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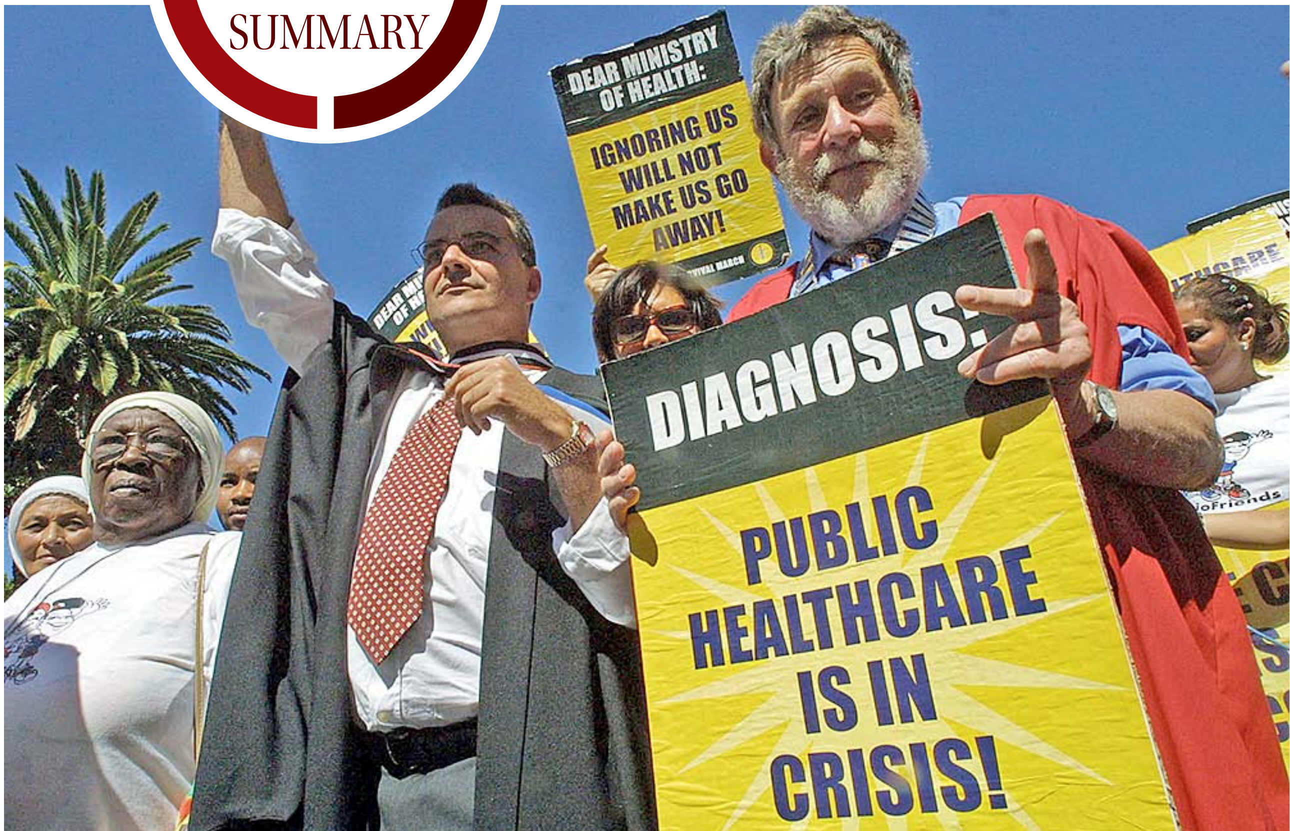

A NATION'S HEALTH IN CRISIS

International experience and public–private collaboration

This is an executive summary of **CDE Round Table no 16**, *A nation's health in crisis: International experience and public–private collaboration* (November 2010). The full-length publication is available from CDE, and can be downloaded from www.cde.org.za.

SOUTH AFRICA'S health sector is in crisis. National health has deteriorated markedly over the past decade, and the country is heading for the bottom of almost every table of international health indicators.

The health system is institutionally fragmented, with starkly different health outcomes. Privately insured people receive better care and live longer, healthier lives than those who attend state health institutions. The costs of private health care are beyond the reach of most citizens; however, public health care offers poor value to citizens and is in a worrying state of decline and dysfunction, with serious consequences for the country.

The Department of Health's 10 Point Plan adopted last year is already behind schedule, with rising concerns about management, implementation, and monitoring capacity. Given this, it is hard to understand the priority given to a national health insurance scheme when so many other fundamentals of health care in South Africa urgently need to be turned around first.

International experience suggests, and many experts believe, that the private sector could make a far greater contribution to health care in South Africa. All these factors provide grounds for an urgent national discussion.

In this context, CDE, in collaboration with the Aurum Institute for Health Research, recently brought together local and international experts to discuss health systems, health funding, and health policy. Participants heard and discussed experiences and lessons from other middle-income countries, and from particular parts of the South African health care system. Key insights from the Round Table are summarised below.

Mistrust and mutual misunderstandings between public and private sectors need to be overcome.

Almost all role players in health feel misunderstood in one way or another, and they are all partly correct. Ideological blinkers, the deteriorating state of the nation's health, resentments over relative resource levels, and mutual isolation contribute to this. There are many dedicated people working under exceptionally difficult conditions in public health services, and those services have achieved some notable successes. This should be recognised, along with the failings of the public system. The successful elements of existing public–private partnerships should also be acknowledged. Similarly, private service providers deliver care of consistently high quality (and to far more people than is usually acknowledged), and the fact that it is private, and that some parts of it operate for profit, does not detract from this. All role players need to overcome mutual incomprehension and mistrust if the country is to play to its strengths and turn a deteriorating situation around through a collaborative national approach.

There is a lot of goodwill, but little direction.

Mutual misunderstandings notwithstanding, participants in the Round Table from different sectors displayed considerable goodwill towards one another. There is a general recognition that South Africa's health crisis demands collaboration. What is lacking is a clear and mutually agreed

vision of how to work together. Much discussion focused on formal public–private partnerships (PPPs), although local experience with them so far has often been frustrating. More attention should be paid to finding ways of enabling markets for health services to work more effectively. Without more intensive discussions, and high-level political support, opportunities for co-operation could be squandered.

Health services are expensive and difficult to distribute. It is vital to set up a system with the right incentives.

Medical services are very expensive; for this reason, some kind of cross-subsidisation or risk-sharing is essential, and there are numerous models (including private insurance, national health schemes, and national insurance) for doing so. The range and expense of possible treatments means that some kind of rationing is inevitable. The widespread lack of resources in the health sector (especially qualified personnel) creates scarcities which can distort market efficiencies, and drive up prices.

Institutional design can lead to some players being motivated by aims other than efficient service delivery. For example, insured individuals have little incentive to be responsible in seeking care. Similarly, practitioners paid by insurers have little incentive to treat and prescribe cautiously, or to support preventive approaches. And insurers, for their part, have incentives to try to limit patterns of payment which can sometimes be damaging in individual cases.

Different countries have found a range of solutions to these problems, with varying success at marrying efficiency and quality of care. Designing a working health system which takes into account the health challenges and constraints facing that country, and deciding what kind of system to aim for, requires paying careful attention to the incentives for individuals, insurers, funders, and providers of care, whether private or public.

Co-operation needs capacity.

As things stand, only some parts of the public health system – especially larger hospitals – are in a position to engage in various forms of co-operation with non-government players. Even then, co-operation is highly dependent on political will. Other parts of the public system lack contracting and management capacity as well as information (including information about the costs of the care they deliver). All this makes it challenging for them to enter into partnerships. Solving these problems is a precondition for implementing the mooted NHI, and for other forms of co-operation. Management of the public health care system must be urgently improved, irrespective of how health care systems may be changed in the future.

South Africa needs more doctors, nurses, and health system managers.

South Africa urgently needs more well-qualified doctors, nurses, and – especially in the public sector – qualified health system managers. We are currently subsidising the education of medical practitioners and nurses, many of whom subsequently leave the country. At the same time, we are limiting the inflow of health and medical skills through restrictive immigration policies and negative attitudes in respect of the recruitment of foreign skills. We need to make it easier for appropriately qualified doctors and nurses among others, to come here (whether temporarily or permanently), to help us expand and improve our health care system, and strengthen our capacity to train South Africans to meet current and future needs.

The private sector can (and does) serve the poor.

Some 36 per cent of health expenditure in Africa is private (with the remainder coming from government and donors), and private expenditure is projected to double over the next six years. Poor people spend significant amounts on private care, sometimes preferring to pay even when they have access to no-fee government services, and sometimes because the only services available are privately provided.

In South Africa, and in other countries, private health providers often serve the poor. For example, mining companies, (the only private companies permitted to employ their own medical staff) have extensive experience of providing primary and other care for those without medical insurance. Whether the motive is to improve productivity, or to make a profit by delivering a service more efficiently than their competitors, private companies can have good reason to deliver low-cost health services when regulations permit this. This potential can be maximised in an appropriate policy and regulatory environment.

PPPs are underutilised …

There are relatively few PPPs delivering health services in South Africa. It is a relatively new mechanism for collaboration in the health sector. The challenges of how to share risk, manage delivery and accountability are currently being tested and explored in a number of new initiatives. We should be looking for ways of expanding the number of partnerships and the range of services they provide.

… however, they are not a cure-all.

Discussions of collaboration and co-operation tend to focus on formal PPPs. While PPPs can be useful, this narrow focus is unfortunate. PPPs are complicated, and take a long time to set up. Also, not all PPPs succeed. For some purposes, there may be better ways of improving the quality and scope of health care in South Africa. These could include opening up many aspects of health care to market players, or portable subsidy arrangements such as health vouchers for therapeutic services, which enable the recipients to choose their own service providers, whether public or private.

In some instances, clearing the way for market forces can be simpler and more effective than PPPs. For example, if they were easier to register, there would be more private facilities for training nurses in South Africa. Also, if this was allowed, private medical schools would probably be established. At present, only the state and mining companies are permitted to employ doctors. If this was not the case, it is likely that far greater opportunities would exist – and be taken up – for delivering health care.

NHI could play a positive role, but would require higher rates of economic growth and higher levels of employment.

NHI may be good way of funding health services in the longer term. As things stand, though, our high levels of unemployment present a major challenge to the affordability of an NHI. Colombia – which is wealthier than South Africa, and has higher levels of formal employment – has not achieved its own targets for expanding coverage partly because of unemployment. Therefore, the way to get to the point where South Africa could definitely afford an NHI is to accelerate economic growth and create sustainable jobs for millions more people.

Besides funding, better and more accountable health management is required.

Whether health care is funded with general taxes, or via a national insurance scheme, there have to be working services for individuals to access, or for their insurance scheme to buy. The reasons why the public sector does not consistently provide such services, despite the sometimes heroic efforts of its clinical staff, are not related to funding but to inconsistent management and weak accountability. Market mechanisms in the health sector have many advantages but also some areas of weakness peculiar to health issues. Who monitors the quality of care and its cost, for example?

CONCLUDING REMARKS

South Africans are dying too early, and too often, in ways we can afford to prevent. The private sector is already playing an important role in health care, including providing care to poorer people, and its role could be greatly expanded. Given an appropriate regulatory environment, it could offer more affordable care to many more South Africans, and become a more active partner in transforming South Africa's ailing health sector.

This Round Table was partly exploratory, and needs to be followed by more substantial discussions between public and private role players. More information is required on how to make better use of markets, existing companies, and entrepreneurs.

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