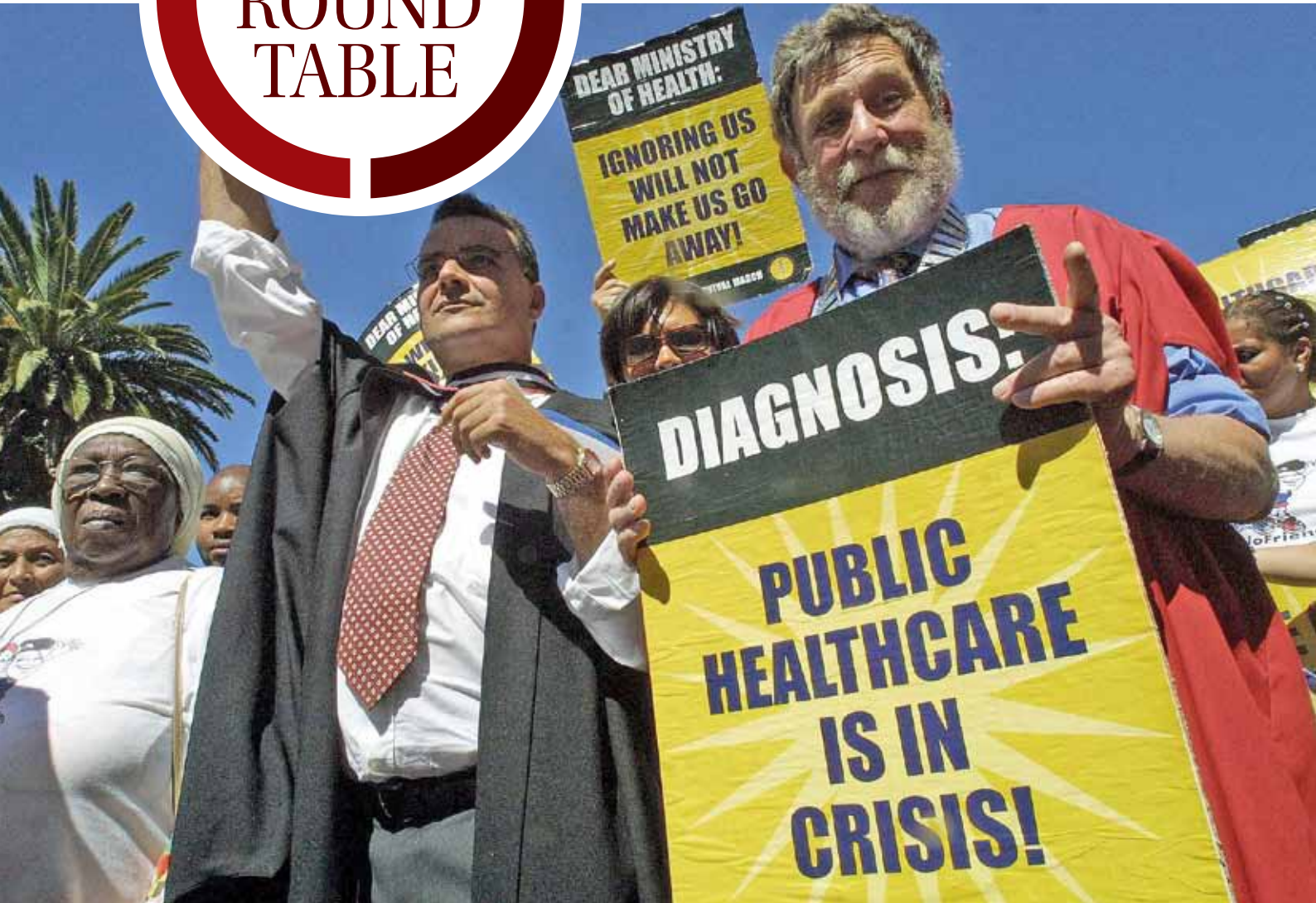




Number 16 · November 2010



A NATION'S HEALTH IN CRISIS

International experience and
public–private collaboration

Convened by the Centre for Development and Enterprise
and the Aurum Institute for Health Research

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.

CDE Round Table Number 16 • November 2010

Series editor: Ann Bernstein

CDE Round Table is an occasional publication by the Centre for Development and Enterprise reflecting discussions held on key national issues. This Round Table was convened on 11 May 2010. It was organised by David Spurrett, senior manager: research and projects at CDE, and Paul Davis, chairman of the Aurum Institute for Health Research. This summary was written by David Spurrett and Marco MacFarlane, with input from Paul Davis and Ann Bernstein.

The Round Table and this publication were funded by The Atlantic Philanthropies.

The funders do not necessarily share the views expressed in this publication.

Published in November 2010 by The Centre for Development and Enterprise
Transmedit Place, 5 Eton Road, Parktown, Johannesburg 2193, South Africa
P O Box 1936, Johannesburg 2000, South Africa
Tel 2711 482 5140 • Fax 2711 482 5089 • info@cde.org.za • www.cde.org.za

All rights reserved. This publication may not be reproduced, stored, or transmitted without the express permission of the publisher. It may be quoted, and short extracts used, provided the source is fully acknowledged.

ISBN: 978-0-9869860-0-0

Contents

Participants	2
Introduction	3
Opening remarks	3
Health care reform in Colombia and private sector participation	7
Costa Rica: The evolution of a mature national health care system	12
A healthy South Africa – two sectors, one goal	16
Expanding the role of the private sector	21
Key insights from the Round Table	29
Concluding remarks	32
Endnotes	32

PARTICIPANTS

- Ann Bernstein**, executive director, CDE
- Dr Ntuthuko Bhengu**, executive head of provider networks, Qualsa
- Esther Bouma**, attaché: health sector, European Union
- Roly Buys**, director for funder relations & contracting, Medi-Clinic
- Dr Ramon Castano-Yepes**, chief of health division, Colsubsidio
- Prof Matthew Chersich**, Centre for Health Policy
- Prof Mary Alison Clark**, associate professor of political science, Tulane University
- Dr Dave Clark**, deputy chief executive officer, The Aurum Institute
- Craig Comrie**, head of business, development and marketing, Metropolitan Healthcare Group
- Melanie da Costa**, strategy & health policy director, Network Healthcare Holdings
- William Dachs**, head of public–private partnership unit, National Treasury
- Aslam Dasoo**, board member, Health Equity Partners
- Dr Paul Davis**, chairman, The Aurum Institute
- Andee Deverell**, research manager: strategic issues, Standard Bank of SA
- Thembi Dladla**, researcher, CDE
- Dr Shane Dorfman**, managing director, Regiment's Health and Wellness
- Dr Colin Eisenstein**, managing member, Equity Health
- Mari Gerpe**, first secretary, Embassy of Brazil
- Alan Fine**, public affairs manager, AngloGold Ashanti
- Dr Jane Goudge**, senior researcher, University of the Witwatersrand
- Dr Lettie la Grange**, head of safety health and environment, Anglo Platinum
- Simon Hendrie**, divisional manager - actuary, Discovery Health
- Dr Anthony Kinghorn**, director, Health & Development Africa
- Jack Koolen**, consultant, J & J Group
- John Kruger**, senior consultant, Oxford Policy Management
- Marco Macfarlane**, project and research co-ordinator, CDE
- Peter Mangena**, senior wellness advisor, Eskom
- Thulani Masilela**, cluster manager: strategic planning, Department of Health
- Dr Phila Mazamisa**, senior manager, Gauteng Department of Health
- Lerato Mosiah**, general manager healthcare, Afrox
- Modise Mzimba**, associate, Actis
- Dr Okore Okorafor**, health economist, Medi-Clinic Southern Africa
- Dr Sagie Pillay**, chief executive officer, National Health Laboratory Services
- Dr Fazel Rander**, programme director, The Aurum Institute for Health Research
- Prof Laetitia Rispel**, adjunct professor, Wits University
- Kalaemang Sebeg**, budget analyst, National Treasury
- Joe Seoloane**, provisional curator, Pro Sano Medical Scheme
- Prof Martin Smith**, clinical head, Wits University
- Prof David Spurrett**, research manager, CDE
- Sue Tager**, academic medical director, Wits University: Donald Gordon Medical Centre
- Andrew Titterton**, managing director, Burlington Consultants
- Alex van den Heever**, consultant, Council for Medical Schemes
- Hein van Eck**, research & development manager, Medi-Clinic Corporation
- Mike Waters**, Member of Parliament, Democratic Alliance
- Milani Wolmarans**, director: strategic planning, Department of Health

SELECTED DEFINITIONS

Capitation: A fixed payment remitted at regular intervals to a medical provider by a managed care organisation for an enrolled patient.

Gini coefficient: A measure of income inequality. A zero coefficient indicates that all households in a country have exactly the same income, while a coefficient of 1.0 means a single household earns all the income in the country in question.

National health insurance: This is health insurance that insures a national population for the costs of health care. It may be administered by the public sector, the private sector, or a combination of both. Funding mechanisms vary with the particular programme and country. National health insurance schemes are usually not government-run or government-financed, but are usually established by national legislation.

Risk equalisation: A mechanism used to redistribute or allocate resources, usually between insurers. Risk equalisation can keep costs to individuals constant no matter what scheme they belong to, even where the risk profile of members of individual schemes varies.

Vertically integrated networks: Merger of firms at different stages of production or distribution in the same industry.

Introduction

EFFECTIVE HEALTH care is crucial if citizens are to flourish. In most countries, for most of the past two centuries, growth in GDP and increases in average life expectancy have coincided. In South Africa, however, this trend has been reversed; our national health has declined dramatically over the past decade, and we continue to head for the bottom of every table of global health indicators.

The health system is institutionally fragmented. 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 is in a worrying state of decline, with damaging consequences for individual citizens and South African society as a whole.

In this context, the government is proceeding with plans to create a national health insurance scheme. At the same time, many analysts believe the potential of the private sector to contribute to public health is not being maximised. All these factors provide grounds for an urgent national discussion.

In this context, CDE, in collaboration with the Aurum Institute, brought together local and international experts to engage in a frank and open discussion of health systems, health funding, and health policy. Participants heard and discussed stories and lessons from other middle-income countries, and from particular parts of the domestic health system. The Round Table revealed mutual suspicion among role players in the public and private sectors, as well as some misunderstandings, but also considerable good will and commitment. An edited version of the proceedings appears in the pages that follow.

Many analysts believe the potential of the private sector to contribute to public health is not being maximised

Opening remarks

Ann Bernstein

Executive director, CDE

CDE has often found that when you get experts in specialised fields together, they tend to talk to each other in ways that are familiar to them but exclude other non-experts from the conversation. They share common assumptions and ideas, or are locked into debates and disputes that prevent fresh thinking and ideas from outside the closed doors of their professional expertise. Today's conversation crosses disciplinary boundaries and brings in people from other countries, other disciplines, and the private and public sectors.

It is crucial for the private sector to contribute to key national debates, and make all participants aware of its central role in national development and its potential to contribute to vital national services

Put simply, South Africans need more health for their money. The public health system is struggling to deal with multiple challenges ranging from the AIDS epidemic through TB and malaria to a shortage of medical and managerial skills. Overall, the national health sector appears to be in crisis. We urgently need to find new solutions, including maximising the potential of markets and private enterprise to turn the tide and ensure better health care for more and more South Africans.

The appointment of a new Minister of Health in 2009 has led to a change in attitude. The minister has publicly acknowledged the enormous challenges facing the public health system, and has spoken in positive terms about working with the private sector. This creates opportunities for private players in the sector, and business leaders should respond to this changed environment. They will need to think hard about the role of markets and private enterprise, and how these can be expanded in order to maximise their contribution to South Africa's national health care system.

The private sector is not a monolithic entity. It encompasses many competing organisations, interests and egos, and often finds it difficult to act collectively. Sometimes this is undesirable, as it can lead to collusion and anti-competitive behaviour. At other times, however, it is crucial for the private sector to contribute to key national debates, and make all participants aware of its central role in national development and its potential to contribute to vital national services.

This is certainly the case in respect of health. In South Africa, discussions in this area often focus narrowly on public-private partnerships, even though there are many other ways of involving the private sector and enabling markets to play a far larger role in dealing with national challenges.

As an outsider to this sector, it seems to me that private sector players have to become far more strategic. They have to think about how to engage with government and the wider society over the direction of public health policy, the nature of the reforms the country needs, and what we can actually achieve.

The health sector faces some daunting challenges. Among other things, difficult choices need to be made about how our limited resources should be rationed. This, in turn, requires a well-informed and frank national debate about how to deliver and manage health care in a country with a massive shortage of skills. We hope the Round Table will make a useful contribution to this vital process.

Paul Davis

Chairman, Aurum Institute

We are indeed facing a crisis. The dramatic decline in life expectancies in South Africa over the past two decades is shocking and terrible, comparable in effect to the very worst wars, disasters and plagues in history. This is a significant challenge to our national competitiveness and productivity. We should be collectively distraught, and placing ourselves on something like a war footing in response. For the most part, we aren't.

Table 1: SA in international context: some indicators

Country	Life expectancy at birth (years) (2006) ¹	Annual per capita expenditure on health at average exchange rate US\$ (2006) ²	GDP per capita, current prices US\$ (2006) ³	Health system rank (2000) ⁴	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	
Colombia	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 fraction of the expenditure
Malawi	50	21	239	185*	
Cameroon	51	45	979	164*	
Mozambique	50	16	361	184*	

* = in the worst 25 countries out of 190.

This is partly because the burden of this catastrophe falls unequally, and mostly on the poor and marginalised. One of the leading causes of death of children younger than a year is diarrhoea. Even though this is often complicated by HIV, diarrhoea doesn't generally kill people with access to reasonably clean water, effective sanitation and basic primary health services. People who lack those services are not usually in a position to make a big political noise. Similarly, HIV infection rates are higher among the unemployed. Even among those who do have work, the semi-skilled have higher infection rates than the skilled. A disproportionate share of the effects of our health crisis is falling on those most disadvantaged to start with by the legacy of apartheid in distorting our human geography, and limiting access to education and other opportunities.

Since we are facing a crisis, we need to understand why. There are several connected reasons, but two stand out: first, since 1990 HIV and TB have taken a terrible toll, also on the ranks of health professionals. Second, the publicly provided health services are not delivering care effectively. In his 2010 budget speech, the minister of health noted the 'ineffectiveness' of the health system, and that the health services it provided were of 'poor quality'.⁵

Despite the dedication of many of its medical practitioners, the government's health system is failing to meet the health needs of those who depend on it. The reasons for this are complicated, and include problems of capacity, resources, governance, management, and accountability. The stark reality is that South Africans who depend for their

The government's health system is failing to meet the health needs of those who depend on it

health needs on government health services live shorter and less healthy lives than they did ten or 20 years ago.

This is in sharp contrast to the situation of people who can afford health insurance, and therefore have access to private medical care. This smaller, wealthier sector of the South African population enjoys considerably better health and considerably longer lives – two decades longer on average.

The gap between health outcomes in the private and public sectors can be a divisive issue in policy discussions. Some regard the private system as elitist and mercenary. Occasionally it is even blamed for the failings of the public system. Such attitudes miss the point: the private system works well, and what it costs is roughly in line with international trends for comparable therapeutic services. Considering what it actually provides, it is the public system that is overpriced. Focusing on blame and resentment has also missed a key opportunity – no other country in sub-Saharan Africa has as extensive and advanced a private health system as South Africa. We should be looking for ways to make the most of this. The relationship between private care and poverty is more complicated than many suppose, and there are some popular myths about private sector health care in Africa.

The first is that health in Africa is funded or financed by the public sector. Actually, 36 per cent of health expenditure in Africa is private money (the remainder comes from government spending and donors). Moreover, private sector health expenditure in Africa is growing; it currently stands at about \$16,7 billion, a year, and is projected to reach \$35 billion in 2016.

The second myth is the private health sector is mainly for the rich. This is also untrue – 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.

Given this, it is worth exploring opportunities for collaboration and an alignment of interests. To have this discussion at all requires us to avoid ideological knee-jerk reactions, either assuming that government services can never work effectively, or that co-operating with the private sector should be avoided at all costs. We need to be sensible, and face the fact that co-operation between the players we already have – government, private, international, and others – is our best, if not only, chance.

As the World Health Organisation recognised, in the Jakarta Charter of 1997: ‘There is a clear need to break through traditional boundaries within government sectors, between government and non-government organisations, and between the public and private sector. Co-operation is essential. Specifically, this requires the creation of new partnerships for health on equal ground between the different sectors at all levels of governance in societies.’

The private system works well, and what it costs is roughly in line with international trends for comparable therapeutic services

Health care reform in Colombia and private sector participation

Dr Ramon Castaño-Yepes

Colsubsidio, Colombia

Dr Castano is an expert on Colombian health systems, expanding access to health services, and the economics of health finance. He is currently working in the PPP section of a major Colombian private health provider. He holds a PhD in public health from the London School of Hygiene and Tropical Medicine, and has taught economics at the University of Rosario in Bogota, Colombia.

A NUMBER of factors combine to differentiate health care from other goods in a market-based system. These include information asymmetry, uncertainties and externalities, and, most importantly, the social value of health, which dictates that people's access to health care is determined by need rather than the ability to pay. This leads to various complex arrangements for health care provision, insurance, financial protection, provision by hospitals, and decision-making by doctors and consumers in different countries.

Managed competition

Colombia has a system called managed competition which falls somewhere between the National Health Service in the United Kingdom, all of whose components form part of a single monopoly, and the private market in the United States, in which consumers arrange their own health care. In the employment-based system in Colombia, which covers 35–40 per cent of the population, workers can choose from a number of competing insurers called health-promoting enterprises (*Entidades Promotoras de Salud*, or EPSs). Employers and workers then pay 8.5 per cent and 4 per cent payroll tax respectively. This money goes into an equalisation fund, and the EPS receives a risk-adjusted monthly premium per member in exchange for providing a benefit package to the member and his or her family members. Insurers can contract with public or private providers, with the market traditionally consisting of a mix of the two.

Managed competition 'à la Colombian', as we call it, has some of the features proposed by Alain Enthoven in the 1970s. It has a regulated premium and a regulated benefit package, aimed at getting health insurers to compete on quality and not on segmenting markets through benefits, or by selecting individuals based on risk. Insurers have to accept people regardless of their risk profile, or pre-existing conditions. They are allowed to selectively contract with provider networks, and have their own vertically integrated networks, with some restrictions. However, unlike the Enthoven model, there

What we have is a competitive insurance market in which EPSs, either public or private, compete to enrol people

is no sponsor – in other words, employers who form a purchasing alliance to buy health care for their employees. What we have is a regulated market, a competitive insurance market in which EPSs, either public or private, compete to enrol people. Competition is expected to improve quality, and eliminate poor performers from the market.

Price competition has narrowed the range of prices in the market for all services in the benefit package, but there is evidence that those who provide good services with additional benefits and improved quality are not necessarily rewarded with greater market share. The problem in the health care sector is that consumers cannot observe the main outcome, which is health, and this reduces the incentive for them to choose the best health providers. The effect of this is to create barriers to competition. Instead, 'efficiency' can take the form of restricting doctors' autonomy and limiting access to services, particularly high-cost ones, while competition focuses on politeness to consumers; accessible, modern-style facilities; and reducing waiting times for appointments or surgery, all of which are observable but not necessarily connected with good technical quality or good health outcomes.

This casts doubt on the assumption that insurers are prudent purchasers on behalf of uninformed consumers. To address this, the government has licensing standards to ensure minimum standards for health care providers, as well as voluntary accreditation systems to promote higher level standards, but it is difficult to weed out poor performers.

There are other factors that inhibit competition to provide the best health services. Because insurers receive a premium from the government, and face the risk of variations in expenditure on individuals, there is an incentive to avoid consumers who are likely to be bad risks, and attract those likely to be good risks. This leads to attempts to shift costs to patients, other providers, or other insurers. The result is ongoing contestation between insurers and government about responsibilities, which adds to transaction costs.

Insurers have also adopted capitation payments in order to transfer risk to providers, so that they have an incentive to control variations in service costs. Insurers have varying degrees of vertically integrated health care delivery networks, but free-standing providers have responded by securing legislation limiting the amount of the premium that can be spent on vertically integrated networks to 30 per cent.

There is debate about the presence of multiple insurers, with most opponents of the reform initiative saying that having 21 insurers increases red tape and administrative costs. Although it is true that administrative costs have increased between 1993 and 2003, and now take up a larger share than before of the total budget, it is also clear that implementing managed care tools to control costs increases administrative costs.

Expanded access and improved outcomes

Despite these challenges, the system has increased insurance coverage since 1993 from barely 20 per cent of the population to over 90 per cent. There is a split between the comprehensive coverage in the formal, employment-based system and a reduced package covering primary care and high-cost conditions for the unemployed and indigent. Along with access to care, equity has also improved. It is very difficult to establish a direct

Despite these challenges, the system has increased insurance coverage since 1993 from barely 20 per cent of the population to over 90 per cent

cause-effect relationship between this type of health care system and health outcomes, and there is no evidence of a direct positive or negative effect.

Health outcomes in Colombia have undoubtedly improved. For example, the infant mortality rate has decreased, and life expectancy has increased to 72 years, but it is difficult to be sure how much credit to give to the health care system, as there have been other improvements in income, education and sanitation.

The private sector has increased its participation in the employment-based health insurance scheme. In 1997 about two thirds of those insured in this sector were enrolled with public insurers, whereas 13 years later these insurers have practically disappeared, with most participation in private hands, some for profit and some not. Out-of-pocket payments for health care have decreased dramatically, with the latest available figures for the period from 1993 to 2003 showing a reduction from about 45 per cent to about 7 per cent of total health expenditures. This shows that the health insurance scheme has been effective in protecting households against catastrophic expenditures, with workers in the formal sector now 40 per cent less likely to incur such expenditures. Even those in the parallel, subsidised scheme, which is also premium-based, with an insurer who controls the money and pays the bills, are 12 per cent less likely to incur catastrophic expenditures, thus underlining the positive role of insurance in protecting households against financial disaster.

An unintended consequence of extending health care coverage is that people with insurance are more likely to go to a doctor and seek treatment. This has caused aggregate health care costs in the country to skyrocket, particularly for high-end technologies, creating a very inflationary dynamic in the system.

Ongoing challenges

There are some unresolved issues. Is it possible to achieve patient-driven, quality-based competition? We have seen some improvement in competition in the observable attributes, but not in the key ones that predict better health outcomes, so we have not achieved this yet.

The fact that much of the information the government needs for policy-making is in private hands has made it very difficult for the minister of social protection to collect and analyse data for informed policy-making. There is also a big issue around public health, because insurers are focused on interventions that affect the health outcomes of their enrollees, and these are not always adequately linked to public health interventions such as sanitation and clean water. This is a strong point in the debate between those who favour the current system and those who oppose it.

Rationing is another big issue. As with any country, we have limited resources to satisfy social needs in health care, so we have to face rationing. It is easier to deal with this in a system such as the British National Health Service than in a market-based system with private providers which make profits out of denying services, and can have a problem of legitimacy.

The insurance-based health care system in Colombia has increased access to health care, but equity remains a problem

To sum up, the insurance-based health care system in Colombia has increased access to health care, but equity remains a problem. This is largely because the contributory system, based on formal employment, only reaches 35–40 per cent of the population, with the remainder relying on the subsidised government scheme, which provides a reduced package of benefits.

Managed competition has narrowed the range of prices for services in the benefit package, but the fact that consumers cannot observe health care outcomes has limited the effect of competition on improved health care. Instead, competition tends to focus on more observable but not necessarily vital factors such as modern facilities and interpersonal manners. Because they receive a fixed premium from the government, insurers have also tried to compete by avoiding high-risk consumers, transferring risk onto providers, and vertically integrating services. The government has experienced difficulty in regulating these aspects, because insurers have better access to information.

Discussion

The discussion centred on three issues: equity, benefit packages, and funding and employment. Participants made the following points:

- *Equity*

The issue of equity is addressed both by the contributory scheme for the formally employed and the non-contributory insurance scheme provided by the government for those not formally employed. The government does not subsidise the contributory scheme, higher paid individuals contribute more to the equalisation fund than the premium paid on their behalf to insurers. The difference is used to cross-subsidise lower paid workers whose contributions are less than the premium. In addition 1.5 per cent of the 12.5 per cent payroll tax paid into the employment based scheme is added to the government funding that supports the subsidised scheme. As a result both schemes have strong redistributive effects and a positive effect on equity. A 2001 exercise to measure the impact of the new health care scheme on the Gini coefficient showed that it had reduced the coefficient from 0.56 to about 0.52. The scheme has had a really positive effect on equity in financing but its impact on equity in access is more open to question as the package of benefits in the subsidised scheme does not match the package in the contributory scheme.

- *Benefit packages*

The discussion moved on to look at benefit packages, specifically at regulations to define minimum packages, prevent overtreatment, and preserve the autonomy of doctors. It has been a challenge to define the minimum benefit package clearly. Conflicts can arise when doctors want to use interventions freely, while some EPSs can be very restrictive. There are clinical guidelines, but these cannot be adopted by law or decree. This is a very contentious issue between doctors and the health care system. The constitution

The fact that consumers cannot observe health care outcomes has limited the effect of competition on improved health care

in Colombia defines the right to health care in very general terms. However, the Constitutional Court has extended it well beyond the scope of the benefit package. This is a big challenge to financial sustainability, and has created incentives to push individuals to get services excluded from the package, because they are reimbursed by the equalisation fund. Where people face catastrophic expenses, they can appeal to 'Acción de Tutela' (an exceptional judicial mechanism to demand the protection of fundamental rights), and most of the time they get relief, but this adds to the perverse dynamic.

- *Funding and employment*

Some people have argued for increasing the payroll tax to include services that fall outside the benefit package, but government is reluctant to agree to such increases because of the negative effect on employment and particularly on formal employment. The discussants noted that the Constitutional Court in South Africa had set a precedent that the state has a right to limit access to health care services within the context of constrained resources.

The subsidised scheme only has about half the money of the contributory scheme to spend per person and so it only provides about half the benefit. The high cost to government of providing this scheme and the limited benefit package it offers raises the question whether this was the right decision. Dr Castaño-Yepes pointed out that when the scheme was introduced in 1993 the expectation was that, over time, the contributory regime would come to provide for about 70 per cent of the population and that the benefits provided by the subsidised system (the remaining 30 per cent of the population) would catch up with those in the contributory system. This has not happened due to low formal employment and in practice about 70 per cent of people use the subsidised regime. This underlines how important high formal employment is for a system like the Colombian one which depends on contributions from employed workers for maximum benefits. Providing all the services the system aims to provide will cost at least twice as much as is currently available and this would have prohibitive macro-economic effects for a developing country, something that South Africa should bear in mind.

Asked what he would do if he were the minister of health, Dr Castaño-Yepes said his priorities for the private sector would be to ensure financial sustainability, especially in view of the rapid escalation of costs due to high tech, high cost interventions. The other priority would be to capitalise on the private sector's strong advantages in terms of flexibility in reacting to changes in the environment. The discipline of capital also plays a positive role. Where markets are imperfect he would try to build indicators or a system of accountability to show real benefits of specific interventions rather than relying on aggregate outcomes such as infant mortality.

The Constitutional Court in South Africa had set a precedent that the state has a right to limit access to health care services in the context of constrained resources

Costa Rica: The evolution of a mature national health care system

Mary Clark

Tulane University, Louisiana, United States

Professor Clark is an expert on Latin American health systems reform, and has published wide-ranging reviews of the reform processes in Costa Rica and elsewhere. She is an associate professor at Tulane University, and has served as executive director of the Center for International Studies at that institution.

COSTA RICA'S health care system is predominantly public, dominated by a single institution, the Costa Rican Social Security Institute (*Caja Costarricense de Seguro Social*), or 'Caja', which has been operating since 1943 and insures about 89 per cent of the population of 4,5 million. Those insured consist of formal sector workers and informal sector workers, especially in agriculture; those left out are some informal sector workers and some self-employed professionals. The Caja dominates the delivery of care with 97 per cent of hospital beds and 240 clinics. Over 90 per cent of doctors work for Caja, but at least a third also have private practices. Government spending accounts for 76 per cent of spending on health although private sector health care is booming, particularly primary care in the fields of dentistry and optometry, and some specialist care, particularly obstetrics and gynaecology.

The system is insurance-based, with mandatory payroll deductions, which the constitution defines must go to the Caja and not to any other public or private entity. Employers contribute 9,25 per cent and employees 5,5 per cent of their income, and the state adds 0,25 per cent to make 15 per cent of workers' income. There are special regimes for agricultural workers and informal sector workers who are basically self-employed, with rates ranging from 5,75 per cent to 13,75 per cent depending on income. There is a special regime for the very poor who receive free care, but they are a small percentage of the total.

Reasons for reform

In the 1990s Costa Rica undertook a reform of the system to address problems such as long waiting lists for diagnostic tests in hospitals, and overcrowding in clinics. Like most Latin American countries, Costa Rica had gone through a severe economic recession in the 1980s which resulted in a substantial drop in public spending on health, and some deterioration of the health system. The reforms were aimed at improving primary and hospital care, and splitting purchasers and providers to arrive at an internal market type

Government
spending accounts
for 76 per cent
of spending
on health

of reform, though this was not achieved. Most of the energy went into primary care. Moreover, 1 600 health provider personnel were moved from the Ministry of Health, which no longer provides services, to Caja. The ministry is responsible for public health services, such as spraying to control malaria, but no longer provides any medical services.

To address overcrowding in primary health care, a lack of access in some remote rural and marginal urban areas, and an overly curative service, they put together comprehensive basic health care teams. The teams were also intended to address population movement that had left some clinics poorly located. The work started in the poorest rural areas in 1995 and ended in the capital in 2004 after covering the whole country. In some cases this just meant that existing clinics reorganised themselves into teams, and continuing doing what they had done before. In others it meant getting new personnel and providing services in more convenient locations.

The World Bank, which financed the final package of reforms in 1993, wanted to see the creation of an internal market with a split between purchaser and provider, but the Costa Ricans were not keen on this, partly for ideological reasons and partly because they did not know how to do it and would have had to depend on outsiders. The Bank also wanted to see hospital budgets linked to referrals and performance contracts, and hospital managers given the right to hire and fire personnel. This met with a lot of resistance from hospital directors; in the end, hospitals and other health units were given their budgets up-front but had to justify them based on annual performance contracts that set out what they were expected to produce in return for the budget. Those that scored 85 per cent or more on their annual evaluations received a bonus. Giving hospital directors the right to hire and fire staff met with resistance from the unions, and this function therefore reverted to the central authorities. Managers did get more autonomy in respect of purchasing.

In the 1990s the government was able to provide more money for the Caja's health programmes. This was used to adjust for inflation, and also for inequities resulting from population movement.

Although this is a national health service, there have been interesting experiments with the private sector. In the late 1980s the Caja quietly authorised some experiments in third-party contracting that resulted in six level-two clinics, providing specialist care in obstetrics and gynaecology as well as dental care, being built in densely populated lower income areas of the capital. This has become an important initiative with hot debate about whether the clinics cost more or less than similar clinics run by Caja. Of the six organisations contracted to run the clinics, four are non-profit co-operatives; one an association, essentially a co-operative of medical practitioners; and one is run by the University of Costa Rica, a public entity but still a third party.

An investigation by the Controller General in 2006 found that, on average, the services provided by these clinics were more expensive. However, it was difficult to get a clear picture because the clinics were engaging in a number of unauthorised practices including demanding extra payments, receiving free equipment, and not paying for leasing public facilities, while there had been no tendering process in setting them up,

Although this is a national health service, there have been interesting experiments with the private sector

all of which was illegal. Interestingly, the conclusion seems to be that it is worthwhile continuing with the six clinics, and a bidding process to establish who will run them is under way. In future they will be more closely monitored.

Another development that may impact on the Caja is that Costa Rica has joined the Central American Free Trade Agreement with the United States and has been persuaded to open up its state-controlled insurance monopoly, which previously issued all insurance policies apart from the health insurance dealt with by Caja. Because the attempt to open up the sector fell short of its goals, and given that waiting lists are continuing to grow, this might mean that middle- and upper-income people might find private policies attractive. Companies have only been able to register private policies since March (2010), and so far two companies have done so. One is from the United States, the other from Costa Rica.

The limited success of the internal market reform and the fact that waiting lists are longer than ever makes it possible that middle- and upper-income people will be attracted to private insurance schemes. This means that in the longer term there might be a constitutional amendment allowing payroll deductions to go to private entities. The other development that might support this is the boom in private hospital building. At the moment this is largely aimed at medical tourism, but it does make change possible in the future.

Discussion

The discussion focused on four main areas: health care reform and relations between the public and private sectors in providing health care, the governance and management of the health care system, the nature and coverage of the service, and how public health issues are dealt with in the system.

- *Health care reform and public – private sector relations*

In Costa Rica real spending on health care declined in the 1980s because of an economic crisis in Latin America. The World Bank assisted the country in computerising the payroll collection system, and increasing collections. The private sector is relatively undeveloped, and its role has been to exploit opportunities that arise due to shortfalls in the system and the medical tourism market. American and Canadian health insurers only pay for emergencies in foreign countries, so tourists provide an opportunity for private providers. Private providers have also been involved in experiments such as the contracted-out clinics mentioned in the presentation.

In Colombia the 1993 reform was driven by dissatisfaction with increased costs and poor performance by public hospitals and social security schemes. An additional factor was the wave of market reforms in Latin America driven by the World Bank and IMF, which increased private sector participation in health care, education, and many other sectors. Now the pendulum appears to be swinging back, with increasing discontent with private sector participation exerting pressure on the incoming administration. One

In the longer term there might be a constitutional amendment allowing payroll deductions to go to private entities

of the challenges facing the 1993 reform was to break the health insurance monopoly of the Institute for Social Security (ISS) after repeated attempts to make it more competitive had failed. Opening the market to private insurers saw its enrolment drop from 8–9 million enrollees to the present number of about 3 million. The final step saw the government sell a controlling interest, 51 per cent, of the ISS to six of the family compensation funds, non-profit organisation (NPO) private entities that administer the cross-subsidy between high- and low-income earners.

Despite the criticism of private sector insurers, Dr Castaño-Yepes expressed the view that they had contributed significantly to health care in Colombia since 1993. Efficiency has improved faced with the very tight premium of \$220–250 per head a year for providing the benefits package; competitive purchasing has driven down the difference between the general CPI and the health CPI over the last 15 years. The strong pressure exerted by the premium has forced providers and insurers to innovate in making models of care more efficient and prevent avoidable morbidity, which is basically lost money. They have also built more hospitals and clinics, resulting in strong returns on investment via the rentals they have been able to charge.

- *Governance and management*

In Costa Rica the Caja is an autonomous institution with a tripartite board comprising nine representatives. Three, including the executive director, are government appointees; three are nominated by employers' associations; and three by the labour sector. Of the latter, one is a trade unionist, with trade unions dominant in the public sector; one is from the solidarity movement, a system of company unions unique to Costa Rica, which dominates the private sector; and one from the co-operative sector. This composition appears to favour the continuance of a public health care system, although seven board members recently indicated that they did not foresee that Costa Rica's signing of the Central American Free Trade Agreement, which includes the United States, would pose problems for the health care system as long as formal sector employment did not drop. Personnel management is entirely centralised and governed by rules negotiated with the public sector union. Hospital directors only have discretion to transfer an employee within a radius of eight kilometres with the worker retaining his/her salary, so this hardly happens.

- *The nature of the system*

A participant argued that, as a needs-based system funded by a payroll tax, this could not be regarded as an insurance-based system with private providers and payments based on claims coming from people using the service. It was also argued that this needs-based system is coming under pressure from the demand-based system favoured by higher income groups. Failing to recognise this and ensure a properly designed relationship between the two could result in the unregulated movement of insurers to the health care system, and a breakdown in solidarity. Professor Clark maintained that it *was* an insurance-based system as it was not paid from general tax, and all citizens were not automatically covered.

The strong pressure exerted by the premium has forced providers and insurers to innovate in making models of care more efficient and prevent avoidable morbidity

- *Coverage*

An estimated 10 per cent of people are not covered in both the Costa Rican and Colombian systems. In Costa Rica some of those are high-income, self-employed professionals and executives of multinationals with foreign health insurance policies, but most of those not covered are poor informal sector and agricultural workers. There is a means test to establish whether people are indigent. However, extending coverage to the very poor has been problematic. Hospitals will not deny them care in case of emergencies or serious health problems. A further concern is that entry into the free trade agreement may undermine Costa Rica's high rate of employment in the formal sector relative to other Latin American countries, with negative effects for health care. In Colombia the situation is different with only 35–40 per cent of the workforce in formal employment and most people employed in the informal sector, but still eligible for the insurance-based system if they are not indigent.

Both the Costa Rican and Colombian systems are doctor-based. This is not a problem as both countries have an oversupply of doctors, although there are shortages of specialists in some areas. Having a doctor-based system does increase costs. In the past, Costa Rica has run effective health campaigns using nurses, such as the anti-infant mortality campaign in the 1970s.

Doctors in Costa Rica have been successful in protecting themselves against competition from doctors trained elsewhere by requiring them to write a board test and by getting Caja to agree not to give residencies to foreign doctors. The oversupply of doctors is helping to drive the move towards more private health insurance.

A participant asked who was responsible for public health programmes, including immunisations and health education. In Colombia it has been a big challenge to co-ordinate activities between the health insurance funds, which are responsible for individual curative and preventative services such as ante-natal care, immunisations, screenings, pap smears and so on; and population-based interventions, which the local authorities are responsible for. A regulatory decree requires the insurers to participate in public health plans at the local and community level, but this has only been effective in large urban centres as it is impossible for them to have representatives from all of the more than 1 000 municipalities in the country.

Costa Rica has run effective health campaigns using nurses, such as the anti-infant mortality campaign in the 1970s

A healthy South Africa – two sectors, one goal

Thulani Masilela

Cluster manager, strategic planning, Department of Health

THE SOUTH African government is interested in learning from the experience of its Latin American counterparts in delivering health care along the lines of the comprehensive primary health care teams described by Prof Clark. In line with the 'two sectors, one goal, one vision' slogan, the aim is to have a single national health system

incorporating the public and private sectors. There are already many examples of public-private partnerships (PPPs) for building hospitals and delivering higher levels of care, but the situation at the primary health care level is not ideal.

The new minister has identified five flagship projects for PPPs involving refurbishing and improving services in five tertiary hospitals. The private sector has also been extensively consulted on the TB strategic plan and the HIV and AIDS strategic plan. In addition, the private sector is represented on the South African National AIDS Council through the South African Chamber of Business. The government is keen to develop a national health insurance system, and has appointed a ministerial team with 27 members for this purpose.

While there needs to be one goal, it is important to recognise that the two sectors have different roles and identities. The private sector is profit-driven, while government's role is to regulate and lead transformation in the health sector. However, we will find a way to work together despite these differences as we move forward towards achieving similar

NATIONAL DEPARTMENT OF HEALTH STRATEGIC PLAN

There has been no shortage of high-level plans for health in South Africa. In 2008 the Development Bank of Southern Africa (DBSA) convened several meetings with many of the primary stakeholders in health care. 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 management, accountability, information, benchmarking, and human resources. More recently, and in line with the Medium Term Strategic Framework, the National Department of Health has adopted a Ten Point Strategic Plan. The points are as follows:

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 health care 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.

As 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.'⁶

CDE 2010

The new minister has identified five flagship projects for PPPs involving refurbishing and improving services in five tertiary hospitals

outcomes to those in the Latin American countries with their low infant and maternal mortality rates and high life expectancy.

Alex van den Heever

Independent health economist

Although South Africa is not spending less on health care than other countries at similar levels of development, it has significantly worse outcome statistics. Much of this relates to the HIV/AIDS and associated TB epidemics, which have been worsening, with a particular impact on the burden of disease and services from 2002.

South Africa has a public system that guarantees access to basic health care services with an ancillary insurance service funded by people who buy insurance. It is a regulated system similar to that in Colombia, but has not implemented similar risk equalisation measures, although legislation is pending. The system is distributed across the three tiers of government with strategic policy at the national level, most hospital services at the provincial level, and primary care shared between the provinces and local authorities. Primary care performs very badly, as indicated, for example, by the low TB cure rates and high maternal mortality rates. There is clearly something wrong with how the public system is working, with evaluations pointing to a weak accountability structure, ineffective performance auditing, and poor response to the public. Compared with insurance-based systems, public systems generally tend to be less responsive to their populations unless there are carefully designed mechanisms to ensure responsiveness.

The ancillary system is focused on risk pooling objectives to expand the capacity of the system while the public system is primarily focused on rationed, prioritised, supply-driven health care. The problem is that we are not spending in the right areas, and we need to look at the institutional design that is leading to this result.

Martin Smith

Head of surgery, Chris Hani Baragwanath Hospital

Central to the failure of the South African health care system is that the bureaucratic process has taken precedence over the clinical process. We need decentralisation at all levels, and an accountable delivery system led by health professionals. Integrated management systems must be reintroduced in hospitals in place of the silo systems. We need to improve human resource management at operational rather than higher levels, and improve discipline. Labour has to become an agent for change rather than a disruptive force, as is often the case at present. We need an integrated national health authority linked to a geographically based system that is not based on the current three-tier political structure.

There is clearly something wrong with how the public system is working

The role of the private sector within an integrated delivery system is a challenge. Standards need to apply across the board, and the quality of care should not differ between sectors. The private sector has a role to play in skills transfer to implement these changes.

We need to improve our systems before the current focus on quality care can bring results. Rather than focusing on things such as reducing queue lengths, we need to focus on patient care to improve health outcomes.

Our failure in health care reflects our failure to develop a developmental state, with a bureaucracy that is relatively independent of political changes, so that change can be introduced in a consistent and sustainable way.

Laetitia Rispel

Wits University

I want to raise five issues. The first is context; both the Costa Rican and Colombian systems are based on an existing political system with laws that determine certain issues, and a network of health care facilities that determine the relative importance of the public and private systems. Moreover, the employment rate in these Latin American countries is far higher than in South Africa.

The second is that financing the reforms should not be isolated from the reforms themselves. A big mistake we are making in the current debate on national health insurance is not looking at human resources for health – the whole issue of delivery systems, how it will happen, how it will be structured, decentralisation, and so on.

The third lesson from this morning was the gap between policy on the one hand, and policy objectives and implementation on the other. We had the example of the intention that Costa Rica started off with on decentralisation, on incentives for people to deliver, and what happened.

The fourth important issue is what I would call broadly a public health approach. In both Costa Rica and Colombia this seems to have fallen by the wayside. In the case of Costa Rica the Ministry of Health has retained responsibility for public health programmes, but in Colombia this is clearly a problem. In South Africa, given our disease burden, we need to have a strong public health approach.

The final point, the most vital for me, is that you can't have a good decentralised system and impact on the behaviour of providers and suppliers without a good information system. This is an underdeveloped area, and one where I think we can learn a lot from the private sector about developing information systems for measuring performance. A second area where we can learn is management reforms. We have not heard much about this, but it is a crucial weakness in the public sector.

You can't have a good decentralised system and impact on the behaviour of providers and suppliers without a good information system

Discussion

The discussion focused on three issues: the roles of government and the private sector, the quality of health care, and the need for evidence-based reform. Major points raised included:

- *The roles of government and the private sector*

Participants pointed out that PPPs should not be limited to areas such as high-end services, training, and information management systems; instead, experience in Costa Rica and South Africa showed that the private sector could also deliver primary health care services effectively. Participants agreed that government's role included policy development and regulation, but argued strongly that this needed to be separated from delivery. One participant noted that, in this case, the government was both 'the player and the referee.'

There was, however, consensus in government circles that it was not the right time to split the purchaser and provider roles. The health care system still retained many of the inequalities in the distribution of services of the pre-1994 system. Re-planning needed to address the wrongs of the past, and the new system had to mature before the most viable alternative models of service delivery could be explored. Government was looking at whether national, provincial and local health authorities were needed. The new minister of health had a very open-minded approach, and was engaging with the private sector.

- *Quality*

The major problem was not with access to primary health care services but with the quality of those services, and the key question was whether the private sector could provide better services. Experience with using doctors from the private sector in community health clinics and district hospitals had yielded mixed results.

In terms of training the country was only producing about half the required 2 400 trained doctors a year. Existing medical schools had indicated to government that they had limited capacity for expansion. The government had asked the Health Professions Council and Nursing Council to look into the training provided by private institutions, and they had raised a number of concerns. A participant pointed out that an active strategy was needed to retain trained doctors who were leaving the country in large numbers. Present requirements for newly qualified doctors to perform community service were not effective, and were seen as punitive. The minister of health also needed to take a clear position on importing doctors and nurses from other countries.

- *Reform*

On the issue of whether the entire health care system should be overhauled, or a gradual approach adopted, a participant expressed the view that work needed to start with the delivery system and build on what was there, rather than developing a new national health insurance scheme and new legislation. This should address infrastructural issues such as human resources, management systems, and information technology. Once the

The minister of health also needed to take a clear position on importing doctors and nurses from other countries

delivery system was working, it would be possible to establish the costs of various services, and set up a funding mechanism.

Participants emphasised the importance of basing the NHI reform process on a systematic approach to the evidence. Case studies may be illustrative, but they are not an adequate basis for evidence-based medicine, and while it is expensive to gather and collate evidence this should be a priority for the ministry. Participants agreed that this was an important issue, given the problems with the health information system, and stated that it was a priority for the new ministry that research findings should inform policy. The department was conferring with academic institutions and was in contact with the disease control priorities project at the University of the Witwatersrand, which was looking at the evidence to set priorities.

Expanding the role of the private sector

William Dachs

Head: PPP unit, National Treasury

The PPP unit advises government entities which want to enter into public-private partnerships on how to secure better value-for-money outcomes, and assists the Treasury with regulating PPPs. PPPs in the health sector date back 10 years, with seven level two clinics and three hospitals under PPP arrangements. PPPs are also involved in the local supply of vaccines as well as the pharmaceutical supply chain. Besides this, the military health service is in the process of contracting out its district health services. This is the only PPP involving clinical services. Limpopo is looking at a PPP for developing nursing training colleges. There is no national health strategy for PPPs, and those in the health sector are driven mainly by the particular needs of provinces. The national Department of Health appears to be providing much stronger leadership on PPPs, and is engaging the development finance institutions, the Industrial Development Corporation (IDC), and the Development Bank of Southern Africa (DBSA) to assist with designing and implementing them. Over the next five years the strategic plan envisages procuring five tertiary hospitals under a PPP arrangement. The aim is to extract a range of efficiencies in expenditure on infrastructure from a PPP model.

Some of the discussion has focused on how inefficient the public sector is at doing some quite basic things, but we want to avoid going to the opposite extreme where we implement expensive systems at a high cost that raise long-term affordability issues. As a person with no special knowledge of the NHI, what I would like to see it doing is giving people a choice of which facility to go to, and providing public facilities that offer quality services and the opportunity to generate the revenue needed to sustain that service.

Participants emphasised the importance of basing the NHI reform process on a systematic approach to the evidence

PPP programmes will appear on government's balance sheet, and the Treasury will exercise strong fiscal risk management. On defining roles between the public and private sectors, one issue is that the private sector is very diverse with many other players besides doctors and hospitals. Moreover, there still seems to be a strong adversarial relationship between the public and private sectors, and perhaps they need to resolve their differences.

Jack Koolen

Consultant, J&J Group

The NHI process is fascinating, but I question the benefits of merging an insurance-based and public health system. Even if health care was working well, and it isn't, I doubt whether this would address the situation. As I understand it, what is killing our people is a series of well-understood chronic conditions. We have spoken about HIV / AIDS and TB, and I would add malnutrition, as well as diabetes, cardio-vascular disease, and cancer. In respect of HIV alone, one of every six South African adults will need treatment for about 40 years to keep them alive. Our current system could not do this even if it was working well. We would need a system that could deal with the wide range of drugs required for treating the disease; that could perform regular diagnoses and blood sampling, and provide very consistent case management for millions of cases. Even if the system worked, it could not do this. We want to do that with a system that has a 50 per cent success rate in respect of a six-month TB treatment.

If you started from scratch, I suspect you would design a system that does remote blood sampling, a lot of tele-medicine for diagnosis and clinical responses, with very efficient local distribution and logistics, and a lot of local counselling. Clinical care would be quite removed from individual patients because we do not have the people to deliver in the current design. This means we need a rethink, which seems like a perfect starting point for a PPP that does not just take the existing financing option but builds something new and more relevant to our particular disease burden.

Hein van Eck

General manager: health policy, Medi-Clinic

The biggest problem is the lack of trust between the public and private sector, so the first thing needed is a good debate along the lines of this Round Table. Both sides have to acknowledge that they don't have all the answers or expertise. The public sector has great expertise at rationing care, and stretching every rand to the maximum. The private sector is very efficient once someone is in our hospitals, but is not good at rationing care. That is not really its function. I am going to look at PPPs from the hospital perspective.

In the current dispensation PPPs are mainly about infrastructure development, and here there might be some misconception about the capacity of the private sector. If

The NHI process is fascinating, but I question the benefits of merging an insurance-based and public health system

THE LONG ROAD TO A PUBLIC–PRIVATE PARTNERSHIP

According to the National Treasury PPP unit, a PPP in South Africa has to go through the following stages:

Inception: Inception involves registering the project with the Treasury, appointing a project officer, attracting a transaction advisor, receiving and evaluating transaction advisor bids, and finalising and signing the contract with the transaction advisor.

Feasibility study: Government appoints private sector advisors to do a feasibility study on the most appropriate mechanism (conventional procurement or partnership) for the project.

Procurement: If the feasibility study shows that a PPP is viable bids for the infrastructure and/or service provision project are invited.

Implementation: The project is implemented once a suitable bidder has been chosen and a PPP agreement signed.

Documentation to guide and support the PPP process

- The enabling and regulatory legislation for national, provincial and municipal PPPs includes: the PFMA, Treasury Regulation 16, the MFMA, the MSA, the Municipal PPP Regulations, the Municipal Supply Chain Management (SCM) Regulations, and the Code of Good Practice for BEE in PPPs.
- National Treasury's *Standardised PPP Provisions* provide comprehensive, standardised guidance for PPP contracts in South Africa.
- National Treasury's *PPP Manual* leads national and provincial PPP practitioners through the project cycle. National Treasury's *Municipal Services and PPP Guidelines* provides similar detailed instruction for municipal PPP practitioners.
- The *PPP Manual* and the *Municipal Services and PPP Guidelines* summarise the project cycle: the different phases of the projects, during the preparation period and the project term, from inception to exit.

Source: National Treasury PPP Unit, *Public–Private Partnership Manual; Introducing Public Private Partnerships in South Africa (2007)*.

CDE 2010

The biggest problem is the lack of trust between the public and private sector

we got involved in a project like Chris Hani Baragwanath, it would probably exhaust our technical capacity, leaving nothing for our own requirements. But we can transfer knowledge and learning from our side. For example, the quoted public sector costs for developing the infrastructure and providing a hospital bed are R3,8 million, whereas the private sector does it for R2 million a bed. Clearly there are some efficiencies and learning we could transfer.

Our core competency is private hospital management. We manage clinical services, centralised procurement services, and the supply chain very well. Our stock levels are kept low, but there is never a shortage of drugs, and therefore our stock write-offs are

very low. We have financial discipline, monitor occupancy daily, and know how many nurses we need for the next shift. We provide excellent training for nurses, and we can definitely help government with this. Another core competency is data systems, and capturing data in real time and using it effectively to manage a facility.

Although we have expertise in building and refurbishing hospitals, we don't see this as our core competency. We also outsource services like laundry and catering, and are therefore not well placed to provide them in PPP agreements.

Finally, selective contracting should be done in a controlled environment. I would not advocate giving people complete freedom of choice to use the private sector, since this would lead to inefficient spending of limited funds. Rather, you should selectively contract out those services with the greatest waiting times and biggest bottlenecks to the private sector, and negotiate a very good price for those procedures, thereby getting the best social return for money spent.

Fazel Randera

Former health advisor, Chamber of Mines

The legislation for PPPs is in place, but in practice very little has happened, and this is due both to the private sector not coming to the party and the public sector having an ideological position that stops it from giving major contracts to the private sector. Taking the mining sector, where I have worked, as an example, it is involved in providing NPO health care services in many parts of the country. Historically these were only for workers, but despite some movement to include dependents and surrounding communities this is not happening, and neither the Department of Health nor the industry itself have made a move to make more of it. The one area where PPP has been successful is HIV and AIDS. The United States President's Emergency Fund for AIDS Relief (PEPFAR) has donated about \$850 million to South Africa. Most of that has gone to non-public sector entities, but the work that has been done has included the public sector. Whether it has been building new clinics, staffing them, or providing laboratory services, it has worked very well. We need to look at why it has been so successful when people say there is no basis for a relationship between the public and private sectors; at how PEPFAR and the Global Fund have worked with the groups that they have distributed billions of rands to; and why every cent that has come into the country has been accounted for. We need to write that up as a case study.

If I were the minister of health, I would support PPPs, but only as a means to an end. The end is to honour the commitment to provide a national health system that the government made to those who elected it in 1994. On this issue the private sector should not wait for the minister to ask what we can do; we should be knocking on the door all the time. What I have learnt from our two colleagues today is that we don't have to adopt a particular model. Whether it is a tax-based system or an insurance-based system, we need a national health system, and the private sector has a massive role to play in providing it.

Selectively
contract out those
services with the
greatest waiting
times and biggest
bottlenecks to the
private sector

Dr Ntuthuko Bhengu

Executive head of provider networks, Qualsa

Revenue collection, the pooling of funds, and purchasing and providing health care services all have a significant impact on access, and correct execution will determine our ability to expand access. We spend about 8,5 per cent of GDP on health care, and our outcomes show that we are clearly doing something wrong in terms of allocation. The cost of providing a bare bones package of benefits will amount to about R100 billion, increasing to around R400 billion for a more comprehensive one. Access also needs to be improved, with vast areas of the country either without access or only having access to poor quality services. We have heard about the management challenges in the public sector. There are opportunities for the private sector to participate in all these areas, perhaps focusing on administration and purchasing and leaving revenue collection and the pooling of funds to government. On the financing side, a model that combines state funding with space for private sector players to provide additional products can expand financing.

Besides looking at the breadth and depth of coverage, I would like to see more discussion on the availability of health care professionals and the conditions of employment in order to stem the loss. Lastly, I would like to see our involvement in transforming the health care sector starting now, and not waiting to see what the NHI brings.

Okore Okorafor

Health economist, Medi-Clinic, Southern Africa

I am going to introduce a framework for expanding access to private care. Cost is the major barrier to access to private sector health care, given the income distribution and income levels in South Africa. There are basically three ways to expand access, especially to hospitals. The first is to increase income levels, which is obviously a long-term project. The second is to reduce the cost of private care. And the third is to have someone else pay for those who can't afford it.

It is important to understand that private and public hospitals operate in different markets, with private hospitals needing to generate a return on investment, pay VAT, and pay different prices for drugs, so their costs are different. Given this, it is relatively straightforward to list interventions for reducing the cost of production in the private health care sector. For instance, is it possible to make the medical industry VAT-exempt? Is it possible for private hospitals to get drugs at state tender prices? Then of course there is always room to improve efficiency, even in the private sector. Turning to medical schemes, membership tends to have a high concentration of young families with children and older people who are chronically ill. If you could encourage other people who are working to take out medical insurance, or have mandatory cover, this would reduce the average cost per person. We should also be discussing things like the risk equalisation

Is it possible to make the medical industry VAT-exempt? Is it possible for private hospitals to get drugs at state tender prices?

The private sector does have some additional capacity to provide services to the public sector

HEALTH-RELATED PPPs IN SOUTH AFRICA

The following is a list of active PPP arrangements in health in South Africa as of May 2010, according to the National Treasury. Most do not involve clinical services or hospital management – arguably the areas where the private sector has the most to offer. In fact, most concern functions that are often contracted out by the private health sector itself. This suggests that the specific expertise of the main players in the private health sector is not being significantly exploited.

- Revitalisation of the pharmaceutical supply chain – Eastern Cape Department of Health
- Reconstruction, revitalisation and upgrading of Chris Hani Baragwanath Hospital – Gauteng Department of Health
- Upgrade of Phalaborwa hospital – Phalaborwa hospital
- Tygerberg Hospital Redevelopment – Western Cape Department of Health
- Pharmaceutical supply chain upgrading – Free State Department of Health
- Hospital revitalization – Limpopo Department of Health & Social Development
- Pharmaceutical depot – Limpopo Department of Health & Social Development
- Academic hospital – Limpopo Department of Health & Social Development
- Upgrading George Mkhari hospital – Gauteng Department of Health
- Nursing college – Limpopo Department of Health & Social Development
- New Mangaung Hospital – Free State Provincial Government

Source: National Treasury, *PPP Quarterly Online*, May 2010, http://www.ppp.gov.za/Documents/QuarterlyPubs/May_2010.pdf

CDE 2010

fund in Colombia. Finally, the private sector does have some additional capacity to provide services to the public sector. This will depend on the price and nature of the contract.

Dr Jane Goudge

Director, Centre for Health Policy, University of the Witwatersrand

I hear two debates going on here: one about PPPs and whether we should be engaging them, and the other about fixing the public sector. It is clear that the two sectors are different, and that transferring things from one to the other may not work. But I think the reason we are not fixing it is that it is a long and difficult task. I disagree that it is simply an issue of institutional design. Missing are human resources, people skills, management, and accountability based on interpersonal relationships where we hold each other accountable. Looking at where to start re-engineering business systems is only

half the problem; the other half is getting buy-in from the people involved [in providing health care] through a participatory process.

I want to draw on two examples from Africa that point to the need to strengthen the health system at the district level, an area we have not covered. The example from Tanzania is the five-year TEHIP project in which the International Development Research Centre (IDRC) provided a dollar per head of funding at district level with no strings attached. That brought greater ownership and participation in the planning process at the district level. The project also provided simple district health profiles, did a lot of management training, and improved communication and team work. The result was an early adoption of integrated management of childhood illnesses (IMCI), including treated bed nets, and a 40 per cent reduction in infant mortality over five years.

The other example from Kenya did not have the same astounding results, but it is about direct facility financing. How much of the money filters down through the bureaucratic system to the district level? Schools get some money directly to fix things. Why can't we do that in the health sector, so that they can deal with their problems? I think that would go a long way towards bringing people on board as opposed to top-down attempts to fix things.

Discussion

Participants discussed the differences between the private and public sector models and the implications for interactions, the roles of for-profit and NPO entities in the private sector, the nature and limits of existing PPPs, and the regulatory environment.

- *Models*

The public and private sectors have different models and different objectives. The private sector is geared to making profits, and works in terms of a low-volume, high-care, fee-for-service model. Public health is the guarantor of last resort and cannot turn anyone away, whether they are funded or not. It operates in a high-volume, high-pathology environment, and its complexity should not be underestimated. The challenge is how to get all the different parties involved in health care to participate in a national health effort.

- *Interactions*

In order to get good results from public-private interactions, it is important to deal not only with infrastructure backlogs in the public sector but also to deal with staff shortages, both clinical and managerial, and to sort out the platforms, management systems and processes through which the public sector delivers services, to improve discipline and to get a better idea of the costs involved. Once this is done the public sector will be in a position to know what it wants to achieve out of PPPs and able to enter into well-defined contracts that it can manage effectively. It will also enable the public sector to adopt a more decentralised and innovative approach to PPPs.

The challenge is how to get all the different parties involved in health care to participate in a national health effort

- *Regulations*

The current regulatory framework for PPPs is geared to large infrastructure projects, and its complexity militates against provincial health departments and individual institutions engaging with it. This, along with an apparent reluctance on the part of government to contract out clinical services, limits the opportunities for the private sector to contribute to the national health system. There is considerable spare capacity and underutilisation of resources in the private sector which contributes to overservicing to pay for expensive equipment. There are huge opportunities to use equipment and spare bed capacity, but to do this the private sector will have to look at new ways of pricing its services. As an example of what is possible, in Gauteng the private sector is providing level one beds at a cheaper rate than public sector hospitals. If the private sector can provide services more efficiently than the public sector, it should be able to do so within the framework provided by the national health system.

- *Non-profit organisations*

It is important to recognise the contribution that the non-profit organisation (NPO) part of the private sector can make. Some of the biggest innovations have been around its role in treating HIV and AIDS. Participants noted that the sector depended on funding, and that the PEPFAR funding would not continue indefinitely. At the moment PEPFAR is moving from direct assistance to technical assistance, which might provide openings for market players. The Prevention of Mother to Child Transmission (PMTCT) model is working successfully with communities and NPOs at the district level and with government and other providers at the national level. It is important to work at the district level where there are a range of problems, but this is also where people want to get involved to improve the health of their communities. The question is why these platforms were not being developed before external funding was available, and whether government can step in and provide funding in the longer term. An example of what can be achieved is the Department of Health's expanded partnership programme, with more than 1 000 NPOs involving more than 19 000 care workers providing primary health care and home-based HIV and AIDS care across the country.

- *Unions*

Trade unions in South Africa are often sceptical of or opposed to partnerships. They seem to assume that efficiency increases will result in job losses, even though there are major skills shortages in the health sector. Care will be required to bring them on board.

There is considerable spare capacity and underutilisation of resources in the private sector which contributes to overservicing to pay for expensive equipment

Key insights from the Round Table

IT IS clear that the health sector is in crisis. It is less clear how these huge challenges should be addressed. Key insights from the Round Table include:

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

Almost all role players in health feel misunderstood in one way or another, and they are all partly correct

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

South Africa
urgently needs
more doctors,
nurses, and
– especially
in the public
sector – qualified
managers

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 challenge 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. Also 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?

The way to get to the point where South Africa could definitely afford an NHI is to focus on sustained economic growth and job creation

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.

Endnotes

- 1 World Health Organisation, World Health Statistics 2008, http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf (accessed on 31 August 2010).
- 2 World Health Organisation, World Health Statistics 2009, http://www.who.int/whosis/whostat/EN_WHS09_Full.pdf (accessed on 31 August 2010).
- 3 IMF, World Economic Outlook Database, <http://www.imf.org/external/pubs/ft/weo/2010/01/weodata/weoselgr.aspx> (accessed on 31 August 2010).
- 4 World Health Organisation, World Health Report, 2000, http://www.who.int/entity/whr/2000/en/whr00_en.pdf (accessed 31 August 2010).
- 5 National Assembly, 13 April 2010.
- 6 National Department of Health, Strategic Plan 2010/11-2012/13, p 4.

Previous CDE Round Tables

Poverty and inequality: Facts, trends, and hard choices

CDE Round Table no 15, August 2010

Water: A looming crisis?

CDE Round Table no 14, April 2010

South Africa's Public Service: Learning from success

CDE Round Table no 13, November 2009

Managing migration in South Africa's national interest: Lessons from international experience

CDE Round Table no 12, October 2009

Accelerating growth in tough times

CDE Round Table no 11, March 2009

South Africa's electricity crisis: How did we get here? And how do we put things right?

CDE Round Table no 10, July 2008

Farmers'Voices: Practical perspectives on land reform and agricultural development

CDE Round Table no 9, February 2008

Going for growth: Are AsgiSA and JIPSA bold enough?

CDE Round Table no 8, March 2007

Local government in South Africa: Priorities for action

CDE Round Table no 7, 2003

Why is South Africa failing to get the growth and jobs that it needs?

CDE Round Table no 6, 2001

Local government reform: What's happening and who is in charge?

CDE Round Table no 5, 2000

The future of South African universities: What role for business? Part Two

CDE Round Table no 4, 2000

The 1996 Census: Key findings, problem areas, issues

CDE Round Table no 3, 1999

The future of South African universities: What role for business? Part One

CDE Round Table no 2, 1998

Getting into gear: The assumptions and implications of the macro-economic strategy

CDE Round Table no 1, 1997



CENTRE FOR DEVELOPMENT AND ENTERPRISE
Informing South African Policy

Transmedit Place, 5 Eton Road, Parktown, Johannesburg, South Africa
PO Box 1936, Johannesburg 2000, South Africa
Tel 27 11 482 5140 • Fax 27 11 482 5089
info@cde.org.za • www.cde.org.za

BOARD

L Dippenaar (chairman), A Bernstein (executive director), F Bam, E Bradley,
C Coovadia, M Cutifani, B Figaji, F Hoosain, S Maseko, I Mkhabela, S Ndukwana,
W Nkuhlu, S Ridley, E van As

INTERNATIONAL ASSOCIATE

Peter L Berger



**THE AURUM
INSTITUTE**

This Round Table was convened by CDE and the
Aurum Institute for Health Research.

The Round Table and this publication were funded by
The Atlantic Philanthropies.