDE research project on South African health policy. It was written by Professors Sandy Johnston and David Spurrett under the general editorship of Ann Bernstein. The background research reports commissioned for the project are listed in an appendix. CDE gratefully acknowledges the assistance and encouragement of Dr. Paul Davis, Chairman of the Aurum Institute for Health Research, in conducting this project.

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This report proposes reforms which will allow the private sector to operate more efficiently, broaden access to its services and enable it to contribute to the greater and more urgent task which faces policy makers – the rehabilitation of public sector healthcare.

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## EXECUTIVE SUMMARY

Launching the government's Green Paper on National Health Insurance (NHI) in August 2011, the Minister of Health, Aaron Motsoaledi said that the challenge and intent of NHI was to draw on the strengths of both the public and private health sectors to better serve the public.

The main purpose of this report is to respond to this challenge by documenting not only the strengths but also the weaknesses of the private sector and of the market conditions under which it operates. It proposes reforms which will allow the private sector to operate more efficiently, broaden access to its services and enable it to contribute to the greater and more urgent task which faces policy makers – the rehabilitation of public sector healthcare.

The report is based on 10 specially commissioned research papers, consultations and workshops with international health policy experts and meetings with South African health sector stakeholders.

The essential message is that reform of private sector healthcare and of the market conditions under which it operates will be a step forward on the long road to universal access to quality healthcare and not, as the private sector's critics claim, a backward one.

### **The challenge of healthcare reform**

Healthcare reform is an urgent and at the same time extremely difficult challenge for South Africa's policy makers, one which presents opportunities and risks across both public and private healthcare sectors. In its August 2011 Green Paper on NHI, the government set the ambitious goal of achieving universal access to quality healthcare over the next 14 years.

The ideal that inspires NHI is a scheme that is universal, compulsory and 'free at the point of use'. No matter how much the system will cost to run, no matter how much or how little an individual will contribute to the cost, users of its comprehensive services will not be billed for them.

This is an enormous challenge in one of the most unequal countries in the world. Only 41 per cent of South Africa's working-age population participates in the economy and there are only 5.9 million registered individual taxpayers. This is the very narrow base of 'solidarity' funding which the government is banking on to achieve its healthcare goals for over 50 million people.

However difficult the challenge, no-one seriously denies the urgency of healthcare reform. A full-blown crisis of health outcomes developed in South Africa during the 1990s and the first decade of this century. This only received proper political recognition from about 2007, when increasingly frequent media exposure of the public health system's failings created an atmosphere of crisis and scandal. This, along with the brave efforts of health professionals and health NGOs, helped silence high-level denialism about HIV and AIDS in particular and the poor condition of public healthcare in general. Since 2007 the government has been much franker in acknowledging shortcomings in both policy and delivery and has promised to tackle them with determination.

Healthcare reform is an urgent and at the same time extremely difficult challenge for South Africa's policy makers

The main elements of the crisis are a public sector which is so badly designed and managed that health outcomes are poor and a private sector which serves its customers well, but at prices which ensure that only a small minority of the population can afford adequate coverage

From about the same time, there was an escalating push by ANC Alliance lobbies for an NHI system, focused on one aspect of the crisis: the disparity in health status between those with access to private, self-financed healthcare and those who rely on access to publicly-funded healthcare.

In the course of the developing debate on reform, both the public and the private healthcare sectors have received strong criticism. The main elements of the crisis are a public sector which is so badly designed and managed that health outcomes are poor and a private sector which serves its customers well, but at prices which ensure that only a small minority of the population can afford adequate coverage.

This report outlines how both parts of South Africa's health system should be reformed if the national crisis is to be turned around.

The study on which the report is based profiles the crisis of health outcomes, the public and private sectors, and the health reform process to date. However within this comprehensive review, CDE was motivated by two considerations in particular.

The first was to challenge the view that blames the private health sector for the failings of the public health sector. The second was to show how a reformed private sector would be able to broaden access to high-quality curative health care and do so at lower prices. This potential is largely underestimated or even ignored.

One thing must be made clear from the start. It is not enough simply to defend private sector healthcare against unfounded or exaggerated charges by pointing out that it provides care for more people with fewer resources than its detractors claim.

As we shall see, the private health sector itself is in need of reform to maximise its contribution to overall health sector performance. The key issue is to address price escalation which threatens the viability of the sector and limits access to private healthcare. Dealing with this requires stimulating competition, encouraging innovation in products and services offered, addressing perverse incentives as well as encouraging primary healthcare and early intervention instead of expensive specialist and hospital-based care.

To sum up, the challenge of healthcare reform is to broaden access to quality healthcare and manage healthcare resources better. The principal purpose of this report is to affirm the potential of a reformed private sector to contribute to these goals, to argue that such a contribution will be crucial to achieving better health outcomes and to open up debate on how that contribution can be maximised.

### **South Africa's crisis of health outcomes**

According to the NHI Green Paper, South Africa spends 8.3 per cent of gross domestic product (GDP) between public sector (4.2 per cent) and private (4.1 per cent) sectors. A further 0.2 per cent (in foreign aid and the NGO sector) makes up a total of 8.5 per cent, which is extremely high

expenditure, especially for a middle-income developing country. The World Health Organisation (WHO) recommends that countries spend at least 5 per cent of GDP on health and average expenditure for middle income countries is 5.8 per cent

Despite this high expenditure, South African health outcomes compare very poorly to those of countries which have similar national income and health expenditure. Life expectancy indicators vary according to data source but the most optimistic, contained in South Africa's Country Report on the Millennium Development Goals (MDGs), shows a decline for men from 57.6 years in 2001 to 55.3 years in 2009 and in the same period, for women from 64.8 to 60.4. According to a WHO calculation of disability-adjusted-life-years, South Africans can expect only 48 years of healthy life.

The MDG Country Report also notes that under-five mortality has increased from 59 per 1 000 live births (1998) to 104 per 1 000 live births (2007) and maternal mortality has shown a similar percentage increase.

Health outcomes within the South African population vary starkly and coincide with differences in income and geographical location. In a nutshell, poor rural people who are wholly dependent on public sector healthcare have much worse indicators of well-being than a better-off, racially-mixed class of urban people with access to private sector healthcare, or relatively better public sector healthcare.

However the challenge of health inequality is complex and access to curative hospital care is not the only factor to be considered. Healthcare outcomes in South Africa are so bad partly because of the prevalence of poverty and, for many people, lack of the basic infrastructure for healthy life. Another contributing factor is exposure to interpersonal violence and lifestyle issues such as alcohol and tobacco abuse. Government plans for healthcare reform recognise this and to an important extent are built around primary and preventive healthcare.

A useful reminder of the complexity of health inequality comes from the United Kingdom where a state-funded national health service has for over 60 years offered universal and equal healthcare, free at the point of service. Despite this, health indicators differ sharply between different parts of the country. In the poorer parts of Merseyside (Liverpool) where male life expectancy is 67 years, men can expect on average to be incapacitated by some disability or another at age 44 (which is in fact worse than the WHO figure for South Africa which is quoted above). The corresponding figures for the richer parts of West London are 89 (life expectancy) and 74 (incapacity).

### **South Africa's public health sector**

Public sector healthcare in South Africa is large, complex and fragmented. It is poorly-managed at the strategic level and all too often at the point of service. The effects of mismanagement are particularly clear in finance and human resources.

According to the National Treasury, in 2010 the public health sector consumed 4 per cent of gross domestic product (GDP) and 14 per cent of annual government expenditure. That share is set to rise. The source of this funding is taxation, a substantial portion of which is progressive income

This report outlines how both parts of South Africa's health system should be reformed if the national crisis is to be turned around

The coexistence between a failing public health sector and a private sector that serves a significant minority with high quality healthcare is the most contentious aspect of the health reform debate in South Africa

tax through which the better-off, who by and large do not use public sector health facilities, significantly subsidise those who do use them. As a result, South African healthcare financing is highly redistributive. One of the substantial achievements of government policy since 1994 has been to re-orient public health expenditure away from the affluent towards the poor.

Supporters of NHI claim that 84 per cent of the population depend on public sector healthcare compared to 16 per cent who have access to private medical insurance. However a substantial minority use both the private sector and the public, so that the true percentage for those who use the private sector wholly or in part is around 35 per cent and the corresponding figure for those served exclusively by public expenditure is lower.

Public sector healthcare employs over a quarter of a million people and with the rise in resources promised for health this number will increase. At least one in 34 employees in the formal sector of South Africa's economy and more than one in five public sector employees work in public sector healthcare. The most able, productive and dedicated staff in the public health sector are overworked, overstressed and cannot always rely on support either from above or below.

Bearing these things in mind, it will be a huge task to turn public sector healthcare around by addressing the widely-acknowledged problems of staff morale, productivity and attitudes to service.

### **Private sector healthcare in South Africa**

The coexistence between a failing public health sector and a private sector that serves a significant minority with high quality healthcare is the most contentious aspect of the health reform debate in South Africa. There is a widespread tendency in this debate to dismiss the contribution of the private sector to overall health outcomes, to be suspicious of the motives of private health sector players and to challenge the very legitimacy of private health provision. The Green Paper on NHI reflects these mixed messages, blaming the private sector for the ills of the public sector, making gestures towards a constructive relationship with private stakeholders, but falling well short of spelling out what the private sector might offer and how its contribution might be maximised.

Comprehensive reform has to build on a realistic understanding of private healthcare and should see the private sector properly, without the distorting lenses of blame and ideology. Constructive debate about the role of the private sector in South Africa's overall healthcare system has not been helped by widely-held beliefs based on misconceptions about whom the private sector serves and who works in private healthcare. The drivers of prices of healthcare services, the extent of cross-subsidisation in current funding of public healthcare and the feasibility of raising extra funding for public healthcare from taxation are also poorly-understood.

One constructive side effect of the NHI debate has been to motivate more rigorous research on how national resources for healthcare are generated and distributed. There is no doubt that beneficiaries of private medical insurance have access to much better healthcare than those who depend solely on the public sector. However, the private sector:

- Serves more people than just the rich: up to 35 per cent of the population, if out-of-pocket-payments are included as well as medical scheme members
- Has significantly smaller human resources than its critics claim
- Reduces the burden on the public sector
- Has less 'excess capacity' than has been claimed
- Faces input costs and barriers to market activity which drive up prices.

### Health system reform

South Africa has a very substantial burden of disease, not only from HIV and AIDS but also from preventable conditions arising from poor sanitation, nutrition and other conditions of poverty, as well as a growing burden of non-communicable disease affected by lifestyle. In the face of such a disease burden the essential task of health sector reform is the rehabilitation of public sector healthcare from its current dysfunctional state. Its principal problems are leadership, organisation and management. NHI is a financing mechanism through which, according to the Green Paper, the government hopes to double public expenditure on health in real terms by 2025, while greatly shrinking private expenditure, so that the country's overall spending on health will fall from the present 8.3 per cent of GDP to 6.2 per cent.

It remains to be seen whether or not these are realistic targets. Some experts believe that they are not. Be that as it may, it bears repeating that NHI is a financing mechanism only. No matter how finance is organised and from where it comes, organisation, management and leadership in the public sector will have to be overhauled.

### Public sector reform

Public sector shortcomings are well-documented and in the past few years frankly acknowledged by the government. Both the ANC and the government have made it clear that improvement of the public health sector is a necessary condition for the success of an NHI system.

However it is possible that the Department of Health's 10 Point Plan for 2009-14 and Strategic Plan for 2010-12 underestimate the challenges. It bears repeating that the public health sector employs over a quarter of a million people in over 4 300 establishments. Given the well-documented poor standard of infrastructure, the skills shortages, poor staff attitudes, low levels of patient satisfaction and incompetent management that characterise much of the public sector – by the government's own admission – turning around an establishment of this size will be difficult from within the public health sector's own resources.

According to the DBSA Roadmap, based on 2008 data, the public sector is short of 60 000 – 84 000 health professionals.

There is no hope of quickly making good this shortfall from South Africa's existing resources. According to the Department of Health, internal training capacity for doctors has increased from just over 1 100 graduates in the year 2000 to 1 309 in 2008. Many of these graduates emigrate. An obvious solution is to embark on a vigorous recruitment programme targeting

Both the ANC and the government have made it clear that improvement of the public health sector is a necessary condition for the success of an NHI system

Proponents of NHI see no reason to think creatively and comprehensively about the terms of coexistence between public and private sectors since, in their view, NHI will solve all problems

foreign health professionals. However the Department of Health's most recent human resources document (August 2011) will go no further than 'A rewriting of the legislation and new management processes on recruitment and retention of foreign trained health professionals are required.' The Department of Health Human Resources for Health Strategic Plan (2006) said the same thing without practical effect being given to the promise.

The private sector represents a significant reservoir of human resources. There are 6 500 – 7 000 general practitioners working in the private sector and 5 000 – 5 500 specialists. The corresponding numbers for the public sector are 10 700 – 11 300 (general practitioners) and 4 000 – 4 400 (specialists). For nurses the figures are 104 000 (public sector) and 40 000 (private sector). Short of taking over the private sector lock stock and barrel – a practical impossibility – the challenge is to find strategies that broaden access to this reservoir.

### **National Health Insurance (NHI)**

Since 2007 there has been a tendency to see the introduction of NHI as the endgame in healthcare reform. Proponents of NHI see no reason to think creatively and comprehensively about the terms of coexistence between public and private sectors since, in their view, NHI will solve all problems.

The government's Green Paper on NHI has outlined the basic features of the proposed system but crucial details, including the basis of funding, have yet to be developed. Major areas of concern identified by commentators include:

- *Costing:* the distribution of sources of new funding between income tax, VAT, and/or a dedicated NHI contribution; whether a general increase in taxation will be needed or not and how affordable significant new funding will be, given South Africa's small pool of personal income tax payers
- *Concerns over government capacity to run an NHI fund efficiently and cost-effectively:* critics believe that the government has underestimated how much such a complex scheme, covering the entire population will cost to run; there is a risk that fraud (already a massive problem in both public and private sectors) will be a serious threat
- *The effects on the insured population:* will they be persuaded to opt for their NHI rights and forego private insurance, or at substantial sacrifice of other expenditure (with knock on effects in the wider economy) pay their mandatory contributions and private health cover?
- *The effects of the single purchaser system on private providers:* a central part of the government's case for NHI (rather than other avenues of health policy reform) is that the NHI scheme will be the sole, or at any rate hugely dominant, purchaser of healthcare for the whole population. The rationale is that its power to dictate will significantly and painlessly lower healthcare prices. This is something of a gamble. It remains to be seen whether the government is correct in assuming that there is so much fat in private sector pricing, in the shape of excess profits and remuneration, that this can be done. Research on private sector pricing commissioned by CDE and documented in the main report suggest that this is not

so. Equally it remains to be seen whether private sector providers will simply submit to the superior power of a single buyer and have no other options

- *There is little evidence that a single payer produces better cost containment than do multiple payers, but much to suggest that public dissatisfaction is considerably increased because single payers are far less responsive to consumer needs*
- *The proposals so far have been vague and uncertain about the role of the private sector: messages have been mixed; at best the government recognises that the private sector can have an important role to play, at worst it blames the private sector for all the ills of the public sector: As this report makes clear there is plenty to criticise in the private health sector: However what is missing is a strategic realisation that expansion of a reformed private sector and improvement of the public sector can be complementary rather than contradictory movements.*

In fact the NHI is a work in progress, with many details still uncertain and there is much scope for creative thought. One encouraging recent sign is the proposed 14 year time frame. This allows time to be creative and for policies to mature.

The key insight should be that extending private sector healthcare to a wider public is a step towards realising universal access to quality healthcare, not a retreat from or a postponement of this ideal. It is this ideal, not narrow fixation on one or another institutional form of healthcare funding that should inspire South Africans.

## RECOMMENDATIONS

On the basis of our commissioned research and engagement with both public and private sector healthcare stakeholders, we offer options to broaden debate on the two major tasks of healthcare reform. These are the rehabilitation of the public sector and the introduction over 14 years of an NHI system.

The emphasis is on ways that the private sector might be reformed in order to make it work more efficiently and cheaply, to broaden access to it and allow it to play a greater role in giving space to the public sector to carry out its own massive task of reform. The single-payer approach to lowering prices is a gamble on a blunt instrument. Market and funding reforms could offer incentives rather than compulsion.

### General guidelines

Policy makers have to acknowledge clearly and strongly that the chief priority of health reform is the rehabilitation of the public health sector. It is of paramount importance that all stakeholders understand that everything – including the proposed introduction of NHI – depends on this.

The key insight should be that extending private sector healthcare to a wider public is a step towards realising universal access to quality healthcare, not a retreat from or a postponement of this ideal

The key public sector reform is to deliver on President Zuma's pledge in his 2011 State of the Nation speech to appoint qualified people to manage the public health sector

It is important to revisit the Department of Health 10 Point Plan, not to change the priorities, but to broaden the view of the necessary resources, giving priority to enlisting the resources, not only of the private health sector, but the private sector in general.

For instance using public money to subsidise access to the private sector might be a better way of spending than sending greatly increased funds to the public sector that – given its history of financial mismanagement – it may not absorb productively. We should explore all possible ways of doing this.

### **Reforming the public sector**

The key public sector reform is to deliver on President Zuma's pledge in his 2011 State of the Nation speech to appoint qualified people to manage the public health sector. This is a minimum requirement for all other reforms to happen. Service to patients must not be compromised by anything else – including patronage, political loyalty and racial headcounts in staffing.

Other key initiatives should greatly expand South Africa's resources of skilled health professionals by:

- Delivering on recent promises to expand training of doctors
- Making good the promises in the Department of Health Human Resources for Health Strategic Plan to expand training of intermediate-level professionals
- Embarking on a vigorous overseas recruitment campaign beginning with the African diaspora of health professionals in OECD countries
- Extending private sector involvement in medical training, especially of nurses.

In managing delivery of public health, accountability should be devolved and authority decentralised, following the prescriptions of the 1997 White Paper. Regional and local experiments with specific ways of delivering care and encouraging prevention should be encouraged so that successful models can be taken to scale elsewhere.

### **How the private sector can support public health sector reform**

The government should use the opportunity created by the publication of its plans for an NHI system to initiate a calmer and more constructive debate on overall healthcare reform than has been the case so far. The manner in which the Green Paper was introduced by the Minister of Health was a useful step in this direction. Demonising those who point out difficulties with NHI and stigmatising the private health sector generally will not advance the cause of extending quality healthcare to all South Africans. Debate about healthcare reform has been distorted by inadequate and inaccurate information about the place and role of the private sector in South Africa's overall health system.

Greater clarity and more authoritative figures are needed on complex and disputed issues such as the drivers of prices in private sector healthcare and the relative resources available to the private and public services. These will inform debate about the reforms that will be needed in order to broaden access to quality healthcare.

The government should, at the highest level, develop a strategic vision for how to use private sector resources to extend quality healthcare for all. The Department of Health's key priority under its 10 Point Plan is the 'provision of strategic leadership and creation of a social compact for better health outcomes'. It should make good on this priority and its duty of stewardship to explore more fully the possibilities of private sector involvement and to embed more firmly the idea that the private sector's involvement in rehabilitating the public is legitimate and will be crucial. Stewardship of the whole healthcare system should mean developing ways of mobilising all the available capacity in South Africa.

The private sector means more than private healthcare. Private companies led the way in HIV diagnosis, prevention and treatment programmes during the years of government denial. Businesses such as mining companies and large parastatals have contributed to health outcomes by delivering innovative and cost-effective healthcare to their employees, sometimes in collaboration with trade unions. These programmes show more clearly than the private hospital industry how efficient, cost-effective care can be delivered in South Africa. Possibilities for extending these programmes should be investigated, especially where facilities are underused. The private healthcare sector also has resources and skills in specialised areas like supply chain management and health information systems that could contribute to rescuing the public system.

Private sector healthcare can contribute directly to the rehabilitation of the public sector through:

- Restoration of opportunities for private sector specialists to work in the public sector ('sessional opportunities') and energetic promotion of this kind of public/private mobilisation
- Extension of PPPs from infrastructure where they are encouraged, to hospital management, supply chain management and clinical services
- Development of joint public/private planning on health professional needs and facilitation of training of health professionals by the private sector through easing regulations.

### **Reforming the private healthcare sector**

Although direct private sector support to the public sector as envisaged above will be important – indeed essential – to the enormous task of rehabilitation, the private sector can best contribute to broadening access to quality care by broadening its own coverage. This means that reforms will have to contain costs by helping markets work more efficiently and addressing funding issues.

Businesses such as mining companies and large parastatals have contributed to health outcomes by delivering innovative and cost-effective healthcare to their employees, sometimes in collaboration with trade unions

Increased competition  
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### Helping markets work more efficiently

- Private hospitals cannot employ doctors and so have to compete with each other to attract them. They do this by investing in facilities and equipment in excess of objective needs. This drives up prices and encourages focus on specialised and hospital-based care over prevention and primary care. The existing fee-for-service funding framework provides little incentive to compete on price or innovate in delivery. All of this needs to change. Private entities should be allowed to employ doctors. Other positive changes, including cost containment and innovation in the private healthcare sector by attracting low-cost multinational players, are less likely as long as it is not possible to employ doctors.
- All regulated processes connected with health – for example those relating to licences to open a private medical facility – should be simplified and their administration made as transparent as possible. Details of applications, decisions and timelines should be made public, to allow oversight by civil society.
- Increased competition in private healthcare will help put pressure on prices and encourage innovation in lower-cost delivery. Regulations should be reformed to allow healthcare companies from outside South Africa, for example, from India, where private healthcare delivery is notably innovative and cost-conscious, to operate in South Africa.
- Publication of price lists for medical services should be mandatory, as it is in Singapore. This should be combined with funding models that allow individuals to benefit from prudent expenditure, which will encourage shopping around in non-emergency cases. If private hospitals can employ doctors, instead of having to attract them through excessive investment in expensive equipment, this should reduce over-servicing and energise competition on price.
- Incentives should be developed for the private sector to innovate more on the supply side and specifically to operate a wider range of facilities, including lower-cost ones focused on primary care, such as day surgeries and outpatient facilities, with a greater role for general practitioners and nurses.
- Drastic steps should be taken to increase the supply of doctors and other medical professionals. This is essential for the health system as a whole, in order to reduce the scarcity value of doctors which currently helps drive price increases in the private sector. As we have already noted, joint public/private planning and initiatives on training are essential. Given the long lead times for health training, in the short term at least, immigration is quicker and considerably cheaper than relying exclusively on expanding our own output.

## Reforming health funding

Medical scheme membership is universally acknowledged to be too expensive. Some of this is due to the very high costs of care being passed on to members. In addition, the current regulatory framework leaves very little scope for medical schemes with limited benefits, even though such schemes would have lower premiums, and so would increase access to private healthcare.

The following reforms would address this problem:

- The Treasury has released draft plans to reallocate the tax deduction for medical aid payments to make medical scheme membership affordable to as many more employed people as possible: this should be carried through as quickly as possible. In addition the cost-benefit effects of charging VAT for some private medical services should be assessed to see if prices can be lowered.
- In order to reduce self-selection (which distorts risk pools) medical scheme membership should be expanded, with the eventual aim of making it mandatory for the formally employed. To further stabilise schemes, the long-overdue risk equalisation mechanism should be fully implemented.
- Medical schemes with a set of benefits less extensive than the current PMB list should be allowed, perhaps by having multiple specific schedules of benefits. This will allow lower cost schemes increasing access to private healthcare. One or more of these schemes, perhaps in specific industries or regions, could be pilot programmes of the eventual NHI.
- Individual employed people should be allowed to choose their own scheme rather than have it chosen by their employer. At present scheme selection largely excludes employed scheme members because it is negotiated by employers. This reduces the power of scheme members.

## CONCLUDING REMARKS

It is extremely difficult to provide universal access to quality healthcare in a highly-unequal society which has such low rates of participation in the economy and such high levels of poverty and disease burden. To make progress towards, never mind to achieve, universal access to quality healthcare in South Africa requires the strategic use of all existing resources, which means reform and expansion of both the private and public sectors. The scale of the challenge of delivering as uniform healthcare as possible, given economic circumstances, across the whole of the country, and given the resources already in the public health sector, means that the rehabilitation of the public sector is the central task of healthcare reform. The extension of the capacity and reach of the private sector is essential to the rehabilitation of the public sector. This will be a step towards universal quality healthcare, not a step back from it.

Universal access to quality healthcare in South Africa requires the strategic use of all existing resources

The essential message is that reform of private sector healthcare and of the market conditions under which it operates will be a step forward on the long road to universal access to quality healthcare and not, as the private sector's critics claim, a backward one.

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## Introduction

**L**AUNCHING THE GOVERNMENT'S Green Paper on National Health Insurance (NHI) in August 2011, the Minister of Health, Aaron Motsoaledi said that the challenge and intent of NHI was to draw on the strengths of both the public and private health sectors to better serve the public.

The main purpose of this report is to respond to this challenge by documenting not only the strengths but also the weaknesses of the private sector and of the market conditions under which it operates. It proposes reforms which will allow the private sector to operate more efficiently, broaden access to its services and enable it to contribute to the greater and more urgent task which faces policy makers – the rehabilitation of public sector healthcare.

The report is based on 10 specially commissioned research papers, consultations and workshops with international health policy experts and meetings with South African health sector stakeholders.

It summarises the main evidence that South Africa faces a health crisis. It then profiles both the public and private health sectors to assess their challenges and the reforms that are necessary to realise the potential of each. On the basis of what we have learned, we will offer our conclusions and recommendations.

The essential message is that reform of private sector healthcare and of the market conditions under which it operates will be a step forward on the long road to universal access to quality healthcare and not, as the private sector's critics claim, a backward one.

## The challenge of healthcare reform

Healthcare reform is an urgent and at the same time extremely difficult challenge for South Africa's policy makers, one which presents opportunities and risks across both public and private healthcare sectors. In its August 2011 Green Paper on NHI, the government set the ambitious goal of achieving universal access to quality healthcare over the next 14 years.

The ideal that inspires NHI is a scheme that is universal, compulsory and 'free at the point of use'. No matter how much the system will cost to run, no matter how much or how little an individual will contribute to the cost, users of its comprehensive services will not be billed for them.

This is an enormous challenge in one of the most unequal countries in the world. Only 41 per cent of South Africa's working-age population participate in the economy and there are only 5.9 million registered individual taxpayers. This is the very narrow base of 'solidarity' funding which the government is banking on to achieve its healthcare goals for over 50 million people.

However difficult the challenge, no-one seriously denies the urgency of healthcare reform. A full-blown crisis of health outcomes developed in South Africa through the 1990s and first decade of this century. By the time the warnings of health experts, medical researchers, dedicated public-sector professionals and whistle-blowers received due political recognition from about 2007, the consequences were dire. South Africa lives with them today.

Healthcare reform  
presents opportunities  
and risks across both  
public and private  
healthcare sectors

The life expectancy gap between richer and poorer people in South Africa is approximately two decades

The main features of this crisis are as follows:

- By standard measures – life expectancy, infant mortality and maternal mortality – South Africa’s health outcomes compare badly with countries at a similar level of development and indeed with many poorer ones.
- The life expectancy gap between richer and poorer people in South Africa is approximately two decades.
- South Africa is one of a very small group of countries whose performance has declined against the health targets set by the United Nations for developing countries: the Millennium Development Goals (MDGs) (see box p.21: South Africa’s health crisis in brief).

High-level political response to this crisis changed in 2008 from evasion, denial and aggressive-defensive reactions to one of relative openness in acknowledging shortcomings and the need for reform (see box p.22: Government on South Africa’s health crisis).

The government’s agenda for reform is contained in a 10-point plan for reforming and rehabilitating the health system, both public and private. It has sensibly acknowledged that healthcare reform is a long term project and is allowing 14 years for its realisation. One of the 10 points for reform is the avowed intention to introduce a NHI system. Despite the release of a Green Paper on the NHI in mid-August 2011 much remains uncertain about how it will be financed, about how it will work in practice and what its relationship to the much more important task of rehabilitating the public health sector will be.<sup>1</sup> The Green Paper and another important policy document, the Consultation Document on Human Resources for Health, which was released in the same month as the Green Paper, will be discussed later in this report.

Looking to the future, one major source of uncertainty is the place and role of the private sector – healthcare providers and private medical insurance schemes – in a reformed South African healthcare system. The rising price of private care and scheme membership has hurt taxpayers, and limited the reach of the private sector and its ability to reduce pressure on the public system and contribute to better general health outcomes. At the same time the sometimes tense and abrasive debate on NHI has caused uncertainty about the future of both private care and private financing.

Debate has taken place in an atmosphere that is often very hostile to the private sector and although the government strikes a conciliatory and positive note from time to time – in launching the Green Paper on NHI for instance – it takes very little for its Alliance supporters to relapse into angry rhetoric about the illegitimacy of private healthcare. Even when the government’s attitude to the private sector is reasonably positive, it has failed so far to offer strategic direction on how the private sector can make a contribution to overall health system reform. This combination of uncertainty and aggressive rhetoric has inhibited investment in private healthcare.

The extent of hostility to private sector healthcare in the ANC Alliance – and hence the tensions with which government policy-makers have to deal – is illustrated by COSATU’s reaction to the NHI Green Paper (see box p.23: COSATU and the NHI Green Paper).

CDE has been motivated to research and write this report by concern at this crucial area of uncertainty. The potential of the private sector to contribute to reform and to expand access to quality healthcare is often underestimated or even ignored or denied. However, as we

will argue, this potential will not be realised unless the private sector's own challenges, particularly cost inflation, are addressed with much-needed reforms. If these problems are addressed the private sector can be an important part of the solution to South Africa's healthcare crisis.

From about 2007 onwards, increasingly frequent media exposure of the public health system's failings – for instance revelations about deaths of babies in Eastern Cape hospitals – created an atmosphere of crisis and scandal. From about the same time, there was an

## SOUTH AFRICA'S HEALTH CRISIS IN BRIEF

*'We must confront the fact that life expectancy at birth has dropped from 60 years in 1994 to just below 50 years today.'*

President Jacob Zuma, State of the Nation speech, 11 February 2010

President Zuma's speech effectively recognised the extent of South Africa's health crisis, not least because the figures he quoted are worse than other official estimates. These are shocking enough however. One example is South Africa's Millennium Development Goals (MDG) Country Report (2010).<sup>2</sup> The report was compiled by the South African government, civil society organisations and UN agencies in South Africa and managed by Statistics South Africa (Stats SA).<sup>3</sup> The report (like its predecessors in 2000 and 2005) sets baseline indicators for 1990 (or the nearest year), current status of indicators and the target for 2015. The following indicators help illustrate the extent of South Africa's health crisis.

Indicator	Baseline	Current status	Target 2015
Life expectancy (male)	57.6 years (2001)	55.3	70
Life expectancy (female)	64.8 years (2001)	60.4	70
Maternal mortality per 100 000 live births	369 (2001)	625 (2007)	38
Under-five mortality rate per 1 000 live births	59 (1998)	104 (2007)	20
Infant mortality rate per 1 000 live births	54 (2001)	53	18

The use of different techniques leads to different estimates of health outcomes.<sup>4</sup> Only a few months after the MDG Country Report came out, the Department of Health's Negotiated Service Delivery Agreement (NSDA), which effectively translates the MDG goals into service delivery commitments for the department, fixed current life expectancy at 53.9 years for men and 57.2 years for women. Both figures, especially the female, are substantially worse than in the MDG Country Report, though both documents cite Statistics South Africa and Department of Health figures. World Bank figures paint an even grimmer picture (although the basis of calculation is not clear): combined life expectancy is set by the Bank at 52 years in 2006, 51 in 2007 and 2008 and 52 in 2009.<sup>5</sup> The World Health Organisation (WHO) takes a figure of 52 years for men and 55 for women (2008), but for both sexes the WHO estimates only 48 years of healthy life expectancy.<sup>6</sup>

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We must confront the fact that life expectancy at birth has dropped from 60 years in 1994 to just below 50 years today

South Africans die young as compared to many other countries with similar or worse expertise and resources

escalating push by ANC Alliance lobbies for an NHI system. In this heated context, private sector healthcare provision has been criticised for, among other things:

- Serving only 'the rich'
- Contributing to the crisis of public healthcare by driving 'maldistribution' of human and financial resources
- Driving up prices through 'greed for profits'
- Sitting on enough excess capacity to make good the discrepancy between public and private healthcare outcomes.

### GOVERNMENT ON SOUTH AFRICA'S HEALTH CRISIS

*'We recognise that South Africa is a middle-income country with developing country health performance.'*

Minister of Health Dr. Aaron Motsoaledi: speech at the 18th Annual International AIDS Conference, Vienna, 20 July 2010<sup>7</sup>

*'The ineffectiveness of the health system and poor quality health services ... has led many people into wrongly but increasingly believing that private healthcare is the only way possible towards meeting the health needs of the country.'*

Minister of Health Dr. Aaron Motsoaledi: health budget speech, National Assembly, 13 April 2010

*'In my budget speech last year I elaborated on 11 different factors that contribute to the deteriorating quality of healthcare. Among these factors was the inability of individuals to take responsibility for their commissions or omissions in the healthcare sector.'*

Minister of Health Dr. Aaron Motsoaledi: debate on the president's state of the nation address, National Assembly, 15 February 2010<sup>8</sup>

*'The general health outcomes in South Africa are poor ... Our results are dismal when compared with those of our counterparts in other countries. These outcomes are not commensurate with the level of health expenditure in the country. Our doctors and other health workers, and the entire South African health system, perform badly when compared to Mozambique and Zimbabwe. These countries have less money and other resources available for their health systems ... South Africans die young as compared to many other countries with similar or worse expertise and resources.'*

Former Deputy Minister of Health (2008-10), the late Dr. Molefi Sefularo: address to a medical students' conference, University of the Witwatersrand, 25 September 2009<sup>9</sup>

*'It is evident that all is not right with the health system and health outcomes in this country. All commentators appear to agree that we will not be able to meet all the health-related MDGs by 2015. I will not disagree.'*

Minister of Health Dr. Aaron Motsoaledi: address to the media launch of The Lancet Country Series on Health in South Africa, 24 August 2009<sup>10</sup>

*'We are seriously concerned about the degeneration in the quality of healthcare, aggravated by the steady increase in the burden of disease, in the last decade and a half.'*

President Jacob Zuma: State of the Nation address, 3 June 2009<sup>11</sup>

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In this report, CDE reviews facts and evidence about the private sector to help support a better-grounded and more constructive debate, focused on the positive role that can be played by the private sector. This review is placed within the context of a discussion of dysfunction in the public sector, and of regulation that fails to counteract and sometimes amplifies market failures, so that the private sector functions less efficiently than it should.

Two things must be made clear from the start. Firstly, it is simply not enough to defend private sector healthcare against unfounded or exaggerated charges by pointing out that it provides care for more people and does this with fewer resources than is generally assumed. It is true that the capacity of the private sector is not being used as efficiently as it could, so that real capacity exceeds what some in the private sector like to admit. However the private sector has less spare capacity than its detractors claim and the idea that there are enough resources – of hospital beds for instance – lying idle that can be redistributed to solve the national health crisis is a misleading fantasy. In any case, that crisis has been caused as much by poor policy and bad management in the public health sector as by lack of resources. However, as we shall see, the private health sector is itself in need of reform in order to maximise its contribution to improving overall health sector performance. The key issue is to address cost escalation in order to broaden the base of people who can access private healthcare. This will involve stimulating appropriate competition, including competition on price, encouraging innovation in products and services offered, and encouraging primary healthcare and early intervention at the expense of extensive specialist and hospital-based care.

To sum up, the challenge of healthcare reform is to broaden access to quality healthcare and manage healthcare resources better. The principal purpose of this report is to affirm the potential of a reformed private sector to contribute to these goals, to argue that such a contribution will be crucial to achieving better health outcomes and to open up debate on how that contribution can be maximised.

### COSATU AND THE NHI GREEN PAPER<sup>12</sup>

COSATU welcomed the Green Paper, commended the Minister of Health and demanded the speedy application of NHI to the whole country but went on to say:

*'We are however extremely concerned at the reassurances the minister gave to the private healthcare sector at the release of the Green Paper:*

- *That it had a role to play in NHI*
- *That the challenge and intent of NHI is to draw on the strengths of both healthcare sectors (public and private) to better service the public, and*
- *That people will be able to continue to purchase medical scheme cover, and private sector healthcare providers will be free to choose whether or not to contract with the state.'*

COSATU's reaction to Minister Motsoaledi's sensible and constructive remarks implies that nothing less than the destruction of the private healthcare industry will satisfy the Alliance Left. How this destruction would be achieved within the constitution and what purpose other than ideological purity would be served is not clear.

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Nothing less than the destruction of the private healthcare industry will satisfy the Alliance Left

## Health outcomes in South Africa

HEALTH OUTCOMES ARE CUSTOMARILY calculated in terms of rates of mortality (death) and morbidity (disease). Sometimes these indicators are combined to give an overview measure – ‘disease burden’ – while an increasingly common indicator, which has been devised by the World Health Organisation (WHO), is ‘disability-adjusted-life-years’, a measure of the number of healthy years of life lost to premature death and disability. These outcomes are not a simple measure of a country’s healthcare system. Socioeconomic determinants of health that affect many South Africans are important. These include inadequate access to sanitation, poor nutrition and alcohol abuse which, apart from direct effects on health, leads to high levels of motor vehicle accidents and interpersonal violence. However indicators such as life expectancy, especially when combined with information about expenditure and resources do give a general idea of the comparative effectiveness of healthcare systems.

### South African healthcare - high expenditure, poor outcomes

The most recent authoritative assessment of South Africa’s health outcomes was published in a series of six papers in *The Lancet* medical journal (2009). Although *The Lancet* is an international journal based in London, the work was carried out by a team of distinguished medical researchers, clinicians and public health experts most of whom live in South Africa or are South African. The recurring theme across the six papers is: ‘the paradox of persistently poor health outputs and outcomes despite high health expenditure and many supportive policies.’<sup>13</sup>

Key findings include:

Although South Africa is considered a middle-income country in terms of its economy, it has health outcomes which are worse than those of many lower income countries.<sup>14</sup>

South Africa spends more on health than does any other African country, 8.7 per cent of its gross domestic product, just slightly less than Sweden (8.9 per cent) and more than Hungary (7.8 per cent).<sup>15</sup>

The proportion of the global burden of disease borne by South Africa, with a population of only 48 million, is disproportionately high... The total disability-adjusted life years for high burden diseases in South Africa is almost equivalent to that of Bangladesh, which has a population three times as large and living in much worse poverty.<sup>16</sup>

Progress has been ‘insufficient or even reversed on many ... health goals’: on maternal mortality there has been ‘no progress’; on reducing child mortality, ‘South Africa is one of only twelve countries where child mortality has increased rather than declined, since the Millennium Development Goals baseline was set up in 1990.’<sup>17</sup>

It is of little value to compare health outcomes in South Africa with those of countries that are dramatically better off, because we expect that they can afford to do much better. The nature of the challenge facing South Africa becomes sharper when comparing health outcomes for countries with similar per capita incomes, among middle-income emerging markets and developing countries (see Table 1).

Although South Africa is considered a middle-income country in terms of its economy, it has health outcomes which are worse than those of many lower income countries

**Table 1: Life expectancy, health expenditure, GDP per capita and health system rank for a selection of countries**  
 (\* = in the worst 25 countries out of 190)

Country	Life expectancy at Birth, (years) (2006) <sup>18</sup>	Annual per capita expenditure on Health US\$ (2006) <sup>19</sup>	GDP per capita, current prices US\$ (2006) <sup>20</sup>	Health system rank (1997) <sup>21</sup>	Comment
Singapore	80	1 017	31 931	6	Very high life expectancy for widely varying costs
Finland	79	3 232	39 414	31	
Norway	80	6 267	72 076	11	
Costa Rica	78	402	5 174	36	Similar or lower expenditure than SA for better outcomes
Chile	78	473	8 941	33	
Columbia	74	217	3 743	22	
Turkey	73	406	7 776	70	
Brazil	72	427	5 869	125	
Namibia	61	174	4 007	168*	
South Africa	51	425	5 551	175*	
Burundi	49	10	120	143	Similar outcomes to SA for a small fraction of the expenditure
Malawi	50	21	239	185*	
Cameroon	51	45	979	164*	
Mozambique	50	16	361	184*	

**CDE 2011: Figures drawn from WHO Health Statistics 2008 and 2009, IMF World Economic Database, and WHO Health Systems Report 2000**

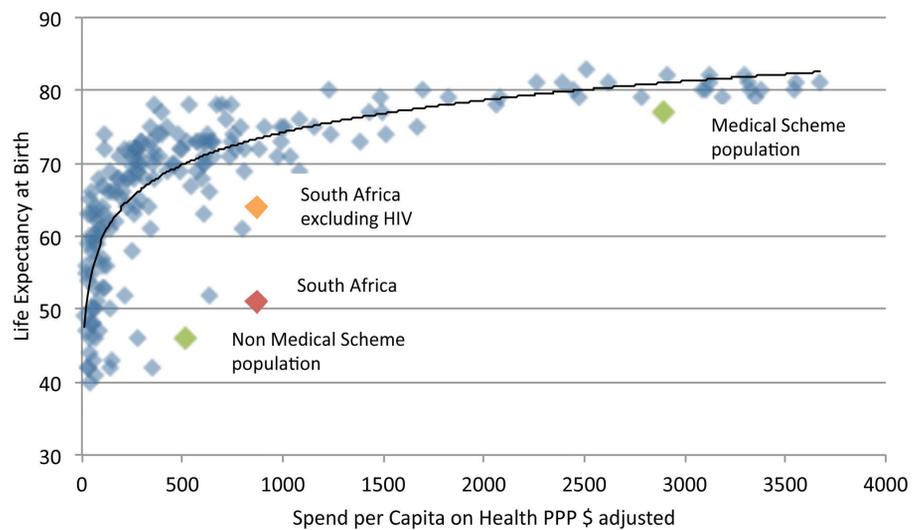
Many countries with life expectancy of over 75 years spend less than two thirds of what the privately-insured in South Africa do, suggesting that there are efficiency gains to be made in the private sector

Life expectancy is not purely a measure of health system performance because, as noted above, factors outside the health system can shorten lives in ways unrelated to health system quality. South Africa has a distinctive profile of disease, lifestyle and provision of infrastructure which, combined with poor delivery of public healthcare, accounts for the country's low life expectancy. Table 2 below lists leading causes of morbidity in South Africa in terms of disability-adjusted-life-years lost.

### Disparity of health outcomes

South Africans with access to privately-insured healthcare enjoy health outcomes comparable to those in well-off nations. It is those South Africans whose only source of healthcare is the public system (that is, for the most part, poor, black South Africans) who lead dramatically shorter and less healthy lives.

Figure 1 below depicts average life expectancy and per capita expenditure on health. Most of the data-points represent averages for whole countries. The four labelled data-points represent different aspects of the situation in South Africa. One is the current national average as things stand. Another is an estimate of where South Africa would be (at current expenditure) without HIV. Two others represent different sections of the population: those with and those without private medical insurance.



**Figure 1. Life expectancy at birth vs. per capita expenditure on health: international comparison, and South Africa. CDE commissioned paper, Understanding cost drivers and how to increase affordability in private sector healthcare (2009)<sup>24</sup>**

This graph illustrates several important comparisons. First, privately-insured individuals in South Africa have health outcomes comparable to the best in the world but at relatively high expense. Many countries with life expectancy of over 75 years spend less than two thirds of what the privately-insured in South Africa do, suggesting that there are efficiency gains to be made in the private sector. Second, even factoring in the impact of HIV, both South Africa considered as a whole and the non-medical scheme population considered separately are outliers. That is, South Africa is spending more per person on health than the other countries with similarly bad outcomes, and more than many countries with much better outcomes. There are many countries with average expenditure the same or lower, with considerably greater life expectancies. Finally, the graph shows the dramatic inequality in outcomes between the insured and non-insured population.

**Table 2: Leading causes of morbidity in South Africa, 2000**

Cause of morbidity	Percentage of total Disability Adjusted Life Years <sup>22</sup>	World ranking <sup>23</sup>
HIV/AIDS	30.9	Worst out of 192
Interpersonal violence injury	6.5	5th worst out of 192
Tuberculosis	3.7	8th worst out of 192
Road traffic injury	3.0	16th worst out of 192
Diarrhoeal diseases	2.9	37th worst out of 192

**Compiled from Chopra and others, 'The health and health system of South Africa: historical roots of current public health challenges', *The Lancet*, September 2009.**

Diverging health outcomes are not only found between healthcare sectors, they are also geographical. This partly reflects differences in burden of disease, infrastructure and lifestyle. Significant differences exist between health outcomes in different regions of South Africa. For instance, the adult mortality rate (the probability of dying between the ages of 15 and 65 per 1 000 people) stands at 70.9 in KwaZulu-Natal; in the Western Cape it is 39.6.<sup>25</sup> Similarly, the Western Cape has an HIV prevalence rate of 6.1 per cent, while 15.8 per cent of the population in KwaZulu-Natal are infected with the disease.<sup>26</sup> In 2008 the cure rates of tuberculosis varied by up to 20 per cent, with Gauteng exhibiting cure rates of nearly 80 per cent (78.7 per cent) and North West 58.3 per cent.<sup>27</sup>

It must be acknowledged that these differences are partly attributable to other differences between regions, including income and population density. Gross geographic product per capita in 2008 varied from R25 916 in the Eastern Cape to R72 307 in Gauteng.<sup>28</sup> The Northern Cape is the largest region, but has the smallest population of any region, while the smallest region, Gauteng, contains nearly a quarter (22.4 per cent) of the national population. Unsurprisingly Gauteng has the highest urbanisation rate (91.9 per cent) while Limpopo has the lowest at 9.9 per cent. The Western Cape has 34.2 public sector doctors per 100 000 people while the North West has just 16.<sup>29</sup>

The Lancet series of papers also lists disparities by race. The authors note that the substantial differences in rates of mortality and disease between races are not attributable solely to differences in healthcare (curative and preventive services) as such, but 'reflect racial differences in the access to basic household living conditions and other determinants of health.'<sup>30</sup> Among the differences noted are variations in infant mortality rates of seven per 1 000 in the white population and 67 per 1 000 in the black population (2002 figures: up-to-date figures broken down racially are less readily available than figures for the whole population). Similarly in 2002 life expectancy for white women was 50 per cent greater than it was for black women.<sup>31</sup>

In summary, South Africa's health outcomes as measured by standard indicators of death and disease compare very poorly with those of peer countries, defined in terms of national income and health expenditure. However these are not true comparisons of whole populations. Health outcomes within the South African population differ starkly and coincide with differences in income and geographical location. In a nutshell, poor rural people have much worse indicators of well-being than a better-off, racially mixed class of urban people with access to private sector healthcare, or relatively better public sector healthcare.

Poor rural people have much worse indicators of well-being than a better-off, racially mixed class of urban people with access to private sector healthcare, or relatively better public sector healthcare

The problem of health inequality is complex and access to quality healthcare is not the only factor to be considered. This is clearly acknowledged in all government proposals on health reform, but is not widely enough recognised in popular attitudes and public debate

These disparities are a serious blight on the prospects of realising the ideals of an equal constitutional democracy and as such they constitute a compelling motivation for health reform.

It should be noted however that they are far from unique. The United Kingdom has had a national health service for over 60 years which offers universal and equal healthcare, free at the point of service. Despite this, health indicators differ sharply between different parts of the country: 'In the poorer parts of Merseyside (Liverpool) where male life expectancy is 67, men can expect to be incapacitated by some disability or another at age 44. The corresponding figures for the richer parts of West London are 89 (life expectancy) and 74 (incapacity).'<sup>32</sup>

This is a useful reminder that the problem of health inequality is complex and access to quality healthcare is not the only factor to be considered. This is clearly acknowledged in all government proposals on health reform, but is not widely enough recognised in popular attitudes and public debate.

We now turn to profile healthcare in the public sector and to ask what contribution its shortcomings make to South Africa's crisis of health outcomes.

## The public health sector

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**T**HE PUBLIC HEALTH SECTOR commands considerable funding, resources and staffing. A central thrust of government policy for health reform is that it should have more money and people. However it should be noted that it is already large enough to pose severe challenges of leadership and management. It is highly likely that the public health sector will find it difficult to productively absorb significant new resources without first strengthening management, a goal which government has acknowledged as a priority.

### Funding the public health sector

According to the National Treasury, in 2009/10 South Africa's public health sector consumed 4.2 per cent of South Africa's gross domestic product (GDP) and accounted for 14 per cent of total government budget spending.<sup>33</sup> Table 3 below sets out comparative figures for public and private financing of health expenditure. On these figures, in 2009/10 public health services received 45 per cent of total health financing and private health services 55 per cent. Just over eight million people are covered by private medical insurance (approximately 16 per cent of an estimated population for mid-year 2011 of 50.59 million<sup>34</sup>).

Some analyses (for instance the Green Paper on NHI<sup>35</sup>) calculate from this by a simple subtraction sum that around 42 million people (84 per cent) rely on public health services. This however omits out-of-pocket expenditure on private healthcare – 16 per cent of total expenditure in 2009-10 according to Treasury figures. Such expenditure makes it clear that it is not only the insured population that relies on private sector healthcare. Indeed the Department of Health's own documents make this clear. The draft HR Strategy for the Health Sector Consultation Document (August 2011) flatly contradicts the Green Paper by saying: 'South Africa has a private health sector which covers about 35 per cent of the country's healthcare needs.'<sup>36</sup> By this (official) estimation, the public sector spends 4.2 per cent of GDP and 14 per cent of government expenditure on 65 per cent of the country's health needs.

As Table 3 below sets out, public health expenditure is on an upward trajectory, rising from R60.3 billion in 2006-7 to an estimated R106.5 billion in 2010-11. Further increases are forecast to the point where in 2012-2013 total public health expenditure, at R122.5 billion, will have more than doubled (in nominal terms) in the six years since 2006-7.<sup>37</sup>

There has been net real growth in public health expenditure since 1994. However this has not been even. Expenditure increased after 1994 but policies of fiscal constraint led to several years of stagnation (1998/9-2000/1). Spending picked up again with economic growth after 2001, but population growth and a greater disease burden have increased the strain on resources for healthcare. Despite this, a recent authoritative survey commissioned by the Minister of Health in 2009 concluded:

‘There is a widespread perception that the public health sector is under-funded. This is an extremely complex issue, which must be considered from a variety of perspectives. Based on macro-economic trends, there is insufficient evidence to support this perception. Over the past 14 years health sector funding has been between 13 per cent and 14 per cent of available government funds, with per capita expenditure increases at a level which exceeds inflation.’<sup>38</sup>

South African healthcare financing is highly redistributive. One of the substantial achievements of government policy since 1994 has been to re-orient public health expenditure away from the affluent towards the poor. According to a major review done for the Kaiser Family Foundation:

South Africa has a very progressive system of healthcare financing, with the richest 20 per cent of the population contributing about three times the proportion of personal income than the poorest 60 per cent of the population does. In fact the richest quintile – which receives 68.7 per cent of total income – contributes 82 per cent of total healthcare funding ... Of this amount, about 45 per cent is retained as direct benefit from private healthcare (32 per cent) and public health services (13 per cent). Fifty-five per cent of total contribution by the richest quintile is redistributed to other quintiles. All other quintiles derive a greater share of benefit than the financial contributions they make.<sup>39</sup>

Although almost five times as much is spent on a beneficiary of medical aid as on an individual reliant on public health: ‘the fact that wealthier people are prepared to spend more on private healthcare does not distort public health financing.’<sup>40</sup> Wealthier people spend more in almost all categories of personal expenditure, and taxation on their income and expenditure is the main basis of any redistributive spending. To say that ‘more is spent on them’ as if the funds were somehow generated elsewhere, distorts the issue. It is more accurate to say that ‘they spend more of their own discretionary resources after progressive taxation on health’.

However critics of the distribution of funding and benefits argue that it is those who depend on the public health sector for care that have the highest health needs (‘disease burden’) and that the uneven distribution of healthcare professionals between private and public sectors damages the ability of the latter to care effectively for those wholly dependent on it. As we shall see later, such critics of the ‘maldistribution of resources’ have relied on calculations that overestimate the number of health professionals in the private sector.

South African  
healthcare financing  
is highly redistributive

**Table 3: Health expenditure in public and private sectors**

R million	2006/7	2007/8 Outcome	2008/9	2009/10 Estimate	2010/11	2011/12 Forecast	2012/13
<b>Public sector</b>							
National department of health	3 136	3 829	4 755	5 134	5 301	5 604	5 826
Provincial departments of health	51 938	60 645	72 444	87 596	93 465	10 1435	10 7833
Defence	1 602	1 743	2 024	2 265	2 468	2 634	2 855
Correctional services	234	261	282	300	318	339	359
Police	234	298	463	405	577	721	787
Local government (own revenue)	1 317	1 478	1 625	1 793	1 829	1 865	1 977
Workmens' compensation	1 415	1 287	1 415	1 529	1 651	1 718	1 821
Road accident fund	488	764	797	740	860	980	1 039
<b>Total public sector health</b>	<b>60 364</b>	<b>70 305</b>	<b>83 805</b>	<b>99 762</b>	<b>106 469</b>	<b>115 297</b>	<b>122 496</b>
<b>Private sector</b>							
Medical scheme	58 349	65 468	74 089	81 128	88 754	96 653	105 255
Out-of-pocket	26 596	31 183	34 270	36 498	38 833	41 125	43 551
Medical insurance	2 056	2 179	2 452	2 660	2 870	3 126	3 404
Employer private	982	1 041	1 172	1 271	1 372	1 494	1 627
<b>Total private sector health</b>	<b>87 983</b>	<b>99 871</b>	<b>111 983</b>	<b>121 557</b>	<b>131 829</b>	<b>142 398</b>	<b>153 837</b>
Donors or NGOs	2 503	3 835	5 212	6 319	5 787	5 308	5 574
<b>Total health expenditure</b>	<b>150 850</b>	<b>174 011</b>	<b>201 000</b>	<b>227 638</b>	<b>244 085</b>	<b>263 003</b>	<b>281 907</b>

Source: National Treasury, Budget Review 2010, Chapter 7, Social security and healthcare financing, Table 7.10

## Facilities and personnel

The public health sector is responsible for a wide range of facilities over the whole country (Table 4 below). The public health sector's 406 hospitals contain 88 920 beds (2009 figures), a little more than three times the 28 980 private hospital beds (2008 figures).<sup>41</sup>

**Table 4: Distribution of Public Health Facilities in South Africa, 2009**

Type of Facility	Number of facilities
Clinic	3 595
Community Health Centre	332
District Hospital	264
National Central Hospital	9
Provincial Tertiary Hospital	14
Regional Hospital	53
Specialised Psychiatric Hospital	25
Specialised TB Hospital	41
Grand Total	4 333

**Source: Department of Health Strategic Plan 2010/1 – 2012/3, citing District Health Information System (DHIS)**

In order to deliver services through these facilities, the public health sector employed 267 992 people (2009 figure)<sup>42</sup>. This represents one in 34 people in formal employment in South Africa in 2010,<sup>43</sup> and a little more than one in five of the 1.24 million public sector employees (including SANDF personnel: 2008 figures).<sup>44</sup> The Treasury's 2011/12 estimate for compensation for these employees is R54,3 billion<sup>45</sup>. The current employment figure is likely to be as great, if not greater. Due largely to tight limits on public expenditure, numbers employed in the public health sector declined consistently from 250 638 in 1997 to 218 661 in 2003.<sup>46</sup> Since 2003 they have risen sharply and now exceed 1997 levels by 6.5 per cent.

The overall increase in staffing conceals varying rates of increase. Figures for 2006 show that 'management' increased by 159.8 per cent from a very low base, while 'medical' and 'nursing' increased by 2.9 per cent and 1.8 per cent respectively. Government has been criticised for employing too many bureaucrats, but in 2006 only 0.43 per cent of public health sector employees were defined as managers. The corresponding figure for the NHS in Britain was 3 per cent.<sup>47</sup> That is, the British health service had seven times as many managers as the South African public health sector. It is likely then that the public health sector suffers from an absolute shortage of managers. However problems with the quality of management are the most damaging, as we shall see next.

More than one in five public servants work in the public health sector

There are formidable difficulties in the governance and management of public health in South Africa

## GOVERNMENT AS STEWARD OF THE HEALTH SECTOR

'Stewardship' is a term developed by the WHO to guide health policies and the management of health systems by governments. It is extensively used by the South African government to characterise its relationship to the whole health system, private as well as public, and to justify its policies.

According to the WHO the main elements of stewardship are: careful and responsible management of the well-being of the population; establishing the best and fairest health system possible; concern about the trust and legitimacy with which activities are viewed by the citizenry; and maintaining and improving national resources for the benefit of the population.<sup>48</sup>

By adopting this framework and claiming the rights expressed in it, over the private as well as the public health sector, the South African government invites assessment of its performance on these criteria.

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## Governance and management

There are formidable difficulties in the governance and management of public health in South Africa. All assessments of delivery and outcomes, both official and independent, pay due tribute to adverse conditions caused by apartheid's legacy and the burden of HIV/AIDS. However all of them acknowledge that even if the politicians responsible for the 'stewardship' of public health and the managers charged with running the system have been dealt a difficult hand, for the most part they have played that hand very badly (See box above: Government as steward of the health sector).

Independent assessments of the South African public health system agree that lack of management capacity, as well as inadequate stewardship and leadership are serious contributors to the generally very poor outcomes achieved. The best-known betrayal of stewardship was the AIDS denialism of the Mbeki administration. But there are others. The Lancet survey by Coovadia and others draws on a large body of research to describe cases of inadequate and absent stewardship across the board, in relations with the private sector, human resources, information management, financing and pharmaceutical policy as well as HIV/AIDS.<sup>49</sup>

Some official documents acknowledge this. The recent draft Department of Health Discussion Document on HR Strategy includes the following frank admission:

*The evidence is that South Africa's performance in terms of health outcomes when compared with peer countries is extremely poor, with much higher infant and maternal mortality. This reflects on poor productivity, poor design and poor management of resources and not only necessarily on the number of available professionals in the health sector<sup>50</sup> (emphasis added).*

*'10 health departments in South Africa'*

Problems of stewardship begin with health system design (see box p.34: The structure of the South African public health sector). Since 1994 health policy has consistently professed a

commitment to decentralisation within a framework of strong national leadership. Neither of these has been delivered. In the judgement of the Department of Health's Integrated Support Team (IST) Enquiry (2009):

There are de facto 10 health departments in operation in South Africa and there is no single national health vision and strategy for the achievement of population health outcomes and on-going health system transformation in South Africa.<sup>51</sup>

## PARLIAMENTARY QUESTIONS REVEAL DISASTROUS HOSPITAL MANAGEMENT APPOINTMENTS

Answers to questions asked in the national parliament in 2009 revealed severely under-qualified hospital CEOs with no significant management training or experience, including one whose highest educational qualification was a matric, a former postmaster who only completed Standard 8, and a former teacher with an education diploma.<sup>53</sup> The following quotations provide more detail:

*'Six per cent of hospital CEOs do not have a management degree or diploma. Two and a half years after Frere Hospital's horror baby deaths the same unqualified hospital manager – who was previously an ANC councillor – remains in charge.'*<sup>54</sup>

*'The worst off province is the Northern Cape, where only two out of 21 hospitals (10 per cent) are managed by anyone with training in management.'*<sup>55</sup>

*'The system of political deployment put untrained, inexperienced people in charge of hospitals with disastrous consequences. We need experienced, trained and professional managers in charge of our healthcare facilities.'*<sup>56</sup>

*'Management is one area where the private sector has a comparative advantage – it knows how to run hospitals efficiently and cost-effectively.'*<sup>57</sup>

The exposure of these departures from best practice has had its effect. In his State of the Nation Address in February 2011, President Zuma said:

*'In the health sector this year, we will emphasise the appointment of appropriate and qualified personnel to the right positions. We need qualified heads of department, chief financial officers, district health officers and clinical health managers.'*<sup>58</sup>

This is a case of better late than never. But it remains to be seen how long it will take to repair the damage of 17 years of neglect.

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Many managers in the public health system were appointed despite lack of qualifications or experience

In the absence of skilled and qualified managers, management by fear of sanction by the PFMA and the guardianship of the National Treasury seems inevitable

These problems are exacerbated by high turnover in leadership positions at provincial level. For instance Dr. Siva Pillay, head of the department of health in the Eastern Cape, recently told a health NGO that in his province there had been five different health MECs (provincial ministers) and four different heads of the provincial department of health in the last four years.<sup>52</sup> With this kind of turnover at the most senior levels, strategic vision and strong management in provinces are simply not possible.

### *Unqualified managers cannot take responsibility*

As responses to parliamentary questions and findings of investigative journalists have shown, many managers in the public health system were appointed despite lack of qualifications or experience (see box p.33: Parliamentary questions reveal disastrous hospital management appointments). The offer of voluntary severance packages to white male health managers (many of whom migrated to the private sector) in the 1990s drained the system of expertise and experience without adequate measures to replace or transfer it. Appointments based on a 'deployment' policy that places political allegiance and loyalty over experience or even competence have done further harm.

In allowing this situation to develop from the mid-1990s, the top political leadership and health policy makers contradicted their own policies. The founding document for post-apartheid health policy, the 1997 White Paper, repeatedly acknowledged the need to boost hospital management. Much of chapter 4 of the 1997 White Paper, 'Developing Human Resources for Health', is devoted to management training. This was not followed through. It took a decade for specific targets for management training to appear in the Department of Health's Strategic Plan (2007-8) and there is still no effective framework for management training. In the meantime enormous damage had been done to the lives of patients and to the credibility of the public health system by ill-judged and poorly-implemented appointment policies.

Two of the problems most frequently cited in critiques of the public health system are a failure to decentralise and devolve responsibility to managers and a culture of over-conservative financial management by managers who are in fear of transgressing the Public Finance Management Act (PFMA).

However it is difficult to see how the central government can devolve responsibility to managers, many of whom have neither skills nor qualifications nor experience. In the absence of skilled and qualified managers, management by fear of sanction by the PFMA and the guardianship of the National Treasury seems inevitable.

Finance and human resources are two of the specific areas where inadequacies of management and stewardship – in the sense of leadership, vision, overall strategy and accountability – are felt most strongly.

## THE STRUCTURE OF THE SA PUBLIC HEALTH SECTOR

The national Department of Health is responsible for health policy

- Nine provincial departments of health are responsible for developing provincial policy within the framework of national policy and public health service delivery
- There are three tiers of hospitals: tertiary, regional and district
- The primary healthcare system – a mainly nurse-driven serviced in clinics – includes the district hospital and community care centres
- Local government is responsible for preventive and health promotion services.

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## Managing public health finances

The Department of Health's Integrated Support Team's consolidated report (2009) summarises the financial problems of the public health sector. Its main finding was that the overspending that prompted its review had been understated and was at least R7.5 billion per annum as at 31 March 2009.<sup>59</sup> The estimated shortfalls were calculated largely on the overdrafts of the provincial health departments, of which the worst were Eastern Province, Gauteng and KwaZulu-Natal. Among the reasons were:

- Carry-over of over-expenditure and overdrafts from previous years
- Unfunded mandates originating with both central and provincial government, including the occupational specific dispensation – a scale of remuneration intended to attract professional staff to the public sector and retain them – resource-intensive clinical policies and unfunded legislative requirements
- Lack of adequate financial management, reporting and accountability, which allows overspending with minimal or no consequences.<sup>60</sup>

Another by-product of weak management, ineffective financial systems and lack of skills is 'deeply systemic' corruption.<sup>61</sup> According to the head of the Eastern Cape Health Department, Dr. S.N. Pillay, in 2010 corruption in public sector health in the Eastern Cape was, 'currently costing R800 million.'<sup>62</sup> In September 2011 Dr. Pillay reported to parliament's appropriations committee that the level of corruption in the Eastern Cape public health sector was, 'beyond imagining' and that in the previous 18 months 720 people had had to be fired for corruption and incompetence.<sup>63</sup>

## Managing human resources

Inadequacies of stewardship, management and leadership have been particularly badly felt in staffing and human resources. The main features of this situation include:

- *South Africa produces too few health professionals:* between 1996 and 2005 South African medical schools graduated 11 754 doctors, rising from 1 106 in 1996 to 1 330 in 2005. In 2006 the Department of Health's Human Resources for Health (HRH) plan called for a doubling of production by 2014. However HRH presented 'no concomitant plans to expand the existing medical schools or... to increase the numbers of medical staff.'<sup>64</sup> By January 2011, an editorial in the South African Medical Journal was stating baldly that the HRH call for doubling graduates 'cannot take place within the current framework for health sciences training, and serious consideration must be given to developing another health sciences training institution in South Africa.'<sup>65</sup> In his 2011 Budget vote the Minister of Health referred to the 'intention' to expand existing medical universities, and the establishment of a new training institution at Polokwane, but the health department's 2011 discussion document on HR strategy suggests that specific plans for these changes have not been developed.
- *A high proportion of South Africa's health professionals emigrate* (see Table 5: p.36): of those who have so far remained a high proportion are considering emigrating. A survey of 1 702 South African health professional respondents, carried out in 2005-6 and published in 2007, found high levels of migration intent. The survey found that almost half of the respondents had already given emigration serious consideration and 52 per cent thought that there was a high likelihood that they would emigrate in the next five years.<sup>66</sup>
- The same survey of health professionals' attitudes found that South Africa's public health sector is under-resourced, mismanaged, badly led and those who work in it display a 'tidal wave of dissatisfaction.'<sup>67</sup>

South Africa  
produces too  
few health  
professionals

As a result of all these factors there are serious shortages of health professionals in the public sector: vacancy rates were estimated in 2009 to be 35.7 per cent overall in South Africa, with a high of 50.7 per cent in the Free State and 48 per cent in the Eastern Cape. Another four provinces had vacancy rates of over one third of posts.<sup>71</sup> Vacancy rates provide at best an imperfect indicator of shortages because, as the draft Discussion Document on HR Strategy notes, they are 'not based on a planned balanced healthcare system.'<sup>72</sup> Another approach is to compare international ratios of doctors per 100 000 population. According to the World Bank, the average ratio for 'middle income countries' in 2008 was 180 doctors per 100 000 people, and for 'low income' countries it was 50. South Africa's ratio is 55 – close to the average for a 'low income' country.<sup>73</sup> Since different countries have different health system designs, simple comparisons can be misleading. The draft Discussion Document on HR Strategy compares South Africa with five other middle-income countries, and tentatively concludes that South Africa has a shortage of doctors and some other professionals, but not of some categories of nurse.<sup>74</sup> However, according to the workforce planning model it uses, it estimates the current total national shortage of 'critical' health professionals at over 100 000. It argues on this basis that with proper planning and assuming consistent annual GDP growth of 3 per cent the shortage will take 15 to 20 years to correct.

Government responses to the shortfall have included: plans to increase the training of health professionals; changes to syllabi and the current demographic intake of students in the hope that this will reduce emigration; service requirements for newly-graduated doctors to boost the ranks of the public service; attempts to limit the growth, if not the size, of the private health sector by limiting opportunities to practise in it.

None of these ad hoc interventions has significantly altered the situation to date. In the more than five years since the flagship April 2006 HRH plan was produced, the Department

**Table 5: Selected estimates of emigration of South African health professionals**

Source	Number and type of SA health professionals abroad and basis of calculation	SA domestic stock and basis of calculation	Estimated brain drain effect
Clemens and Petterson (2008) <sup>68</sup>	'Physicians born in South Africa in eight principal destination states': 7 363 ('around the year 2000')	South African born physicians who live and work in South Africa: 27 551	21 per cent of total stock of South African born physicians (domestic + emigrated) live and work in eight developed destination states
OECD (2005) <sup>69</sup>	Doctors trained in South Africa working in OECD countries: 12 136	Total South African trained doctors in South Africa: 32 973	Number of emigrated doctors is 37 per cent of the number of those that remain (or 27 per cent of total stock if calculated as Clemens and Petterson)
Department of Health, based on OECD <sup>70</sup> (2003)	South African 'diagnostic practitioners' (including dentists, pharmacists, veterinarians) in five OECD countries: 8 921	Doctors working in the public service in South Africa (2001): 11 332	Diagnostic practitioners who have emigrated expressed as a percentage of public sector doctors: 79 per cent

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of Health failed to develop its strategic policy proposals on human resources from discussion document to operational plan. Despite being questioned repeatedly by the parliamentary portfolio committee on health up to 2009, the Department of Health was unable to explain why a study of the capacity of health training institutions called for as a priority in the 2006 plan had not been produced.<sup>75</sup> The Department of Health annual report for 2008/9 cited 'lack of capacity' for the non-appearance of the report on training capacity and it does not appear to have been completed since then.

The recently released document on HR Strategy is a significant step forward, but on many key points it simply documents the need for more plans, and it only has the status of a consultation document. It bears repeating that it has taken over five years to make even this modest progress.

One of the clearest indications of strategic confusion is the official attitude to immigration of health professionals. Despite the widely-acknowledged shortages of medical practitioners, the high vacancy rates in public sector health facilities and the static outputs of South African medical schools, the Department of Health's policies on employing foreign doctors and other health professionals remain hedged around by qualifications and controls.

Throughout Department of Health documents there is an unmotivated – in the sense of without justifying facts, arguments or reasons – aspiration to national 'self-sufficiency' in the production of health professionals. This is a quite unrealistic aspiration in any foreseeable future. In addition, there is the equally unmotivated principle that 'the total foreign workforce shall not at any stage exceed 5 per cent of the total workforce in each health professional category'.<sup>76</sup>

Finally there is the aspiration – like the others simply asserted rather than argued – to confine foreign recruitment of health professionals exclusively to government-to-government recruitment, on the model of the small-scale bilateral aid programmes with Cuba. The only exception is:

The only direct recruitment of individual applications from abroad will be for those applicants who can submit documentary evidence of being a citizen of a developed country.<sup>77</sup>

The policy on recruitment from developing countries lacks clear definition, consistency, transparency and, above all, a sound basis in understanding the dynamics of professional migration in the health sector. Even when a review of policy is promised, it does not come to anything. The 2006 HRH plan admitted that many of the African health professionals who applied to work in South Africa had already been lost to their homelands for five to 10 years (in OECD countries), so that the issue of 'robbing' African states of resources did not apply. However a commitment to assess the restrictions on employing foreign health professionals in this light clearly came to nothing.<sup>78</sup> A general review of the so-called 'ethical recruitment' policy was promised for October 2008, but in its 2009 annual report the Department of Health acknowledged that it had not yet been undertaken and it has not appeared in annual reports since.<sup>79</sup>

In any case, to judge from the attitude of senior Department of Health officials, the motivation for restrictions appears to be protectionist rather than ethical. According to a senior Department of Health official, who was interviewed for a CDE-commissioned research paper in 2010: 'The department has worked hard to improve salaries in the public health sector and must allow time for South Africans to fill these posts. No self-respecting country in the world prioritises foreigners over its own.'<sup>80</sup>

The draft Discussion Document on HR Strategy (August 2011) breaks this trend, and notes emphatically that the current foreign recruitment approach is 'reported to be inefficient

The policy on recruitment from developing countries lacks clear definition, consistency, transparency and, above all, a sound basis in understanding the dynamics of professional migration in the health sector

It will be a huge task to turn public sector healthcare around since its most able, productive and dedicated staff are overworked, overstressed and cannot always rely on support either from above or below

and most offers from governments are not pursued.' It goes on to say that 'In the short term foreign recruitment will be necessary to ensure an adequate number of health professionals. The policy will need to be rewritten and effective management processes established. Foreign recruitment should be carefully managed with an emphasis on recruiting foreign academic clinicians and professionals willing to work in rural areas.'<sup>81</sup> It remains to be seen whether this will be taken seriously in policy or practice.

In summary then, public sector healthcare is large, complex, fragmented and poorly-managed at both the strategic level and in many, though not all, cases, at the point of service. It consumed 14 per cent of annual government expenditure in 2010 and that share is set to rise. The source of this funding is taxation, a substantial portion of which is progressive income tax through which the affluent who by and large do not use public sector facilities, subsidise the poor to quite a high degree.

Public sector healthcare employs well over a quarter of a million people and with the rise in resources promised for health this number is set to rise. It will be a huge task to turn public sector healthcare around by addressing the widely-acknowledged problems of staff morale, productivity and service attitudes, for what already represents at least one in 34 employees in the formal sector of South Africa's economy and more than one in five public sector employees. This is especially true since its most able, productive and dedicated staff are overworked, overstressed and cannot always rely on support either from above or below.

## The private health sector

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**T**HE COEXISTENCE BETWEEN a failing public health sector and a private sector that serves a significant minority with high quality healthcare is the most contentious aspect of the health reform debate in South Africa. There is a widespread tendency in this debate to dismiss the contribution of the private sector to overall health outcomes, to be suspicious of the motives of private health sector players and to challenge the very legitimacy of private health provision.

This tendency is not universal and there has been a countervailing approach from within government that acknowledges the complementarity of public and private healthcare and calls for the rational use of resources in both sectors to the general good. Recently the National Treasury has noted that developing an NHI system in South Africa: 'requires several parallel reform processes that build on existing capacity in both the public and private sectors'; indeed, that 'a closer partnership between the public and private healthcare systems is a prerequisite for the introduction of such a system.'<sup>82</sup>

The Green Paper on NHI reflects these mixed messages, blaming the private sector for the ills of the public sector, making gestures towards a constructive relationship with private stakeholders, but falling well short of spelling out what the private sector might offer and how its contribution might be maximised.

Since the ANC's National Conference in Polokwane in December 2007, there has been an escalation of rhetoric against private sector healthcare in the ANC Alliance. The South African Communist Party, through its general secretary Blade Nzimande in particular, has been to the fore in demonising private sector health players as 'capitalist vultures'. This has been accompanied by a wider tendency to blame the private sector for the ills of the public system. (see box p.39: 'Capitalist vultures'? Or 'An important and treasured component of the South African health sector'?)

## 'CAPITALIST VULTURES'? OR 'AN IMPORTANT AND TREASURED COMPONENT OF THE SOUTH AFRICAN HEALTH SECTOR'?

The most extreme rhetoric comes from the Left of the ANC Alliance.

*'As the SACP we correctly predicted (that) ... the capitalist vultures in the private health sector would leave no stone unturned to oppose the introduction of a national health insurance scheme ... Indeed in recent weeks, reels and reels of columns – written largely by beneficiaries, ideologues and parasites to the hugely exploitative private healthcare and medical aid systems are regularly appearing in some of the major newspapers of our country. These capitalist vultures, which thrive on peoples' illness to make huge profits, have to be taught another lesson ...'* Blade Nzimande: General Secretary of the South African Communist Party and Minister of Higher Education, June 2009<sup>83</sup>

Others portray the private sector as the preserve of 'the rich' rather than of working people with limited resources who are motivated by well-founded distrust of public sector healthcare to seek alternative care.

*'The health system has not been immune to apartheid's infections, and, 13 years down the line we are witnessing how the private sector is becoming wealthier while the public health sector is largely lacking in the necessary human and financial resources to provide good quality care to those who seek its services.'* Olive Shisana: President and CEO of the Human Sciences Research Council (HSRC) and key proponent of an NHI scheme for South Africa (2008)<sup>84</sup>

*'Critics of the NHI were hard at work to prove that we are going to overburden the rich, and the economy will not cope ... It is this part about covering the poor and the unemployed that is bringing discomfort and unprecedented anger in the minds of the enemies of the NHI.'* Minister of Health Aaron Motsoaledi: Budget speech in the National Assembly, 30 June 2009<sup>85</sup>

Co-existing with these expressions of hostility and demands for change, the government consistently tries to articulate three messages: that it does not wish to destroy private sector healthcare; that it values the private sector as a national asset; but that private sector healthcare is doomed to collapse unless it is thoroughly reformed.

*'We should all be aware of the fact that the policy of government and the ANC, as the ruling party, is that the private sector is an important and treasured component of the South African health sector.'* Former Deputy Minister of Health (2008-10), the late Dr. Molefi Sefularo, 31 August 2009<sup>86</sup>

Motsoaledi said that the private health system was pricing itself out of existence and that it was unsustainable as long as the focus was curative rather than preventive. *'We (the ANC-led government) are not going to kill the private health system. It is going to kill itself,'* he said. Press reports of a speech by Minister of Health Aaron Motsoaledi, February 2011<sup>87</sup>

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We (the ANC-led government) are not going to kill the private health system. It is going to kill itself

From this perspective, coexistence of the private and public sectors is portrayed as a zero-sum game – that is one without the possibility of mutually-beneficial outcomes

From this perspective, coexistence of the private and public sectors is portrayed as a zero-sum game – that is one without the possibility of mutually-beneficial outcomes. Every asset, human or infrastructural, in the private sector is perceived as lost – or more dramatically robbed – from the public good.

Among the assumptions that shape this attitude are that the private sector:

- Serves only the rich
- Causes ‘maldistribution’ of health personnel
- Represents inequity in financing
- Drives up prices through greed for profits
- Has considerable excess capacity.

This section will consider these assumptions in the light of the best available facts in a profile of private sector healthcare that reviews finance, staffing and population served and confronts the issue of rising healthcare prices. Before doing that however it is important to profile the private health sector in order to understand the diversity of Interests involved.

### Diversity of private interests

Critics of private sector healthcare reform often speak as though the private health system is a single monolithic entity. This obscures the reality that the private health system includes a range of players whose interests are often divergent. Different parts of the system sometimes try to blame other parts for problems such as rising costs and different parts need different reforms.

The principal stakeholders are:

- *Medical schemes* which are non-profit entities providing health insurance by collecting revenue, pooling contributions and purchasing healthcare on behalf of the insured. They are essentially mutual societies under statutory regulation. However, they are ‘surrounded by a number of for-profit entities that provide administration, marketing, managed care, consulting and advisory services. In the mind of consumers there is often confusion between the not-for-profit medical schemes and the high-profile listed companies that act as administrators.’<sup>88</sup> In 2009, the privately-insured population comprised 3 488 009 principal members and 4 580 496 dependents, giving a total of 8 068 505 beneficiaries, or just over 16 per cent of the South African population.<sup>89</sup> In 2 009 the gross contribution per average beneficiary was R890 per month<sup>90</sup>
- *Private hospitals*: of which there were 211 in 2008, with a total of 34 000 beds<sup>91</sup>
- *Independent medical practitioners* (generalists and specialists) who are not employed by, but often have close relationships with, private hospitals. It is difficult to establish precisely the number of doctors working in either the public or private sectors. As we shall see, among other problems, registration with professional bodies (the basis for many estimates) is unreliable. In addition, some doctors work in both sectors. A recent (2010) estimate which attempts to correct for both these factors puts the number of GPs in the private sector as between 6 500 and 7 000 and of specialists between 5 000 and 5 500. The corresponding numbers for the public sector are estimated at between 10 700 and 11 300 (GPs) and 4 000 and 4 400 for specialists. These estimates drastically reduce the staffing imbalance between the sectors which is assumed by some critics of the private sector<sup>92</sup>

- *Nurses and other professional and support staff* who are employed by private hospitals, clinics and practitioners. It is no easier to estimate precisely the number of nurses working in South Africa than it is for doctors, for the same reasons. One estimate (2010) which attempts to correct for known biases puts the number of nurses working in the public sector at 104 000 and in the private sector, 40 000.<sup>93</sup>
- *Supply chain companies* (pharmaceutical and other)
- *Industry bodies* like the Council for Medical Schemes (CMS) and the Hospitals Association of South Africa (HASA)
- *Professional bodies* which regulate the various branches of the health professions, and act as lobbyists for their interests.

### Getting the facts right: Who is served by private sector healthcare?

We have already noted the basic figures for medical insurance membership, indicating coverage for a little over 16 per cent of the population. This does not tell the whole story however, since there is evidence of substantial out-of-pocket expenditure on private sector healthcare. According to National Treasury figures, out-of-pocket expenditure on healthcare was R26.6 billion (17.6 per cent of the total) in 2006/7, R31.83 billion (16 per cent of the total) in 2007/8 and R36.5 billion (16 per cent of the total) in 2009/10. Out-of-pocket expenditure underlines the often ignored fact that it is not only the insured population that is served by private healthcare. Reporting in 2007, McIntyre and Van den Heever calculated that in 2005 there were seven million people (14.9 per cent of the then population) in voluntary medical aid schemes, while 9.8 million people (20.9 per cent of the population) used private primary care on an out-of-pocket basis instead of or in addition to public hospitals.<sup>94</sup> According to these figures – which are widely accepted including in some government policy documents – 35.8 per cent of the population is served in whole or in part by the private sector.

In 2006 an investigation of the feasibility of low-income medical schemes (LIMS) found that: ‘The evidence on current household (HH) expenditure by low income (R2 000-6 000 per month) households suggests that current out-of-pocket expenditures are in the region of 3 per cent-10 per cent of household income depending on the income category examined.’<sup>95</sup> Similarly in 2010, the South African Health Review (SAHR) noted findings of the StatsSA General Household Study (2009) on household usage of public and private sector healthcare facilities. In 2009 the most frequently-used health facility was a public clinic (59 per cent) followed by a private medical practitioner (25.3 per cent). Separating the insured from the non-insured population, the survey asked households what the usual place of consultation was; 13.9 per cent of households with no insurance reported usually consulting the private sector.<sup>96</sup>

All of this makes it abundantly clear that the private sector serves more than just those that can afford private insurance.

Reviewing a wide range of data on health facilities and survey findings on satisfaction levels with public and private healthcare facilities, the SAHR noted that:

The quality and perceptions of poor quality of public health services may also help explain why a considerable share of the very poorest households are paying for consultations with private providers when public healthcare is available free of charge.<sup>97</sup>

The private sector serves more than just those that can afford private insurance

More accurate methods of calculation have shown that there are fewer human and material resources at the disposal of the private sector than its critics claim

To show that private healthcare serves the poor is an essential step to a better-grounded reform debate. However that this should be through high levels of out-of-pocket expenditure is not desirable.

The risk pool should be expanded by working towards making health insurance mandatory for those that can afford it and by making both insurance and private care more affordable by encouraging competition on price. Improvement in the quality of public care will also reduce the rate at which people seek private care on an out-of-pocket basis.

## Getting the facts right: 'Maldistribution of resources'?

To a considerable extent hostility towards the private health sector is motivated by perceptions that 'Our private healthcare system absorbs the lion's share of resources and serves a smaller part of the population.'<sup>98</sup> In the words of the ANC:

It is an established fact that the current command of health resources by the private health sector, which serves a minority section of the population, has been to the detriment of the public sector on which the vast majority of South Africans depend.<sup>99</sup>

Often these perceptions are expressed in ways that beg important questions about the rights of people in a free society to choose where to work and how to use their after-tax resources to fund their own healthcare. Some (though not all) critics of private healthcare also find it convenient to ignore how hostile and unpleasant a working place the public health sector can be for professional staff and how this is an incentive to seek employment in the private sector. The recent draft HR strategy discussion document by the Department of Health is a notable exception. It admits that:

The process of mass advertisement of provincial vacancies, lack of a professional website and information about post location, exceedingly slow processing of applications, all lead to a negative employment process and the loss of the potential professional to the public sector. Once employed, the negative management process of meeting health professionals' working needs and expectations continues, contributing to a negative work environment.<sup>100</sup>

In any case recent research has challenged the factual basis of the 'maldistribution' of resources. More accurate methods of calculation have shown that there are fewer human and material resources at the disposal of the private sector than its critics claim.

One problem with estimates of numbers working in the private and public sectors has been the practice of taking the number of health professionals registered with the appropriate professional body and subtracting the number known (though not necessarily with great accuracy) to be working in the public sector.

This crude and unreliable method has been used to generate figures which have in turn been employed to illustrate the 'maldistribution' of health professionals between the private and public sectors and as a yardstick for inequity in the overall South African health system. It is the approach used in the September 2010 NHI discussion document of the ANC National General Council which is largely followed by the Green Paper on NHI in 2011. One problem with such calculations is that they do not take account of individuals on the various registers who are not practising for one reason or another (emigration, retirement, working in another sector of the economy or in healthcare but not practising medicine, working part-time). Thus

numbers working in the private sector are frequently overestimated and ratios of practitioner to population served seem unduly favourable to the private sector.

In the on-going debate over healthcare reform in South Africa, fresh calculations have been carried out to cross-check professional registrations with other surveys and information provided by medical schemes. This research has been done by consultant actuaries and health economists, notably by the consultancy Econex.

These calculations demonstrate that many fewer medical professionals work in the private sector than some critics claim. Although the ratios of professionals to population served are still higher among the insured, the differences are not dramatic. This reduces the credibility of accusations that the private sector 'absorbs the lion's share of resources.' Table 6 below summarises ratios of practitioner to populations served for three groups: those who have private medical insurance; those who use a mixture of public and, through out-of-pocket payments, private healthcare providers; those who use public facilities only. The table compares these new calculations with figures used in the discussion document on a national health insurance scheme which was presented at the ANC's National General Council in September 2010.

### Getting the facts right: 'Funding inequity'?

Fresh perspectives on healthcare financing are also part of the reform debate. Spending on public sector healthcare increased by 16.7 per cent annually between 2005/6 and 2008/9.<sup>104</sup> Some of the increase has been absorbed by population growth, increasing burden of disease and increased usage. However, 'on a real per capita basis, health spending was projected to increase by an average annual 4.8 per cent between 2005/6 and 2011/12.'<sup>105</sup>

As the Treasury figures for healthcare financing (2010) in Table 4 on page 31 above make clear, this has had an effect on the balance between public and private funding. In 2006-7 private healthcare accounted for 58 per cent of total healthcare expenditure and public budgets 40 per cent of the total. That is, there were 18 percentage points of difference between public and private shares of total healthcare funding. By 2010-11, when public expenditure accounted for 44 per cent of the total and private for 54 per cent this had been reduced to 10 points of difference, and total medical scheme expenditure is now lower than total public funding.

Calculations of funding disparities in health financing frequently rely on estimates of expenditure per beneficiary of private healthcare, public healthcare and a mix of the two. Here is a typical version (in ANC Today) in 2009:<sup>106</sup>

- R11 300 per beneficiary, per annum for those belonging to medical schemes (this includes both medical scheme spending of R9 600 and estimated out-of-pocket payments of R1 700)
- R2 500 per beneficiary, per annum for the middle group (includes out-of-pocket payments to private primary care providers and government spending on hospital care)
- R1 900 per beneficiary, per annum for those using government primary care and hospital services.

As Ramjee and McLeod point out, this is a misleading analysis. It does not compare like with like because it does not distinguish tax-funded public expenditure from private funds devoted to healthcare after obligations to a progressive tax system have been met.<sup>107</sup>

Spending on public sector healthcare increased by 16.7 per cent annually between 2005/6 and 2008/9

What needs to be compared is the public spending per head on users of public sector facilities, with the per head subsidy allowed by the government to taxpayers who buy private medical insurance.

A ministerial task team on social health insurance reported in 2005 that this tax expenditure subsidy (TES) was estimated in 2005 to be R10.1 billion, which in that year was equal to some 20 per cent of the public health budget.<sup>108</sup> According to more recent calculations, the effect of National Treasury reform of the tax subsidy is that the subsidy per head for those who purchase private insurance now stands at R1730 and government spending per head on a person in the public sector is R2500. Thus the true comparison of like for like is that a person using public health facilities benefits from R2500 public spending and a person using private facilities benefits from R1730 that the government foregoes in tax revenue.<sup>109</sup> In return he or she refrains (overwhelmingly) from using publicly-funded facilities. It is through this abstention that these individuals ‘repay’ the subsidy they receive.

### Getting the facts right: ‘Excess capacity in private healthcare’?

Another area of criticism of distribution of resources is that there is substantial excess capacity in the private sector. For instance the influential ANC/Development Bank of Southern Africa (DBSA) Roadmap (2008) notes that ‘The private health sector is operating at lower levels of capacity utilisation (e.g. bed occupancy) than public health’ and, ‘If (the) private sector was made to carry more of the burden (whether “encouraged” or “compelled”), it could reduce (the) burden on public health sector.’<sup>110</sup>

**Table 6: ANC estimates of population per healthcare provider (based on 2005/6 figures) compared with Econex calculations (2010)**

	Healthcare provider						Comment on ANC NGC figures
	Private healthcare only (insured population)		Some private (usually GP) + public (usually hospital)		Public sector only (primary + hospital)		
	ANC	Econex	ANC	Econex	ANC	Econex	
Population per primary care practitioner	243	2 723	588	2 723	4 193	2 861	Overestimates ‘private only’ resources per patient more than tenfold
Population per pharmacist	765	1 567	1852	3 594	22 879	16 626	Estimates ‘private only’ resources at double their actual level
Population per specialist	470	1 767	10 811	9 581	10 811	9 581	Estimates ‘private only’ resources at more than triple their actual level
Population per nurse	102	197	616	394	616	394	Dramatically overestimates ‘private only’ and also underestimates ‘public only’ resources per patient
Population per hospital bed	194	303	399	482	399	482	Significantly overestimates ‘private only’ and also underestimates ‘public only’ resources per patient

Sources: ANC National General Council Discussion Document<sup>101</sup>; Econex, Updated GP and specialist numbers for SA<sup>102</sup>; Ramjee and McLeod, Private sector perspectives on national health insurance, Tables 1 and 2<sup>103</sup>

Assumptions about private sector 'overcapacity' are not always well-founded. For instance in the NHI discussion document presented to the September 2010 National General Council of the ANC, private sector hospital capacity is noted as 28 000 beds and the occupancy rate as 65 per cent.

This leads the authors of the document to conclude that the 'oversupply' is 10 000 beds, presumably on the grounds that 65 per cent of 28 000 is 18 200. This presumes a desirable occupancy rate of 100 per cent. However international best practice dictates that any occupancy rate over 80-85 per cent compromises infection control and risks emergency cases being turned away.<sup>111</sup> In 2005 the average bed occupancy rate in the 30 OECD countries was 75 per cent.<sup>112</sup>

While some estimates of capacity are incorrect and simplistic, there is nonetheless good evidence that capacity in the private sector is not being as efficiently used as possible, and that were it to be better allocated a significantly larger number of insured people could be serviced with current clinical resources. To understand this requires examining the costs for private care.

### Getting the facts right: Cost drivers in private healthcare<sup>113</sup>

The average annual cost of belonging to a medical scheme has increased fivefold in real terms since 1980. Average cost in 1980 was R1 805 (adjusted to 2008 prices to make comparison meaningful). By 2008 this had risen to R9 610 per life per annum. Data from the annual reports of the Council for Medical Schemes over the 30-year period since 1980 allow identification of cost drivers. The costs of benefits (93 per cent of costs in 1980 and 87 per cent in 2008) are the more significant drivers of increases. The bulk of benefit costs are incurred in payments to providers of healthcare and medicines.

In summary, healthcare costs contributed 86.45 per cent to the increase in cost of private healthcare over the last 30 years. The main drivers were:

- Hospital costs: 36.66 per cent of the increase (a 12-fold increase in real terms)
- Specialist costs: 19.28 per cent of the increase (a five-fold increase in real terms)
- Medicine costs: 13.37 per cent of the increase (a four-fold increase in real terms).

By contrast with these drivers, the costs of general practitioners contributed only 4.43 per cent to the increases. All non-healthcare costs (administration, managed care, brokers) increased ten-fold, but contributed only 14.35 per cent to the overall increases.

Such significant increases should not be viewed in isolation, nor automatically and simplistically attributed to greed. In the face of consumer anger, insurers and care providers (especially hospitals and professional associations) have offered competing explanations, each attempting to blame someone else. Left-leaning interests blame 'capitalist vultures'. Insurers try to blame the increases on carers, who they say are exploiting insurers by over-charging and by over-using services. Hospitals blame users for being older and sicker. Insurers and hospitals blame regulations for driving them not to compete on the basis of price. In many cases different interests offer competing analyses of the same facts.

One uncontroversial contributor to the rising price of insurance is continuing reduction in use of state facilities by insured individuals. In 1989, provincial hospital care purchased by scheme members (which was already in decline) accounted for 27 per cent of schemes' expenditure (R149 of R410 in 2008 prices). Since then there has been a dramatic decline in parallel with the drop in standards of public hospital care.

The average annual cost of belonging to a medical scheme has increased fivefold in real terms since 1980

Skills shortages affect the private sector as well as the public and help to drive up prices

Another important factor is the absolute shortage of doctors and specialists. Skills shortages affect the private sector as well as the public and help to drive up prices.

Making sense of the rest of the picture is complicated by the fact that the healthcare context is continually changing. The range of diagnostic procedures and treatments has widened and includes increasing numbers of new and expensive procedures. The South African burden of disease has also changed in various ways, most strikingly through the spread of HIV/AIDS, TB and diseases such as heart disease and cancer to which lifestyle makes a significant contribution. The demographic makeup of the general population and of the insured population, are changing, as is the economy in which the prices of different inputs do not change uniformly. The regulatory environment has also not remained constant. Despite these difficulties, insurers and hospitals agree that a major driver of costs is increased hospital admissions.

The profile of the insured population has changed to one that includes more individuals who are relatively high risk, especially infants under one year of age and adults older than 40 years. This is not merely a reflection of a changing age profile of the national population. The proportion of the non-medical scheme population aged 65 or over increased by approximately 10 per cent over the 2002 to 2007 period, while the insured population of 65 or over increased by almost 40 per cent over the same period. Higher risk individuals need, on average, more medical attention, which costs more. So changing the risk profile of a group of insured individuals should be expected to lead to some cost increases.

The relative number of dependents on medical insurance has also declined, especially in open schemes. This may be evidence of the impact of reduced affordability, especially since it occurred against a backdrop of overall GDP growth and an increasing population.<sup>114</sup>

According to those in the hospital industry these changes explain increased admissions and lengths of stay.<sup>115</sup> This view, which blames the changing patient profile, is disputed by the medical schemes. The 2008 CMS report on cost increases maintains that none of the frequently-cited factors – HIV/AIDS, legitimate utilisation, technology, nursing costs – can explain the increases. The CMS argues that they account for too small a fraction of claims. The same report argues that the main cost drivers are excessive investment in technology and utilisation patterns which are contrary to international trends (where hospital use in medically comparable populations enjoying similar health outcomes is declining).

The report notes that the SA private sector has more magnetic resonance imaging (MRI) and computed tomography (CT) scanners for its population than Canada, France, Germany, the Netherlands, Sweden and the United Kingdom.<sup>116</sup> The CMS also documents both the rise in average age of members of open schemes, and the declining dependent ratio, but disputes the view that either is a major cost driver.

A second disputed area is the Prescribed Minimum Benefit (PMB) framework. This arises from the Medical Schemes Act of 1998, and makes a specific schedule of benefits mandatory for any scheme. Requirements of this sort are a standard policy feature in countries with regulated private medical insurance, and are partly intended to ensure reasonable risk pooling. According to the insurance industry the PMB policy is worded in a way that places almost no limits on pricing for prescribed benefits. In practice, they say, once a case (such as a hospital admission) is coded as being a PMB, there is almost nothing a managed care company can do to curb costs related to the admission. The coding of a case is at the discretion of the doctor, who has a financial interest in the diagnosis and treatment. Insurers argue that, given their scarcity value and ability to charge above 'medical scheme rates' for PMBs, few specialists are interested in trading off volume for price.

Again, this interpretation is disputed. The most dramatic increases in the price of private insurance occurred before, rather than after, the implementation of the PMB-framework. Since then prices have been comparatively flat in real terms. Schemes are permitted to specify designated service providers for PMB related care, and can levy co-payments in cases where users decide to use a different provider. So insurers have some capacity to negotiate prices for PMBs. In addition, if the claim that doctors used PMB coding as an opportunity to fleece insurers were true, then the same procedures would be expected to attract different pricing depending on whether the condition treated was a PMB or not. A CMS analysis of almost 10 000 service providers for a total set of claims worth over R600 million found no significant overall difference (less than 1 per cent) in pricing.<sup>117</sup> Forthcoming litigation may lead to the framework being refined, but calls for its abandonment should be approached with caution.

The pattern of claims reflects a declining fraction of benefits being paid to general practitioners, and a growing fraction being paid to specialists. The average fraction of benefits allocated to GP visits per medical insurance beneficiary has decreased from around 18 per cent in 1980 to about 7 per cent in 2008. Until 1998 average benefits allocated to specialists were lower than those to general practitioners, since then the ranking has reversed and the gap is widening. This need not reflect an overall decline in use of GPs – a significant fraction of out-of-pocket payments is for GPs. It is rather a different way of viewing the increase in hospital utilisation, since most hospital visits involve specialists. Hospital groups themselves claim that they have no direct control over allocation of services. Doctors decide who is admitted, which wards they should stay in and what diagnostic procedures, prescriptions and treatments should be used. Insured individuals themselves and practitioners remunerated on a fee-for-service basis have little incentive to spend cautiously. Doctors and specialists are under no significant pressure to compete over price.

Whether or not the investment in technology by hospitals amounts to an incentive for doctors to use it, there is evidence of a pattern of over-servicing. The insurance industry sees this as an important cause of price increases. South Africa's private hospital industry has three major hospital groups: Netcare, Medi-Clinic, and Life Healthcare. These groups own 80 per cent of all private theatres, 76 per cent of all private hospital beds and 66 per cent of all private hospitals.<sup>118</sup> This level of concentration has raised concerns regarding market power. The funding model, where most revenue is fee-for-service paid by insurers with limited oversight, suggests that one should expect some over-servicing and over-utilisation of equipment. Changing patterns of service over time, and rates of service in comparison to other countries, indicate that this is indeed happening.

Caesarean sections, MRI and CT scans, as well as angiograms are all high-cost services that have seen a steady increase in utilisation over the years.<sup>119</sup> At present about 62 per cent of private sector births are by caesarean, while just 17.7 per cent of public sector births are by caesarean. Countries such as the UK, US and Australia have a rate of slightly more than 20 per cent.<sup>120</sup> Other examples of the South African private sector's tendency to over-care can be seen in the very high equipment-to-population ratio. As noted above, the South African private health sector has more MRI and CT scanners per million people than each of the United Kingdom, Canada, Germany and France.<sup>121</sup>

The CMS argues that given the demographics and disease burden of the insured population, the number of beds required (assuming 80 per cent occupancy, which may be higher than ideal) is just under 17 000 while the actual number of beds is over 25 000 – nearly one and a half times as many. It maintains that the persistence of the surplus is evidence of 'non-price competition' exemplified by investment in equipment and over-servicing. For their part the hospital groups maintain that regulation effectively forces them to make intense

Doctors and specialists are under no significant pressure to compete over price

Doctors and specialists are scarce, so hospitals compete to make themselves into attractive places to base a practice, and they do this in an 'arms race' of equipment purchasing

investment in technology and equipment. Their business is fundamentally dependent on doctors and specialists, but regulation prevents them from directly employing them. Doctors and specialists are scarce, so hospitals compete to make themselves into attractive places to base a practice, and they do this in an 'arms race' of equipment purchasing. This point is, unlike some others relating to price increases made by hospital groups, endorsed by the CMS, which supports the call for allowing salaried employment of doctors in the private sector because it would help remove perverse incentives.<sup>122</sup>

What conclusions can we take from this collection of claims and counter-claims? While there is room for debate about the specific quantities of over-service, influence of demographics, and fine tuning of regulation, some very large trends stand out:

- Hospital groups are engaged in significant non-price competition. They have to be in order to operate at all in the current framework, and a combination of monopoly power and their inability to employ doctors and specialists, both of which are in short supply, are major contributors to this.
- The privately-insured population in South Africa makes more hospital visits than comparable populations in other countries, and the trend is for them to make increasing numbers of them, where elsewhere visits are declining.

The fact that price increases can be explained in this way does not make them acceptable. Whether caused by 'greed' by a monolithic private sector as some critics maintain, or by perverse system design, increases that sharply exceed inflation are alarming and not sustainable. South Africa needs to expand access to private care, and address the fact that price increases risk making it unaffordable to increasing numbers of people. If reform measures significantly increased the size of the insured population, perhaps by 40 per cent, then the current capacity of the private care sector could largely cater for them assuming reduction in over-servicing.

### Reforming the private health sector

Minister of Health Aaron Motsoaledi was probably deliberately exaggerating when he said that the private sector would kill itself with high prices. However unless it can mobilise more and better-managed resources at more affordable prices it will stagnate and fail to realise its potential to deliver quality healthcare to more South Africans.

Under such circumstances, it is sure to come under intensified political pressure as the public sector struggles to cope with a massive disease burden while trying to reform itself from top to bottom with its own resources.

There are four areas in which reform is urgent:

- The way private healthcare is funded
- The way private healthcare is organised and delivered
- Barriers to market activity in the health sector
- The ways in which the private sector makes direct contributions to the public sector health system.

### Funding

*Low Income Medical Schemes (LIMS):* ideally the population that wants and can afford private medical care will expand with economic growth and rising employment levels. However the urgency of the challenges of healthcare reform will not wait. In recognition of this, both government and the private sector have put considerable resources into researching the possibilities of LIMS

These are vehicles which could broaden access for lower income people to private sector resources, at least at the level of primary healthcare, on the basis of insurance rather than through out-of-pocket payments. This would be done through a mixture of government and/or employer subsidy, combined with regulatory revision of statutory prescribed minimum benefits, along with innovative design and delivery. The revision should allow income-based tiers, with tax relief targeting marginal gains in access, and assuming that benefits that were not insured could still be received in the public sector. An efficiently run private care sector could care for more patients than it currently does – the policy challenge is enabling more people to access insurance.

Despite the work put into investigating the LIMS as a policy option, that approach to extending insurance coverage has recently been side-lined by the often strident NHI debate. Even so, revival of the LIMS option offers a genuine reform path for anyone (including proponents of the NHI) who is concerned to extend the contribution of the private sector to a wider population. If the range of available schemes is extended by making LIMS available, it will be necessary to take steps to reduce self-selection on the basis of risk. As explained above, this can drive costs, and destabilise risk pools.

*Regulation of medical schemes:* the Medical Schemes Act (131 of 1998) governs the behaviour of medical schemes. The Act has been praised for good intentions and salutary effects in this regard, but it has also been criticised for unintended consequences, resulting both from what is included in it as well as what has been left out. In this sense the Act exemplifies problems of both over- and under-regulation. One key problem is community rating without mandatory participation.

Under community rating insurance premiums cannot be differentiated on actuarial risk factors like age. Community rating increases equity because the young and healthy subsidise the old and sick. But although they will in turn be subsidised, it acts as a disincentive for young potential members to join medical schemes (this disincentive is called ‘anti-selection’). Reformers argue that community rating must be accompanied by compulsory membership, for instance to those in formal employment, thus enlarging the risk pool.

*Non-implementation of a risk equalisation fund (REF):* the function of an REF is to extend the principle of risk-pooling from individuals to medical schemes. In the interest of the overall stability of the scheme environment, all medical schemes would need to participate in an REF that receives money from some schemes and redistributes it to others according to the risk profile of each scheme’s members relative to the average of all schemes.<sup>123</sup> Risk equalisation is also important for the viability of small schemes, which could otherwise be compromised by uneven distribution of risk within their members. Considerable work was done by government committees between 1995 and 2005 to research and develop proposals for an REF. By 2006 a ‘shadow’ risk equalisation process to test the reporting and operational requirements of such a mechanism was in place. The Department of Health took the decision that the risk equalisation mechanism be housed within the Council for Medical Schemes (CMS) and that the legislative framework should proceed by way of amendment to the Medical Schemes Act No.131 of 1998. Cabinet finally gave the full go-ahead in January of 2006, with funds approved for the full implementation of the

LIMS are vehicles which could broaden access for lower income people to private sector resources

A frequently-voiced grievance of the private hospital sector is difficulties in obtaining licences for private hospitals

required systems over the next two years. The implementation of the systems and results of the shadow process were seen as central to obtain final approval for the passing of the legislation. However, despite the full implementation of the systems and the finalisation and approval of legislation by Cabinet in 2008, further progress with the legislation was blocked by ANC lobbies on the grounds that it would undermine the implementation of a full NHI scheme.<sup>124</sup>

### *Delivery of private sector healthcare*

One way of addressing the cost spiral of private sector healthcare is by attacking on the front of fee for service and over-care. Private sector stakeholders point to two possible reforms. Firstly, hospitals (and insurers) could ration and deliver care more effectively if the legislated ban on the employment of doctors were removed. This would be a step towards encouraging competition on price, especially if users were more motivated to make decisions on the basis of price. Secondly, if the decline in the usage made of general practitioners were reversed and more attention paid in the private sector to primary care, conditions could be managed at an earlier, pre-acute stage, with less recourse to expensive high-level curative care. One way of doing that is by giving users incentives to be prudent.

### *Barriers to market activity*

A frequently-voiced grievance of the private hospital sector is difficulties in obtaining licences for private hospitals. Ideological hostility to private enterprise, bureaucratic incompetence and outright corruption are cited by stakeholders as obstacles to the provision of more healthcare facilities.<sup>125</sup> Another barrier to markets making a greater contribution to overall health outcomes is that for the last several years the private sector has been prevented from training nurses by a prohibition on accrediting new institutions. Although the moratorium was lifted in 2008, the South African Nursing Council has since insisted that accreditation cannot be granted until a new curriculum has been finalised.<sup>126</sup> For example, although Medi-Clinic obtained approval for a nursing college by the South African Qualifications Authority (Saqa) in 2007, the new curriculum is only set to be introduced in 2012, which delays the training of many new nurses.<sup>127</sup> Private sector hospitals are seeking to recruit nurses from abroad. Medi-Clinic has been recruiting specialist nurses from India, while Netcare is attempting to attract South African nurses working in Britain.<sup>128</sup>

### *Private sector contributions to the public health sector*

The White Paper for the Transformation of the Health System in South Africa (April 1997) was in many ways a pragmatic and realistic document. This is certainly true in respect of its promotion of ways to use private sector resources such as session work by private specialists in public hospitals<sup>128</sup> and contracting with the private sector based on negotiated tariffs 'for the utilisation of all hospital beds in a province before more are created by either public or private sector'.<sup>130</sup>

However the opportunities for collaboration and pooling of resources that the white paper opened up appear very largely to have been missed and in some instances appear to have been deliberately curtailed. Certainly this is the view of many private sector stakeholders interviewed for a CDE-commissioned research paper on sources of mistrust between the public and private sectors.<sup>131</sup>

Missed opportunities for collaboration were emphasised in the response of the private sector interviewees in this research paper. The demise of opportunities for private sector specialists to work in public health facilities ('sessional opportunities'), as promoted in the 1997 White Paper, was singled out. According to one respondent, 'from about 2006 the Department of Health had simply stopped making sessional opportunities available.' Ideological hostility to the private sector (at provincial level if not as national policy) and budget cuts were cited by private sector stakeholders as reasons for this. The relatively meagre flow of public-private partnerships (PPPs) was also noted:

Private sector representatives expressed disappointment at the slow rate of project flow, and a sense of 'opportunity lost' in the mutual failure to come up with solutions to urgent problems affecting both sectors. They bemoaned the fact that no study had fully costed the delivery of health in the public sector, taking all expenses into account... This... had led to the prevailing assumption that the public sector was more cost effective and the main reason that previously outsourced projects had been transferred to in-house management over the previous 10 years.<sup>132</sup>

Public private partnerships (PPPs), in which private sector players contract with government entities, typically to share resources, invest in infrastructure or provide services, are widely recognised across both the developed and developing worlds as key instruments in making rational and efficient use of scarce resources and in spreading financial and operating risk. Where the resources of the public sector are stretched, either in terms of financial or human capacity, and where the private sector has resources to invest and skills to deploy, PPPs are potentially useful. It is scarcely surprising then that PPPs are well-established – in principle at least – as part of the South African government's policy armoury. They received resounding support from President Jacob Zuma in his 2010 State of the Nation Address, in which he emphasised partnerships with the Development Bank of Southern Africa (DBSA) aimed at developing public hospitals, as well as a PPP with the DBSA and the Industrial Development Corporation aimed at improving project financing and hospitals.<sup>133</sup>

Despite this, PPPs have only been rather sparingly used so far. A CDE-commissioned review of PPPs in the health sector noted eight, covering infrastructure (hospital building or refurbishing), sharing of under-used resources between public and private sectors and delivery of clinical and non-clinical services.<sup>134</sup> The biggest was for R4.5 billion; the longest was for 21 years while the shortest was for four years. A further 11 were at various preliminary stages.

Clearly the subject of PPPs is a complex one and there are several reasons why they have been so sparingly used. Among the reasons are ideological hostility to the idea of a market in health services (on the part of unions, even when government officials were sympathetic to the idea), fears that the private sector, 'would knife us in the back when we least expect it'<sup>135</sup> (as a senior Department of Health official put it to CDE researchers), failure to agree on how to cost health service delivery and above all, lack of public sector capacity to negotiate, manage and monitor contracts with the private sector in order to achieve good value for public funds.

To sum up, debate about healthcare reform has been distorted by inadequate and inaccurate information about the place and role of the private sector in South Africa's overall health system.

Greater clarity and more authoritative data are needed on complex and disputed issues such as the drivers of prices in private sector healthcare and the relative resources available to the private and public services. These will inform debate about the reforms that will be needed in order to broaden access to quality healthcare.

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## Health sector reform

THE GOVERNMENT'S STRATEGY for health sector reform has two complementary components. The first is the introduction of an NHI System and the second is a comprehensive rehabilitation and revitalisation programme for the public health sector. The government and the ANC have emphasised in all recent policy documents, and the health minister in policy statements, that the rehabilitation of the public health sector is of paramount importance. As the Green Paper puts it 'improvement of quality in the public health system is at the centre of the health sector's reform endeavours,' and 'No amount of funding will be sufficient to ensure the sustainability of the NHI unless the systemic challenges within the health system are also addressed.'<sup>136</sup> It is not difficult to see why this is so:

The intention is that the NHI benefits, to which all South Africans will be entitled, will be of sufficient range and quality that South Africans will have a real choice as to whether to continue medical scheme membership or simply draw on their NHI entitlements.<sup>137</sup>

Since the potential cost of meeting both the mandatory NHI payments and continuing private insurance is likely to be crippling for all but the very rich, as well as have adverse effects in the wider economy (on consumer demand and the cost of labour for instance), rehabilitation of the public health sector is crucial.

### National Health Insurance

The government has committed itself to the introduction of an NHI system through legislation to be brought before parliament by the end of 2012.<sup>138</sup> Five committees or commissions on healthcare financing and social insurance were appointed between 1994 and 2002. However the genesis of current plans for NHI did not come as a natural continuation of this process, but a radical departure from it, driven from within the ANC Alliance. The ANC National Conference in Polokwane in 2007 made a commitment to introduce NHI. This political momentum made itself felt in a policy-making process which initially made little effort to involve a broad range of stakeholders and was criticised by some of those who did become involved on the grounds that dissenting or even inquiring views on NHI were treated with scant respect.

The first substantial proposal for NHI came in the ANC discussion document which was presented to the movement's National General Council in September 2010. Essentially the proposal was for a mandatory prepayment-based health financing system. This would constitute the entire population as a single risk pool and force those deemed to be able to afford to do so to cross-subsidise those with a lower income and higher 'disease burden'. This cross-subsidy would be at a much higher level than under the current already-progressive system of financing public healthcare from direct general taxation.

These essential features have been carried over into the government's Green Paper on NHI (see box p.54: the Green Paper on National Health Insurance).

Both the NGC discussion paper and the Green Paper place considerable emphasis on the importance of wider health systems reform by setting extravagant targets signalled by language like, 'complete transformation,' 'total overhaul' and 'radical change'. However they are equally insistent that these things can only be achieved through the new funding model of the NHI.

The declared aims of national health insurance are to raise considerably more funds for the public health sector while opening access to the resources of the private health sector to the

The potential cost of meeting both the mandatory NHI payments and continuing private insurance is likely to be crippling for all but the very rich

whole population. According to the ANC NGC document and the Green Paper success in these aims will depend on the 'single purchaser' (sometimes called 'single payer') principle. In economic theory such a 'monopsonistic' system gives power to the single purchaser to determine prices. This is the reason for setting up a single, government-run fund to: 'receive funds, pool resources and purchase services on behalf of the entire population.'<sup>139</sup> This 'offers government a high degree of control over total expenditure on health,<sup>140</sup> that is, control over the way healthcare is rationed and the prices paid for it.

The Green Paper also makes price control through a single payer a fundamental plank of the NHI, but dilutes the principle slightly by leaving open the possibility exploring a multi-payer system. This provoked COSATU's displeasure and the claim that leaving open the possibility of a multi-payer system had been 'smuggled into the Green Paper by the Treasury.'<sup>141</sup>

Despite its advocacy of a single-purchaser structure, the ANC discussion document does not envisage outlawing private healthcare. The continuance of private providers and private insurance is envisaged, although the hope is that the previously-insured will opt for their rights under the NHI and feel that they will not need private insurance. Indeed at one point, the document goes so far as to note that: 'It should be stressed that public financing of healthcare need not imply that all healthcare is provided by the public sector. An increasing number of countries use public money to contract private doctors or organisations, an arrangement that can increase efficiency.'<sup>142</sup> This point is made again in the Green Paper but without further detail.

The ANC NGC document prompted a large critical literature on the desirability and feasibility of an NHI for South Africa. While the Green Paper has provided some more information, the principal areas of concern remain:

- *Costing:* the Green Paper on national health insurance envisages a scheme that is universal, compulsory and 'free at the point of use'. No matter how much the system will cost to run, no matter how much or how little an individual will contribute to the cost, users will not be billed for it. That much seems clear. What is a matter for concern is the distribution of sources of new funding between income tax, VAT, and/or a dedicated NHI contribution to pay for all this; whether a general raise in taxation will be needed or not; how affordable significant new funding will be, given South Africa's small pool of personal income taxpayers and the economic and political difficulties involved in raising existing taxes (like VAT) or devising new ones; the Green Paper does provide annual cost estimates for the 14-year period that will see the NHI developed, but does not commit itself on the sources of funding, promising only that this is the subject of on-going policy development. Two assumptions seem to underpin this policy development: the first is that cost containment will play a substantial role in the NHI's viability: the second is that diverting from taxpayers to the NHI fund sums that are comparable to what they are paying for private medical insurance will take care of increased funding for the public sector
- *Government capacity to run an NHI fund* efficiently, cost-effectively and without vulnerability to serious fraud
- *The effects on the insured population:* will they be persuaded to opt for their NHI rights and forego private insurance? Or at substantial sacrifice of other expenditure (with knock on effects in the wider economy) pay their mandatory contributions and private health cover?
- *Absence of shared understanding* between government and private stakeholders (who are themselves divided between funders and providers) on the subject of healthcare pricing

No matter how much the NHI system will cost to run, no matter how much or how little an individual will contribute to the cost, users will not be billed for it

The rationale for introducing National Health Insurance is therefore to eliminate the current tiered system where those with the greatest need have the least access

and drivers of price rises. The government's assumptions are that the NHI will, on behalf of the government, be able to price all healthcare at public sector rates, that these are necessarily lower, that a single payer/buyer will be more efficient and in the last analysis private providers will simply be compelled to accept what is offered. This key issue is summed up in paragraph 27 of the Green Paper, which simplistically reverts to casting the private sector as villains: 'The private sector will have to accept that the charging of exorbitant fees completely out of proportion to the services rendered have (sic) to be radically transformed.' The government hopes that by controlling prices it can double public expenditure on health in real terms by 2025, while greatly shrinking private expenditure, so that the country's overall spending on health will fall from the

### THE GREEN PAPER ON NATIONAL HEALTH INSURANCE

Released for public comment in August 2011, the Green Paper maps the government's vision for national health insurance.

#### **Health reform overview:**

'To successfully implement a healthcare financing mechanism that covers the whole population such as NHI, four key interventions need to happen simultaneously: i) a complete transformation of healthcare service provision and delivery; ii) the total overhaul of the entire healthcare system; iii) the radical change of administration and management; iv) the provision of a comprehensive package of care underpinned by a re-engineered Primary Healthcare.' (paragraph 6 p.5)

#### **Rationale for NHI:**

'The rationale for introducing National Health Insurance is therefore to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes. National Health Insurance will improve access to quality healthcare services and provide financial risk protection against health-related catastrophic expenditures for the whole population. Such a system will provide a mechanism for improving cross-subsidisation in the overall health system, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from health services would be in line with an individual's need for care. Moreover, by significantly reducing direct costs for healthcare, families and households under National Health Insurance are less likely to face impoverishing healthcare costs.' (paragraph 51 p.16)

#### **Objectives of NHI:**

'The objectives of National Health Insurance are:

- a) To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not.
- b) To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund.
- c) To procure services on behalf of the entire population and efficiently mobilise and control key financial resources. This will obviate the weak purchasing power that has been demonstrated to have been a major limitation of some of the medical schemes resulting in spiralling costs.
- d) To strengthen the under-resourced and strained public sector so as to improve health systems performance.' (paragraph 55 p.18)

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present 8,3 per cent of GDP to 6,2 per cent. The rationale is that its power to dictate will significantly and painlessly lower healthcare prices. This is something of a gamble. It remains to be seen whether the government is correct in assuming that there is so much fat in private sector pricing, in the shape of excess profits and remuneration, that this can be done. This view of pricing and costs has been challenged by critics who warn that the entire basis for claims that the NHI is financially feasible and sustainable rests on shaky foundations

- *Lack of evidence that a single payer produces better cost containment than do multiple payers, but much to suggest that public dissatisfaction is greatly increased because single payers are far less responsive to consumer needs*
- *Vagueness and uncertainty about the role of the private sector.*

These and other criticisms will be at the centre of public comment on the Green Paper. However as all stakeholders repeatedly acknowledge, the NHI is only one aspect of health system reform and for it to be a success the public health sector has to be dramatically improved. This is a suitable point to consider the second arm of healthcare reform: the Department of Health's 10 Point Plan for improvement of public healthcare and its Strategic Plan for 2010/11 – 2012/13.

### Revitalising the public health sector

The key points in the Department of Health's 10 Point Plan (see box p.57 National Department of Health Strategic Plan) are: improving the quality of health services; overhauling the healthcare system and improving its management; improving human resources planning, development and management; and revitalisation of physical infrastructure. In choosing these and other priorities the Department of Health has drawn on extensive consultation with stakeholders and experts.<sup>143</sup> The sense of urgency and purpose is praiseworthy, as is the frankness with which the need for improvement has been acknowledged. However the fact that every concerned South African must hope for, and where appropriate, work for the plan's success does not mean that it is above criticism.

The following points arise from a close reading of the Department of Health's Strategic Plan:

- The document is very largely concerned with the production of plans, with little indication of how they will be carried through and implemented. A particular feature is how many of the plans mentioned will be 'revised', 'refined', 'upscaled' and 'updated' versions of previous ones
- This is because many of the impressive commitments in the document are in fact repetitions of past commitments that have not been implemented. Most references to human resources repeat material from the Human Resources for Health Document of 2006; commitments to upgrade skills of managers go back to the White Paper of 1997; a key priority in improving the quality of health services is to 'Refine and scale up the detailed plan on the improvement of quality of services and directing its immediate implementation'. It transpires that a set of core standards was set in 2008; they were revised in 2009; they will be revised again and finalised in 2010/11 and implemented over the following three years
- The impression given throughout the Strategic Plan is that in all matters of quality, management and skills, the public health sector will revitalise itself with the aid of

The government hopes that by controlling prices it can double public expenditure on health in real terms by 2025, while greatly shrinking private expenditure

Unless access to the private sector is broadened in such a way that its resources and assets are first of all preserved and better still strengthened, then further harm will be done to an overall healthcare system that is already in crisis

increased funding. The emphasis is on upgrading those who are already in the sector. The ANC NGC Discussion Document gives an insight into this culture when it insists on 'capacity-building and skills transfer at all levels.' The public sector has unqualified managers who can't manage and skills shortages and vacancies at all professional levels. Doctors, specialists, senior nurses and those managers who can manage are all heavily overworked. Whose skills are going to be transferred to whom, and when? What is missing is a commitment to the essential principle to actively recruit a large enough number of qualified and experienced personnel for rehabilitation of the public sector to be a realistic hope: such recruitment should be without restrictions and quotas – either on skilled foreigners or South Africans for reasons of race, politics or who they know.

What is lacking in the 10 Point Plan is any sense of a strategy through which the resources of the private sector might be employed to assist the rehabilitation of the public health sector. Government officials make scattered calls for cooperation with the private sector through public private partnerships (though mainly in infrastructure rather than service delivery) and in the training of professionals.

## Key findings and their implications

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**T**HE SOUTH AFRICAN HEALTH system is in a bad and worsening state. Neither the public, nor private for-profit parts of the system give value for money. The whole system, public and private, needs well-considered and on-going reform.

South Africa has a very substantial burden of disease and comparatively modest means. An employment rate of 41 per cent and 5.9 million income taxpayers constitute a narrow base of revenue and solidarity for universal coverage of over 50 million people.

The terms of coexistence between public and private health sectors are vital to the prospects of health policy reform, leading to improved healthcare outcomes in South Africa. Unless access to the private sector is broadened in such a way that its resources and assets are first of all preserved and better still strengthened, then further harm will be done to an overall healthcare system that is already in crisis.

If the inconsistencies, uncertainties and lack of strategic vision that this report has noted in the government's 'stewardship' of the private sector are not replaced with something more coherent, credible and constructive, then there is a serious prospect of such harm being done.

Comprehensive reform has to build on a realistic understanding of private healthcare and should see the private sector properly, without the distorting lenses of blame and ideology.

Regrettably the NHI Green Paper sees healthcare reform through this distorted or inaccurate lens when it states that South Africa's poor health performance: 'has been attributed mainly to the inequities between the public and private sectors.'<sup>144</sup> The implication is that if there were no private healthcare sector in the last 17 years and the government had control of all health expenditure in that period, health outcomes would have been better. This is an implication with which few informed witnesses of the government's record of stewardship, management and service delivery in the public sector since 1994 are likely to concur. Indeed, it is possible to argue that that without the private sector, health outcomes could have been even worse.

Constructive debate about the role of the private sector in South Africa's overall healthcare system has not been helped by widely-held beliefs based on ill-founded 'facts' about who the private sector serves and who works in it. The drivers of prices of healthcare services, the extent of cross-subsidisation in current funding of public healthcare and the feasibility of raising extra funding for public healthcare from taxation are also poorly-understood.

One constructive side effect of the NHI debate has been to motivate more rigorous research on how national resources for healthcare are generated and distributed. There is no doubt that beneficiaries of private medical insurance have access to much better healthcare than those who depend solely on the public sector. However, the private sector:

- Serves more people than just the rich
- Has significantly fewer human resources than its critics claim
- Relieves burdens on the public sector
- Has less 'excess capacity' than has been claimed
- Has resources and means of operating that can help expand care for more South Africans
- Has potential that can be harnessed, if there is a more receptive attitude by government, as well as a more coherent and facilitative regulatory regime
- By its nature the private sector will develop resources to respond to problems and opportunities given the chance.

### NATIONAL DEPARTMENT OF HEALTH'S 10 POINT PLAN

There has been no shortage of high-level plans for health in South Africa. The origins of the most recent are in the 2008 'roadmap' process. The Development Bank of Southern Africa (DBSA) convened several meetings with many stakeholders in healthcare. From these consultations, a 10-point plan was developed that laid out a 'roadmap' to improved health outcomes. That plan did not refer to an NHI or to major funding reform, but emphasised factors such as management, and accountability. More recently the National Department of Health has adopted a 10 Point Strategic Plan for 2009-14. The points are:

1. Provision of strategic leadership and the creation of a social compact for better health outcomes.
2. Implementation of National Health Insurance (NHI).
3. Improving the quality of health services.
4. Overhauling the healthcare system and improving its management.
5. Improving human resources management, planning and development.
6. Revitalising infrastructure.
7. Accelerated implementation of HIV/AIDS and sexually transmitted infections control, and an increased focus on TB and other communicable diseases.
8. Mass mobilisation for better health for the population.
9. Reviewing the drug policy.
10. Strengthening research and development.

The Minister of Health has noted, 'Ambitious targets have been set for these priorities. It can no longer be business as usual. Planning, organisation, and health services delivery must reflect an added sense of urgency.'

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The drivers of prices of healthcare services, the extent of cross-subsidisation in current funding of public healthcare and the feasibility of raising extra funding for public healthcare from taxation are poorly understood

The NHI system is a work in progress about which many things are uncertain and there is much scope for creative thought

Public sector shortcomings are well-documented and to an extent honestly acknowledged by the government. Both the ANC and the government have made it clear that improvement of the public health sector is a necessary condition for the success of an NHI system.

However it is possible that the Department of Health's 10 Point Plan for 2009-14 and Strategic Plan for 2010-12 underestimate the scale of the challenge. It bears repeating that the public health sector employs well over quarter of a million people in over 4 300 establishments. According to its own estimates it is short of around 100 000 medical professionals.<sup>145</sup> There is absolutely no hope of making good this shortfall in the short term from South Africa's own resources, even if the private sector were to be taken over lock stock and barrel. Yet an aggressive policy of importing health professionals has only recently been raised in a discussion document, and is not (at least yet) reflected in policy.

The Department of Health's Strategic Plan calls for 25 per cent of health facilities to be accredited by an independent standards body each year from March 2012. That is well over one thousand facilities a year. Given the well-documented poor standard of infrastructure, the skills shortages, poor staff attitudes, low levels of patient satisfaction and incompetent management that characterise much of the public sector – by the government's own admission – it is difficult to believe that over one thousand facilities in the public sector alone will be positively rated every year between 2012 and 2016.

The most worrying aspect of the strategic plan is the assumption that the public health sector can upgrade itself sufficiently from its own resources.

Since 2007 there has been a tendency to see the introduction of an NHI as the endgame in healthcare reform. Proponents of an NHI seem to see no reason to think creatively and strategically about the terms of coexistence between private and public sector, since, in their view, it is assumed the NHI will solve all problems by driving down private sector prices and opening up 'excess capacity' to all who have not learned to trust the public sector.

The true situation is that the NHI system is a work in progress about which many things are uncertain and there is much scope for creative thought. The most encouraging sign is that the government has signalled that 14 years is the time frame. This allows time to be creative and policies to mature. The long time frame is a double-edged sword however. Fourteen years is a long time – spanning three general elections and an unknown number of health ministers and presidents – to maintain focus and manage expectations.

That is why it is essential to involve an expanded and strengthened private sector now rather than waiting for all its facilities to be open to everyone in some distant utopia when the public sector is a credible alternative. Unless access to private sector facilities is broadened soon, albeit gradually, in order to take pressure off the public sector, that day might never come.

The key insight should be that extending private sector healthcare to a wider public is a step towards realising universal access to quality healthcare, not a retreat from or a postponement of this ideal. It is this ideal, not narrow fixation on one or another institutional form of healthcare funding, that should inspire South Africans.

## Recommendations

**I**N THIS FINAL SECTION we suggest options to broaden debate on the two major tasks of healthcare reform: the rehabilitation of the public sector and the introduction over 14 years of an NHI system. The emphasis is on ways that the private sector might be reformed in order to make it work more efficiently and cheaply, to broaden access to it and allow it to play a greater role in allowing space to the public sector to carry out its own massive task of reform.

### General guidelines

Policy makers have to acknowledge clearly and strongly that the chief priority of health reform is the rehabilitation of the public health sector. It is of paramount importance that all stakeholders understand that everything – including the proposed introduction of NHI – depends on this

It is important to revisit the Department of Health 10 Point Plan, not to change the priorities, but to broaden the view of the necessary resources, giving priority to enlisting the resources, not only of the private health sector, but the private sector generally.

Using public money to facilitate access to the private sector might be a better way of spending than sending funds to the public sector that – given its history of wasteful expenditure and poor management – it may find difficult to absorb. We should explore all possible ways of doing this.

### Reforming the public healthcare sector

The key public sector reform is to deliver on President Zuma's pledge in his 2011 State of the Nation address to appointment qualified people to manage the public health sector. This is a minimum requirement for all other reforms to happen. Service to patients must not be compromised by anything else – and especially not by patronage, political loyalty and racial headcounts in staffing that sometimes lead to rejecting the only applicants for positions.

Greatly expand South Africa's resources of skilled health professionals by:

- Delivering on recent promises to expand training of doctors
- Making good the promises in the Department of Health Human Resources for Health Plan to expand training of intermediate-level professionals
- Embarking on a vigorous overseas recruitment campaign beginning with (but not limited to) the African diaspora of health professionals in OECD countries
- Extending private sector involvement in medical training, especially of nurses.

### How the private sector can support public sector reform

The government should use the opportunity created by the publication of its plans for an NHI to initiate a calmer and more constructive debate on overall healthcare reform than has been the case so far. Demonising those who point out difficulties with an NHI and the private health sector generally will not advance the cause of extending quality healthcare to all South Africans. As a first step towards changing attitudes to the private sector, a common factual base on who works where and with what will be essential.

Demonising those who point out difficulties with an NHI and the private health sector generally will not advance the cause of extending quality healthcare to all South Africans

Private companies led the way in HIV diagnosis, prevention and treatment programmes during the years of government denial

The Department of Health's key priority 1 under its 10 Point Plan is 'provision of strategic leadership and creation of a social compact for better health outcomes'. An essential part of this should be to develop a strategic vision for how to use private sector resources to extend quality healthcare for all. A key part of this will be to take the lead in embedding the idea that the private sector's involvement in rehabilitating the public sector is legitimate and will be crucial.

The private sector means more than private healthcare. Private companies led the way in HIV diagnosis, prevention and treatment programmes during the years of government denial. Businesses such as mining companies and large parastatals have contributed to health outcomes by delivering innovative and cost-effective healthcare to their employees, sometimes in collaboration with trade unions. These programmes show more clearly than the private hospital industry how efficient cost-effective healthcare can be delivered in South Africa. Possibilities for extending these employer-driven healthcare schemes should be investigated, especially where facilities are underused. The private healthcare sector also has resources and skills in specialised areas like supply chain management and health information systems that could contribute to rescuing the public system.

Private sector healthcare can contribute directly to the rehabilitation of the public sector through:

- Restoration and energetic promotion of opportunities for private sector specialists to work in the public sector ('sessional opportunities')
- Extension of PPPs from infrastructure where they are already encouraged, to hospital management, supply chain management and clinical services
- Facilitation of training of health professionals by the private sector by easing regulations and developing joint public/private planning on health professional needs.

None of this will be possible without skilled people, appointed on merit, who understand the private sector and know how to manage the interface with it. Such people do exist in the public sector (in the Treasury's public/private partnership unit for example) but their skills need to be much more widely transferred and utilised.

### Reforming the private healthcare sector

Although direct private sector support to the public sector as envisaged above will be important - indeed essential - to the enormous task of rehabilitation, the private sector can best contribute to broadening access to quality care by broadening its own coverage. This means that reforms will have to address rising costs by addressing both supply side and funding issues. Private hospitals cannot employ doctors and so have to compete with each other to attract them. They do this by investing in facilities and equipment. This drives up prices and encourages focus on specialised and hospital-based care over prevention and primary care. The existing fee-for-service funding framework provides little incentive to compete on price, or innovate in delivery. All of this needs to change.

### Supply side reforms

- All regulated processes connected with health – for example those relating to licences to open a private medical facility – should be simplified and their administration made as transparent as possible. Details of applications, decisions and timelines should be made public, to allow oversight by civil society
- Increased competition in private healthcare could help put pressure on prices and encourage innovation in lower-cost delivery if accompanied by other measures to encourage competition on price and efficiency. Allow healthcare companies from outside South Africa for example, from India, where private healthcare delivery is notably innovative and cost-conscious, to operate in South Africa
- Publication of price lists for medical services should be mandatory, as it is in Singapore. This should be combined with funding models that allow individuals to benefit from prudent expenditure, which will encourage shopping around in non-emergency cases
- Provide incentives for the private sector to innovate more on the supply side and specifically to operate a wider range of facilities, including lower-cost ones focused on primary care, such as day surgeries and outpatient facilities, with a greater role for general practitioners and nurses
- Allow private hospitals to employ doctors. The fact that they cannot is a major driver of rapidly rising costs, and a barrier to supply side innovation and to competition in delivery of private healthcare. Other positive changes in the private healthcare sector are less likely as long as it is not possible to employ doctors
- Take steps to increase the supply of doctors and other medical professionals. Expand the private training of health professionals, learning from other countries (for instance India) how to regulate and cooperate with the private sector in training. In the short term make good on the promises to facilitate immigration of health professionals. This is essential for the health system as a whole, in order to reduce the scarcity value of doctors which currently helps drive price increases in the private sector.

### Reforming health funding

Medical scheme membership is universally acknowledged to be too expensive. Some of this is due to the very high costs of care being passed on to members. In addition the current regulatory framework leaves very little scope for medical schemes with limited benefits, even though such schemes would have lower premiums, and so would increase access to private healthcare. The following reforms would address this problem:

- The Treasury has released draft plans to reallocate the tax deduction for medical aid payments to make medical scheme membership affordable to as many more South African employed people as possible. This should be carried through as quickly as possible. In addition the cost-benefit effects of charging VAT for some private medical services should be assessed to see if prices can be lowered
- In order to reduce self-selection (which distorts risk pools) begin a staged process to make medical scheme membership mandatory for the formally employed. Since driving up the cost of labour in SA's already fragile labour market would harm growth, this has to be handled with care. Phasing out the tax deduction for scheme contributions among the

Allow healthcare companies from outside South Africa for example, from India, where private healthcare delivery is notably innovative and cost-conscious, to operate in South Africa

Reform and expansion of both public and private sector healthcare will be crucial to meeting the challenge of universal access to quality health services

wealthiest should create some space for subsidies to people currently at the margins of affordability. To further stabilise schemes, fully implement the long-overdue risk equalisation mechanism

- Allow medical schemes with a set of benefits less extensive than the current single PMB list, perhaps by two or more specific tiers of regulated benefits. This could allow lower cost schemes, increasing access to private healthcare among employed people who cannot currently afford it. Measures would be needed to prevent competition on risk. Phasing in mandatory participation with income would be one approach
- Allow individual employed people to choose their own scheme rather than have it chosen by their employer. At present, scheme selection largely excludes employed scheme members because it is negotiated by employers. This reduces the power of scheme members. It should eventually be required that the formally-employed be members of some medical scheme, but should be up to them to choose a scheme that is not the default option chosen by their employer. Such reform will need some care to make sure additional administrative demands don't outweigh any gains from competition, and to prevent individual choices from distorting risk pools.

## Concluding remarks

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**I**T IS EXTREMELY DIFFICULT to provide universal access to quality healthcare in a highly-unequal society which has such low rates of participation in the economy and such high levels of poverty and disease burden. To make progress towards, never mind to achieve, universal access to quality healthcare in South Africa requires the strategic use of all existing resources, which means reform and expansion of both the private and public sectors. The scale of the challenge of delivering as uniform healthcare as possible, given economic circumstances, across the whole of the country, and given the resources already in the public health sector, means that the rehabilitation of the public sector is the central task of healthcare reform. The extension of the capacity and reach of the private sector is essential to the rehabilitation of the public sector. This will be a step towards universal quality healthcare, not a step back from it.

## Appendix A: Research papers commissioned by CDE for this document

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Mia Malan, Private sector contributions to public health in South Africa

Claire Keeton, Breakdowns in the public health system

Liz Still, Understanding sources of mistrust between public and private health sectors

Alex van den Heever, Health systems and health system reform in emerging and middle income countries: international comparisons

Nicholas Crisp, Health human resources

Alex van den Heever, Trends in government health policies and programmes

Barry Childs, Understanding cost drivers and how to increase affordability in the private sector

Reg Magennis and Christopher Wolsternholme, Public-private partnerships: a review of progress made by the Eastern Cape Department of Health

CMF Eisenstein and MD Smith, Improving the functionality of the public health system

Paul Davis and Lisa Haagensen, Public-private partnerships in the South African

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