



The Centre for Development and Enterprise



REFORMING HEALTHCARE IN SOUTH AFRICA

What role for the private sector?

This is an executive summary of **CDE Research report no 18**, *REFORMING HEALTHCARE IN SOUTH AFRICA: What role for the private sector?* (November 2011). The full-length publication is available from CDE, and can also be downloaded from www.cde.org.za



INTRODUCTION

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

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

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

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

THE CHALLENGE OF HEALTHCARE REFORM

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

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

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



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

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

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

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

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

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

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

As we shall see, the private health sector itself is in need of reform to maximise its contribution to overall health sector performance. The key issue is to address price escalation which threatens the viability of the



sector and limits access to private healthcare. Dealing with this requires stimulating competition, encouraging innovation in products and services offered, addressing perverse incentives as well as encouraging primary healthcare and early intervention instead of expensive specialist and hospital-based care.

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

SOUTH AFRICA'S CRISIS OF HEALTH OUTCOMES

According to the NHI Green Paper, South Africa spends 8.3 per cent of gross domestic product (GDP) between public sector (4.2 per cent) and private (4.1 per cent) sectors. A further 0.2 per cent (in foreign aid and the NGO sector) makes up a total of 8.5 per cent, which is extremely high expenditure, especially for a middle-income developing country. The World Health Organisation (WHO) recommends that countries spend at least 5 per cent of GDP on health and average expenditure for middle income countries is 5.8 per cent

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

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

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

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



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

SOUTH AFRICA'S PUBLIC HEALTH SECTOR

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

According to the National Treasury, in 2010 the public health sector consumed 4 per cent of gross domestic product (GDP) and 14 per cent of annual government expenditure. That share is set to rise. The source of this funding is taxation, a substantial portion of which is progressive income tax through which the better-off, who by and large do not use public sector health facilities, significantly subsidise those who do use them. As a result, South African healthcare financing is highly redistributive. One of the substantial achievements of government policy since 1994 has been to re-orient public health expenditure away from the affluent towards the poor.

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

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

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



PRIVATE SECTOR HEALTHCARE IN SOUTH AFRICA

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

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

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

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

HEALTH SYSTEM REFORM

South Africa has a very substantial burden of disease, not only from HIV and AIDS but also from preventable conditions arising from poor sanitation, nutrition and other conditions of poverty, as well as a growing burden of non-communicable disease affected by lifestyle. In the face of such a disease burden the essential task of health sector reform is the rehabilitation of public sector healthcare from its current dysfunctional state. Its principal problems are leadership, organisation and management. NHI is a financing mechanism through which, according to the Green Paper, the government hopes to double public expenditure on health in real



terms by 2025, while greatly shrinking private expenditure, so that the country's overall spending on health will fall from the present 8.3 per cent of GDP to 6.2 per cent.

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

PUBLIC SECTOR REFORM

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

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

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

There is no hope of quickly making good this shortfall from South Africa's existing resources. According to the Department of Health, internal training capacity for doctors has increased from just over 1 100 graduates in the year 2000 to 1 309 in 2008. Many of these graduates emigrate. An obvious solution is to embark on a vigorous recruitment programme targeting foreign health professionals. However the Department of Health's most recent human resources document (August 2011) will go no further than 'A rewriting of the legislation and new management processes on recruitment and retention of foreign trained health professionals are required.' The Department of Health Human Resources for Health Strategic Plan (2006) said the same thing without practical effect being given to the promise.

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



NATIONAL HEALTH INSURANCE (NHI)

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

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

- *Costing:* the distribution of sources of new funding between income tax, VAT, and/or a dedicated NHI contribution; whether a general increase in taxation will be needed or not and how affordable significant new funding will be, given South Africa's small pool of personal income tax payers
- *Concerns over government capacity to run an NHI fund efficiently and cost-effectively:* critics believe that the government has underestimated how much such a complex scheme, covering the entire population will cost to run; there is a risk that fraud (already a massive problem in both public and private sectors) will be a serious threat
- *The effects on the insured population:* will they be persuaded to opt for their NHI rights and forego private insurance, or at substantial sacrifice of other expenditure (with knock on effects in the wider economy) pay their mandatory contributions and private health cover?
- *The effects of the single purchaser system on private providers:* a central part of the government's case for NHI (rather than other avenues of health policy reform) is that the NHI scheme will be the sole, or at any rate hugely dominant, purchaser of healthcare for the whole population. The rationale is that its power to dictate will significantly and painlessly lower healthcare prices. This is something of a gamble. It remains to be seen whether the government is correct in assuming that there is so much fat in private sector pricing, in the shape of excess profits and remuneration, that this can be done. Research on private sector pricing commissioned by CDE and documented in the main report suggest that this is not so. Equally it remains to be seen whether private sector providers will simply submit to the superior power of a single buyer and have no other options
- *There is little evidence that a single payer produces better cost containment than do multiple payers, but much to suggest that public dissatisfaction is considerably increased because single payers are far less responsive to consumer needs*



- *The proposals so far have been vague and uncertain about the role of the private sector: messages have been mixed; at best the government recognises that the private sector can have an important role to play, at worst it blames the private sector for all the ills of the public sector: As this report makes clear there is plenty to criticise in the private health sector: However what is missing is a strategic realisation that expansion of a reformed private sector and improvement of the public sector can be complementary rather than contradictory movements.*

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

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

RECOMMENDATIONS

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

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

GENERAL GUIDELINES

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

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

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



REFORMING THE PUBLIC SECTOR

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

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

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

As better stewardship and management permit, it should be possible to devolve accountability and decentralise authority, following the prescriptions of the 1997 White Paper. Regional and local experiments with specific ways of delivering care and encouraging prevention should be encouraged so that successful models can be taken to scale elsewhere.

HOW THE PRIVATE SECTOR CAN SUPPORT PUBLIC HEALTH SECTOR REFORM

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

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



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

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

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

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

REFORMING THE PRIVATE HEALTHCARE SECTOR

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

Helping markets work more efficiently

- Private hospitals cannot employ doctors and so have to compete with each other to attract them. They do this by investing in facilities and equipment in excess of objective needs. This drives up prices and encourages focus on specialised and hospital-based care over prevention and primary care. The existing fee-for-service funding framework provides little incentive to compete on price or innovate in delivery.



All of this needs to change. Private entities should be allowed to employ doctors. Other positive changes, including cost containment and innovation in the private healthcare sector by attracting low-cost multinational players, are less likely as long as it is not possible to employ doctors.

- All regulated processes connected with health – for example those relating to licences to open a private medical facility – should be simplified and their administration made as transparent as possible. Details of applications, decisions and timelines should be made public, to allow oversight by civil society.
- Increased competition in private healthcare will help put pressure on prices and encourage innovation in lower-cost delivery. Regulations should be reformed to allow healthcare companies from outside South Africa, for example, from India, where private healthcare delivery is notably innovative and cost-conscious, to operate in South Africa.
- Publication of price lists for medical services should be mandatory, as it is in Singapore. This should be combined with funding models that allow individuals to benefit from prudent expenditure, which will encourage shopping around in non-emergency cases. If private hospitals can employ doctors, instead of having to attract them through excessive investment in expensive equipment, this should reduce over-servicing and energise competition on price.
- Incentives should be developed for the private sector to innovate more on the supply side and specifically to operate a wider range of facilities, including lower-cost ones focused on primary care, such as day surgeries and outpatient facilities, with a greater role for general practitioners and nurses.
- Drastic steps should be taken to increase the supply of doctors and other medical professionals. This is essential for the health system as a whole, in order to reduce the scarcity value of doctors which currently helps drive price increases in the private sector. As we have already noted, joint public/private planning and initiatives on training are essential. Given the long lead times for health training, in the short term at least, immigration is quicker and considerably cheaper than relying exclusively on expanding our own output.

Reforming health funding

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



The following reforms would address this problem:

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

CONCLUDING REMARKS

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



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