

B5 | SOUTH AFRICA: BUILDING OR DESTROYING HEALTH SYSTEMS?

South Africa has a deeply divided health system. About 17 per cent of the population, comprising the richest groups, have private health insurance (called medical schemes) and use private for-profit providers. While some who are not covered by medical schemes occasionally pay out of pocket to use a private GP or retail pharmacy, 83 per cent of the population are heavily dependent on tax-funded public sector services, particularly for specialist and hospital care (McIntyre et al. 2012). South Africa has the highest percentage of health expenditure funded by private health insurance in the world (Drechsler and Jutting 2005).

Funding for public sector health services declined in real per capita terms from the mid-1990s to the early part of the twenty-first century (McIntyre et al. 2012) owing to a self-imposed structural adjustment programme. This was precisely the time when the HIV epidemic was exploding, placing a growing burden on the under-resourced public health system and contributing to declining quality of care and staff morale. While there is no fee for care at public primary-level facilities, user fees are charged at public hospitals. Pregnant women and children under six years are exempt and the poor can apply for a fee exemption, but anyone outside of these categories and earning an income is faced with paying the not inconsiderable hospital fees on an out-of-pocket basis. Many South Africans, particularly those living in rural areas, face substantial barriers in accessing healthcare (Sikal et al. 2012; Cleary et al. 2013).

The clearest indicator of the massive disparities in the health system is the differential in financial resources between the public and private sectors relative to the population they serve. While only 17 per cent of the population benefit from medical schemes, well over 40 per cent of total healthcare expenditure is attributable to these schemes. The effect of this is that while US\$1,370 was spent per medical scheme beneficiary in 2008, less than \$220 was spent on healthcare for those entirely dependent on tax-funded health services (McIntyre et al. 2012).

Proposed reforms

The South African government has committed itself to introducing a National Health Insurance (NHI) as a means of achieving a universal health system. Although termed NHI,¹ it is envisaged as a tax-funded system with universal entitlements to comprehensive health services for which there will

be no user fees at the point of service delivery (Department of Health 2011). Key elements of the proposed NHI reforms are: to begin by rebuilding the public health system, with a particular emphasis on primary healthcare; to increase management authority in public hospitals and districts, accompanied by improved governance and accountability mechanisms; to increase tax funding for health services; and to introduce an NHI Fund (NHIF) as a strategic or active purchaser of services at a later stage. The NHIF would *not* be an insurance scheme; it is envisaged as a public institution with strong governance and accountability mechanisms tasked with allocating resources to equitably meet the needs of the population.

These reforms have the *potential* to move South Africa towards a universal health system.² The NHIF would create a single pool of tax funds that could be used to purchase services that benefit the entire population, promoting equity through maximizing cross-subsidies from the rich to the poor and from the healthy to those with greater healthcare needs. As an *active* purchaser, the NHIF would assess population needs for health services and allocate resources in line with these needs to ensure that quality services are available where and when needed. It could also use its financial power, as a single purchaser, to ensure that the cost of health services is affordable and sustainable and to pay providers in a way that promotes efficient delivery of quality care and an equitable distribution of services across the country.

The South African government has appropriately identified the starting point for these reforms as rebuilding the public healthcare *delivery* system.

Some of the current initiatives include: addressing infrastructure gaps and deficiencies (poor distribution of facilities and lack of equipment); improving the availability of essential medicines in facilities; increasing capacity for health worker training; appointing managers who meet specific criteria and embarking on extensive management training; and introducing mechanisms for quality assessment and improvement.

This is a mammoth undertaking, given the serious damage inflicted on the system during the period of neoliberal reforms by ‘macroeconomic adjustment’ policies. From 1994 to 1996, the broad policy agenda of the ANC government headed by Nelson Mandela was the Reconstruction and Development Programme (RDP). In 1996, the RDP was replaced by a neoliberal macroeconomic policy – GEAR (Growth, Employment and Redistribution) – favoured by the International Monetary Fund (IMF) and the World Bank (Mooney and McIntyre 2008).

Currently, primary healthcare is to be prioritized. However, there are some concerns about progress with the primary healthcare agenda. A key element of the ‘PHC Re-engineering’ initiative was to deploy ‘primary healthcare agents’ (i.e. community health workers, CHWs) in every municipal ward, to contribute to the delivery of population-oriented primary healthcare with extensive community- and home-based services to complement services at clinics and other

primary-level facilities. While there was initially considerable enthusiasm about this programme, there now appears to be very slow progress in implementing it in some areas, with at least part of the reason reportedly being insufficient funds to cover the stipends of the primary healthcare agents (see also Chapter B7). Further, the number of CHWs in current policies is far too low for the work they are supposed to do, and completely neutralizes their activist role as catalysts of community mobilization around social determinants (People's Health Movement 2013).

Obstacles posed by Treasury policy

Increased public funding is key to the success of these different initiatives. Although the health sector has received some budget increases in the last decade, given that human resources are the single largest expenditure item and that there is an urgent need to increase staffing in public facilities, more funds are required. Building new facilities, rehabilitating existing ones and maintaining this infrastructure also requires funding, as does procuring and maintaining essential equipment, improving medicine supplies and other efforts to improve the accessibility and quality of care in public sector facilities. Without these improvements, the NHIF will provide merely 'paper entitlements' without real access to quality care.

The National Treasury has been very circumspect in terms of increasing government spending in recent years, citing the impact of the global economic crisis as the key reason for this approach. However, it could create more fiscal space for increased spending on healthcare, and other social services that impact on the social determinants of health, if it chose to change its fiscal policy. The National Treasury is insistent on maintaining a tax-to-GDP ratio of 25 per cent (National Treasury 2012; Forslund 2012). To maintain this level, when tax revenue increased dramatically through improved tax collection efforts, the Treasury responded by systematically reducing personal income tax rates (e.g. the tax rate for the highest tax bracket has declined from 45 to 40 per cent) and corporate tax rates (from 35 to 28 per cent). Restricting the tax-to-GDP level is a policy choice; a change in this fiscal policy could translate into substantial increases in tax revenue and government expenditure. This could be achieved through reversing decreases in personal and corporate tax rates, but more importantly by addressing aggressive tax avoidance by multinational corporations and high-net-worth individuals. The South African Revenue Service (SARS) estimates that it was losing R48 billion in tax revenue annually as a result of tax avoidance by high-net-worth individuals, equivalent to about 7 per cent of total government revenue (Vanek 2012).

Private sector challenges

A key concern relates to the role of private healthcare providers. The stated intention is that the NHIF could purchase services from both public and private

providers. There are particular concerns about the power of private for-profit healthcare providers and the potential for them to drain the NHIF's public funds to provide high-tech, costly, curative services (particularly secondary and tertiary care) for the urban population, leaving few resources to meet the needs of the rest of the population. There are associated concerns that the NHI will become unaffordable and unsustainable. These are not unrealistic concerns, given the current experience of medical schemes in South Africa. While only 7 per cent of total medical scheme expenditure is devoted to general practitioners, about 3 per cent to dental health services and 8 per cent to allied health professionals (optometrists, physiotherapists, etc.), 23 per cent is allocated to specialists and over 36 per cent to private hospitals (Council for Medical Schemes 2013), highlighting the dominance of secondary and tertiary care in this sector. There is an imbalance of power between the hundred or so medical schemes and private providers, particularly hospitals, where three groups own more than three-quarters of all private hospital beds (McIntyre et al. 2012). This power imbalance has contributed to rapid increases in provider fees and provision of certain services and hence medical scheme expenditure, translating into large annual increases in contribution rates.

There are clearly potential risks in engaging with the private for-profit health sector, and its power should not be underestimated. The question is, how should low- and middle-income countries (LMICs) seeking to ensure access to quality health services and financial risk protection for their whole population deal with large existing private healthcare provision sectors, particularly given that the majority of the most highly skilled health professionals often work in the private sector?

One approach could be to see private providers as outside the universal health system and to attempt to limit the potential adverse impact on public health objectives (such as 'internal brain drain' from public to private sectors) through strong regulation. However, experience has shown that regulation of the private health sector is often ineffective in LMICs, owing largely to poor enforcement capacity (Kumaranayake 1997). In the South African context, the private health sector has repeatedly instituted court action to overturn government regulations.

Strategic 'purchasing' of care?

Another approach is to purchase services from private providers, but strictly on terms that are in line with achieving public health objectives (i.e. strategic purchasing). In the South African context, this could *potentially* fast-track improved access to health services as the majority of most categories of healthcare professionals work in the private sector. The NHIF could draw on the human resources in both the public and private sectors to provide services for the entire population. However, this would undoubtedly require uncomfortable changes for private providers, who focus on curative care, seldom see some



Image B5.1 Community health workers at a meeting in South Africa (Louis Reynolds)

of the conditions that are key contributors to the burden of disease for the majority of the population (such as tuberculosis), and are concentrated in the largest urban areas. The NHIF, as an institution that would have the major share of funds available for health services, would effectively ‘hold the purse-strings’ and be in a powerful position to influence the behaviour of providers (public and private).

In order for this strategic purchasing approach to dealing with the reality of the existence of a large private health sector to be successful, there are certain prerequisites or ‘non-negotiables’. First, a strong, well-distributed public delivery system is essential and must be the backbone of the universal health system. Nothing would challenge the power of private service providers as much as quality, accessible public sector health services. Secondly, purchasing of services from private providers should occur where this would further the goals of the universal health system. For example, priority should be given to purchasing from private providers in geographic areas where there is inadequate public sector service delivery capacity and not in areas where there is an oversupply of service providers relative to the population to be served. Thirdly, the process of drawing on the human resources currently located in the private sector must be undertaken in a way that is subject to the public health system ethos (e.g. provision of comprehensive promotive, preventive, curative, rehabilitative and palliative services; working as a member of a team of health workers; etc.). Fourthly, the emphasis should be placed on purchasing services from primary healthcare providers (e.g. general practitioners, primary dental practitioners, physiotherapists, optometrists, pharmacists and pharmacy assistants, etc.). This is in line with the emphasis on strengthening primary healthcare services and ensuring primary-care gatekeeping to higher levels

of care. Conversely, great caution should be exercised in purchasing high-technology diagnostic, specialist and inpatient services from private providers to ensure that the quantity of secondary and tertiary services available is in line with what is determined as being needed through appropriate referral practices.

Finally, the design of the NHIF must be such that it is empowered to undertake strategic purchasing and can be held accountable for its use of public funds. As a single purchaser, it can wield considerable power in determining how providers will be paid and payment levels; it can avoid the current pitfalls of the private health system of paying on a fee-for-service basis and having providers dictate their fee levels. The NHIF should also be empowered to ensure that service delivery by public and private providers from whom services are purchased is subject to standard treatment guidelines and other measures to promote efficiency and quality in services. There would also need to be routine monitoring of services provided to assess that they are in line with population needs, and not the result of supplier-induced demand, and adhere to standard treatment guidelines. Most importantly, there must be mechanisms for strong governance and public accountability, to ensure that public funds are used appropriately and that access to quality health services in line with the health care needs of the population is being achieved. Importantly, the NHIF must not be vulnerable to ‘capture’ by the private sector; its integrity in serving the public interest must be secured. (See also Chapter B1 regarding other issues related to the role of government as a ‘purchaser’ of healthcare services.)

A key assumption underlying this visualization of the role of strategic purchasing (including selective purchasing from private providers) is that an appropriate balance in the distribution of total healthcare expenditure between public funds and private voluntary insurance schemes is restored. The success of strategic purchasing in addressing challenges posed by the large private provision sector is critically dependent on the NHIF ‘holding the purse-strings’ for the majority of healthcare financing. There is clear evidence that many medical scheme members are concerned about the high and rapidly increasing cost of belonging to such schemes and would relinquish membership if the NHIF ensured access to quality services at lower cost (McIntyre et al. 2009).

There are considerable potential risks and obstacles to achieving a universal health system in South Africa. Nevertheless, the status quo cannot remain. The experience of South Africa in pursuing the proposed set of reforms will provide valuable lessons for other low- and middle-income countries that have large private health sectors.

Notes

¹ The use of the term NHI is a political artefact, in that the ruling party committed to introducing an NHI before detailed proposals on the most appropriate health system reforms

had been developed, and has continued to use the terminology initially adopted. Unfortunately, the term NHI has created considerable public confusion about the nature of the

proposed reforms, and is contributing to international concerns that the drive for 'Universal Health Coverage' (UHC) is being equated with introducing or expanding the role of insurance schemes.

2 There is considerable debate at present about the concept of 'Universal Health Coverage' (UHC) and what it may or may not imply in terms of health system reform. This chapter, instead, uses the term universal health system, and interprets this to be founded on two fundamental principles: 1) Universalism, where everyone is entitled to the *same* health services (in terms of range, clinical quality of care and ability to access); 2) Social solidarity, where health services are funded on the basis of financial means (with cross-subsidies from the affluent to the impoverished) and accessed on the basis of need (with cross-subsidies from the healthy to the sick or those in need of preventive services).

References

- Cleary, S., S. Birch, N. Chimbindi, S. Silal and D. McIntyre (2013) 'Investigating the affordability of key health services in South Africa', *Social Science and Medicine*, 80: 37–46.
- Council for Medical Schemes (2013) *Annual Report, 2012–13*, Pretoria: Council for Medical Schemes.
- Department of Health (2011) *National Health Act (61/2003): Policy on National Health Insurance. Government Gazette 34523*, Pretoria: Department of Health.
- Drechsler, D. and J. Jutting (2005) *Is there a role for private health insurance in developing countries?*, Berlin: German Institute for Economic Research.
- Forslund, D. (2012) *Personal income taxation and the struggle against inequality and poverty: tax policy and personal income taxation in South Africa since 1994*, Observatory: Alternative Information Development Centre.
- Kumaranayake, L. (1997) 'The role of regulation: influencing private sector activity within health sector reform', *Journal of International Development*, 9(4): 641–9.
- McIntyre, D., J. Doherty and J. Ataguba (2012) 'Health care financing and expenditure', in H. van Rensburg (ed.), *Health and Health Care in South Africa*, Pretoria: Van Schaik Publishers.
- McIntyre, D., J. Goudge, B. Harris, N. Nxumalo and M. Nkosi (2009) 'Pre-requisites for National Health Insurance in South Africa: results of a national household survey', *South African Medical Journal*, 99: 630–4.
- Mooney, G. H. and D. E. McIntyre (2008) 'South Africa: a 21st century apartheid in health and health care?', *Medical Journal of Australia*, 189(11/12): 637–40.
- National Treasury (2012) *2012 Budget Speech: Minister of Finance*, Pretoria: National Treasury.
- People's Health Movement (2013) Testimonies from community care workers, meeting convened by People's Health Movement, Wellness Foundation, Community Care Workers' Forum, 25 May.
- Silal, S., L. Penn-Kekana, B. Harris, S. Birch and D. McIntyre (2012) 'Exploring inequalities in access to and use of maternal health services in South Africa', *BMC Health Services Research*, 12(120).
- Vanek, M. (2012) 'SARS uncovers 1000s of missing rich tax cheats', *Moneywebtax*, 13 January.