The National Health Insurance:

Healing South Africa's Ailing Public Healthcare System?

Public Servants Association

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Acronyms

CDE	Centre for Development Enterprise
CMS	Council for Medical Schemes
GEMS	Government Employees Medical Scheme
HPCSA	Health Professional Council of South Africa
MCC	Medicines Control Council
MRC	Medical Research Council
NDOH	National Department of Health
NHI	National Health Insurance
NHLS	National Health Laboratory Service
PERSAL	Personnel and Salary Administration System
PMB	Prescribed Minimum Benefits
POLMED	South African Police Service Medical Scheme
PSA	Public Servant's Association
RAMS	Representative Association of Medical Schemes
RPL	Reference Price Listing
SANAC	South African National Aids Council
SAPPF	South African Private Practitioners Forum
UPFS	Uniform Patient Fee Schedule
WHO	World Health Organisation

Preface

Since the introduction of the Green Paper on the National Health Insurance two years ago, the voice of labour has not been at the forefront of those debating the merits and demerits of the proposed health initiative. In the main, the debate has been conducted as though it is a boxing ring in which government and the private sector exchange blows like enemies who are determined to annihilate each other. As a result, an important national matter such as healthcare has been victimised by attempts to prove who is right and who is wrong.

As the Public Servants' Association, we do not believe that discourse on the health of the people of South Africa should be victimised like grass when two elephants – government and the private sector – fight. This weighty matter has implications for sectors of our society far beyond profit makers and those who run the state. If implemented, the NHI will affect our members, too. And so will it impact on the general health of the majority of South Africans. This is precisely the reason why we deemed it necessary to contribute to the debate. Hopefully, participants in the discourse on the National Health Insurance will derive substantive value from this monograph, which encapsulates the perspective of our union.

Introduction

On 12 August 2011, the National Department of Health (DOH) released a Green Paper on the National Health Insurance (NHI). The Paper proposes far-reaching reforms with potentially serious implications for ordinary citizens, labour, medical aid schemes and the private healthcare sector as a whole. Since the release of the Paper, a national debate has been raging, focusing on specific aspects of the proposed NHI. Unfortunately, the debate has been approached by most participants from the polarised standpoints ofthe public healthcare system versus the private medical health sector.

The polarisation of the debate between the private and public sectors has not only revealed the adversarial relationship between the two sectors, it has also highlighted an on-going phenomenon in South Africa – the existence of a two-nations state. On the one hand is a public state, run by government. In the main, this state is characterised by dysfunctionin public institutions, i.e. public schools, public hospitals, public transport etc. Alas, this public state serves the majority of South Africans, mainly the poor. On the other hand is the private sector, which is independent of government, albeit regulated by it. While the private sub-state is characterised by efficiency and quality of services, it is inaccessible to the majority of citizens, as itsfees are far beyond the pocket of the poor in society.

While some have been asking if the NHI would yield better benefits for public servants, others are curious about the impact it would have on the disposable incomes of many employees who are already subscribers to a variety of medical aid schemes. The idea of a national health insurance has also induced anxiety on the part of some workers as to the prospects of paying for private medical insurance and the NHI simultaneously. Others are concerned about the protection of their right to access quality healthcare under a new NHI regime.

These are genuine questions preoccupying the minds of ordinary public servants as the debate on the NHI rages on. This monograph deals with these and other pertinent questions. It is meant to offer the PSA's perspective. The strategic aim is to rescue the current debate from the marsh of the "us versus them" that is preventing real movement to the higher planes of national consciousness.

South Africa's public healthcare system in context

South Africa's public health service is organised around three tiers – national, provincial and district. There are nine provincial departments divided into 53 districts. The National Department of Health is responsible for policy stewardship and for the distribution of provincial budgets. Provinces and districts constitute the coalface of service delivery, including the maintenance and functioning of provincial hospitals and the provision of primary care.

Health services are also devolved into three levels; level one being the primary health services that are provided predominantly by the district and municipal clinics.Hospitals provide secondary and tertiary health services. There are nine academic hospitals which also fall under the control of the provinces.In 2010, there were approximately 4 200 public health facilities in South Africa.

As political head, the Minister of Health has jurisdiction over both the public and private sectors, and is assisted by the Director General who leads an elaborate administrative architecture.At lower levels, each line-function provincial department has its own Member of Executive Council (MEC) who takes political responsibility for health.

Regulatory and institutional organisations that fall under the Minister of Health include the Health Professions Council of South Africa (HPCSA), the Council for Medical Schemes (CMS), the National Health Laboratory Services (NHLS), the South African Medical Research Council (MRC), the Medicines Control Council (MCC) and the South African National AIDS Council and Trust (SANAC and SANAT).

Each of South Africa's provinces is responsible for its own budget and pays for its own provincial and district health services.The funds come from a variety of sources, the largest of which takes the form of a grant from the National Treasury. As the wealthiest country in Africa, South Africa's allocation to the public health sector as a percentage of GDP is 4.2%. By comparison, this is more than most developing countries. For example, Kenya's allocation is at 1.7%, Egypt at 2.4% and Nigeria at3.9%.

Beyond Africa, South Africa's spending on public health also compares favourably among its peers. The country spends R2,766 per person per year on public health, while Thailand spends R1,700 and China R846.[1] But all of these countries have better healthcare indicators than South Africa. This suggests strongly that the problems affecting the public sector in South Africa are not due to insufficient funding.

For South Africa, access to healthcare is not a major issue. The greatest challenge is the poor quality of healthcare received from public health institutions. For example, the country's population per clinic ratiois not far from the World Health Organisation (WHO) guidelines of 10 000 per clinic. Already in 2010, people per clinic ratio was 13 718.[2]While on paper South Africa has universalised access to healthcare, the quality of healthcare remains less than ideal.

The South African public health services provide exclusive healthcare to about 66% of South Africa's 54 million people, the majority of whom are poor and pay very little for the services received.The introduction of district based system for healthcare deliveryand the roll out of primary healthcare services were commendable innovations by the Department of Health since 1994. Although these innovations have in the main been supported by legislation, implementation has been poor, marred by underutilisation and, in other cases, characterised by the abuse of resources.

In properly functioning public healthcare systems, such as those of Europe, members of the middle class do not pay extra fees for their health and that of their families. This is not the case in South Africa. There is a general preference on the part of the middle class and the rich for health services provided by the private health sector. This is despite the fact that it is taxes from wealthy citizens and the middle classes that sustain the public healthcare system.

Essentially, the increasing number of people serviced by the private sector, estimated at 8.2 million, is an indication of the deepening crisis facing public health in South Africa.[3] This crisis needs further exploration.

A public healthcare system in crisis

It is standard in the medical profession always to diagnose an ailment before prescribing a cure. The PSA similarly poses the question: What is the aetiology of South Africa's ailing public healthcare system?

The advent of democracy in South Africa heralded a new Constitution which recognises access to healthcare as a fundamental human right. Thus, post-1994, the democratic government introduced a number of measures towards the realisation of this Constitutional right. Among the initiatives introduced were free primary healthcare services, the rolling out of public immunisation programmes, the provision of essential drugs in public facilities, and the introduction of compulsory community service programmes for graduating health professionals. These and others were good intentions to ensure the provision of quality public healthcare in South Africa.

The initiatives notwithstanding, South Africa's public healthcare system is in bad shape. It is crippled by a chronic shortage of medical doctors, poor management of hospitals, mismanagement of funding, and the burden of diseases. Thus the human resource strategy of the DOH could not have been more apt in describing the aetiology of South Africa's ailing public healthcare system,

> *The past fifteen years have been underscored by health workforce redundancy and vacancy freezes, staff shortages, graduate unemployment, and cuts in education and training provision. This has led to worsened health outcomes and drastic inequalities to access to care between the public and private sectors and between rural and urban areas.*[4]

All these have resulted in the loss of confidence in the public healthcare system, on the one hand,and the concomitant mushrooming of private healthcare institutions, on the other. Access to quality healthcare has thus become a privilege enjoyed by the few and no longer has the full status of a right as enshrined in the country's Constitution.

There is no better indicator of a country's state of public health system than the health of its people. In South Africa, life expectancy has been going down, estimated to have decreased from 65 years in 1994, to 45 in 2007. Although it went up to 56 in 2009, it again dropped to 54 in 2011.[5] This means South Africans die at a younger age than in other BRICScountries, where average life expectancy is estimated at 65 years.High rates of deaths in public hospitals cannot give hope to the sick and their families.

Statistics on infant mortality in South Africa do not communicate a positive message.There were 41 deaths per 1 000 live births in 2010, while under-5 mortality rate was 57 per 1 000 live births. Maternal mortality ratio was 310 deaths per 100 000 live births. There is indeed a direct link between infant, maternal mortality and a bad state of public healthcare system.

Some of the country's health problems are due to bad management. In February 2013, newspaper reports revealed shockingly that a nurse, with neither managerial nor administrative experience was appointed to act as hospital manager in the George Masebe District Hospital in Limpopo.This was when four infants died due to negligence on the part of hospital management.[6]At Baragwanath Hospital in Gauteng, three new born babies were found placed in cardboard boxes instead of cribs because the hospital management had no budget to buy enough cribs.[7]

Financial mismanagement takes the share of the country's health problems. Various provincial departments of health recently owed approximately R1.8 billion to the National Health Laboratory Services. A report by the Auditor-General in 2011 painted a worrying picture of the finances and administration of the Gauteng Department of Health. According to the report, this department faced R875 million in lawsuits.It wasted R217 million in fruitless expenditure, failed to provide sufficient audit evidence for tangible assets valued at R3.1 billion, and wasted R1.5 billion on the premature cancellation of contracts with service providers.[8] This is not evidence of a department whose finances are managed soundly.

The crisis facing public health facilities in Gauteng led to an intervention by the national government in 2010. This notwithstanding, shortages of immunisation supplies and cases of stillborn babies due to negligence in the management of hospitals have not disappeared. Alarming as the situation in Gauteng is, it is not the worst. Other rural province such as the Eastern Cape and Limpopo face deeper crises.

The burden of disease has also put a strain in the public healthcare system. South Africa accounts for 17 % of HIV infections in the world, and has the highest TB and HIV/AIDS co-infection of 73 %.[9] It is said that non-communicable diseases, for example, high blood pressure, diabetes, chronic heart diseases, etc. contributed 28 % to the burden of diseases in 2004.[10] The high prevalence of these and other killer diseases is a symptom of an ailing public healthcare system, failing to cope with the demand for healthcare.

Public hospitals have been struggling to cope with the high demand for healthcare. There were only 342 public hospitals with about 100 000 beds in South Africa by 2009. Meanwhile, it took about 24 hours a day for Doctors to admit 50% of people in hospital beds. In a report presented to Parliament in 2009, Prof. Bongani Mayozi of the University of Cape Town painted a bleak picture of very sick people sitting on chairs, some lying on a trolley for 24 hours waiting to be admitted. According to Prof. Mayozi, "Some people wait up to three days to get into a bed. We regard this situation as completely unacceptable, something that you would not wish on your mother or father."[11]

For someone detached from the reality of South Africa's public healthcare system, the picture painted by Prof. Mayozi may appear sensational and exaggerated.Yet this is part of the daily experiences of ordinary South Africans yearning for quality healthcare all over the country. It is indeed an experience no one would wish on their relatives.

So dysfunctional is the public healthcare system that the Constitutional Court had to make a scathing judgement in a case of *Law Society of South Africa and Others v Minister of Transport and Another*,2011 (1) SA 200 (CC). The case was about the treatment of victims of road accidents in public hospitals. The Constitutional Court found that (a) Public health institutions are in certain material respects "not able to provide adequate services crucial to the rehabilitation of accident victims who are permanently disabled"; (b) "A quadriplegic or paraplegic is constantly at risk in a State hospital as a result of the chronic lack of resources, paucity of staff and inexperience in dealing with spinal-cord injuries"; (c) there were "serious deficiencies within the State health care centres" and there are "vast disparities between the public and private sector"; (d) The National Plan for the Efficient and Equitable Development of Tertiary and Regional Hospital Services of 2004 "frankly confesses to serious systemic challenges due to chronic underfunding and an ever increasing demand for services. It recognises that this under-resourcing of public health care establishments leads to poor quality of care, substantial geographic inequality of care, poor referral systems between regional and tertiary hospitals and a lack of patient transport"; (e) The Minister of Transport and the Road Accident Fund "did not meet head-on the complaint that quadriplegic and paraplegic road accident victims would not easily survive the health care services at public hospitals"; (f) The Road Accident Fund's use of the UPFS tariff as a measure of compensation for medical treatment for road accident victims gave rise to inadequate compensation and was irrational.[12]

Given all this, how are we to expect the public to have confidence in the public healthcare system? The public is losing confidence because of poor service and unmitigated dysfunction in public institutions. For members of the middle class and the rich who can afford it, access to private medical care is therefore an escape from the undesirable state of public institutions to a functioning private state. The tragedy is that the poor have no option; they remain trapped in the public state of dysfunction and inefficiency.

The Minister of Health, Dr Aron Motswaledi,admits that South Africa's public healthcare system needs rehabilitation. When launching the Green Paper on NHI, he acknowledged that "it is true that the quality of care in public health institutions is often totally unacceptable and that radical measures are needed to put matters in order."[13] It is encouraging to hear the political head of our country's healthcare system speak like this. Recently, the Minister has backed up his positive statements by the appointment of appropriately trained managers and administrators to improve service delivery. This is a step in the right direction.

The need to improve the quality of public healthcare cannot be over emphasised, for there cannot be confidence in the public sector without improvement in this regard. Otherwise confidence in the public sector will continue to plummet while preference for the private sector would increase.

Making quality healthcare services accessible to the majority must be at the top of the country's national priorities. As the South African Private Practitioners Forum (SAPPF) suggests, emphasis should be placed on measures to ensure management accountability and to provide managers with the powers to run healthcare facilities without political interference.[14]

The scourge of corruption is pervasive in the healthcare sector. As the late Chief Justice Arthur Chaskalson reminded us:

> *Corruption and maladministration are inconsistent with the rule of law and the fundamental values of our Constitution. They undermine the constitutional commitment to human dignity, the achievement of equality and the advancement of human rights and freedoms. They are the antithesis of the open accountable democratic government required of the Constitution. If allowed to go unchecked and unpunished, they will pose a serious threat to our democratic state.*[15]

There is no doubt that corruption is among the major causes of the unending qualified audits disclaimers in the administration of our public healthcare system. All provincial departmentsof health, except in the Western Cape, have repeatedly had qualified audits from the Auditor General's office.

Given the bad state of South Africa's public healthcare system, characterised by the problems we have highlighted above, the question arises: will the NHI turn the situation around? This is precisely the question we confront hereunder.

NHI: claims and facts

> *The South African public health system stands on the edge of a chasm, which can only be bridged by new resources and decisive leadership…There is however the risk that the NHI will be viewed as the panacea for both financing shortfalls and health service deficiencies, and sight should not be lost of the fact that the NHI is essentially a financing mechanism … Of itself, it [the NHI] is not a national health priority.*[16]

The proposed NHI has been presented to the public like a magic wand that would wipe awayour country's public health problems.While the PSA is not emptily dismissive of the NHI, we do not believe that the implementation of the initiative will necessarily lead to the disappearance of all the problems currently associated with our national system of public healthcare. We concur with David Harrison's view – cited above – that, in the main, the NHI is a financing mechanism, not a panacea to the country's health problems.

Principles: old wine in a new bottle?

The proponents of the NHI make promiseswhose feasibility remains doubtful.For example, they promise to "ensure that everyone has access to appropriate, efficient and quality health services."[17] According to the Green Paper, the main intention of the NHI is to "improve service provision" in the health sector and bring about "equity and efficiency" in the system. All these are noble ideals that no reasonable person would disagree with. A fundamental question however remains – why have we failed to achieve these in the past 17 years of democratic governance? In other words, must we rest content with the mere promise that the NHI will overcome all the obstacles that have undermined the good intentions of previous Ministers of Health in the post-apartheid South Africa?

The principles that are said to be guiding the NHI are all laudable. Viewed closely, without being blinded by the enthusiasm that normally comes with the promise of something new, it is hard to differentiate NHI principles from those that have underpinned policy and legislation on public healthcare in South Africasince 1994. They are the following:

- the right to access;
- social solidarity;
- effectiveness;
- appropriateness;
- equity;
- affordability; and
- efficiency.

Memory is a reliable resource. From the early days of Dr Nkosazana Dlamini-Zuma to the fresh experience of the late Dr Manto Tshabalala-Msimang as Ministers of Health, the above-mentioned principles capture the essences of post-apartheid's grand pursuit in public health. Indeed, the PSA has been and continues to be supportive of such noble principles. But South Africa's experience over the past 17 years has taught us the dangers of enthusiastic gullibility. A healthy dose of scepticism is as important as a good measure of patriotic support for well-intentioned initiatives by government. What we must always keep in mind is that neither goodwill nor the abundance of money can replace the necessity for the development of adequate capacity and sound management in the provision of quality healthcare services.

The right to access and social solidarity are very important principles. Let it not be forgotten that these are the same principles that informed the National Health Act of 2003.Section 2(a) of the Act specifies that its objects are to "regulate national health and to provide uniformity in respect of health services across the nation by … establishing a national system which (i) encompasses public and private providers of health services; and (ii) provides in an equitable manner, the population of the Republic, with the best possible health services that available resources can afford"[18] However motivated later-day actors may be, there would be no basis to accuse those who have been grappling with South Africa's public health problems of ill-intentions.

As the demand for service increases, so must the state be capacitated to meet the demand.The principle of affordability has a flip side called sustainability, which must not be obscured by the enthusiastic spirit of the NHI. In other words, the service must be affordable, available and, more importantly, sustainable. While the emphasis placed on the affordability needs of the poor is necessary, it must not overshadow the needs of the practitioners to cover their costs for the services rendered. If this balance is not struck, there would be the greater risk of skills flight that South Africa cannot afford to ignore.

Effectiveness, it is suggestedby the NHI proposal, will be improved through the application of evidence-based interventions, strengthened management systems and better performance of the health care system. While we agree that these would improve effectiveness, it must be noted that none of these is of necessity dependent on NHI; they can be achieved outside the NHI.With or without the NHI, government has a constitutional obligation effectively to provide quality healthcare to all. The problems that led to the failure to achieve effectiveness in the healthcare will not vanish by the mere introduction of the NHI.

The case of Procrustes?

The NHI Green Papersuggests that the fundamental cause for the poor performance in the public healthcare sector is the existence of the two tier system of healthcare – private and public. Therefore, the Green Paper seeks "to eliminate the current tiered system where those with greatest need have the least access and have poor health outcomes" It further suggests that the funding arrangements only benefit those that are employed and who are subsidised by their employers. The PSA does not believe that throwing money at a problem will simply make the problem disappear. As we have demonstrated above, financial mismanagement is rife in the public sector. Those who believe the NHI must be used as a fundraising mechanism have a responsibility to convince the public that, once raised, the funds will not be mismanaged.

Attributing the problems afflicting the public healthcare system to private medical aid schemes seems absurd. It must not be forgottenthat private medical insurance is a voluntary option foremployees. Essentially, it constitutes an extra tax burden since employees already pay tax to the state, which tax revenue is currently used to fund, amongst other things, the dysfunctional public healthcare system. It is also worth noting that the current public health system policy compels persons earning above a certain threshold to pay for medical services at the prescribed rate as determined by the DOH. If such employees do not subscribe to a medical scheme, there are tax consequences attached thereto. In fact, the DOH's Uniform Patient Fee Schedule (UPFS) Policy of 2006 states that the subsidies in the public health service are structured in such a way that those earning above a certain threshold must pay in full or in part for public services, so as "to encourage those individuals to take out medical aid."[19]

This was a progressive policy decision made by government. The PSA supported it then and supports it now because it is in line with the objective to ensure that our members have access to quality healthcare.

The number of people benefiting from Government Employees Medical Scheme (GEMS) is perhaps testament to this. The annual report of the Council for Medical Schemes shows that GEMS alone had 1 663 075 beneficiaries in the 2011/12 financial year.

It is strange for the DOH to blame the failure of the public healthcare system on the existence of the private medical sector,while, at the same time, the official DOH policy is to encourage membership of medical schemes by those that are in formal employment, including public servants. The PSA is of the impression that the state is engaged in procrustean attempts to justify the political decision to establish an egalitarian healthcare system through the NHI.

According to legend, Procrustes was a robber from Attica, who chained his victims to an iron bed. If they were too tall, he chopped off the offending limbs to make them fit the bed, and, if they were too short, he stretched them until they fitted. This process of making evidence fit a preconceived diagnosis is in medical circles known as committing the crime of Procrustes. Similarly, the view that the poor performance of South Africa's public healthcare system is due to the existence of a two tier system seems designed to make evidence fit a wrong, preconceived diagnosis.

Funding is also not a major problem in the public healthcare system. An assessment by the Development Bank of Southern Africa found that "the health system is performing poorly as a consequence of factors under the control of government….more important than financial resources, the most important factor related to poor leadership and structural weaknesses in the institutional framework."[20]In response to the NHI Green Paper, the Helen Suzman Foundation alluded to "lack of governance and accountability, ineffective monitoring and evaluation, poor management, over centralisation, lack of implementation of existing policies, and corruption" as the major problems afflicting the public healthcare sector.

These problems are not insurmountable and cannot be addressed necessarily by introducing an NHI, or by throttling the private healthcare sector. Neither will the pouring of money into the public sector solve problems of poor leadership and structural weaknesses as identified by such credible institutions as the Development Bank of Southern Africa.

The money argument

The NHI policy paper suggests that lack of money is the cause of poor performance in the health sector. Yet, South Africa currently spends in excess of 8.3% of GDP on health, with the state responsible for about 4.2% and the private sector 4.1%. Despite this South Africa has worse health outcomes than other countries that spend less. The draft HR Strategy, published by DOH a few days after the Green Paper states that "South Africa's performance in terms of health outcomes when compared with peer countries, is extremely poor, with much higher levels of infant and maternal mortality. This reflects on poor productivity, poor design and poor management of resources and not necessarily only on the number of available professionals in the health sector."[21]

South African health care funding is derived from three major sources, which, as the Green Paper points out, is consistent with expenditure trends as reported by the World Bank. These sources are: public sector allocations derived from general revenue (not limited to the health allocation, but also health expenditure in public works, social development and welfare, the military, and other departments), private voluntary contributions in the private sector to medical schemes, and out-of-pocket payments. The 4.1% of GDP that is contributed by the private sector is private money and is therefore a saving to government, and is generally paid by the same individuals who, in addition to their voluntary medical scheme expenditure,contribute through their personal income tax approximately 78% of the taxes used to fund public healthcare services.[22]

Some commentators (the Green Paper authors included), refer to the inequity of the state spending on 84% of the population, almost the same as the private sector spends on the insured 16% of the population. They blame this unfair and inequitable spend between the two sectors on the existence of the private sector, and therefore blame the two tier system for the malaise in the public sector.

What these critiques are unwilling to admit is that they should not be conflating taxpayer's money spent by the state on behalf of the poor with private money spent by private individuals on their own health, and at little or no cost to the state. What is also usually ignored is that these same individuals who are paying for their own healthcare needs are also, through taxation, contributing the bulk of money that is supporting the public sector.

Sight should not be lost of the fact that the funding of the South African health system is currently highly redistributive, and characterised by a high level of cross-subsidisation. This follows from the approach of funding public health through tax revenues and making public health services freely available at the point of use (for those below a specified income threshold). As CDE recently stated, the source of public health 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."[23]

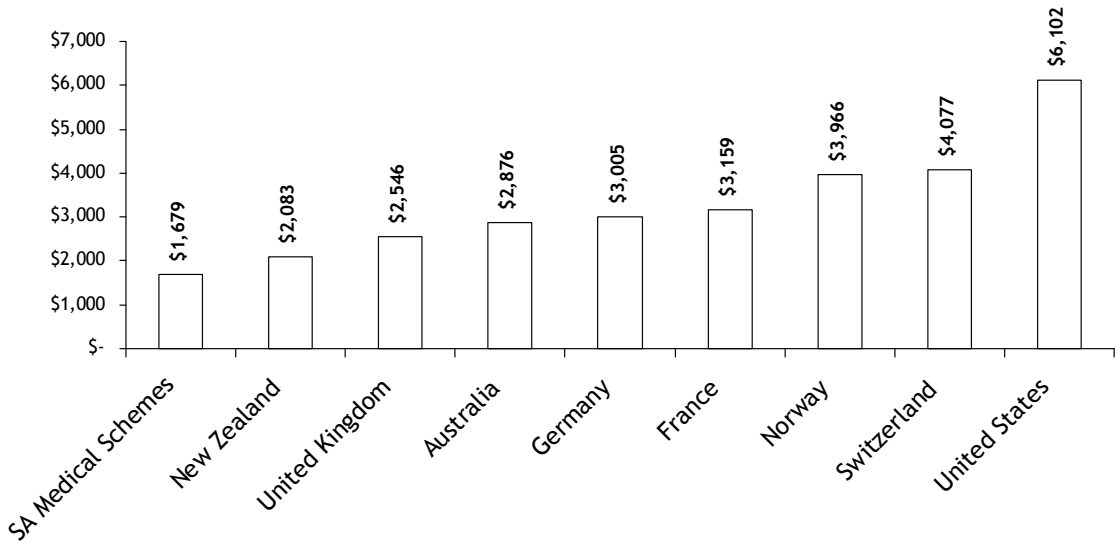
The Green Paper also criticises what it refers to as the doubling of medical scheme contribution rates over the past seven years, on the basis that this increase has not been accompanied by a proportionate increase in access to services. This contention is unfounded. In fact, increases in medical scheme contributions over the last decade have only risen (in real terms) by 27.3%, while the increase over the last five years has been 5.1% (these figures are based on a CPI/X adjustment rather than on medical inflation). As the Council for Medical Schemes noted in its 2010 Annual Report, increases in medical scheme contributions over the preceding nine years had "been similar to inflation".[24] It is unfortunate that the Green Paper paid no attention to this report.

Moreover, many of the factors that have contributed to the poor performance in the public sector have little or nothing to do with the existence of the private sector.

Factors such as the mothballing of wards and nursing colleges, have nothing to do with the private sector, but have damaged severely the state's capacity to provide appropriate, efficient and quality healthcare to South Africa's people.

By international standards, South African private healthcare is affordably priced and service provider fees are not inappropriately high. A 2005 survey showed expenditure on private healthcare in South Africa in 2005 compared favourably in relation to other developed countries. See figure 1 below.

Figure 1: Developed countries' health systems (in PPP adjusted US$)



Source: Adapted from S. van den Heever, 2009b

Medical scheme disbursements to providers have declined in real terms by roughly three fold over the past 40 years. We note in this regard that the Representative Association of Medical Schemes (RAMS) tariff in 1968 employed a unit value of 48 cents, which, if adjusted for inflation (i.e. CPI/X), translates to R20.72 in 2009 terms. This indicates that, compared to their colleagues of forty years ago, current healthcare professionals are poorly remunerated. Had rates of medical scheme reimbursement kept pace with inflation, the 2009 medical aid reimbursement rate would have been R20.72 per unit, as opposed to the R11.35 for consultations and R7.03 for procedures (as reflected in the 2009 RPL). This figure of R20.72 would, of course, be higher if VAT and medical inflation were taken into account.[25]

Costs and human resources

Very few people have asked the question: why do computers get cheaper and healthcare doesn't? William J Baumol has done so in his book titled "The Cost Disease." Baumol has turned the spotlight on an aspect of healthcare financing that most legislators and health economists have hitherto ignored. Baumol and his colleague William G Bowen have for several decades been interested in the phenomenon of why healthcare costs rise faster than inflation, coining "The Cost Disease" or what has become known as the Baumol Effect.

Baumol argue that rapid productivity growth in the modern economy has led to cost trends that divide its output into two sectors – the stagnant and the progressive sectors. It is an unfortunate reality that the goods and services supplied by the stagnant sector grow increasingly unaffordable relative to those supplied by the progressive sector over time. We are already witnessing this in the rapidly rising costs of a hospital stay and college tuition fees which are also quoted as examples of rising costs in two key stagnant-sector services. As a union representing workers, this is our site of struggle.

Because the CPI is the averageof all costs, fifty percent of all costs will be above the average and fifty percent will be below. Furthermore, because costs in the progressive sector are always falling due to improvements in automation processes, costs in the stagnant sector will continue to rise simply because services in the stagnant sector (such as healthcare) are people intensive and therefore not as amenable to cost saving through automation. For example, it takes as long today for an orchestra to play a Beethoven symphony as it did two hundred years ago, but the costs of the orchestra's performance today have increased well above CPI over the past two centuries. The PSA is fully alive to these dynamics.

It is suggested in the Green Paper that available financial and human resources are heavily skewed in favour of the minority of South Africans who can afford private care. According to the document, this is inequitable and discriminates unfairly against the poor.

However, information from the Government's Personnel and Salary Administration System (PERSAL) suggests that the majority of human resources are found within the public health care sector. For example, of the total of 156 030 nurses in the country, 120 023 work in the public sector. This is more than 77% of the total number of nurses in South Africa. The distribution of doctors follows the same pattern. While 61.9 % of general practitioners were in the state, only 38.1% operated in the private sector. Only the specialists were predominately in the private sector where there were 56.2% compared to 43.8% in the State.[26]Other than a generalised approach, the PSA believes that particular attention must be paid to the factors that repel specialists from working for the state.

Given that it has been government policy since 1994 to de-prioritise tertiary care in favour of primary care, the lower numbers of specialists in the public sector cannot be blamed on the private sector. Indeed, were it not for the existence of the private sector, many more specialists may have been lost to South Africa through emigration.

The figures we have presented here roughly match the patient demographic split between the public and private sector, and are accordingly not out of sync with that split.

Moreover, a consideration of comparative international ratios of health workers per population suggests that South Africa has national shortages in most categories of health workers.[27] There is obviously a need for more detailed research on these issues. What is urgent is clarity on how the NHI will address the limitation on human resources in the public and private sectors. For now, it does not, for example, deal with how private health care professionals can assist in addressing the shortage of human resources in both sectors.

The PSA is aware of the recently published draft human resources strategy document, the "Human Resources of Health South Africa 2030: Consultation Document V5 of August 2011", which will hopefully bring some important information to this debate, and is therefore to be welcomed.

It is however strange that this draft strategy seems to have been developed without taking into account the specific needs of the proposed NHI. While South Africa is, irrespective of the implementation of NHI, obviously in dire need of more and better quality human health resources, it is also clear that the NHI model will have specific implications for the human resource requirements. It is therefore unfortunate that neither the Green Paper nor the draft HR Strategy conducts a comprehensive analysis of the human resource requirements arising from NHI, and how those requirements are to be met.

If access to "appropriate" and "available" health care is to be achieved, there needs to be a comprehensive human resources strategy alongside any healthcare system reform. This strategy needs to take into account the length of time it takes to train those human resources, and thus needs to pragmatically engineer healthcare reform within that time frame so as to ensure practical access to healthcare services.

It is erroneous to suggest that the mere existence of the private health care sector is inequitable. If that were the case, almost every healthcare system where there is either private healthcare or limited private healthcare would be inequitable, including in those jurisdictions where the state seeks actively to partner with private healthcare in the delivery of health care services to its population. Most, if not all first world countries as well as the BRIC countries and a number of African countries, such as Kenya, Uganda, Nigeria and Mozambique, that have established publically-funded universal access health care systems, also make use of the private sector to varying levels to achieve a comprehensive level of health care for their citizens.

As we have pointed out, the PSA will support reforms in the healthcare sector that stand to benefit our members and society at large. Similarly if the NHI will "improve access to quality healthcare services" as purported in the Green Paper, the PSA will support it.

However, the proposed Risk Equalisation Fund and the Prescribed Minimum Benefit would be necessary in the private sector than in the public healthcare services. In fact, there should be no need to refer to "financial risk protection", as the public sector should provide quality services to all persons, including indigent persons who cannot afford to make any payment for healthcare, let alone cost-related payments for significant procedures and extended hospital stays.

In 2009,the University of Cape Town's Health Economics Unit produced a paper to examine which socio-economic groups bear what burden of funding health services. In their analysis – which has been widely quoted at the ANC General council in September 2010 – Ataguba and McIntyre concluded that there was a lack of cross-subsidies in the overall health system in South Africa. They highlighted that although healthcare financing is 'progressive,' this is largely due to the richest groups bearing the burden of medical scheme funding of which they are the exclusive beneficiaries of these funds. It is therefore "indisputable that benefit incidence in South Africa is inequitable and pro-rich."[28] But there is alternative evidence that suggest that the healthcare financing in South Africa is actually progressive. A 2009 study found that the "richest quintile finances 82.3% whilst receiving 36% of the healthcare benefits."[29]

The private sector: asset or liability?

The private healthcare sector does not only service 16.2% of the South African population as suggested in the Green Paper. Out-of-pocket expenditure and voluntary purchasing of private healthcare suggests that the number of individuals serviced by the private healthcare sector is far more than those who are medically insured. Many non-insured individuals access portions of their healthcare needs in the private sector, including those who make out-of-pocket payments together with a vast number of patients who receive free emergency medical treatment in that sector.

The figure of 16.2%, does not take into account the number of individuals who access healthcare through the Department of Defence (military personnel and their families), as well as the total health-related expenditure as provided in Social Services, Education, Public Works and Local Government. Not all of these are funded out of DOH's budget allocation. All of these factors reduce the burden on the public sector and should be considered when assessing figures on the usage of the public and private sectors. In this regard, it should be noted that the draft HR Strategy of the DOH suggests that the public/private healthcare split is approximately 65/35 and therefore contradicts the Green Paper alleged split of 16/84.[30]

Similarly, the Centre for Development and Enterprise (CDE) report on the NHI observes that "the true percentage of those who use the private sector wholly or in part is around 35 per cent."[31] Furthermore, the DOH's pamphlet entitled "National Health Insurance: Healthcare for all South Africans" published in September 2011, states that 68% of South Africans "rely entirely on public health services."[32] It is therefore generally accepted that the private sector services a great deal more patients than might be thought to be the case, if one only has regard to the number of persons that are medically insured.

The Green Paper suggests that NHI would have the net effect of extending coverage to all South Africans and of reducing the negative effect of out-of-pocket expenditure. In this regard it should be noted that South Africa's out of pocket expenditure is not exceptional by international standards.[33]

South Africa already provides universal access albeit imperfectly "through the current two tier system, with the tax funded public sector providing coverage to those unable to afford private care. Formally employed individuals and their families and those able to afford it are covered via contributions to medical schemes. The problem is therefore one of access and quality not coverage."[34] The deteriorating state of public healthcare facilities is an impediment to acceptable universal access.

We agree with the Green Paper's observation that "the national health system has a myriad of challenges, among these being the worsening quadruple burden of disease and shortage of key human resources."[35] These are the most pressing challenges of our times and remedies should urgently be found to curb them. In our view, demonising the private sector will not resolve these issues. We agree with the view that the reform of healthcare must be focused on the rehabilitation of public healthcare sector, boosting staff morale, and changing of attitudes to public service.[36]

The tendency to value political loyalty above competence in deploying cadres to key managerial positions within the health service, the closure of nurse training academies, poor managerial performance, infrastructure maintenance and procurement problems, and the freezing of posts within the public sector, are all examples of policy decisions and administrative realities that have contributed to the observable failures in the public sector. The private sector played no role in this.

Private healthcare servicesplay a complimentary role in many countries where NHI systems have been introduced. This is a fact acknowledged in the World Health Organisation's report.[37] However, we should not be oblivious to some of the imperfections in the private sector. The issues resulting in rising costs and inefficiencies in the private sector have been highlighted as some of the areas that need urgent fixing. The "lack of price competition and effective regulation"[38] need urgent attention. Hand in hand with reform in the public sector must go reform in the private health sector that will see the broadening of access to quality healthcare services.The PSA agrees with the CDE that "The key insight should be that extending private sector healthcare to a wider public is a step towardsrealizing universal access to quality healthcare, not a retreat from or postponement of this ideal. It is this ideal and not a narrow fixation on one or another institutional form of healthcare funding that should inspire South Africans." We therefore regard the private sector as an asset, not a liability.

The future of medical schemes

There is a suggestion in the Green Paper that the medical schemes industry is under pressure and that schemes are experiencing problems of sustainability. It is said that the number of schemes has decreased from 180 in 2001 to 102 in 2008. While this is true, the reason provided for the reduced number of medical schemes does not paint the whole picture.

The paper suggests the cause of decline to be due to “over pricing of healthcare”,which has forced schemes to either raise premiums or reduce benefits, and sometimes with the result that benefits are often depleted by mid-year.

The suggestion that the medical scheme industry is under pressure of sustainability due to over-pricing of health care is not supported by evidence. Perusal of the 2010/2011 Registrar of Medical Schemes' Annual Report shows that net surpluses increased from R972 million in 2009 to R2.85 billion in 2010, with an average solvency ratio of 31.6%, well above the required 25%.[39]

It is important to stress in this regard that the financial difficulties of a limited number of medical schemes may be due to a variety of factors other than so-called over-pricing of health care, such as mismanagement and high administration fees. It should also be noted that the Green Paper does acknowledge the impact that state policy has had on premium increases. In this regard, it is worth mentioning the effect of increasing the solvency levels of medical schemes to 25% and the requirement that medical schemes place significant sums of their resources into such accounts to meet that requirement.

Moreover, it should be noted that, despite a decrease in the number of medical schemes, the number of medically insured persons has grown steadily over the last decade, and levels of scheme solvency have improved. The decline in the number of schemes therefore does not reflect a decline in the medical schemes market. There is thus no basis to contend that medical schemes have been placed into difficulty through over-pricing of health services. The tables below show clearly that the medical scheme industry is sustainable and not in danger of market failure.

Table 1: Sustainability of medical schemes

	Beneficiaries	**Contribution R’000**	**Reserves R’000**	**Reserves/ Contribution**
Discovery	2 354 351	31 192 835	7 419 231	23.8%
Bonitas	609 211	7 209 866	2 781 407	38.5%
GEMS	1 663 075	17 397 970	1 493 157	8.5%
Bankmed	200 238	2931 340	1 668 286	56.9%
POLMED	483 379	5 615 811	2 628 109	46.%

Source: Council of Medical Schemes Annual Report 2011/12

Table 2: Medical schemes financial review

	2011	2010
	Billion (R)	**Billion (R)**
Net premium income	97,561	87,732
Relevant healthcare expenditure	(84,403)	(76,627)
Gross healthcare surplus	13,158	11,105
Administration & related expenditure	(12,123)	(11,395)
Net healthcare surplus/(deficit)	1,034	(459)
Investment / finance income	3,365	3,427
Net surplus of the year	4,290	2,852
Total member funds	36,842	32,603
Total hospital payments	34,143	31,115

Source: Council of Medical Schemes Annual Report 2011/12

The implementation of the NHI cannot be done without providing clarity on the role of the existing medical insurance schemes. It is suggested thatmembership of NHI will be mandatory for all South Africans, while at the same time members of the public may choose to continue their membership of voluntary private medical schemes. There will, however, be no tax subsidies for those who choose to continue with medical scheme cover. In our view, this requires further clarity.

Many countries, including developed and developing nations that have introduced mandatory health insurance, have allowed voluntary health insurance to co-exist in parallel. These systems can be complementary, supplementary or duplicative. In South Africa, for example, the current private healthcare system duplicates and in some instances supplements those services that are available in the public service.

The introduction of a mandatory tax that is equivalent to the average medical scheme premium may make continued contribution towards voluntary insurance unaffordable for many medical scheme members. In addition, many will be forced to use state facilities at a point in time when those facilities do not provide access to adequate quality health care.

This diversion of private resources into a public fund may offend the constitutional requirement that there must be *progressive realisation of the right of access to health care*[40]andimprovement in access for all South Africans. For those persons who are currently beneficiaries of medical schemes, their current access is likely to be diminished, should the proposals in the Green Paper be implemented as they are. The PSA is obviously worried about this prospect.

As the PSA, the right for our members to have medical health insurance or medical scheme is a right we are not prepared to compromise. Our struggles in the bargaining councils for our members to have medical aid schemes were precisely to ensure that the failure of the state to provide quality healthcare does not bar our members from enjoying this right.

We still believe that our members should be entitled to choose whether to use public healthcare facilities or not, and this should not be imposed on them.

The PSA believes that “choice” is a cornerstone of a democracy. There cannot be democracy without the right to choose; the infringement of this right borders on dictatorial tendencies. Our members are entitled to choose which hospital to go to, which Doctor to consult and which medical insurance they wish to join.

Clarity must also be provided on what would happen to member funds of approximately R32 billion, currently within the medical scheme market, especially the funds of those members that no longer maintain their private medical insurance and become dependent on NHI. The future of medical schemes in the public service, especially the Government Employees Medical Scheme (GEMS), the South African Police Services Medical Scheme (POLMED) and the schemes of state-owned entities should be clarified.

Moreover, if many South Africans elect to continue with their own private medical insurance in addition to making contributions to NHI, the net result for those persons will be a sizeable increase in health expenditure. A failure to place sufficient emphasis on the costs of NHI is to ignore the possible impact that the imposition of NHI will have on the economy as a whole.

The potential implications of the NHI for labour relations should not be underestimated. The majority of our members are already members of different medical aid schemes; to expect them to forego their schemes without a guarantee of access to quality healthcare in the public sector would be unreasonable.

We are concerned that many of our members will not afford to make payments for private medical aid in addition to their compulsory payments to NHI. Those persons will, in effect, continue to make equivalent payments but they will no longer have ready access to services that they were previously able to access. A large group of employees will thus be worse-off under NHI, as they will no longer be able to access the quality of care that they currently enjoy.

It must be noted that these current medical scheme members (and their dependants) will then become dependent on the public sector, which, in turn, will have to meet its existing demands as well as an added burden previously shouldered by the private sector. We are concerned that this issue is not considered in the Green Paper, and believe that it is critical for NHI cost analysis.

The implications for medical schemes are potentially dire, as they will be faced with declining membership (as members battle to meet their additional obligations to make NHI contributions), which could in turn lead to increasing prices. Declining medical scheme membership could, in turn, negatively impact on healthcare providers who are unable or unwilling to contract with the NHI, potentially resulting in these highly skilled persons exiting the profession or emigrating.

Given that a basic tenant of the financial model would appear to be the migration of the majority, if not all medical scheme members to the state service, the prospects for the medical scheme industry appear to be bleak. It is likely that the majority of current medical scheme members will find it impossible in our current financial climate, to pay both the new tax and continue their medical scheme contributions, in which case the casualty is likely to be the medical scheme. Declining memberships generally will see accelerated consolidations in medical schemes with weaker schemes closing and remaining members transferring to more robust schemes. Schemes may need to change their focus and concentrate on providing niche products that will not be offered in the NHI environment.

The PSA believes that rather than chastise the private sector, the most efficient way to achieve meaningful and quality universal coverage is through the strengthening of both the public and private sectors. We agree with the observation by the Ministerial Task Team that "the historical debate that has focused on polarised elements of the public and private sectors is not constructive."[41] We further submit that the rules governing the application of VAT to health services and the issue of tax subsidies should be treated in such a way as not to undermine or inflict harm to either sector.

The NHI Fund

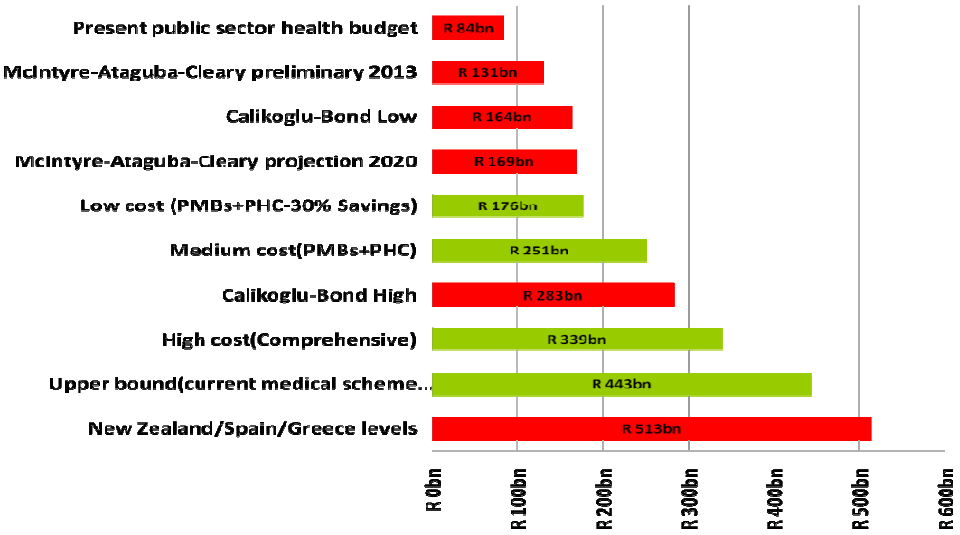
The Green Paper states that the NHI Fund will be a government-owned entity that is publicly administered. It goes on to provide that the NHI Fund will be a single-payer entity with sub-national offices. In this regard, the PSA would like to advise that the administrative responsibilities of a single fund model should not be under estimated. Government must therefore be prepared and be up to the task to ensure efficiency in the scheme. We concur that a multi-payer option must be explored to relieve the administrative burden in a single fund model. Given that health is a concurrent function shared between the national and provincial governments, this would be permissible.

It is suggested that the NHI fund will report to the Minister of Health. As a union operating in the public service, we are not necessarily opposed to this. However, a balance must be struck to ensure that the DOH does not act as both a referee and player at the same time. The establishment of the Office of Standards must also be immunised against undue political interference.

Can South Africa afford the NHI?

The total estimates for the NHI is R117.796 billion, comprising of total direct healthcare costs of R117 billion in 2012 and administration costs of R586 million. Added to this will be the operational costs estimated to start off at 0.5% and end at 2.9% of the total costs, i.e., R7.45 billion in 2025. This amount compares to medical scheme administration costs of approximately R7.8 billion in 2010 for administering 8.3 million people. Given the magnitude of the NHI, it therefore appears that the total NHI operational costs may have been grossly underestimated. NHI implementation costs are included in the figure below. These costs vary from R7.5 billion in 2012 to a high of R9.2 billion in 2024.

Figure2: Estimated NHI costs



Source: S. van der Berg and H. Mcleod

The question remains: how much healthcare can South Africa afford? In 2011, the state spent approximately R102.1 billion out of a total budget of R900.9 billion on health care, which was about 11% of the total budget. Given a population of approximately 50 million, the State is spending about R2 500 per person (the Green Paper puts it at R2 766, which is about US$350). In comparison, the United Kingdom spends about US$2500 and New Zealand US$2385. If one were to add the R89 billion spent in the private sector and distribute it over the entire population of 50 million it would increase the total spend available per capita by a further R1780 per person, bringing the total per head to R4280 (US$475.6), well short of the amount spent in the UK and New Zealand.

It is suggested that the increased spending on NHI will be partially offset by the likely decline in spending on medical schemes. The stated intention is that NHI benefits "will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply to draw on their [NHI] entitlements."[42] While this is a good intention, it may be a long while before such a choice is realised. Moreover, the realisation of this goal would require a significant increase in spending on healthcare.

Whilst the Green Paper asserts that the NHI is affordable for South Africa, a number of sources suggest that it is not. There are serious discrepancies between the projected costs in the Green Paper and the calculations performed by various experts. For example, health economists Servaas van der Berg and Heather Mcleod estimate that NHI will require R156 billion per annum, if based on current Prescribed Minimum Benefits (PMB), R251 billion for a basic benefit package and R334 billion for a comprehensive package.

Whilst the Green Paper envisages a comprehensive package of care, its calculations are far lower at R117.796 billion. Meanwhile Nicola Theron of Econex stated, at the 2010 Hospitals Association of South Africa conference, that one of the scenarios in Econex's research suggested that additional tax revenue of R244 billion would be required for the NHI to succeed.

While the model proposed predicts that resource requirements will increase from R125billion in 2012 to R214billion in 2020 and R255billion in 2025 expressed in real 2010 financial terms, by contrast, Servaas van der Berg and Heather Mcleod in August 2009 produced a number of cost Scenarios as follows:

a. Upper Bound Scenario:This scenarioapplies the R770 average per capita per month (2008) medical scheme premium to the whole population. Cost: R443billion in 2009, equal to two thirds of budgeted tax revenue.
b. High Cost Scenario:This scenarioapplies actuarial price curves for comprehensive cover to the whole population taking into account gender and age. Cost: R339billion, at 44% of tax revenue.
c. Medium Cost Scenario:This scenario applies price curves for Prescribed Minimum Benefits (PMBs) plus primary health care to the whole population (i.e. less than the "comprehensive range of health benefits" promised by the Green Paper). Cost: R251billion, at 33% of tax revenue.
d. Low Cost Scenario:This applies PMBs plus primary health care coverage to the whole population but also assumes a 30% cost reduction. Cost: R176billion, equal to 27% of tax revenue.

The upper bound scenario at R443billion is low by international standards, if it is compared with New Zealand, Spain and Greece levels at R513billion. Based on the above, it would appear that NHI is not affordable to South Africa even at the low cost scenario level. South Africa cannot afford to spend 27% of tax revenues on health and it is highly unlikely that private sector doctors would contract with NHI at prices that assume a reduction of 30% in payments on benefits calculated at 2008 medical scheme rates. Given that the cost studies mandated by the Reference Price Listing (RPL) process indicated that private sector medical professionals were significantly under-remunerated already, it is extremely unlikely that they would be able to meet their practice cost expenses, let alone earn a return on their investment or a reasonable income if their earnings were to be reduced to 2008 medical scheme rates, less a further thirty percent.

The current position is that South Africa only has 5.9 million registered taxpayers. A number of these registered taxpayers are currently unemployed and the number of actual taxpayers is thus probably substantially less than 5.9 million. This limited number of persons, pay about 34.3% of total tax revenue collected, (the top 10% of earners pay 55% of this). About 22.5% is contributed from companies and 24.7% from VAT.[43]There is thus limited room for more collections.

Added to the problem of the narrow tax base is the high level of unemployment. The prevailing economic climate has resulted in a serious contraction in the labour market in recent years, in the order of 13%.

Only 40.8% of working age people are employed, while 17 million people receive social grants. This makes South Africa the largest welfare state in Africa, funded by taxes paid by only 5.9 million people.

Nevertheless, South Africa's highly progressive tax system has managed to lift many millions of poor people out of the deepest depths of poverty. But the middle classes – a large part of it coming from the public service – who have borne the brunt of these taxes, are in consequence finding it increasingly difficult to keep up with the burgeoning increase in the cost of living. It is debatable if they will be able or prepared to accept a further tax hike of the magnitude needed to fund the NHI. The question therefore is: will this additional tax be begrudged?

The middle classes are under threat globally. Rex van Skalkwyk, a former South African Supreme Court Judge and author of "*Panic for Democracy"* wrote that the middle class in the USA "has been systematically destroyed through inflation and government policy…and that in the past two decades the US middle class has been eviscerated through its inability to keep up with the cost of living."[44]

Furthermore, South Africa has a very low GDP per capita, about US$350, compared, for instance, to that of the United Kingdom, which is about US$2 500, which seriously limits the country's ability to fund an overly ambitious healthcare reform as the NHI.

Against this economic backdrop, the PSA has real concerns relating to the affordability of the NHI as envisaged in the Green Paper, and this issue requires careful consideration. We note in this regard that it has been estimated that the implementation of NHI will result in an increase in personal income tax of 35%, if the full NHI funding is derived from personal income tax or a 20% increase in both VAT and personal income tax, if the cost is spread across these two taxes.

It is important to note that the cost of increased taxation (or a mandatory NHI contribution) on employers will ultimately be passed on to consumers through higher prices. This will, in turn, result in a loss to consumer welfare through the erosion of disposable income. The additional burden imposed on employers will also increase the labour cost which will, in turn, limit job creation and place downward pressure on salaries.

It is also suggested that the NHI will be free at a point of service. We know that there is no such thing as a free lunch, someone always pays. In this regard, the taxpayer will foot the bill on NHI. The thinking behind the concept of "free at the point of service" may seem to protect the poor against the inability to access care when needed. But in a situation where care will be curtailed simply because there are insufficient care givers to meet the demand, this laudable objective may have the very opposite effect to that intended. It might see much needed emergency care simply being crowded out by trivial complaints. In addition, the cost for this free service may result in less money being spent elsewhere.

Our reading is that the problems afflicting the South African public health sector are not due to a lack of money. As we suggested above, simply pouring more money into the state health coffers, through the NHI, will not fix the problems of mismanagement, maladministration and corruption.

Lessons from abroad

The benefits of a healthy population are recognised world-wide. The goal of universal access to quality healthcare for all, as spearheaded by the World Health Organisation, has been adopted by many countries as a laudable ideal to strive for.

However, there are two interesting trends developing, which are causing a convergence in healthcare systems internationally. Wealthy nations with well-established universal access healthcare systems funded by taxation are finding that affluence, aging and new technology together with what has become known in economic circles as the "Baumol Effect" or "the cost of disease", are driving up healthcare costs faster than incomes. This in return, is making it increasingly difficult to fund the increasing demand from taxation. As a result, many countries are turning increasingly to the private sector for assistance.

On the other hand, many poor countries with a poorly developed state health service are turning to their governments to provide access to better healthcare through programmes of healthcare reform. In almost all countries, healthcare funding is a combination of general taxation, private insurance, out of pocket funding, and, in certain instances, donor funding. That being the case, the demand for healthcare services exceed supply and, as a consequence, healthcare has become a major political priority throughout the world.

Yet, there is no single NHI model in the world. The methods of financing healthcare vary in different countries but are usually a combination of several sources, from general taxation, private and social insurance, out of pocket funding as well as donor funding in poorer countries. Most countries that have introduced some form of public funding of healthcare through taxation also rely, to some extent, on private insurance.[45]

Many developed countries, with the exception of the US, spend high levels of public finance on health, but a wide range of health systems have evolved in response to different needs. For example, the UK and France have public delivery systems, but Germany, the Netherlands and Belgium have regulated private health insurers.

Australia

The Australian Medicare system raises public funds through taxation, including a compulsory health tax levy on income. Medicare reimburses 75% of the scheduled fee for private in-patient services and 85% for ambulatory services, including GP consultations. There are out of pocket payments for pharmaceuticals not covered by the Pharmaceutical Benefits Scheme, dental treatment, the gap between Medicare payments and fees charged by physicians and for other services such as physiotherapy. The federal government is responsible for policy, but operational matters are the responsibility of the states.

Individuals with private insurance receive a 30% subsidy from the state. Despite there being universal access, about half of all Australians have private health insurance.

Canada

InCanada, Medicare is funded by a National Health Insurance from general and dedicated taxes and covers all physician and hospital services. The majority of the population also carry private insurance to cover dental care, prescription drugs, rehabilitation services, private nursing and private rooms in hospitals. However, all seems not well with the Canadian Medicare system. The system is already burdened by the rising costs of medical care and its ability to continue to deliver is becoming questionable. Costs have risen from 35% of provincial budgets in 1999 to 46% today, and in Ontario it is set to reach 80% by 2030.[46] This is becoming unsustainable for Canada.

United Kingdom

The United Kingdom has its National Health System (NHS) which is funded predominantly through general taxation. About 12% of the population carry supplementary private insurance. The NHS is free at the point of service, except for charges on prescription drugs, ophthalmic services and dental services.

Because of current fiscal constraints, public health services are being cut back by 2.7% per annum, and there is increasing use of outsourcing to the private sector as the government battles to keep within its budget. The Health and Social Care Act of 2012 recognises that the NHS can no longer afford to deliver all the services it used to and provides a framework for the private sector to offer a range of services with GPs acting as gatekeepers of the NHS budget with control over 80% of the budget.

Brazil

In Brazil healthcare reforms introduced in 1989 have been frustratingly slow. The reforms were too ambitious and there are suggestions that it should be modified to include only primary care for the poor and high tech and emergency care for all.[47]

The Brazilian system of healthcare is based on family health teams comprising doctors, nurses and community health workers with between 100 and 2000 families being assigned to each team. The South African Authorities have shown a keen interest in the Brazilian model, but need to be cognizant of the differences between the two countries. Brazil, for example, has twice the number of doctors per 10000 people with more than 63.9 percent of the economically active population being employed. Meanwhile, South Africa is producing 0,58 doctors per 1 000 people, and more than half of the population is economically inactive. According to Minister Aron Motswaledi, we need triple the number of doctors than we currently have to implement the NHI[48]. South Africa has a deficit of 83000 healthcare professionals and no capacity to overcome the problem in a short to medium term, and it would cost R40billion to fill the healthcare vacancies that are currently listed.[49]

India

In India which has the greatest burden of disease in the world and massive poverty, the state funds only 19% of the total healthcare budget with 81 percent of healthcare spend being by private health insurers or charities. Per capita government spend is US$19 compared with South Africa's US$338.

The South African Department of Health does not fare well when compared with other countries with similar health budgets. Rand for rand the South African public health sector outcomes, as measured by longevity, healthy life expectancy, infant and under 5 mortality are often worse than countries that spend less public money on health.

The lessons from other countries show that, even as they embrace the goal of universal access to quality healthcare for all, many countries are achieving this through partnerships between the private and public sectors. The financial burden that comes with egalitarian schemes such as the NHI is making other developing countries to reconsider their decisions to implement national health insurance schemes. South Africa can learn from others.

A PSA perspective: what is to be done?

There can be no argument that South Africa is in urgent need of healthcare reform. The argument in favour of the NHI as the most compelling strategy for effecting the needed reforms however is less clear. The Green paper has not in our view made a logical and coherent case for the introduction of a new funding mechanism, (which is all that NHI is), as the panacea for all the ills besetting our public healthcare sector.

Rehabilitation of public healthcare

The chief priority of health reform in South Africa must be the rehabilitation of the public health sector. This can be best achieved by a competent, nonpartisan public health service free of corruption and political interference. The two tier system of healthcare in South Africa is not the cause of the problems in the public health sector. Neither will the demise of the private sector through the introduction of a single purchaser model of the NHI and the imposition of a tax, equivalent to the average medical aid spend, produce the good and effective management and administration in the public healthcare sector.

It is the view of the PSA that government should revert back to the proposals in the National Health Act, which calls for a progressive realisation of the right of access to healthcare within the resource constraints of the state. Therefore, the mechanism proposed should by all accounts strive to make healthcare accountable, affordable and efficient through strengthening what works in the public sector and removing the deficiencies. This must be properly planned, implemented in a responsible, affordable and sustained manner. Our goal to achieve universal access to quality healthcare must not goad us into implementing any and every programme without due regard to the efficacy and effectiveness of programmes.

Principles to guide healthcare reform

We concur with the view of the South African Private Practitioners Forum that healthcare reform should be based on the following principles:

a. Transparent – all aspects of the proposal must be made known for a comprehensive and necessary understanding of the healthcare reform.
b. Consultative – throughout the process, all stakeholders should be engaged. This is at the identification of the problem, as well as the means by which it is to be addressed.
c. Researched– all recommendations should be supported by empirical evidence, based on actual figures, using universally accepted measurement tools.
d. Qualified – each recommendation (where applicable) should be validated, piloted if necessary, and tested prior to implementation.
e. Contextual – health care reform must be adapted to the South African population, mindful of its needs and cognizant of its unique health care design.
f. Flexible – it must be acknowledged that there is manifest uncertainty within any health care reform, and a great deal of adaption and change throughout implementation may be necessary.
g. Accountable – this requires monitoring and accountability of persons both for policy formulation and implementation. It also contemplates that decision-makers should be willing to adapt their policy in light of input from the public.

The PSA calls for the full implementation of the Human Resource Strategy to resolve the skills shortages in the health sector. There can be no reform of the public sector if shortages of skilled personnel persist. We need urgently to improve our graduate output in order to meet the demands in the health sector.

A merit based system

The key to public sector reform is 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, and loyalty in staffing.

We need a public health system that promotes merit over patronage. This means that the appointment of hospital staff, including managers, should be based on merit, qualifications and experience.Appropriate management across all levels of the health system is crucial for the successful reform of the healthcare system. Gambling with the lives of the people – including innocent children – through the appointment of unqualified and inexperienced people must come to an end.

This meritocratic system must be accompanied by a clear separation of political and managerial responsibilities to enable senior health managers to focus on service management. One of the major problems in our healthcare system is that regulatory institutions, hospital management, district structures, etc. have become highly politicised. A de-centralised district health system, with de-politicised governance structures, is ideal. This, in our view, would help rebuild public confidence in public health institutions.

A performance based management system must also be fostered to encourage accountability in the system. Equally important are strategies to improve the morale of healthcare workers. This should include, but not limited to, the affirmation of their value through incentives.

Improved regulation

There is also a need to tighten regulatory frameworks in the health sector. The pricing of medical care, hospital tariffs, professional fees, consultation fees, medical devices and medical products should be regulated. The current variation of these feesis testimony to the weaknesses and failures of existing institutions to ensure uniformity and eliminate abuse in the system.

Meanwhile, we need a body that can bring about predictability of medical expenses and reduce the over pricing of medical services. In this regard, the PSA calls for the establishment of a medical price regulatory body. This would necessitate the dissolution of the Medicines Pricing Committee, currently operating in terms of the Medicines and Related Substances Act. It would also necessitate the amendment of the Act to allow for these functions to be located in the new regulatory institution.

Securing the independence of institutions

The success of the NHI would depend on the strength of the institutions to support it. Such institutions as the mooted National Health Insurance Fund would need to be independent and maintain a degree of credibility. This would depend mainly on its governance model and the quality of managers appointed to lead such institutions. The PSA urges that these institutions should be immunised against undue political interference. The role of the DOH must be clearly defined and care should be exercised to ensure that DOH does not play a referee and a player at the same time.

Medical scheme benefits

The future of medical schemes, especially as it relates to employees' access to medical aid schemes is contestable. The PSA is concerned that the introduction of the NHI may reverse the gains our members have made thus far in respect of access to quality healthcare.

While we pledge our support to the rehabilitation of the public healthcare sector, our view is that our members, like other citizens,must reserve the right to choose whether to use public or private healthcare.This choice must not be punished by imposing an extra tax burden on employees. The choice should include whether to subscribe to a government related medical aid scheme or a private one.

Costing scenarios for public servants

The introduction of the NHI, especially with regard to public servants, is potentially going to be a labour relations issue.As the cost of living is rising and our economy is growing at a slow pace, an additional health insurance tax would impose a burden on workers.

The PSA proposes an independent committee should be constituted to conduct a costing exercise to explore benefits and losses that individual public servants would incur as a result of the NHI.

Single tier is not the answer

Our view is that the systemic issues in the health system relating to the lack of accountability and governance, poor management and inefficiencies should be prioritised to effect a meaningful reform of the sector. As we have argued above, we do not believe that the two tier system is the main cause of the ailing public healthcare sector.

Conclusion

The polarisation of the debate on the Green Paper on National Health Insurance has been allowed to unfold for too long. This is because the debate has been monopolised largely by two players – government and the private sector. While workers will certainly be affected by the introduction of a new healthcare regime, the voice of labour has been missing in the discourse.

Through this monograph, we sought to contribute to the voice of labour to the debate. As we have outlined herein, the PSA does not approach the debate from the rigidity of ideological dogma. Ours is to ensure that the interests of our members are not jeopardised. And, more importantly, we are interested in what will work better for the people of South Africa, not what justifies ideological positions. It is for this reason that we have in this monograph interrogated various positions offered by different stakeholders, and adopted flexible attitude to the discourse. We hope that, going forward, other participants in the debate will follow our open-mindedness as an example.

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